

A Practice of a Cognitive Behavioral Oriented Group Psychotherapy In Adolescents

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ÖZET

Ergenlerde bilişsel davranışçı yönelimli bir grup psikoterapisi uygulaması

Amaç: Bu çalışmada, Bakırköy Prof. Dr. Mazhar Osman Ruh Sağlığı ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi Ergen ve Genç Erişkin Psikiyatrisi İkinci Basamak Biriminde yürütülen ayaktan bilişsel davranışçı yönelimli grup terapisi programı ve sonuçları hakkında bilgi verilmesi amaçlanmıştır.

Yöntem: Grup psikoterapisi programı, majör depresyon tanısı almış ergenlerin tedavisine yönelik olarak Clarke, Lewinsohn ve arkadaşları tarafından geliştirilen bilişsel davranışçı yönelimli grup terapisi programı temel alınarak hazırlandı. Her biri 12 seanslık 10 grup programına katılan ve farklı tanıları bulunan (depresif bozukluk, anksiyete bozukluğu, davranım bozukluğu gibi) 100 ergen hastanın tedavi süreç ve sonuçları değerlendirildi.

Bulgular: Hastaların %24'ü tedaviyi tamamlamadı. Cinsiyetin veya psikiyatrik tanının tedaviyi tamamlama üzerinde etkisi olmadığı görüldü. Özellikle öğrencilerin okul dönemindeyken programı tamamlayamadığı saptandı.

Sonuç: Ergenlere yönelik bu terapi programı, pratik olarak kolay uygulanır bir programdır. Öğrencilere tatil dönemlerinde uygulanması tedaviyi tamamlama oranını artırabilir.

Anahtar kelimeler: Ergen, bilişsel davranışçı terapi, grup psikoterapisi

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ABSTRACT

A practice of a cognitive behavioral oriented group psychotherapy in adolescents

Objective: Cognitive behavioral psychotherapy is one of the effective methods in the treatment of various psychiatric problems seen in adolescence. This paper is aimed to report on the cognitive behavioral oriented group therapy program which was conducted in Bakırköy Prof. Dr. Mazhar Osman Training and Research Hospital for Psychiatric and Neurological Diseases, Adolescence and Young Adult Psychiatry Second Step Clinic.

Method: This group therapy program was adopted from a cognitive behavioral group therapy course, which was developed by Clarke, Lewinsohn and their friends in order to treat adolescents diagnosed with major depressive disorder. The treatment processes and outcomes of 100 adolescents with different diagnoses and who had participated in 10 group therapy programs, each consisted of 12 sessions, were evaluated.

Results: Twenty-four percent of the participants did not complete the group therapy program. Gender and psychiatric diagnoses were found to have no effect on the completion of the treatment. It was seen especially that the students have not completed the program during the school term.

Conclusion: Practically, this therapy program for adolescents is an easily applicable program. The percentage of treatment completion could be increased by implementing it on holiday periods.

Key words: Adolescent, cognitive behavioral therapy, group psychotherapy

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INTRODUCTION

Adolescence is a period distinguished by rapid change in physical, mental and social development. Although many teenagers emerge from adolescence unscathed, thirteen percent of children and adolescents under 18 are at risk for a psychiatric disorder, according to studies (1).

Epidemiological research indicates that depression is one of the leading mental issues that can occur

during childhood and adolescence (2). Depression is associated with a decrease in social skills and regression in cognitive development in the long term and risk of suicide in children and adolescents (3). The most widely-researched treatment is behavioral therapy, rather than pharmacological treatment, for adolescent depression. (4). Studies report that individual cognitive-behavioral and problem solving therapies, for adolescent patients with diagnoses like anxiety disorder, social phobia and

obsessive-compulsive disorder (OCD), are effective either alone or combined with medication (5). The exception is depression.

Group therapy, in addition to pharmacological treatment and individual psychotherapy is also effective in treating the depression, anxiety, behavioral and OCD seen in adolescents. Hoag and Burlingame, in a meta-analysis of 56 publications that encompassed the years between 1974 and 1997, concluded that group therapy is effective in children and adolescents (6). There are also publications reporting that cognitive-behavioral therapy, combined with pharmacological treatments, are effective in adolescents who are diagnosed with behavioral disorders and/or drug abuse (7).

Hayward et al, as a result of a pilot study, reported that cognitive-behavioral group therapy would be effective in adolescent girls with social phobia (8). In a study conducted by Clarke et al. with adolescents in an acute depressive period, cognitive behavioral group therapy was shown to be effective (9). Clarke and his colleagues arranged a course of coping with depression that was based on cognitive-behavioral therapy and included the parents (9). In this course, composed of sixteen sessions, topics like positive thinking, changing thought, anger management, relaxation, communication, reconciliation, problem-solving and development of purpose were discussed. For three of the program sessions, parents attended the group session together with the adolescents. In another cognitive behavioral group therapy seminar for adolescents with major depression conducted by Clarke and his colleagues, there was a reduction in depressive signs for 66.7% of the adolescents in the group at the end of the session (10).

The research on behavioral disorders shows that behavioral disorders are associated difficulties in problem-solving in interpersonal relationships, depression and anxiety (11). Reports indicate that cognitive-behavioral-oriented group therapy conducted with adolescents who have behavioral disorders have a therapeutic effect on adolescents (12).

In this article, cognitive-behavioral therapy as a treatment for the psychiatric problems that can occur during adolescence and the objective is to provide

information about the outpatient cognitive-behavioral oriented group therapy conducted in the Bakırköy Prof. Dr. Mazhar Osman Training and Research Hospital for Psychiatric and Neurological Diseases, Adolescence and Young Adult Psychiatry Second Step Outpatient Unit, and to share the processes and results of this experience. In general, the goal is to share therapists' evaluations of the therapy process for the groups; and to determine the effects of completing a group therapy program, of gender and of clinical diagnosis variations on completing a treatment program.

METHOD

A Group therapy program was set up using the manual and the student's workbook prepared for group managers of the Course of Coping with Depression for Adolescents, prepared by Clarke, Lewinsohn and et al (9). This manual was not directly translated into Turkish, but the program was based on research from the manual. The program was set up as a cognitive-behavioral group therapy of 12 sessions for adolescent and young adult patients, who have no psychotic findings and are followed as outpatients. The title, objective and content of each session were determined beforehand. Except for the 12th session, homework was assigned after each session on the content of that session; feedback on the homework was offered in the subsequent sessions. The titles and objective of each session follows:

1. What is Disease?

The first session began with group members meeting, and communicating the intention of the therapy process. The objective is for participants to gain an awareness of their symptoms and collaborate on the treatment process. During the session, participants are informed that their diseases are amenable to treatment, the importance of relationships between the members during the group process; compliance with the group rules for the treatment is also emphasized.

2. Feeling, Thoughts, Behavior Modal

Objective is to enable participants to grasp the

relation between feeling, thought and behavior and to gain insight about their own behaviors and thought processes. An explanation of the human personality as composed of three basic parts, of which the most easily controllable part is behavioral, is emphasized.

3. Introduction to Expressing Feelings

The objective in this session is to enable participants to recognize how they express feelings in interpersonal relationships and social environments, to be able to identify these feelings and to develop the ability to empathize. In this session, the connections between feeling, thought and behavior are emphasized. Participants are also offered an explanation of the importance of recognizing the feelings of others, and the significance of empathy in human relationships.

4. Anger Management

In this session, participants learn about expressing anger and are given tools to recognize inappropriate ways of expressing anger and develop healthier ways of expressing anger. The association between negative beliefs associated with feelings of anger and non-adaptive behaviors is emphasized; and healthier coping mechanisms are examined.

5. Relaxation

This session aims at enabling participants to develop the skills necessary for effective relaxing exercises on their own; explaining the benefits of relaxation exercises in daily life.

6. Stress and How to Cope with It

This session aims at teaching participants to recognize stress and how to cope with it. A certain amount of stress may be experienced during daily life; however, the important factors are frequency and duration of stress. Through this session participants will learn that unhealthy solutions will lead to more problems.

7. Communication Skills

The basic objective of this session is increasing participants' awareness about optimal communication

processes in interpersonal relations, non-verbal communication and miscommunication; and to gain insight on their own ways of communicating. During the sessions, the role of communication in establishing positive relationships is emphasized.

8. Introversion, Extraversion and Aggressiveness

Enabling participants to recognize these concepts – aggressiveness, introversion, and extraversion – and to develop and increase their extraversion levels and gain insight into their own responses. Participants are given an explanation of the difference between confidence and aggressiveness. The role of self-confidence in protecting oneself and one's rights is emphasized.

9. and 10. Family Relationships

This session's objective is to enable participants to gain awareness with regard to their family relationships, and their positions in the family; and best methods of identify opportunities for change by establishing an alternative family modal. Emphasis is given to change one's own behaviors rather than attempting to change the behaviors of family members, and connections are established between feelings, thoughts and behaviors in existing scenarios.

11. Setting Goals

This session's objective is to enable participants to identify short- and long-term goals and to guide them in achieving these goals in certain periods of their lives. Emphasis is placed on identifying and reaching short-term goals in order to achieve long-term goals, and on the importance of using problem-solving strategies for potential obstacles.

12. Depression

The session's objective is to enable participants to identify and acknowledge the signs of depression and learn the appropriate coping methods. Using healthier coping mechanisms to deal with depression is emphasized; the importance of utilizing all the therapeutic tools learned during the sessions is also communicated. The process of group therapy ends each participant offering an evaluation; the therapist

also provides evaluations of the process and the group's development throughout the sessions.

Program Implementation:

A total of 10 group therapy programs were completed between November 2008 and December 2009. Each session lasted 60 minutes. In the first 3 groups, the sessions took place two days per week. The second and third groups were conducted as parallel groups. However, as most of the participants were students and had problem in getting permission from school two days per week, the sessions were rearranged for once per week and four parallel groups were established. Using the guidelines of the prepared program, the groups closed; no participant was accepted to the group after the therapy had commenced. The groups were conducted by two psychologists who are graduate students in Istanbul and Bilgi University.

In the Bakırköy Prof. Dr. Mazhar Osman Training and Research Hospital for Psychiatric and Neurological Diseases, 13th Psychiatry Service Second Step Outpatient Treatment Unit, 139 adolescent patients, whose treatments were arranged here and who were not diagnosed with psychotic symptoms, were interviewed and informed about the group process. They were given content during these interviews, written rules of the group were given, and the required explanations about the rules were also given to both the patient and (for the underage) one of the parents. Of 139 patients, 26 patients were not included due to lack of motivation, and/or limited mental capacity as determined by interviewing therapists or patient's refusal to attend therapy. Of the remaining 113 patients, 13 did not show up for their appointment or for the group therapy. One hundred patients participated in the study. Follow-up diagnoses of the participants, found by the following physicians according to clinical interviews and DSM-IV measures, were evaluated by the researchers under four main diagnosis categories: depressive disorder (major depression), anxiety disorder (generalized anxiety disorder, post-traumatic stress disorder, and obsessive-compulsive disorder), behavioral disorders and other diagnoses (somatoform disorder, dissociative disorder,

compliance disorder and tic disorder).

While evaluating the data, the SPSS 13.0 statistic program was used, and frequency analysis and chi-square test were applied.

RESULTS

Of 100 patients in this study, 72 were female (72%), and the age difference between females and males was not determined (interval: 14-20 years old; average age of females: 17.4, average age of males: 17.7). Of the participants, 31% (n=31) had depressive disorder, 24% (n=24) had anxiety disorder, and 20% (n=20) had behavioral disorder. 25% (n=25) had other diagnoses. 24% (n=24) of the patients completed the treatment. 27.8% of the females and 14.3% of the males did not complete the treatment. No difference was found between genders in terms of departing the treatment ($\chi^2=2.012$, $sd=1$, $p>0.05$). 32.3% of the patients with depressive disorder, 8.3% of the patients with anxiety disorder and 15% of the patients with behavioral disorder did not complete the treatment. No significant difference was found between rates of leaving treatment and psychiatric diagnoses ($\chi^2=7.250$, $sd=3$, $p>0.05$).

Therapists' evaluations and observations on the group process:

Examples of observations and evaluations of the group process, from the therapists, are given below:

M.A aged 17, a student in the third class of high-school, said that "when somebody asks him/her a question, he/she gets very excited, does not know

Table 1: Demographic qualities of adolescents participating in therapy process

Demographic Qualities	Number of Participants (n)	Percentages (%)
Female	72	72%
Male	28	28%
Depressive Disorder	31	31%
Anxiety Disorder	24	24%
Behavioral Disorder	20	20%
Completion of Therapy	76	76%
Discontinuing the Therapy	24	24%

what to say, his/her tongue lapses and he/she becomes uneasy in the situation, he/she participated in the group therapy". During second session of the group therapy, the Feelings, Thoughts and Behaviors Modal, he/she said that a thought like "I will be disgraced" comes to his/her mind when he/she feels himself/herself become tense and/or excited. This was discussed with other group members. In following sessions, he/she stated that he/she is more conscious of the thoughts in his/her mind in states of excitement; and he/she tries to change those thoughts leading him/her to get excited when he/she recognizes them and he/she is benefiting from this method.

B.S aged 16, a student in the second class of high-school, did not speak if no question was addressed to him/her, did not wish to disclose information and avoided it by providing only short answers. He/she said that he/she is always quarreling with family members, especially with his/her father; for this reason, he/she prefers to stay alone in his/her room. In the fourth session, Anger Management, after another patient described the conflict between himself/herself and his/her family, the aforementioned patient began to talk and said that he/she is angry with his/her father because of to a similar situation; however, he/she did not mention this his/her anger to anyone as he/she is ashamed of it, and he/she prefers to stay alone at home in order to avoid expressing bad things when he/she gets angry. During the following sessions, he/she was more willing to disclose himself/herself and participate in the process. Towards the end of therapy, he/she told that she is now spending more with his/her family.

D.U. aged 15, a student in the first class of high-school, applied for the group therapy with complaints like an inability to establish friendships, feeling tense and sidelined in social environments". Until the seventh session, he/she did not speak unless questions were directly addressed to him/her; abstained from relationships with other participants. In the seventh session, Communication Skills, other participants said that gestures and facial expressions of D.U. make it difficult for them to approach him/ her, and that D.U. seems unwilling to come across with them. At this, D.U. said that he/she is unaware of the messages

he/she gives to others with non-verbal expressions in relationships within social environments. During subsequent sessions, observation revealed that the emotional interaction of D.U. with other participants increased, and he/she started to share his/ her feelings and thoughts of his/her own accord.

As seen in the first example of the case above, some sessions were more effective, therapeutically, with different patients. As shown in the second and third cases, an important element leading to change in many patients is interaction with the group, in addition to the content of session.

DISCUSSION

The program we use as a foundation in our study is a group therapy program prepared approximately 30 years ago by Clarke et al, for treatment of adolescents diagnosed with depression (13). This program was rearranged in accordance with experimental and theoretical insights acquired during of the last thirty years and was weighted towards the cognitive-behavioral orientation program. The basic objective of the program was for participants to replace their negative cognitive structures with more positive and realistic structures, and develop a more positive interaction within their environment as a result of these changing attitudes. Cuijpers and his colleagues assert that this group therapy program is the most widely used one, throughout the world, and the most widely researched group therapy program for the recent thirty years (13). This program has been translated into many languages and used in numerous places, first in the USA, and also in Canada, Finland, Germany, Mexico and Peru. The program is flexible and covers a broad range of content, and it is also used for groups other than those diagnosed with depression within the scope of treatment and protective mental health with the appropriate arrangements and amendments. In a meta-analysis study composed of 25 studies conducted to evaluate the efficacy of the program, the efficacy of the treatment is high (13). With this program as a foundation, we prepared and applied a group therapy program composed of 12 sessions.

In evaluating sessions at the end of group therapy, the majority of adolescents completing the group therapy said that the therapy process helped diminish their psychiatric problems and improved their interpersonal and family dynamics. Similar feedback came from the psychiatrists and psychiatry residents who are following the adolescent participants. This feedback leads us to believe that, in addition to group therapies for only a certain group of diagnosis (e.g.; only group of patients with depressive disorder), a general cognitive-behavioral coping program for groups of patients with different diagnoses (as in our study, the group of patients with depressive disorder, anxiety disorder and behavioral disorder) can be of great use for patients.

Including an additional or parallel session for parents of the patients included in the program can also increase the effectiveness of therapy. Brent et al, in their studies, compared the effectiveness of cognitive-behavioral group and family therapy with the adolescents diagnosed with depression according to DSM-IV diagnosis measures, and stated that there is not a significant difference between the two groups in terms of treatment effectiveness (14). However, David-Ferdon and Kaslow examined the studies researching the efficacy of cognitive-behavioral group and family therapy, and stated that simultaneous implementation of both therapies produces better results in terms of effectiveness (15).

Another issue requiring study would be why participants discontinued the treatment. It is believed that lack of motivation on the part of the adolescents may play a role in their decision to discontinue the therapy. Many participated in the therapy process in accordance with the desires of their parents and there were also issues with school absenteeism: these are also leading factors in the decision to discontinue therapy. Students also had problems attending the program while they were attending school. Observations and these insights indicate that attendance rates for treatment might be better if these programs were conducted during holidays.

Although participants, their parents and the psychiatrists offered positive feedback about the

therapy process, it is believed that it will be more expedient to determine the efficacy of the therapy process in quantity through administration of the preliminary test and final test, and this will contribute to the literature in this respect.

Rohde et al examined the effect of an additional diagnosis in adolescents with major depression on the effectiveness of cognitive-behavioral group therapy, and they determined that anxiety disorder accompanied by depression does not adversely affect the effectiveness of group therapy and concomitant misuse/addiction of drugs slows down the process of improvement (16). However, the researchers state that adolescents diagnosed with destructive behavioral disorder. in addition to major depression are treated because the diagnosis of major depression recurred in the periods after group therapy. In light of this information, it would be appropriate to evaluate the adolescents accepted into the group therapy program in terms of co-morbidity.

A study conducted by Clarke et al, examined the effect of follow-up sessions to determine signs and recurrence of depression after completing group therapy. (10). The research indicates that the follow-up sessions increase the effectiveness of treatment in the adolescents who continued to display signs of depression at the end of group therapy. It would be appropriate to arrange follow-up sessions for the participants who continue to show signs of depression at the end of group therapy.

Limitations of the Study:

The primary limitation of our study is that we did not use an interview chart structured for the clinical diagnosis of the patients and the evaluation scales at the beginning and end of the therapy program. Not using an objective evaluation scale where the benefit of the program is evaluated by the participants is a limitation. Also, sessions were conducted twice per week in the first 3 out of 10 therapy groups, and they were conducted just once per week in the remaining therapy groups, and treatment results were not compared between these two groups. It should be

considered that the frequency of the therapy sessions may affect the results of treatment.

CONCLUSION

Despite the limitations mentioned above, we think

that this cognitive-behavioral group therapy program for adolescents is a useful, practical and easily applicable program. Similar treatment programs should be more widely used in Turkey and further studies should be conducted together with quantitative evaluations in this respect.

REFERENCES

1. Costello EJ, Mustilla S, Erkanli A, Keler G, Angold A. Prevalence and development of psychiatric disorders in childhood and adolescence. *Arch Gen Psychiatry* 2003;60:837-844.
2. Kolvin I, Barrett ML, Bhat SR, Berney TP, Famuyiva OO, Fundidis T, Tyrer S. The newcastle child depression project: Diagnosis and classification of depression. *Br J Psychiatry* 1991;159 (Suppl.11):9-21.
3. Harrington RC. Affective Disorders: In Rutter M, Taylor E, Hersov L (editors). *Child and Adolescent Psychiatry: Modern Approaches*. Oxford: Blackwell Scientific, 1994, 330-350.
4. Weersing VR, Brent DA. Cognitive behavioral therapy for depression in youth. *Child Adolesc Psychiatr Clin N Am* 2006;15:939-957.
5. Reinecke MA, Ryan NE, Du Bois DL. Cognitive-behavioral therapy of depression and depressive symptoms during adolescence: A review and a meta-analysis. *J Am Acad Child Adolesc Psychiatry* 1988;37:26-34.
6. Hoag JM, Burlingame MG. Evaluating the effectiveness of child and adolescent group treatment: A meta-analytic review. *J Clin Child Psychol* 1997;26:234-246.
7. Riggs PD, Mikulich-Gilbertson SK, Davies RD, Lohman M, Klein C, Stover SK. A randomized controlled trial of fluoxetine and cognitive behavioral therapy in adolescents with major depression, behavior problems, and substance use. *Arch Pediatr Adolesc Med* 2007;161:1026-1034.
8. Hayward C, Varady S, Albano AM, Thienemann M, Henderson L, Schatzberg AF. Cognitive-behavioral group therapy for social phobia in female adolescents: Results of a pilot study. *J Am Acad Child Adolesc Psychiatry* 2000;39:721-726.
9. Clarke G, Lewinsohn P, Hops H. Adolescent coping with depression course. http://www.kpchr.org/public/acwd/CWDA_manual.pdf
10. Clarke GN, Rohde P, Lewinsohn PM, Hops H, Seeley JRJ. Cognitive-behavioral Treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *J Am Acad Child Adolesc Psychiatry* 1999;38:272-279.
11. Loeber R, Keenan K. Interaction between conduct disorder and its comorbid conditions: Effects of age and gender. *Clin Psychol Rev* 1994;14:497-523.
12. Albano AM, Krain AL, Podniesinski E, Ditzkowsky KS. Cognitive-Behavioral Therapy with Children and Adolescents: In Wright JH (editor). *Cognitive-Behavioral Therapy; review of psychiatry*. Washington DC: American Psychiatric Publication, 2004, 123-150.
13. Cuijpers P, Muñoz RF, Clarke GN, Lewinsohn PM. Psychoeducational treatment and prevention of depression: The "coping with depression" course thirty years later. *Clin Psychol Rev* 2009;29:449-458.
14. Brent DA, Holder D, Kolko D, Birmaher B, Baugher M, Roth C, Iyengar S, Johnson BA. A clinical psychotherapy trial for adolescent depression comparing cognitive, family and supportive therapy. *Arch Gen Psychiatry* 1997;54:877-885.
15. David-Ferdon C, Kaslow NJ. Evidence-based psychosocial treatments for child and adolescent depression. *J Clin Child Adolesc Psychol* 2008;37:62-104.
16. Rohde P, Clarke GN, Lewinsohn PM, Seeley JR, Kaufman NK. Impact of comorbidity on a cognitive-behavioral group treatment for adolescent depression. *J Am Acad Child Adolesc Psychiatry* 2001;40:795-802.