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The Use of Pretherapy Training to Enhance Group
Cognitive Therapy for Depressed Elderly Persons

David Latour

A thesis submitted to the School of Graduate Studies of the
University of Ottawa as partial fulfillment of the requirements for
the degree of Doctor of Philosophy



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This thesis is dedicated to my parents,
Joan Mary Gleason and Roméo Laurent Latour

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The Use of Pretherapy Training to Enhance Group
Cognitive Therapy for Depressed Elderly Persons

ABSTRACT

Depression is one of the most serious mental health problems among older adults. Outcome research currently supports the general effectiveness of psychotherapy for the treatment of late-life depression, but it is apparent from the high dropout rate and the low rate of complete remission that there is still considerable room for improvement. One method which has been used previously to enhance therapy is the preparation of clients before therapy begins. This approach may be particularly useful with a population of older adults, as they may harbor a number of misconceptions about the psychotherapeutic process. This study was devised to determine the effectiveness of a theoretically-based pretherapy training procedure in enhancing group cognitive therapy for depressed older adults. Twenty-nine subjects were randomly assigned to a pretherapy training condition or an attention-placebo control condition. All subjects were 65 years of age or older, had a score of 14 or higher on the Beck Depression Inventory or 14 or more on the Geriatric Depression Scale, and had no previous experience in psychotherapy or special knowledge of the psychotherapeutic process. Subjects in both conditions received four sessions in the pretherapy phase, followed by 12 sessions in the therapy phase. The pretherapy training procedure was based on Bandura's social cognitive theory

and included verbal persuasion (written and verbal material), vicarious experience (videotape), and performance accomplishment (structured group exercises). Four categories of dependent variables were examined: attendance and dropout rates, immediate effects of pretherapy training (i.e., knowledge about therapy and role expectations), observer ratings of in-therapy client behavior, and outcome as measured by subject and observer ratings of improvement throughout therapy. The results revealed no significant differences between conditions on attendance and dropout rates. Subjects in the pretherapy training condition had significantly greater knowledge of psychotherapy at the end of the pretherapy phase than subjects in the attention-placebo condition. The analysis of subject role expectancies in the pretherapy phase revealed that subjects in the pretherapy training condition exhibited significantly less audience-seeking expectancies than subjects in the attention-placebo condition. The process measure revealed that subjects in the pretherapy training condition made more statements related to the problems they were experiencing than subjects in the attention-placebo condition. There were no significant differences between conditions with respect to outcome. For the two conditions taken together, 53.7% of the subjects exhibited clinically significant improvement by the end of therapy. The results were discussed in terms of the appropriateness of measuring role expectancies, and suggestions were made for measuring other expectancies, based on social cognitive theory. The clinical implications of the

findings as well as the feasibility of in vivo use of pretherapy training procedures were also discussed.

Table of Contents

| | |
|--|-----|
| Dedication | ii |
| Acknowledgments | iii |
| Abstract | v |
| List of figures | xi |
| List of tables | xii |
| Introduction | 1 |
| Depression in the Elderly | 2 |
| Epidemiology | 2 |
| Etiology | 5 |
| Symptoms, Course, and Prognosis | 7 |
| Diagnosis | 9 |
| Treatment of Depression in the Elderly | 11 |
| Pharmacotherapy | 11 |
| Electroconvulsive Therapy (ECT) | 14 |
| Psychotherapy | 16 |
| Individual treatment | 17 |
| Group treatment | 21 |
| Pretherapy Training | 24 |
| Information Only | 25 |
| Modeling Only | 29 |
| Simulated Group Experience Only | 32 |
| Activity Combinations | 32 |
| Information and modeling | 32 |
| Information and simulated group experience | 33 |
| Information, modeling, and simulated group experience | 34 |
| Pretherapy Training and the Elderly | 35 |
| Analysis of the Literature Review on Pretherapy Training for Group Psychotherapy | 37 |
| Methodology | 37 |
| Dependent Variables | 37 |
| Pretherapy Procedures | 40 |
| Study Rationale | 44 |
| Hypotheses | 46 |
| Method | 47 |
| Subjects | 47 |
| Procedure | 49 |
| Pretherapy Phase Conditions | 51 |
| Pretherapy Training | 52 |
| Attention-Placebo Condition | 54 |
| Therapeutic Modality | 55 |
| Pretherapy Group Leaders, Therapists, and Raters | 55 |

Table of contents ix

| | |
|---|-----|
| Treatment Setting | 57 |
| Measurement Instruments | 57 |
| Telephone Screening Procedure | 57 |
| Inventory to Diagnose Depression | 58 |
| Mini-Mental State Examination | 59 |
| Knowledge About Psychotherapy Questionnaire | 60 |
| Psychotherapy Expectancy Inventory-Revised | 61 |
| Hill Interaction Matrix-Modified | 62 |
| Hamilton Rating Scale for Depression | 64 |
| Geriatric Depression Scale | 65 |
| Beck Depression Inventory | 66 |
| Data Analysis | 67 |
| Results | 71 |
| Sociodemographic Comparisons | 71 |
| Screening Comparisons | 72 |
| Hypothesis #1: Effect of Pretherapy Phase on Dropout and Attendance Rates | 73 |
| Hypothesis #2: Effect of Pretherapy Phase on Knowledge of Psychotherapy | 74 |
| Hypothesis #3: Effect of Pretherapy Phase on Role Expectations | 75 |
| Hypothesis #4: Effect of Pretherapy Phase on Level of Work | 77 |
| Hypothesis #5: Effect of Pretherapy Phase on Severity of Depressive Symptomatology | 79 |
| Hypothesis #6: Effect of Therapy Phase on Severity of Depressive Symptomatology | 82 |
| Discussion | 83 |
| Hypothesis #1: Effect of Pretherapy Phase on Dropout and Attendance Rates | 83 |
| Hypothesis #2: Effect of Pretherapy Phase on Knowledge of Psychotherapy | 85 |
| Hypothesis #3: Effect of Pretherapy Phase on Role Expectations | 86 |
| Hypothesis #4: Effect of Pretherapy Phase on Level of Work | 89 |
| Hypothesis #5: Effect of Pretherapy Phase on Severity of Depressive Symptomatology | 93 |
| Hypothesis #6: Effect of Therapy Phase on Severity of Depressive Symptomatology | 94 |
| Implications | 96 |
| Research Implications | 96 |
| Clinical Implications | 99 |
| References | 102 |
| Appendix A: Information and Informed Consent | 141 |
| Appendix B: Manual for Pretherapy Training Condition | 146 |

Table of contents x

Appendix C: Manual for Attention-Placebo Condition 182

Appendix D: Main Components of Group Cognitive Therapy 201

Appendix E: Group Cognitive Therapy Manual 212

Appendix F: Telephone Screening Procedure 249

Appendix G: Knowledge About Psychotherapy Questionnaire 253

Appendix H: Copyright Permissions 256

List of figures

| | |
|---|-----|
| Figure 1. Mean KAPQ scores | 116 |
| Figure 2. Mean scores on PEI-R APPROV subscale | 117 |
| Figure 3. Mean scores on PEI-R ADVICE subscale | 118 |
| Figure 4. Mean scores on PEI-R AUDIEN subscale | 119 |
| Figure 5. Mean scores on PEI-R RELAT subscale | 120 |
| Figure 6. Percentage of work statements for first 6 sessions | 121 |
| Figure 7. Mean scores on BDI | 122 |
| Figure 8. Mean scores on GDS | 123 |
| Figure 9. Mean scores on HRS-D | 124 |

List of tables

| | |
|--|-----|
| Table 1: Number of subjects in each phase by condition . . . | 125 |
| Table 2: Data collection protocol | 126 |
| Table 3: Sociodemographic characteristics of the total sample | 127 |
| Table 4: Screening comparisons for the total sample | 128 |
| Table 5: Number of dropouts in each phase by condition . . . | 129 |
| Table 6: Means and standard deviations for sessions attended by condition | 130 |
| Table 7: Means and standard deviations for KAPQ scores . . . | 131 |
| Table 8: Means and standard deviations for PEI-R subscales . | 132 |
| Table 9: Internal consistency estimates for PEI-R | 133 |
| Table 10: Subscale intercorrelations for PEI-R | 134 |
| Table 11: Summary of logit model for work dimension on HIM-M | 135 |
| Table 12: Observed frequencies for work dimension on HIM-M . | 136 |
| Table 13: Marginal frequencies for work dimension on HIM-M . | 137 |
| Table 14: Means and standard deviations for scores on the BDI, GDS, and HRS-D | 138 |
| Table 15: Intercorrelations for the three depression measures (BDI, GDS, HRS-D) | 139 |
| Table 16: Correlation between KAPQ and other measures | 140 |

**The Use of Pretherapy Training to Enhance Group
Cognitive Therapy for Depressed Elderly Persons**

During the last century and a half, the world population has increased from one to five billion (Robinson, 1988). In the same time period, the expectation of life has roughly doubled, from 40 to 80 years (Hayflick, 1982). This increase in life expectancy has brought about a worldwide demographic shift towards old age. In Canada, the percentage of the population aged 65 and older has been steadily increasing, and currently 3 million Canadians are in this age group (Statistics Canada, 1990a). Population projections predict that this trend will continue, such that the proportion of those aged 65 and over will grow from the present 11.3% to 15.5% in 2011 and to 24.5% by the year 2036 (Statistics Canada, 1990b). More than half will be 75 years of age or older. One logical implication of this increase is that the number of elderly persons presenting with psychiatric disorders will increase. There is also some evidence to suggest that the aged are frequent users of psychiatric services. In Canada, the elderly accounted for 18.9% of all admissions to psychiatric hospitals in 1986-1987, despite representing only 10.9% of the total population (Statistics Canada, 1987, 1990c). It is crucial, therefore, that research aimed at understanding and treating mental disorders in the aged be vigorously pursued, in

order to meet the future mental health needs of this growing segment of the population.

Depression in the Elderly

Depression is one of the most serious mental health problems among older adults. Some researchers also claim that it is also the most common (Butler, 1975; Gaitz, 1977). In a large geriatric mental health outreach program, depression ranked second to dementia among all mental disorders (Reifler, Raskind, & Kethley, 1982). So that the reader may appreciate the importance and complexity of late-life depression, this section will review the existing knowledge of this disorder under the following headings: epidemiology, etiology, symptoms, course and prognosis, and diagnosis.

Epidemiology

The paucity of Canadian research examining the prevalence of depression in the elderly forces us to look elsewhere for reliable data. The rates obtained from studies conducted mainly in the United States, which has a demographic profile similar to that of Canada, will therefore be presented here.

Statistics on the prevalence of depression among older persons tend to vary markedly as a function of measurement approach and criteria for diagnosing depression (Parmelee, Katz, & Lawton, 1989). Other difficulties include the relatively small number of studies which (a) were designed to assess depression in

the elderly from the outset, and (b) examined the contribution of aging in bringing about or maintaining depressive symptomatology (Newmann, 1989). Despite these problems, a number of tentative findings have been put forth.

Although few studies have examined the prevalence of depression among the institutionalized aged, the existing evidence suggests that depression is more common in this population than among elderly individuals living in the community (Hyer & Blazer, 1982; Parmelee et al., 1989; Snowdon & Donnelly, 1986; Teeter, Garetz, Miller, & Heiland, 1976). The only pertinent Canadian study (Bland, Newman, & Orn, 1988) reported that among community-dwelling elderly persons, the lifetime prevalence rates for major depression was 4.1%, while for mood disorders in general it was 5.3%. A recent review of prevalence studies (Cappeliez, 1988) reported that among persons aged 65 years or older living in the community, 20-25% suffer from dysphoria (dissatisfaction, lack of interest, moodiness, etc.) of various degrees of intensity. About half of these cases (10-15%) experience moderate to severe symptoms of depression, and approximately half of these (5-8%) suffer from "clinical" depression, i.e., they meet the DSM-III (American Psychiatric Association (APA), 1980) criteria for major depressive disorder. These numbers indicate that a large proportion of elderly persons do not experience symptoms severe enough to satisfy the DSM-III criteria, but that a large number do experience symptoms which

produce significant distress and can seriously impair their lives.

Other researchers have examined whether depression is more prevalent in the elderly than in younger age cohorts. Although early studies appeared to support this contention (Gurland, 1976), recent comprehensive reviews of the available research have found surprisingly little evidence that clinical depression is more frequent in the aged (Feinson, 1985; Newmann, 1989). Newmann (1989), however, in a review of studies which assessed depressive symptomatology (as opposed to clinical depression), came to the opposite conclusion, i.e., an increase in depressive risk in the last two decades of life, compared to the middle adulthood years.

Although depression may manifest itself for the first time at any point in the life span of individuals, a preponderance of depressive episodes in the elderly are reoccurrences of an existing disorder (Shulman & Post, 1980). It is a well established fact that women are more likely than men to experience depression throughout the life cycle (Ruegg, Zisook, & Swerdlow, 1988). Some evidence suggests, however, that by age 55, the likelihood of experiencing depression is about equal for both sexes, and that by age 80 men are more likely to experience such symptoms (Gurland, Dean, Cross, & Golden, 1980).

Etiology

There are a number of age-related changes which are likely to be implicated in the development and exacerbation of depressive symptomatology in older adults. The significant depletion of biogenic amine neurotransmitters such as dopamine, norepinephrine, choline, and acetyltransferase with advancing age has been documented in recent years (Adolfsson, Gottfries, Roos, & Winblad, 1979; Berry & Berry, 1977; Carlsson & Winblad, 1976; McGeer & McGeer, 1976; White et al., 1977). Moreover, some evidence suggests that the enzyme monoamine oxydase tends to increase in the aging brain, thereby effecting a further decrease of available neurotransmitters (Alexopoulos, Young, & Shamoian, 1985; Robinson, 1979). Proponents of biogenic amine theories of depression contend that this reduction plays a central role in the biological underpinning of depression (Akiskal & McKinney, 1973). It should be stressed, however, that firm statements regarding the relationship between the neurobiologic effects of aging and depression are premature. The effects of normal aging on central nervous system neurotransmitter systems, and their potential contribution to the etiology of late-life depression, remain to be determined (Veith & Raskind, 1988).

As will be seen later, impaired physical health is a predictor of poor prognosis in late-life depression (Murphy, 1983). This association has led some researchers to assert that medical illness may be a causative factor in the etiology of late-life depression (Meyers & Alexopoulos, 1988). It is

unclear, however, whether depression causes medical illness or whether it is the psychological consequence of chronic disability and loss of health. Evidence against the latter possibility was provided by Meyers and Greenberg (1986), who found that 54% of physically well depressed elderly individuals had their first episode after age 60. On the other hand, the contribution of an unidentified medical illness to the exacerbation of depressive symptomatology could not be ruled out. Further research will be required to disentangle the complex relationship between medical illness and late-life depression.

Psychosocial factors have also been implicated in the etiology of late-life depression. Retirement, poor living conditions, economic deprivation, social isolation, loss of spouse or other significant persons, and rejection by children are some of the psychosocial stressors which the elderly are more likely to experience (Ciompi, 1969; Murphy, 1983, 1985; Zisook & DeVaul, 1983; Zisook, Shuchter, & Lyons, 1987). The basic rationale is that the elderly are more likely to experience serious negative life events (i.e., separation, death, financial or material loss) which bring about increased levels of stress, which, in turn, predisposes them to new depressive episodes (Brown & Harris, 1978). Other researchers have suggested that "micro-stressors", i.e., sources of frustration associated with daily functioning, such as coping with memory difficulties, household management, and personal finances, may also contribute to the etiology of depression (Kanner, Coyne, Schaefer, &

Lazarus, 1981; Monroe, 1983). The frustration and helplessness brought on by these micro-stressors could, in effect, represent the truly stressful consequences of negative life events.

Although earlier studies focused on the role of negative life events (Paykel et al., 1969), in recent years an increased emphasis has been placed on an examination of social support (Cutrona, Russell, & Rose, 1986; Krause, 1987). These authors argue that social support (i.e., emotional support and social integration) may act as a buffer by reducing the likelihood of experiencing stress associated with negative life events, thereby promoting self-worth, self-esteem, confidence, and self-efficacy. By extension, the absence of social support leaves the elderly individual vulnerable to the pernicious effects of stress and the possible concomitant induction of depressive symptomatology. Although the exact nature of the interrelationship between negative life events, social support, and emotional well-being remains uncertain, these theories help stimulate research aimed at elucidating the role of social stress in the etiology of late-life depression.

Symptoms, Course, and Prognosis

The presentation of depression in the aged tends to be somewhat different than that found in younger individuals. Specifically, the most common symptoms of depression in the elderly tend to be apathy, loss of energy, constipation, sleep disturbance, anxiety, preoccupation with physical symptoms, and

disinterest in their environment (Hendrie & Crossett, 1990; Klerman, 1983; Zung, 1980). Brown, Sweeney, Loutsch, Korsis, and Frances (1984) found that a first episode of depression in middle- to late-life was distinguished from earlier onset depressions by a loss of libido, fewer complaints of guilt feelings and suicidal intent, a lower likelihood of a family history of depression, and increased somatization and hypochondriasis.

Not much is known about the course of depression in older adults. Whether in younger or older age cohorts, this disorder is often a chronic, relapsing, or recurring condition (Bialos, Giller, Jatlow, Docherty, & Harkness, 1982; Cook, Helms, Smith, & Tsai, 1986). Taken together, most studies which have examined the prognosis of late-life depression conclude that it is relatively poor (Baldwin & Jolley, 1986; Murphy, 1983; Post, 1972). The subjects in these studies were severely depressed elderly patients. One study, however, examining the prognosis of depressed elderly persons living in the community (i.e., relatively less severe cases), reported the promising finding of good outcome in almost half the subjects in the sample (Kivelä & Pakkala, 1989). The factors associated with poor prognosis include cerebral organic illness (Post, 1972), severity of the initial depressive disorder (Murphy, 1983), low social participation (Kivelä & Pakkala, 1989), male gender (Baldwin & Jolley, 1986), and poor physical health (Murphy, 1983; Baldwin & Jolley, 1986). Two studies, however, found that late onset of

the first depressive episode was a factor associated with a favourable prognosis (Cole, 1985; Magni, Palazzolo, & Bianchin, 1988).

Diagnosis

The current accepted criteria for diagnosing a major depressive disorder in older adults are those outlined in the DSM-III-R (APA, 1987). There are a number of factors, however, which make the diagnosing of depression difficult in an elderly population. Elderly individuals are less likely to seek treatment for depression than younger adults (Hendrie & Crossett, 1990); therefore, many cases in the community go undetected. When they do seek treatment, they are rather reluctant to acknowledge feelings of sadness or loss of pleasure and tend to focus on somatic complaints. Physicians then tend to concentrate on ferreting out the underlying physical cause and fail to recognize the presence of depression. This overshadowing of dysphoric affect by prominent somatic symptoms has been termed "masked depression" (Lehmann, 1982).

Diagnosis can also be complicated by the presence of a manifest physical illness. Advanced age has been shown to be accompanied by an increase in the incidence and prevalence of medical illness (Rossman, 1979). Physical illness can precipitate depression because, as we have seen, older people may be more vulnerable to stress brought on by poor health or physical disability (Jarvik & Gerson, 1983). Depression can also

be the direct result of a number of physical illnesses, including neoplasm, infection, cardiovascular disease, degenerative disease (Parkinson's), and electrolyte imbalance. Furthermore, some of the medications prescribed to treat these illnesses are known to produce depression-like syndromes. In fact, a wide variety of medications, including antihypertensives, antiparkinsonian agents, hormonal preparations, anticancer agents, as well as psychotropic agents, are all capable of producing depression.

Another condition which is common in the elderly and which may mask depression is dementia. Elderly depressed patients often seek treatment because of difficulty in concentrating or remembering. The term pseudodementia has been used to refer to global cognitive impairment similar to that seen in irreversible senile dementias but which is actually brought on or exacerbated by depression. Often the two clinical pictures are indistinguishable, although a number of features do exist which may clarify the picture. In pseudodementia, symptoms are of a short duration and are rapidly progressive, the symptoms of depression may have preceded those of dementia, and there may be a personal or family history of depression (Wells, 1979). Cavenar, Mattbie, and Austin (1979) reported that some cases can only be differentiated after a positive response to a trial of tricyclic antidepressants. Once the diagnosis of depression has been made, however, a number of treatment modalities are available, and these are discussed in the next section.

Treatment of Depression in the Elderly

Unfortunately, ageism, stereotyping, and victimization all contribute to decreasing the probability that older persons will receive adequate treatment when they present with depression. Poor physical health, loneliness, and apathy are more likely to be seen as "typical" or "understandable" for the aged person, rather than symptoms of depression. Klerman (1989) has found that effective intervention for depression can reduce the likelihood of developing a subsequent medical illness. Another important factor to consider is that depression and hopelessness often lead to suicide. Given that the suicide rate is highest in the elderly population, that elderly white males have the highest rate of suicide of any age group, and that the aged person is more likely to be "successful" when an attempt is made (Ban, 1978), aggressive intervention when depression is present may be life-saving (Templer & Cappelletty, 1986). Existing treatment modalities will be discussed under the following headings: pharmacotherapy, electroconvulsive therapy (ECT), and psychotherapy.

Pharmacotherapy

Compared to studies using younger adults, there are relatively few studies which have examined the efficacy of antidepressant medication with elderly patients. A wide variety of drugs have been used for their thymoleptic effects, including tricyclic and tetracyclic compounds, monoamine oxydase

inhibitors, lithium salts, neuroleptics, stimulants, and even anti-anxiety drugs (Gerner, 1985; Strauss & Solomon, 1983). One general conclusion which has been drawn from the literature on the efficacy of pharmacotherapy for depressed older adults is that this form of therapy is as effective in treating this population as it is with younger adults (Gerner, 1985). Others have claimed outright that antidepressants, especially the tricyclic variety, are the treatment of choice for elderly depressed individuals (Ford & Sbordone, 1980). Yet, the studies on which these conclusions are based are replete with serious methodological flaws, such as the absence of a placebo condition, unsystematic diagnosing of subjects, only partial blinding of raters, and the absence of a drug wash-out period. Moreover, not all patients respond to pharmacotherapy, and some only improve partially (Elkin, Parloff, Hadley, & Autrey, 1985). Also, some evidence suggests that although benefits occur with the short-term use of antidepressants, a considerable portion of those treated will relapse within the first year or two following treatment (Cook et al., 1986; Kessler, 1978; Klerman, 1978).

Although some antidepressants have been effective in treating depression in older adults, there are a number of factors which complicate the use of this form of therapy with this population. In aging, organs undergo physiological alterations which alter the pharmacokinetics of psychotropic drugs. Partly because of the aging body's diminishing physiological and biochemical capacities, there is a general

potentiation of drug effects. Alterations in the absorption, distribution, metabolism, and excretion of drugs can produce an increased sensitivity to the effects of psychotropic medications (Friedel, 1977). Therefore, lower doses are generally advocated, but the relationship between blood levels and therapeutic effect in this age group is not yet clearly understood (Gerner, 1985). Many elderly individuals cannot be prescribed psychotropic agents because of possible drug-drug interactions with agents they are taking for chronic physical conditions. Antidepressants are also contraindicated for a large number of older persons because of the serious side-effects these compounds produce, such as orthostatic hypotension, cardiotoxicity, and anticholinergic effects (dry mouth, constipation, weakness, etc.), which may exacerbate preexisting physical illnesses. The potential iatrogenic effects of antidepressants necessitate close monitoring to prevent complications, which limit their use with this population. Moreover, the discomfort produced by side-effects may reduce compliance.

In summary, antidepressants in general and tricyclics in particular have been shown to reduce symptoms of depression in older adults. At the same time, several factors, such as altered pharmacokinetics, drug-drug interactions, side-effects, and compliance issues, seriously limit their use with this population.

Electroconvulsive Therapy (ECT)

ECT has been used as an alternative treatment to pharmacotherapy and psychotherapy when: a) neurovegetative symptoms create a life-threatening situation; b) the risk of rapid deterioration precludes waiting for a response from pharmacotherapy or psychotherapy; c) the individual has a physical illness which may be exacerbated by pharmacotherapy; d) delusions are present; e) there is no response to pharmacotherapy; or f) there is active suicidal ideation or suicidal gestures have been made (Salzman, 1982; Zorumski, Rubin, & Burke, 1988). Few research studies have examined the efficacy of ECT with an elderly population. A few studies have found positive clinical response rates as high as 80% (Burke, Rutherford, Zorumski, & Reich, 1985; Fraser & Glass, 1980; Gaspar & Samarasinghe, 1982). Other studies have found initial recovery rates in the vicinity of 50%, with roughly 20-30% improved but not fully recovered (Benbow, 1987; Godber, Rosenwinge, Wilkinson, & Smithies, 1987). These studies, however, had small sample sizes and some did not include a control condition. Some researchers have argued that depressed older adults may have a better therapeutic response to ECT than younger adults (Weiner, 1982). Many of the studies cited, however, did not restrict their population to persons 65 years of age and over, and few studies included patients in the old-old category (75+). To the author's knowledge there is no information on relapse rates for older adults treated with ECT, nor is there any evidence on the

efficacy of maintenance ECT in this population. In addition, no studies have compared ECT to other treatments in order to ascertain its relative efficacy (in fact, only nine such studies have been conducted with a general adult population, with equivocal results). Furthermore, some studies have shown that roughly 15-30% of elderly patients do not respond at all to this treatment modality (Abrams, 1982; Mielke, Winstead, Goethe, & Schwartz, 1984). One predictor of nonresponse to ECT was longer duration of preceding depressive episodes, suggesting that ECT may be less effective for depressed older adults showing a chronic long-term pattern of depressive illness (Magni, Fisman, & Helmes, 1988). From this evidence, then, it seems somewhat premature to conclude, at the present time, that ECT offers any benefits beyond what might be obtained with pharmacotherapy or psychotherapy in non life-threatening situations.

Regardless of the actual efficacy of ECT with depressed older adults, there are several difficulties which complicate the use of this form of therapy with this population. Zorumski et al. (1988) argued that aging, independent of major medical illnesses, does not increase the risk of medical morbidity when ECT is employed. The fact remains that more than half the elderly patients presenting with depression will have at least one medical illness, and that medical difficulties resulting from treatment with ECT are more common over age 65 because of that very fact (Alexopoulos, Shamoian, Lucas, Weiser, & Berger, 1984). ECT may be contraindicated for elderly patients with

cardiovascular difficulties, because cardiovascular complications resulting from ECT may be fatal (Zorumski et al., 1988). Also, ECT is incompatible with tricyclic antidepressants because these agents interfere with the induction of seizures (Clifford, Rutherford, Hicks, & Zorumski, 1985). Finally, ECT produces a number of side-effects, including acute confusion and memory impairment. Although these effects subside somewhat after discontinuation, some permanent memory impairment is possible.

In summary, some studies have shown that ECT may be beneficial for depressed older adults. However, ECT is contraindicated in a number of cases and produces serious side-effects. Its main value appears to be as an alternative treatment when pharmacotherapy is contraindicated (e.g. preexisting physical illnesses) and psychotherapy is not likely to be useful (e.g. presence of dementia or psychosis), or when a life-threatening situation exists and therefore action must be taken immediately.

Psychotherapy

Prior to 1970, the most ubiquitous myth in the field of geriatric mental health was that the elderly could not be treated effectively with psychotherapy (Brink, 1979). The traditional view was that the aged were frail, inflexible, and senile, and were generally a waste of time since they were approaching the end of life. In the 1970's enough clinical data had been amassed showing that older adults did benefit from psychotherapy that the

question of whether to treat was no longer an issue (Willner, 1978). Rather, the emphasis was placed on adapting existing psychotherapies for use with an elderly population.

Psychotherapy became particularly attractive when clinicians became aware of the previously discussed limitations of pharmacotherapy and ECT. From the early 1980's to the present, the emphasis has shifted to carrying out controlled research investigations evaluating the efficacy of psychotherapy in the treatment of late-life depression. Since most studies compare one treatment approach with another, dividing the studies according to treatment approach did not seem appropriate. Therefore, it was decided to divide the studies along treatment format: individual or group.

Individual treatment. To the author's knowledge, only six controlled studies have examined the efficacy of individual psychotherapy as a treatment for late-life depression. One of the earliest investigations was designed to examine the relative efficacy of the combined use of interpersonal psychotherapy with alprazolam or imipramine versus the same form of psychotherapy with a placebo (Rothblum, Sholomskas, Berry, & Prusoff, 1982). The eleven patients who remained in the study improved from baseline to post-treatment, with the steepest decrease in depression occurring after the first and second weeks of treatment. To date, no final results have been presented regarding the differential response to the treatments. Thirty-

nine percent of the sample did not complete the six weeks of treatment, either because they refused treatment or were withdrawn due to deterioration, toxicity, or a concurrent illness. The results of this study are difficult to interpret because of the small sample size and the absence of a control condition.

Gallagher and Thompson (1982) examined the relative therapeutic value of behavioral, cognitive, and relational/insight (the latter resembled a psychodynamic approach). Thirty elderly patients were randomly assigned to the treatment conditions, where they received 16 therapy sessions over a 12-week period. The results indicated that all subjects showed a significant improvement over time (they were followed for one year) on observer ratings and self-report scales, regardless of treatment modality. However, subjects in the cognitive and behavioral treatment conditions showed significantly more improvement than those in the relational/insight condition at the end of therapy, a finding which was even more pronounced at one year follow-up. Half the subjects in this study had a Research Diagnostic Criteria (RDC)(Spitzer, Endicott, & Robins, 1978) diagnosis of endogenous depression, while the other half were classified (in RDC terms) as nonendogenous depressives. Eighty percent of the nonendogenous patients were within normal limits on the Beck Depression Inventory (BDI)(Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and none had relapsed into another major depressive episode at the one year follow-up, whereas only

thirty-three percent of the endogenous patients were noticeably improved at the end of treatment and seven percent of these patients had relapsed (Gallagher & Thompson, 1983). Twenty-six percent of those initially randomized to the treatment conditions dropped out before the end of the third week of treatment. Although practical concerns were frequently cited by the early terminators, some patients were simply no longer interested in continuing treatment. A differential dropout rate was not observed with respect to the two RDC categories.

In an effort to replicate these results with a larger sample and a better design, Thompson and Gallagher (1984) randomly assigned 61 patients to one of four treatment conditions: cognitive, behavioral, time-limited psychodynamic, and a 6-week delayed treatment group. Roughly 75% of the subjects in the treatment conditions had substantially improved or were in full remission at the conclusion of the 6 weeks of treatment. The three treatment conditions were equally effective in obtaining positive results. At 6 weeks post-termination, the treated subjects improved significantly more than the subjects in the 6-week delayed treatment group, suggesting that the observed improvement was not due to spontaneous remission or to non-specific factors. At one year post-termination, only 9% of patients had a full relapse, while 15% had a partial relapse. Twenty-six percent of the subjects dropped out of treatment, although half of these were removed purely to maintain the integrity of the study.

Fry (1984) gave 35 nonpatient depressed elderly subjects cognitive-behavioral therapy with an emphasis on cognitive restructuring and cognitive rehearsal procedures either immediately or after a 1-month wait period. Subjects were seen individually three times a week for four weeks. The results indicated that at follow-up (one month and two months post-treatment), subjects in both groups were less depressed and had a decrease in dependency beliefs, self-criticism, and inefficacy beliefs. She reported a dropout rate of 20%.

Finally, Thompson, Gallagher, and Steinmetz-Breckenridge (1987) examined the comparative effectiveness of behavioral, cognitive, and brief psychodynamic psychotherapy with 91 elders who had a major depressive disorder. They also used a 6-week delayed treatment condition. By the end of six weeks, patients in the treatment conditions showed improvement whereas the controls did not. By the end of therapy, 52% of those receiving treatment attained remission and another 18% showed significant improvement. The three treatment conditions were equally effective in obtaining positive results. They also reported a 20% dropout rate. At 1-year follow-up, 58% of the sample no longer met criteria for any RDC depressive disorder and at 2-year follow-up this figure climbed to 70% (Gallagher-Thompson, Hanley-Patterson, & Thompson, 1990). The therapy modality received did not affect response rate. Those who were free of depression at post-treatment remained so for longer time periods than those who had minor symptoms or still had a major depressive

disorder at the conclusion of therapy. This study provides the best evidence yet of the effectiveness of individual psychotherapy with depressed older adults, and of the long-lasting benefits derived from psychotherapy.

Group treatment. There are a number of reasons why group therapy might be especially beneficial for the older adult. Group therapy helps combat loneliness, which has been shown to be more common in old age and to be correlated with poor adjustment (Hansson, Jones, Carpenter, & Remondet, 1987; Larson, 1990). One consequence of loneliness and isolation is that social skills may become "rusty". Group therapy encourages resocialization and may instill hope and confidence that change is possible by seeing others grapple with similar problems. Group therapy provides an outlet for the older adult's strong need to contribute to others, which used to be filled by the familiar work setting. It gives them the opportunity to feel useful once again, which may in turn enhance their self-esteem.

To the author's knowledge, only four studies have examined the effectiveness of group psychotherapy for depressed older adults. Gallagher (1981) reported that both behavioral group therapy and supportive group therapy were effective in alleviating depression by the end of therapy and at 5-week follow-up. There were no significant differences between treatments, although subjects in behavioral therapy improved more

on the use of positive social skills. An 18% dropout rate was also reported.

Moran, Walsh, and Lax (1984) evaluated the use of group therapy to keep depressed elderly patients out of institutions. Fourteen subjects, 55 years of age or older, received thirty-two treatment sessions. They found that participation in the program led to reduced depression, increased life satisfaction, and involvement in a wider range of community activities. They reported a 21% dropout rate. The significance of these results is difficult to determine, however, because the subjects were concurrently receiving psychotropic medication.

Steuer et al. (1984) set out to examine the comparative effectiveness of cognitive-behavioral and psychodynamic group psychotherapy with depressed geriatric patients. The 33 subjects were randomly assigned to the groups and were offered a 9-month course of treatment. They reported that patients in both psychodynamic and cognitive-behavioral group therapy showed statistically significant decreases in depression on all their measures; 40% of those who completed treatment and 27% of those who started treatment were no longer depressed. This finding suggests that remaining in therapy is associated with a better outcome. Although both treatments were equally effective in alleviating depressive symptomatology, cognitive-behavior therapy was more effective in reducing depression scores on the BDI. The dropout rate reported was 39%. This may have been inflated,

however, because of an unusually long treatment schedule; only 9% of the patients left within the first three months of treatment.

In the first study of the differential effectiveness of pharmacotherapy and group psychotherapy with an older sample, Beutler et al. (1987) randomly assigned 57 subjects to one of four groups: alprazolam support, placebo support, cognitive therapy plus placebo support, and cognitive therapy plus alprazolam support. The results indicated that group cognitive therapy was superior to pharmacotherapy in alleviating depressive symptoms in older adults, and that these gains were maintained at 3-month follow-up. Moreover, the subjects receiving group cognitive therapy were less likely than their pharmacotherapy counterparts to prematurely terminate treatment. The overall dropout rate was a staggering 62%, with 14% of dropouts occurring during the first 4 weeks of treatment.

In summary, the results from both individual and group psychotherapy studies seem to suggest that psychotherapy is effective in alleviating depressive symptoms in older adults. Some studies also suggest that cognitive therapy may be more effective than either psychodynamic therapy or pharmacotherapy. In the Beutler et al. (1987) study, a manual for group cognitive therapy tailored to older adults was put together (Yost, Beutler, Corbishley, & Allender, 1986). The promising empirical results obtained with group cognitive therapy and the existence of the

manual mentioned above led the author to adopt this treatment modality in the present study.

Two other important findings can be gleaned from this body of research. First, researchers typically report high dropout rates, in the range of 25-50%. Second, only one patient in two, on the average, will achieve complete remission. Different avenues have been explored by researchers in an attempt to improve these figures. One line of reasoning suggests that if one could reduce the dropout rate and increase attendance, then the effectiveness of therapy may be increased by virtue of patients staying longer in therapy. One means which has been advocated to reduce dropout rates, increase attendance, increase desirable in-therapy client behaviors, and improve therapy outcome has been the use of pretherapy training.

Pretherapy Training

It has been nearly thirty years since the publication of the first report (Martin & Shewmaker, 1962) which explored the issue of preparing clients for therapy. Since then, over 50 published studies have examined the effectiveness of pretherapy training in modifying a whole host of variables related to individual and group psychotherapy, such as client expectations, attendance and dropout rates, process variables (e.g. in-therapy verbal behavior), client satisfaction, and therapy outcome. Over the years researchers have concocted a wide array of pretherapy procedures combining different stimuli with different activities.

Researchers have used chiefly four types of stimuli (separately or in combination): (a) written (printed material), (b) verbal (live presentation by a leader of a group or an interviewer), (c) audiovisual (taped material), and (d) experiential (live situation which simulated actual therapy). The pretrainer has also used different types of activity (separately or in combination): (a) providing information, (b) providing a model, and (c) providing an experience which allows clients to practice behaviors performed in actual therapy. For reasons to be explained later, the latter classification was adopted as a framework for the presentation of empirical work in this area. Also, because the treatment modality used in this study was in a group format, only studies which pretrained for group psychotherapy will be presented here. A general summary and an analysis of these studies will be provided later. The closing section deals with the particular appeal of pretherapy training for use with an older population.

Information Only

Pretherapy training studies which provided information only (e.g., dispelling myths about therapy, outlining desirable client behaviors, etc.) mainly used written and verbal stimuli to convey the information (Garrison, 1978; Heitler, 1973; Jacobs, Trick, & Withersty, 1976; Kochendorfer, 1975; Meadow, 1988; Staunton, 1981; Strupp & Bloxom, 1973; Yalom, Houts, Newell, & Rand, 1967), although one study used audiovisual means (Pastushak, 1978). Six

of the nine studies provided data on the immediate pretreatment effects of pretherapy training. Meadow (1988) reported that patients who received pretherapy training had more realistic expectations and perceptions of group membership and had a clearer understanding of the group's purpose than those who did not receive training. Strupp and Bloxom (1973) found that patients who received a role induction interview had a greater desire to begin group therapy, had more congruent expectations about their role, and expected greater improvement than control subjects. Jacobs et al. (1976) found that pretherapy patients were more knowledgeable regarding the content of preparatory lectures than controls, while Staunton (1981) did not find any differences between groups on knowledge of group psychotherapy. The other studies reported no significant differences between groups on the following variables: client ratings of readiness to begin therapy (Kochendorfer, 1975); clients expectations regarding group therapy (Garrison, 1978); and client's ability to identify personal goals which were compatible with the purpose of the group (Meadow, 1988).

Only two studies provided both attendance and dropout data (Garrison, 1978; Yalom et al., 1967) and one study reported on attendance alone (Strupp & Bloxom, 1973). Only Garrison (1978) found a significant difference in attendance between the pretherapy condition and the control condition. The two studies reporting dropout data found no significant differences between groups.

All the studies save one (Meadow, 1988) reported on variables related to therapy process. Three studies examined the amount of self-disclosure; two found significant differences between prepared and unprepared patients (Garrison, 1978; Pastushak, 1978). Yalom et al. (1967) found that pretrained patients made more relationship and group-oriented statements, made fewer superficial statements, and engaged themselves more quickly in the therapeutic task than controls. Heitler (1973) reported more self-exploratory verbal behavior in subjects receiving pretherapy training, although results on verbal initiative and talk time were equivocal. Unlike the previous study, Staunton (1981) found no significant differences between groups on amount of talking done by patients, amount of talking by patients to each other, amount of feedback, and amount of "feeling" statements. Strupp and Bloxom (1973) found more "appropriate" in-group behavior evinced by prepared clients, although Jacobs et al. (1976) did not. Pastushak (1978) found greater interpersonal openness in prepared subjects, while Garrison (1978) found no differences in guidance-seeking behavior.

Five studies reported data on client satisfaction and therapy outcome. Three of four reported no significant differences between pretrained and non-pretrained groups on client satisfaction (Heitler, 1973; Kochendorfer, 1975; Jacobs et al., 1976). The only two studies to report on client improvement found no significant differences between groups (Strupp & Bloxom,

1973; Pastushak, 1978). Heitler (1973) found significant differences between prepared and unprepared subjects on therapist ratings of client's active involvement, prognosis, and similarity to "ideal" patient, while Strupp and Bloxom (1973) reported that subjects who received pretherapy training rated themselves as more improved at the end of therapy than controls. On the other hand, Pastushak (1978) reported no differences on client ratings of therapy effectiveness.

Three studies compared different means of providing information. Kochendorfer (1975) found that subjects that completed a questionnaire instead of an interview were more likely to express material relevant to their problems in the initial stages of therapy. Meadow (1988) reported that a questionnaire plus an interview was more effective than the questionnaire alone in bringing about more realistic expectations and perceptions of group membership, and that the questionnaire alone was not effective in providing subjects with a clearer understanding of the group's purpose. Garrison (1978) compared oral and written presentations of material and found no significant differences between groups on any of the variables studied.

Providing information only is the most commonly employed form of pretherapy training for group psychotherapy. As the reader can see, regardless of the dependent variables studied, the findings are equivocal.

Modeling Only

Pretherapy training studies which examined modeling only were roughly evenly divided between those which used audiotape only (Truax & Carkhuff, 1965; Truax, Shapiro, & Wargo, 1968; Truax & Wargo, 1969; Truax, Wargo, & Volksdorf, 1970), and those which used audiovisual presentations (Causey, 1985; Strupp & Bloxom, 1973; Walter, 1975). Only two of the seven studies provided data on the immediate effects of pretherapy training. Strupp & Bloxom (1973) reported that patients receiving pretherapy had a greater desire to begin group therapy, had more congruent expectations about their role, and expected greater improvement than control subjects. However, there were no significant differences between these two groups on client rating of discomfort prior to therapy. On the negative side, Causey (1985) found no differences in initial adjustment to the group setting between subjects who viewed a modeling videotape, viewed a neutral videotape, or received no preparation whatsoever. In addition, she found no significant differences in therapist ratings of client likelihood to benefit from therapy.

The two previous studies were also the only ones to report data on attendance and/or dropouts. In the Causey study no significant differences were found in the dropout rates, and in the Strupp and Bloxom study no significant differences were found in attendance.

Three studies looked at process variables. Walter (1975) found that modeling plus instructions was more effective than

instructions alone in producing increased expression of feelings and requests for feedback, but no differences were found for self-disclosure and the client's ability to produce alternate behaviors [note: the pretherapy training used in this study is not considered a combination of activities because the instructions were purely structural (as opposed to role-related) in nature]. Strupp and Bloxom (1973) reported therapist ratings indicating that subjects in the pretherapy conditions exhibited significantly more "desirable" behavior than those in the attention placebo-condition. They also reported that throughout therapy prepared patients reported significantly greater satisfaction than unprepared patients, while Causey (1985) did not find any differences on client ratings of satisfaction after one week of therapy.

All but one study (Causey, 1985) provided data on outcome measures. The studies headed by Truax and colleagues all compared audiotape modeling to a no-preparation control. Truax and Carkhuff (1965) found significantly more constructive changes on scales 7 and 8 of the MMPI in favor of the pretherapy group, but found no differences on the other MMPI scales. Truax, Shapiro, and Wargo (1968) found constructive changes on scales 2 and 8 on the MMPI but not on the other MMPI scales. They also reported healthier client ratings of "ideal self" in pretrained groups, but not on client ratings of "actual self". Truax and Wargo (1969) found constructive changes on scales 2, 3, and 7 of the MMPI for pretrained groups, but not on the other MMPI scales,

nor on other self-report "personality" measures. Truax, Wargo, and Volksdorf (1970) also reported non-significant differences on a series of self-report "personality" measures (the MMPI was not used in this study). Strupp and Bloxom (1973) found both pretrained groups to be significantly different from the attention-placebo group on client ratings of satisfaction with therapy and of posttherapy improvement, and on therapist ratings of client attractiveness, but not on therapist ratings of posttherapy improvement. Walter (1975) found no significant differences between her groups on client ratings of the overall group experience and client ratings of their current functioning in personal and social areas of experience at posttherapy.

The reader may have noted that the Strupp and Bloxom study was mentioned both in this section and in the previous one. This is because these researchers had three groups in their study: one group received a role induction interview, one received a modeling film, and one received an attention placebo. Since they reported results for both pretherapy groups, the study was included in both sections. Their comparisons revealed that the group which received the modeling film fared somewhat better than the group receiving information only on a number of measures, but not to a significant degree.

On the whole, the same conclusion regarding studies which used information only may also be applied to studies which used modeling only: regardless of the dependent variables, the findings remain equivocal.

Simulated Group Experience Only

Only one study used a pretherapy training procedure which was limited to a simulated group experience (Wogan, Getter, Amdur, Nichols, & Okman, 1977). Unfortunately, this study compared this condition with a condition which combined three activities, and separate results were not provided. The next section describes this study and others which have combined different activities to form a pretherapy "package".

Activity Combinations

No study examined the effectiveness of combining modeling and a simulated group experience in a pretherapy procedure. The studies in this section will therefore be discussed under the following headings: information and modeling; information and a simulated group experience; and information, modeling, and a simulated group experience.

Information and modeling. Two studies used videotape and an instructional lecture to convey the information and present the modeling (Curran, 1978; France & Dugo, 1985), while another used videotape and written material (Ernst, Vanderzyl, & Salinger, 1981). Two studies collected data on the immediate effects of the pretherapy procedure. While Curran (1978) found prepared patients to have a significantly greater motivation to change, Ernst et al. (1981) found no significant differences between prepared and unprepared patients on client ratings of role

expectations. France and Dugo (1985) were the only ones to present data on attendance and dropouts, and on process variables. They found no significant differences between groups on number of dropouts, but they did find that prepared patients attended significantly more sessions. Their process measures examined therapist ratings of spontaneous self-disclosure and verbal initiative. They found no significant differences between prepared and unprepared patients and, in the case of verbal initiative, unprepared patients actually had higher ratings. Curran (1978) was the only researcher to include outcome measures. He found significant differences between groups on therapist ratings of patient's family functioning, vocational functioning, and primary goal attainment, but not on social functioning. Client ratings of behavioral changes showed no significant differences between groups, while equivocal results were obtained for client ratings of primary, secondary, and tertiary goal attainments.

Information and simulated group experience. All three studies used an interview or a lecture to convey the informational component and role-playing to provide a simulated group experience (Peake, 1979; Piper, Debbane, Garant, & Bienvenu, 1979; Piper, Debbane, Bienvenu, & Garant, 1982). None of these studies reported data on the immediate effects of pretherapy training. The two Piper studies reported on attendance and dropout rates. The results were identical:

significant differences were found between groups on attendance, but not on the number of dropouts. Only Piper et al. (1982) collected data on process measures. They found that the level of work (defined as time spent discussing a symptom, an unobtained goal, or an obstacle to goal attainment) was not significantly different between prepared and unprepared patients. With respect to outcome measures, the previous study reported non-significant differences between groups on patient ratings of improvement, interpersonal functioning, and general psychiatric symptoms, while Peake (1979) also found no significant differences regarding personality change and agreement between therapist and patients on how well the therapist related to the client.

Information, modeling, and simulated group experience. Only two studies combined all three activities in a pretherapy procedure: Hilkey, Wilhelm, and Horne (1982) and the Wogan et al. (1977) study referred to earlier. The former investigation reported that patients in the pretherapy condition had more adequate role expectations than control subjects prior to the onset of group therapy, while no significant differences were found on pretreatment levels of anxiety. Neither study reported on attendance and dropout rates, but both studies included process and outcome measures. Wogan et al. (1977) found no significant differences between groups on in-therapy verbal behaviors, while Hilkey et al. (1982) obtained negative findings on the overall quality of group interaction. However, the latter

researchers did find significantly more positive social-emotional responses in prepared patients, but only in the first few sessions. Wogan et al. (1977) found the prepared groups to have significantly higher client ratings of improvement, while Hilkey et al. (1982) found no differences on client ratings of perceived outcome. The latter researchers did find significant differences between groups on peer and therapist ratings of perceived outcome.

Pretherapy Training and the Elderly

Over the years researchers have not only used a variety of media and activities, but they have also used a variety of "special" populations, including low socioeconomic status (Strupp & Bloxom, 1973), penitentiary inmates (Hilkey et al., 1982), psychiatric inpatients (Truax & Carkhuff, 1965), and juvenile delinquents (Truax et al., 1970). These groups have often been selected on the assumption that, due to misinformation, they are more likely to have unrealistic expectations about the therapeutic process. Yet, it is a conspicuous omission that no pretherapy training study has focused on an elderly population.

There are a variety of reasons why the elderly are especially likely to benefit from pretherapy training. Yost et al. (1986) have suggested that many elderly persons may harbor the following misconceptions about therapy: a) since in their formative years psychological services were not extensively used, they may believe that, on the whole, few people seek such

services; b) because they have had little exposure to treatment of a psychological nature and therefore lack psychological sophistication, they tend to believe it is disgraceful and shameful to have emotional difficulties; c) they are more likely to believe that any emotional problem constitutes "craziness", which they may associate with eventual admittance to an "insane asylum"; d) because their contact with mental health professionals has been largely limited to medical practitioners, they may believe that self-disclosure is inappropriate. Other researchers have reported that aged persons are often unaware that chronic emotional illnesses and symptoms are treatable (Brody & Kleban, 1981) and those who are aware that they are treatable may tend to believe that treatment is applicable only for the hospitalized mentally ill (Knight, 1983). These beliefs may also be superimposed on other popular misconceptions of therapy, which include the following: a) a passive role by the client; b) an active, directive, and advice-giving role of the therapist (Nunnally, 1961); c) rapid improvement within five sessions; and d) cure within ten sessions (Garfield & Wolpin, 1963). Older adults who enter therapy with these misconceptions may be severely limited in the benefit they can derive from such an endeavor. There have been no studies, unfortunately, which have systematically canvassed older adults in an attempt to ascertain empirically the nature and prevalence of myths and misconceptions about the therapeutic process.

Analysis of the Literature Review on Pretherapy

Training for Group Psychotherapy

Although many studies have found that pretherapy training can enhance group psychotherapy, almost as many studies argue against this assertion. This state of affairs reflects the absence of progressive inquiry in this field. There are three main problems, which will be discussed under the following headings: methodology, dependent variables, and pretherapy procedures.

Methodology

Most of the research described in the literature review is, unfortunately, fraught with methodological flaws. Some of these limitations include the absence of random allocation to conditions, the absence of a no-pretherapy-training control group or an attention-placebo control group, therapist knowledge as to which groups were pretrained, and the absence of control for previous knowledge of psychotherapy. These methodological flaws limit the interpretive value of individual studies, and make comparisons across studies very difficult. Clearly, more rigorous research is necessary if any headway is to be made.

Dependent Variables

From the literature review, there appear to be 4 major categories of dependent variables: (a) immediate effects of pretherapy training (i.e., before treatment begins), (b)

attendance and dropout rates, (c) process measures, and (d) outcome measures. Yet, most studies only provide results on 1 or 2 categories of data, and only 2 studies (Hilkey et al., 1981; Strupp & Bloxom, 1973) reported data in all four categories.

A wide variety of variables have been examined to ascertain the immediate effects of pretherapy training, such as client ratings of motivation to change, level of anxiety, knowledge about group therapy, and client expectancies. Only a few researchers measured client expectancies, despite the heightened importance of this variable. There is a strong possibility that client expectancies are related to length of stay in therapy. Some researchers (Heilbrun, 1970; Overall & Aronson, 1963) have argued that a client's decision to discontinue therapy may be largely based on a wide discrepancy between what they expect from therapy and what actually occurs in therapy. Client expectancies may also be an important determinant of the effectiveness of therapy in cases where the client remains long enough to benefit from it. Moderate researchers (Heppner & Heesacker, 1982) suggest that at the very least client expectancies affect the degree of client's cooperation in therapy, while extremists (Goldstein, 1962) suggest that the outcome of therapy is contingent on client's expectancies. In any event, many researchers believe that client expectancies are an important variable which influences client's decisions to seek and remain in therapy, and that these expectancies moderate the effectiveness of therapy. Of the 24 studies in the review, only

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three measured the effect of the pretherapy procedure on client expectancies (Ernst et al., 1981; Garrison, 1978; Hilkey et al., 1982).

As mentioned earlier, 25-50% of depressed older adults prematurely terminate therapy. High dropout rates are especially deleterious in group therapy because it is a demoralizing experience not only for the dropouts but also for the remaining patients and, secondarily, for the therapists. Furthermore, one person dropping out may precipitate a chain of additional dropouts. Obviously, one can only benefit from therapy if one stays in therapy. These arguments indicate the importance of measuring the effect of pretherapy training on attendance and dropout rates. Yet, only one third of the studies reviewed did so.

The category entitled "process measures" includes a wide variety of variables, assessed at different times, by different people, using different instruments. Researchers typically measure one particular type of statement, e.g., requests for feedback, statements of feeling, statements about a pertinent problem (e.g., "work"), statements reflecting interpersonal openness, etc. More than half the studies reviewed measured at least one process variable. Comparisons across studies are very difficult, though, because as noted by Piper and Perrault (1989), consistency and replication are lacking. Although the inclusion of a process measure is time consuming, it remains important to use such measures, as they remain the best way to ascertain the

effects of pretherapy procedures on specific (often microscopic) in-therapy client behaviors.

Almost 75% of the studies reviewed included an outcome measure. The "popularity" of this category of measurement is perplexing since it is the most temporally removed from the initial pretherapy procedure, and therefore is the least likely to be affected by pretherapy training. The term "outcome" as used within this field most often refers to client ratings of their satisfaction with therapy, or therapist ratings of client's likeability, coping ability, or degree of comfort. While these measures are important, few studies actually assessed the effectiveness of the therapy itself by measuring symptoms in a pre-post fashion with instruments which have well established psychometric characteristics. But clearly, there is little point in trying to enhance a therapeutic modality with the use of pretherapy training if the modality itself has not been shown to be effective.

Pretherapy Procedures

Perhaps the most serious impediment to progressive inquiry is the variety of pretherapy procedures employed. Mayerson (1984) has noted that the selection of pretherapy procedures tends not to be theoretically guided. He has proposed Bandura's (1977) social learning theory (now called social cognitive theory) as a theoretical framework to be used in the selection and conceptualization of pretherapy procedures.

According to Bandura (1986), individuals are more likely to perform a specific behavior if they believe they can perform it adequately. He referred to this as an efficacy expectation. When applied to psychotherapy, then, clients are more likely to engage in necessary in-therapy behaviors if they have knowledge of the client's role and believe that they can perform such a role adequately. Bandura (1986) also states that there are 4 sources which influence efficacy expectations: emotional arousal, verbal persuasion, vicarious experience (modeling), and performance accomplishment (direct experience). He theorized that these experiences form a hierarchy from emotional arousal (least effective) to performance accomplishment (most effective). By grafting self-efficacy theory onto pretherapy training procedures, a hierarchy can be developed that would theoretically account for the differential effectiveness of pretherapy training activities. In addition, one could also use the theory to predict the success of different pretherapy training "packages".

As mentioned above, the least effective means of modifying expectations is emotional arousal. Since group psychotherapy is likely to intensify emotional arousal, and since high arousal debilitates performance, any pretherapy procedure which reduced anxiety and general physiological arousal would help patients benefit from therapy. Unfortunately, not one pretherapy procedure has been devised to specifically reduce anxiety associated with beginning group therapy.

At the second level, verbal persuasion can be used to convince people that they can be successful in dealing with issues they have previously perceived as overwhelming. The pretherapy procedures used in the information only section of the literature review exemplify the use of verbal persuasion in expectation development. The most important asset of verbal persuasion is that it can provide patients with a cognitive framework to help them understand the importance of performing certain behaviors during group therapy.

At the third level, vicarious experience consists of seeing others performing threatening activities without any adverse consequences. This helps create the client expectation that if others can do it, then they should be able to achieve at least some improvement in performance (Bandura & Barab, 1973). The pretherapy procedures used in the modelling only section of the literature review exemplify the use of vicarious experience.

At the fourth and most effective level, performance accomplishment provides the patient with an opportunity to actually practice the behaviors required in a supportive environment. Repeated success at producing a behavior creates strong efficacy expectations, and increases the likelihood that the very same behaviors will be exhibited in the therapy situation. The pretherapy procedures which used simulated group experiences exemplify performance accomplishment.

It should be apparent to the reader that the author used Bandura's theory, specifically the sources of expectation

development, as a framework for the categorization of pretherapy training studies presented in the review. Previous reviews used categories of dependent variables or the medium employed as a basis for categorizing the studies. At the very least, Bandura's theory provides a refreshing and more meaningful basis for comparing studies. More importantly, it had been hoped from the outset that the hierarchy proposed by Bandura would be reflected in the relative effectiveness of the different pretherapy procedures. However, this has not been the case. In the first instance, no studies have attempted to manipulate emotional arousal only or performance accomplishment only, the least effective and most effective means, respectively, of expectation development according to Bandura. When comparing the studies which used information only or modeling only, both types have produced significant results on a variety of dependent variables, and the only study which compared modeling only to information only (Strupp & Bloxom, 1973) found that the modeling group did somewhat better but not to a significant degree. The notion of combining 2 or more sources of expectation so as to maximize the probability of strengthening efficacy expectations is interesting and holds promise. The eight studies which did just that provided promising results. There is a distinct possibility, therefore, that the maximum benefit could be achieved by combining the most effective sources of expectation development into one pretherapy "package". This line of reasoning, along with the issues surrounding dependent variables and methodology

presented earlier, guided the research design and selection of the pretherapy procedure employed in this study.

Study Rationale

Depression is one of the most serious mental health problems among older adults. With respect to the treatment of depression, psychotherapy is generally considered to be effective with older adults (Leszcz, 1987). More specifically, as reviewed above, outcome research currently supports the general effectiveness of psychotherapy (individual or group) in the treatment of late-life depression. In addition, some studies suggest that cognitive therapy may be more effective than other treatment modalities. This empirical data, along with the existence of a treatment manual, led the author to select group cognitive therapy as the treatment modality for the study. In reviewing the outcome studies, it also became apparent that the high rate of dropouts (25-50%) and the low rate of complete remission (roughly 50%) indicated that there is still considerable room for improvement.

One method used in the past to achieve this goal has been to prepare clients before they begin therapy. Twenty-four studies have been identified which used pretherapy training to enhance the effectiveness of group psychotherapy. An analysis of this literature revealed a number of issues which may be responsible for the lack of progressive inquiry in this field. First, the generally poor quality of the research was highlighted. Many of

the pitfalls mentioned have been avoided in this study by randomly allocating subjects to groups, using an attention-placebo control group, controlling for client's previous knowledge of psychotherapy, using more than one therapy group per condition, ensuring therapists were blind to the experimental manipulation, and measuring the effectiveness of the treatment modality employed. Second, although four categories of dependent variables have been identified, most studies report data on variables which fall into only one or two categories. In this study the author ensured that all 4 categories of dependent variables were covered by measuring client's knowledge of the psychotherapeutic process and client role expectations (immediate effects), attendance and dropout rates, in-therapy client behaviors (process), and degree of improvement (outcome). Third, and most importantly, none of the studies reviewed provided a theoretical underpinning to justify the selection of the pretherapy procedures. The pretherapy procedure employed in this study is explicitly based on Bandura's social cognitive theory. Specifically, the most effective means of manipulating efficacy expectations, according to Bandura, were employed, i.e., verbal persuasion (written and verbal material), vicarious experience (videotape), and performance accomplishment (structured group exercises). For the vicarious experience, a 20-minute videotape was developed which was specifically tailored for an older population.

In summary, the present study is unique in several ways. First, no other study has measured the effects of a theoretically-based pretherapy procedure on four separate categories of dependent variables within the context of a sound research design. Second, no other pretherapy training for group (or individual) psychotherapy study has specifically targeted an elderly population. Third, no study has examined the effects of a pretherapy procedure on the treatment of a single diagnostic category (i.e., depression).

Hypotheses

In accordance with the specific nature of this study, and the empirical literature on the treatment of depression in older adults and on pretherapy training for group psychotherapy, it is hypothesized that:

1. The subjects in the pretherapy training condition will have higher attendance and lower dropout rates during therapy than the subjects in the attention-placebo condition.
2. Immediately after pretherapy training and before the onset of therapy, the subjects in the pretherapy training condition will be more knowledgeable about the therapeutic process than subjects in the attention-placebo condition.
3. Immediately after pretherapy training and before the onset of therapy, the subjects in the pretherapy training condition will have more realistic role expectations than the subjects in the attention-placebo condition. Specifically, subjects in

- the pretherapy training condition will have significantly lower scores on the approval-seeking (APPROV) and audience-seeking (AUDIEN) subscales, and significantly higher scores on the advice-seeking (ADVICE) and relationship-seeking (RELAT) subscales of the Psychotherapy Expectancy Inventory-Revised, as compared to subjects in the attention-placebo condition.
4. The subjects in the pretherapy training condition will exhibit more desirable in-therapy behavior than the subjects in the attention-placebo condition, especially in the early stages of therapy. Specifically, subjects in the pretherapy training condition will make more "work" statements (as defined by the Hill Interaction Matrix-Revised), than subjects in the attention-placebo condition.
 5. The subjects in the pretherapy training condition will experience a more rapid remission of depressive symptomatology than subjects in the attention-placebo condition and, by the end of therapy, the subjects in the pretherapy training condition will have improved more on measures of depression than the subjects in the attention-placebo condition.
 6. Regardless of the condition to which they are assigned, all subjects will be less depressed at the end of therapy.

Method

Subjects

The subjects were recruited by placing advertisements in local newspapers, on radio, on television, and on bulletin boards of

residences reserved for older persons. Due to time constraints, subjects were recruited and entered the study at 3 different times, hereinafter referred to as phase I, phase II, and phase III. Phase I subjects were recruited and entered the study in May 1989, phase II subjects in February 1990, and phase III subjects in May 1990. The criteria for inclusion were as follows:

1. Must be 65 years of age or older
2. Must provide written consent to participate in the study
3. Must be anglophone or fluently bilingual
4. Must not be currently receiving psychotropic medication or being stabilized on such medication
5. Must receive a diagnosis of major depressive disorder (MDD) on the Inventory to Diagnose Depression (IDD) (Zimmerman, Coryell, Corenthal, & Wilson, 1986) or must achieve a minimum score of at least 14 on the BDI or 14 on the Geriatric Depression Scale (GDS) (Yesavage et al., 1983).

The criteria for exclusion were as follows:

1. Elevated risk of suicide on the basis of either (a) previous suicide attempt, (b) an endorsement of intention to commit suicide on the BDI, or (c) upon questioning, disclosure of serious intent to commit suicide
2. Presence of alcoholism or drug abuse

3. Presence of a psychiatric disorder other than primary depression
4. Presence of a physical ailment which may seriously inhibit participation in group therapy
5. Presence of significant cognitive impairment as indicated by a score of 24 or less on the Mini-Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975)
6. Involvement in any other form of psychological treatment
7. Previous experience in psychotherapy or unusual or special knowledge of the psychotherapeutic process.

A total of 87 persons answered the various advertisements. Of those, 56 (64%) passed the telephone screening and were given an appointment for an assessment session. Of those, 46 (82%) actually came to the assessment session. Of those, 29 (63%) were accepted into the study. Subjects were individually randomly assigned by means of a coin flip to the pretherapy training condition or the attention-placebo control condition. Table 1 shows the number of subjects in each phase by condition. The sociodemographic characteristics of the subjects can be found in the results section.

Procedure

Potential subjects who passed the telephone screening were invited to come in for an assessment session. At this session, potential subjects were given information on the major procedures

and requirements of the project and were assured confidentiality of information. Each potential subject was asked to sign an information and consent form (see Appendix A) reminding them that the testing and therapy were free of charge, that their participation was voluntary, and that they were free to withdraw from the study at any time. They were then given a demographic questionnaire, the IDD, the MMSE, the Knowledge About Psychotherapy Questionnaire (KAPQ), the Psychotherapy Expectancy Inventory-Revised (PEI-R) (Berzins, 1971), the GDS, and the BDI. Subjects who did not satisfy the inclusion and exclusion criteria were offered therapy outside the context of the study and were given an appropriate explanation as to why they were refused. Subjects who did meet the inclusion and exclusion criteria signed a confirmation of consent and were given the time and date of the first meeting of the condition to which they had been randomly assigned.

The pretherapy phase, which was comprised of the pretherapy training condition and the attention-placebo condition, was initiated and lasted two weeks. The same group leader delivered the activities in the two conditions. At the end of the pretherapy phase subjects were re-administered the KAPQ, the PEI-R, the GDS, and the BDI.

The following week the therapy phase of the project began, where subjects received 12 sessions of group cognitive therapy in as many weeks. The subjects in the pretherapy training condition remained together and formed one therapy group, while the

subjects in the attention-placebo group also remained together and formed a second therapy group. Thus, there were two therapy groups which received the same therapeutic modality, administered by the same co-therapist team. The therapy groups were seen on different days, thereby ensuring that there would be no communication between the subjects in the two therapy groups. After session 6 the order in which the therapy groups were seen was inverted to control for the experience acquired by the co-therapists. Subjects were administered the BDI at session 3, 6, and 9 and the GDS at session 6. At posttherapy subjects were administered the BDI, the GDS, and the HRS-D. The data collection protocol is summarized in Table 2. All sessions in the pretherapy phase and the therapy phase were recorded on videotape. Sessions 1, 2, 4, and 6 were analyzed using the Hill Interaction Matrix-Modified (Piper, Montvila, & McGihon, 1979). This entire procedure was repeated for phase II and phase III. The consent form and all procedures were approved by the Research Ethics Committee of the University of Ottawa.

Pretherapy Phase Conditions

Subjects in both the pretherapy training condition and the attention-placebo condition received four 1-hour sessions, twice a week for two weeks. The two conditions are described below.

Pretherapy Training

During the first session the subjects first received information on the structural features of group therapy, followed by a lecture which contained information aimed at disproving popular myths and misconceptions regarding the psychotherapeutic process. Afterwards they were encouraged to participate in a group discussion of the material presented. This lecture represented the first part of the information component of the pretherapy training.

In the second session subjects viewed a 20-minute videotape entitled Simulated Group Cognitive Therapy. The videotape consists of 3 vignettes depicting older adults discussing difficulties in a group setting. The videotape portrays models similar to the viewers who are engaged in desirable in-therapy behaviors, such as actively collaborating with the therapists, talking candidly with the group about one's problems (self-disclosing), expressing feelings and emotions, giving and receiving feedback, and taking responsibility for one's problems. The group leader stopped the videotape after each vignette and highlighted the important elements. The rest of the hour was spent in a group discussion of the videotape (the introduction to and a transcript of the videotape can be found in the pretherapy training manual, in Appendix B). At the end of the session subjects were instructed to read a handout before the next session which outlined how to give and receive feedback. This printed material can also be found in Appendix B. The printed

material was the second part of the information component and the videotape represented the vicarious experience component of the pretherapy training.

Session 3 consisted of a structured group exercise on the role of feedback in group therapy. The handout provided at the end of session 2 was designed to prepare them for this session. The Candle technique (Kipper, 1986) was used to structure a role playing situation where evaluative feedback may be offered in a relatively non-threatening atmosphere, where the personal integrity of the target person is more or less safeguarded, and where none of the group members are singled out. Essentially, each group member takes on a new identity (object, animal, or plant) and they give feedback to each other on the desirable and undesirable features of the new identity. The structured group exercise provided an experience of the concept of feedback and an opportunity to link the printed material with the experience.

Session 4 also consisted of a structured group exercise, this time on the role of self-disclosure. Subjects were invited to draw inside a circle symbols, marks, and abbreviations which represented different levels of the self. They were instructed to make the symbols sufficiently ambiguous so as not to be self-evident. Subjects were then asked to show their drawing to the other subjects, who could ask questions about the meaning of the symbols. The subject then self-disclosed to the extent they wished. The structured group exercises in sessions 3 and 4

represented the performance accomplishment component of the pretherapy training.

Attention-Placebo Condition

The purpose of the attention-placebo condition was to control for any benefits incurred by the subjects in the pretherapy training condition through contact with other subjects and the group leader. The two basic rules, which were strictly adhered to, were that (a) the sessions must last one hour, and (b) the group leader was to prevent the subjects from discussing their depression and anything related to therapy. The four sessions followed a group discussion format where the group leader initiated topics relevant to older persons, but theoretically unrelated to the therapeutic intervention. Thus, in session 1 the group leader briefly described the structural features of the therapeutic intervention (e.g., date and time, number of therapists, number of sessions), followed by a discussion of sensory and physical changes in older adults. In session 2 the subjects viewed a 26-minute film entitled The Business of Aging. This activity was included to control for the video seen by the subjects in the pretherapy training condition. This film focused on the financial infra-structure of public and private homes for the aged. The topic for session 3 was the change in family roles as one grows older, while the exploitation of the aged was discussed in session 4.

The group leader followed separate manuals which were written for the pretherapy training condition and the attention-placebo condition, and they can be found in Appendixes B and C, respectively. Although this study did not employ formal random checks on the implementation of the activities in the two conditions, every single session in the pretherapy phase was monitored through a one-way mirror by the author to ensure consistent and appropriate application of the activities in both conditions.

Therapeutic Modality

The treatment modality used in this study was modeled on Yost et al.'s (1986) adaptation of group cognitive therapy for use with depressed older adults. A detailed outline of the main components of the treatment modality can be found in Appendix D. The treatment manual devised for this study can be found in Appendix E. Once again, this study did not use formal random checks to ensure that the treatment modality was delivered in the same way to both therapy groups. However, the clinical supervisor monitored all sessions in the therapy phase through a one-way mirror and provided supervision to the therapists on a weekly basis to ensure uniform implementation of the treatment.

Pretherapy Group Leaders, Therapists, and Raters

The pretherapy group leaders were two senior doctoral-level female students in clinical psychology at the University of

Ottawa. One of them carried out the pretherapy phase for phase I, while the other did the same for phase II and phase III. The latter group leader viewed the videotapes from the pretherapy phase of phase I, to ensure uniformity of application. The pretherapy group leaders received brief supervision from the author after each session of the pretherapy phase.

All the therapists who participated in the study were senior doctoral-level students in clinical psychology. All therapists had received at least one year of clinical supervision, part of which included group therapy. In addition, each therapist completed a 4-week training program which focused on the theoretical and practical aspects of group cognitive therapy. All therapists received at least one hour of clinical supervision a week, delivered by a psychologist registered to practice in Ontario. As part of their training, the co-therapists for phase I led a pilot group of nondepressed older adults. For each phase, a mixed gender co-therapist team was formed. After phase I the female therapist was no longer available and a new female therapist was recruited. After phase II the male therapist was then no longer available and a new male therapist was recruited. Therefore, a total of four therapists participated in the study. At least one member of each co-therapist team led two groups, thereby assuring continuity from the pilot group to phase III. The therapists were blind to the true purpose of the study.

Two undergraduate students in psychology were recruited as raters. They were trained by the author and a research assistant

on the rating system of the Hill Interaction Matrix-Modified. The audiotapes from the pilot group were used as practice materials. The raters were kept blind to the true purpose of the study.

Treatment Setting

All components of the study were carried out at the Center for Psychological Services of the University of Ottawa, a research and training facility that provides psychological services to the Ottawa-Carleton community. The Center is staffed by registered psychologists who provide clinical supervision to doctoral-level interns in clinical psychology. The Center is equipped with soundproof rooms and audiovisual equipment. The clinical supervisor for this study is on staff at the Center.

Measurement Instruments

The following instruments were used to screen the subjects.

Telephone Screening Procedure

The telephone screening procedure was especially devised for the purposes of this study. Its purpose was to provide an initial screening of those individuals who responded to the advertisements. It includes questions pertaining to the inclusion and exclusion criteria for this study, some general information concerning what is required from the selected subjects, as well as additional information in the event callers

required clinical referrals for problems (e.g., substance abuse). The form also includes the setting up of the appointment (if the caller met the initial criteria) for the assessment session. A copy of the telephone screening procedure can be found in Appendix F.

Inventory to Diagnose Depression

The IDD has been developed recently by Zimmerman et al. (1986) to serve as a DSM-III-based measure of major depressive disorder. This instrument appears to be emerging as the instrument of choice for the differential diagnosis of depression, as it provides for the reliable assessment of the type and severity of depressive disorder. The IDD consists of 22 groups of five statements, with each group of statements representing one DSM-III based symptom of depression. Statements within each group are graded on a 5-point scale so that the severity of depression can be quantified. The possible range of scores on the IDD is 0 to 88, with a maximum score of 4 on each of the 22 groups of statements. The duration of depressive symptoms can also be assessed since each item can be scored as present for more or less than two weeks. Zimmerman et al. (1986) have reported a mean score of approximately 42 for a depressed inpatient population, which is slightly below the mean score of approximately 44 found in severe cases of depression. Mean scores for mild and moderate clinical depression are reported as

27 and 39, respectively. The IDD can be completed in roughly 15 minutes by a depressed population.

According to Zimmerman et al. (1986), the IDD can accurately discriminate the severity of depression and it correlates highly with the Hamilton Rating Scale for Depression ($r = 0.88$, $p < .001$) and the Beck Depression Inventory ($r = 0.87$, $p < .001$). The split-half reliability coefficient of the IDD was reported to be .93 with an internal consistency of .92 (Cronbach's alpha). The diagnostic performance of the IDD suggests that it is a sensitive and specific instrument which can reliably classify major depressive disorder according to severity and type.

Mini-Mental State Examination

The MMSE (Folstein, Folstein, & McHugh, 1975) is a measure designed to assess the degree of cognitive impairment on the basis of a short interview. The MMSE is divided into two sections, the first of which requires vocal responses only and covers orientation, memory, and attention. The maximum score on this section is 21. The second part tests ability to name, follow verbal and written commands, write a sentence spontaneously, and copy a complex polygon similar to a Bender-Gestalt figure. The maximum score on this section is 9. The possible range of scores is therefore 0 to 30. The test is not timed and can be completed in 5 to 10 minutes. Folstein et al. (1975) reported a mean score of 9.7 for patients with dementia, 19.0 for those experiencing depression with cognitive

impairment, 25.1 for uncomplicated affective disorder (depressed), and 27.6 for normals.

With respect to its psychometric properties, the MMSE was reported to have a test-retest reliability of 0.89. The concurrent validity was determined by correlating MMSE scores with the WAIS Verbal and Performance scores. The Pearson coefficient was 0.78 between the MMSE and the Verbal IQ, while a correlation of 0.66 was obtained between the MMSE and the Performance IQ.

The BDI and the GDS were also used as screening measures to assess the initial level of depression. These instruments are described below in the section on outcome measures. The following instruments were used to assess the immediate effects of the pretherapy training.

Knowledge About Psychotherapy Questionnaire

The KAPQ is an instrument which was developed specifically for the purposes of this study. It was developed by examining the content of the group leader's presentations in the pretherapy training condition and then constructing questions based on that content. It is a 10-item questionnaire designed to assess client knowledge of the information and ideas about psychotherapy contained in the pretherapy training. This questionnaire was also given to the clients in the attention-placebo group to assess their knowledge about psychotherapy without the benefit of

pretherapy training. Subjects were asked to respond true or false for each of 10 items. The possible range of scores was 0 to 10. The psychometric properties of this measure and the measure itself can be found in Appendix G.

Psychotherapy Expectancy Inventory-Revised

The PEI-R was developed by Berzins (1971) to measure clients' role expectancies, i.e., how clients expect to enact the "role of patient" during therapy hours. This measure consists of a 30-item questionnaire (24 keyed items and 6 fillers) with each item rated on a scale from 1 to 7. The items are divided into four subscales: approval-seeking (APPROV), advice-seeking (ADVICE), audience-seeking (AUDIEN), and relationship-seeking (RELAT). These subscales were initially developed on rational grounds but were later confirmed through factor analysis (loadings of 0.40 or greater) (Berzins, 1971). The first two subscales (APPROV and ADVICE) have in common the client's greater dependency on the therapist for emotional and/or rational guidance. In general, clients scoring high on either of these scales expect that the therapist will take care of them. In particular, the APPROV subscale indicates the extent to which the client is concerned with obtaining and maintaining the therapist's support and emotional guidance, while the ADVICE subscale specifically denotes expectancies that the therapist will provide cognitive guidance and evaluation. Clients scoring high on the latter two scales (AUDIEN and RELAT) have in common

relatively greater expectation for autonomy and status relative to the therapist. In particular, the AUDIEN subscale indicates the extent the client expects to engage in verbal initiative during therapy sessions, while the RELAT subscale denotes expectancies of spontaneous self-disclosure in the context of an egalitarian relationship with the therapist.

Internal consistency or homogeneity estimates (Cronbach's alpha coefficients) for a sample of 1241 patients were 0.75 for APPROV, 0.83 for ADVICE, 0.86 for AUDIEN, and 0.87 for RELAT. To date, no test-retest coefficients have been obtained for the PEI-R. Validity studies have concentrated on the convergent/discriminant validity of the PEI-R. The PEI-R has been examined relative to such criteria as: a) clients' concurrent scores on the Personality Research Form; b) clients' self-reported symptomatology; and c) outcome of brief psychotherapy. The PEI-R emerged from these analyses as a brief expectancy measure whose four subscales generally relate meaningfully, although modestly, to the validation criteria examined.

The following process measure was used to assess the level of desirable in-therapy behaviors.

Hill Interaction Matrix-Modified

The HIM (Hill, 1965) was initially developed to categorize and score interactions in psychotherapy groups. Although other

process analysis systems exist, they have rarely been used with therapy groups. The system was modified by Piper, Montvila, and McGihon (1979) in order to increase its conceptual clarity and its internal consistency. The modified version resembles the original structurally, i.e., a two-dimensional 16-cell matrix, but it differs substantially from the original with respect to unit and category definitions. The two dimensions of the matrix are content and work. Content refers to the subject of a statement. It consists of topic, group, personal, and relationship categories. Topic statements are general discussion subjects. Group statements identify the group as a unit. Personal statements provide information about individual members. Relationship statements indicate how two parties within the group affect each other. Work refers to the investigation of a problem, i.e., a symptom, an unobtained goal, or an obstacle to goal attainment. The work dimension consists of conversational nonwork, affective nonwork, undocumented work, and documented work categories. Conversational nonwork statements are neutral material that does not deal with a problem. Affective nonwork statements are affect-laden material that does not deal with a problem. Undocumented work statements identify a problem. Documented work statements identify a problem and offer evidence. Any statement made in the group can be placed within one of the cells.

Piper et al. (1979) have reported two types of reliability coefficients for this instrument. The first concerned the

percent unit-by-unit cell agreement between two raters for a therapy session. The mean percent agreement for 20 sessions was 71.2% with a range from 57.9% to 82.2%. The second type of coefficient concerned the correlation between two raters' distribution of cell scores for a therapy session (otherwise known as marginal agreement reliability). The mean correlation coefficient for 10 sessions was 0.95, with a range from 0.86 to 0.99. To date there have been no studies of the validity of the HIM-M.

The following outcome measures were used to assess the level of depression before, during, and after subjects' involvement.

Hamilton Rating Scale for Depression

The HRS-D (Hamilton, 1967) is a measure designed to assess the presence of depressive symptomatology on the basis of a clinical interview. The scale contains 17 variables, divided into those which are defined in terms of categories of increasing intensity, and those which are defined by a number of equal valued terms. Examples of variables include depressed mood, retardation, and work and interests. The possible range of scores is 0 to 62. Yesavage et al. (1983) have reported a mean score of 5.43 for a normal population, 13.35 for mildly depressed, and 25.42 for severely depressed.

A recent validation of the HRS-D (Ramos-Brieva & Cordero-Villafila, 1988) indicates good inter-rater reliability

($r = 0.99$), split-half reliability ($r = 0.89$), and alpha reliability ($r = 0.72$). They also report good concurrent ($r = 0.82$) and content (average frequency = 62%) validity. A factor analysis of the HRS-D revealed five factors which explained 56% of the total variance.

Geriatric Depression Scale

The GDS (Yesavage et al., 1983) was specifically designed to measure depression in the aged, and was originally intended as a screening instrument. This measure consists of a 30-item questionnaire in a Yes/No format. This instrument was included in this study because it was designed to be used with older adults and because of its sound psychometric properties. The possible range of scores on the GDS is 0 to 30. Yesavage et al. (1983) have reported a mean score of 5.75 for a normal population, 15.05 for mildly depressed persons, and 22.85 for the severely depressed. The GDS can be completed in less than 15 minutes by a depressed population.

According to Yesavage et al. (1983), the GDS has a high degree of internal consistency, with a mean inter-item correlation of 0.36 and an alpha coefficient of 0.94. In addition the scale has a split-half reliability of 0.94 and a test-retest reliability of 0.85. Convergent validity has been assessed by calculating correlations between the GDS and well-established measures of depression. The correlation between the GDS and the Zung Self-Rating Depression Scale (SDS) was found

to be 0.84 while a correlation of 0.83 was found between the GDS and the Hamilton Rating Scale for Depression (HRS-D). The correlation between the SDS and the HRS-D was 0.80. All these correlations were statistically reliable at or beyond the .001 level.

Beck Depression Inventory

The BDI (Beck et al., 1961) is a widely used measure of the severity of depressive symptomatology. This measure consists of 21 sets of four statements, with each set reflecting a characteristic symptom of depression such as pessimism of outlook, social withdrawal, and dissatisfaction. The four statements in each item set are scaled from 0 to 3 to reflect symptom severity, with a possible range of scores from 0 to 63. Beck, Steer, and Garbin (1988) have reported a mean score of 10.9 as indicating no or minimal depression, 18.7 for mild depression, 25.4 for moderate depression, and 30.0 for severe depression.

This inventory has excellent psychometric properties and correlates significantly with both clinical and self-report ratings of depression (Zimmerman, Coryell, Corenthal, & Wilson, 1986). Beck, Steer, and Garbin (1988) have reported that a meta-analysis of the BDI's internal consistency estimates yielded a mean coefficient alpha of 0.86 for psychiatric patients and 0.81 for nonpsychiatric patients. They also reported that the mean correlations of the BDI samples with clinical ratings and the Hamilton Rating Scale for Depression (HRS-D) were 0.72 and

0.73, respectively, for psychiatric patients. With nonpsychiatric subjects, the mean correlations of the BDI with clinical ratings and the HRS-D were 0.60 and 0.74, respectively. They also report evidence to suggest that the BDI discriminates subtypes of depression and differentiates depression from anxiety.

Data Analysis

For sociodemographic comparisons, screening comparisons and to test hypothesis #1 (dropout and attendance rates), chi-squares, Fisher's exact test, and t-tests were computed using SPSS^x (SPSS Inc., 1986).

Hypotheses #2 (knowledge about psychotherapy) and #5 (level of depression) were tested using repeated-measures ANOVA designs, while hypothesis #3 (role expectations) was tested using a repeated-measures MANOVA design. It was not considered appropriate to employ a repeated-measures MANOVA design for the three depression measures (i.e., BDI, CDS, and HRS-D) used to test hypothesis #5, because each measure was administered a different number of times. These analyses were performed using BMDP (BMDP Statistical Software, 1985) and the SPSS^x MANOVA procedure (SPSS Inc., 1986).

Because subjects entered the study and the data were thus collected at three separate times (May, 1989; February, 1990; and May 1991), this created a nuisance variable, i.e. "phase" (see Table 1). The three phases were nested within the two conditions

(Kirk, 1982). On theoretical grounds, "phase" was not expected to be an influential factor, but it was necessary to adopt a strategy which empirically determined its actual influence; otherwise, the data would have mistakenly been treated as though they had been obtained from a completely randomized design (Kirk, 1982). Therefore, a hierarchical (nested) strategy was adopted, using a between-subjects error term in MANOVA that takes into account "phase" variability as nested within the two conditions.

For hypothesis #4 (level of work), the decision to collect data for sessions 1, 2, 4, and 6 was based on theoretical and financial grounds. Since there were three phases, with two conditions per phase, and four timepoints, the total number of tapes to be rated was 24. Unfortunately, 4 tapes (the 2 tapes for phase II, session 1 and the 2 tapes for phase I, session 6) were unusable due to poor sound. The data, therefore, were based on 20 sessions. For each tape, the 100 consecutive statements following the start of an activity were rated. The choice of the activity to be rated was not made arbitrarily. It had to be an activity where it was possible for subjects to emit both work and nonwork statements. For session 1, then, the activity selected was when subjects introduced themselves, while for sessions 2, 4, and 6 the activity selected was the homework review. In all cases, the 100 statements rated fell within the confines of these activities.

Separately, the two raters placed each statement in one of the 16 cells of the matrix. Since only the work dimension was of

interest, frequencies were collapsed across the content dimension. Then the conversational nonwork and affective nonwork categories were collapsed, as were the undocumented work and documented work categories. For each rater, then, the frequency of work and nonwork statements was tabulated. For subsequent analyses, the average frequency of work and nonwork statements for each tape was used. To determine the reliability of the raters, two indexes were used. The marginal agreement reliability is the correlation between raters' distribution of cell scores for a given tape. The unit-by-unit perfect agreement reliability is the percentage of statements where both raters placed a given statement in the same cell. The latter index provides a more stringent test of the raters' reliability.

To test hypothesis #4 the relationships between the three discrete variables (condition, session, and statement type) were examined by performing a 3-way frequency analysis, also known as a loglinear analysis. Of the three discrete variables, statement type is considered to be a dependent variable, since category membership (i.e., work vs nonwork) was determined by applying specific criteria. When loglinear analysis is used with one variable (statement type) considered a dependent variable, it is called logit analysis. The associations between terms in logit analysis are understood best by thinking in terms of ANOVA. A main effect of condition in ANOVA is tested by the statement by condition association in logit analysis. Similarly, the condition by session interaction is the three-way association

between condition, session, and statement type. The nonhierarchical logit analysis was performed using the SPSS² LOGLINEAR procedure (SPSS Inc., 1986).

To test hypothesis #6 (effectiveness of therapy), the main effect for time term from the repeated-measures analyses used to test hypothesis #5 were used. This, however, only provided information on the average improvement scores for all subjects, and therefore provided no information on the effects of therapy for individual subjects (Jacobson, Follette, & Revenstorf, 1984). Furthermore, those analyses would only reveal whether the difference in scores was statistically significant, but would provide no information on the clinical significance of those findings. Jacobson et al. (1984) have proposed a strategy for determining clinical significance. First, the author determined whether the posttherapy BDI, GDS, and HRS-D scores of subjects who completed treatment were more likely to be in a functional or dysfunctional population. This was accomplished by using the value midway between two standard deviations below the mean (direction of functionality) of the completers, and two standard deviations above the mean (direction of dysfunctionality) of a normal elderly sample as the cut-off score. Second, a reliable change index was calculated for each subject's posttherapy score following the method suggested by Jacobson et al. (1984). The reliable change index is equivalent to the difference score (post - pre) divided by the standard error of measurement. The standard error of measurement is calculated by multiplying the

standard deviation of the experimental group at pretest by the square root of one minus the test-retest reliability of the measure. Only subjects whose posttherapy scores were likely to be in a functional population and whose scores showed a statistically reliable change (i.e., a reliable change index greater than ± 1.96) from screening levels were considered to have made a clinically significant change. For the BDI, the normal elderly sample mean and standard deviation, as well as the test-retest reliability for the BDI were provided by Vézina, Landreville, Bourque, and Blanchard (1991) and J. Vézina (personal communication, March, 1990). For the GDS, the normal elderly sample mean and standard deviation, as well as the test-retest reliability for the GDS were provided by Bourque, Blanchard, and Vézina (1990). For the HRS-D, the normal elderly sample mean and standard deviation, as well as the test-retest reliability for the HRS-D were provided by Yesavage et al. (1983).

Results

Sociodemographic Comparisons

Chi-square, Fisher's exact test, and t-test were employed to detect differences between conditions on sociodemographic variables. The following analyses are based on the total sample of 29 subjects. There were no significant differences between the two conditions on the following sociodemographic variables: age, $t_{(27)} = -.23$, $p > .05$; gender ($p > .05$, Fisher's exact test);

educational level ($p > .05$, Fisher's exact test); marital status, $X^2_{(1)} = .02$, $p > .05$; perceived health, $X^2_{(1)} = .91$, $p > .05$; and living arrangements, $X^2_{(1)} = .32$, $p > .05$. All subjects were retired at the time of the study. The only significant difference between conditions was on income level, $X^2_{(1)} = 5.32$, $p < .05$. Subjects in the attention-placebo condition had a significantly higher income level than subjects in the pretherapy training condition. Table 3 displays the descriptive data for these variables.

Screening Comparisons

There was no significant difference between conditions on the distribution of subjects with or without a diagnosis of major depressive disorder on the IDD, $X^2_{(1)} = 2.04$, $p > .05$. Also, there was no significant difference between conditions on level of cognitive functioning, as measured by the MMSE, $t_{(27)} = -.57$, $p > .05$. The conditions did not differ on initial levels of depression as measured by the BDI, $t_{(27)} = -1.78$, $p > .05$, and the HRS-D, $t_{(27)} = -1.20$, $p > .05$. However, there was a significant difference on initial level of depression as measured by the GDS, $t_{(27)} = -3.14$, $p < .05$; subjects in the pretherapy training condition obtained significantly higher scores than subjects in the attention-placebo condition. Table 4 displays the descriptive data for these variables.

Hypothesis #1: Effect of Pretherapy Phase on
Dropout and Attendance Rates

A total of eight subjects (27.6%) dropped out from the study. A dropout was defined as a subject who decided, unilaterally, to leave the study prematurely. One subject left after the first session of the pretherapy phase and the seven others left during the therapy phase. Five subjects (17.2%) were in the attention-placebo condition while three (10.3%) were in the pretherapy training condition. Although more subjects in the attention-placebo condition dropped out from the study, the distribution of dropouts across conditions was not significant ($p > .05$, Fisher's exact test). There were no significant differences between dropouts and completers on sociodemographic variables, initial level of depression, or diagnosis. Condition equivalence on sociodemographic variables and diagnosis was maintained after the dropouts were removed from the analyses. Condition equivalence on initial level of depression as measured by the BDI and the HRS-D was also maintained. The initial non-equivalence of conditions on initial level of depression as measured by the GDS was no longer present when the dropouts were removed from the analyses. Table 5 displays the number of dropouts in each phase by condition.

Attendance at the four sessions of the pretherapy phase and the 12 sessions of the therapy phase were recorded. There was no significant difference between conditions on mean attendance at the pretherapy phase sessions, $t_{(26)} = .50$, $p > .05$. Thus, subjects

were exposed to a similar extent to the activities in their respective conditions. Similarly, there was no significant difference between conditions on mean attendance at the therapy phase sessions, $t_{(26)} = -1.57$, $p > .05$. Descriptive statistics for attendance data can be found in Table 6.

Hypothesis #2: Effect of Pretherapy Phase on
Knowledge of Psychotherapy

The statistical model used to assess the effects of the pretherapy intervention on knowledge of the therapeutic process was a 2 X 2 repeated measures ANOVA. The between-subjects variable had two levels, corresponding to the pretherapy training and attention-placebo conditions, and the within-subjects variable comprised the two timepoints where the KAPQ was administered. Figure 1 presents the mean scores on the KAPQ over time.

There was a significant condition by time interaction, $F_{(1,26)} = 7.67$, $p < .05$, indicating that there was a differential effect of condition on knowledge of psychotherapy over time. To further analyse the condition by time interaction, simple main effects holding group constant were investigated. This analysis revealed that the interaction was due to a significant increase in knowledge of psychotherapy by subjects in the pretherapy training condition over time.

The univariate main effect for condition was not significant, $F_{(1,26)} = .16$, $p > .05$. There was no significant effect

for phase within condition by time, Hotellings $T^2 = .40$, $F(4,22) = 1.0$, $p > .05$. Therefore, variance related to phase nested within conditions was not a significant factor (i.e., phase was not a significant nuisance variable). The main effect for time was also not significant, $F(1,26) = 3.26$, $p > .05$. Descriptive statistics for KAPQ scores are presented in Table 7. The psychometric properties of this measure can be found in Appendix G.

Hypothesis #3: Effect of Pretherapy Phase on Role Expectations

The statistical model used to assess the effects of the pretherapy intervention on role expectations was a 2 X 2 X 4 repeated measures MANOVA. The between-subjects variable had two levels, corresponding to the pretherapy training and attention-placebo conditions, the within-subjects variable comprised the two timepoints when the PEI-R was administered, and the dependent variables were the four subscales of the PEI-R: APPROV, ADVICE, AUDIEN, and RELAT. Results of evaluation of assumptions of normality, homogeneity of variance-covariance matrices, linearity, and multicollinearity were satisfactory.

With the use of Wilks' criterion, the combined subscales on the PEI-R revealed a significant condition by time interaction, $F(1,26) = 3.84$, $p < .01$. The phase within condition by time interaction was not significant, Hotellings $T^2 = 3.28$, $F(4,22) = 1.38$, $p > .05$. Variance related to phase within condition was not

a significant factor, thus phase was not a significant nuisance variable. The main effect for condition did not reach significance, $F_{(1,26)} = .99$, $p > .05$, nor did the main effect for time, $F_{(1,26)} = .73$, $p > .05$. Figures 2-5 present the mean scores on the PEI-R for conditions over time.

To investigate the impact of the condition by time interaction on the individual subscales, a stepdown analysis was performed. All subscales had correlations greater than 0.40 and were judged to be sufficiently reliable to warrant stepdown analysis. In the stepdown analysis the subscales were entered arbitrarily since there was no compelling priority ordering of them. Each subscale was also tested in a univariate ANOVA, but more emphasis was given to the subscales that were significant in the stepdown analysis (Tabachnick & Fidell, 1989).

A unique contribution to the significant condition by time interaction was made by the AUDIEN subscale, stepdown $F_{(1,26)} = 14.77$, $p < .001$. The simple main effects obtained from the univariate ANOVA for the AUDIEN subscale revealed a significant decline in scores over time for the subjects in the pretherapy training condition. Thus, subjects in the pretherapy training condition exhibited significantly less audience-seeking behaviors, e.g., initiating conversation, bringing up topics to discuss, being "in charge" of sessions, than subjects in the attention-placebo condition. No other subscale reached significance on either the stepdown analysis or on the univariate ANOVA's. Descriptive statistics for PEI-R scores are presented

in Table 8. Internal consistency or homogeneity estimates (Cronbach's alpha coefficients) are presented in Table 9. Subscale intercorrelations can be found in Table 10.

Hypothesis #4: Effect of Pretherapy Phase on
Level of Work

For the 20 tapes which were rated, the mean marginal agreement reliability was .98 (range: .93 - .99), while the mean unit-by-unit perfect agreement reliability was 82.3% (range: 70.0 - 94.0%).

A three-way frequency analysis was performed to develop a logit model of the work dimension on the HIM-M. Predictors were condition (pretherapy training vs. attention-placebo) and session (sessions 1, 2, 4, and 6). All component two-way contingency tables showed expected frequencies in excess of five.

A preliminary loglinear analysis was performed to determine which associations containing the dependent variable (STATEMENT TYPE) were not statistically significant, by using both partial and marginal tests of association. This preliminary analysis revealed that all associations involving statement type were significant (i.e., STATEMENT TYPE, STATEMENT TYPE by CONDITION, STATEMENT TYPE by SESSION, and STATEMENT TYPE by CONDITION by SESSION). Therefore, the three-way nonhierarchical logit analysis produced a saturated model.

A summary of the model with results of tests of significance appears in Table 11. Observed frequencies are presented in Table

12, while marginal frequencies for the separate effects appear in Table 13.

Overall, there were significantly more nonwork statements (71.2%) than work statements (28.8%). The STATEMENT TYPE by CONDITION association (main effect of condition) indicated that subjects in the pretherapy training condition made significantly more work statements (60.5%) than subjects in the attention-placebo condition (39.5%). The STATEMENT TYPE by SESSION association (main effect of session) revealed that subjects were making significantly more nonwork statements (21.9%) than work statements (14.9) at session 1, that there were no significant differences at sessions 2 and 4, but by session 6, subjects were making significantly more work statements (28.0%) than nonwork statements (16.9%). The STATEMENT TYPE by CONDITION by SESSION association (condition by session interaction) is illustrated in Figure 6. The pattern of work statements across time for the two conditions were quite dissimilar. For the attention-placebo condition, there was an increase in work statements from session 1 to session 2, but a levelling off occurred as therapy progressed. For the pretherapy training condition, there was virtually no change in number of work statements from session 1 to session 4, but from session 4 to session 6 there was a dramatic increase in work statements. Comparisons between conditions at each timepoint were also quite revealing. At session 1, subjects in the pretherapy training condition were making twice as many work statements (66%) as subjects in the

attention-placebo condition (33%). At session 2 and session 4, this difference was no longer present, but at session 6, an even greater difference than at session 1 re-emerged: subjects in the pretherapy training condition were making two and a half times more work statements (71%) than subjects in the attention-placebo condition (29%).

Hypothesis #5: Effect of Pretherapy Phase on
Severity of Depressive Symptomatology

The statistical model used to analyze the effects of the pretherapy phase on the level of depression was a repeated-measures ANOVA. Three measures were available to test this hypothesis, i.e., the BDI, the GDS, and the HRS-D.

For the BDI, a 2 X 6 repeated-measures ANOVA was performed. The between-subjects variable had two levels, corresponding to the pretherapy training and attention-placebo conditions, while the within-subjects variable represented the 6 timepoints where the BDI was administered (screening, session 1, 3, 6, 9, and posttherapy). Figure 7 illustrates mean BDI scores over time. Three cases were dropped due to missing data, therefore, for this analysis $n = 18$. Since the assumption of homogeneity of variance-covariance was violated, the F value was adjusted using the Hotellings T^2 correction.

The absence of a significant condition by time interaction, adjusted $F_{(5,12)} = 2.29$, $p > .05$, indicated that the trend of BDI scores over time was virtually parallel for the two conditions.

Observed power at alpha = .05 for the interaction term was .53. The phase within condition by time interaction was not significant, Hotellings $T^2 = 6.86$, $F(4,12) = 1.57$, $p > .05$. The variance related to phases was not a significant factor; therefore, phase was not a significant nuisance variable. The univariate main effect for condition was not significant, $F(1,16) = 2.19$, $p > .05$. However, there was a significant main effect for time, adjusted $F(5,12) = 5.98$, $p < .01$. This finding will be discussed in the context of testing hypothesis #6. Descriptive statistics for BDI scores can be found in Table 14.

For the GDS, a 2 X 4 repeated-measures ANOVA was performed. The between-subjects variable had two levels, corresponding to the pretherapy training and attention-placebo conditions, while the within-subjects variable represented the 4 timepoints where the GDS was administered (screening, session 1, 6, and posttherapy). Figure 8 illustrates mean GDS scores over time. Assumptions of homogeneity of variance and covariance were satisfied. There were no missing data points; therefore, for this analysis, $n = 21$.

The absence of a significant condition by time interaction, Hotellings $T^2 = .45$, $F(1,19) = 2.55$, $p > .05$, indicated that the trend of GDS scores over time was virtually parallel for the two conditions. Observed power at alpha = .05 for the interaction term was .53. The phase within condition by time interaction was also not significant, Hotellings $T^2 = 1.64$, $F(4,15) = 1.08$, $p > .05$. The variance related to phases was not a significant factor;

therefore, phase was not a significant nuisance variable. The univariate main effect for condition was not significant, $F_{(1,19)} = 3.65$, $p > .05$. However, there was a highly significant main effect for time, Hotellings $T^2 = 2.85$ $F_{(1,19)} = 16.15$, $p < .001$. This finding will be discussed in the context of testing hypothesis #6. Descriptive statistics for GDS scores can be found in Table 14.

For the HRS-D, a 2 X 2 repeated-measures ANOVA was performed. The between-subjects variable had two levels, corresponding to the pretherapy training and attention-placebo conditions, while the within-subjects variable was comprised of the 2 timepoints where the HRS-D was administered (screening and posttherapy). Figure 9 illustrates mean HRS-D scores over time. Assumptions of homogeneity of variance and covariance were satisfied. There were no missing data points; therefore, for this analysis, $n = 21$.

The absence of a significant condition by time interaction, $F_{(1,19)} = .81$, $p > .05$, indicated that from screening to posttherapy, the changes in HRS-D scores were parallel for the two conditions. Observed power at alpha = .05 for the interaction term was .16. The phase within condition by time interaction was also not significant, Hotellings $T^2 = .32$, $F_{(4,15)} = .52$, $p > .05$. The variance related to phases was not a significant factor; therefore, phase was not a significant nuisance variable. The univariate main effect for condition was not significant, $F_{(1,19)} = .95$, $p > .05$. However, there was a highly significant main effect

for time, $F_{(1,19)} = 132.0$, $p < .001$. This finding will be discussed in the context of testing hypothesis #6. Descriptive statistics for HRS-D scores can be found in Table 14. The intercorrelation matrix for the three depression measures can be found in Table 15.

Hypothesis #6: Effect of Therapy Phase on
Severity of Depressive Symptomatology

As reported in the analyses above, for all three measures of depression there was a highly significant main effect of time: for the BDI, adjusted $F_{(5,12)} = 5.98$, $p < .01$; for the GDS, Hotellings $T^2 = 2.85$, $F_{(1,19)} = 16.15$, $p < .001$; and for the HRS-D, $F_{(1,19)} = 132.0$, $p < .001$. To further analyze the main effect of time, simple main effects holding condition constant were investigated. This analysis revealed the same finding for all three measures: subjects in both conditions had significantly lower depression scores at the conclusion of the study than they had had at the beginning of the study.

The clinical significance of these improvements was evaluated using the strategy described in the data analysis. Only subjects whose posttherapy scores were likely to be in a functional population and whose scores showed a statistically reliable change from screening levels were considered to have made a clinically significant change. Because both conditions received the same treatment and because there was no difference between conditions on depression scores across time, the

following percentages are based on the total sample of completers ($n = 21$). The percentage of subjects showing a clinically significant change on the BDI, GDS, and HRS-D was 57 (12/21), 33 (7/21), and 71 (15/21), respectively.

Discussion

The purpose of this study was to examine the effectiveness of a theoretically-based pretherapy training procedure in enhancing group cognitive therapy for depressed older adults. In this section each hypothesis will be discussed in turn. This will be followed by a general discussion of the research and clinical implications of the study.

Hypothesis #1: Effect of Pretherapy Phase on

Dropout and Attendance Rates

Hypothesis #1 was not supported by the data. Although more subjects from the attention-placebo condition dropped out of the study, the difference in the number of dropouts between conditions was not significant. An overall dropout rate of 27.6% and a dropout rate of 20% for the pretherapy training condition both fall at the lower end of the range typically encountered in studies of group psychotherapy with older adults. With respect to the pretherapy training studies reviewed earlier, all six studies which reported dropout data obtained non-significant results (Causey, 1985; France & Dugo, 1985; Garrison, 1978; Piper et al., 1979; Piper et al., 1982; Yalom et al., 1967). One

possible explanation for the negative findings may be that at least some reasons which lead subjects to drop out of therapy (e.g. transportation, illness) are unrelated to or unaffected by what might be learnt in pretherapy training sessions.

Although subjects in the pretherapy training condition attended more sessions, on average, than subjects in the attention-placebo condition, the difference between the conditions was non-significant. The absence of a significant difference in attendance may be due at least in part to the small sample size and the concomitant relatively low statistical power (.57). Aside from the low statistical power explanation, it might also be suggested that the attention received by the subjects in the attention-placebo condition contributed in an unspecified manner to bolstering subjects' commitment to therapy, thereby erasing any differences which might have been present between conditions with respect to attendance data. Of the studies reviewed earlier, seven reported attendance data (France & Dugo, 1985; Garrison, 1978; Hilkey et al., 1982; Piper et al., 1979; Piper et al., 1982; Strupp & Bloxom, 1973; Yalom et al., 1967). Although four of these studies reported significant differences in attendance in the expected direction (France & Dugo, 1985; Garrison, 1978; Piper et al., 1979; Piper et al., 1982), three of them had control conditions where subjects received less attention than subjects in the experimental condition. The possibility remains that, in these three studies, significant differences in attendance were obtained because

subjects in the control condition received less attention than subjects in the experimental condition.

Hypothesis #2: Effect of Pretherapy Phase on
Knowledge of Psychotherapy

As hypothesized, subjects in the pretherapy training condition had significantly greater knowledge of psychotherapy at the end of the pretherapy phase than subjects in the attention-placebo condition. The questions posed on the questionnaire were answered directly in the group leader's presentations to the subjects in the pretherapy training condition and, therefore, it was not surprising to find that they were able to obtain more correct answers on this measure at the end of the pretherapy phase. It should be mentioned that, as can be seen in Appendix G, the internal consistency of this measure was modest and thus conclusions derived from the KAPQ should be made with caution. It should also be kept in mind that the KAPQ was constructed specifically for the purposes of this study; therefore, the generalizability of the results to other pretherapy training procedures is limited. Nevertheless, the finding mentioned above indicated, at the very least, that the subjects in the pretherapy training condition were able to retain the information presented in the pretherapy training sessions. In this sense, the KAPQ served as a manipulation check for the pretherapy training procedure.

A corollary finding was the high percentage of correct answers by subjects in both conditions (approximately 80%). None of the subjects in this study had ever received psychotherapy, nor did any of them have special or unusual knowledge of the psychotherapeutic process. It is possible that high scores were obtained on the KAPQ because the questionnaire was too easy. Alternatively, the high scores on the KAPQ may suggest that this group of therapeutically naïve older adults had greater knowledge of the psychotherapeutic process than one might have expected. The extent of the current older cohort's knowledge of and misconceptions about the psychotherapeutic process remains an important and as yet uncharted avenue of research.

Hypothesis #3: Effect of Pretherapy Phase on
Role Expectations

Hypothesis #3 was not supported by the data. The stepdown analysis revealed that the significant condition by time interaction was due entirely to a significant decrease in AUDIEN scores for subjects in the pretherapy training condition, a finding which was contrary to what had been hypothesized. Berzins (1971) has indicated that this subscale measures the extent to which subjects expect to initiate conversation, to bring up topics to discuss, and to be "in charge" of the sessions. Given the highly structured nature of the pretherapy training, where subjects essentially followed instructions given by the group leader, it is possible that the pretherapy training

inadvertently fostered a "passive" role on the subject's part. Interestingly, scores on the AUDIEN subscale increased (although not significantly) for subjects in the attention-placebo condition. The unstructured nature of the attention-placebo condition, where subjects spent most of their time discussing topics provided by the group leader, may have placed relatively greater demands on subjects in that condition to be active in initiating and maintaining the conversation. Although data from the relationship-seeking (RELAT) subscale did not make a significant contribution to the interaction term, it is important to note the trend suggested by the data, in part because it was also contrary to what had been hypothesized. Relationship-seeking expectancies increased for subjects in the attention-placebo condition and decreased for subjects in the pretherapy training condition. Berzins (1971) reported that this scale measures the extent to which subjects expect to behave in a spontaneous manner, to be comfortable in expressing feelings, and to say whatever comes to mind. Once again, it is conceivable that the format of the activities in the pretherapy training condition hindered the development of such expectancies. The question as to which activity or activities within the pretherapy training contributed to these findings remains an empirical one. It should also be noted that although there was a decrease in scores for subjects in the pretherapy training condition on the approval-seeking (APPROV) and advice-seeking (ADVICE) subscales,

as hypothesized, this difference did not reach statistical significance.

Unfortunately, the two studies which employed the pretherapy training procedure which resembled the most the one used in this study (Piper et al., 1979; Piper et al., 1982) did not measure role expectancies and, therefore, no comparisons were possible. Of the studies reviewed earlier, three of the five studies which measured expectancies used the PEI-R (Ernst et al., 1981; Garrison, 1978; Strupp & Bloxom, 1973). Garrison (1978) used the least effective source of expectation development (information) and obtained non-significant results. Strupp and Bloxom (1973) also used information only in addition to modeling only and in both cases found significant differences on only the AUDIEN and RELAT subscales. Ernst et al. (1981) used a combination of information and modeling and obtained non-significant results. In this study a combination of information, modeling, and simulated group experience was used and significant results were found on the AUDIEN subscale only, but in the opposite direction. These discrepant findings appear to suggest that there is little relationship between the type and number of sources of expectation development employed in the pretherapy training and the modification of role expectations. However, as Piper and Perrault (1989) have noted, despite the emphasis placed on role expectancies in the literature, previous research (and this study) does not support the contention that pretherapy training has a significant impact on role expectancies. One plausible

explanation for the lack of a relationship between the type and number of sources of expectation development mentioned above, then, might be that pretherapy training procedures are producing changes in expectancies, but not role expectancies. Perhaps the greatest immediate effects of pretherapy training procedures is on other expectancies, such as outcome or self-efficacy expectancies. In retrospect, it would have been interesting to have included, in this study, measures of outcome expectancies and self-efficacy expectancies.

Hypothesis #4: Effect of Pretherapy Phase on
Level of Work

As hypothesized, subjects in the pretherapy training condition made significantly more work statements than subjects in the attention-placebo condition in the first six sessions of therapy. Thus, the pretherapy training was effective in getting subjects to focus on discussing issues related to their depression right from the onset of therapy. Other findings revealed by the logit analysis proved to be quite interesting. Overall, there were significantly more nonwork statements than work statements. Almost three out of every four statements made were classified as nonwork. Although ideally subjects would have made only work statements, realistically one would have conservatively expected that at least half their statements would have been classified as work statements. Thus, although a differential effect was obtained for the conditions, the overall

frequency of work statements for the first 6 sessions of therapy was disappointingly low.

Another interesting finding was the trend of work statements across time. At session 1, subjects were making significantly more nonwork statements than work statements. By session 2, and continuing through to session 4, this difference had declined. This was due to an increase in work statements and a concomitant decrease in nonwork statements. This trend continued and by session 6, subjects were now making significantly more work statements than nonwork statements. Thus, from sessions 1 to 6 there was a gradual increase in the frequency of work statements. Although this had not been hypothesized a priori, this finding is what one would have hoped for: as therapy progressed and the task at hand became clearer, subjects made more and more statements related to the problems they were experiencing, and fewer statements related to peripheral issues. This finding suggests that the therapists succeeded in conveying to the subjects the importance of discussing one's problems in a therapeutic framework. To the author's knowledge, this is the first controlled study to obtain such a finding with the HIM-M.

The significant three-way association (condition by session interaction) was a most surprising finding. As noted earlier, the pattern of work statements across time for the two conditions was quite dissimilar. For the attention-placebo condition, there was an increase in work statements from session 1 to session 2, but a levelling off occurred as therapy progressed. For the

pretherapy training condition, there was virtually no change from session 1 to session 4, but from session 4 to session 6 there was a dramatic increase in work statements. One might venture to speculate that the absence of change for subjects in the pretherapy training condition for the first four sessions was a reflection of having been "primed" by the pretherapy training procedure, i.e., they already knew that they were expected to talk about their problems. As therapy progressed and the preliminaries of group therapy were dealt with, subjects were given progressively more opportunities to discuss issues related to their depression. Therefore, the dramatic increase in work statements observed at session 6 may have been due to this relative increase in opportunities for discussing problems as the therapy progressed. For the attention-placebo condition, the increase from session 1 to session 2 may have been a reflection of being told, in the first session, that they were expected to discuss issues related to their depression, a fact which was not revealed to them during the pretherapy phase. From session 2 to session 6 there was no appreciable change in the frequency of work statements. It was as though having been told they were expected to discuss their problems, their number of work statements then increased to some maximal level, which they then maintained through to session 6, regardless of increased opportunities for discussing their problems.

Comparisons between conditions at each timepoint were also quite revealing. At session 1, subjects in the pretherapy

training condition were making twice as many work statements as subjects in the attention-placebo condition. Thus, subjects in the pretherapy training condition were behaving in a manner more congruent with what would be expected of them right from the first session. By session 2, this difference was no longer present, as subjects in the attention-placebo condition were now making roughly as many work statements as subjects in the pretherapy training condition. There was no change at session 4, but by session 6, an even greater difference than at session 1 re-emerged: subjects in the pretherapy training condition were now making two and a half times more work statements than subjects in the attention-placebo condition. It seemed as though the subjects in the attention-placebo condition had reached their maximal level of work statements by session 2, the level at which subjects in the pretherapy training condition began therapy. By session 2 subjects in the attention-placebo condition had "caught up" with subjects in the pretherapy training condition; however, perhaps because they had been "primed" by the pretherapy training procedure, subjects in the latter condition were still capable of improvement, which was observed mainly at session 6. In light of these results, a worthwhile future endeavor would be to rate the tapes of the sessions from the second half of therapy, in an effort to ascertain whether the trends mentioned above persisted.

Of the studies reviewed earlier, only one used the HIM-M (Piper et al., 1982). Their only significant finding on the work dimension was that the experimental subjects made significantly

fewer undocumented work statements, a finding which was contrary to their hypothesis. Although the HIM-M has been used in other pretherapy training studies, to the author's knowledge, this is the first study to obtain findings supporting a positive effect of pretherapy training with this measure.

Hypothesis #5: Effect of Pretherapy Phase on
Severity of Depressive Symptomatology

Hypothesis #5 was not supported by the data. On all three measures of intensity of depressive symptomatology (BDI, GDS, and HRS-D), the interaction term did not reach statistical significance. The absence of a significant difference may be due at least in part to the small sample size and the concomitant relatively low statistical power. In the case of both the BDI and the GDS, the observed power was .53, indicating that there was roughly a 50-50 chance of detecting a difference between conditions if a difference truly existed. On the HRS-D, the odds were much worse. The chances of detecting a difference between conditions, if a difference truly existed, was only about one in six (observed power = .16). Thus, it is possible that a true difference existed between conditions but that this difference went undetected due to the low statistical power. Alternatively, it is equally conceivable that no true difference existed between conditions, as the absence of statistical significance suggested. One possible explanation for the absence of differences between conditions was that the pretherapy training procedure was not

powerful enough to effect a change in depressive symptomatology, even in the early stages of therapy. In retrospect, it may have been overly optimistic to expect that benefits incurred from pretherapy training would still be noticed at the end of therapy, given that the effects produced by the therapy itself, which specifically targeted depressive symptomatology, would most likely have overridden any effects that the pretherapy training may have had on depressive symptomatology.

Of the studies reviewed earlier, none examined the effects of a pretherapy training procedure on a single disorder; thus, comparisons with other studies are difficult. However, two studies which used heterogeneous groups measured, among other things, depressive symptomatology (Truax et al., 1968; Truax & Wargo, 1969). In both studies, subjects receiving pretherapy training had significantly lower scores on the MMPI "D" scale at the end of therapy. Since a different measure of depression was employed, it is difficult to make meaningful comparisons.

Hypothesis #6: Effect of Therapy Phase on
Severity of Depressive Symptomatology

Hypothesis #6 was supported by the data. For all three measures of depression, subjects in both conditions had significantly lower depression scores at the conclusion of therapy. Although one might conclude from this that the treatment modality was effective in alleviating depressive symptomatology, it can be argued that, in the absence of a

control condition for the therapy phase, one cannot make such a conclusion since the improvement may have been due to spontaneous remission. In an effort to circumvent such criticism, the clinical significance of the results was ascertained by following the methods outlined by Jacobson et al. (1984). For the BDI, the GDS, and the HRS-D, the percentage of subjects who improved to a clinically significant degree was 57, 33, and 71, respectively.

The reader may have noted the discrepancy across measures in the percentage of subjects achieving clinically significant change. Lambert, Hatch, Kingston, and Edwards (1986) have argued that different measures of depression may measure different aspects of depression and, therefore, one should not expect them to yield strictly comparable results. For example, their content analysis revealed that 50 to 80% of the total score on the HRS-D is made up of somatic components, whereas only 29% of a BDI score may be attributable to physiological components (their analysis did not include the GDS). Another difference between measures is that the BDI and the GDS are self-report measures, while the HRS-D is a clinician-rated measure. Lambert et al. (1986) have argued that if the clinical judge is aware that all subjects received treatment (as was the case in this study), then he/she may have been biased towards reporting more treatment gains than was actually the case. In any event, one might conclude that the "true" clinical change probably fell somewhere between the discrepant estimations yielded by the different outcome measures. If the average clinical improvement is taken, then slightly more

than half the subjects (53.7%) achieved clinically significant gains. This suggests that the treatment modality may have been effective in alleviating depressive symptomatology.

Another means of judging the effectiveness of therapy is to compare results across studies. Of the studies reviewed earlier, only one reported results in terms of clinical significance (Thompson et al., 1987). They examined the comparative effectiveness of behavioral, cognitive, and brief psychodynamic psychotherapy with 91 elders who had a major depressive disorder. They also used a 6-week delayed treatment condition. Their results were remarkably similar to those reported here. The percentage of subjects showing a clinically significant change on the BDI and the HRS-D was 50 and 75, respectively (they did not use the GDS). The data presented here compare favorably with these rates of clinically significant change, which provides additional support for the contention that in this sample, group cognitive therapy was effective in reducing depressive symptomatology.

Implications

Research Implications

Taking the study as a whole, one can say that the results are equivocal, much like the rest of the literature on pretherapy training. While positive findings were obtained on subject's knowledge about psychotherapy and subject's statements about their problems (i.e., "work" statements), the results revealed

that the pretherapy training procedure was not effective in reducing dropouts, in increasing attendance, in modifying role expectancies in the expected direction, or in reducing depressive symptomatology. Unlike any other pretherapy training procedure employed by other investigators, the procedure used in this study was theoretically-based. This meant, essentially, that the activities included were carefully selected according to social cognitive theory so as to provide the most effective means of modifying subject expectancies. The pretherapy training procedure employed in this study was also longer and more intensive than in most other pretherapy training studies. Most of these studies employed a procedure which lasted an hour or less and did not require active participation by the subject. In this study, four hours of pretherapy training were provided and the activities required subjects' active participation. Furthermore, many of the shortcomings of previous pretherapy training studies were avoided in this study by randomly allocating subjects to groups, using an attention-placebo control group, controlling for subject's previous knowledge of psychotherapy, using more than one therapy group per condition, and ensuring that therapists were blind to the experimental manipulation. When all these factors are taken into account, it can be concluded that the results of this study did not provide much support for the effectiveness of the pretherapy training procedure in enhancing group cognitive therapy for depressed older adults.

The fact that all four categories of dependent variables were represented in the results was another significant improvement over previous studies. The author strongly advocates such an approach in future studies. Also, some additional consideration should be given to the immediate effects of pretherapy training in general, and in particular the measurement of role expectations. For future studies, it would be of great benefit to measure other types of expectancies, such as self-efficacy and outcome expectancies, in an attempt to identify which expectancies are being manipulated by the pretherapy training procedure. This might also clarify the contribution of social cognitive theory in the selection of pretherapy training procedures. In the meantime, future studies should strive to provide a theoretical underpinning for the procedures used in the pretherapy training.

In recent years, an important question which has been raised is the comparability of solicited and nonsolicited (traditionally referred) samples. One issue (among others) is that solicited subjects do not seek treatment because they are less distressed than traditionally referred patients. It should be noted that although all the subjects in this study were solicited through direct advertisements and feature articles which ended with a request for subjects, 65.5% met DSM-III criteria for a major depressive disorder. Having said this, the author shares the view of Krupnick, Shea, and Elkin (1986), who have concluded that while research examining this question is equivocal, caution is

advised in generalizing results from solicited to unsolicited samples. This caveat should be kept in mind when generalizing the present results to populations of traditionally referred patients.

In fact, obtaining enough subjects for this study through solicitation alone proved to be quite difficult. One possible explanation was that some elderly persons found the university setting an unusual place to receive psychological treatment, which may have decreased their desire to participate in the study. Another possible explanation was that features associated with depression, such as lethargy and lack of motivation, may have contributed, at least in part, to the low response rate. The low response from solicitation alone, coupled with the limited generalizability of solicited samples, makes it difficult to conduct such research without the cooperation of a mental health institution. Also, having to settle on a smaller sample had direct repercussions on the testing of hypotheses #1 and #5, where statistical power was compromised.

Clinical Implications

Dropouts is one of the main problems encountered when conducting group therapy. Therefore, any procedure which can reduce dropouts should not be discarded lightly. Thus, even though the dropout data did not reach statistical significance, the fact remains that fewer subjects from the pretherapy training condition dropped out of therapy, and therefore subjects in that

condition had a greater potential for benefitting from therapy. An additional danger is that one dropout may lead to a series of dropouts. It is interesting to note, therefore, that only in the pretherapy training condition was there an instance of no dropouts (phase II), a rarity in group therapy. The same argument may be applied to the attendance data. On average, the subjects in the pretherapy training condition attended one session more than subjects in the attention-placebo condition. Furthermore, almost half the subjects (45.5%) in the former condition attended all 12 sessions compared to less than a third (30.0%) for the latter condition. These figures indicate the possibly positive effect of the pretherapy training on attendance. This higher assiduity may indicate a greater commitment to therapy, which may be perceived by other group members (and the therapists) and may promote greater member cohesiveness and a more fruitful therapeutic experience.

Another important issue in this area is whether the pretherapy training procedures can be carried out in vivo. Some researchers have advocated very short preparation (1 session) on the grounds that a longer procedure would not be feasible in an in vivo setting. However, this approach may seriously compromise the effectiveness of the pretherapy training. It is the author's belief that the pretherapy training procedure employed in this study could be implemented easily in an in vivo setting. Four sessions of pretherapy training in an average 20 session course of group therapy appears quite reasonable, if in fact future

research reveals that pretherapy training enhances therapy. Furthermore, almost any health care provider can perform the preparation by following the detailed manual. Finally, the concepts presented are sufficiently general to be applicable for most forms of group therapy, not just group cognitive therapy.

Although the main purpose of the study was to measure the effectiveness of the pretherapy training procedure, an ancillary finding was that group cognitive therapy was apparently effective in alleviating depressive symptomatology. More than half the subjects had a clinically significant reduction in depressive symptomatology in a course of therapy one-third shorter than that advocated by Yost et al. (1986). The results obtained here provide additional evidence that depression in some older adults can be treated effectively with psychotherapy and, in a small way, they also instill hope for a better quality of life for older adults who suffer from this disorder.

References

- Abrams, R. (1982). Technique of electroconvulsive therapy. In R. Abrams & W.B. Essman (Eds.), Electroconvulsive Therapy: Biological Foundations (pp. 41-55). Lancaster: MTP Press.
- Adolfsson, R., Gottfries, C.G., Roos, B.E., & Winblad, B. (1979). Postmortem distribution of dopamine and homovanillic acid in human brain, variations related to age, and a review of the literature. Journal of Neural Transmission, 45(2), 81-105.
- Akiskal, H.S., & McKinney, W.T., Jr. (1973). Depressive disorders: Toward a unified hypothesis. Science, 182, 20-29.
- Alexopoulos, G.S., Shamoian, C.J., Lucas, J., Weiser, N., & Berger, H. (1984). Medical problems of geriatric psychiatric patients and younger controls during electroconvulsive therapy. Journal of the American Geriatrics Society, 32(9), 651-654.
- Alexopoulos, G.S., Young, R.C., & Shamoian, C.A. (1985). Depression with reversible dementia: Phenomenology. Paper presented at the meeting of the new research section of the American Psychiatric Association, Dallas, TX.
- American Psychiatric Association. (1987). Diagnostic and Statistical Manual of Mental Disorders (3rd ed. rev.). Washington, DC: Author.
- Baldwin, R.C., & Jolley, D.J. (1986). The prognosis of depression in old age. British Journal of Psychiatry, 149, 574-583.
- Ban, T.A. (1978). The treatment of depressed geriatric patients. The American Journal of Psychotherapy, 32(1), 93-104.
- Bandura, A. (1977). Social learning theory. New Jersey: Prentice-Hall.
- Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs, NJ: Prentice-Hall Inc.
- Bandura, A., & Barab, (1973). Processes governing disinhibitory effects through symbolic modeling. Journal of Abnormal Psychology, 82, 1-9.
- Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). Cognitive therapy of depression. New York, NY: Guilford Press.
- Beck, A.T., Steer, R.A., & Garbin, (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. Clinical Psychology Review, 8, 77-100.

- Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. Archives of General Psychiatry, 4, 53-63.
- Benbow, S.H. (1987). The use of electroconvulsive therapy in old age psychiatry. International Journal of Geriatric Psychiatry, 2, 25-30.
- Berry, E.K., & Berry, R. H. (1977). Cholinergic and gaba systems in dementia and old age. British Journal of Psychiatry, 131, 319.
- Berzins, J.I. (1971). Revision of the psychotherapy expectancy questionnaire. Unpublished manuscript, University of Kentucky, Department of Psychology, Lexington, KY.
- Beutler, L.E., Scogin, F., Kirkish, P., Schretlen, D., Corbishley, A., Hamblin, D., Meredith, K., Potter, R., Bamford, C.R., & Levenson, A.I. (1987). Group cognitive therapy and alprazolam in the treatment of depression in older adults. Journal of Consulting and Clinical Psychology, 55(4), 550-556.
- Bialos, D., Giller, E., Jatlow, P., Docherty, J., & Harkness, L. (1982). Recurrence of depression after discontinuation of long-term amitriptyline treatment. American Journal of Psychiatry, 139(3), 325-329.
- Bland, R.C., Newman, S.C., & Orn, H. (1988). Period prevalence of psychiatric disorders in the elderly in Edmonton. Acta Psychiatrica Scandinavica, 77(Suppl. 338), 57-63.
- BMDP Statistical Software (1985). BMDP Biostatistical Software Manual. Berkeley, CA: University of California Press.
- Bourque, P., Blanchard, L., & Vézina, J. (1990). Étude psychométrique de l'échelle de dépression gériatrique. La Revue Canadienne de Vieillesse, 9(4), 348-355.
- Brink, T.L. (1979). Perspectives on geriatric psychotherapy. In T.L. Brink (Ed.), Geriatric Psychotherapy (pp. 132-150). New York: Human Sciences Press.
- Brody, E.M., & Kleban, M.H. (1981). Physical and mental symptoms of older people: Who do they tell? Journal of the American Geriatrics Society, 29, 442-449.
- Brown, G.S., & Harris, T. (1978). Social origins of depression. London: Tavistock Publications.

- Brown, R.P., Sweeney, J., Loutsch, E., Korsis, J., & Frances, A. (1984). Involutional melancholia revisited. American Journal of Psychiatry, 141(1), 24-28.
- Burke, W.J., Rutherford, J.L., Zorumski, C.F., & Reich, T. (1985). Electroconvulsive therapy and the elderly. Comprehensive Psychiatry, 26(5), 480-486.
- Butler, R. N. (1975). Psychiatry and the elderly: An overview. American Journal of Psychiatry, 132, 893-900.
- Cappeliez, P. (1988). Some thoughts on the prevalence and etiology of depressive conditions in the elderly. Canadian Journal on Aging, 7(4), 431-438.
- Carlsson, A., & Winblad, B. (1976). Influence of age and time interval between death and autopsy on dopamine and 3-methoxytyramine levels in human basal ganglia. Journal of Neural Transmission, 35, 271-276.
- Causey, A. (1985). Preparation for group psychotherapy using a modeling/instructional videotape with a female inpatient population. (Doctoral Dissertation, Memphis State University, 1985). Dissertation Abstracts International, 47(1), 367-368-B.
- Cavenar, J.O., Matthe, A.A., & Austin, L. (1979). Depression simulating organic brain disease. American Journal of Psychiatry, 136, 521-523.
- Chaisson, G.M., Beutler, L.E., Yost, E.B., & Allender, J. (1984). Treating the depressed elderly. Journal of Psychosocial Nursing, 22, 25-30.
- Ciampi, L. (1969). Follow-up studies on the evolution of former neurotic and depressive states in old age: Clinical and psychodynamic aspects. Journal of Geriatric Psychiatry, 3(1), 90-100.
- Clifford, D.B., Rutherford, J.L., Hicks, F.G., & Zorumski, C.F. (1985). Acute effects of antidepressants on hippocampal kindled seizures. Annals of Neurology, 18(6), 692-697.
- Cole, M.G. (1985). The course of elderly depressed outpatients. Canadian Journal of Psychiatry, 30(3), 217-230.
- Cook, B.L., Helms, P.M., Smith, R.E., & Tsai, M. (1986). Unipolar depression in the elderly: Reoccurrence on discontinuation of tricyclic antidepressants. Journal of Affective Disorders, 10, 91-94.

- Corder, B.F., Haizlip, T., Whiteside, R., & Vogel, M. (1980). Pre-therapy training for adolescents in group psychotherapy: Contracts, guidelines, and pre-therapy preparation. Adolescence, 15(59), 699-706.
- Curran, T. (1978). Increasing motivation to change in group treatment. Small Group Behavior, 9, 337-348.
- Cutrona, C., Russell, D., & Rose, J. (1986). Social support and adaptation to stress by the elderly. Psychology and Aging, 1, 47-54.
- Elkin, I., Parloff, M.B., Hadley, S.W., & Autrey, J.H. (1985). NIMH treatment of depression collaborative research program: Background and research plan. Archives of General Psychiatry, 42, 305-316.
- Ernst, C., Vanderzyl, S., & Salinger, R. (1981). Preparation of psychiatric inpatients for group therapy. Journal of Psychiatric Nursing, 19(7), 28-33.
- Feinson, M.C. (1985). Aging and mental health: Distinguishing myth from reality. Research on Aging, 7(2), 155-174.
- Folstein, M., Folstein, S., & McHugh, P. (1975). "Mini-Mental State" -- A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research, 12, 189-198.
- Ford, C.V., & Sbordone, R.J. (1980). Attitudes of psychiatrists toward elderly patients. American Journal of Psychiatry, 137, 571-575.
- France, D.G., & Dugo, J.M. (1985). Pretherapy orientation as preparation for open psychotherapy groups. Psychotherapy: Theory, Research, and Practice, 22(2), 256-261.
- Fraser, R.M., & Glass, I.B. (1980). Unilateral and bilateral ECT in elderly patients: A comparative study. Acta Psychiatrica Scandinavica, 62, 13-31.
- Friedel, R.O. (1977). Pharmacokinetics of psychotherapeutic agents in aged patients. In C. Eisdorfer & R.O. Friedel (Eds.), Cognitive and Emotional Disturbance in the Elderly (pp. 139-149). Chicago, IL: Year Book Medical Publishers.
- Fry, P.S. (1984). Cognitive training and cognitive-behavioral variables in the treatment of depression in the elderly. Clinical Gerontologist, 3(1), 25-45.

- Gaitz, C.M. (1977). Depression in the elderly. In W.E. Fann, I. Karacan, A.D. Pokorny, & R.L. Williams (Eds.), Phenomenology and Treatment of Depression (pp. 155-166). New York, NY: Spectrum Press.
- Gallagher, D. (1981). Behavioral group therapy with elderly depressives: An experimental study. In D. Upper & S. Ross (Eds.), Behavioral Group Therapy (Vol. 3, pp. 187-219). Champaign, IL: Research Press.
- Gallagher, D.E., & Thompson, L.W. (1982). Treatment of major depressive disorder in older adult outpatients with brief psychotherapies. Psychotherapy: Theory, Research, and Practice, 19(4), 482-490.
- Gallagher, D.E., & Thompson, L.W. (1983). Effectiveness of psychotherapy for both endogenous and nonendogenous depression in older adult outpatients. Journal of Gerontology, 38(6), 707-712.
- Gallagher-Thompson, D.E., Hanley-Paterson, P., & Thompson, L.W. (1990). Maintenance of gains versus relapse following brief psychotherapy for depression. Journal of Consulting and Clinical Psychology, 58(3), 371-374.
- Garfield, S.L., & Wolpin, M. (1963). Expectations regarding psychotherapy. Journal of Nervous and Mental Disease, 137, 353-362.
- Garrison, J.E. (1978). Written versus verbal preparation of patients for group psychotherapy. Psychotherapy: Theory, Research, and Practice, 15(2), 130-134.
- Gaspar, D., & Samarasinghe, L.A. (1982). ECT in psychogeriatric practice: A study of risk factors, indications, and outcome. Comprehensive Psychiatry, 23, 170-175.
- Gerner, R.H. (1985). Present status of drug therapy of depression in late life. Journal of Affective Disorders, 9(Suppl. 1), S23-S31.
- Godber, C., Rosenwinge, H., Wilkinson, D., & Smithies, J. (1987). Depression in old age: Prognosis after ECT. International Journal of Geriatric Psychiatry, 2(1), 19-24.
- Goldstein, A.P. (1962). Therapist-patient expectancies in psychotherapy. New York, NY: MacMillan.
- Gurland, B.J. (1976). Comparative frequency of depression in various age-groups. Journal of Gerontology, 31(3), 283-292.

- Gurland, B.J., Dean, L., Cross, P., & Golden, R. (1980). The epidemiology of depression and dementia in the elderly: The use of multiple indicators of these conditions. In J.O. Cole & J.E. Barnett (Eds.), Psychopathology in the aged (pp. 37-62). New York, NY: Raven Press.
- Hamilton, M. (1967). Development of a rating scale for primary depressive illness. British Journal of Social and Clinical Psychology, 6, 278-296.
- Hansson, R.O., Jones, W.H., Carpenter, B.N., & Remondet, J.H. (1987). Loneliness and adjustment to old age. International Journal on Aging and Human Development, 24(1), 41-53.
- Hayflick, L. (1982). Biological aspects of human aging. British Journal of Hospital Medicine, April, 366-375.
- Heilbrun, A.B. (1970). Toward resolution of the dependency-premature termination paradox for females in psychotherapy. Journal of Consulting and Clinical Psychology, 34, 382-386.
- Heitler, J.B. (1973). Preparation of lower-class patients for expressive group psychotherapy. Journal of Consulting and Clinical Psychology, 41(2), 251-260.
- Hendrie, H.C., & Crossett, J.H.W. (1990). An overview of depression in the elderly. Psychiatric Annals, 20(2), 64-70.
- Heppner, P.P., & Heesacker, M. (1982). Interpersonal influence process in real-life counseling: Investigating client perceptions, counselor experience level, and counselor power over time. Journal of Counseling Psychology, 29, 215-223.
- Hilkey, J.H., Wilhelm, C.L., & Horne, A.M. (1982). Comparative effectiveness of videotape pretraining versus no pretraining on selected process and outcome variables in group therapy. Psychological Reports, 50(3), 1151-1159.
- Hill, W.F. (1965). Hill Interaction Matrix. University of Southern California. Los Angeles: Youth Study Center.
- Hyer, L., & Blazer, D.G. (1982). Depression in long-term care facilities. In D.G. Blazer (Ed.), Depression in late life (pp. 268-295). St. Louis, MO: C.V. Mosby.
- Jacobs, M.K., Trick, O.L., & Withersty, W. (1976). Pretraining psychiatric inpatients for participation in group psychotherapy. Psychotherapy: Theory, Research, and Practice, 13, 361-367.

- Jacobson, N.S., Follette, W.C., & Revenstorf, D. (1984). Psychotherapy outcome research: Methods for reporting variability and evaluating clinical significance. Behavior Therapy, 15, 336-352.
- Jarvik, L.F., & Gerson, S. (1983). Outcome of drug treatment in depressed patients over the age of fifty. In A. Shamoian (Ed.), Progress in Psychiatry Series (pp. 31-36). Washington, DC: American Psychiatric Association Press.
- Kanner, A.D., Coyne, J.C., Schaefer, C., & Lazarus, R.S. (1981). Comparisons of two modes of stress measurement: Daily hassles and uplifts versus major life events. Journal of Behavioral Medicine, 4, 1-39.
- Kessler, K.A. (1978). Tricyclic antidepressants: Mode of action and clinical use. In M.A. Lipton, A. DiMascio, & K.F. Killam (Eds.), Psychopharmacology: A Generation of Progress (pp. 1289-1302). New York, NY: Raven Press.
- Kipper, D. (1986). Psychotherapy through clinical role playing. New York, NY: Brunner/Mazel Publishers.
- Kirk, R.E. (1982). Experimental design (2nd ed.). Monterey, CA: Brooks/Cole.
- Kivelä, S.-L., & Pahkala, K. (1989). The prognosis of depression in old age. International Psychogeriatrics, 1(2), 119-133.
- Klerman, G.L. (1978). Long-term treatment of affective disorders. In M.A. Lipton, A. DiMascio, & K.F. Killam (Eds.), Psychopharmacology: A Generation of Progress (pp. 1303-1311). New York, NY: Raven Press.
- Klerman, G.L. (1983). Problems in the definition and diagnosis of depression in the elderly. In L.O. Breslau & M.R. Haig (Eds.), Depression and aging: Causes, care and consequences (pp. 3-19). New York, NY: Springer Publishing Company.
- Klerman, G.L. (1989). Depressive disorders: Further evidence for increased medical morbidity and impairment of social functioning. Archives of General Psychiatry, 46, 856-858.
- Knight, B. (1983). Assessing a mobile outreach team. In M.A. Smyer & M. Gatz (Eds.), Mental Health and Aging: Programs and evaluation (pp. 23-40). Beverly Hills, CA: Sage.
- Kochendorfer, S.A. (1975). Group preparation: Interview vs. questionnaire. The School Counselor, 23(1), 38-42.

- Krause, N. (1987). Chronic financial strain, social support, and depressive symptoms among older adults. Psychology and Aging, 2(2), 185-192.
- Krupnick, J., Shea, T., & Elkin, I. (1986). Generalizability of treatment studies utilizing solicited patients. Journal of Consulting and Clinical Psychology, 54(1), 68-78.
- Lambert, M.J., Hatch, D.R., Kingston, M.D., & Edwards, B.C. (1986). Zung, Beck, and Hamilton rating scales as measures of treatment outcome: A meta-analytic comparison. Journal of Consulting and Clinical Psychology, 54(1), 54-59.
- Larson, R.W. (1990). The solitary side of life: An examination of the time people spend alone from childhood to old age. Developmental Review, 10, 155-183.
- Lehmann, H.E. (1982). Affective disorders in the aged. Psychiatric Clinics of North America, 5(1), 27-44.
- Leszcz, M. (1987). Group psychotherapy with the elderly. In J. Sadavoy & M. Leszcz (Eds.), Treating the Elderly with Psychotherapy: The Scope for Change in Later Life (pp. 325-349). Madison, CT: International Universities Press Inc.
- Loether, H.J. (1975). Problems of aging: Sociological and social psychological perspectives (2nd Ed.). Encino, Ca: Dickenson Publishing Company, Inc.
- Magni, G., Fisman, M., & Helmes, E. (1988). Clinical correlates of ECT-resistant depression in the elderly. Journal of Clinical Psychiatry, 49(10), 405-407.
- Magni, G., Palazzolo, O., & Bianchin, G. (1988). The course of depression in elderly outpatients. Canadian Journal of Psychiatry, 33, 21-24.
- Martin, H., & Shewmaker, K. (1962). Written instructions in group therapy. Group Psychotherapy, 15, 24-29.
- Mayerson, N.H. (1984). Preparing clients for group therapy: A critical review and theoretical formulation. Clinical Psychology Review, 4, 191-213.
- McGeer, E., & McGeer, P.L. (1976). Neurotransmitter metabolism in the aging brain. In R.D. Terry & S. Gershon (Eds.), Neurobiology of Aging (Vol. 3, pp. 389-403). New York, NY: Raven Press.
- McPherson, B.D. (1983). Aging as a social process: An introduction to individual and population aging. Toronto, Canada: Butterworths.

- Meadow, D. (1988). Preparation of individuals for participation in a treatment group: Development and empirical testing of a model. International Journal of Group Psychotherapy, 38(3), 367-385.
- Meyers, B.S. & Alexopoulos, G. (1988). Age of onset and studies of late-life depression. International Journal of Geriatric Psychiatry, 3(3), 219-228.
- Meyers, B.S., & Greenberg, R. (1986). Late-life delusional depression. Journal of Affective Disorders, 11, 133-137.
- Mielke, D.H., Winstead, D.K., Goethe, J.W., & Schwartz, B.D. (1984). Multiple monitored electroconvulsive therapy: Safety and efficacy in elderly depressed patients. Journal of the American Geriatrics Society, 32(3), 180-182.
- Monroe, S.M. (1983). Major and minor life events as predictors of psychological distress: Further issues and findings. Journal of Behavioral Medicine, 6, 189-205.
- Moran, J.A., Walsh, C.P., & Lax, R.L. (1984). Adult day care: Psychological practice and evaluation. Professional Psychology: Research and Practice, 15(1), 67-74.
- Murphy, E. (1983). The prognosis of depression in old age. British Journal of Psychiatry, 142(3), 111-119.
- Murphy, E. (1985). The impact of depression in old age on close social relationships. American Journal of Psychiatry, 142, 323-327.
- Neuhaus, R.H., & Neuhaus, R.H. (1982). Successful aging. New York: John Wiley and Sons.
- Newmann, J.P. (1989). Aging and depression. Psychology and Aging, 4(2), 150-165.
- Nunnally, J. (1961). Popular misconceptions of mental health. New York, NY: Holt, Rinehart, and Winston.
- Overall, B., & Aronson, H. (1963). Expectations of psychotherapy in patients of lower socioeconomic class. American Journal of Orthopsychiatry, 33, 421-430.
- Parmelee, P.A., Katz, I.R., & Lawton, M.P. (1989). Depression among institutionalized aged: Assessment and prevalence estimation. Journal of Gerontology: Medical Sciences, 44(1), M22-29.

- Pastushak, R. (1978). The effects of videotaped pretherapy training on interpersonal openness, self-disclosure, and group psychotherapy outcome. (Doctoral Dissertation, Temple University, 1978). Dissertation Abstracts International, 39(2), 993-B.
- Paykel, E.S., Myers, J.K., Dienelt, M.N., Klerman, G.L., Lindenthal, J.J., & Pepper, M.P. (1969). Life events and depression: A controlled study. Archives of General Psychiatry, 21(6), 753-760.
- Peake, T. (1979). Therapist-patient agreement and outcome in group therapy. Journal of Clinical Psychology, 35(3), 637-646.
- Piper, W.E., & Perrault, E.L. (1989). Pretherapy preparation for group members. International Journal of Group Psychotherapy, 39(1), 17-34.
- Piper, W.E., Debbane, E.G., Bienvenu, J.-P., & Garant, J. (1982). A study of group pretraining for group psychotherapy. International Journal of Group Psychotherapy, 32(3), 309-325.
- Piper, W.E., Debbane, E.G., Garant, J., & Bienvenu, J.-P. (1979). Pretraining for group psychotherapy: A cognitive-experiential approach. Archives of General Psychiatry, 36(11), 1250-1256.
- Piper, W.E., Montvila, R.M., & McGihon, A.L. (1979). Process analysis in therapy groups: A behavior sampling technique with many potential uses. In Upper, D., & Ross, S. (Eds.), Behavioral Group Therapy: An Annual Review. Champaign, IL: Research Press.
- Post, F. (1972). The management and nature of depressive illnesses in late life: A follow-through study. British Journal of Psychiatry, 121, 393-404.
- Price, L.J., Fein, G., & Feinberg, I. (1980). Neuropsychological assessment of cognitive function in the elderly. In L.W. Poon (Ed.), Aging in the 1980's: Psychological issues (pp. 78-85). Washington, DC: American Psychological Association.
- Ramos-Brieva, J.A., & Cordero-Villafila, A. (1988). A new validation of the Hamilton Rating Scale for Depression. Journal of Psychiatric Research, 22(1), 21-28.
- Reifler, B., Raskind, M., & Kethley, A. (1982). Psychiatric diagnoses among geriatric patients seen in an outreach program. Journal of the American Geriatrics Society, 30(8), 530-533.

- Robinson, D.S. (1979). Age-related factors affecting antidepressant drug metabolism and response. In K. Nandy (Ed.), Geriatric Psychopharmacology (pp. 17-19). New York, NY: Elsevier North Holland.
- Robinson, J.R. (1988). The developmental history of mental disorder in old age. Psychiatric Bulletin, 12(11), 476-480.
- Rossman, I. (1979). Mortality and morbidity overview. In I. Rossman (Ed.), Clinical Geriatrics (Vol. 2, pp. 113-131). Philadelphia, PA: J.B. Lippincott.
- Rothblum, E.D., Sholomskas, A.J., Berry, C., & Prusoff, B.A. (1982). Issues in clinical trials with the depressed elderly. The Journal of the American Geriatrics Society, 30(11), 694-699.
- Ruegg, R.G., Zisook, S., & Swerdlow, N.R. (1988). Depression in the aged: An overview. Psychiatrics Clinics of North America, 11(1), 83-99.
- Salzman, C. (1982). A primer on geriatric psychopharmacology. American Journal of Psychiatry, 139(1), 67-74.
- Shulman, K., & Post, (1980). Bipolar affective disorder in old age. British Journal of Psychiatry, 136, 26-32.
- Snowdon, J., & Donnelly, N. (1986). A study of depression in nursing homes. Journal of Psychiatric Research, 20(4), 327-333.
- Spitzer, R., Endicott, J., & Robins, E. (1978). Research diagnostic criteria: Rationale and reliability. Archives of General Psychiatry, 35, 773-782.
- SPSS Inc. (1986). SPSS^X Users Guide (3rd ed.). Chicago, IL: SPSS^X Inc.
- Statistics Canada. (1987). Postcensal estimates of population by marital status, age, sex, and components of growth for Canada, provinces, and territories, June 1, 1987, Vol. 5. (Catalogue No. 91-210). Ottawa, Canada: Minister of Supply and Services Canada.
- Statistics Canada. (1990a). Postcensal estimates of population by marital status, age, sex, and components of growth for Canada, provinces, and territories, June 1, 1990, Vol. 8. (Catalogue No. 91-210). Ottawa, Canada: Minister of Supply and Services Canada.
- Statistics Canada. (1990b). Population projections for Canada, provinces, and territories 1989-2011. (Catalogue No. 91-520). Ottawa, Canada: Minister of Supply and Services Canada.

- Statistics Canada. (1990c). Health Reports: Mental Health Statistics 1986-1987. (Catalogue No. 82-003S), Suppl. #3, 2(2). Ottawa, Canada: Minister of Supply and Services Canada.
- Staunton, J.G. (1981). An account of a research project designed to investigate the effects of preparing patients for group psychotherapy. British Journal of Projective Psychology and Personality Study, 26(1), 17-19.
- Steuer, J.L., Mintz, J., Hammen, C.L., Hill, M.A., Jarvik, L.F., McCarley, T., Motoike, P., & Rosen, R. (1984). Cognitive-behavioral and psychodynamic group psychotherapy in treatment of geriatric depression. Journal of Consulting and Clinical Psychology, 52(2), 180-189.
- Strauss, D., & Solomon, K. (1983). Psychopharmacologic intervention for depression in the elderly. Clinical Gerontologist, 2(1), 3-29.
- Strupp, H.H., & Bloxom, A.L. (1973). Preparing lower-class patients for group psychotherapy: Development and evaluation of a role-induction film. Journal of Consulting and Clinical Psychology, 41(3), 373-384.
- Tabachnick, B.G., & Fidell, L.S. (1989). Using multivariate statistics. New York, NY: Harper & Row.
- Teeter, R.B., Garetz, F.K., Miller, W.R., & Heiland, W.F. (1976). Psychiatric disturbances of aged patients in skilled nursing homes. American Journal of Psychiatry, 133(12), 1430-1434.
- Templer, D.I., & Cappelletty, G.G. (1986). Suicide in the elderly: Assessment and intervention. Clinical Gerontologist, 5(3/4), 475-487.
- Thompson, L.W., & Gallagher, D. (1984). Efficacy of psychotherapy in the treatment of late-life depression. Advances in Behavior Research and Therapy, 6(2), 127-139.
- Thompson, L.W., Gallagher, D., & Steinmetz-Breckenridge, J. (1987). Comparative effectiveness of psychotherapies for depressed elders. Journal of Consulting and Clinical Psychology, 55(3), 385-390.
- Truax, C., & Carkhuff, R. (1965). Personality change in hospitalized mental patients during group psychotherapy as a function of the use of alternate sessions and vicarious therapy pretraining. Journal of Clinical Psychology, 21, 225-228.

- Truax, C., Shapiro, J., & Wargo, D. (1968). The effects of alternate sessions and vicarious therapy pretraining on group psychotherapy. International Journal of Group Psychotherapy, 18, 186-198.
- Truax, C.B., & Wargo, D. G. (1969). Effects of vicarious therapy pretraining and alternate sessions on outcome in group psychotherapy with outpatients. Journal of Consulting and Clinical Psychology, 33, 440-447.
- Truax, C.B., Wargo, D.G., & Volksdorf, N. (1970). Antecedents to outcome in group counseling with institutionalized juvenile delinquents: Effect of therapeutic conditions, patient self-exploration, alternate sessions, and vicarious therapy pretraining. Journal of Abnormal Psychology, 76, 235-242.
- Veith, R.C., & Raskind, M.A. (1988). The neurobiology of aging: Does it predispose to depression? Neurobiology of Aging, 9, 101-117.
- Vézina, J., Landreville, P., Bourque, P., & Blanchard, L. (1991). Questionnaire de Dépression de Beck: Étude psychométrique auprès d'une population âgée francophone. La Revue Canadienne de Vieillesse, 10(1), 29-39.
- Walter, C. (1975). Therapy preparation and its effect on group member behavior. (Doctoral Dissertation, Texas Tech University, 1975). Dissertation Abstracts International, 37(2), 995-996-B.
- Weiner, R.D. (1982). The role of electroconvulsive therapy in the treatment of depression in the elderly. Journal of the American Geriatrics Society, 30, 710-712.
- Wells, C.E. (1979). Pseudodementia. American Journal of Psychiatry, 136(7), 895-900.
- White, P., Hiley, C.R., Goodhart, M.J., Carrasco, L.H., Keet, J.P., & Williams, I.E.I. (1977). Neocortical cholinergic neurons in elderly people. Lancet, 1, 668-670.
- Willner, M. (1978). Individual psychotherapy with the depressed elderly outpatient: An overview. Journal of the American Geriatrics Society, 26(5), 231-235.
- Wogan, M., Getter, H., Amdur, M., Nichols, M., & Okman, G. (1977). Influencing interaction and outcome in group psychotherapy. Small Group Behavior, 8(1), 25-46.
- Yalom, I.D., Houts, P.S., Newell, G., & Rand, K.H. (1967). Preparation of patients for group therapy. Archives of General Psychiatry, 17, 416-427.

- Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M., & Leirer, V.O. (1983). Development and validation of a geriatric depression scale: A preliminary report. Journal of Psychiatric Research, 17, 37-39.
- Yost, E.B., Beutler, L.E., Corbishley, M.A., & Allender, J.R. (1986). Group cognitive therapy: A treatment approach for depressed older adults. Elmsford, NJ: Pergamon Press.
- Zimmerman, M., Coryell, W., Corenthal, C., & Wilson, S. (1986). A self-report scale to diagnose major depressive disorder. Archives of General Psychiatry, 43, 1076-1081.
- Zisook, S., & DeVaul, R.A. (1983). Grief, unresolved grief, and depression. Psychosomatics, 24(3), 247-256.
- Zisook, S., Shuchter, S.R., & Lyons, L.E. (1987). Predictors of psychological reaction during early stages of widowhood. Psychiatric Clinics of North America, 10(3), 355-368.
- Zorumski, C.F., Rubin, E.H., & Burke, W.J. (1988). Electroconvulsive therapy for the elderly: A review. Hospital and Community Psychiatry, 39(6), 643-647.
- Zung, W. (1980). Affective disorders. In E.W. Busse & D.G. Blazer (Eds.), Handbook of Geriatric Psychiatry (pp. 337-367). New York, NY: Van Nostrand Reinhold Company.

Figure 1. Mean KAPQ scores.

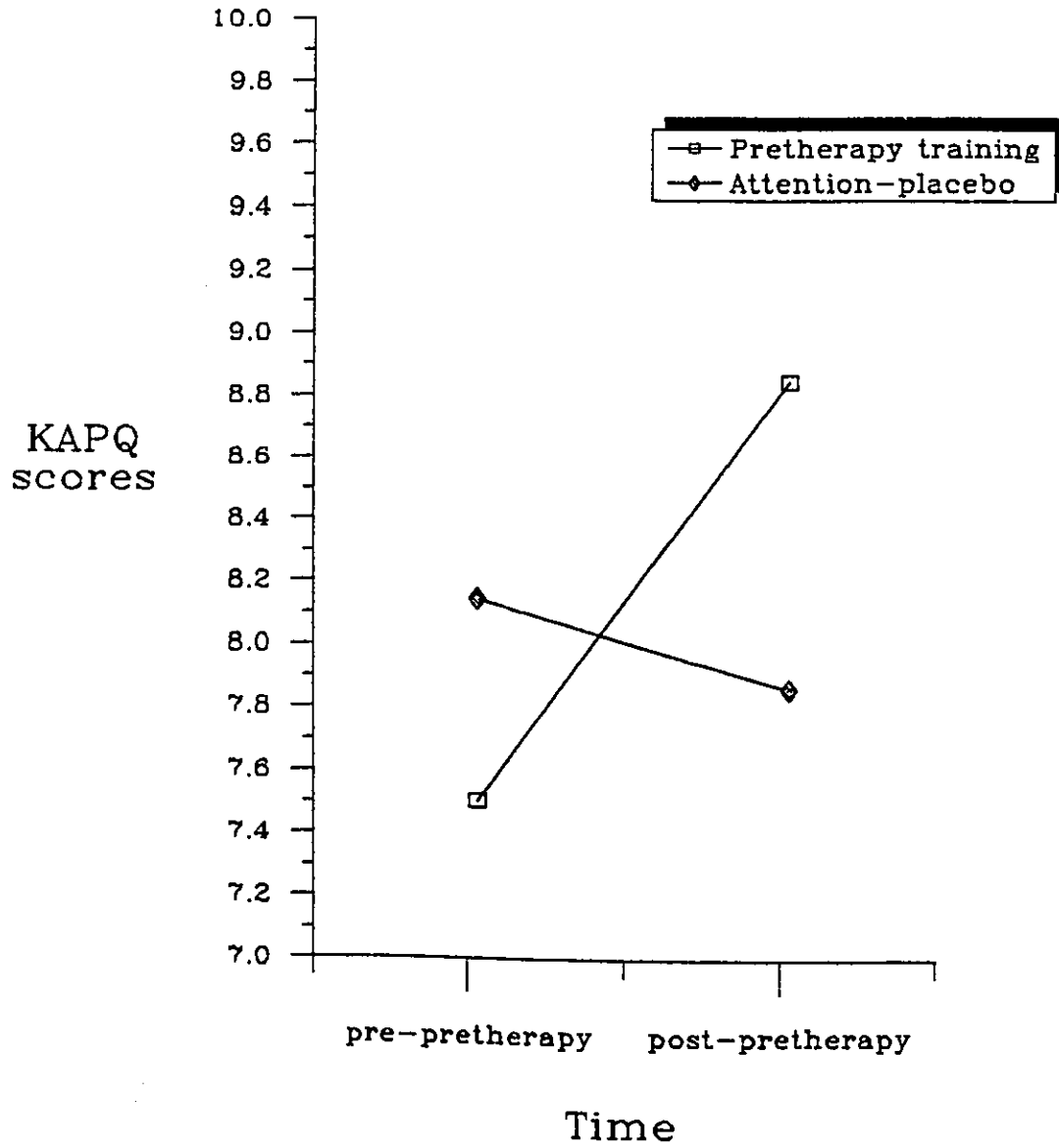


Figure 2. Mean scores on PEI-R APPROV subscale.

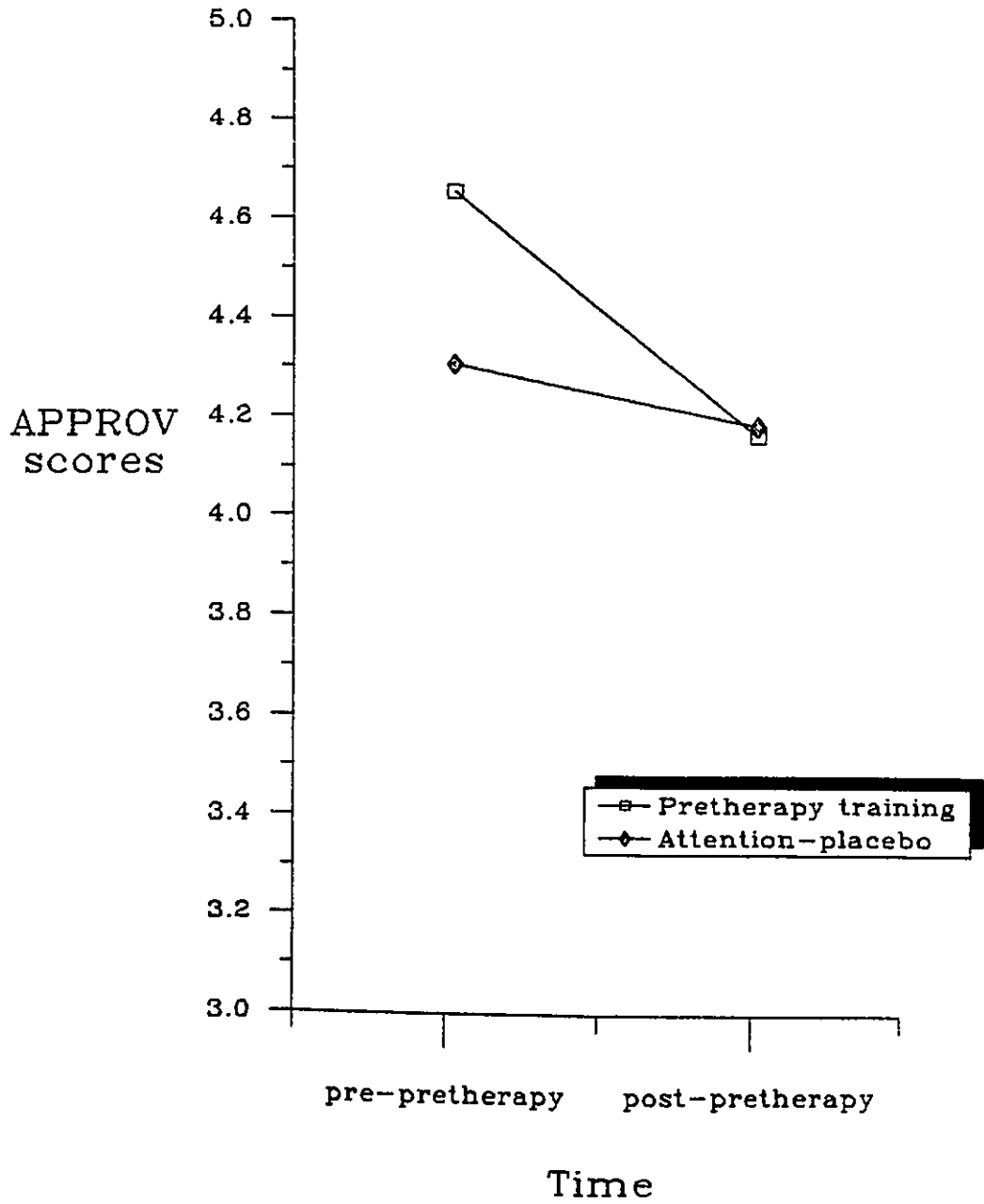


Figure 3. Mean scores on PEI-R ADVICE subscale.

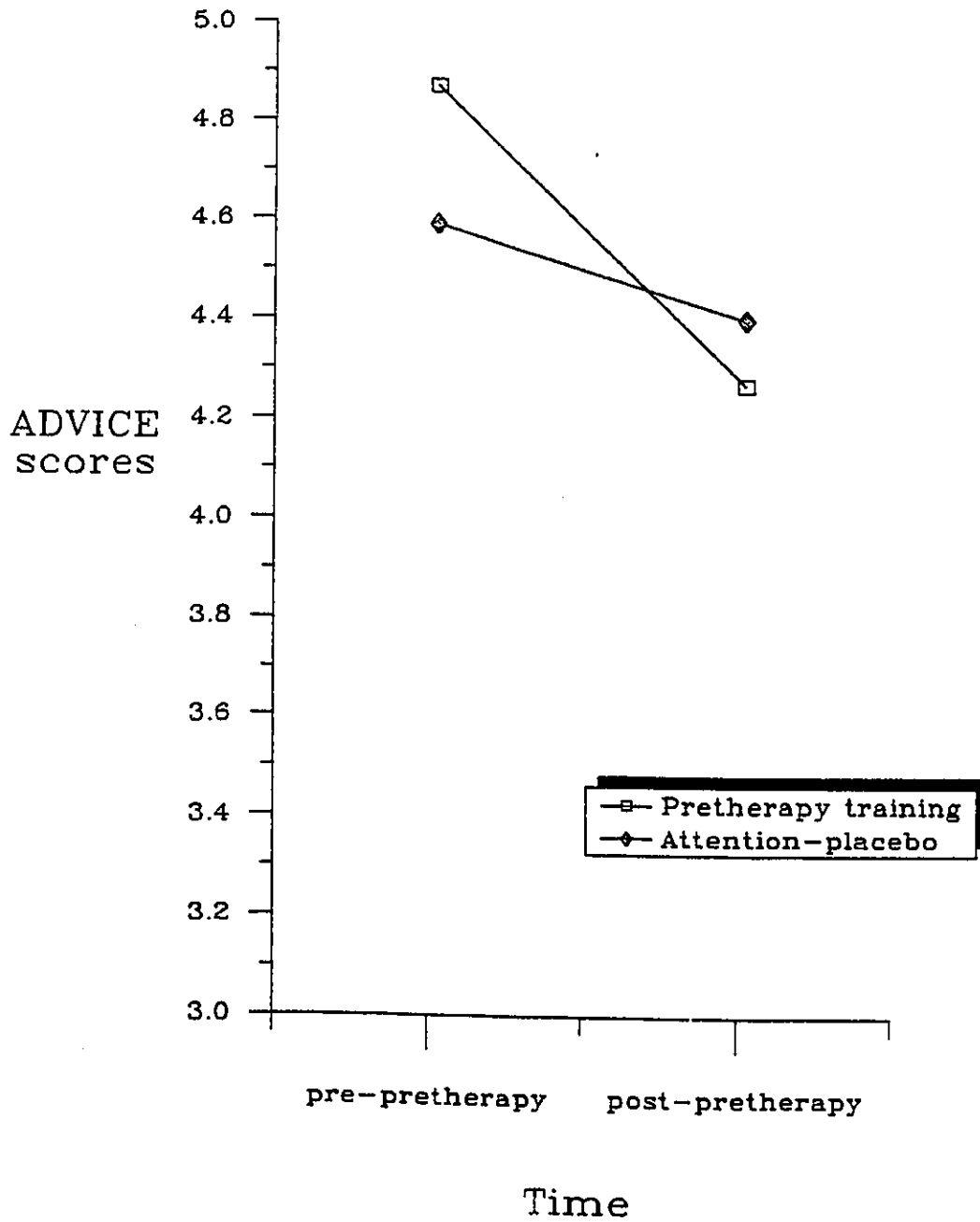


Figure 4. Mean scores on PEI-R AUDIEN subscale.

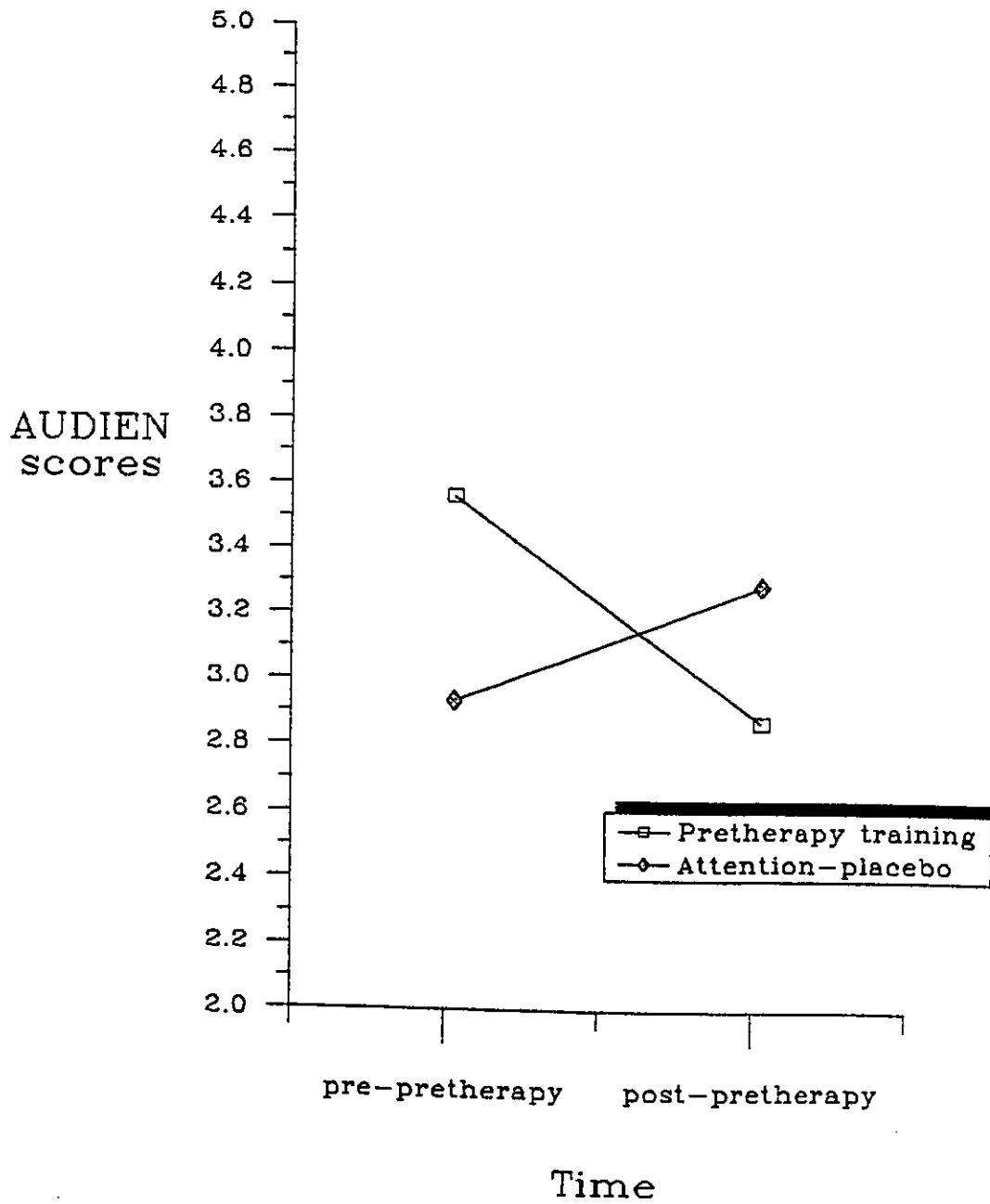


Figure 5. Mean scores on PEI-R RELAT subscale.

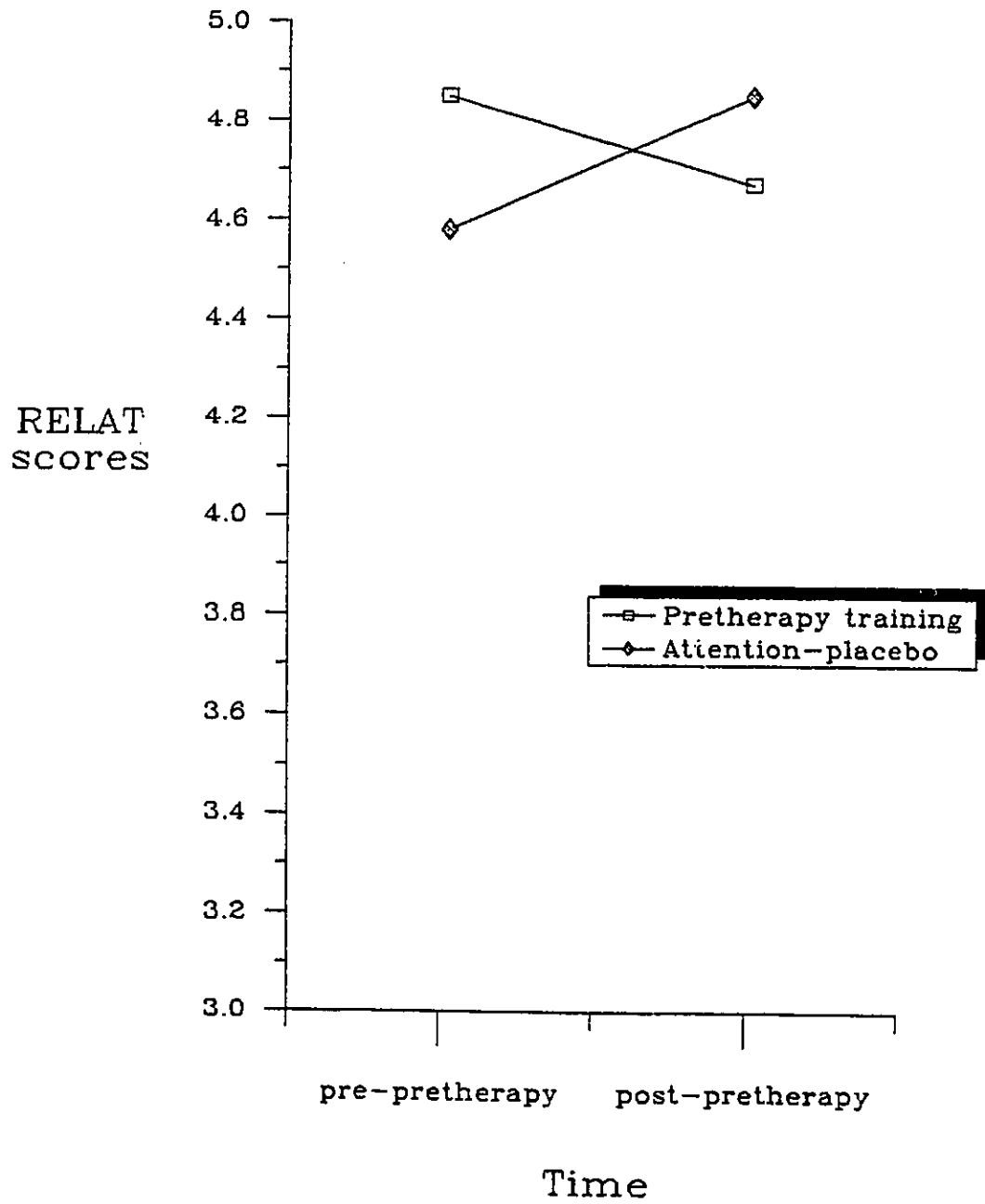


Figure 6. Percentage of work statements for first 6 sessions.

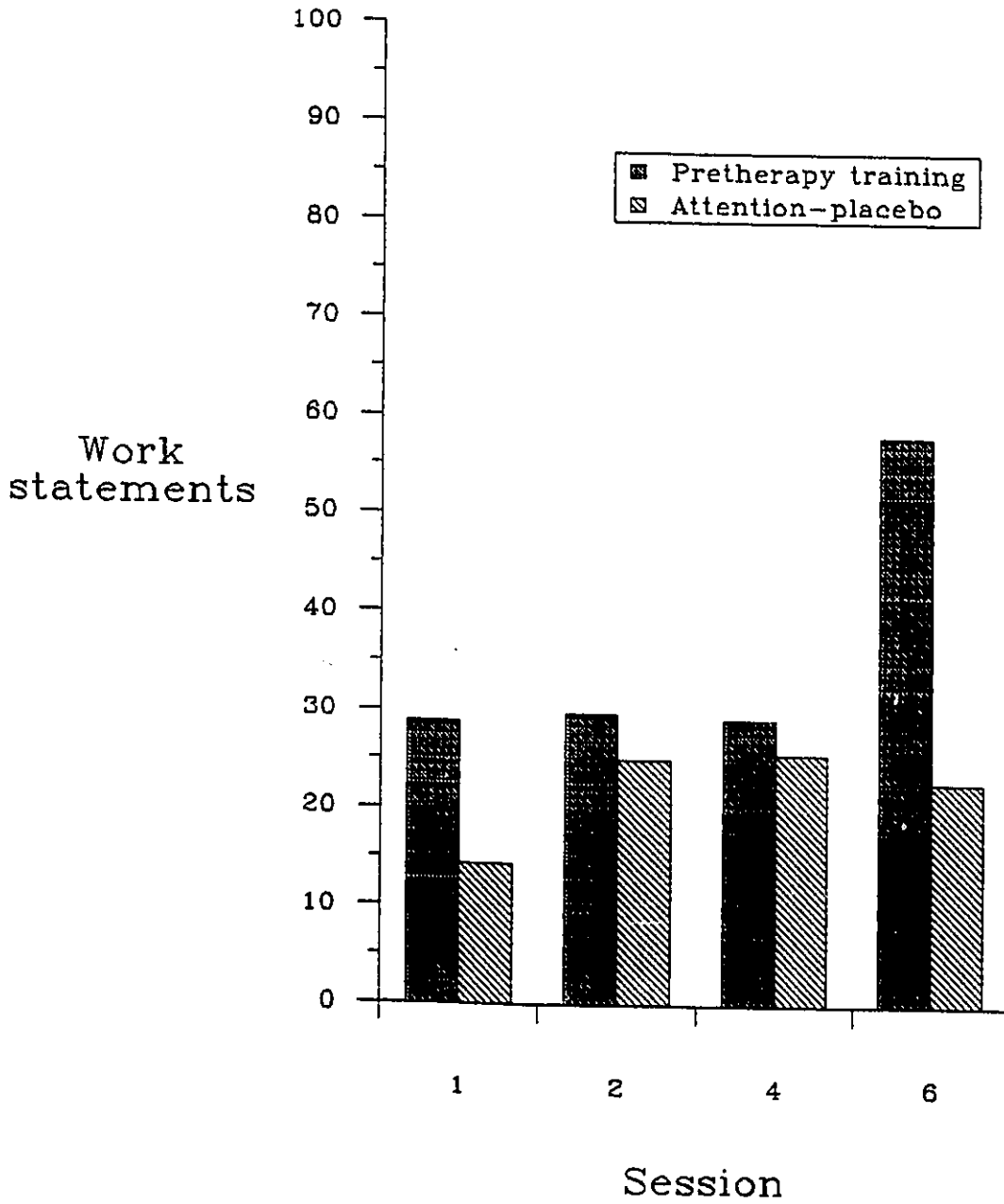


Figure 7. Mean scores on BDI.

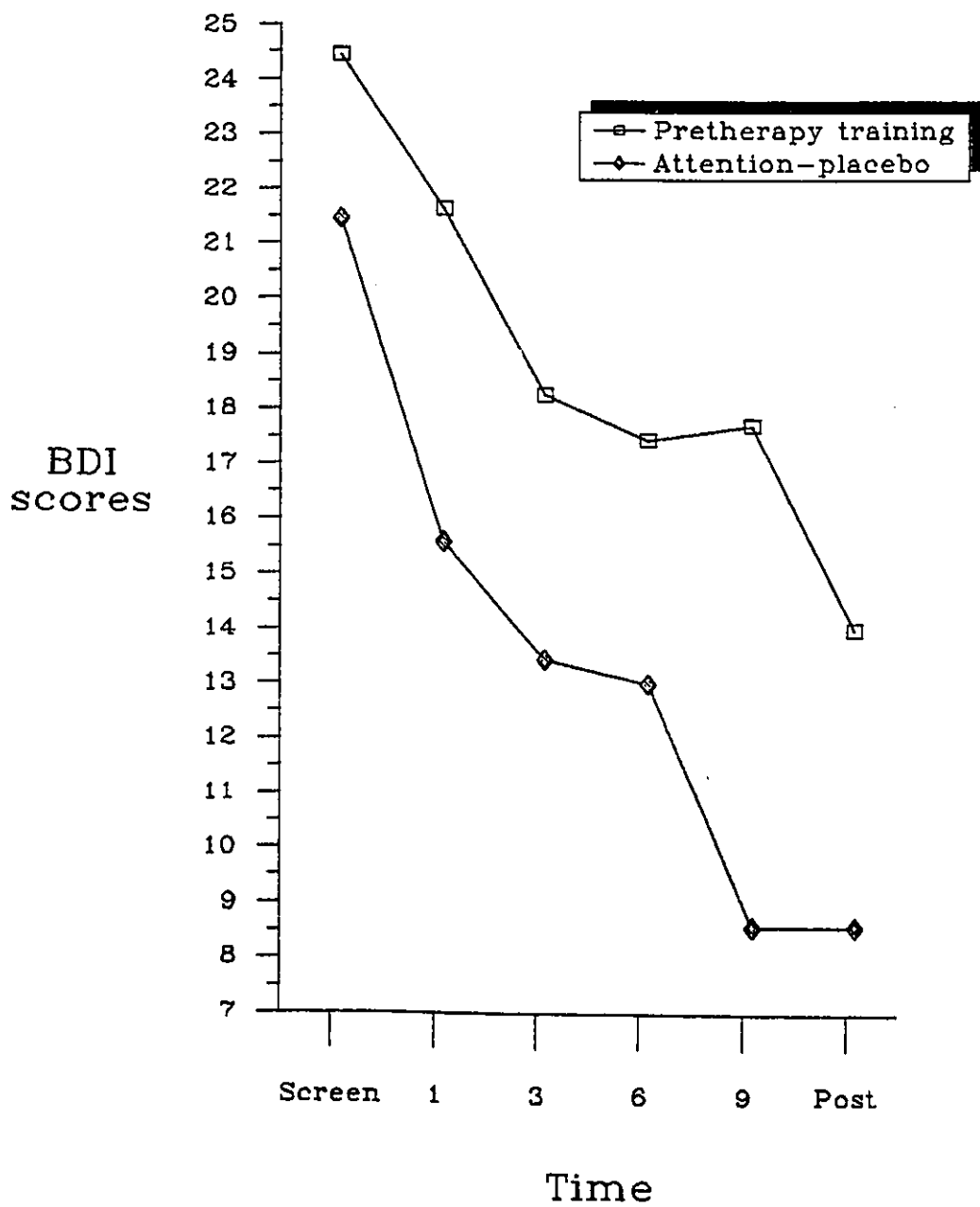


Figure 8. Mean scores on GDS.

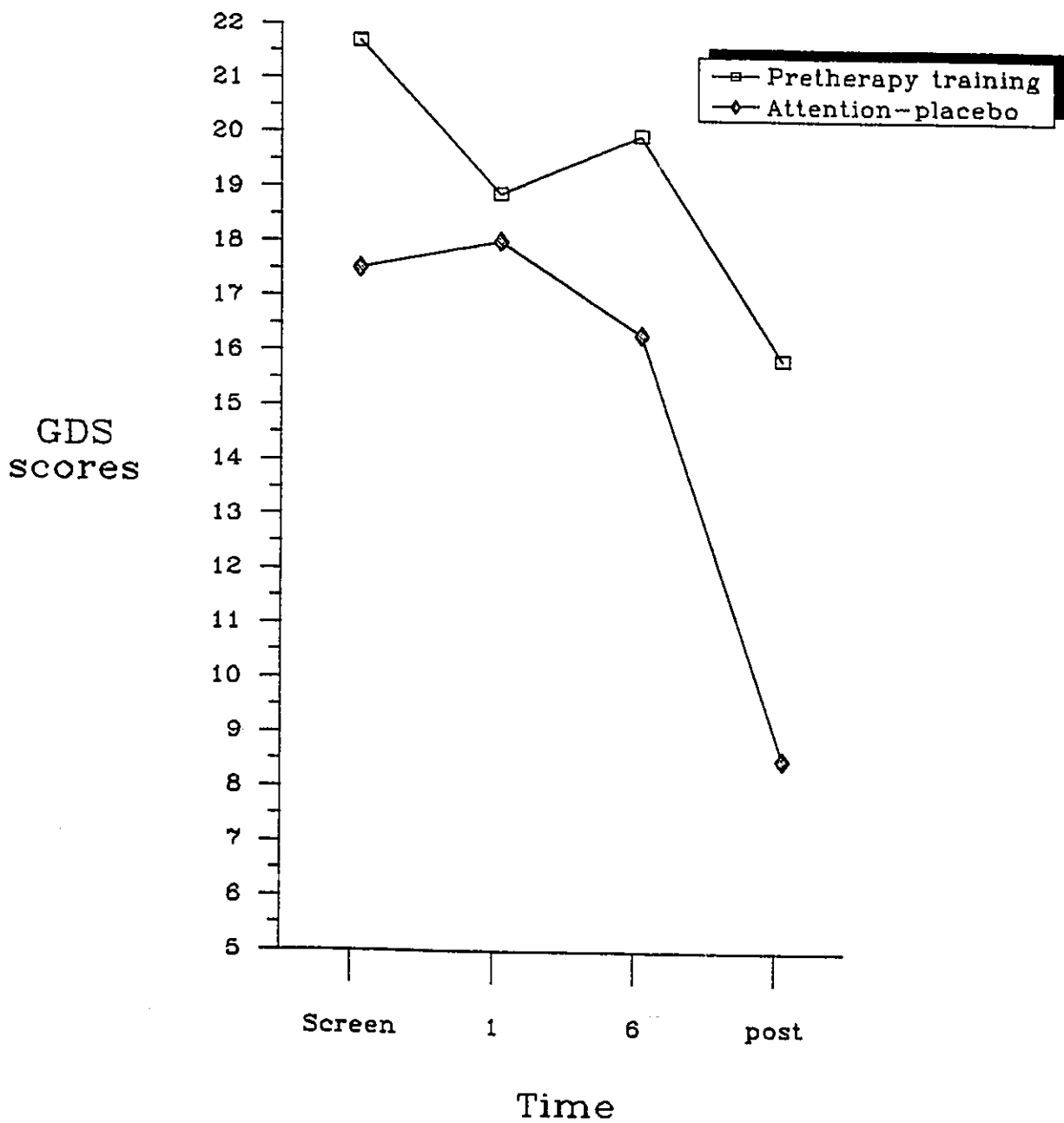


Figure 9. Mean scores on HRS-D.

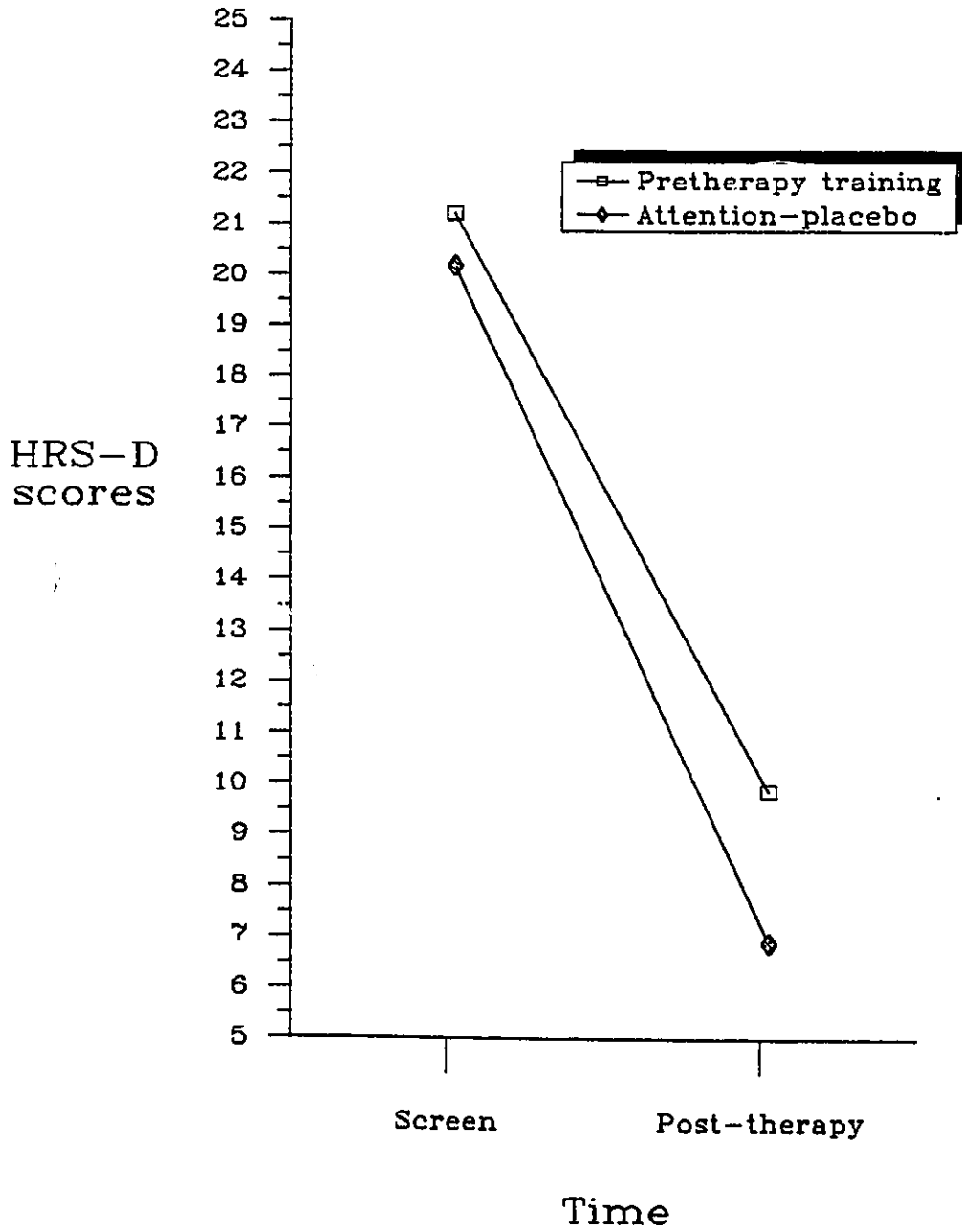


Table 1

Number of subjects in each phase by condition

| Condition | Phase | | | Total |
|---------------------|-------|----|-----|-------|
| | I | II | III | |
| Pretherapy training | 6 | 4 | 5 | 15 |
| Attention-placebo | 6 | 4 | 4 | 14 |

Table 2

Data collection protocol

| Instrument | Time of Administration | | | | | |
|------------|---------------------------------|------------------------------|--------------|--------------|--------------|------------------|
| | Prior to pretherapy phase | After pretherapy phase | Session 3 | Session 6 | Session 9 | Post- therapy |
| IDD | X | | | | | |
| MMSE | X | | | | | |
| KAPQ | X | X | | | | |
| PEI-R | X | X | | | | |
| GDS | X | X | | X | | X |
| HRS-D | X | | | | | X |
| BDI | X | X | X | X | X | X |

Table 3

Sociodemographic characteristics of the total sample

| Variable | Conditions | | <u>F</u> | χ^2 | Fisher's |
|-----------------------|------------------------|-----------------------|----------|----------|-----------|
| | Pretherapy training | Attention- placebo | | | |
| Age | | | | | |
| M | 69.79 | 69.40 | | -.23 | |
| SD | 3.38 | 5.50 | | | |
| Gender | | | | | |
| Male | 2 | 3 | | | $p > .05$ |
| Female | 12 | 12 | | | |
| Education | | | | | |
| Up to high school | 11 | 9 | | | $p > .05$ |
| More than high school | 3 | 6 | | | |
| Marital Status | | | | | |
| Married | 6 | 6 | | .02 | |
| Other | 8 | 9 | | | |
| Perceived Health | | | | | |
| Bad and Somewhat Bad | 9 | 7 | | .91 | |
| Good and Excellent | 5 | 8 | | | |
| Living Arrangements | | | | | |
| Alone | 6 | 8 | | .32 | |
| With someone | 8 | 7 | | | |
| Income | | | | | |
| \$20,000 or less | 10 | 5 | | 5.32* | |
| More than \$20,000 | 3 | 10 | | | |

Note. N=29; * $p < .05$.

Table 4

Screening comparisons for the total sample

| Variable | Conditions | | <u>F</u> | X ² |
|----------|------------------------|-----------------------|----------|----------------|
| | Pretherapy training | Attention- placebo | | |
| IDD | | | | 2.04 |
| MDD | 11 | 8 | | |
| Non-MDD | 3 | 7 | | |
| MMSE | | | - .57 | |
| M | 29.00 | 28.80 | | |
| SD | .39 | 1.27 | | |
| BDI | | | -1.78 | |
| M | 24.57 | 19.33 | | |
| SD | 9.53 | 6.06 | | |
| HRS-D | | | -1.02 | |
| M | 21.36 | 19.13 | | |
| SD | 4.99 | 5.01 | | |
| GDS | | | -3.14* | |
| M | 22.21 | 16.87 | | |
| SD | 5.13 | 4.00 | | |

Note. N=29; *p<.05.

Table 5

Number of dropouts in each phase by condition

| Condition | Phase | | | Total |
|---------------------|-------|----|-----|-------|
| | I | II | III | |
| Pretherapy training | 2 | 0 | 1 | 3 |
| Attention-placebo | 1 | 2 | 2 | 5 |

Table 6

Means and standard deviations for sessions attended by condition

| Variable | Conditions | | <u>F</u> |
|------------------|------------------------|-----------------------|----------|
| | Pretherapy training | Attention- placebo | |
| Pretherapy phase | | | .50 |
| M | 3.50 | 3.64 | |
| SD | .86 | .63 | |
| Therapy phase | | | -1.57 |
| M | 11.10 | 10.10 | |
| SD | 1.22 | 1.66 | |

Note. n=21.

Table 7

Means and standard deviations for KAPO scores

| Condition | Time of Administration | |
|---------------------|------------------------|-----------------|
| | pre-pretherapy | post-pretherapy |
| Pretherapy training | | |
| M | 7.43 | 8.78 |
| SD | 1.09 | 1.12 |
| Attention-placebo | | |
| M | 8.07 | 7.79 |
| SD | 1.07 | 2.08 |

Note. $n = 28$.

Table 8

Means and standard deviations for PEI-R subscales

| Condition | Time of Administration | |
|---------------------|------------------------|-----------------|
| | pre-pretherapy | post-pretherapy |
| APPROV | | |
| Pretherapy training | | |
| M | 4.61 | 4.12 |
| SD | 1.30 | 1.15 |
| Attention-placebo | | |
| M | 4.26 | 4.14 |
| SD | 1.33 | 1.34 |
| ADVICE | | |
| Pretherapy training | | |
| M | 4.82 | 4.22 |
| SD | 1.07 | 1.23 |
| Attention-placebo | | |
| M | 4.54 | 4.35 |
| SD | 1.10 | 1.23 |
| AUDIEN | | |
| Pretherapy training | | |
| M | 3.49 | 2.80 |
| SD | .82 | 1.20 |
| Attention-placebo | | |
| M | 2.86 | 3.22 |
| SD | 1.17 | 1.05 |
| RELAT | | |
| Pretherapy training | | |
| M | 4.80 | 4.62 |
| SD | 1.10 | 1.40 |
| Attention-placebo | | |
| M | 4.53 | 4.80 |
| SD | 1.23 | .97 |

Note. $n = 28$.

Table 9

Internal consistency estimates for PEI-R

| Time | Subscale | | | |
|-----------------|----------|--------|--------|-------|
| | APPROV | ADVICE | AUDIEN | RELAT |
| Pre-pretherapy | 0.85 | 0.70 | 0.79 | 0.71 |
| Post-pretherapy | 0.69 | 0.78 | 0.84 | 0.74 |

Table 10

Subscale intercorrelations for PEI-R

| | pre-pretherapy | | | | post-pretherapy | | | |
|-----------------|----------------|--------|--------|-------|-----------------|--------|--------|-------|
| | APPROV | ADVICE | AUDIEN | RELAT | APPROV | ADVICE | AUDIEN | RELAT |
| Pre-pretherapy | | | | | | | | |
| APPROV | ---- | .64 | .32 | .38 | .77 | .29 | .18 | .24 |
| ADVICE | .64 | ---- | .54 | .42 | .54 | .46 | .43 | .43 |
| AUDIEN | .32 | .54 | ---- | .55 | .19 | .09 | .67 | .30 |
| RELAT | .38 | .42 | .55 | ---- | .25 | .07 | .33 | .69 |
| Post-pretherapy | | | | | | | | |
| APPROV | .77 | .54 | .19 | .25 | ---- | .44 | .33 | .40 |
| ADVICE | .29 | .46 | .09 | .07 | .44 | ---- | .38 | .48 |
| AUDIEN | .18 | .43 | .67 | .32 | .33 | .38 | ---- | .50 |
| RELAT | .24 | .43 | .30 | .69 | .40 | .48 | .50 | --- |

Table 11

Summary of logit model for work dimension on HIM-M

| Effect | Partial Association chi-square |
|-----------------------------------|--------------------------------------|
| Statement | 373.75 ^{***} |
| Statement by condition | 38.42 ^{***} |
| Statement by session | 36.62 ^{***} |
| Statement by condition by session | 30.35 ^{***} |

*** $p < .001$.

Table 12

Observed frequencies for work dimension on HIM-M

| Statement type | Conditions | | Total |
|----------------|------------------------|-----------------------|-------------|
| | Pretherapy training | Attention- placebo | |
| Nonwork | | | |
| Session 1 | 142 | 172 | 314 |
| Session 2 | 211 | 227 | 438 |
| Session 4 | 217 | 225 | 442 |
| Session 6 | 84 | 159 | 243 |
| Total | 654 | 783 | 1437 |
| Work | | | |
| Session 1 | 58 | 29 | 87 |
| Session 2 | 89 | 76 | 165 |
| Session 4 | 89 | 78 | 167 |
| Session 6 | 116 | 47 | 163 |
| Total | 352 | 230 | 582 |

Table 13

Marginal frequencies for work dimension on HIM-M

| Variable | Statement type | | Total |
|---------------------|----------------|---------|-------|
| | Work | Nonwork | |
| Statement | 582 | 1437 | 2019 |
| Condition | | | |
| Pretherapy training | 352 | 654 | 1006 |
| Attention-placebo | 230 | 783 | 1013 |
| Total | 582 | 1437 | 2019 |
| Time | | | |
| Session 1 | 87 | 314 | 401 |
| Session 2 | 165 | 438 | 603 |
| Session 4 | 167 | 442 | 609 |
| Session 6 | 163 | 243 | 406 |
| Total | 582 | 1437 | 2019 |

Table 14

Means and standard deviations for scores on the BDI, GDS, and HRS-D

| Condition | Time of Administration | | | | | |
|--------------------|------------------------|--------------|--------------|--------------|--------------|------------------|
| | Screen | Session 1 | Session 3 | Session 6 | Session 9 | Post- therapy |
| BDI ^a | | | | | | |
| Pretherapy tr. | | | | | | |
| M | 24.00 | 21.18 | 17.82 | 17.00 | 17.27 | 13.55 |
| SD | 10.59 | 9.66 | 11.02 | 9.65 | 10.08 | 8.34 |
| Attention-pl. | | | | | | |
| M | 21.00 | 15.14 | 13.00 | 12.57 | 8.14 | 8.14 |
| SD | 4.93 | 8.34 | 6.56 | 6.21 | 4.02 | 3.63 |
| GDS ^b | | | | | | |
| Pretherapy tr. | | | | | | |
| M | 21.27 | 18.46 | | 19.55 | | 15.46 |
| SD | 5.26 | 7.22 | | 7.40 | | 6.09 |
| Attention-pl. | | | | | | |
| M | 17.10 | 17.60 | | 15.90 | | 8.10 |
| SD | 4.68 | 4.97 | | 3.28 | | 4.33 |
| HRS-D ^b | | | | | | |
| Pretherapy tr. | | | | | | |
| M | 20.73 | | | | | 9.36 |
| SD | 5.42 | | | | | 5.57 |
| Attention-pl. | | | | | | |
| M | 19.70 | | | | | 6.40 |
| SD | 5.66 | | | | | 4.40 |

Note. ^an = 18; ^bn = 21.

Table 15

Intercorrelations for the three depression measures (BDI, GDS, HRS-D)

| | Screening | | | Posttherapy | | |
|--------------------|-----------|-----|-------|-------------|-----|-------|
| | BDI | GDS | HRS-D | BDI | GDS | HRS-D |
| Screening | | | | | | |
| BDI | --- | .59 | .45 | .52 | .34 | .45 |
| GDS | .59 | --- | .57 | .38 | .60 | .48 |
| HRS-D | .45 | .57 | --- | .37 | .31 | .57 |
| Posttherapy | | | | | | |
| BDI | .52 | .38 | .37 | --- | .81 | .61 |
| GDS | .34 | .60 | .31 | .81 | --- | .48 |
| HRS-D | .45 | .48 | .57 | .61 | .48 | --- |

Table 16

Correlation between KAPO and other measures

| Instrument | KAPQ | |
|-------------------------|----------------|-----------------|
| | Pre-pretherapy | Post-pretherapy |
| PEI-R (Pre-pretherapy) | | |
| APPROV | -.08 | -.08 |
| ADVICE | -.02 | .23 |
| AUDIEN | -.03 | .46 |
| RELAT | -.07 | .11 |
| PEI-R (Post-pretherapy) | | |
| APPROV | -.17 | -.14 |
| ADVICE | -.37 | -.21 |
| AUDIEN | .07 | .28 |
| RELAT | -.21 | .03 |
| MMSE | -.11 | -.04 |
| Screening | | |
| BDI | -.29 | .32 |
| GDS | -.49 | .11 |
| HRS-D | -.11 | -.10 |
| Posttherapy | | |
| BDI | -.46 | .22 |
| GDS | -.47 | .23 |
| HRS-D | -.31 | .30 |

Appendix A

Information and informed consent

General information

Studies on human subjects require the written consent of the participants. It is understood that this does not imply that the project described below carries any risk or embarrassment; it is simply the respect to which the individuals involved are entitled that has prompted the University of Ottawa and the granting agencies to make this type of agreement mandatory.

The purpose of this study is to assess the role of information in helping people benefit more from therapy. There seems to be a relationship between what a person knows about therapy and how much benefit they can derive from it, and we would like to assess how different ways of giving information will affect the outcome of therapy. To participate in this study, you must be 65 years of age or older and you must be suffering at least moderately from a specific kind of depression.

If you agree to participate in this study you will undergo psychological testing in order to determine your suitability for this research. If you satisfy our criteria for participation, you will be randomly assigned to one of two information-giving groups. This means that you are really agreeing to participate in either one of the information-giving groups. If you do not

meet the criteria for this study, you will be given feedback about the initial testing and referred to an appropriate agency.

Study Phases

There are two phases to this study. In the first phase, you will be assigned to an information group which you will attend a total of four times; twice a week for two weeks. Each session will last approximately one hour.

In the second phase you will receive group cognitive therapy which has been especially adapted for older adults. The therapy sessions will occur once a week for 12 weeks with each session lasting approximately one and one half hours. Group therapy will be conducted by senior doctoral-level interns in clinical psychology under the supervision of a clinical psychologist, Dr. P. Cappeliez of the Center for Psychological Services of the University of Ottawa. All therapy sessions will be audiotaped for the purposes of clinical supervision and to ensure that the treatment model is being followed. Therapy will be offered free of charge at the Center.

Psychological Testing

To participate in this study you must complete research questionnaires. This will include the initial testing to determine if you satisfy the criteria for this study as well as three testing periods throughout therapy and one period at the end of therapy. Psychological testing will involve

questionnaires that will examine the intensity of your depression. This testing will take place at the Center for Psychological Services and will be no longer than an hour per testing period. There is no charge for the testing. If you do not meet the criteria for this study you will be given feedback about the initial testing and referred to an appropriate agency.

Confidentiality

Results of testing and videotapes of group therapy will be kept in confidence and in accordance with the guidelines of the Ontario Board of Examiners in Psychology. Your names will only be known to those who are involved in your care or in the clinical supervision of your treatment. A research assistant will be involved in psychological testing with you and they will respect the confidentiality of all information. All data from this study will be pooled so that individuals cannot be identified and if data from this study is published you will not in any way be identified. At the end of the study we may request to keep the tapes of certain group therapy sessions for training purposes and you would be asked to complete a consent form agreeing to the use of specific tapes. All other tapes will be destroyed at the end of the study. You may refuse to have the tapes used for training purposes and this will not affect the availability of treatment for you.

Debriefing

At the end of therapy you will be informed of the purpose of the study and we will answer any questions that you may have. At that time you can also request a summary of the results of the study when they become available.

I, _____, understand that I am being asked to participate in a study to assess the effect of providing information to clients before they begin therapy, and I agree to participate in the group therapy being offered. I give permission for the collection of data for the study and for the creation of a clinical file that will be used to monitor my progress in treatment. I understand that all information gathered about my treatment will be held in strict confidence within the limits of the law and according to the ethical principles of the Ontario Board of Examiners in Psychology, and that this information will be available only to those who are directly involved in my treatment or in this study. My participation in this research is voluntary and I may withdraw from this study at any time without penalty and without affecting my ability to request other psychological or psychiatric services. I can contact either Dr. P. Cappeliez or David Latour at the Center for Psychological Services of the University of Ottawa (564-6875) to answer any questions or concerns that I may have.

I have received a copy of this consent form and I have read and understood it. I hereby agree to participate in the testing and in this study if I am selected.

Signature _____

Witness' Signature _____

Telephone (H) _____ (W) _____

Date _____

Confirmation of consent

I have been accepted into this study and assigned to one of the information-giving groups being offered. I hereby confirm my consent to participate in the study.

Signature _____

Witness' Signature _____

Date _____

Appendix B

Manual for pretherapy trainingSession 1: Myths and misconceptions about psychotherapy

Coming into group therapy and joining a new group is not always an easy thing to do. Most of us feel a little worried about meeting new people and are somewhat unsure of ourselves when we don't know what to expect in a new situation. The purpose of today's meeting and the next three meetings is to give you a better idea of what to expect in your therapy group so that you can feel more comfortable in the beginning, especially in the first few sessions.

Coming into a new group can be a hard thing to do. Some of us can just take new experiences in stride without worrying about them beforehand, and you may be like that, but most of us feel some amount of concern when we don't know what a new situation is going to be like. When you come into a new group, not only are you not quite sure what other people will be expecting of you, but you also don't know what to expect of them. In a situation like that, it's normal to feel uncertain or concerned. I know I would be having some pretty uncomfortable feelings at this point if I were about to enter a new group. As you know, your group therapy will start on (give starting date) and will continue for 12 weeks. I can't tell you exactly what will be happening in your group. What I can do is to give you some general

information that will give you a feel for the kinds of things to expect.

Today we will be talking about what is expected of you in therapy and what, in return, therapy has to offer you.

Are there any questions at this point?

I imagine you probably have some idea of what you expect group therapy to be like. Maybe you even know someone who talked about being in therapy. Books, movies, and television often show what therapy might be like, sometimes accurately but other times nothing at all like real life. Before we begin, it would be helpful to talk about what you're expecting, or any questions or concerns you might have.

Let's start with what you can expect of the people leading your group. A therapist acts very differently from a doctor that you go to when you feel physically sick. When you have an infection or pain, you go to your doctor, tell him what your complaints are, and then he tells you what to do. When you go into therapy, you also talk about things that are wrong in your life and that are making you feel bad, but the therapists won't be giving you advice or definite solutions or telling you exactly what to do. Instead they will be helping you to go through a gradual process of learning to find your own solutions and your own answers. How does this agree with your own ideas of what to expect from a therapist? I'd like to hear a little bit about what you're expecting.

You'll also find that you can get a lot of help from the other people in the group. I think you'll find that as you all get to know one another, they'll care about you and about what happens to you. They're on your side and can give you a great deal of emotional support. At the same time, you'll begin to care about them and what's going on in their lives.

Sometimes the therapists don't say much, and they let the people in the group work together and help one another. On the other hand, the therapist will be there to oversee what people are saying to one another, and they will step in and make comments when they feel it'll be helpful. Basically, what I'm saying is that if you expect the therapists to tell you exactly what to do to solve your problems, you may be disappointed, especially in the beginning. But if you expect the therapists to cooperate with everyone in the group in helping you learn how to find your own answers, that will be closer to what you can expect to happen in group therapy.

In addition, the therapists want to help you feel good about yourself, and eventually that is what therapy does, but the therapist can't make you feel good all the time. Sometimes you'll be learning new things about yourself that you don't like or that make you feel uncomfortable or that even make you feel extremely angry with yourself and with other people in the group. This is part of the process, too. If you feel upset some of the time, it doesn't mean the therapists aren't doing a good job. It may mean that you are growing and learning new ways of coping,

and sometimes that's wonderful and exciting and sometimes it's painful. The important thing is whether in the long run it will be helpful to you.

How do people feel about what I've been saying?

Up to now we have been talking about what you can expect of other people. What about their expectations of you? There are no rules in therapy. You're free to talk about anything you want, but maybe I can give you some guidelines that will help you to get the most out of being in a group. In the beginning, you may feel a little bit hesitant about talking, and that's O.K. You can take your time and wait until you begin to feel more relaxed with the other people in the group. However, eventually you will want to talk and participate and begin sharing what you think and feel with the others. Being in a therapy group gives you an opportunity you rarely get anywhere else to really be open about yourself and to say things you may not be able to say anywhere else.

We all have both pleasant and unpleasant feelings. Sometimes we're happy, sometimes we feel pleased with ourselves, but other times we're scared to death, or so mad we feel ready to explode, or maybe just miserably unhappy. In therapy, it's O.K. to talk about all your feelings, the unpleasant ones as well as the pleasant ones. In fact, as things are going on in the group, you will find yourself experiencing all kinds of feelings. Sometimes you'll feel good about the other group members and very close to them. Other times you may be angry or worried or upset by what

other people are saying or doing. In most situations outside of therapy, when we have these kinds of feelings about other people, we usually try not to say anything. It can feel very uncomfortable to tell someone that he or she makes you feel angry. On the other hand, we often feel equally uncomfortable talking about feelings of warmth and closeness. But in the group, it's perfectly all right to tell people how they affect you, to let them know you're feeling angry or frightened or upset with them or that you like them or admire the way they're handling a situation. In fact, it's more than just all right to talk about your feelings. You're encouraged and expected to talk about them. You can talk about all of your feelings, no matter what they are, right then as you're feeling them and without keeping them bottled up inside you.

In polite conversation, we may feel free to tell people pleasant things, but we usually hesitate to tell them that they make us mad or make us feel stupid or whatever other unpleasant effect they may be having on us. In therapy it's O.K. to talk about all kinds of feelings, pleasant and unpleasant, because it's done for a reason. It helps us all to learn about what kind of effect we have on others. Most of the time, people are not so frank with one another, and we really don't know how other people see us. For example, I may have some irritating habit that rubs people the wrong way. I could change if I knew about it, but unless someone tells me what I am doing that is annoying, I just may not be aware of the effect I'm having. In therapy people can

be honest with one another. You have a chance to learn how other people see you, what kind of an impression you are making, how you affect other people and make them feel. Sometimes this may hurt you, other times you may be pleasantly surprised. Even if it hurts, it is a way of learning how other people react to you and it gives you a chance to try out new ways of acting toward others and to decide whether you want to change some of the things you are doing.

At the same time, you'll be learning to listen to other people, to really hear what they're saying and to listen for the feelings behind their words. Communication is a two-way process. That sounds so obvious when you say it, but sometimes we forget that communication involves both give and take. The group members help one another. Not only will other people be expected to give you their honest reactions, you are also expected to help others by giving them information about how they make you feel. An important part of being in a group is helping others to learn about their strengths and weaknesses at the same time you're learning about your own. You give as well as take in a group. There can be a fringe benefit in giving. Sometimes when you help someone else to change in a positive way, it can do really good things to the way you feel about yourself, too.

People have a lot of different kinds of reactions to being told about this kind of open and honest talking about feelings. How do you expect you'll feel in the group when people talk about how you make them feel and also when they expect you to talk

about your own reactions to them? How do you think you'll handle this? Now let me back up a little. I've been saying that in the group it will be O.K. to talk about everything and anything you feel or think. You'll want to talk about your feelings, not just in a general way, but as they are coming up right there in the group. You'll be encouraged to be open and honest with other people in the group and to have them be the same way toward you. The benefit is that you get a clearer picture of yourself and how others see you and react toward you.

On the other hand, I'm well aware that being really open and honest can sometimes be a frightening prospect or make you feel like you could be hurt if you talked about things that you considered deeply personal or private. I've seen a lot of television programs that show groups being nasty and insulting toward one another instead of being open and honest. In the beginning, you can't be sure how other people are going to react. You don't know if they'll understand you. We're all sometimes worried that we'll sound dumb or that people will think we're strange or that we'll feel embarrassed. That's why I said before that at first it's O.K. not to talk if you don't feel ready. As you feel more comfortable though, try joining in little by little. Experiment with being open and honest both about yourself and about the other people in the group. Even if it's hard at first, I think you'll find yourself gradually trusting the others more and more. You're there to help one another, not hurt one another.

I'd be interested in hearing how you think you'll feel about joining into the conversation in the group, especially in the beginning.

We've been talking about how to act in therapy and how to expect others to act in the group. Now I'd like to talk a bit about what you can expect to eventually get out of it. Neither your therapists nor the other group members can be expected to provide sure-fire answers to all your problems. Well, if you aren't going to get advice and solutions, what will you be getting? It's important to remember that you are trying to change ways of doing things that you have been doing for years. You're trying to change attitudes and ways of thinking that took years to form. You won't change quickly but gradually and your work should pay off, just as it has in the past when you've worked hard at things.

If you're in a difficult situation, and the situation itself can be changed in some way, that's fine. But lots of times we're in situations that can't be changed easily. Often there's some other person in your life that you're having problems with, and the group can't do anything to change people who aren't there. Sometimes when your situation can't be changed, you may need to learn to compromise and to change yourself in some way, or find a new way of coping. Surprisingly, when you change the way you act toward others, they too gradually begin to change, and little by little the whole situation does change.

I believe you will get a lot out of being in the group if you are willing to put a lot into it. You'll learn to understand yourself better, you'll become more honest with yourself about your own feelings, and you'll have a clearer picture of how you affect others.

At the same time, I want to let you know that it isn't all fun and games. Especially in the first few sessions, you may sometimes feel all kinds of unpleasant feelings in addition to the happier feelings. You may feel discouraged or frustrated, sometimes you may feel like you don't fit in or you don't know what is going on. You may have a hopeless feeling about the whole thing or just feel confused. There may be a feeling of who are all these people and what the heck is going on here. These kinds of feelings don't always happen, but they're not unusual in the beginning.

You'll walk out of group meetings with all kinds of different feelings. Sometimes you may have a good session and go home feeling on top of the world, like now you can handle anything that the world throws at you. At these times you'll find yourself looking forward to the next group meeting.

Other times it's possible you may feel like you're getting worse instead of better, or else like you're going up and down, getting better and then worse and then better again. If these kinds of feelings and doubts do start getting stirred up, you may not want to come back to the group the next time. I know that if I leave someplace feeling lousy, I'm not too eager to go back

there again. But if you get these negative feelings, I think you'll find that the most effective way of handling the situation is to talk about your feelings in the group itself. As I've said before, you can talk about all of your feelings in therapy. This includes unpleasant feelings about the group itself and your experiences in it.

After you've had a good session that has been especially helpful, you'll probably look forward to coming back the next week and discussing your feelings about what's going on in the group. But if you've had a difficult group meeting or bad week, you may feel like you don't want to come back. Instead of staying away when you feel bad about the group, come and talk about your feelings and discuss what's causing them. It may be a hard thing for you to do, but exploring these feelings can be a helpful step in the process of gaining self-understanding and control of your life.

Usually, the first few sessions are the hardest and the most discouraging. If you stick with it, you can gain quite a bit. People who stay with it find that there is a tremendous feeling of satisfaction associated with growth and with finding more satisfying ways of dealing with problems. There can be a feeling of closeness and mutual caring that grows out of working in a group and getting to know one another that can be an extremely personally meaningful experience.

It would be helpful for us to talk about how you think you would feel about actually telling the group about your feelings

concerning the group itself, whether you think they're helping you or if you don't like what's going on.

It's also important to realize that even after you work out the problems you have now, it doesn't mean you'll never have problems again. Life just isn't like that. There are always new problems. What you learn in therapy is better ways of handling your problems so that when the next one comes up, you're able to work things out better than you did the last time.

You can learn to be more flexible in finding solutions to your problems. You can learn to get a more realistic picture of the way other people see you. You can learn to be more honest with yourself about your own feelings and your reactions to other people. Eventually all of this gets transferred to situations and to relationships with people outside the group. You learn to take on responsibility for changing yourself. Therapy doesn't change you by some magical process. You learn that you are responsible for what you do, and you are also responsible for choosing whether or not you want to change what you are doing. Other people can tell you how your actions make them feel, but it is you yourself who decides what you want to accept and whether you want to change what you're doing, both in the group and outside of it. To me, some of the most gratifying things about therapy are that you learn to be honest with yourself, to trust yourself and feel good about yourself, and to take responsibility for your decisions and for what you do so that you learn to

recognize the inner strength you have to handle new problems that come up.

The other people in your group will help you, but in the end everything is up to you. You don't have to accept everything they tell you. You won't be pressured to accept someone else's impressions of you. You can listen to what people say and decide for yourself what seems right for you. Even if you don't accept everything that the other group members say, you can sift out the things that seem to describe you accurately or that will be useful to you in understanding yourself better, and you can just use the parts that seem helpful. In other words, listen to what people say and decide for yourself what seems appropriate for you.

I'd really like to know how you feel about what I've been saying.

As I said before, there are very few rules in therapy, very few shoulds or have tos. One of the very few requirements is that everything said in the group is confidential. You want to be able to talk about personal things and know that they won't be repeated anywhere else by the others in the group. They want the same assurance. So we ask that outside the group, no one should talk about the people in it or about what specific people have said, although you can talk in a general way about topics that have been discussed without mentioning names of people.

I know that the need for confidentiality was also covered in the contract that you've already signed when you agreed to be in

a therapy group. There are a few other things from that contract I'd like to review with you here. You're expected to come to all the meetings and to be on time. The reason for this is that, since you are agreeing to be a member of the group, the group will miss you if you are not there. When you come regularly, there's a general feeling that you've made a personal commitment to be a part of the group and to be involved in what goes on at the meetings. If you really can't come one week for some reason, please call and let us know in advance that you won't be there. This will reassure the group that you do want to be a part of the group.

I'd also like to talk about some other concerns about group therapy that a lot of people seem to share in the beginning. Sometimes people feel that in a group they have to divide the time with all these other people and they're not sure whether there will be enough time for their own problems. What actually happens is that you learn not only by discussing your own concerns, but by hearing how other people are handling theirs. Even when others are temporarily the center of attention, you can be benefitting from the time. You discover that even when people have different problems, we all share the same feelings. We all know how it feels to be embarrassed, to be proud of something we've done, to be worried about the future, to be hurt when other people say hurtful things, to be pleased when they show they care about us, to be scared or angry or happy or the whole range of human feelings that we all experience. You can be learning

things from other people's problems as well as from discussing your own.

Another concern that people sometimes have is how other people who can't solve their own problems are going to help you. Or on the other hand, how can you help someone else if you haven't been able to help yourself. It can seem like it is going to be a case of "the blind leading the blind". Sometimes you might wonder how just sitting around and talking is going to help anything. The answer leads back to what I've talked about before. Therapy is a learning process. You can learn to talk about your feelings and to understand them better. You learn how people are reacting to you, and you can try out new ways of talking to people and of acting toward them. You learn to take responsibility for working out ways of handling your problems. The group can help you to look at new alternatives that you might not have considered before or to see things in a new light. But eventually you discover coping abilities you never knew you had. It's you who has to decide what you'll do and you who is responsible for your own decisions. The group is there to help you learn to take on responsibility for whatever you choose to do, and the talking and activities are means to that end. You'll learn that you have more choices open to you and more control over your life than you may think possible right now. And I think you'll be able to take what you learn and use it in dealing with all kinds of situations outside the group.

If you have any comments or questions or reactions to any part of what we've talked about, or overall reactions to the whole thing, I'd be glad to talk about them with you. Also, if you have any concerns about anything that I haven't brought up, please feel free to ask me about anything you would like to talk about.

All right, next time (say exact day) we will be watching a videotape of simulated group therapy to give you an idea of what it's like to be in therapy.

Session 2: Videotape "Simulated Group Cognitive Therapy"

Introduction. The videotape you are going to see is not a real group therapy session. It's an example using actors who are pretending to be members of a group. This is because the actual group sessions are confidential, and we would not show films of people discussing their real problems in this way. However, this tape will give you an idea of how some of the things we talked about look in action.

The videotape is designed to illustrate a number of concepts in a short time so things will proceed on the film somewhat faster and more smoothly than they would in an actual group session. You can expect that in a real group there will sometimes be awkward silences, people won't change as fast as the film implies, and other group members may not be as sensitive as the people in this group. The group on the tape is not

unrealistically perfect, but as I said, events go along faster and more smoothly than they usually do in real life.

In the film, the two people on both ends of the semi-circle are the co-therapists who are leading the group. I'll be stopping the videotape occasionally so that we can discuss what you've seen.

After vignette #1. Group members tell their honest reactions to Dan. This feedback is a very important part of group therapy. Dan recognizes that he has been thinking about how to solve his own problem. This is more characteristic of people who have been in therapy for a while than of people in the early stages. The feedback leads to the consideration of new behavior to be tried out.

He is beginning to accept responsibility for contributing to his own situation regarding German classes. When he first says it may be his own fault, he doesn't seem to really accept his own statement until others tell him how he appears to them.

After vignette #2. The group does not give Linda direct answers to her questions, but she is led to begin looking at her problem from a new perspective. She can't pinpoint the problem at first, but the discussion begins to bring it into focus. She starts out by saying she does not know what is wrong and progresses to the beginning of exploring communication problems in her marriage.

When Linda explores her negative reaction to John's feedback, she relates this to her reactions to her husband. She would also have been free to reject John's observations if she disagreed. Her behavior in the group helps her to understand what is happening in a situation outside the group.

Talking about your personal life, or self-disclosing, is expected of the members of the group. However, Linda has the right to decline discussing an area she does not yet feel ready to share with the group. She is not pressured to reveal more than she feels comfortable sharing.

After vignette #3. In the first part the leader helps Sue identify a basic belief which is preventing her from doing the things she likes. The leader helps her to explore what would happen if she changed this belief. An important part of therapy is helping people see that there are alternative ways of looking at things.

In the second part the leader enlists the help of two other members who have experienced difficulties similar to those Sue is currently experiencing. People often believe that group therapy might be like "the blind leading the blind". Here we see how the others in the group can help Sue out of her depression. In turn, the list given to Sue will help her to tackle her problem. What she learns in therapy can be used to help her in her everyday life.

Transcript of "Simulated Group Cognitive Therapy"

Therapists: Male therapist (MT); Female therapist (FT)

Clients: Dan; John; Linda; Sue.

Vignette #1

MT: Okay. The next item on the agenda is Dan's bad week.

Are you ready to work on this Dan?

Dan: Yeah, I guess so.

MT: What was it about your week that was bad?

Dan: Well, I just joined up for these German classes at the Senior Center where I live. And, well, I guess it really wasn't that bad. But it was sorta bad for me.

Well yeah, I guess it was pretty bad.

MT: I get the impression you're feeling down about this.

Dan: Yeah, I feel lousy. I just started these classes and I just felt like I was an outsider, all these people seemed to know each other. I mean I guess I was a stranger, but they didn't have to make me feel like one. Nobody said hello. They just kind of ignored me. No one asked me to have coffee with them after or anything. I just felt completely out of things.

FT: It sounds like you felt really miserable the rest of the day.

Dan: Yeah, I felt depressed. They made me feel worthless, like I don't count for anything. I thought this would be a fresh start, but it's the same thing all over

again. I can't handle being around people like that. How do you expect me to learn anything. I can't take that kind of pressure. I can't think clearly in an unfriendly atmosphere like that. If the teacher calls on me I'll make stupid mistakes 'cause I always make stupid mistakes when I'm pressured. I want to learn German but I think I'm going to quit anyway.

MT: I see. I'm wondering what the others are thinking. Would anyone like to comment at this point?

(Silence of about 10 seconds. Members are just looking around, nobody says anything.)

Sue: Maybe I'm wrong... But you sound, I dunno, sort of scared.

Dan: (Defensively) What do you mean, scared?

Sue: I don't know. Scared the people won't like you. Scared you won't learn as fast as they will maybe. I don't know. Just sounds to me like you're afraid to go back for some reason, and you're looking for an excuse not to do it.

Dan: I don't think so. Well, I don't know... maybe. I'm not sure I want to take this class anyway. I'm not sure about anything in my life. It's really my fault, I guess.

MT: How do you mean, it's your fault?

Dan: Like I said, it's my fault. This always happens to me with new people. I'm never sure if it's me or them. I

guess I don't try hard enough to get out and do things and to make the first move with people.

MT: It sounds to me like at the same time that you've been saying you feel helpless, you've also been thinking about what you're doing to contribute to the situation.

Dan: Maybe I am. I feel like I'm just kind of bumbling along, but underneath I guess I am thinking about what I can do. I always wait for someone else to say hello. I never say hello first.

FT: I wonder if anyone here has noticed this.

(Pause for about 5 seconds).

John: I noticed in here that you usually hold back. Last week we came in and you just looked at me and didn't say anything and I thought, hey, I've been in a group with this guy for weeks, and he won't even say hello. I felt like you were putting me down and it took me a long time before I felt like saying anything to anybody that night because I felt like maybe nobody in the group thinks I'm any good.

Dan: (Surprised) Really? You always seem so sure of yourself to me. I didn't think you could possibly care about what I do.

John: No, you made me feel pretty bad. Maybe that's the way you're coming across at your class. Maybe they feel ignored and put down too.

Sue: I feel like that with you too, sometimes. You just look at me when you come in, and I'm not sure if you want me to say hello or talk to you or anything. It makes me feel uncomfortable and I don't know how to act.

MT: Dan, how do you feel about what Sue and John have been saying?

Dan: I'm not sure how I feel about it. I think it might help me at class but, well, I didn't know I came across as a snob.

Sue: Maybe not like a snob exactly, but sort of cold sometimes.

MT: Dan, you seem rather surprised by what people are saying, even though it's pretty much the same thing you were saying about yourself.

Dan: I'm sort of confused, I guess. I always think people are cold to me or are ignoring me, but I don't usually think about how I look to them. I figure if I wait for the other guy to say hello, I won't be taking a chance with him not answering me if I talk first. I guess I could try saying hello to some of the people in the class and see what happens.

MT: Good. Why don't we make that your personal homework for the week. You can tell us how it went next time we meet.

Vignette #2

FT: Okay. The next item on the agenda is Linda's desire to get a job. Are you ready to work on this Linda?

Linda: Yes, you know, I never really had a job because I spent my whole time at home taking care of the kids. Now that they are gone there is just Bill and me and the house is pretty empty. I know I'm kind of old to start working but I want to give it a try. I don't know what I can do. I'm not qualified to do anything really, I mean, to get a job. I could go back to school and study shorthand or something, but I don't know if that's what I really want to do either. I don't know what's wrong. I have a good husband, two successful kids, a beautiful house... I should be completely happy, but I feel so dissatisfied and I can't even say why. It doesn't even make any sense to me.

FT: I get the impression that you're confused.

Linda: I guess so. I'm so proud of my house and the way we live, but underneath I feel so mixed up and so depressed. One of the things that bothers me is I feel like I've lost control over my life.

FT: How do you mean, you've lost control?

Linda: Well, most of the time I can handle situations that come up. If I have to babysit the grandchildren or if I have to give a dinner party or something like that, I

handle things just fine. Then why am I afraid all the time? Why do I feel I can't control what happens to me? I'm a capable person. I have lots of abilities. Why do I think I can't control how I feel or what I do?

FT: Let's open that question up to the group. Would anyone like to comment?

Sue: You sound so confused and frightened.

Linda: In my head, I know I function all right and somehow I survive. But in my gut, I'm afraid I can't cope. Why is that? I get upset and I snap at people in the family, and then I get upset with myself for the way I treat them, and I want to get myself under control.

FT: That sounds like a heavy burden you put on yourself, wanting to have absolute control over everything. I don't know if it's possible to feel in complete control all the time. I wonder if we could start by recognizing those situations you have control over and then working towards extending this skill.

Linda: Well, I don't know. I get so mixed up. Sometimes my husband wants me to be the strong one in the family, but other times he doesn't like me being strong. Before we were married, he told me what to do. He was the authority and I accepted it. I feel like he wants me to be perfect, and I feel so pressured. I wish I could stand up for myself. Why am I like this? I'm ashamed to complain. I have a good husband, wonderful

kids, a nice house. I have so much. Why can't I be satisfied?

MT: I get the sense that you're sad right now.

Linda: I feel desperate... and miserable, like I want to cry.

MT: It's okay if you do cry.

Linda: No, I don't think I'm going to. I just feel like it, but I'm not going to cry. I just feel so unhappy. Sometimes I just want to run away and get away from my house. All my husband needs me for is cooking and cleaning the house. He's never listened to me, never talked to me much. He gives me everything and assumes I'm contented.

FT: It sounds to me like there's a lot of resentment and anger there.

Linda: Oh no, I love my husband.

FT: It is possible to be angry with someone and still love him.

Linda: Yeah, sometimes I get mad when he won't talk to me. He never seems to understand what's bothering me. He always seems to be hearing something different than what I'm saying.

John: (Interrupting and slightly annoyed) Well, in a way I can understand him. Sometimes I have trouble in here understanding you, and I'm not married to you. You keep asking us to tell you what's wrong, but you keep saying everything is just fine and your life is so nice

and your family is so wonderful. I don't always know what you're talking about or what you want from us.

Sue: (Offended) Hey, that's not fair. Sometimes I think maybe we're too ready to criticize other people and tell them what's wrong with them. Maybe she just can't make herself clear to you, John. I hear Linda saying she can't talk to her husband, and that seems like a real problem to me.

MT: It would be wrong if John was just trying to put Linda down. That can happen sometimes, but I don't feel that's what's happening here. If John has trouble understanding the point that Linda is making, that's a valid comment for him to make. At the same time, though, I would prefer that comments be kept for when we open the discussion up, since now we are focusing on Linda. Since the comment has been made, I would like to know how Linda feels about what John said.

Linda: I guess I was annoyed when he said it... No, that's not true. I really felt pretty mad at him -- like how dare you say such a thing to me. But, well, I hate to say this but it sounds pretty much like what my husband's always saying to me and I get mad at him too, just like I felt when John said the same thing. My husband says I talk and talk without ever saying anything, and then I get mad when he doesn't understand. I don't know, I

always know what I'm trying to say. I always feel that if he really loved me, he would understand me.

MT: If you're not expressing yourself clearly to John, this could be helpful in understanding the communication problem with your husband, too. Maybe discussing your relationship with your husband will help us clarify your thoughts about not having control over your life.

Linda: I don't know if I feel ready to talk about that right now. It's so complicated and so personal. Can I wait a while and think about what's been said?

FT: Sure. We can back off for the time being but I think it might be a good idea to talk about this again when you're more ready. It might be a good idea for you to put a "C" beside the activities listed in your Weekly Activity Schedule in which you felt control. This way we will have some data to bear on your belief. Can you do that for next week?

Linda: I guess I could.

Vignette #3

FT: Okay. Last week we agreed to put Sue's dinner party on the agenda. This is coming up soon, isn't it? (Looking at Sue).

Sue: Yeah, it's on Friday. I just don't know how I'm going to be able to manage it.

- FT: This is an annual party isn't it?
- Sue: Yes, one of us, one of the cousins, has it every year... It's my turn this year... I just don't think I can do it.
- FT: Why is that Sue?
- Sue: It's too much, I just can't do it... I have trouble getting dinners on the table, I have trouble getting out of bed in the morning, I even have trouble getting here to group... How can I give a party for a group?... I just feel so pressured to get it perfect, to put out a nice spread.
- FT: I've noticed that the idea of doing things perfectly has come up often when you're having problems. It seems that you have this basic assumption that in order to be happy you have to be perfect.
- Sue: I guess so. If I don't do something perfectly I feel like a total failure. If I know I can't do something perfectly I won't even bother trying it. What do you see as the advantages of giving up this belief?
- Sue: Well, without this belief I could do a lot of things I've been avoiding -- like learning how to knit. Ah... I guess if I gave it up I wouldn't be so anxious about making mistakes or depressed because I did make one.
- FT: Okay. That's good. Now what do you see as the disadvantages?

Sue: Ah... What I do, I do well. If I gave up this belief maybe I wouldn't do things as well as I do them now. Let's see... I avoided a lot of trouble and problems by just avoiding things.

FT: That's good. Now. Let's try something. Sometimes it is a good idea to stand one's beliefs on their heads and see if they make more sense. For example, is it more reasonable to think, "I have to be imperfect" than "I have to be perfect"?

Sue: You mean anything worth doing is worth doing poorly?

FT: Exactly. Let me ask you. If learning to knit or learning to make friends is worth doing, is it worth doing poorly?

Sue: I guess it would be better than not doing it at all.

FT: Furthermore, the things you do now you do to an excellent degree. Just because you soften the demands on yourself, that doesn't mean you will do things sloppily. Your good habits will stay.

Sue: What about the idea that I avoided trouble?

FT: When you avoid a problem you often create others. Mental health includes a large portion of taking risks. Is there any way that you can avoid all problems?

Sue: No.

FT: Okay. What exactly do you have to do for this dinner party?

- Sue: Everything... I've got to clean the house, do the shopping, cook the meal, everything...
- FT: Sounds like you're feeling overwhelmed. John, if you were Sue, how would you try to go about organizing for the party?
- John: (Surprised) For the party? I don't know...
- FT: I'm thinking about the way you went about getting your apartment cleaned up last week...
- John: Oh, you mean breaking it up?
- FT: Yes. You're something of an expert now in chopping big jobs down to size. What kinds of steps might be helpful for Sue, do you think?
- John: Well, it was helpful to me to make a list of what I needed to do, then check things off as I finished them.
- FT: You mean actually write things down?
- John: Yeah, write out a list. When we did that last time, I just took the list home and went through it.
- Dan: I always try to start with something easy first; that seems to make it easier to get started...
- FT: Sue, you look upset; what's going on for you?
- Sue: It just seems all like so much. I'll never be able to do it.
- FT: That's a good example of an automatic thought, isn't it? Why don't we try listing the things you'll need to do; then we will see whether or not some of John's and Dan's suggestions might not help make it easier.

- Sue: It just seems like too much.
- John: It did for me, too. I know just how you feel, like it's all too much. But breaking it up seems to really help.
- FT: Dan, will you write down things for Sue?
- Dan: Sure.
- FT: John, what would you want to know from Sue about what she needs to do?

Handout on group guidelines and how to give and receive feedback

Group guidelines. The following set of guidelines will help prepare you for your group therapy experience:

1. It is not very useful to talk about things about yourself that you think are impossible to change ("I can't help my temper... that's the way I am"). You can change anything about yourself you really want to change.
2. When someone else is talking, listen and try to understand what they are saying about themselves. It might also apply to you, and they need your view about what they are talking about. This is as much a part of your job as talking about yourself.
3. Sometimes suggesting a way of solving a problem is helpful to others. But most of the time, it is more helpful to help them find out why they didn't do the right thing in the first place. People usually know what they should do -- they just have trouble doing it.

4. You're supposed to practice what you talk about in the group. Just talking won't help you very much. You have to practice the changes you think about in the group in your everyday life. Afterwards, you can let the group know about how things went when you practiced new ways of coping outside the group.
5. You have an obligation to tell the group about things that are worrying you. The therapists and the group members cannot read your mind. They will help you talk, but you have to make yourself talk about things that concern you.
6. You have an obligation to tell others in the group what you think about the things they say. You have agreed to help each other and you can do it by telling others in a kind way how they come across to you in the way they act and talk.
7. Try to be as honest as you can. The others in the group cannot read your mind, and hiding stuff won't help anyone. Try to talk straight about your feelings and thoughts.
8. When something important is happening to you, inside or outside the group, be willing to let the group know about it.

Giving feedback. The following guidelines will help you to tell other people what you think about what they say and do.

1. Telling someone else what you think can be done in a kind way that is also honest. There's a real difference in attacking someone and letting them know how they're coming across to you.

2. It's usually better to talk about things you actually see people doing and saying in the group; then you have the real thing to report on.
3. Tell the person how what they did or said made you feel, or what you thought about it without using bad labels (don't say, "You acted like an idiot" or "That was dumb") or name calling. Instead you might say "What you did makes me think you were madder than you admit" or "What you said made me think you were making fun of me and that hurt my feelings".
4. Don't talk about people in a general, fuzzy way (don't say "He always makes trouble" or "She's just like that"). Talk about the actual things they do and say (You sounded like you did not hear what I said"). Be as specific as you can and don't wait a long time to say what you thought about what is happening in the group.
5. Tell people how you feel about good things you think they say and do. People also need to know when they come across in a good way to others.

Receiving feedback. These guidelines will help you accept what others say to you about what you say and do.

1. Be willing to talk about what they say to you.
2. Try not to get angry when people have to say things you don't like. You are in the group to learn how you affect others and how they affect you.

3. You don't have to agree with what people say about you. But you should be willing to accept that this is how it looks and feels to them.
4. If you don't understand what somebody is saying, say so.
5. Ask people to tell you about how they feel about what you do and say. If you take their ideas reasonably, they will be more likely to give them attention.

(From Corder, B.F., Haizlip, T., Whiteside, R., & Vogel, M. (1980). Pre-therapy training for adolescents in group psychotherapy: Contracts, guidelines, and pre-therapy preparation. Adolescence, 15(59), 699-706. Reprinted by permission of Libra Publishers Inc.)

Session 3: Structured group exercise on the role of feedback

One of the most sensitive issues in every form of group psychotherapy is that of providing clients with honest feedback about themselves in a relatively nonthreatening manner. While ideally it is expected that feedback provided by group members will be based on more or less objective observations, there is always the potential danger that they may use the opportunity for launching personal attacks on the feedback recipient. Furthermore, providing feedback to only one person may sometimes be misinterpreted as a license for making him or her the scapegoat of the group.

The Candle Technique (Kipper, 1975) represents an attempt to structure a role playing situation where evaluative feedback can be offered in a relatively non-threatening atmosphere, where the personal integrity of the target person is more or less safeguarded, and where none of the group members are singled out. The group leader introduces the technique as an exercise in providing feedback and says: "I would like each of you to think of what you would like to be if you had the chance to be someone or something else. You may choose to become a different person, an object, an animal, or perhaps a plant". After a few moments each member describes his or her new identity. The group leader then says that he has now become a candle (hence the title of the technique), which gives light:

"If you put me next to something, you may see it better and clearer. I cannot talk. The only sound I can utter is 'pss pss.' I would like one of you to move me and place me behind each member at a time. Leave me there for awhile, and as I stand there the rest of you may tell that person or object what you see in him or her in the new identity. Tell both the desirable and the undesirable features of what you see. But as soon as I say 'pss pss,' move me to another person."

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Experience has shown that members tend to receive the feedback and consider it seriously. The protective shield (i.e., the temporary new identity) minimizes undesirable emotional reactions and accentuates objective-rational attitudes.

Session 4: Structured group exercise on the role of self-disclosure

The purpose of the last session is to demonstrate the importance of self-disclosure in therapy. In order to accomplish this the following exercise will be used. Each member of the group will be given a blank piece of paper and pens of different colors and asked to draw a circle. Inside the circle they are to put symbols, marks, abbreviations which are to represent different levels of the self. They are to put symbols representing the outer self, i.e. that which is presented to the public, and progress to symbols which represent the core of themselves. They may divide the circle any way they want, if they want. The symbols should be obscure enough so as not to be obvious what they represent, except perhaps the symbols representing the outer self which may be self-evident (e.g., initials). The clients do not have to represent all levels of themselves, though they are encouraged to do so. They should be encouraged to represent the deepest levels of self but to disguise them so that others will not guess what the symbols mean. Once this task is completed each person will be asked if they are willing to let others see the symbols they have drawn.

Some may not want to show the page and this is fine. If they do want to show the page then it will be projected using an appropriate projector. They will then be invited to explain only those symbols which they are prepared to share with others. Other group members may ask questions, but the person has the right to refuse to answer them, thereby respecting the amount that the person is willing to self-disclose.

At the end of the exercise the group leader must get across the following points:

1. It is important to self-disclose in therapy, that this material forms the backbone of what is discussed in therapy.
2. This exercise shows that all people self-disclose to different degrees, i.e., not wanting to show the paper, not wanting to explain all symbols, etc.
3. In therapy, the group leader ensures that others respect the degree to which the participants are willing to self-disclose. Nobody will be forced to self-disclose more than they are willing.

Appendix C

Manual for attention-placebo conditionSession 1: Structural features of therapy and discussion of sensory and physical changes in the aged

The first half of this session will be spent getting to know the participants and presenting the structural features of therapy. The leader may start by welcoming the participants and asking them to introduce themselves (e.g., name, family, area of residence, how they found out about the group, etc.). The leader will then present the structural features of the group, as follows: (a) 12-week course on how to cope with depression, (b) preceded by 2 weeks of information giving and discussion, (c) each session will be one hour for the first two weeks (pretherapy phase) and one and one half hours during the therapy phase, (d) two people will be leading the group; e) it will be a mixture of discussion and activities, (f) it is very important to attend all sessions but if you cannot make it advise in advance. Answer any questions they may have without divulging the true purpose of the study or specifics about the treatment they will receive.

Sensory and physical changes in the aged

Vision. About 10% of the elderly have some vision impairment. However, in studies of people over 100 years old, only 5% were totally blind. Although most older people need

glasses, poor vision is not as widespread as is usually thought. About 80% have fair to adequate visual sharpness to age 90 and even beyond. Often one eye continues to function even if the other does not. As we get older the acuity of our senses begins to decline. Visual acuity remains fairly constant until age 45 to 50, after which it tends to decline. Another common normal age change is that the eye loses its ability to keep images sharp at close range (accommodation). A decrease in this control is a result of changes in eye structure and muscles. Most of the more serious problems relate to the lens and retina. In general, with aging, the lens of the eye usually allows less light to pass through the retina; however, more light is required by the aging retina than in younger years, and the ability to see clearly in low illumination decreases (as in night driving). More time is needed for both light and dark adaptation. The tear glands, which secrete the fluid necessary for continual cleansing and lubrication, lose function with aging, contributing to dryness and eye irritation. The eye condition known as glaucoma produces an increase in pressure in the eye fluid because of fluid drainage obstruction. Cataracts cause 17% of blindness in the elderly. In this case the aging process transforms the normally transparent organ called the lens into an opaque (cataractal) one.

Hearing. The loss of hearing is more usual in older people than the loss of sight; hearing is an area in which more

disabilities are related to aging than to any other factor. This decline is especially noted in the ability to hear high-pitched notes (e.g., doorbells and women's voices), which is first noted after 50 but varies with each individual. The changes are so gradual that so many older people fail to recognize them until the disability is extreme. One of the major sources of such hearing impairment involves the cochlea, a spiral tube of the inner ear that resembles a conch shell. At birth, the cochlea contains about 20,000 hair-like nerve cells that gradually die off and are not replaced. Loss of these cells is called presbycusis, and it impairs the transmission of high-frequency sounds. These and other changes seldom occur where there is little noise; hearing is aggravated by acoustic trauma, and noise pollution is more and more a factor in hearing loss. About 5% of the population have hearing difficulties at age 50. After age 65, 30% of the population have hearing difficulties. Men show more significant hearing loss than women (probably because of noise in the work place). Hearing loss is a severe impediment because it isolates the aged from the verbal communication vital to interaction with others.

Taste and Smell. Smell also declines with age, and up to 30% of people over age 80 have difficulty identifying common substances by smell. Taste, too, is affected, since 67% of taste sensations are dependent on the ability to smell; in addition, taste buds decrease sharply with age. Originally there are 250

taste buds in each capsule (on the tongue) but, by old age, the number may drop to 100. Thus higher levels of stimulation of taste and smell are required for older persons than for younger persons; this need may be partly responsible in some older people for the complaints and lack of interest in food that sometimes result in poor nutrition.

Touch. Special receivers for the sense of touch are located in the skin. These receivers are sensitive to five types of stimulation: cold, heat, touch, pain, and pressure. On the basis of present knowledge, it is believed that there are two significant changes in cold/heat sensitivity with aging. Although it is not certain why, with advancing age most older people experience a general reduction of resistance and ability to recover from temperature stress and change. Sensitivity to pain and pressure as a danger signal is extremely important. Its loss in older persons seems to be related to a loss of tactile response as both perception and motor abilities decline in reaction to stimuli. Pain is a more frequent concern for the aged. The periodic daily aches of rheumatism, the unrelenting pain of arthritis, and the sharp distress of angina are examples. The elderly learn to deal with these according to their personality, background, and the nature and extent of pain. As sensitivity to pain decreases, elderly individuals may fail to attend to minor injuries when they occur, may not be alert to

potential sources of harm, and may repeatedly incur injury or damage.

Skin, Hair, and Stature. As we age, visible changes occur in the skin, the hair, and in the shape of the body. For example, during middle age the skin becomes dry and wrinkled as it becomes thinner and loses elasticity and subcutaneous fat. Similarly, hair becomes thinner and loses its original color. Because of the negative connotations frequently associated with wrinkles and gray hair, some individuals actively fight a 'cosmetic battle' to change their physical appearance and thereby appear younger than their chronological age. In addition to changing one's appearance, the loss of hair and subcutaneous fat in the middle and later years leads to greater heat loss and to increased susceptibility to 'feeling cold'. This in turn may initiate a shift from outdoor to indoor activities, and perhaps even a move to a warmer climate if this is economically feasible.

For many adults, especially women, body weight increases up to about 50 years of age, and then there is a decline thereafter because of a change in body metabolism. This increase in weight is due to an accumulation of fat and a reduction in muscle tissue which appears most frequently in the stomach area for men, and in the limbs and stomach area for women. As a result, body shape may change from a lean and youthful appearance to a more portly, rotund, or mature appearance. This visible change in shape sometimes results in a social labelling process whereby the

individual is perceived by others to be older than his or her actual or chronological age.

Another visible sign of aging is the shortening of stature that begins in late middle age. This is related to changes in the structure and composition of the spine: vertebrae may collapse or intervertebral discs may become compressed. These changes are visibly reflected in an increased 'bowing' of the spine and the loss of a few inches of height.

[From Neuhaus, R.H., & Neuhaus, R.H. (1982). Successful aging. New York: John Wiley and Sons (reprinted by permission of Macmillan Publishing Company) and McPherson, B.D. (1983). Aging as a social process: An introduction to individual and population aging. Toronto, Canada: Butterworths (reprinted by permission of Butterworths)]

Session 2: Film "The business of aging"

In this session the group leader will show a 26-minute film entitled "The Business of Aging". This will be followed by a discussion of the film.

Session 3: Changing family roles

There is an extremely important cluster of social roles which derive from our family relationships. Most people, at some time in their lives, play son or daughter roles, brother or sister roles, husband or wife roles, father or mother roles, and grandfather or grandmother roles. Such roles tend to be enduring

but not unchanging. As we progress through the various stages of the life cycle, each of our family roles tends to change qualitatively. Today we are going to examine three of those roles -- those of spouse, parent, and grandparent.

Most adults, sooner or later, assume the spouse role. The relations between spouses gradually change over the years. There is a qualitative difference in the relations between newlyweds and the relations between a couple married for some time. During the early years, the success of the marriage is dependent upon successful and enduring adaptations made in the relations between spouses; if these adaptations are not made this could lead to divorce.

The birth of children leads to further changes in the relations between spouses. Symptomatic of the change is the tendency for spouses to call each other Mother or Dad or equivalent names. The presence of children leads to an additional source of common interest and concern. Occasionally, in fact, the motivation for having children is to relieve strained marital relations and to put the marriage on a sounder footing.

Children in the home lead to profound alterations in the uses of leisure time. Mobility tends to be decreased. The night life enjoyed by the childless couple becomes inconvenient and expensive for a couple with children. Baby-sitters bite into funds available for leisure-time activities. There is a tendency to switch to the kinds of activities which can be engaged in by

the family as a unit. For several years, while the children are young, it is necessary to plan family activities around them. The occasions where husband and wife can do things together without the children may be very few and, for that reason, may take on special significance.

As the children get older, the occasions when the husband and wife may do things alone together increase. The relations between spouses may again take on some of the flavor of relations between the childless couple. There is a definite freeing effect (although it may not be viewed as such) once the children marry and leave home.

One of the most significant changes that has taken place since the turn of the century has been the lengthening of the marriage relationship. Men and women marry earlier and stay married longer. The average gain in married life has been about 10 years. The number of children in the family has decreased, and the last child leaves home sooner. In the average family of 1890, the last child left home about two years before the death of one parent. In the mid-1960's the last child left home 15 years before the death of either parent. This means that in 1890 the average husband and wife had no time together after their children married and left home, while in the 1960's the average couple still had one-third of their married life together. Furthermore, there was less of a tendency for married children to live with their parents than at the turn of the century.

This period after the last child has left home is often seized upon as the opportunity to do "all the things we had planned to do, but couldn't because of the children".

A new dimension develops in the relations between husband and wife when the husband retires. Prior to retirement, the husband generally spends his days away from home, and home is the wife's domain. The wife experiences some change in her household routine when the last of her children leaves home, but her cooking and cleaning continue on an altered scale.

The typical wife is faced with a new and unique situation after the retirement of her husband in that, for the first time in their married life, he is home during the day. For the first time he may intrude upon her daily routine. Problems frequently arise with respect to the roles to be played by the husband and wife in maintaining the home. For some women, the presence of the husband offers the opportunity to share household drudgery. For others, his presence is looked upon as an invasion of her proper domain. Some husbands adjust to the situation by developing daily routines outside the home, to stay out of the wife's way and allow her routine to continue substantially unchanged. Others stay at home and seek to carve out a section of the domain which they may call their own.

When the child marries, their primary identification shifts from their family of orientation to their family of procreation. Their concern for their parents becomes secondary to their concern for their spouse and children. Their own family

responsibilities may conflict with obligations felt towards their parents. It may be difficult for Mother or Father to accept the fact that the married child has assumed family responsibilities that take precedence over his obligations toward them.

One role the aging may use to compensate for the loss of the active parent role is that of the grandparent. For many, the grandparent role is more pleasurable than the parent role. It is looked upon as an opportunity to enjoy one's relations with children without having to assume responsibility for them. Many a grandparent has said, "I have done my job of raising my own children, now I am going to enjoy my grandchildren".

In addition to the relaxation of responsibility which accompanies the grandparent role, there is a certain amount of prestige that attaches to it. The grandparent role, among peers, has about it an aura of maturity and stability. The person who has become a grandparent may take great pleasure in flaunting his new status before the members of their peer group who have not yet become grandparents.

There has been a qualitative change in the grandparent-grandchild relationship since 1900. Because birth and death rates have been lowered, the grandparents of today have fewer grandchildren than those of 1900, and the grandchildren of today are more likely to have living grandparents. Not only is the grandparent-grandchild relationship of longer duration, but the grandparent has fewer grandchildren upon whom to bestow his attentions. There is potential, at least, for a closer

relationship between grandparent and grandchild because the child of today has less competition. Paradoxically, however, the greater rate of social change now, compared to the turn of the century, has led to a greater communication gap between persons of different generations. Then too, grandparent and grandchild are less likely to live in close proximity.

Children who look upon their parents as members of the older generation may consider grandparents to be relics of the prehistoric past. The fact that our society is oriented toward youth and the future has aggravated problems of grandparent-grandchild interpersonal relations. The problem, however, is not one of an antagonistic relationship between grandchild and grandparent. It is, rather, a problem of the grandparent's being considered a curiosity out of the past or -- worse yet -- being ignored.

(From Problems of aging: Sociological and social psychological perspectives (2nd Ed.), by Herman J. Loether. Copyright 1967, 1975 by Dickenson Publishing Company, Inc. Used with the permission of Brooks/Cole Publishing Company, Pacific Grove, CA 93950, USA)

Session 4: Exploitation of the aged

There are many unscrupulous persons seeking to make a dishonest dollar wherever they can. Although the elderly are not the only victims, they are a favorite target. Because they are so highly vulnerable, older people are, in fact, almost

irresistible targets for exploitation. The annual incomes of those in the 65-and-over category are generally meager, but collectively the elderly have financial resources that run into hundreds of millions of dollars. These resources are largely pensions, returns on savings and investments, and wages and salaries from regular or part-time employment. The elderly constitute a lucrative market, not only for reputable businessmen, but also for burglars, robbers, confidence men, swindlers, and quacks.

A number of factors explain the particular vulnerability of many older people. First, they frequently live in public housing or apartments that are located in high crime-rate areas. Those seeking to rob them can easily find out what time of the month they receive government pension checks. Furthermore, many older people would be unable to protect themselves from assault.

Second, older people generally have small, fixed incomes barely large enough to meet their needs. They are anxious to take advantage of any proposition that promises to provide them with supplementary income, and they are inexperienced or gullible enough to fall for "get-rich-quick" schemes.

Third, if they live in social isolation and loneliness, they can be taken in very easily by apparent friendliness shown them by strangers. They are unaware of the many schemes that abound to part them from their money, and confidence games work precisely because of this naïveté.

Fourth, many old people become desperate because of illness, pain, or infirmity their doctors cannot help. They are willing to try almost anything promising relief. Moreover, many are constantly in search of the elixir of youth and will submit to almost any torture to remove wrinkles and firm up flabby flesh. Those on the brink of death may be willing to pay any cost and go to any length to keep lit the spark of life. In a word, countless old people are willing targets for quacks and food faddists.

Many old people will not admit that they have been victimized, either because they are afraid of reprisals, because they are unaware of the fact, or because they do not want to appear foolish. Those who do admit they have been victimized are often unable to supply the information necessary to apprehend those responsible. And even if the culprits are apprehended, older victims who are forgetful and infirm make very poor witnesses.

Exploitation of the elderly is very difficult to combat. Many of the schemes employed to exploit them are not clearly illegal; they are, rather, on the fringe of the law. There is a very fine line between fraud and sharp business practice. As a matter of fact, in some cases enterprising businessmen have borrowed practices originated by confidence men and have made them respectable through common usage.

Because of their age and physical weakness the elderly are victimized much more often than those in other age categories.

Particularly prone to assault, robbery, and burglary are those elderly persons who live in public housing or private apartments located in high crime areas. Many older persons have been beaten or murdered for their money and property. Nor are elderly women safe from rape.

To protect themselves against attacks many elderly persons have taken to shopping and going to their mail boxes in groups. Housing projects and apartment buildings are increasingly being protected by guards, locked doors, television monitors, and alarm systems. These steps, however, treat the symptoms of the problem rather than its root causes. It is obvious that more basic measures must be adopted to achieve lasting solutions to this serious social problem. What measures have any of you taken to protect yourself from crime?

Confidence games and frauds. It is difficult to determine the total annual "take" from confidence games and frauds, because only about 2% of the victims file complaints. However, conservative estimates place the figure in the hundreds of millions.

The confidence man is a student of human nature. He is astute at sizing up his victims and picking out their points of greatest vulnerability. He is adept at misrepresenting himself, his schemes, or his products so as to befuddle his victims into actions that are against their better judgment. Once the victims realize they have been fleeced, they often feel too embarrassed

to file complaints with the authorities. Because of their particular vulnerabilities, old people are often the favorite victims of confidence men. Some old people, as a matter of fact, fall prey to swindlers repeatedly.

There are many confidence games in use, and more are being invented all the time. Though old people fall prey to all kinds of confidence games, many games are not directed particularly toward or limited to older victims. People of all ages are taken in by fast-talking swindlers "selling" dance lessons, magazine subscriptions, aluminum siding, fertilizer, health insurance, and so on. Phony mail order schemes to "earn money in your own home" or to get rich overnight through vending-machine franchises bilk victims from the preteens through the eighties. Some schemes, however, are deliberately aimed at the elderly, and older persons are particularly vulnerable to others. It is to these schemes I wish to speak of today.

Numerous elderly women have fallen victim to a scheme that originated in Canada in 1963. Hundreds of thousands of dollars have been obtained through the "bank examiner" scheme. This swindle works this way: A man calls an elderly woman on the telephone and identifies himself as a bank examiner. He tells her that someone is believed to be tampering with her bank account and asks her to aid in the apprehension of the culprit. She is instructed to go to the bank and withdraw all of her money, which she does. After she returns home with her money, she gets another call from the bank examiner, who informs her

that the plan worked and that the teller who had been tampering with her account has been caught. The bank examiner thanks her for her cooperation and tells her that, rather than inconvenience her so late in the day, he will send a bank messenger to her house to pick up her money and return it to the bank. The bank messenger shows up, collects the money, gives her an official-looking receipt, and disappears. This swindle is used almost exclusively on elderly women who live alone.

Older people who dream of spending their last days in some pleasant far-off spot like Hawaii, Florida, California, or Arizona, are sitting ducks for the sharks in the mail order land sale business. Land is sold through misleading advertisements which make the location sound like paradise. Low down payments and low monthly payments put these bargain lots within the reach of the limited incomes of older people.

Many dream lots in Hawaii are on the slopes of active volcanoes, those in Florida are sometimes under water, and those in the southwest are often in the midst of desert wastelands. In some locations it is necessary to bring water in by truck. Distances are often misrepresented. Facilities said to be minutes away are often hours away.

The "free lot" gimmick is often used to sell land. The victim is informed that he has won a free lot and has only to pay closing costs ranging from \$30 to \$90. However, it turns out that the free lot is so narrow that it is not usable. Therefore,

the promoter seeks to sell the "lucky winner" an adjoining lot so that he will have an "estate".

Confidence men frequently take advantage of Social Security beneficiaries by impersonating Social Security agents and extorting money from elderly victims. This is done by promising the victims that their monthly benefits will be increased upon payment of a fee to the agent; by persuading the victims to pay a fee to the agent to guarantee continuation of benefits; or by creating a fictitious overpayment to the victims and having them return them to the Social Security Administration. One elderly man told the swindlers he didn't have the money demanded of him, but would get it for them the next day. Instead, he reported the matter to the Social Security office and the swindlers were arrested.

Many older persons try writing after they retire. If they wish to publish a book, there are always the "vanity" publishers on hand to accommodate them. These publishers advertise in magazines and newspapers, "New York publisher wants manuscripts". Regardless of quality, the vanity publisher is likely to find any manuscript publishable. He assures the author that the book is excellent and is likely to be successful and profitable. The catch is that the author must pay all the costs of having the book published. As a matter of fact, the costs to the author include a healthy profit for the publisher. Once the book is published, the publisher does very little to help sell it and bookstores generally will not stock it.

A notorious vanity publisher who was eventually convicted of fraud used the following method. He advertised that he was a writers' agent who would read manuscripts for a fee. When he received a manuscript he informed the author that it had merit and talked him into paying a fee for marketing it. The manuscript was submitted to some or all of four phony publishing houses. Rejection slips were forwarded to the author to prove that the agent was hard at work. A fifth publishing house run by the agent himself would accept the manuscript on a subsidy basis and the agent would recommend that the author go ahead with the project on that basis. In the last eighteen months of operation before he was arrested for fraud the publisher-agent collected \$92,792 from authors while paying out \$77.84 in royalties.

Among the most pernicious schemes designed to fleece the elderly are those which prey upon grief-stricken widows and widowers. One such scheme involves identifying the newly widowed by reading obituaries in the newspapers and seeking to collect money from them for nonexistent debts of the deceased. In another variation of the same scheme, the swindler arrives at the door with an expensive looking Bible, supposedly ordered by the deceased. The survivor is told that the deceased ordered the Bible and deposited \$5 on it. The swindler then attempts to collect \$20 "still owed" for the bible. This swindle may be worked with any number of other commodities, but it is most effective with goods which suggest sentimental or religious values.

The confidence man who is out for larger stakes may introduce himself to a distressed and helpless widow as a financial advisor and offer her to take care of her affairs for her. In helping her settle the affairs of her departed husband's estate he will take every opportunity to get his hand into the till.

Many of the schemes used to exploit the elderly are clearly violations of the law. These violations can be handled through efficient law enforcement practices. Also, such swindles can often be prevented by far-ranging educational programs. Local law enforcement agencies often do so through public lectures, wide circulation of pamphlets and warnings through various news media. What can you do to protect yourself from swindles?

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Appendix D

Main components of group cognitive therapyGeneral overview

In conducting group work with older adults, it is important to choose a mode of therapy that accommodates the mental and psychological struggles of these people while allowing for individual differences and needs. The concern is sometimes expressed that cognitive therapy may be too difficult for older people, in view of the cognitive changes generally associated with aging. In fact, quite the opposite is true; the high level of structure in a cognitive therapy group makes it particularly appropriate for people whose mental functioning is changing. Therapists should recognize, however, that many older adults show few, if any, signs of cognitive impairment and require no special aids to understanding and concentration (Price, Fein, & Feinberg, 1980). It is also important to realize that a slight diminution in mental ability is just that -- it is not an indication that the older adult is incapable of grasping abstract concepts. Unfortunately, negative and exaggerated judgments are encountered frequently by older people, who accept such views uncritically yet resent being treated as if they are unable to think at all. Comments by several members of one cognitive therapy group indicated that one of the most enjoyable aspects of therapy was the opportunity to use their minds in new ways. They appreciated

the respect conveyed by the therapists, who assumed that members had the ability to grasp new ideas.

Phases of therapy

Our experience has led us to emphasize the importance of training clients in a few fundamental concepts, both for self-monitoring and for instigating change, and developing individually tailored, therapeutic experiences for each group member. With these cardinal and central concepts, our approach closely follows the structure outlined by Beck, Rush, Shaw, and Emery (1979). We found within these central concepts superordinate phases of therapy, which can be defined on the basis of skill acquisition and movement of the group toward self-sufficiency and autonomy (Chaisson, Beutler, Yost, & Allender, 1984). Like Beck et al. (1979), we emphasize time limited (20 sessions) treatment that can be subdivided into four phases of active therapy. Each phase is designed to build upon the previous one by introducing new skills or new methods of practice. Treatment begins with the preparation phase, which actually takes place independent of the group experience. During this phase, the therapist builds upon the particular problems and patterns revealed during the client selection and screening process in order to teach these clients what to expect in the course of treatment (in this study, this phase was the pretherapy training). The preparation phase is followed by the identification and collaboration phase, which is designed

primarily to assist clients to identify problems in their lives in terms conducive to subsequent change. During this initial treatment phase, a major concern of the therapist is to develop a collaborative relationship among the group members that will provide social support and initiate the client's active participation in therapy.

The middle phase of treatment emerges gradually out of the identification and collaboration phase, defined by the movement from an educational process, wherein the client is taught to identify problems in treatment terms, to one emphasizing the processes of change. During this change phase, the client is given the opportunity to experience and practice various methods of changing cognitive, affective, and behavioral experiences.

Finally, the final stage of therapy emerges gradually out of the change phase as the client consolidates what has been learned and moves toward termination and self-sufficiency. The cardinal skills taught during this consolidation/termination phase, are methods for expanding the client's social support network, inoculating the client against future stress, and learning methods of self-evaluation. These procedures help clients determine when to implement strategies previously learned for assessing their impact.

Structural Elements of Cognitive Therapy Sessions

The structure that generally underlies group cognitive therapy serves to meet many of the needs of older adults.

Cognitive therapy sessions contain several devices that are particularly effective in focusing members' attention and in orienting them to the concepts to be learned. After the initial session, all sessions follow a similar format with distinct intrasession phases, none of which should last for more than approximately 30 minutes. The blackboard and preprinted homework forms focus the session, and frequent requests for feedback on both process and content keep therapists and members on track. Two or more co-therapists are usually used to help coordinate the presentations and group observations. Additional methods are used to help members analyze and remember key concepts in the therapeutic experience. The various skills and concepts of importance to cognitive therapy are developed and integrated logically and sequentially, from week to week, with ample opportunity for review. The most central structural elements and general organization of cognitive therapy sessions as applied to groups of older adults are described on the following pages.

Agenda

In the interest of both time and collaborative responsiveness, an agenda is developed at the start of each session and is posted prominently in the room. Although there is value in the familiarity of a consistent pattern to sessions, this suggested agenda must of necessity be flexible. As therapy moves through different phases, the time allotted for various activities will change considerably. For example, more time is

devoted to individual contact work during the change phase. In addition, the agenda, although planned at the outset of the session, may be modified during the session, as needs dictate. A typical cause for adjustment arises when individual problems put on the agenda for consideration consume more time than expected. Decisions to modify the agenda are not made unilaterally, but through collaborative discussion with group members.

In preparing the agenda, therapists invite clients to submit personal issues they wish to discuss in group, in the section headed *Contact Work*. Because the therapeutic focus of the group is on cognitions and depression, some limits must be placed on the sort of issues considered appropriate for the agenda. In the initial sessions, and even later, leaders need to explain to clients that the ideal item for the agenda is a behavior, thought, or feeling they would like to change. Usually, this means that the item will be a recent occurrence that directly affected a member's depression, although occasionally it can be a concern from the past that appears relevant to the present depression. When items are presented, therapists should help clients express them in terms of their subjective distress.

During the first few attempts to set an agenda, clients can be expected to present unsuitable items, because they do not yet understand the criteria for selection. Thus, they might wish to discuss nontherapeutic topics, such as current events, philosophical questions, and social events. They might also prefer to introduce past events about which they can complain

without needing to focus on current efforts to change. When a client wishes to place an item on the agenda, therapists should ask the client if the concern relates to the client's personal and current depression. If not, can the client rephrase the problem in terms of personal concerns? If not, the item is probably not appropriate for contact work, and therapists can explain that, although the issue may be important to both the individual and the group, it does not provide suitable material to be dealt with in contact work. Members will be helped to select personal agenda items by being given several examples of relevant ones. It is important, when setting the agenda, that items not be discussed in any detail, simply noted for later attention.

Cognitive therapy makes frequent use of rounds, that is, a brief canvassing of each or several group members on a particular issue, usually expressed in the form of a stimulus question. In a group of older adults, who may be reluctant to volunteer their opinions, this technique ensures that each member is allotted "air time" during the session. The client, of course, may choose not to speak and "pass". Rounds are typically used at the start of the session to discover how homework went, later to evaluate client's comprehension of material, when initiating personal application of the lecturette, and any time feedback about treatment is desired. It is not essential that rounds include all group members every time; clients should be encouraged to respond to the material in question with brevity, so that the

round does not detract from other agenda items. Used in this way, the technique can be a most valuable method of involving members in the session and of keeping their attention focused.

Lecturette

We found it useful to present the concepts of cognitive therapy in the form of a brief lecture, delivered in a somewhat formal manner by a therapist standing at the blackboard. This form of presentation provides a change of pace and heightens the impact of the material by involving several forms of learning. Since most group members are accustomed to hearing lectures and sermons, they are likely to be comfortable in the role of listener/student and less likely to interrupt or start side conversations. This is especially true if the lecturette uses examples from the members' own experiences. Each lecturette is prepared at the start of the session, contains only one major point, takes about 5 minutes to deliver, and is followed by a group discussion, both to ensure that the material has been understood and to help members apply the concepts to their own lives. It is often helpful to provide members with a written summary of the main points of the lecturettes and to mail the summary to absent members.

Homework

An integral part of cognitive therapy is the assignment of homework, whereby clients transfer in-session learning to in vivo

practice. There are two basic kinds of homework: general homework, for all group members, develops directly out of lecturette material and frequently involves monitoring and recording clients' emotional and cognitive reactions to events or applies to the use of behavioral techniques. These assignments can, and should, be modified to some extent by altering the complexity of the task or the quantity of production, in accordance with the resources and capabilities of different members. Individualized homework proceeds from contact work and is, therefore, designed to meet specific, individual needs. When either type of homework is assigned, therapists should ensure that clients understand what is being planned and that they accept the assignment as both feasible and desirable. There is no value in assigning a task that the client either cannot perform or believes to be useless.

The inertia and the negative cognitions of depression can reduce compliance with homework. This consideration warrants allotting ample time to methods designed to increase the likelihood that clients will make serious efforts to complete assignments. It is usually helpful to provide clients with a rationale for homework: they are learning new skills that require practice; it makes sense that the skills be applied in the environment where symptoms occur; there is insufficient time in group sessions to expect that these alone will be effective in reducing depression.

Reviewing homework is essential if clients are to consider homework an integral part of therapy. Therefore, the first task of therapists in the session is to review client's experience with prior homework. This step has been seen as a common element in most discussions of formatting behavioral and cognitive treatments (Beck et al., 1979). The review is designed to assess symptom progress, provide clarification about concepts, and set the stage for feedback from other members. Homework review should begin with successes, however small, with all members encouraged to provide positive reinforcement for any achievement, albeit less than totally successful. Thus, therapists model both the acceptance of a realistically limited level of success and the ability to shift focus from negative to positive aspects of events.

During the early phases of therapy, homework feedback by the therapists is particularly important since clients are just learning to identify relationships between thoughts and feelings, an essential concept that the therapists must ensure is well understood. Later in therapy, the group can provide a good deal of feedback as members evaluate the adequacy of cognitive and behavioral strategies and assess their impact. Any problems with homework that appear to need further exploration can be added to the agenda for individual contact work.

Contact Work

A one-to-one encounter between a single therapist and client in the group setting is called contact work. The client is invited to do the work and retains the right to refuse, although in most cases the work is around an agenda item initially agreed upon by the client and therapists. Sometimes, the therapist realizes that a client is struggling with a particular issue arising, for example, out of the homework assignment and judges that individualized help would be appropriate. For the duration of the encounter (usually no more than 20 minutes), the other therapists and other group members are asked to refrain from commenting unless specifically requested to do so by the "active" therapist. At the end of this "mini session", feedback is solicited from the client about the meaning and impact of the work. Then other group members are asked to share their understanding of the work and its possible application in their own lives.

When clients elect to do contact work with the therapist, the work typically proceeds with the therapist's efforts to clarify the client's problem, gain permission to explore that problem, relate the problem to the events-thoughts-feeling (ABC) format, direct the client to target dysfunctional ideas, and either create ideas that are more functional or evaluate the significance of the dysfunctional belief. The work usually concludes with the designing of an "experiment" in order to test

or further clarify what has been discovered during the contact work.

Feedback

Feedback is the request by therapists to receive client's reactions to any aspect of therapy, from homework assignments to a particular element of a session to the impact of the session itself. It occurs formally after the lecturette, after each piece of contact work, and at the end of each session, but therapists frequently will ask for informal feedback. If therapists elicit feedback frequently and act upon it quickly, the effect is to increase client's perception that the theory is tailored to their needs and that they can have a significant impact on the means of their own recovery. The resulting sense of control, collaboration, and mastery may be, in itself, therapeutic.

(From Yost et al. (1986). Group Cognitive Therapy: A Treatment Approach for Depressed Older Adults. Elmsford, NJ: Pergamon Press. Reprinted by permission of MacMillan Publishing Company.)

Appendix E

Group cognitive therapy manualInstructions for Session 1

The primary objectives of this session are (a) initiating the process of group cohesiveness, and (b) providing members with a didactic and experiential introduction to cognitive therapy.

Preliminaries. Since it is not uncommon for older adults to arrive as much as an hour early for the first session of a group, arrangements should be made to handle early arrivals; ideally, a waiting room in which participants can visit with one another. A handshake on arrival and departure represents a familiar social pattern for many older adults, thus decreasing anxiety, especially on this first occasion of meeting.

Before the session begins, the time that the group will end should be repeated and any difficulty with transportation should be addressed, in order to reduce members' anxiety about keeping others waiting or possibly missing a ride home.

First Session Agenda. Once the members are seated, the next task is to discuss the agenda for the day. Before proceeding to set the day's agenda, leaders should provide a rationale for the activity and should explain how the group members will be asked to participate in setting the agenda in future sessions.

Rationale: An agenda will help us keep track of what we are doing and what comes next. At the beginning of each session we will set the agenda. Starting at our next session we will be asking you to give us personal agenda items to discuss in the group, such as recent events which have affected your depression. Since today you are just learning about how we will be working together, we have set the agenda for you, as follows:

1. Introductions
2. Expectations
3. Lecturette
4. Homework
5. Feedback
6. Summary of therapy.

Leaders should acknowledge that many of these items might be obscure, and that this first session will involve both an experience of the items and an explanation of their inclusion.

Introductions. After the agenda has been set, the group begins with a brief round of introductions. First, the leaders introduce themselves in order to model both the kind of information that is expected and the brevity that will allow this section to be completed fairly rapidly. Since one of the purposes of the introductory round is to enable each member to have a successful first experience in speaking to a group without embarking on depressive material, the leaders' modeling might focus on relatively non-threatening personal material, such as

marital status, children's names, hobbies. A nondisclosing stance by therapists tends to increase distance and distrust in the group. When the participants are asked to introduce themselves, it would be helpful to provide a choice of several quite specific stimulus prompts, such as, "Please tell us what you like to be called, how long you've lived in town, what sort of family you have, and how you spend most of your time these days".

After the introductory round, leaders might wish to offer some information about their professional work to the group and respond to members' questions about the leaders. A typical question concerns the leaders' interest and purpose in working with older adults. Before moving to the next agenda item, leaders should take this opportunity to tell members that what they have completed is called a "round" and explain both the reasons for rounds and the brief and focused manner in which they need to be conducted.

Rationale: Rounds are used to give each member of our group the chance to make a comment about what we are currently discussing. You are not obliged to say something, but we encourage you to do so. Your comment should be brief so that everyone gets a chance to speak and so that we do not get too detracted from what's on the agenda.

The technique of rounds should be used several times during this first session, to allow participants to become accustomed to the practice and to speaking up in the group. The leaders will

need to develop ways either to solicit more from clients or to contain them during rounds.

Expectations. The behavior expected of clients in a cognitive therapy group should be discussed in the first session. These norms include the expectation that members will discuss their own personal problems, not just the problems of other people, and that they will make a commitment to change, rather than simply waiting for the leaders or other group members to provide answers to problems. Members are also reminded that they are expected to attend every session, even if they do not feel like making the effort, unless attendance is absolutely precluded by an unavoidable circumstance, such as illness. The role of depression in reducing motivation and activity can be emphasized here. Any misunderstandings clients might have about the therapy should be cleared up here and discussed.

Three additional points should be covered with group members at this juncture: contact work should be described, and issues relating to self-disclosure and confidentiality should be presented. The point should be made that although members will be expected to discuss their personal problems, they will not be coerced into disclosing more information than they are ready to provide at any particular time. Leaders should also explain that it is the custom in therapy groups for the group members to agree not to repeat anything that occurred in the group to anyone outside the group, in order to help people feel safe disclosing personal material. As privacy is highly valued by older adults,

considerable discussion is often provoked by the topic of confidentiality and by exploration of what material is appropriate to raise in group. At the conclusion of this discussion, therapists might ask participants the extent to which they agree with the norm of confidentiality, considering group therapy's built-in limitations on confidentiality (i.e., although leaders can control their own confidentiality, they cannot guarantee that of the members).

Clients should be asked if they have any suggestions about structure that they would like to add to the list. In this first session, the rules most commonly added are likely to concern such practical issues as bathroom breaks and smoking.

It can be hoped that clients will arrive at the first session with reasonable expectations of group cognitive therapy. One way to do this is to ask members to set personal goals, related to their depression, that they would like to meet by the end of the group sessions. This goal setting accomplishes several purposes. It allows people to talk about their depression and share personal material with the group in a manner that discourages rambling and self-pity, while instilling hope for a better future. It exemplifies to members the fact that, although this is a group experience, therapy will be individualized. Finally, and perhaps most important, it allows therapists to check for unrealistic hopes and lead all members toward an end that they can reasonably expect to reach.

In the case of goals that are vague or general, therapists should ask members to explain how such a goal would make itself apparent in daily life. If the answer to that question indicates that the person expects to be restored to a level of functioning that is unrealistic, both the therapists and the other group members can help the person to assess whether such recovery is likely. Frequently, the goal can be phrased in more realistic terms simply by the addition of a qualifier; e.g., "I'd like to feel more like my old self". The most important aspect of more goal-setting is that group members do not set themselves up for failure and disappointment by aiming for an unattainable level of recovery from depression.

Lecturette. Therapists should explain briefly the purpose and format of lecturettes and the role played by members in listening and responding to them. Then, the lecturette entitled "Demystifying depression" should be presented as outlined.

Homework. The homework for the first lecturette consists of reading the "Coping with Depression" booklet and writing down questions and comments about the pamphlet. The rationale for homework should be provided, concerns about the homework elicited and resolved, and agreement by clients to at least attempt the assignment should be obtained. With more difficult homework, the mechanics of completing it should be fully explained.

Rationale: Homework is used in cognitive therapy to get you involved in your treatment. Homework will also help you see if what you perceive corresponds to what is really happening. Sometimes depression distorts reality and these distortions contribute to your depression. Homework will help you identify if this is happening and then help you to change your perceptions so that they are more in tune with reality.

Feedback. Leaders can now point out that they have been asking group members throughout the session if various activities make sense to them and if they believe they will be able to participate in these activities. This process can be defined as feedback, and the rationale for the activity explained.

Rationale: It's important for us to know what thoughts or feelings you might be experiencing. We want to make sure you understand what is happening and it is important that you tell us even when we don't ask for it. Therapists should solicit feedback from the participants on the initial session. The most likely response, as it is the most socially acceptable one, is that everything was just fine and that they liked the group a lot. At this point such general statements are acceptable, but leaders might want to set the stage for the possibility of negative reactions in later sessions by a comment such as, "We're glad things seemed to go well today, and that we got off to a good start. However, this is not always the case, and if we are to be of most help in overcoming your depression, it is important

that you let us know anything about the sessions that is not of value or that is not clear". In later meetings, leaders will attempt to elicit more specific comments and opinions, both positive and negative. Any complaints about the group content or process should be handled, if possible, before the session ends or at least tabled to the next session.

Summary of therapy. It might be appropriate for therapists to provide clients with an overview of the remaining sessions. The overview should involve a brief explanation of the phases of therapy, both their timing and content, without too rigid a structure. Members might be told, for example, that for the first few weeks the focus will be on understanding the variety of situations, thoughts, and feelings that members have relating to their depression, since everyone experiences depression in different and highly individualized ways. During this time, people will be asked to make some small changes in their daily lives that, it is hoped, will begin to alleviate their depression. Once people understand how their thoughts and feelings are related, the majority of the remaining sessions will be spent on learning ways to change attitudes and thoughts that bring on or intensify depression. Group members will also be asked to continue making other practical efforts outside of therapy sessions. During the last few weeks of the group, the main focus will be on discussing how people can manage their

lives once the group is over so that they continue to reduce any remaining depressive symptoms and to prevent their recurrence.

Concluding the session. It is important to conclude this first, and all subsequent sessions, on time because of potential transportation problems and because of their reduced attention spans. A formal leave taking at the door, including a personal comment to each member, clearly signals the end of the session and finishes the day's meeting on a positive and socially pleasant note. Clients should be adequately prepared to begin therapy by the conclusion of the first group session. They should understand what is expected of them as group members, will believe that they can adequately perform their role in group, and will expect that their performance is likely to result in some therapeutic gain.

Lecturette for Session 1: Demystifying depression

In part to reassure clients by demystifying the nature of depression and in part to give them a rationale for the proposed treatment, therapists should discuss depression. To explain the process of depression, you should emphasize the role played by loss, by a sense of helplessness, and by a negative view of the past, present, and future. You should also talk about the cyclical nature of the problem and the symptoms typical of depression. Since there is a wide range of symptoms and few people display all of them, clients are often relieved to find

that they do not suffer from them all. Clients are also often reassured by the realization that their own experiences are not unusual among those who are depressed and that some of their confusing and frightening symptoms result from a treatable condition rather than an insidious and incurable disease. Frequently, clients are not aware that depression can be associated with many physical symptoms, and we emphasize the fatigue and lethargy that usually have considerable effect on motivation. Discussing the memory loss attendant to depression is reassuring, too.

Session 2

1. Preliminaries (10 minutes)
 - a. Social time
 - b. Agenda
2. Homework Review (50 minutes) "Demystifying depression"
 - a. Successes (i.e. did they read it, did they understand it, etc.)
 - b. Problems
 - c. Contact work and individualized homework assignments
 - d. Feedback on contact work
3. Lecturette on Activity Scheduling (50 minutes)
 - a. Lecturette (5 minutes)
 - b. Feedback regarding comprehension of lecturette
 - c. Personal application
 - d. General homework assignment

- e. Contact work and individualized homework, if appropriate
 - f. Feedback on contact work
4. Concluding Activities (10 minutes)
- a. Review homework assignments to ensure tasks are understood. They should start scheduling activities immediately.
 - b. Feedback on session.

Lecturette for Session 2: Activity Scheduling

Procedure. The following steps are used to initiate activity scheduling:

1. A rationale for the technique is provided to clients, including the following points:
 - a) Three major symptoms of depression are fatigue, loss of interest, and difficulty in starting and finishing tasks
 - b) Because tasks are more difficult and less rewarding, depressed people tend to procrastinate or avoid daily activities, even those they used to enjoy or do well. This procrastination and avoidance applies to social relationships as well as to intrapersonal activities
 - c) Inactivity can produce harmful effects on health, relationships, and self-esteem
 - d) The situation gets worse as the withdrawal increases. A good way to reverse this process is to deliberately engage in selected activities on a daily basis.
 - e) The following paragraph could also be used: The anhedonia and inertia of depression lead to low levels of activity

and, frequently, the failure to complete asks. These, in turn, give rise to self-blame for laziness, boredom, and the belief that one is no longer capable of doing nothing at all. Scheduling activities restores structure and a sense of self-control; it acts as a stimulus to perform preplanned activities and provides evidence of achievement. A structured day tends to pass more quickly and be somewhat less boring than a day without plans.

2. Negative thoughts are elicited from the group members about their decreased functioning and the resultant emotions.
3. Clients are then provided with a blank schedule for the daytime hours of the coming week and asked to insert one item in each hour's space. They are also guided through an average day, writing in all activities that are part of their normal routine. Thus, they are asked to include meals, baths, household chores, reading the newspaper, phone calls, etc.
4. Clients are then asked to fill in the remaining spaces. Frequently, depressed clients find one part of the day more difficult than others, usually the "dead" afternoon hours or the evening time before bed. By sharing their own time use and by using their imaginations and knowledge of each other, group members can be helpful in providing ideas for activities.
5. When schedules are completed (at least in part), clients will be asked to perform at least a part of each activity as scheduled during the coming week and to check off each time an

effort is made. It is important to emphasize that performing the activity at the correct time is what counts initially, not how well it was done or for how long. For example, if reading the paper is the task planned for Monday between 2 and 3 P.M., then it is enough to pick up the paper and read only the headlines. It does not matter if the person cannot concentrate or falls asleep after 10 minutes.

6. Clients are asked to bring the schedule with them to the next session, regardless of whether they have been able to follow it completely.
7. An effort is made to put homework in a framework that will be likely to increase compliance. For example, therapists might ask clients to compare themselves to a man who has a broken leg, whose cast has just been removed. Obviously, he must exercise or the leg will stay weak. It is equally obvious that exercising will be painful for a while, and he will not run marathons for some time. The man will also most probably feel discouraged and find it hard to believe that just walking around the yard is of any use at all. But if he does not start somewhere, the leg may be permanently damaged. Since most elderly people are also parents, this particular metaphor can be effective if they are asked to imagine that the injured person is a child. What would they say to that child in order to persuade him or her to exercise despite the pain and the minimal progress? If clients remain skeptical about the value of the exercise, it might be suggested that they perform an

experiment in which they take careful note of and compare their feelings during times when they are doing nothing (which usually means brooding) and at times when they are active. The results can then be discussed the following week.

Discussion. Activity Scheduling can be problematic in several ways:

- a) Sometimes clients fail to understand the purpose and assume that the therapist is requiring hourly accomplishments they feel they have no energy or motivation to perform. For these clients, it might be helpful to emphasize once more the enervating and demoralizing effects of depression and the step-by-step nature of recovery. If possible, mobilize other group members to help persuade reluctant clients to define the least amount of acceptable effort.
- b) Some clients can have the unrealistic expectation that simply following the schedule will significantly reduce their symptoms and are disappointed when this does not occur. This concern should be anticipated by explaining that during recovery from depression, improved functioning frequently precedes symptomatic relief. In the meantime, they need to focus on how successful they are in taking control of their lives again.
- c) Some clients might wish to fill their schedules with all the tasks they have neglected for months, without considering whether this is realistic. The therapist should encourage

clients to write down only those activities within their resources of time and energy, so as to avoid exhaustion at best and a sense of failure at worst.

A practical consideration in using this technique in a group setting is the amount of time that can be required to complete a full week's schedule, especially if the whole group gets involved in the process for each member. One way to handle this potential time problem is to ask clients to bring to the session a schedule showing the previous week's activities; this schedule can be used as a model for planning a week ahead. Alternatively, therapists might plan only one or two days of the following week during the session and either ask clients to follow the schedule for those days only or ask them to complete the schedule at home.

By following the daily schedule, the client is usually able to cope with small but necessary tasks, such as bill paying, that have been a source of procrastination and worry up to this point. The resulting sense of accomplishment can reassure the client that recovery from depression is possible.

Session 3

1. Preliminaries (10 minutes)
 - a. Social time
 - b. Agenda
2. Homework Review (50 minutes) Activity Scheduling and columnar records.
 - a. Successes

- b. Problems
 - c. Contact work and individualized homework assignments
 - d. Feedback on contact work
3. Lecturette on Relationship between thoughts and feelings (50 minutes)
- a. Lecturette (5 minutes)
 - b. Feedback regarding comprehension of lecturette
 - c. Personal application
 - d. General homework assignment
 - e. Contact work and individualized homework, if appropriate
 - f. Feedback on contact work
4. Concluding Activities (10 minutes)
- a. Review homework assignments to ensure tasks are understood. They should continue scheduling activities and begin recording situations and their feelings on their three-column record.
 - b. Feedback on session.

Lecturette for Session 3: Relationship between thoughts and feelings

Explanation. Before beginning this lecturette, make three columns on the blackboard entitled "Situation" "Thoughts" and "Feelings". Write under "Situation" "Crash in another room". The way a person thinks about or interprets events affects how he feels and behaves. There is a close relationship between the way a person thinks about himself, his environment, and his future

and his feelings, motivations, and behavior. Many people believe that feelings, such as joy, sadness, anger, etc., are caused by other people's behavior or by things that happen to us; therefore, we assume that we have no control over our feelings. In reality, our feelings are caused by the thoughts and beliefs we have learned to have about an event or about someone's behavior. For example, say a person is home alone one night and they hear a crash in another room. If he thinks, "There's a burglar in the room," how do you think he would feel? (get a response from the group and write feelings under the appropriate column). And how would he behave? (they will say something along the lines that he might be afraid and hide or phone the police). In response to a thought that a burglar made the noise, the person would probably feel anxious and behave in such a way as to protect himself. Now, let's say he heard the same noise and thought, "The windows have been left open and the wind has caused something to fall over". How would he feel? (hopefully, they will say not afraid but annoyed that something might be broken or that the window was left open). And would his behavior be different following this thought? (sure, he'd probably go see what the problem was and not call the police). Now, what this example shows us is that there are a number of ways in which you can interpret a situation. Also, the way you interpret the situation affects your feelings and behavior. The main focus of this therapy is for us to be scientific collaborators in investigating the content of your thinking. We will define what

types of information are important and we will help you to discover how the way you interpret events in your life contributes to your depression.

Personal Application. Can anyone think of a recent situation where you felt sad, angry, depressed, etc.? Is there a situation that occurs often in your life, where you feel bad? (Elicit several examples and write them on the board, fill in the Situation and Feelings columns. Elicit from each volunteer the thoughts that contributed to the feelings. If this is difficult, ask the volunteer or other group members to invent or imagine what thoughts might have occurred). Suppose you wanted to feel differently, what might a more comfortable or less distressing feeling be in this situation? (Write them on the board). Has anyone had an experience of first feeling bad about a situation, then feeling somewhat better? (Write the situation and both sets of feelings on the board).

Homework. Often, feelings are very strong and occur so rapidly that it's hard to believe any thoughts are involved. Especially when we are in the habit of experiencing a particular feeling quite often, the thoughts that precede the feeling become automatic, so that we do not think them consciously. Before we can do anything to change these thoughts, we have to learn to "catch" them. Before we can catch thoughts, we must notice when unpleasant feelings happen, since they are the clue to what we

are thinking. Clients are then asked to complete the sheet under the Situation and Feelings columns. Ask members to gather several examples during the week, focusing primarily on unpleasant feelings. Emphasize that this may be difficult and not to feel discouraged if they cannot find any examples.

Sessions 4, 5 and 6

The major goal of these sessions is to help clients identify their problems within the framework of cognitive therapy, so that they are prepared to begin the change phase of therapy. Essentially, identification consists of monitoring dysphoric feelings along with the thoughts and situations that precede and cause those feelings. As clients are taught to observe these relationships, they are also taught to recognize and label dysfunctional thoughts. This is a considerably more complex task than might be imagined. Since most people, including and perhaps especially elderly adults, are unlikely to be accustomed to systematic introspection, it takes time and effort to reach the point where each client is able to construct a written list of his or her own dysfunctional cognitions and the events that typically precipitate them.

The principal technique for achieving the goal of identifying dysfunctional cognitions is the use of columnar records, which is taught early in treatment and continues to be used through all phases of therapy. The first step in teaching this technique is to ask clients to identify times during the

week when they experience a dysphoric mood and to identify both the feeling state (the mood itself) and the situation they believe occasioned the mood. Initially, two columns are used. This is what they will be taught in the lecturette of Session 2. Many clients tend to believe that their depression is all pervasive, resembling a permanent state of being, and they are initially unable to identify specific moods or to notice specific occurrences that heighten feelings of sadness and despair. Therapists who are knowledgeable about common precipitators of depression in the elderly can encourage the identification process by asking specific questions:

1. How much worse do you feel when you find yourself unable to perform a task that was easy for you just last year?
2. What happens to your depressed feelings when you read in the paper about the death of an old friend? Not until the two columns can be completed satisfactorily as a homework assignment and the appropriate lecturettes have been presented are group members asked to complete a third column. This third column introduces the thoughts that connect the situations to the feelings. Usually, considerable direction is required to help clients identify:
 - a) any thoughts at all that precede the feelings
 - b) those thoughts that particularly relate to the unpleasant feelings
 - c) the effects of these thoughts as dysphoria.

The automatic nature of depressogenic cognitions makes it difficult for clients to "catch" their thoughts, especially during the days between sessions when they are without therapist help. In order to help them catch these dysfunctional but unrecognized thoughts, clients might be asked to replay a distressing situation aloud, in slow motion. They might also be asked to imagine or create thoughts and images that will bring on or intensify the feeling. The therapist could also ask what conclusions clients draw about a situation, in order to elicit negative thoughts. Should difficulties in identifying automatic thoughts persist, other group members might be asked to guess at possible expectations, fears, worries, or other cognitive responses to the situation that could have produced the feelings.

If clients create a stream-of-consciousness report of every thought that preceded their feelings, including those clearly irrelevant to the emotion, they can be guided to evaluate each thought in terms of its possible connection to the target emotion. For example, therapists can ask, "When you thought about what you wanted to eat for breakfast, did that make you feel any worse or any better?" Alternatively, clients with a long list of cognitions might be asked to identify the two or three they believe occur most often or contribute the most to their dysphoric mood.

Throughout this phase, therapists will do contact work with individual clients, though not with the frequency that this technique will be used in ensuing phases. In this early phase,

contact work is not designed to produce change but to help the client identify cognitive structures and understand the connection between thoughts and feelings. It should be explained to clients that although this step is a necessary antecedent to change, it cannot be expected to provide significant relief of emotional distress. In this phase, the therapist is content to allow the group process to account for any emotional relief that occurs, expecting that specific techniques for cognitive change will carry the burden for long-term effects as therapy enters the middle and final phases of active treatment. Contact work is conducted during this phase mainly with those clients who are having difficulties, such as inability to identify specific situations, or depressogenic thoughts, or negative cognitions about homework. Since clients are usually unfamiliar with the cognitive approach, and at the same time often eager to receive advice with practical problems, it can be difficult to maintain a cognitive focus in this early contact work. Therapists need to ensure, however, that the time for one-to-one contact is used appropriately from the start, in order to set the pattern for the more extensive use of contact work later. Clients may have to be reminded of the purpose and focus of contact work and gently kept on track.

On the whole, contact work does not differ in this phase from work that therapists do with the whole group. That is, the client is first asked to recall a specific situation when dysphoria was experienced. The therapist then guides the client

through the situation, using whatever imaging or questioning techniques that best elicit, first, the dysfunctional feelings and, second, the contributing dysfunctional cognitions. The therapist ascertains that the client acknowledges the relationship between the thoughts and feelings by asking questions such as, "Does it make any sense to you that, if you think these thoughts, you might feel this way?" Time permitting, the client can be taken in this way through several incidents. At any point, the therapist can request help from the group, although members should not be allowed to volunteer unsolicited comments. When contact work is completed, the therapist might, with the collaboration of the client, design an individualized homework assignment. Finally, the therapist asks for feedback from both the individual client and other group members concerning the meaning and relevance of the contact work. Once identified, dysfunctional thoughts continue to be monitored via homework assignments using the three column record, in order for the therapist to determine the pervasiveness in the client's life of specific dysfunctional thoughts and more general dysfunctional automatic patterns. Building on both homework assignments and the concepts described in *Coping with Depression*, the therapist can assist clients to identify key words and feelings that will cue them to the presence of dysfunctional thoughts.

Throughout this phase, therapists will find it invaluable to keep a running list of typical trigger situations and

dysfunctional thoughts for each group member. In time, this list will provide a portrait of the client's cognitive errors and basic schema and will help both client and therapist select the most relevant cognitions to target during the change phase. By using this list, the therapist will also be in a position to recognize whether a particular issue arises frequently for the client or is a relatively infrequent, and perhaps insignificant, event that may not warrant therapeutic attention. This function should be carried out by the co-therapist. Other responsibilities of the co-therapist include: (a) carrying out most administrative tasks, i.e., gathering materials, phoning clients, etc., (b) informing the senior therapist of time limitations during therapy, (c) being attentive to client reactions "away from the action" and intervening appropriately, and (d) performing some of the lecturettes.

As clients develop their individualized lists of negative thoughts, therapists, and sometimes clients too, will notice repetitions and patterns of cognitions, either within single lists or across group members. This patterning is the focus of the next step in cognitive therapy. Once individuals are able to identify dysfunctional thoughts and feelings, they need to learn how to classify the thoughts into categories. Therapists need to decide when to initiate the process of categorizing thoughts. We hope that this can begin at session 7. It is important not to confuse clients with the details of classification until the majority of group members have completed the identification

process. For this reason, categorizing usually occurs during the next phase of therapy, when clients learn how to categorize and how to challenge their cognitions. Sometimes, however, some clients who have already mastered the tasks of identification will begin to see and inquire about patterns. Perhaps the best way to deal with these inquiries, if they are considered premature for the group, is for therapists to acknowledge that there are patterns, encourage individuals to look for patterns in their own thoughts, and explain that the investigation of these patterns represents the next step in therapy. Even though classification is not typically undertaken during the identification phase, therapists need to be aware of the different categories so that they can begin to assess the typical errors of each group member.

Session 7, 8, and 9

These sessions constitute the cognitive change phase, and their purpose is to move clients from the process of identifying dysfunctional thoughts to the process of changing these thoughts in a manner likely to alleviate depression. To this end, the objectives of the change phase are to teach clients how and when to question the validity of their thoughts, to implement alternative thinking processes, and to practice such alternatives through homework assignments and other outside activities. The general format of the sessions remains the same as during the identification phase of treatment; the differences are in the

emphasis placed on change in the lecturettes and in the greater time allotted for one-to-one contact work.

It is hoped that by session 7 clients will be adequately familiar with the nature of dysfunctional thoughts, in general, and with those particular dysfunctional thoughts that characterize their own depression. Since different individuals might be ready to move on at different times, the clinician's judgment of each client's readiness to implement individualized treatment interventions becomes critical for maintaining a collaborative spirit among group members. Clients can be considered to have adequately mastered the tasks in the identification phase when they have developed a list of their negative cognitions and demonstrated the ability to monitor these thoughts via homework assignments. This list will serve as a source of targets for change during the present phase.

A feature of cognitive therapy that accommodates individual differences is large amounts of therapy accomplished through one-to-one interactions (contact work). These interactions allow the therapist to begin moving different clients into the change phase at different points. By also individualizing homework assignments and remaining sensitive to each client's particular struggles, therapists can ease the transition between phases. Indeed, as some clients begin working on change activities, they provide motivation and even modeling for other clients who lag behind somewhat. As a cardinal principle, however, one does not encourage or define cognitive change for specific clients until

they have clearly established the ability to both identify important cognitive patterns in their own experience and to appreciate the impact of these cognitions on their mood.

The possibility of change lies in the client's ability to successfully eradicate cognitive errors. This process is facilitated by the use of questions designed to challenge specific erroneous concepts. The most common errors are the following:

- a) Overgeneralization
- b) Awfulizing
- c) Unrealistic Expectations of Self
- d) Demands on Others
- e) Exaggerating Self-Importance
- f) Mind Reading
- g) Self-Blame

For each of these errors, a lecturette has been developed and can be found on pages 83-94. Based on the patterns of cognitions seen across group members, leaders can decide what lecturettes to highlight, and in what order, during the change phase.

With practice, therapists become adept at creating a variety of questions that can help clients explore, assess, and understand their errors in thinking. Therapists' ability to use questions rather than statements or other persuasion is critical, since it is important that clients reach conclusions about their cognitive errors for themselves rather than be coerced into

accepting the therapist's view. Examples of therapist questions can be found on page 82. New viewpoints and beliefs that clients develop under the guidance of therapeutic questioning carry more conviction and are more likely to persist over time than those imposed by a therapist to whom clients merely acquiesce.

Restructuring cognitions through questioning is assisted by an extension of the three-column record technique learned in the previous phase. In the change phase, clients learn to add a fourth column in order to identify possible alternative thoughts. An example of this can be found on page 83.

Thus the goals of these sessions is as follows:

- a) Focus on changing errors in thinking
- b) Present lecturettes most relevant to the type of errors shown in the group
- c) Use contact work more often and personalize it to meet the requirements of each group member
- d) Explain and use four-column records.

Session 10: Consolidation/Maintenance of Therapy Gains and Termination

Cognitive therapy groups are time limited; the group will end at a pre-determined date. This limitation allows leaders to prepare for termination in several different ways and at different stages of the group. It is important that leaders allow several sessions to work through the termination process and obtain closure, since too abrupt a transition from the group

experience, with its support and education, to an independent life can result in a rapid loss of therapeutic gains.

Participants will, of course, be informed during the selection interview of the group's termination date and, as this date approaches, additional references should be made to it (i.e., We only have three weeks left in the group). In this way, the end of the group becomes an integral part of each member's life, and ambiguity and surprise are reduced.

The purposes of the consolidation/termination phase are:

- a) To help group members consolidate the gains they made in the group
- b) to teach them how to maintain those gains
- c) to assist them in separating from the group.

In general, new concepts are not introduced during this final phase, the assumption being that members have already learned all the material the therapists deem appropriate and are now focused on the practice and refinement of skills and concepts acquired thus far. This shift in emphasis frequently results in a departure from the agenda pattern followed in earlier sessions. Only one lecturette will be presented and homework will not be planned in advance, but will be derived ad hoc from group discussions or from individual contact work.

During this final stage, the members' lives outside and beyond the group command most of the attention. The importance of homework increases and much of a session might be devoted to debriefing the previous week's work and preparing for the next

homework. Typically, during the last sessions, therapists encourage increasing interaction among members, whose receding depression allows for such involvement and who have generally learned how to provide each other with helpful feedback, suggestions, and reinforcement. Thus, the emphasis of the sessions anticipates and mirrors a condition of self-management and interaction with others, without constant therapist intervention. In essence, members spend this last phase working on individual treatment plans that will enable them to maximize their therapeutic experience.

Consolidation. Clients need to learn two processes in order to maintain the gains made in the cognitive therapy group. The first process is specifying and reinforcing the therapeutic gains that they made. The second process is learning to anticipate and address new, potentially depressive situations. Partial accomplishment of both steps can be achieved when therapists help clients develop a more generalized view of their depressive themes. However, it is fully recognized that this may not be possible given the small number of sessions.

Maintenance of Gains. In session 10, in the place of a lecturette, members might be asked to describe the gains they made thus far in the group. After their responses have been listed on the board, leaders can initiate a brainstorming discussion around the questions of how to maintain these gains

after the group ends, adding any ideas of their own that they believe would be helpful. Typically, group members are able to list many practical and effective ways to handle problem situations and thoughts, such as:

- a) Avoid times, places, people, and conditions that have elicited depression in the past
- b) Seek out people who make you feel good and reward you for being cheerful and for making an effort
- c) Refer frequently to a notebook containing hints and plans that you know from experience help you to manage your thoughts
- d) Find a support group other than this one.

The following session, participants are given a typewritten copy of the list of suggestions, which can be revised or added to in subsequent sessions as people develop new ways of coping.

If time permits, leaders can ask clients to recall the goals they set for themselves at the beginning of the group and evaluate the progress they made toward these goals. As long as the initial goals were realistic, all clients can be expected to have progressed at least a little. However minimal this progress, it can nevertheless be presented as evidence that the person has indeed made changes and, thus, further change is possible. Clients might be encouraged at this point to set small, attainable goals for themselves for the posttherapy period. Discussing their initial expectation and the actual results of the group treatment helps clients see and retain therapeutic gains.

Session 11: Separating from the Group

Separating from the group often raises emotional reactions in members. The imminent closing of the group can elicit a variety of feelings in the participants, some of whom may react with a dramatic increase in problem behaviors and depressive symptoms. Indeed, our experience is that symptoms are often exaggerated, nearly to pretreatment levels, just prior to and after the final group sessions. These symptoms pass rapidly, however, and should be addressed as temporary events. Some participants might feel rejected or abandoned by the leaders; others, sad that the relationships are now ending, a sadness that is intensified if termination of the group brings up memories of past separations. Still others might dread the loss of support provided by the group, the extent of this dread often depending on the extent of their social isolation. Although some participants might feel relieved that they have successfully resolved their difficulties and can operate independently now, others will feel anxious about their ability to handle future problems.

Separation issues need to be addressed directly; if these concerns are left to the last session, they are likely to be overwhelming. The issue of termination should therefore be addressed near the end of therapy. Leaders could, for example, explain common reactions to the termination of a group and ask if any member is experiencing similar reactions. Clients often feel

relief in sharing the feelings and discovering that others feel the same way. Once the feelings have been aired and acknowledged as normal and reasonable, they can be approached in one-to-one contact work and investigated for any irrational thoughts (for an example of how to do this see page 111). If group members are not aware of any cognitions, it might be useful to initiate a group exercise in which participants imagine that the group has ended and are asked what thoughts and feelings this situation evokes.

The development of alternative social support can minimize the impact of the loss of the group. The continuance of social support can be directed either at finding other support systems or at continuing to hold informal gatherings of the group. It is likely that someone in the group will suggest that the members continue to meet after the official end of the group. Leaders should, therefore, discuss this possibility with one another, in advance, in order to be ready to respond to the idea. In particular, the leaders need to decide the extent to which they are willing to be involved in any extension of the group. Some of the issues related to social supports can be addressed through lecturettes and homework assignments.

Lecturette: Building Support Networks

Explanation. We all need the support of other human beings, not only in times of crisis, but also in our everyday lives. Unfortunately, the elderly are often without such support, as

social networks tend to shrink when people get older. Friends and family die or move away, retirement brings with it an automatic loss of co-workers, and frequently the elderly, themselves, move to nearby retirement communities or even across the country to places with more hospitable climates. In addition, aging tends to increase social isolation because the physical effort to make social contacts becomes increasingly difficult, and many older adults think it takes too much effort.

Although it is common for the elderly to have diminished social support networks, the situation need not stay that way; lack of social support networks is a problem to be solved like any other. Social networks can be restored, but to do so a person must make a systematic effort to both maintain old social contacts and establish new ones. This task is not as simple as it may seem, because dysfunctional cognitions often stop people from taking action. They tell themselves that it takes too much effort to make social contacts ("I don't have the energy any more to entertain") and that they shouldn't have to make such an effort ("If she wanted to see me she'd call me"). They compare new acquaintances with old friends and find the acquaintances wanting, and they fear rejection, believing that they have nothing to offer.

For example, family problems over several months took Joe's time away from his usual circle of golfing friends. When he finally had more time, he waited for someone to invite him to play golf and was hurt and angry when this did not happen. He

thought, "They've all forgotten me. That's how much they care about me". When someone finally called, Joe was grumpy and brusque and refused the invitation. Joe missed people and became increasingly depressed.

Personal Application. Therapists should initiate a brief discussion of members' social support networks, focusing mainly on whether the networks are perceived as adequate and on possible options for expansion. If networks have shrunk over the years, there is little point in encouraging much talk about reasons for the loss. Instead, therapists should investigate the barriers, especially cognitive ones, to increasing social support in the present time. Ask, "What is preventing you now from building a new circle of friends?" Usually, the group is very helpful in dealing with practical barriers, such as transportation, and knowledgeable about available activities. Dysfunctional thoughts can be addressed within a cognitive framework (see page 113).

Most of the personal application section of the lecturette should be focused on intervention; that is, on building social support networks. Therapists should assume that the participants already have the requisite skills to establish and maintain social relationships and do not need to be taught. In order to define and plan or expand the network, ask participants the following questions:

- a) Who is in your social network now?
- b) Do you feel you have enough people in your life?

- c) What acquaintances do you have who could conceivably be friends?
- d) How might you go about strengthening your relationships with these people?
- e) If there are no acquaintances who could be friends, how and where could you meet people?

Homework. In order to build a social support network, you must be active in initiating and maintaining friendships; you cannot build a support network by waiting for other people to come to you.

Identify two occasions over the next week in which you could either take the initiative to meet someone new or extend an invitation to someone whom you already know but haven't seen recently. Specifically, how, when, and where will you take these steps.

Session 12: The Final Session

If leaders remain sensitive to the needs and responses of the group members, and build in the termination process from the start of the group, the final session should entail a minimum of disappointment and panic. The actual content and format of this last meeting is usually determined by the leaders' perceptions of any final business that needs attention and by the decision of the members. The extended number of sessions recommended for older adults and the inclusion of social time each week usually

results in the formation of friendships, or at least social relationships among the members, who frequently enjoy turning at least a portion of the last meeting into a social occasion.

However flexible this final session, leaders should attempt to meet several goals: as far as possible, no one should have any serious unfinished business; group members should leave on a positive note, conscious of gains made and skills acquired; no one should feel abandoned, with no place to turn for help.

Resulting from these goals, a possible agenda for the last session might contain:

- a) any unfinished business
- b) quick review of methods for handling problems
- c) a round where both leaders and other members describe changes that they have seen each member make in the course of therapy
- d) referral sources



Appendix F

Telephone Screening Procedure

These procedures are to be implemented for each person who calls the Center for Psychological Services and expresses an intent to participate in the research project on group cognitive treatment for depressed elderly.

Basic Information

We will be conducting a research study on the group treatment of depressed older adults. You will need to satisfy certain criteria to participate in this study. If you appear suitable for this study, you will need to come to the Center for Psychological Services of the University of Ottawa to complete some psychological testing that will decide if you can in fact participate. If you come in for the testing, you will be given more information about the study and you will have to complete a consent form before we can test you. Because we will be testing people for participation in this study over a certain period, you will have to wait until the beginning of (month) before treatment begins, if you are accepted into the study and if you agree to participate.

--> Do you understand?

May I have your full name? _____

How old are you? M _____ F _____

Must be 65 years of age or older.

Are you English-speaking or fluently bilingual?

Must be anglophone or bilingual.

Are you alcoholic or have problems with drug abuse?

Answer must be no to both.

If the caller is currently receiving treatment for drug or alcohol abuse suggest that they continue with that treatment. If the caller is not receiving treatment ask if they wish to be referred to treatment elsewhere.

Treatment for alcohol and/or drug abuse:

Al-Anon 725-3431

Rideauwood Institute 728-1727

Royal Ottawa Hospital 724-6508

Have you ever received psychological or psychiatric treatment before?

Must answer no to both.

Are you currently receiving psychological treatment for your depression?

Answer must be no.

If Yes

It might be better for you to continue with the treatment you are receiving now.

Are you currently taking medication for your depression?

If yes, must be taking the same drug at the same dose for at least 3 months.

Will you be participating in any form of psychological or psychiatric treatment in the next few months?

Cannot be involved in other treatment for duration of study.

Have you ever made a suicide attempt?

Answer must be no.

If there appears to be serious intent, suggest that they call the Royal Ottawa Hospital at 724-6508.

Disposition of call

Does not meet criteria

If the caller does not meet the inclusion/exclusion criteria offer them therapy at the Center for Psychological Services and tell them why they were refused.

Meets criteria

If the phone screen is successfully passed on all items, obtain the telephone number of the potential subject and make an appointment for an assessment session.

Telephone number _____

Set-up an appointment for testing

Date _____ Time _____

(Be sure they have directions to the Center)

Appendix G

Knowledge About Psychotherapy Questionnaire

Because the KAPQ is a new instrument, it seemed appropriate to present preliminary results on its psychometric properties. For the sample used in this study, the internal consistency estimate (Cronbach's alpha coefficient) for the first administration of the KAPQ (i.e., prior to the onset of the pretherapy phase) was 0.21. The alpha coefficient for the second administration (i.e., immediately after the end of the pretherapy phase) was 0.61. The Spearman-Brown split-half reliability for the first administration was .07 and for the second administration it was .77.

Discriminant validity was determined by correlating the KAPQ with other measures employed in this study (see Table 16). The correlations between the KAPQ and the other measures were quite low. The questionnaire itself can be found on the following page.

Knowledge About Psychotherapy Questionnaire

Please answer the following questions to the best of your knowledge.

- 1) A therapist acts pretty much the same way as a doctor that you go to when you feel physically sick. TRUE/FALSE
- 2) A therapist tells you exactly what to do to solve your problems. TRUE/FALSE
- 3) When giving a person feedback in a group situation, it is better to be indirect and ambiguous so as not to hurt the person's feelings. TRUE/FALSE
- 4) It is important to self-disclose in group therapy. TRUE/FALSE
- 5) When receiving feedback, you don't have to agree with what people say about you, but you should be willing to accept that this is how it looks and feels to them. TRUE/FALSE
- 6) In a therapy group, it's perfectly all right to tell people how they affect you, to let them know that you're feeling angry or upset with them or that you admire them. TRUE/FALSE

- 7) An important part of being in a group is helping others to learn about their strengths and weaknesses at the same time you're learning about your own. TRUE/FALSE
- 8) In group therapy, you can learn to take responsibility for working out ways of handling your problems. The group members can help you, but in the end it's up to you. TRUE/FALSE
- 9) The therapists make sure that the group finds out what they want to know from a group member, even if that person does not want to self-disclose to that extent. TRUE/FALSE
- 10) If you had a difficult group meeting or you had a bad week and do not feel like going to the next meeting, then it is best that you not show up and skip it. TRUE/FALSE

Appendix H

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September 25, 1991

David Latour, B.A.
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Ottawa, Ontario
Canada K1G 0B6

Dear Mr. Latour:

Re: Your letter of Sept. 12, 1991

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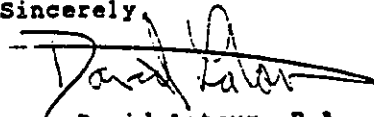
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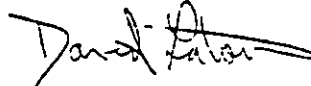
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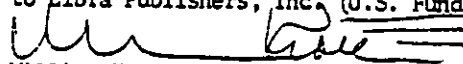
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