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My therapy

Visagie, HMP

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THERAPY

Patient Work Book: Nurse-led Cognitive Behavioural Group Therapy
Compiled by: HMP Visagie, Mafube Affective Ward / FSPC
Mentor: Dr E du Plessis, Principal Clinical Psychologist / FSPC
Supervisor: Mrs A van den Heever, Department Nursing Education / University of the Witwatersrand, Johannesburg

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ORIENTATION AND INTRODUCTION – ANNEXURE A:

A special letter to you -

Our client!!

Dear Patient

The following information serves first of all to welcome you to our ward, but also to explain ***"what"*** *you can expect during your stay. At the same time you will also be familiarized with regard to your responsibilities whilst being admitted. Patients treated in our ward benefit from an intensive psychosocial, multi-disciplinary rehabilitation programme.*

Our aim is to empower our patients - ***that is you*** *- by providing* ***specific psychotherapeutic interventions (Cognitive Behavioural Group Therapy)*** *as well as* ***educational information*** *in order assist you to effectively deal with the impact of mood disorders; life traumas & personal challenges. You will also benefit from* ***learning*** *different coping strategies.*

Our multi-professional team consists of the following members:

- ***Ward consultant [Psychiatrist];***
- ***Ward doctor [Registrar – psychiatry];***
- ***Nursing personnel;***
- ***Psychologist;***
- ***Occupational therapist;***
- ***Physiotherapist*** *[on a referral basis];*
- ***Social worker;***
- ***Dietician*** *[on a referral basis]*

Each *of the abovementioned members will make a* ***specific, unique contribution*** *regarding your* ***treatment regimen / plan*** *as well as pertaining to* ***specific***

therapeutic interventions. *Each and every discipline plays a vital role in the process of* ***personal development and growth.*** ***NB! Remember so do you!!*** *Different contributions from different members of the multi-professional team will be explained to you by the person representing that specific discipline.*

Admission to our ward will provide you with a therapeutic environment that represents certain aspects of your life. As mentioned earlier we strive to provide a therapeutic environment in which you ***"can"*** *learn adaptive coping, interaction and relationship skills that can be generalized to other aspects of your life.*

Hence the purpose of your admission and treatment in Mafube are to enable you to make ***substantial changes*** *in your immediate life circumstances and environment*. A person can therefor reason that personnel attending to your needs; acts as* ***'agents of change'*** *accompanying you on your therapeutic journey.*

During your journey in Mafube, you will participate in ***group therapy sessions.*** *These sessions consist of* ***9 sessions*** *and are conducted by the* ***Professional Nurses*** *in the ward. Sessions will take approximately* ***60 – 90 minutes.*** ***Group therapy sessions*** *are conducted under the supervision of a Principal Clinical Psychologist.*

Group therapy sessions will introduce you to the ***concepts of Cognitive Behaviour Therapy*** *– the key to* ***change.*** *You will learn how* ***'thoughts, feelings and behaviour'*** *influence each other / how these aspects contribute to your mood.*

You will realize that your feelings / ***emotions*** *are* ***influenced*** *by your* ***perceptions*** *and* ***thoughts*** *about* ***life events,*** *and not always by the event itself. These thoughts can be* ***realistic or unrealistic*** *as compared to the event itself.*

You will be familiarized with the concept ***"dysfunctional thoughts".*** *Group therapy sessions will also assist you to be able to recognise* ***automatic thoughts*** *(unhelpful thinking). You will learn how certain* ***styles of thinking*** *can lead to* ***distress;*** *as well as* ***strategies*** *to* ***counteract these thoughts.***

Group therapy sessions offered are based on ***"Cognitive Behavioural Therapy"*** *and entail the following themes:*

PART 1:

Session 1: *Understanding depression*

Session 2: *Socialization of cognitive behavioural therapy (CBT) model.*

Session 3: *It's all about thoughts (how thoughts affect my mood).*

Session 4: *Cognitive errors (mistakes in thinking)/ challenging unhelpful thoughts.*

PART 2:

Session 5: *Behaviour and depression.*

Session 6: *Behavioural activation.*

Session 7: *Mastery and meaning.*

Session 8: *Hopelessness, unhelpful thinking / behaviour and suicide.*

Session 9: *Bringing it all together ..... planning for the future.*

You will be required to sign a contractual agreement – ***personal contract*** *(please see example,* ***Annexure B)*** *to participate in the group sessions. It will also be expected of you to comply with appropriate homework assignments, as well as to honour group rules as specified (please see* ***Annexure C).***

NB! *It is important to note that the principles underlying your stay in Mafube as well as attending group therapy can be applied in all spheres of your life, as well as be implemented by any person who might benefit from such interventions. Furthermore, participation in these groups and interaction with fellow group members will enable you to realize that you are not on your own.*

Finally – ***Why group therapy?***

(Yalom, 1985:13) quoted the following story about a rabbi who had a conversation with the Lord about Heaven and Hell: "I'll show you Hell" said the Lord, and led the rabbi into a room in the middle of which was a very big round table. The people sitting at the table were famished and desperate. In the middle of the table was an enormous pot of stew, more than enough for everyone. The smell of the stew was delicious and made the rabbi's mouth water.

However, there was a problem; the people around the table were holding spoons with very long handles. Each person found that it was just possible to reach the pot to take a spoonful, but because the handle of the spoon was longer than anyone's arm, no one could get the food into his mouth. The rabbi realized that their suffering was indeed terrible. "Now I'll show you heaven," said the lord, and they went into another room, exactly the same as the first. There was the same big round table and the same pot of stew. The

people, as before was equipped with the same long-handled spoons – but here they were well nourished, laughing and talking. The rabbi could not understand this. "It is simple" said the Lord, "But it requires a certain skill. This group has learned to feed each other".

The essence of attending group therapy is - We receive through giving!

Compiled by the Nursing staff *– Mafube Affective Ward.*

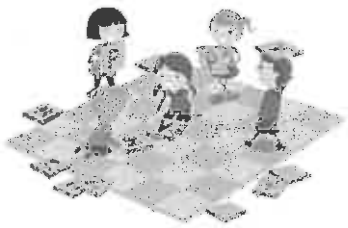
PERSONAL CONTRACT – ANNEXURE B

I, _____ hereby commit myself to the following:

- To participate in group sessions.
- Not to discuss any personal information of group members with people outside the group.
- To respect all information regarding other group members as confidential.
- To do homework assignments.

Signed: _____ Date: _____

1. Rules – Therapeutic groups (ANNEXURE C):



Please familiarize yourself with the following group rules. Also feel welcome to add anything which you might feel is important.

- Arrive on time and remain for the entire session.
- Attend every session / make appropriate arrangements if you have other commitments.
- Cell phones should be turned off unless you expect an emergency call. In such cases please inform the group leader beforehand.
- Be supportive of each other, but still respect personal boundaries of other group members.
- Be constructive during group participation:
    - Avoid negative criticism, give constructive feedback.
    - Listen and think before you respond to a fellow group member. Different words and phrases might be perceived differently by different group members. Be caring and thoughtful.
- Talk about yourself and your own experiences. Do not challenge the validity of other's experiences.
- Do not generalize from your own experience and feelings to the experience and feelings of others.
- Equal time for all: Give everyone a chance to speak and do not interrupt a fellow group member. Do not engage in conversations on the side. This will distract other

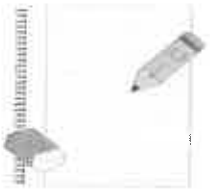
group members and you will miss important information, as well as different insights from the group.

- Keep it practical: Focus on solutions and not on how bad things are.
- Do homework assignments: Practice what you learn. You will only learn how to manage depression effectively if you practice strategies offered during the sessions. Doing homework assignments will also assist you to look at certain aspects of your life more objectively.
- Confidentiality: Do no discuss personal things mentioned during sessions with people outside the group. However, you may tell other people about the principles that you are learning. Do not talk about the people that are in the group.
- When you are unhappy: Please mention your concerns during group sessions. Do not remain unhappy.
- Come back to the group: Do not drop out. Tell us if you are unhappy, then we can work things out.
- Be constructive during group participation.
    - Avoid negative criticism, give constructive feedback.
    - Be caring and thoughtful.
- Equal time for all.
    - Give everyone a chance to speak.
    - Do not interrupt a fellow group member.
    - Do not engage in conversations on the side. This will distract other group members and you will miss important information, as well as different insights from the group.
- Keep it practical.
    - Focus on solutions and not on how bad things are.
- Do the homework assignments.
    - Practise what you learn.
    - You will only learn how to control depressive and anxious feelings if you practise.
    - Doing homework will help you look at certain aspects more objectively.

Note:

- Time: Group sessions will take approximately 60 – 90 minutes.
- Benefits of attending / participating in group sessions:
    - You will realize that they are not struggling alone.
    - You will learn how others perceive and understand certain aspects differently.
    - Group interaction can facilitate emotional support.
    - Attending group therapy will assist you to look at certain aspects more objectively.

(Johnson, 2013:370).



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SESSION 1: UNDERSTANDING DEPRESSION

A. Purpose of this session:

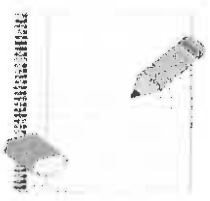
- To understand depression in terms of symptoms and available treatment.
- Understanding my 'world of reality' this point in time.

B. Depression:

1. Understanding depression:

1.1 What is depression? How do you experience depression?

How do you see depression? If you were asked to give a definition for depression, what would your answer be? This aspect will also be explored during group interaction.



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1.2 Defining depression:

Definition: Depression is a mental condition (mood disorder). People suffering from depression feel intensely sad, down and hopeless. Depression affects a person's thinking, feelings, behaviour as well as interaction with other people.

Depression is a clinical condition that causes us to experience severe emotional pain. Our functioning levels are also influenced by depression to the extent that we can no longer adequately fulfil our daily activities.

1.3 Symptoms of depression:



Experiencing a low mood from time to time is normal. However, when the intensity becomes severe, or the period becomes prolonged to the extent that our functioning level is hampered – we become clinically depressed.

The following symptoms are generally experienced by patients suffering from depression (see list below):

- Extremely depressed mood, for most of the day over a prolonged period.



- Experiencing a loss of interest in pleasurable activities. Not being able to enjoy activities you previously enjoyed doing.

- Thought patterns are negative, pessimistic and evident of profound hopelessness.





- Experiencing recurrent thoughts about death; suicide; self-blame and self-criticism.

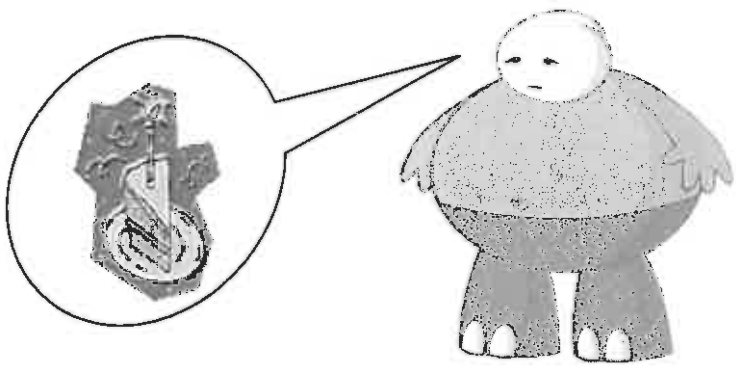
- Feelings of guilt, anger, anxiety and worthlessness.



- Difficulty in concentrating and making decisions.
- Inability to manage stress.
- Insomnia (changes in sleeping pattern). Some of us will find it difficult to fall asleep, whilst some of us will wake-up frequently during the night. Others will go to sleep, only to wake up very early in the morning. Some of us might be unable to sleep for a prolonged period of hours.

  Insomnia will result in experiencing fatigue (tiredness) as well as feeling demotivated. Your may have a decreased level of energy. It is also important to note that some of us may experience hypersomnia (sleeping for prolonged periods of time). You might simply be hiding or just feel so tired that you need to sleep all the time.

- Changes in appetite: Some people won't have any appetite and might lose weight. Others might have an increase in appetite resulting in weight gain. This can have an influence on our self-esteem and body image.



- Avoiding social interaction with others. People with depression have a tendency to avoid other people, isolating themselves.

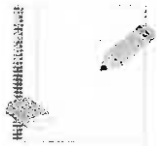
- Depression influences our functioning level. Therefore our family life, work life as well as recreational life will change.

- Behavioural changes. For example changes in movement. We may experience that they cannot move as quickly as previously (this called psycho-motoric retardation). On the other hand some of us may feel restless, agitated and irritated.

Use the space below to list some of the symptoms experienced by you. During the group discussion you will become aware of other patients' symptoms. Thus you will realize that you are not alone in this.

(Use the worksheet below to list your symptoms).

What are some of your symptoms of depression?



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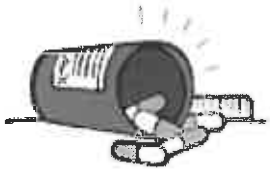
2. Different ***treatment options***:

2.1 Biological / Medical treatment (Discuss the following with patients):



Treatment is based on different theories related to what causes depression. Causes can relate to biological factors e.g. changes in brain functions / brain chemistry. Over the years research has found evidence that certain neuro-chemicals are dysfunctional in people with depression, causing what is commonly referred to as "chemical imbalances".

Medication is used to treat the biological aspects of depression. These are called anti-depressants. Anti-depressants help to restore "chemical imbalances" in the brain. There are various different types of antidepressants and your psychiatrist will prescribe the most suitable anti-depressant that meets your clinical needs. For example: If you feel agitated and struggles to sleep you may benefit from medication that is more sedative in nature (helping you to sleep better and feel less irritated).

Medication will help your mood to "lift" as well as restore your level of energy. Your concentration and appetite may also improve when taking anti-depressants. Anti-depressants will also assist you to respond more appropriate when faced with stressful life events.

Important note: Anti-depressants are not addictive. Quite a number of patients usually are concerned with the side-effect of anti-depressants. All medication has side-effects. During research and clinical trials all side-effects has to be listed. However, all patients do not necessarily experience all the side – effects. Side – effects usually clear within ± 2 weeks when our bodies get used to the medication.

Medication, although important, does not represent the focus point of group sessions. However, if you need more knowledge related to the medical treatment of depression, an additional session can be arranged with the attending psychiatrist.



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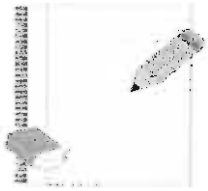
2.2 Psycho-social interventions:

Are there other possible causes of depression? Can you think of any?

For example:

- Stressful life events.
- Grief and loss.
- Problems with interpersonal relationships (conflict).
- Physical ill health.

At this stage you probably realize that the cause of depression is multi-factorial. Therefore treatment is based on "How depression is viewed?"



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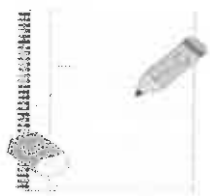
EVERYDAY LIFE EVENTS:





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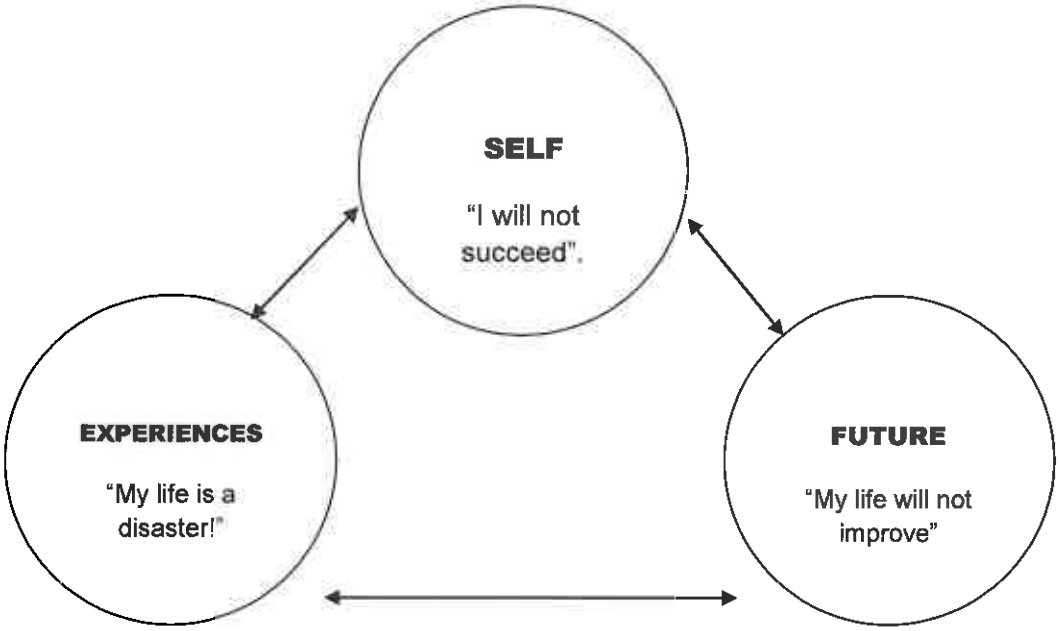
C. BECK'S COGNITIVE MODEL OF DEPRESSION:

1. "HOW DO *WE* SEE DEPRESSION?"

The theoretical approaches that underline our treatment approach are based on Beck's cognitive theory of depression. According to this approach depressed people have **negative ways** of **thinking** about **themselves, their experiences** and their **future** (see diagram below). This is referred as to as the **"Negative Cognitive triad".** The above-mentioned aspects will formulate the core of group sessions offered in the unit.

Negative Cognitive Triad:



Practical exercise (Negative Cognitive Triad – Hand-out):

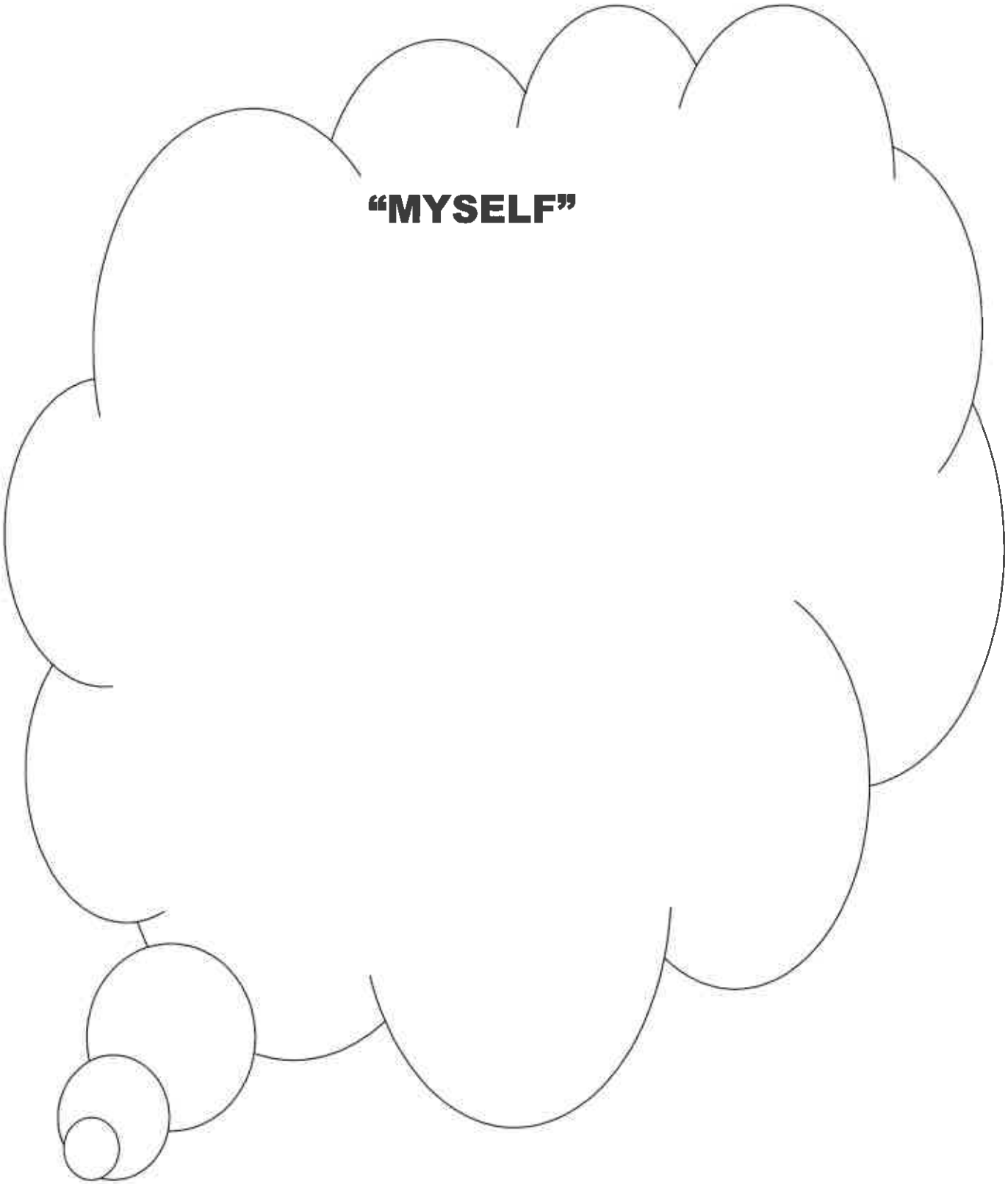
During this exercise you will be given the opportunity to explore Beck's Cognitive model of depression – **"My Cognitive Triad"- How do I see / think about "myself", my "experience / life events" and my "future".**

Utilize the worksheets below for the abovementioned exercise. You have to do some introspection and explore how you see yourself, your experiences as well as future. This exercise has to be repeated at the end of the nine (9) sessions.

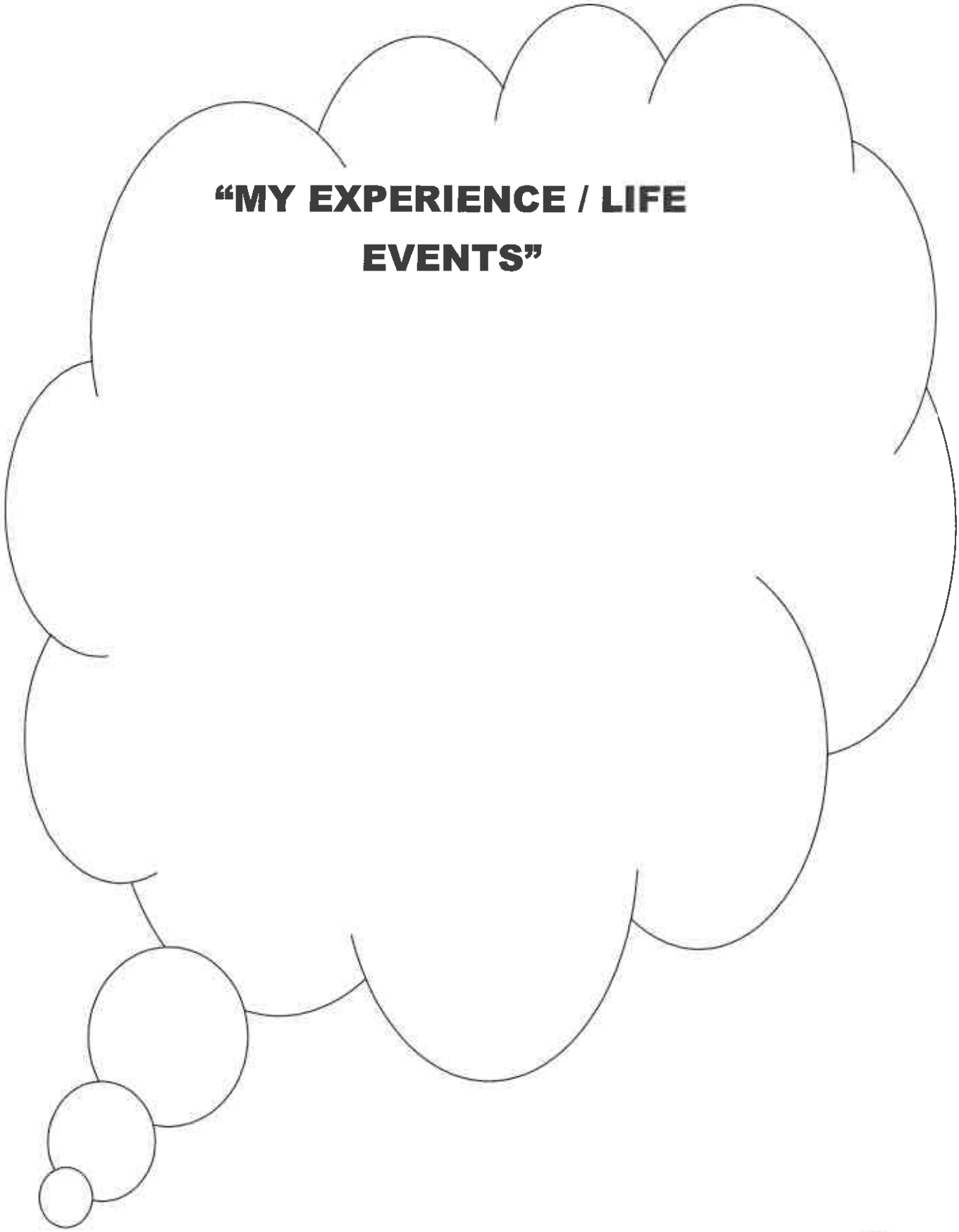
The purpose of repeating this exercise is to determine objectively how your viewpoint has changed pertaining to "How you see yourself, your experiences as well as your future?"

"MY COGNITIVE TRIAD"

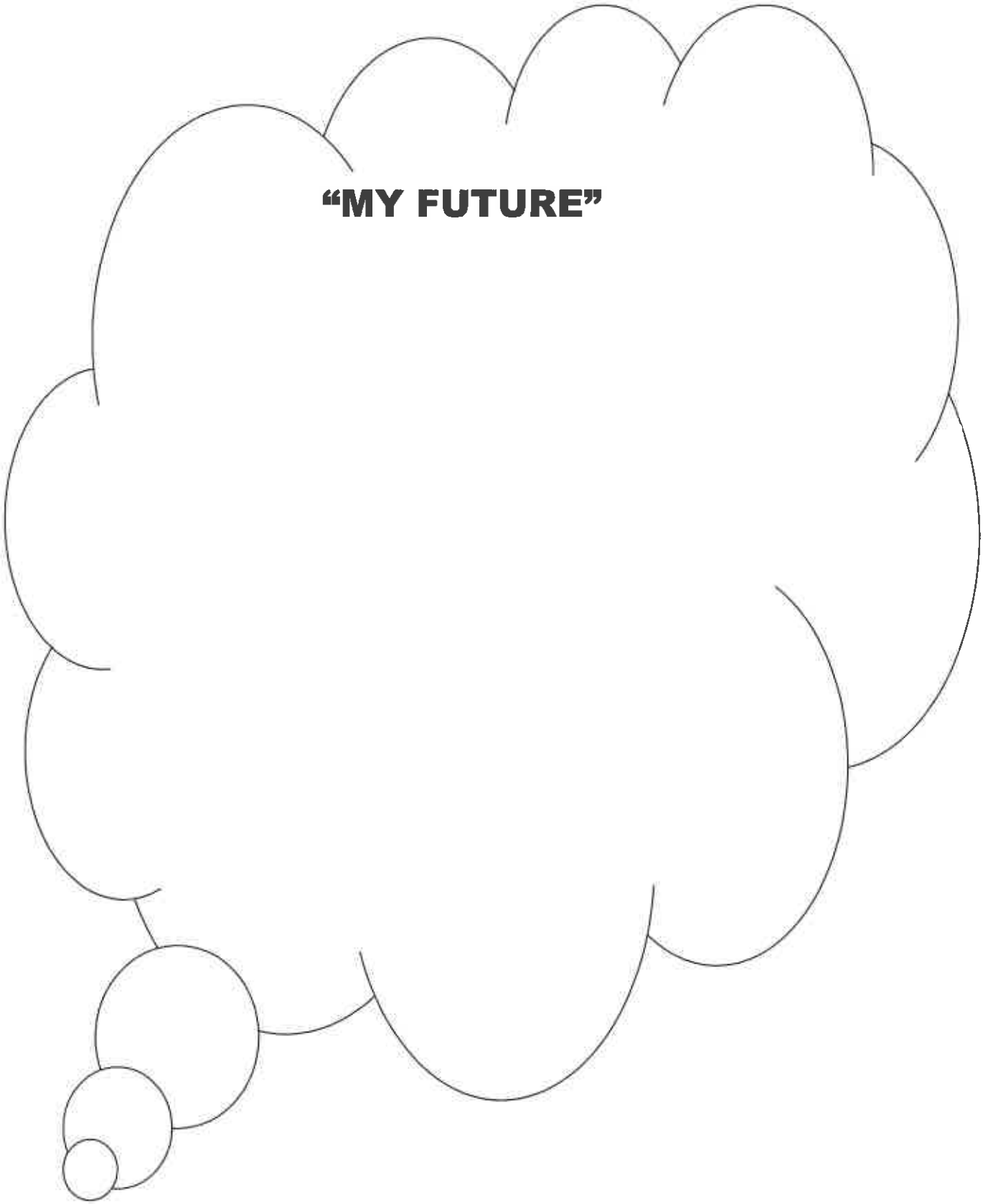
"HOW DO I SEE / THINK ABOUT.....?"



"HOW DO I SEE / THINK ABOUT.....?"



"HOW DO I SEE / THINK ABOUT.....?"



D. INTRODUCTION TO COGNITIVE BEHAVIORAL THERAPY (THEORETICAL MODEL):

As mentioned earlier, the type of therapy that formulates the core of our group sessions are - **"Cognitive Behavioural Therapy"**.

- **"Cognitive"** refers to our **"thoughts".**
- **"Behaviour"** refers to our **"behaviour / actions".**
- **"Depression / Anxiety"** refers to the **"feelings / emotions"** we experience.

1. WHAT IS CBT (Cognitive Behaviour Therapy)?

Cognitive behaviour therapy focuses on the significant role of thoughts and behaviour in your emotions. This has the following implication: The way YOU think and behave impact directly on YOUR emotions.

From a treatment perspective, cognitive behaviour therapy is all about **"CHANGE".**

Thoughts, behaviour and emotions are interrelated. This implies that by changing our thoughts and behaviours; we can also change our feelings / emotions.

When we are depressed, we are inclined to misinterpret information from our external environment. During this session we will become aware of how specific thought patterns affect our mood and behaviour. Thus, the purpose is to become **"agents of change"** in our own lives.



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2. THE ROLE OF THOUGHTS AND BEHAVIOUR IN EMOTIONS:

2.1 Thoughts, feelings & behaviour.

What is the difference between thoughts, feelings and behaviour?

- **Thoughts** refer to – the things we tell ourselves themselves (in our minds).
- **Feelings** refer to – the emotions we experience. For example anger; happiness; sadness; fearfulness etc.
- **Behaviour** refer to - the things we do (our actions), as well as the physical symptoms we experience e.g. sweating; running away; fighting, crying; avoiding etc.

Practical exercise (during group session): During this exercise we will explore the abovementioned concepts.

2.2 Monitoring and Recording your mood:

It is very important to monitor and record your mood on a daily basis. This will assist you to identify specific aspects that are directly linked with your current mood. You will use the worksheet **"Daily Mood Chart"** (p15) for this purpose.

Instruction for completing the "Daily Mood Chart":

Completing the **"Daily Mood Chart"** will assist you to objectively see how your mood changes from day to day. This will also enable you to effectively monitor your progress throughout the therapeutic process. Therefore you need to complete the **"Daily Mood Chart"** every day. During this exercise you should also indicate the number of positive and negative thoughts you experienced throughout every day.

You can complete the "Daily Mood Chart" before going to bed. You also need to reflect back on your mood during the course of the day and rate your mood accordingly. You have to encircle the number most appropriate to the mood you have experiences throughout the day.

Mood rating:

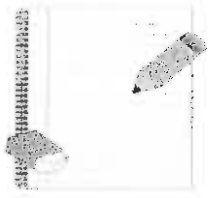
"9" – This is the best mood you experience e.g. the happiest they can be.

"5" – This is an average mood, experienced by us most of the time when not depressed.

"1"- This is the worst possible mood you experience. This number represents the worst day of your life.

You also need to indicate the number of positive and negative thoughts you have during the day. This aspect will assist you to directly link the type of thoughts you have when

experiencing a specific feeling / mood. This will also help you to become aware of your thoughts. The purpose of this part of the **"Daily Mood Chart"** is to prepare you for the following sessions related to **"thoughts"**.



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DAILY MOOD CHART (Muñdoz, R.F., Miranda, J. 2000:9)

Week Number : .....

No: .....

Day:	.....	.....	.....	,.....	.....	.....	.....
D (BEST)	**9**	**9**	**9**	**9**	**9**	**9**	**9**
A							
I	**8**	**8**	**8**	**8**	**8**	**8**	**8**
L							
Y	**7**	**7**	**7**	**7**	**7**	**7**	**7**
M	**6**	**6**	**6**	**6**	**6**	**6**	**6**
O							
O (AVERAGE)	**5**	**5**	**5**	**5**	**5**	**5**	**5**
D							
	4	**4**	**4**	**4**	**4**	**4**	**4**
S							
C	**3**	**3**	**3**	**3**	**3**	**3**	**3**
O							
R	**2**	**2**	**2**	**2**	**2**	**2**	**2**
E							
(WORST)	**1**	**1**	**1**	**1**	**1**	**1**	**1**

Number of thoughts:

Positive:	.....	.....	.....	,.....	.....	.....	.....
Negative:	.....	.....	.....	,.....	.....	.....	.....

DAILY MOOD CHART (Muñdoz, R.F., Miranda, J. 2000:9)

Week Number : .....

No: .....

Day:	.....	.....	.....	,.....	.....	.....	.....
D (BEST)	**9**	**9**	**9**	**9**	**9**	**9**	**9**
A							
I	**8**	**8**	**8**	**8**	**8**	**8**	**8**
L							
Y	**7**	**7**	**7**	**7**	**7**	**7**	**7**
M	**6**	**6**	**6**	**6**	**6**	**6**	**6**
O							
O (AVERAGE)	**5**	**5**	**5**	**5**	**5**	**5**	**5**
D							
	4	**4**	**4**	**4**	**4**	**4**	**4**
S							
C	**3**	**3**	**3**	**3**	**3**	**3**	**3**
O							
R	**2**	**2**	**2**	**2**	**2**	**2**	**2**
E							
(WORST)	**1**	**1**	**1**	**1**	**1**	**1**	**1**

Number of thoughts:

Positive:	.....	.....	.....	,.....	.....	.....	.....
Negative:	.....	.....	.....	,.....	.....	.....	.....

DAILY MOOD CHART (Muñdoz, R.F., Miranda, J. 2000:9)

Week Number : .....

No: .....

Day:	.....	.....	.....	,.....	.....	.....	.....
D (BEST)	**9**	**9**	**9**	**9**	**9**	**9**	**9**
A							
I	**8**	**8**	**8**	**8**	**8**	**8**	**8**
L							
Y	**7**	**7**	**7**	**7**	**7**	**7**	**7**
M	**6**	**6**	**6**	**6**	**6**	**6**	**6**
O							
O (AVERAGE)	**5**	**5**	**5**	**5**	**5**	**5**	**5**
D							
	4	**4**	**4**	**4**	**4**	**4**	**4**
S							
C	**3**	**3**	**3**	**3**	**3**	**3**	**3**
O							
R	**2**	**2**	**2**	**2**	**2**	**2**	**2**
E							
(WORST)	**1**	**1**	**1**	**1**	**1**	**1**	**1**

Number of thoughts:

Positive:	.....	.....	.....	,.....	.....	.....	.....
Negative:	.....	.....	.....	,.....	.....	.....	.....

E. Homework:

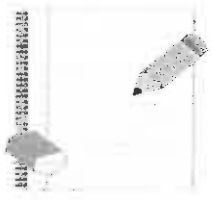
1. Record your mood on the – "Daily Mood Chart". This has to be done daily.

2. Record the amount of positive and negative thoughts experienced through the day.

3. Complete Beck Depression Inventory.

4. Read notes for the next session (Session 2 – Socialization of Cognitive behavioural model).

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).



My Notes: .....

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SESSION 2: SOCIALIZATION OF COGNITIVE BEHAVIORAL THERAPY (CBT) MODEL.

A. Introduction - Session 2:

During the previous session we explored our understanding of depression pertaining to the following:

- What is depression?
- Causes of depression.
- What kind of symptoms do the patients experience?
- How do we treat depression?

1. Purpose of session 2:

The purpose of session 2 is to gain a better understanding of "thoughts", "emotions" and "behaviour". During this session you will be guided to examine the relation between your "thoughts", "behaviour" & "feelings". These aspects will be explored by means of a practical exercise, as well as a homework assignment.

The aim of this session is to socialize you to the A – B – C model of emotional reactions.

Practical exercise: Read the following scenario and answer the questions below.

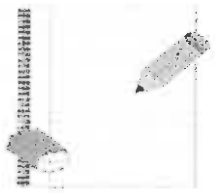
"You have to imagine that you are asleep at home. You suddenly wake up to the sound of braking glass". How did you feel and react?

- What would you think? E.g. there is an intruder!

- How would you feel emotionally? E.g. I felt scared!

- How would you feel physically (your body)? E.g. my heart started pounding.

- What would you do (action)? E.g. stood up to investigate; started crying; looked for something to defend myself with.



My Notes: .....

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After the abovementioned exercise read the scenario below (adjusted). Once again: How did you feel and react?

"When you stand up, you remember that you forgot to close the window and seemingly a vase was broken.

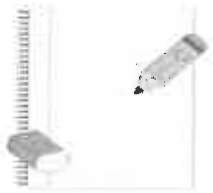
Respond to the very same questions previously asked pertaining to the scenario whilst considering newly acquired information.

- What would you think now, based on the new information? E.g. do you still think there is an intruder?

- How would you feel emotionally? E.g. are you still scared?

- How do you feel physically (your body)? E.g. is your heart still pounding?

- What actions would you take now that the situation has changed? E.g. Cleaning / Going back to sleep / Planning to fix broken window.



My Notes: .....

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The abovementioned activity allows you to examine how you interpret, think, feel and act in relation to different situations.

B. The A – B – C of thoughts, behaviour and feelings ..... ZOOMING IN:

1. The difference between "thoughts", "behaviour" & "feelings / emotions".

Let's look at the meaning of the following:

- **Thoughts** – the things we tell ourselves in our minds.
- **Feelings** – the emotions we experience. For example anger; happiness; sadness; fearfulness etc.
- **Behaviour** - the things we do (actions), as well as the physical symptoms we experience / the things our bodies do e.g. sweating; running away; fighting, crying; avoiding etc.

2. The three components of emotional reactions:

Emotional reactions consist of the following components.

- **Thoughts:** What a person says to themselves.
- **Behaviours:** What a person does when experiencing specific emotions.
- **Body's physiological reaction:** How a person's body reacts when experiencing specific emotions.



2.1 Understanding the A – B – C of emotional reactions (thoughts, feelings & behaviour):

2.1.1 What causes emotions?







Practical exercise: During this exercise you have to select a "mood face chart" that represents how you are currently feeling and pin it on the visual mood board that will be provided during the session. Answer the following question: "What do you think is the cause of your current feeling?" You can note the possible causes in the space provided below.

E.g.

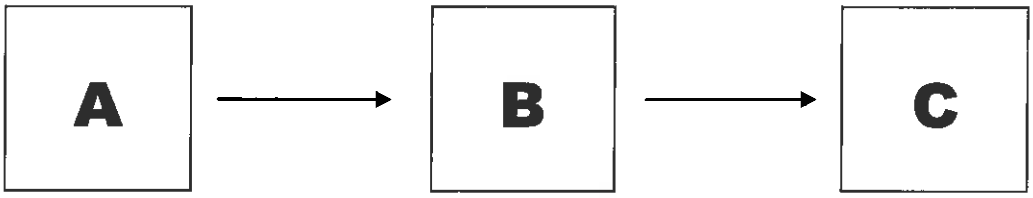


Why? What happened? .....

We often assume that emotions are merely the result of events experienced in everyday life. Thus, we feel and behave in a certain manner as a result of a specific event. This is referred to as the **"activating agent"**.

However, it is actually the **"perception"** we have of the event that causes us to feel and react in a certain manner. It is how we interpret and think about external events that

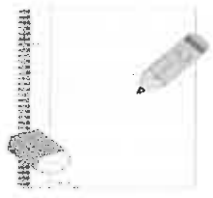
determine how we feel and react. Therefore, the meaning we assign to life events as well as our beliefs largely determines how we feel and how we react. Thoughts and perceptions are largely shaped by our life experiences.



A = Activating agent (Events in our world)

B – Thoughts / beliefs (How we perceive & interpret events)

C = Consequences (Emotions & behaviours)



My Notes: .....

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2.1.2 Thoughts.

As mentioned earlier "thoughts" are the things we tell ourselves about:

- Ourselves.
- Our experiences with our external world / other people.
- Our future.

Sometimes we are aware of these thoughts, whilst at other times we are not consciously aware of them. Our brain is a "thinking organ". We are in a constant conversation with ourselves (talking to ourselves), telling ourselves things about our **internal and external world** even though we are not always consciously aware of it.

The kind of thoughts we have will influence our mood as well as behaviour. Certain thoughts more likely result in a depressed mood, whilst other thoughts will less likely result in a depressed mood. This aspect will be explored in more detail during **Session 3.**

2.1.3 My emotions:

"Do you think emotions are important and necessary?" and if so, why? What is the importance of experiencing emotions (advantages / disadvantages)? Emotions assist us to measure our internal as well as external world. For example: What is good? What is bad? What is dangerous? What is safe & comfortable?

2.1.3.1 Defining emotion:

Emotion is our reaction to our internal as well as external world (our feelings). Emotions can act as a "warning system" to our environment as well as our interaction with other people.



My Notes: .....

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2.1.3.1.1 Negative versus positive emotions:

Emotions are negative when.....

- They are inappropriate e.g. laughing when you were in a motor vehicle accident.

- They are to intense (e.g. extremely angry; extremely sad; severely anxious).

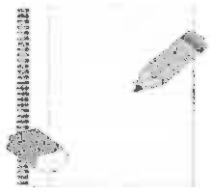
- Emotions cause discomfort. For example: resulting in negative symptoms (palpitations; headaches, nausea, sweating & loss of sleep.

- Emotions result in an inability to feel good about yourself.

- They stop you from achieving personal goals.

- They influence your social interactions negatively e.g. Not being able to interact with significant others.

- When they preoccupy your life to the extent that you are unable to participate in pleasurable activities / or experience pleasure in your life.



My Notes: .....

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2.1.3.2 Identifying emotions (group activity):

***ALL* people experience a wide range of emotions from time to time.** Please see examples below.

Earlier during the session you had to select a mood face character from the "Velcro mood face characters" (examples below). The mood character selected by yourself had to represent the most appropriate feeling currently experience by yourself. You were then given the opportunity to show the character chosen. You also had to elaborate on "why?" you have chosen that specific character. Now, let us explore a little further!







Aggressive	Angry	Safe	Depressed	Anguished
Bored	Cautious	Envious	Alone	Optimistic
Exited	Disgusted	Alienated	Confused	Anxious
Discouraged	Exhausted	Confident	Disappointed	Annoyed
Happy	Helpless	Embarrassed	Frightened	Curious
Innocent	Interested	Fearful	Hostile	Enthusiastic
Loved	Loving	Hopeful	Joyful	Frustrated
Paranoid	Peaceful	Jealous	Miserable	Humiliated
Sorry	Shocked	Mischievous	Puzzled	Jumpy
Surprised	Suspicious	Proud	Satisfied	Negative
Unmotivated	Pessimistic	Shy	Indecisive	Regretful
Wary	Energetic	Thoughtful	Flat	Stubborn
Affectionate	Cooperative	Terrified	Independent	Withdrawn
Agitated	Steady	Relaxed	Scared	Numb
Avoidant	Evasive	Inhibited	Isolated	Needy
Ecstatic	Insecure	Lethargic	Secure	Brave
Impulsive	Determined	Apathetic	Sad	Repelled
guilty	Vindictive	Relieved	Grief	Pained
Hysterical	Lonely	Jittery	Hurt	Placid

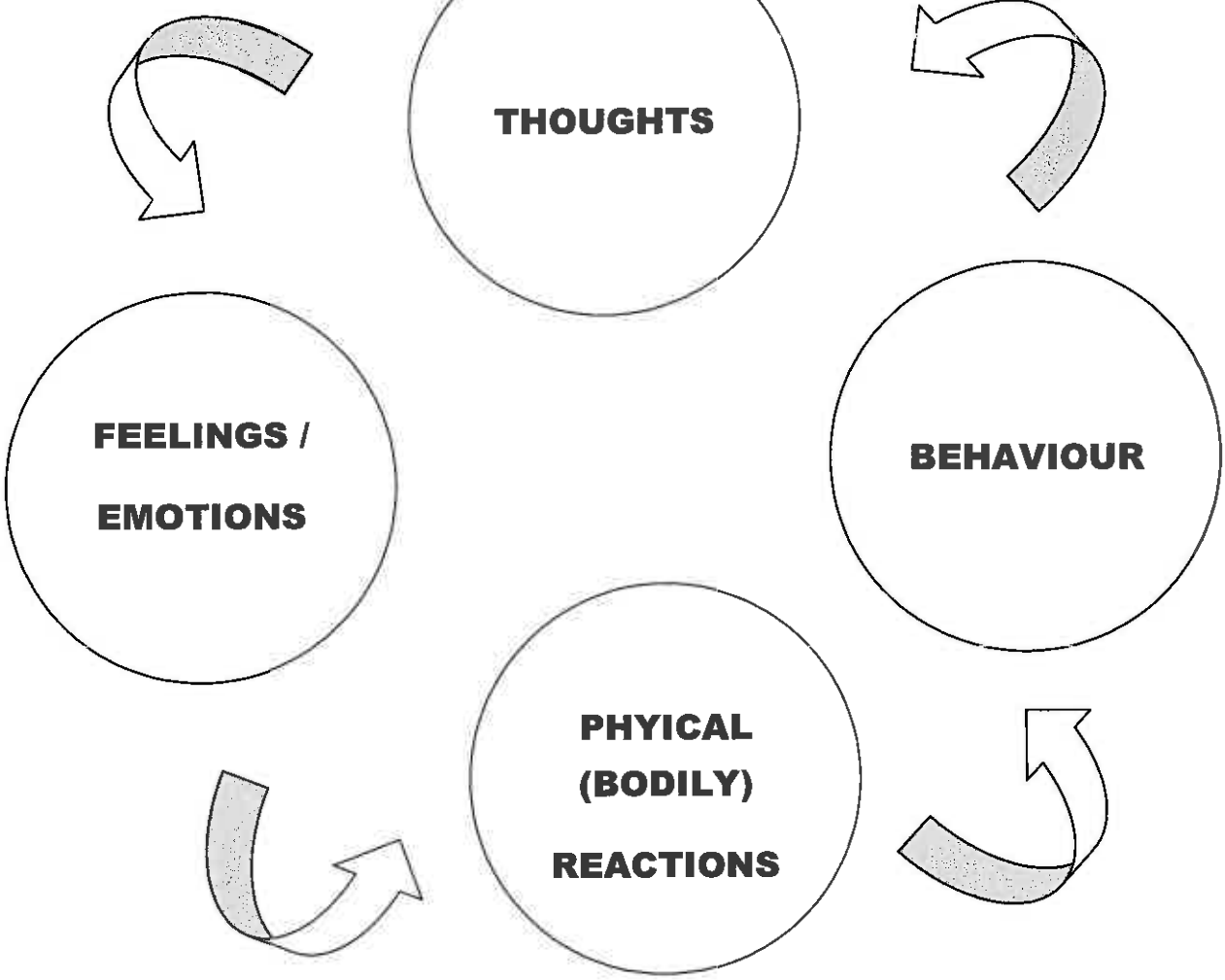
(Rosoman, C. 2008:50)

This exercise will assist you to objectively identify emotions experienced by you. This will also allow you to express your emotions in a safe / constructive manner.

3. EMOTIONAL REACTIONS - linking thoughts, emotions & behaviour:

External event (Activating agent):



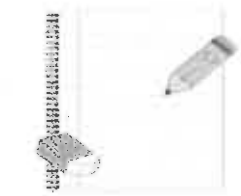


Practical exercise & Homework assignment: At this stage we will explore "how" to recognize and identify the link (relationship) between your thoughts, feelings and behaviour (A – B – C Model). Use the worksheet below. During the session you will be requested to give at least one (1) example.

3.1 A – B – C Worksheet (linking thoughts, feelings & behaviour):

Event: (What happened?)	**Thoughts:** (What did you think / tell yourself?)	**Emotions:** (How did you feel emotionally & physically?)	**Behaviour:** (How did you react?)

The abovementioned session as well as related practical exercises will help you to understand the A – B – C model of emotional reactions. Understanding this model is essential to Cognitive behavioural therapy (CBT) and fosters the possibility of hope and change in the therapeutic process (Freeman & Freeman, 2005:35). This aspect will also motivate you to actively participate in your own treatment / therapeutic process.



My Notes: .....

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D. Homework:

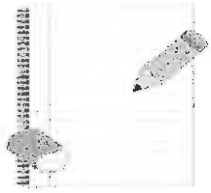
1. Continue with recording of your mood – "Daily Mood Chart "rating, as well as the amount of positive and negative thoughts experienced through the day.

2. Complete the "A – B – C worksheet"; linking thoughts, feelings and behaviour.

3. Complete the Beck Depression Inventory.

4. Please read the notes for the next session (Session 3 – How thoughts relate to my mood).

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).



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SESSION 3: IT'S ALL ABOUT THOUGHTS - HOW THOUGHTS AFFECT MY MOOD.

A. Introduction to Session 3:

Remember - thoughts are the things "I tell myself about; myself; my life & my future). Can you still remember the A – B – C model? Were you able to identify the link between feelings; thoughts and behaviour? What causes emotions (according to the A – B – C model)?

The purpose of this session is to:

- Explore how thoughts affect our mood?
- Differentiate between "depressed thinking "and "non-depressed thinking".
- Recognize different types of thinking.
- Learn about the process of "change".
- Analyse the way we think - **Schemas & Automatic thoughts.**

B. About thoughts in general:

Thoughts are part of our internal reality. Our minds are constantly processing information from our external as well as internal world. We process what happens in our lives with thoughts; we remember what happened to us with memories.

Certain thoughts are within our conscious awareness, whilst we are not aware of other thoughts. For example: The way we have learned to think and process information. We might have learnt to think and process information in such a manner that we never question these thoughts. These thoughts are hidden and form part of our internal reality and occur automatically (this aspect will be discussed later in the session).

1. Thoughts – How do thoughts affect my mood?

As previously discussed most people assumes it is the things that happen to them, that cause them to feel bad. However, during session 2 we learnt that it is actually our thoughts **(how we perceive & interpret events)** that cause the emotions experienced by us. **REMEMBER THE A – B – C MODEL!**

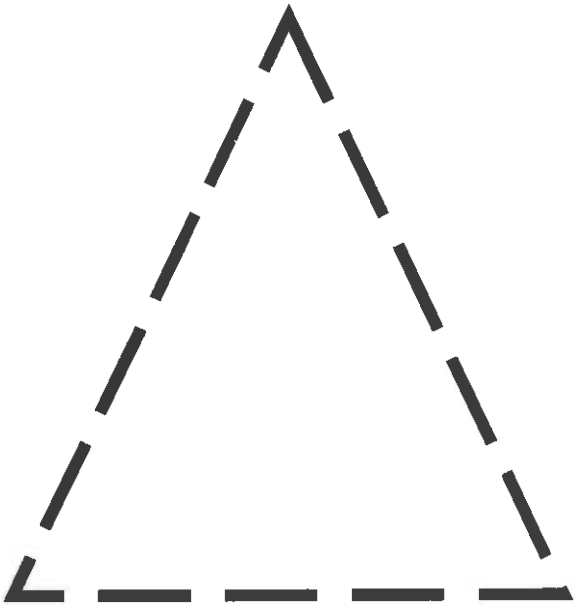
Thoughts are the things we tell ourselves about ourselves; the world and our future. Therefore, **depression is not merely caused by the things that happens to us, but rather by what we think about those events as well as ourselves.**

According to Beck's cognitive model, patients with depression have a **negative view** of **themselves**; the **world** as well as the **future** (called the **NEGATIVE COGNITIVE TRIAD**).

How do I see ..... MYSELF?









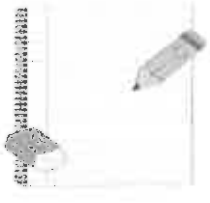
(Source - Illustrations: Videbeck, S.L. 2011)

How do I see the ..... WORLD? **How do I see the ..... FUTURE?**

During Session 2 we were made aware that it is not necessarily the things that happens to us (A – Activating agent), that causes us to feel and react in a certain manner.

Thoughts and beliefs regarding ourselves; as well as external events shape our emotions as well as how we react. Thus, the things we tell ourselves will have an impact on our mood, our bodies (how we physically feel) as well as our behaviour.

Some thoughts are more likely to result in a depressed mood, whilst other types of thoughts will make it less likely to feel depressed.



My Notes: .....

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1.1 When I'm depressed I think like .....

What are my thoughts like when I'm ..... depressed?

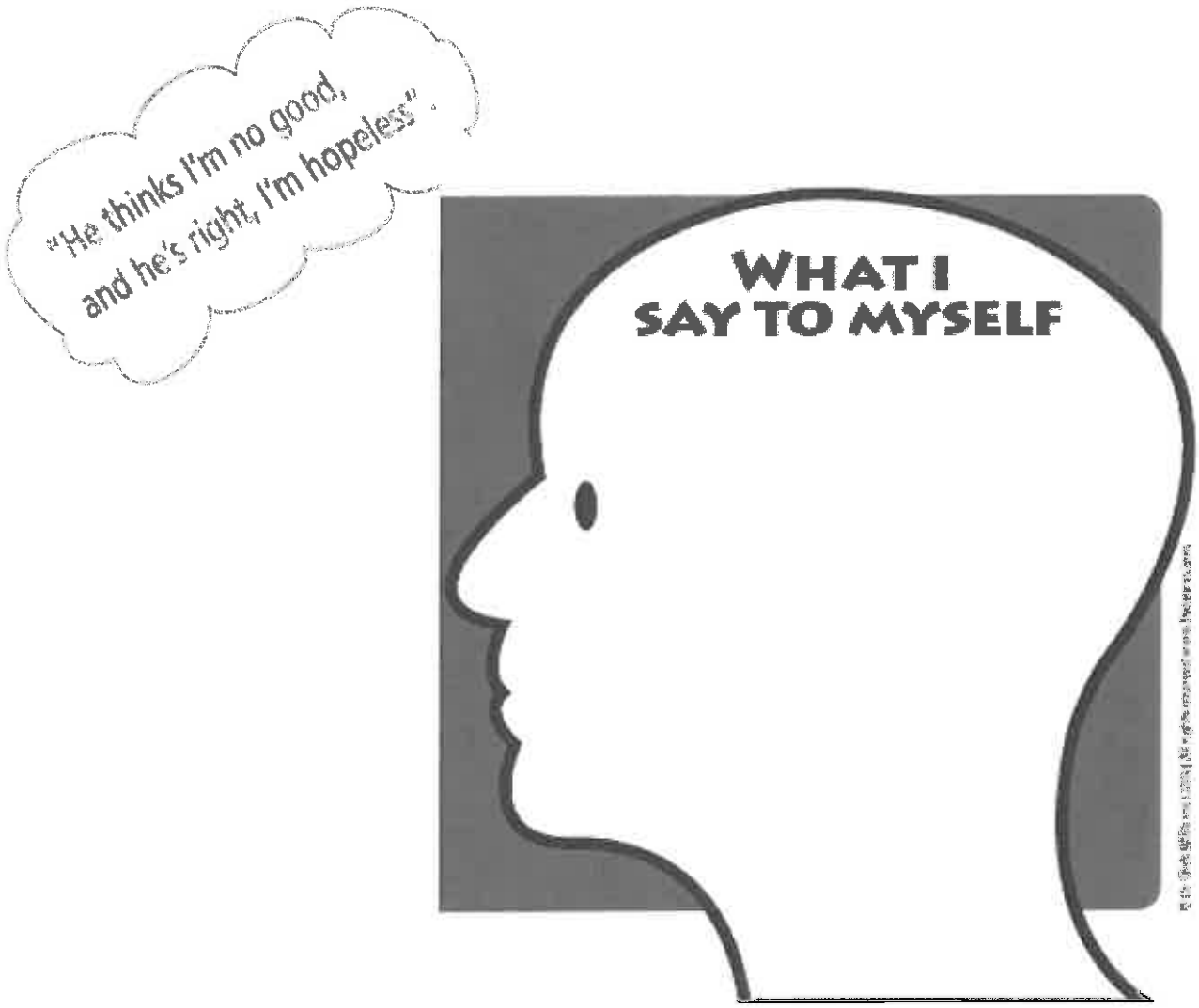
What do I tell myself when I'm feeling ..... depressed?

a. **Not flexible** – E.g. a person with depression will likely think: "I will never become better!", whilst a person with flexible thinking will more likely think: "Currently I'm being admitted for depression and attending group therapy. At least I'm seeking help and trying to feel better!

b. **Judgemental** – E.g. a person with depression might think: "My colleagues are upset with me. Nobody likes me!" Non-judgemental thinking will more likely be: "Yes, they are upset about my decision, but I cannot please everybody".

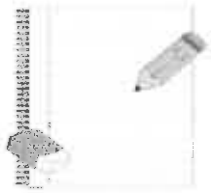
When struggling with depression, people often **"label"** themselves in a negative, self-destructive manner.

What do you tell yourself when you feel depressed? We will practise this exercise using the worksheet **"The things I tell myself" below".**



(Source: Williams, C. 2009)

When feeling depressed, people often **"label"** themselves in a negative, self-destructive manner. Brainstorm activity: Group members have to identify and write down examples of the negative thoughts they **"label"** themselves with (Please see worksheet below).



My Notes: .....

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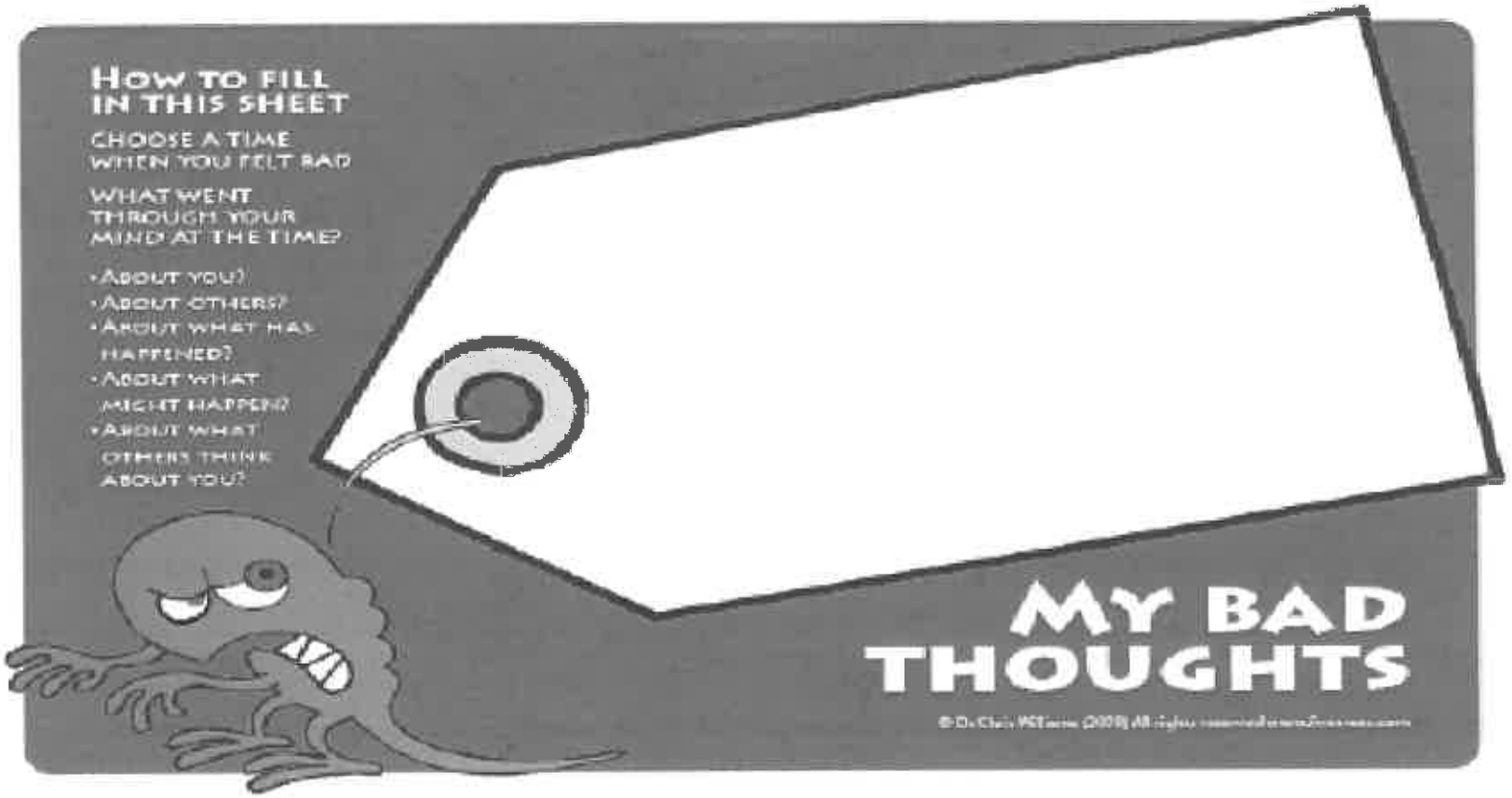
MY PERSONAL LABEL:



I'm a failure!!!!!!

HOMEWORK SHEET – MY BAD THOUGHTS (Source: Williams, C. 2009)

You have to choose a time when you felt bad; record the negative thoughts you had about yourself ; the event etc on the **"Bad Thought Label Worksheet"**- below.



1.2 What are my thoughts like when I'm ..... NOT depressed?

What do I tell myself when I'm ..... NOT depressed?

How will you explain "functional / constructive thinking"?

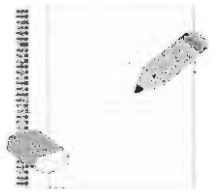
A. Flexible:

When we are not depressed, we will most likely think in a more **"flexible** "manner.

Examples:

Depressed thinking: "I could not submit the work in time. I'm useless!" This person "labels" him / herself in a destructive manner.

Non-depressed thinking: For example: "I had many obligations, and struggled to meet the deadline. But that does not mean that I'm irresponsible. I have worked hard and tried my best!"



My Notes: .....

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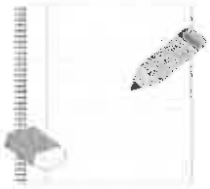
B. Looking at what I'm doing!

A **depressed person may think**: "I was born to suffer and struggle", whilst **a non-depressed person** most likely look at what they themselves are doing that may contribute to / or aggravate difficulties experienced in their lives. For example: "The things I do might be an obstacle in my life"



My Notes: .....

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C. Hope for "change":

Depressed thinker: "I will never get better!"

Non-depressed thinker: "I'm attending group therapy. This time I might actually feel better and learn a lot"



My Notes: .....

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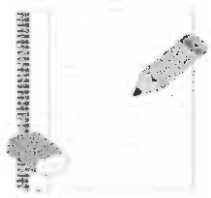
1.3 Learning to recognize the different types of thinking:

1.3.1 Constructive thinking versus destructive thinking:

Constructive thoughts "build" and empower us. Example: "If I take one step at a time, I will move forward.

Destructive thoughts simply does what is says. These thoughts "destruct" us. Example: "I will never accomplish my goal!"



My Notes: .....

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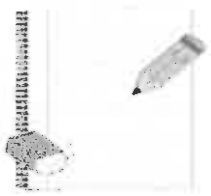
1.3.2 Necessary thinking versus unnecessary thinking:

Necessary thinking is goal directed in nature. These thoughts remind us of what is important in our lives / reminds us of things we have to do. For example: "I must remember to at least list on positive aspect of my life before I go to bed".

Unnecessary thinking does not play any role in empowering us; these thoughts only make us feel worse.



My Notes: .....

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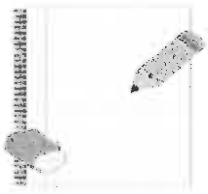
1.3.3. Positive thinking versus Negative thinking:

Positive thinking makes us feel better. For example: 'Being depressed makes me feel bad, but at least I'm attending therapy and trying to help myself".

Negative thinking drags us down, resulting only in feeling worse. Example: "This is a waste of energy".



My Notes: .....

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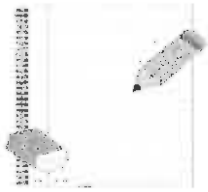
2. The process of change:

As discussed previously we are in a constant interaction with ourselves (by means of our thoughts, what we tell ourselves, how we label ourselves), our environment as well as other people. The good news is: **Chance in** one area will have an impact on the other area and vice versa.

The same applies to styles of thinking: Learning different, more functional styles of thinking will result in changes in our emotional status (our mood); as well as our behaviour. Hence there is **HOPE**.

However, change does not merely take place by simply replacing negative thoughts about yourself, external life events and the future with so called **"positive thinking".** The goal of therapy is to learn to restructure dysfunctional thought patterns to a more functional stance. By implication "learning" also implies the ability to effectively implement more functional thoughts.



My Notes: .....

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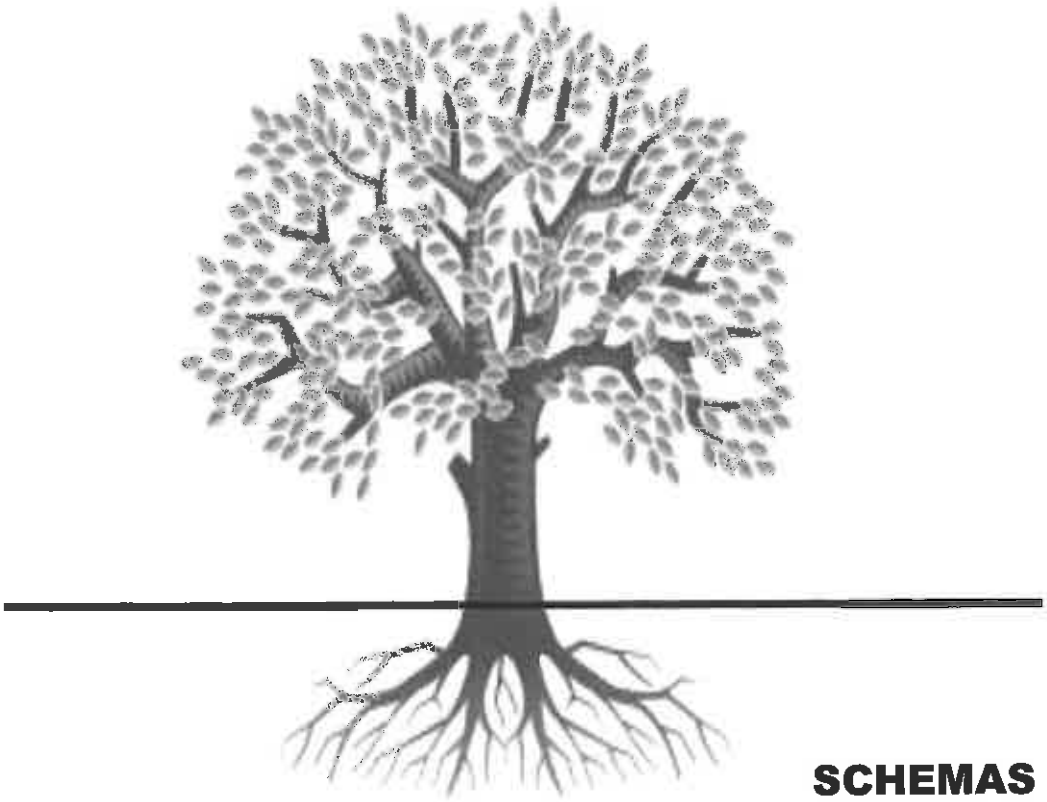
2.1 The way we think: Schemas & Automatic thoughts.

AUTOMATIC THOUGHTS



SCHEMAS (Core beliefs / assumptions)

2.1 Schemas:

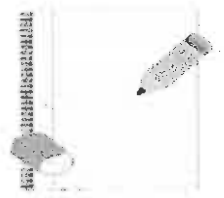
Throughout our lifetime we process information about ourselves; our world (environment & life experiences). Cognitive structures called **schemas** develop early in our life and are shaped by personal experiences, as well as interaction with significant others. Thus schemas (cognitive structures) are based on previous learning; previous life experiences. These **schemas** (cognitive structures) consist of our fundamental beliefs and assumptions.

Although **schemas** represent past experiences it is important to note that schemas also play an important role in the **organizing and structure of new experiences.** Our fundamental beliefs and assumptions are reinforced by new learning experiences and have an impact on the development of other beliefs, values as well as attitudes.

Schemas can be adaptive (functional) or maladaptive (dysfunctional). As previously mentioned schemas are deeper cognitive structures. Schemas remain dormant during non-stressful periods. However, these can become active when triggered by stressful life events. When information processing becomes dysfunctional (biased); **"schemas"** would constitute of a **negative theme** pertaining to the **self,** the **world** and the **future.** For example, a person with depression will think: "I'm incompetent!"

2.1.1 Adaptive & maladaptive schemas (examples):

SCHEMAS	
ADAPTIVE (Functional)	**MALADAPTIVE** (Dysfunctional)
People respect me.	No matter what I do, I won't succeed.
I'm lovable.	I'm unlovable.
Not much can scare me.	The world is too dangerous for me.
If I work on something, I can succeed.	If I chose to do something, I must succeed.
Whatever happens, I'll manage somehow.	I must be perfect, otherwise others won't accept me.
Others can trust me.	If I do not have a partner I am doomed.



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2.2 Automatic thoughts

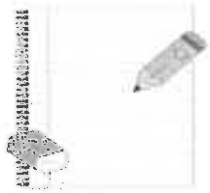
Automatic thoughts are those thoughts that arise automatically and rapidly when we are confronted with a specific situation, or when we remember a specific situation.

For example: **Driving an automobile.**

Think back to the period when you were learning how to drive. Each action was carried out with careful consideration (thinking) as well as deliberate intent and action.

Now, compare those actions with your actions after many years of driving. An experienced driver don't think how to change gears for example, this action is carried out automatically. The same applies for example to – looking in the rear-view mirror. The same applies to **automatic thoughts.**

Automatic thoughts are usually based on erroneous (faulty) logic. Irrespective of this, we accept these thoughts without rationally analysing these thoughts. We can access automatic thoughts by using specific questioning techniques. The **faulty logic** evident in **automatic thoughts** is called **cognitive distortions.**



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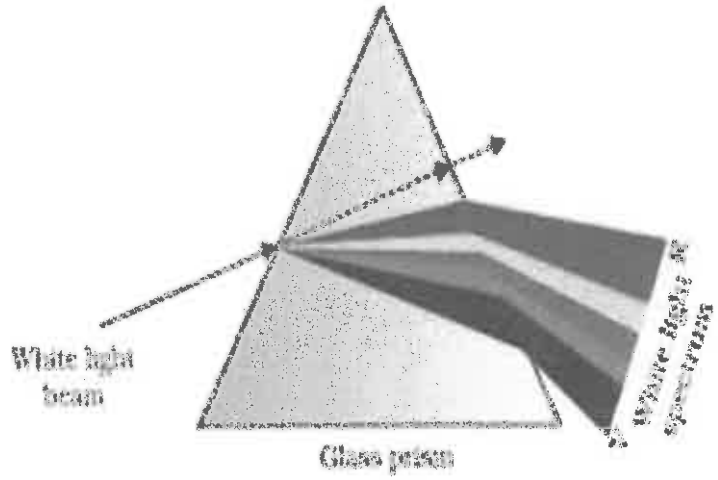
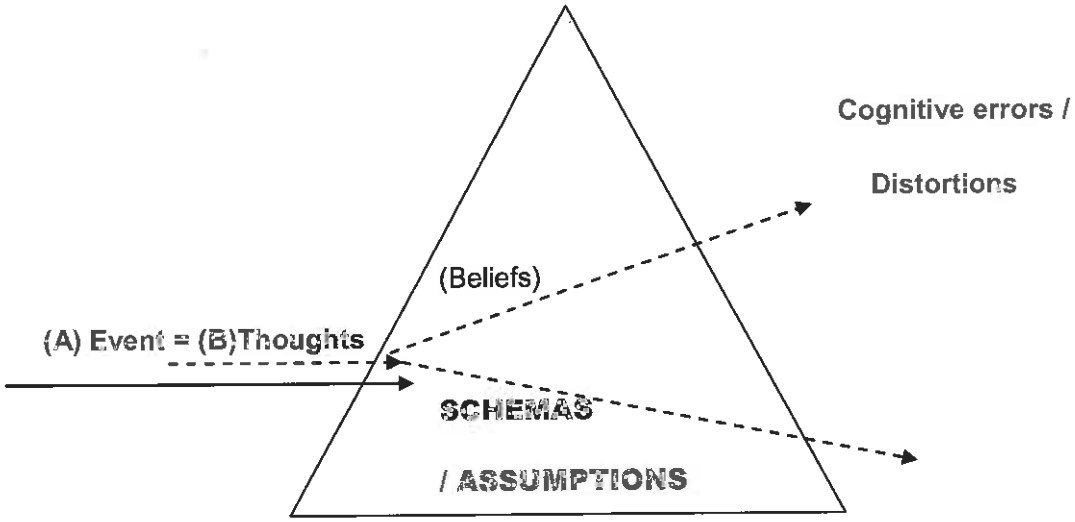
Cognitions (thoughts) can be compared with light reflected through a prism. When looking at light beams reflected through the prism, these light beams changes their course as well as colour (see diagrammatic presentation below).

The same applies to our cognitions and our interpretations pertaining to self and / or events as well as our future. When exposed to specific life events for example, our interpretation of such an event will be shaped by our personal constructs (our schemas; assumptions / core beliefs).





According to the CBT model a person with depression has negative schemas about themselves; their environment and future. These **negative schemas** contain **absolute beliefs of the self** for example e.g. **"I'm unlovable"**, as well as **conditional beliefs e.g. "If I'm not successful, my life is worthless.**

As mentioned earlier cognitive errors represents the faulty logic in "automatic thoughts". Cognitive errors will be discussed in detail in Session 4.

In summary depression is associated with:

- Negative thought patterns.

- Distorted (dysfunctional) schemas.

- Cognitive errors or faulty information processing.

C. Homework:

1. Complete homework sheet "My bad thoughts".

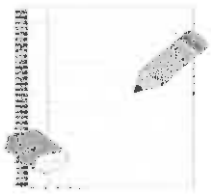
2. Identify your own "automatic thoughts" with relevant examples.

3. Continue with recording of mood – "Daily Mood Chart "rating, as well as amount of positive and negative thoughts experienced through the day.

4. Complete Beck Depression Inventory.

5. Read notes for next session (Session 4 – Cognitive errors & Challenging unhelpful thoughts).

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).



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SESSION 4: - COGNITIVE ERRORS (Mistakes in thinking).

- CHALLENGING UNHELPFUL THOUGHTS

A. Purpose of Session 4:

During this session you will learn how to identify cognitive errors (unhelpful thoughts). You will also be introduced to different strategies that will assist you in dealing with these thoughts.

B. Cognitive errors & Dysfunctional thoughts.

As discussed in session 3, our thinking styles have an impact on our mood and related behaviour. Thought patterns are influences by cognitive structures established throughout our lives (core beliefs & assumptions).

These structures are referred to as **"schemas".** The formation of schemas are based on previous life experiences as well as our interaction with significant others. **Automatic thoughts** are influenced by schemas, our basic beliefs and assumptions regarding ourselves, our world (environment) and our future. The faulty reasoning evident in automatic thoughts is referred to as **"cognitive errors".**

1. Mistakes in thinking (faulty thinking / cognitive errors):

1.1 All – or – nothing thinking / Black – and – white thinking:

This implies that the individual sees things **as either all "bad" or "good"** (in extreme terms). Situations are interpreted as positive or negative; there are no "in-between". This also applies to thoughts about other people.

For example: When a person has scored low in one test, the individual labels his / her work as "useless', "not worth the effort".

Alternatively one might rather think (functional): "I did not do well in this test; however I'll work harder and try to improve!"

A very good example is "dieting". When a person has eaten something e.g. cake when on a diet, he / she might easily think: "I've cheated during my diet. I'm a failure I might as well eat everything and become fat. On the other hand a more constructive approach might be as follows: "I've eaten some cake, but most of the time I adhere to my diet.

1.2 Overgeneralizing:

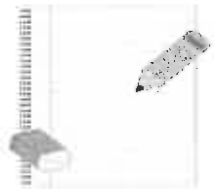
This type of thinking; implies focussing on one negative event and believing that this negativity is going to apply to all life circumstances. For example: "I'm feeling down this morning, I will always feel depressed. There is no way out of this!"

1.3 Mental Filter:

This type of thinking involves selecting one single negative event and ignoring all other positive aspects. "I hate hospitals. Although personnel are friendly, I dread going to fetch my treatment".

1.4 Mind-Reading:

With this kind of thinking people assumes they know what other people think and feel. Hence also knowing why people react in a certain manner. E.g. "I know people think I'm a failure now that I'm depressed!"



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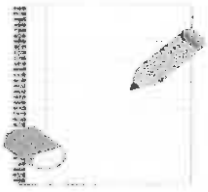
1.5 Catastrophising – Magnifying events (Maximizing):

This type of thinking involves exaggerating the importance of things (seriousness of things), especially negative situations (making a big issue out of one negative event). For example: "I am feeling down this morning, I will be depressed the rest of my entire live!"

1.6 Minimizing (downplaying) positive aspects:

This type of thinking involves downplaying or ignoring positive aspects of yourself; other people or events. E.g. "People thanked me for my work, but actually I did nothing!"



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1.7 Personalization:

This kind of faulty thinking involves you taking responsibility and / or blaming yourself for a negative incident over which you had little or no control. E.g. "My husband says degrading things to me, but I did not keep quiet."

1.8 Jumping to conclusion:

A person with this type of thinking jumps to conclusions without any supporting evidence, or despite contradictory evidence. For example: "Nobody in the ward likes me!" - Irrespective of being asked to participate in recreational activities on several occasions.

1.9 Emotional reasoning:

This error involves thinking that what you are feeling (about yourself, others or life circumstances) reflects the way things really are (your thinking/reasoning is based upon your emotions). Example: "I'm currently emotional and depressed. I must be a huge burden to my family."



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1.10 Demandingness:

("Should"; "Must" & "Ought")

A person with this type of thinking has very rigid views regarding how they / other people should / must behave. This kind of thinking illicit specific negative emotions (when directed at yourself). For example: Guilt & despair. E.g. "I must always be available to my family; going to the gym will interfere with this."

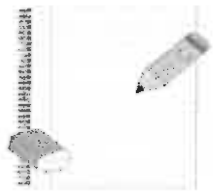
When directed towards other people; emotions, such as the following are experienced: Anger, resentment, frustration and annoyance. When you direct these statements towards yourself, you tend to feel guilt and despair. E.g. "When I enter a shop; shop assistants should attend to me immediately."

1.11 Labelling / Mislabelling:

This thinking error involves an extreme form of overgeneralization. You tend to attach a negative label to yourself or others on the basis of one negative experience. Example: A person thinking: "I am depressed, I'm a failure." / "My husband is impatient with me; he does not love me anymore!"

1.12 Blaming:

This type of faulty thinking involves blaming yourself for other people's troubles. On the other hand blaming other's for your problems. E.g. "My family expect too much of me, hence I started drinking again."



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3. **Group activity:**

Within the group you will be guided to identify – **Cognitive Errors by** using a specific tool (provided by the group leader). You will also practise this aspect by means of a homework assignment (see below).

4. **Homework sheet: "My Unhelpful thoughts"**

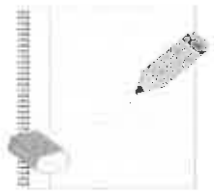
Which mistakes do you make? Write down your own individual examples. This will assist you to practice identifying and analysing unhelpful thoughts.

"UNHELPFUL THOUGHTS"	"MY MISTAKES IN THINKING"
Catastrophysing: When you predict that a disaster will follow, even though it is not likely to happen e.g. You go for minor surgery, and you	
Overgeneralization: You draw a conclusion from a single bad event & apply it to your whole life. E.g. You have a break-up in your	
Mental filter: You focus on a single negative incident and ignore everything else.	
Minimising the positive: When you minimise or ignore positive aspects about yourself and only focus on negative aspects.	
Taking good things the wrong way: Somebody compliments you interpret it the wrong way. E.g. You are being complimented	
Black and white (All-or-Nothing Thinking): You see things as all good or bad.	
Emotional Reasoning: You use your feelings as key to the truth. E.g. You feel depressed and you belief this represents your whole life.	
Jumping to conclusions: You draw conclusions which are irrelevant to the facts / situation.	

"UNHELPFUL THOUGHTS"	"MY MISTAKES IN THINKING"
Labelling or Mislabelling: You describe yourself using a negative term or label.	
Shoulds or Musts: You assume that people (including you) must follow certain rules and if they (you) don't ... They / you are no –good.	
Mind-reading: You assume people can read each other's minds. E.g. Ï know they think I'm stupid".	
Personalizing: You assume everything bad that happens is your fault and that you are responsible for these things. This also applies	
Blaming: You assume that others are to be blamed for your problems / or you blame yourself.	
Belief that you have no control: You belief you are a helpless victim of others behaviour or decisions.	

C. Challenging unhelpful thoughts – Changing your thinking!

Note! Thinking styles / thought patterns are learnt over years and become part of our internal cognitive processes. However, we can learn to monitor our automatic thoughts, but this takes practice. Like any new skill we learn (e.g., knitting; gardening) we need to practice identifying and challenging our automatic thoughts on a regular basis.



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1. Disputing your thoughts – The A – B – C – D method.

During earlier session's we were taught that it is not necessarily the external event that causes us to feel bad. In fact, it is actually our thoughts & perceptions about the event that makes us depressed. **Remember the A – B – C model!** Look at the following example.

A = Activating agent	**B = Thoughts / beliefs**	**C = Consequences**
(Events in our world)	(How we perceive & interpret events)	(Emotions & Behaviour)
		

1.1 Talking back to your thoughts:

Consider the following.

A is the **A**ctivating agent (what happened).

B is the **B**elief or the thoughts that you have about the event (what you tell yourself).

C is the **C**onsequences (feeling you have because of the thought).

D is the way you **D**ispute or talk back to the thought.

Now let us practise!

Example:

Activating agent: "I have been diagnosed with depression"	**B**elief / thought about the incident: "I am doomed forever"
Consequence (feeling about the event): 	**D**isputing the thought (talking back to the thought): "There are other patients in the ward and they have improved"



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1.1.1 Homework sheet: Talking back to my thoughts / practising the A – B – C – D method (Use worksheet below):

Activating agent:	**B**elief / thought about the incident:
Consequence (feeling about the event):	**D**isputing the thought (talking back to the thought):

2. Other ways to decrease the thoughts that make us feel bad:

2.1 Thought stopping:



When a thought is making you feel bad .....

a) "Identify the thought"

b) Acknowledge what the thought is doing to your mood.

c) Tell yourself **"STOP"** and think about something else.

2.2 Worrying time:

When we are depressed our thoughts centre on the negative aspects of our lives. We tend to only concentrate on the problems (worries). Schedule a specific time of the day e.g. 1hr during which you can think about your worries.

2.3 Consider the worst possible thing that can happen:

We often feel depressed and fear what can happen; this only aggravates our depression. "**Think things through**" by using the following alternatives:

a) Tell yourself that there is more than one possible outcome.

b) Tell yourself – "Just because it is the worst, it doesn't mean it will happen".

2.4 Coaching yourself:

Ask yourself the following questions:

a) How would you like things to turn out?

b) Is your expectations of the outcome really realistic?

Think about the following:

a) What steps can you take to reach your goal?

b) Acknowledge that be coaching yourself; you are controlling your emotions.



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2.5 Add humour to your thoughts:

When you feel very angry; imagine for example smoke coming from your ears.

2.6 Increasing healthy thinking:

a) Make a list of good thoughts about yourself and your life.

b) Give yourself "mental time out" by taking a break from your negative thoughts.

c) Time projection: Imagine a time when things will be better!

d) Give yourself credit for positive aspects in your life. E.g. attending therapy!

E. Homework:

1. Complete the following homework sheets:

- "My mistakes in thinking" (with own individual examples).

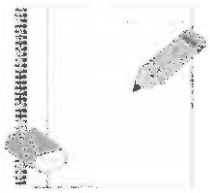
- "Talking back to my thoughts" (the A – B – C- D model).

2. Read the notes for the following session.

3. Complete the Beck Depression inventory.

4. Continue with the recording of your mood – "Daily Mood Chart "rating, as well as amount of positive and negative thoughts experienced through the day.

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).



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SESSION 5: BEHAVIOUR AND DEPRESSION

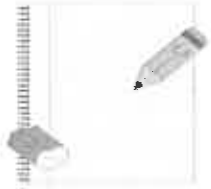
A. INTRODUCTION:

What have we learnt so far?

During the previous sessions you were orientated pertaining to the cognitive approach when dealing with depression **(Negative cognitive triad).** According to this approach a depressed person has a **negative view of themselves; their environment as well as their future.**

You were also familiarized with the **concepts** of **"schemas** "and **"automatic thoughts" (thought patterns incorporated by individuals through earlier life experiences, as well as interaction with significant others).** The **link** between **depression and thoughts (the A – B – C model)** were explored. You were familiarized regarding **mistakes in thinking (cognitive errors),** as well as how to **counteract (dispute) these thoughts (the A – B – C – D model).**

Based on the previous sessions it becomes evident that **depression affects a persons' mood** as well as **mode of thinking.** However, **depression** also has a **significant impact on a person's behaviour (functioning level / daily activities etc.).**



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This brings us to the core of this session. **Depression** can **lead to – *ALTERED BEHAVIOUR*** and can cause various **physical symptoms**.

B. THE FIVE (5) LINKS OF DEPRESSION:

Let's think back. Depression has 5 links – remember the **"A – B – C model"**.

- Life situation / relationship and / or practical problems.

- Altered thinking.

- Altered emotions.

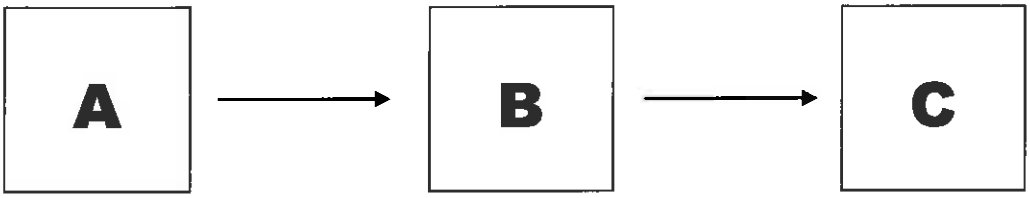
- Altered physical feelings / emotions.

- **Altered behaviour.**

Let us review the **A – B – C model** (please see diagram below).

Depression and the A – B – C model.

Depression =



A = Activating agent

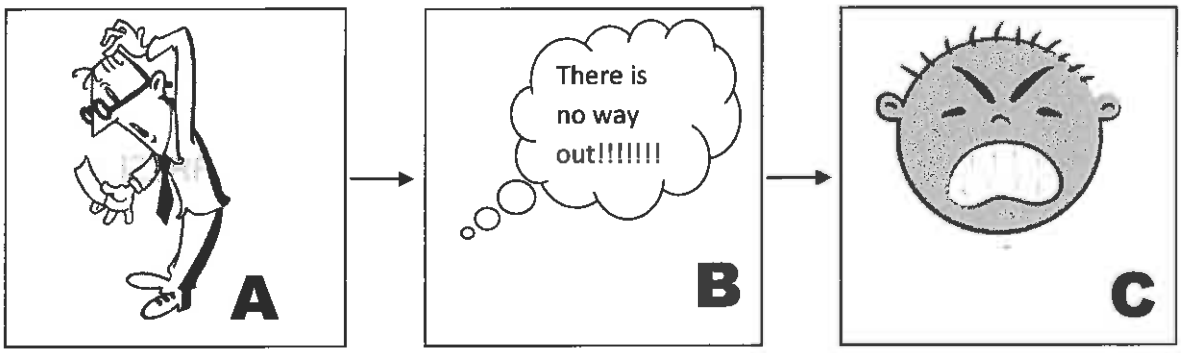
(Events in our world)

B – Thoughts / beliefs

(How we perceive & interpret events)

C = Consequences

(Emotions & behaviours)



When reflecting back on the **A – B – C model** you were made aware that our perceptions; **what we think** about the **things that happen to us; our situation; our problems** may **affect how we feel emotionally.** However, our **physical feelings (physical symptoms)** may also be affected.

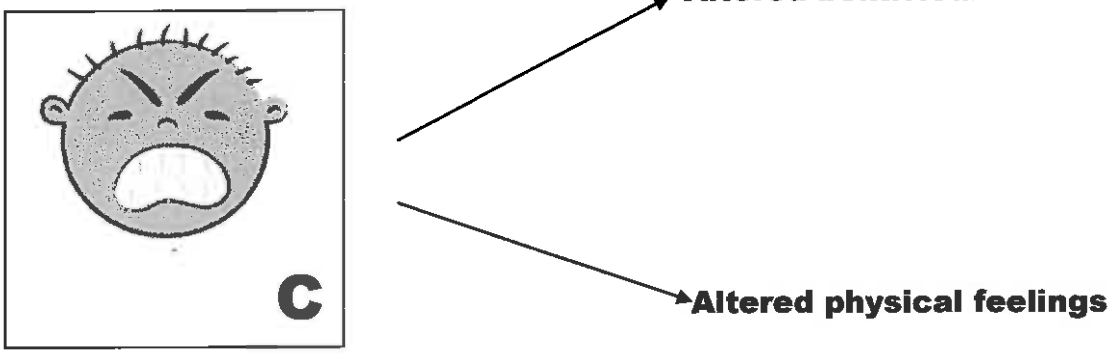
1. Depression results in .....

- Altered thinking.

- Altered emotions (feelings) – **discussed during previous sessions.**

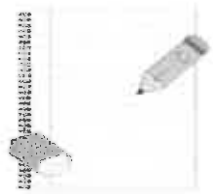
- Altered physical feelings (symptoms in the body).

- ***Altered behaviour (reduced activity or unhelpful behaviour).***



C = Consequences

(Symptoms in the body)



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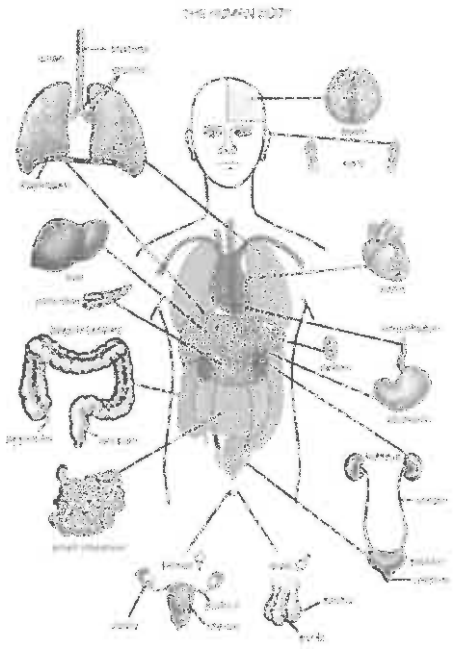
1.1 Altered physical feelings:

Group activity:

This aspect will be explored briefly during this session by means of a practical exercise. What are some of the physical symptoms you have experienced whilst being depressed / stressed out? See the example below: **Altered physical feelings board.**

Altered physical feelings:	
	- **Headache.** - **Muscle tension / spasm.** - **Tiredness / decrease in drive.** - **Insomnia.** - **Constipation.** - **Stomach cramps.** - **Dry mouth.** - **.....** - **.....**



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Now we will have a look at **altered behaviour** and **how** it **affects our mood.**

1.2 Altered behaviour and depression:

Certain behaviours can influence your mood negatively. On the other hand certain behaviours can actually be helpful and make you feel better (this will be discussed during the next session). When we are depressed we stop doing things. For example: Daily activities of living e.g. household chores; grooming and self-care; exercising; preparing nutritional meals etc.

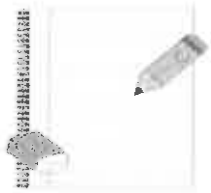
We also disengage ourselves from pleasant activities e.g. visiting friends; watching a movie; reading a book etc. We might simply feel too down, too tired and this brings us to the following statement:

NB! The more depressed we feel the less we do! The less we do the worse we feel!

Think back to the concept of feelings and thoughts. In the very same manner that **thoughts** influence **feelings; thoughts** also has an impact on **behaviour. Behaviour** on the other hand can also **influence feelings** and **thoughts.** This becomes a ***vicious circle.***

Example: Peter has financial problems and feels depressed. Peter thinks "I'm useless, I can't even provide for my family" = what does Peter do? / What does Peter think?

Please see the diagram below - ***Vicious circle.***



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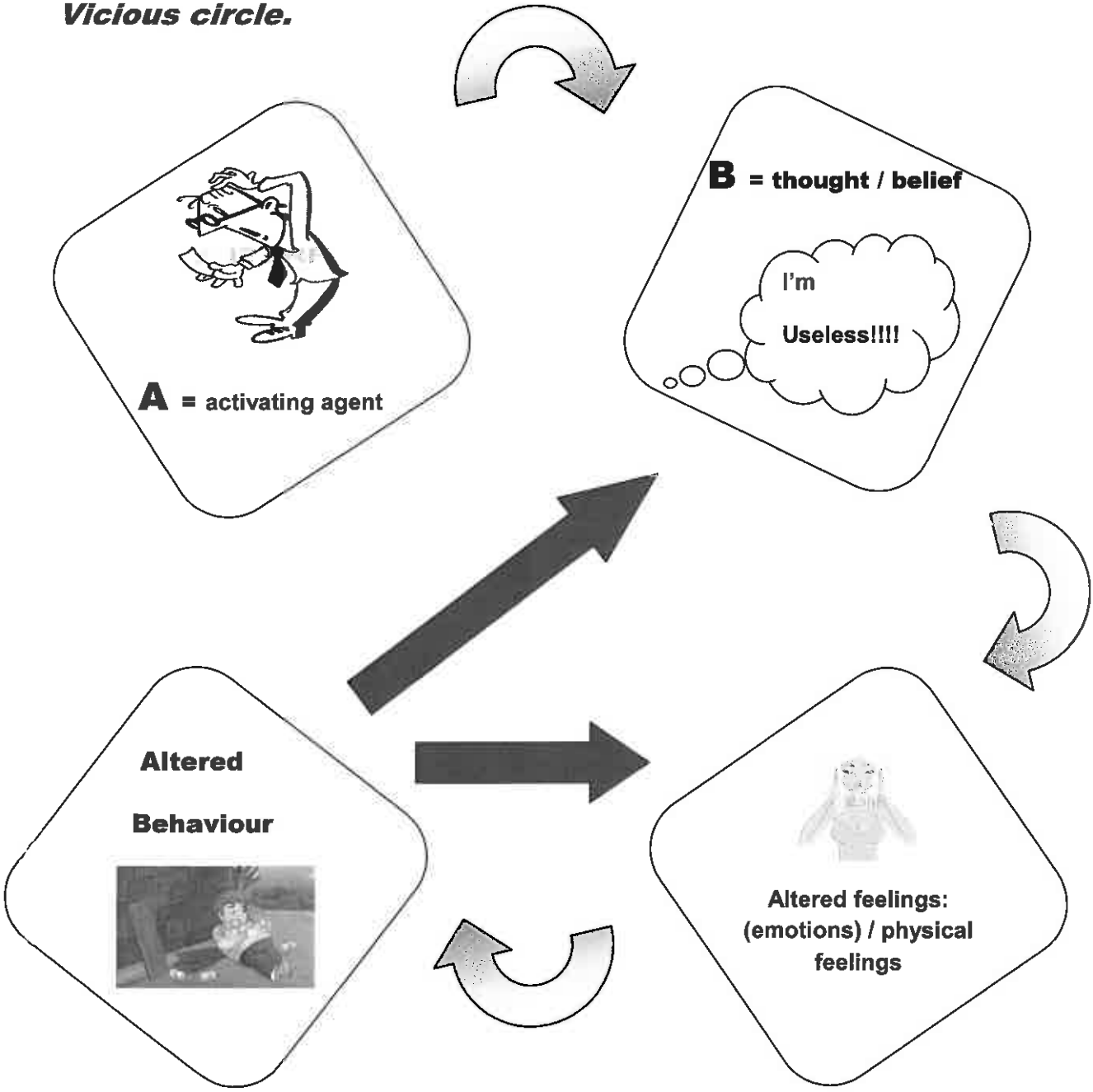
Vicious circle.

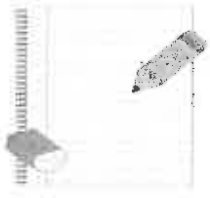


1.2.1 Altered behaviour:

Altered behaviour has **two (components):** When we become depressed we **stop doing** the things that we **used to do** as well as the things we used to **enjoy.** For example: Everyday household chores; we may even stop doing the things we previously enjoyed doing e.g. Fishing; reading a book etc. Most of the time we end up; not participating in any activity that fosters pleasure or a sense of achievement and fulfilment. This is usually followed by an inability to even do everyday tasks.

On the other hand some patients engage in **behavioural patterns** that are **harmful** to them.

Group activity: We will explore the consequences of harmful behaviour during a practical group activity. What do you think are possible outcomes of harmful behaviour?



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1.2.1 "The things I do - ***Do I sabotage myself?"***

Explore your own current behavioural patterns whilst being depressed (utilize the work sheet below). Give one (1) or (2) examples of your own **altered behaviour** with which you feel comfortable sharing within the group. This worksheet also forms part of a homework assignment (see example below).



Work sheet: ***"Do I .... Sabotage myself?"***

"THE THINGS I DO – DO I ..... SABOTAGE MYSELF?"	
"Do you .....?"	
Drink too much... (To feel / sleep better)	Tick
Eat too much to comfort yourself... (Comfort eating).	Tick
Spend too much... (Retail therapy – to feel better)	Tick
Being clingy... (This actually pushes people away).	Tick
Take risks... (Do actual things that can harm you)	Tick
Harm yourself... (This is destructive and does not help).	Tick
Hitting out at people... (This can result in feeling very alone).	Tick
Hide away... (Spiralling downwards; loosing self-confidence).	Tick
Set yourself up to fail / to be rejected... (Doing things that prove to you that you are bad / a failure).	Tick
Bully other people... (This is not assertive).	Tick
Act impulsive... (Quitting your job without thinking it through).	Tick

Become addictive to .... TV / Internet... (This cannot substitute actual relationships with real people).	Tick
Want others to sort out your problems... (This does not promotes your confidence / or a sense of achievement).	Tick
Doing ... Doing ... doing ... (not giving yourself any time to recharge).	Tick
Sleep and nap during the day... (This only result in problems to sleep – insomnia).	Tick
Drink too much coffee / coke.	Tick
Put things off... (This will frustrate you and others and will contribute to feeling "stressed out").	Tick
Worry all the time... (Worrying all the time does not actually solve any problems).	Tick
Other things I do ..... !	

(Source: Williams, C. 2009)

1.2.2 The impact of harmful behaviour:

Group discussion:

Explore within the group the impact and / or possible impact of harmful behaviour on your life. Use the work sheet below. The purpose of this exercise is to assist you to objectively look at the impact of harmful behaviour as well as to gain insight in your own ***"viscous circle"***.

Work sheet: "Unhelpful behaviour .... Does it help?

"Unhelpful behaviour – Does it help?"	
Unhelpful behaviour	**Impact on my life**

.

1.2.3 "The things I stopped doing – looking back!"

What are the things you stopped doing? Give a few examples. Examples must include both **activities of daily living** as well as **pleasurable activities.**

Homework sheet: **"The things I stopped doing!"**

"Things I stopped doing!"	
Daily activities of living.	**Pleasurable activities.**

At this point in time it is important to be aware that ***change*** is possible. There is hope! We can ***reverse*** our ***"vicious circle". "Unhelpful behaviour"*** can be addressed by using certain principles – this is called ***"Behavioural Activation".*** Behavioural activation will be addressed during the next session (Session 6).

C. Homework:

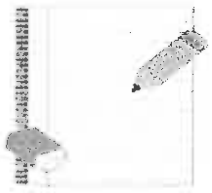
- Complete work sheet – "How do I .....Sabotage myself?"

- Complete worksheet: "The things that I stopped doing"

- Complete Beck Depression Inventory.

- Read notes for next session – Session 6: Behavioural Activation.

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).



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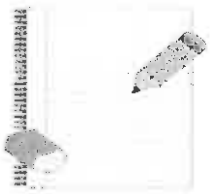

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SESSION 6: BEHAVIOURAL ACTIVATION.

A. INTRODUCTION TO SESSION 6:

During the course of session 5 you were made aware of the significant impact of depression on your behaviour. Unhealthy behaviour easily results in a "mental trap" and becomes part of a behavioural pattern. Therefore, the worse we feel, the less we do. The less we do; the worse we feel.

Unhealthy behaviour usually involves the following components:

- Not doing rewarding or pleasurable activities (These foster a sense of wellbeing / enjoyment).

- Neglecting your self-care (e.g. grooming – can boost your self-esteem and confidence).

- Stop doing or procrastinate small necessary tasks and daily activities of living (Running errands; not cleaning the house – leads to a sense of inadequacy and loss of control).

- Isolation from the outside world (Feeling connected and belonging is part of human nature). Our whole life is built on how we relate to others and our environment.



My Notes: .....

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1. Purpose of Session 6: Behavioural Activation.

What is behavioural activation?

One of the most difficult things when feeling depressed, is to get "***going again".*** Most of the time we simply do not have the energy or the motivation; to do even simple tasks.

We often think that we first have to be motivated before we will be able to engage in activities. However, it is actually the other way around. When depressed, we simply have to ***start "doing things".*** Research has proven that activities have a significant impact on brain chemistry. Our thoughts are also influenced by our level of activity.

It is important that we realize, that if we **wait** to ***"feel better"*** before we start doing things (activate our lives); we may once again get trapped in a ***"vicious circle".*** Therefore, the main purpose of this session is to ***"activate our lives".*** In cognitive behavioural therapy this is referred to as ***"Behavioural Activation".***



My Notes: .....

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B. Components of "behavioural activation"

During the previous session we discussed the key components implicated in "unhealthy behaviour". These components imply the following areas:

- Important functional areas of everyday life.

- Doing things that we enjoyed doing.

- Isolating ourselves from others.

Therefore, this session "behavioural activation' will focus on these main areas.

1. Monitoring of activities:

During this exercise you will be expected to record (monitor) your daily activities. The purpose of this exercise is to enable you to objectively analyse how depression has in actual fact influenced your level of functioning. This will also assist you to gain insight; in order to

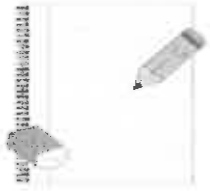
be able to identify which areas you need to ***"re-activate"*** to become more functional (in other words - how to get going)

Activity monitoring has to be specific pertaining to how you actually spend your time. This will also help you with planning and restructuring activities in your life. This exercise forms part of a homework assignment (see below).

Example: Activity log (Source: Riggenbach, J. 2013:237)

Time:	Activities
11:00am	**Woke – up and got .out of bed.**
11:30am	Ate left over pizza from the previous evening.
12:00pm	Watched TV and went on Facebook.
14:00pm	Picked up children from school.
15:00pm	Took an afternoon nap.
17:00pm	Played video games.
18:00pm	Went to store and bought "fish & chips" for supper.
19:00pm	Drank a glass of wine (to relax) & watched TV.
20:30pm	Went to bed. Laid in bed for an hour and a half (couldn't sleep).
12:00am	Watched TV in bed.
01:45am	Fell asleep.

You can use the example above to assist in completing your own "Activity Log" (see worksheet below).



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Homework sheet: "Activity Monitoring Log" (Source: Riggenbach, J. 2013:239)

Time:	Activities

1.1 Observations made during "activity monitoring & scheduling":

What did you see when you actually started monitoring your own activities? Could you identify any trends / behavioural patterns?

For example:

- How much time was spent playing video games?

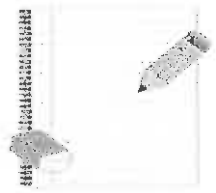
- Went to bed too early and only woke up at 11:00am the following morning.

- Drank too many glasses of wine to block out feelings.

- Ate unhealthy food at awkward times of the day.

- Had little contact with other people.

- Didn't do any necessary activities of daily living.



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C. How to get going ..... Just do it! - Scheduling activities.

"Can you recall why it is important to engage in pleasurable activities?"

Engaging in pleasant activities fosters.....

- A sense of wellbeing.

- Feelings of enjoyment.

- Relaxation.

- Inspiration.

- Meaning.

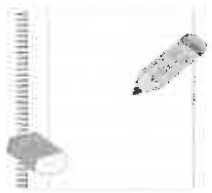
1. "The things I do that's good for me" (also part of homework assignment).

During Session 5 you had to make a list of the things "You stopped doing". You also had to include things that you previously enjoyed doing. When feeling depressed, we may have a decrease in the ability to experience any pleasure from any activity. This can even apply to things we previously enjoyed doing. This is called ***anhedonia.***

One important area in overcoming depression is - ***to become more active.*** This includes ***engaging in pleasurable activities*** (some of which you might have stopped doing). Can you name some of the pleasant activities you used to do, but now have stopped doing them? Below is a list with practical examples of pleasant activities.

Examples of pleasurable activities in general:

Reading	Going to movies	Playing with children	Scrapbooking
Swimming	Sight seeing	Playing with pets	Yoga
Gardening	Listening to music	Seeing live sport.	Bike riding
Sewing	Cleaning	Going to the theatre	Playing cards/games
Embroidery	Drawing or painting	Going for a picnic	Going for a massage
Hobbies	Walking	Fishing	Being near water
Cooking	Exercise	Camping	Meditating
Pampering yourself	Calling a friend	Smiling	Having a long bath



My Notes: .....

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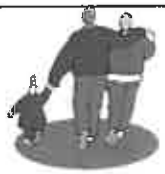
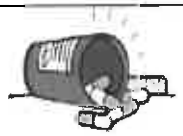
Let us be specific. What activities can you engage in that will enhance emotional and physical wellbeing? You can use the list below to identify activities that you will benefit from.

1.1 Worksheet – "The things I do that good for me!"

"THE THINGS I DO ..... THAT'S GOOD FOR ME!"		
Eating regularly and healthy ... (Take time to enjoy a nutritious meal)		Tick ☐
Allow yourself to get adequate sleep ... (To start the day fresh and rested).		Tick ☐
Keeping up with routine work ... (e.g. Household chores)		Tick ☐
Doing things with other people ... (e.g. Contact with significant others / friends).		Tick ☐
Doing things that gives you a boost ... (e.g. Hobbies – re-charging).		Tick ☐
Stop yourself from focussing on negative thoughts ... (Stop reflecting on negative thoughts).		Tick ☐
Use humour to cope ... (A good laugh can make you feel better).		Tick ☐
Exercise / going for a walk... (This can improve your mood).		Tick ☐
Sharing problems with a trusted friend or family... (This can really help and fosters a feeling of support).		Tick ☐
Finding out more about how you feel... (Joining a self-help group / therapy group).		Tick ☐
Let upset thoughts just be... (Quitting your job without thinking it through).		Tick ☐

"THE THINGS I DO ..... THAT'S GOOD FOR ME!"		
Set time aside for yourself as well as others.... (Devoting all your time to other people can make you feel overwhelmed).		TICK
Take your medicine as prescribed... (Part of the recovery process).		TICK
Relaxation ... (Give yourself time to recharge).		TICK
Make use of available resources... (E.g. Therapist / support groups).		TICK
Doing daily essential tasks... (Not giving attention to these can only result in creating additional problems / lead to feelings of guilt / failure).		TICK
Other things I do ..... !		

(Source: Williams, C. 2009)

Let's be practical and commit ourselves! You need to identify and agree to commit yourself to re-engage in at least one (1), possibly two (2) **pleasant activities** you previously enjoyed doing. Initially you may find it difficult to start re-activating your life. It is therefore important to take **small steps at a time**. Be **realistic** and **increase activities gradually**.

Please indicate appropriate pleasant activities; you are willing to engage in (use the space below).



1. .....

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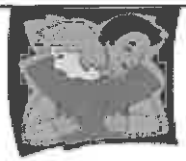
Advantages / Why?.....

How to start: .....



2. .....

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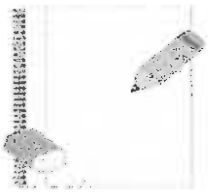
Advantages / Why?.....

How to start: .....

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).



My Notes: .....

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1.2 A few things about pleasant activities!

1.2.1 Pleasant activities DO NOT have to be special activities. It can be everyday activities. Can you remember a time when you engaged in doing something pleasant? What were you're your mood like at that time? How did you feel afterwards?



1.2.2 Pleasant activities do not have to be expensive.

1.2.3 When we are depressed it sometimes become difficult to remember a time when we engaged in pleasant activities. We may even face difficulties when attempting to re-activate this aspect of our lives. You can use the activity list to identify appropriate activities you are willing to engage in.

1.2.4 Remember we are individuals; hence pleasant activities are different for different people.

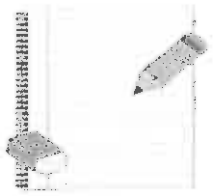
1.2.5 Pleasant activities are things that make us feel happy and relaxed.

1.2.6 Just as our bodies need certain nutrients to survive and be healthy; our minds also need to recharge.

1.2.7 There should be a balance between the things you **"want to do"** and the things you **"have to do"**. A healthy balance will improve emotional as well as physical health. Remember! We have more control over the things we want to do. Therefore make use of the opportunity.

1.2.8 Pleasant activities do not just "happen". The only person that can make them happen is **YOU.** By setting realistic goals, planning your activities and scheduling activities; you can re-activate your life!

Let's look at things that may hamper you in the process of re-activating your life.



My Notes: .....

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1.3 Obstacles / barriers when working with pleasant activities:

Thoughts – unhelpful thoughts may play an important role in preventing us from becoming more active.

Examples of possible stumbling blocks:

- It won't make me feel better.

- I do not have time.

- Fear of failure.

- I won't succeed, so there is no point in trying.

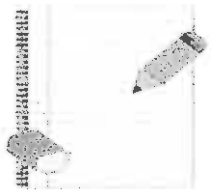
- I do not feel well.

- There are too many things that I must do first.

- I am too tired.

- If I cannot do it perfectly; I cannot do it at all.

- It will only be disappointing.



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During this session we have explored the following:

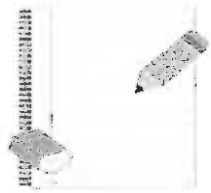
- The concept of behavioural activation;

- The importance of activity monitoring & scheduling;

- The value of pleasure and pleasant activities in our everyday lives.

Since we are now focussing on behavioural activation you will continue with "daily mood monitoring". However, we will be using the "Adjusted Daily Mood Monitoring Scale" which will include a space to record activities that you have participated in during the day.

This exercise will also form part of activity monitoring and will assist you to identify whether you actually engage in any scheduled activities. This will also enable you identify the link between your mood; positive and negative thoughts as well as the relationship pertaining to activities / behaviour.



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D. In summary:

Note that you have committed yourself to ***reactivate your life;*** pertaining to **enjoyment** and **healthy pleasure.**

You can now continue with your **therapeutic journey** of **commitment** and **change** to other aspects of your life. This brings us to ***"Mastery and Meaning!"*** which will be the focus of the next session.

E. Homework assignments:

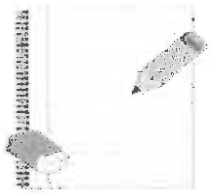
- Complete adjusted "daily mood monitoring scale"

- Complete Beck Depression inventory.

- Schedule at least one (1) possibly two (2) pleasant activities and be committed to reactivate these.

- Read notes for next session (Session 7).

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).



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ADJUSTED DAILY MOOD CHART (Muñdoz, R.F., Miranda, J. 2000:9)

Week Number : .....

Day:	.....	.....	.....	,.....	.....	.....	.....
D (BEST)	**9**	**9**	**9**	**9**	**9**	**9**	**9**
A							
I	**8**	**8**	**8**	**8**	**8**	**8**	**8**
L							
Y	**7**	**7**	**7**	**7**	**7**	**7**	**7**
M	**6**	**6**	**6**	**6**	**6**	**6**	**6**
O							
O (AVERAGE)	**5**	**5**	**5**	**5**	**5**	**5**	**5**
D							
	4	**4**	**4**	**4**	**4**	**4**	**4**
S							
C	**3**	**3**	**3**	**3**	**3**	**3**	**3**
O							
R	**2**	**2**	**2**	**2**	**2**	**2**	**2**
E							
(WORST)	**1**	**1**	**1**	**1**	**1**	**1**	**1**
Number of thoughts:							
Positive:	.....	.....	.....	.....	.....	.....	.....
Negative:	.....	.....	.....	.....	.....	.....	.....
Number of (to do) activities:	.....	.....	.....	.....	.....	.....	.....
Number of pleasant activities:	.....	.....	.....	.....	.....	.....	.....

ADJUSTED DAILY MOOD CHART (Muñdoz, R.F., Miranda, J. 2000:9)

Week Number : .....

Day:	.....	.....	.....	,.....	.....	.....	.....
D (BEST)	**9**	**9**	**9**	**9**	**9**	**9**	**9**
A							
I	**8**	**8**	**8**	**8**	**8**	**8**	**8**
L							
Y	**7**	**7**	**7**	**7**	**7**	**7**	**7**
M	**6**	**6**	**6**	**6**	**6**	**6**	**6**
O							
O (AVERAGE)	**5**	**5**	**5**	**5**	**5**	**5**	**5**
D							
	4	**4**	**4**	**4**	**4**	**4**	**4**
S							
C	**3**	**3**	**3**	**3**	**3**	**3**	**3**
O							
R	**2**	**2**	**2**	**2**	**2**	**2**	**2**
E							
(WORST)	**1**	**1**	**1**	**1**	**1**	**1**	**1**

Number of thoughts:

Positive:	.....	.....	.....	.....	.....	.....	.....
Negative:	.....	.....	.....	.....	.....	.....	.....
Number of (to do) activities:	.....	.....	.....	.....	.....	.....	.....
Number of pleasant activities:	.....	.....	.....	.....	.....	.....	.....

SESSION 7: MASTERY AND MEANING.

A. INTRODUCTION TO SESSION 7:

The focus of Session 6 was behavioural activation and evolved specifically around the theme – pleasant activities as an essential part of our lives. The **balance** between **"what we must do"** and **"what we want to do"** were highlighted.

1. The purpose of Session 7: Mastery & Meaning.

Commitment to Change, Mastery and Meaning!

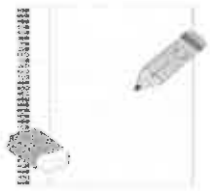
As previously discussed (Session 6), we need to **engage in pleasant activities** in order to experience **feelings of enjoyment and emotional wellbeing**. According to research there are **three (3) main areas** of **coping with depression** when considering **behavioural activation** (Riggenbach, 2013:241). These areas involve the following:

- Pleasure

- Mastery

- Meaning

Pleasure and scheduling pleasant activities in order to enhance feelings of happiness and emotional wellbeing were addressed in the previous session. During this session ***Mastery*** and ***meaning*** will be explored.



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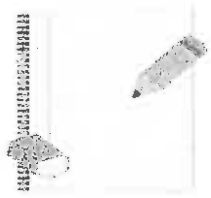
B. MASTERY:

Just as we need joy and pleasantries in our lives in order to enhance emotional wellbeing (recharge our battery); we also need to experience a sense of achievement, fulfilment and belonging (self-actualization). This is especially important if you value performance – often referred to as a ***"go getter".***

Symptoms of depression, for example lack of energy, lack of motivation, inability to experience pleasure can lead to inactivity. Most of the time inactivity maintains depression or even aggravates symptoms of depression.

When depressed we usually lack motivation. Often important everyday tasks are neglected resulting in feelings of being overwhelmed. When this happens we are prone to resort back to feelings of quilt and inadequacy.

Re-activating our lives is an important part of overcoming depression. Becoming more active creates feelings of achievement and purpose.



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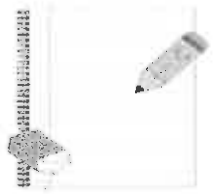
What activities of everyday life are important to you? The list below can serve as a basic list that can assist you to identify relevant **"mastery tasks"**. Mastery – related tasks will be explored during a group discussion.

Examples of **"Mastery – Related Tasks"** (Source: Riggenbach, J. 2013:241).

Having done a full day's work.	Repairing things around the house.	Exercising / going for a walk.
Cleaning a room in the house.	Doing therapy homework.	Making a grocery list.
Running errands.	Doing school assignment.	Think about possible outcomes of your achievements.
Thinking how to advance my career.	Going to work.	Picking up around the house.
Doing laundry.	Painting your nails (self-grooming). Deliberately thinking about the results.	Joining a club.
Planning a day's activities.	Refinishing the furniture.	Making a list of tasks.
Taking care of my plants.	Mowing the lawn.	Volunteering.
Gardening.	Sewing.	Thinking about past achievements.
Embroidery.	Knitting.	Paying bills.



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1. Taking charge!

As mentioned previously, when depressed we often lack the energy and motivation to conduct important tasks of daily living. The importance of different necessary tasks will differ from person to person.

Most of the times patients with depression; "just do not feel like doing anything". This type of behavioural pattern does not contribute to the process of recovery. Quite the opposite is true. The less we do, the worse we feel. This may also influence our thoughts in a negative manner e.g. guilt feelings; negative thoughts about self – Telling ourselves we are failures.

Therefore we consciously have to re-activate this aspect of our lives. For example: Planning and implementing an individual ***"personal mastery list"***

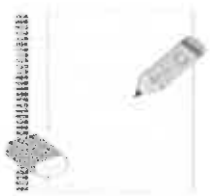
1.2 Advantages of re-activating our lives:

- Being active helps you feel better. Participating in an activity (even small activities), helps you to focus on something else besides just thinking of your misery. You will experience a sense of moving forward as well as taking control of your life.

- Increase your level of energy. While being depressed and deprived of any energy we might think that we need to do nothing in order to get some rest. However when depressed; inactivity actually makes us to feel even more tired. Having ample time to ruminate on negative thoughts and how bad we feel; will only make it worse.

- Engaging in activities can help you to clear your mind. You will also be able to see things / problems in a different perspective.

- Achieving something and taking control might even prompt you to do more.



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1.3 Important areas of mastery (practical group exercise): Can you identify important areas of mastery that you have neglected to do. **See list below for some examples of mastery tasks (to – do list):**

- Scheduling a time to shop for healthy food, instead of resorting to unhealthy fast food.

- Taking a long relaxing bath / shower before going to bed instead of a glass wine.

- Doing one (1) household chore they have neglected to do during the period of feeling depressed.

- Finish my homework assignment.

- Complete my tax return.

- Pay bills.

Now that you have explored the concept of **"mastery"** in your life; you need to indicate at least two (2) areas of important necessary tasks that you commit yourself to re-activate (See mastery task list worksheet below). Once again, remember - be specific and realistic.

Unrealistic goals will only lead to ..... "Setting yourself up to failure". Remember when feeling depressed even simple tasks might seem as being "too much". Therefore, start with small activities and take it slow. Just start **"DOING".**

Worksheet – My personal mastery (to-do-list) for today.



My personal mastery task (to-do list) for today: .....

1. ... Watering the flowers. .....

2. ... Paying my electricity bill. .....

3. ... Completing my therapy homework. .....

4. .....

5. .....



My personal mastery task (to-do list) for today: .....

1. .....

2. .....

3. .....

4. .....

5. .....

(Source: Riggenbach, J. 2013:242)

Up to so far we have learned that depression involves; as well as influences more than one area of our lives. Can you recall these areas?

- Emotions;

- Thoughts;

- Actions;

- Physical functioning;

- Life situation e.g. social interactions, relationship with significant others (family), work as well as financial aspects etc.

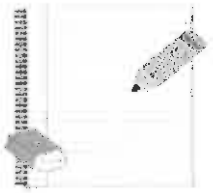
These components are inter-related. The implication there-of is significant. In actual fact it means that change in one area will have an impact on another area. You might have realized how things just seem to spiral down-wards. This leads to a perception of having no control what-so-ever.

Committing ourselves to re-activate small significant areas of everyday life will increase a sense of gaining control over our lives. Tension with others will also decrease if everybody own up to certain responsibilities. Take small steps at a time; achieving realistic goals will enhance your confidence as well as self-worth.

We do not always have control over the things that happens to us! Events in our lives are real and sometimes painful. These adverse events are part of our lives (part of reality).

The goal of therapy is not to belittle our life experiences. But, rather to focus our energy towards aspects that we have more control over e.g. our thoughts and our behaviour.

People are unique individuals with a deep sense of belonging. Our lives revolve around how we relate – to ourselves; other people as well as our environment. At the very core is **meaning (how we make sense of our world).**



My Notes: .....

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Therefore the third (3rd) aspect considered to be significant; when dealing with depression is - ***"meaning".***

1.4 Meaning:

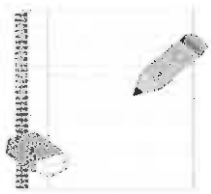
"Meaning" per implication will differ from person to person. All people have certain values and a unique manner in which they **interpret** their **lives as** being **"meaningful"- serving a purpose. So do you!** We often hear about people who went through a negative ordeal and then turn the situation around into a positive experience.

For example: "Allison" who was brutally assaulted and left for dead many years ago. After a very difficult recovery she wrote a book called "I have life!" How did she manage to do that? She used her own experience to create meaning and purpose in her life and became a very good motivational speaker.

As mentioned earlier on, having a **"meaningful" life** will be different for **every person.** For some people this aspect involves faith and religion. Quite a few years ago we had a

voluntary worker in this very unit who was diagnosed with depression. After recovery she shared her faith and recovery with patients by visiting them once a week (if they were comfortable with it). Sometimes she brought something small like soap if they needed some. This way, **life** to her had **purpose** and **meaning.**

Other people value worthy **"causes" or relationships** with others as meaningful. During this part of this session we will explore – what **we** consider as a **meaningful life.**



My Notes: .....

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1.4.1Possible meaningful areas in life:

1.4.1.1 Faith / Religion

1.4.1.2 Family

1.4.1.3 Education

1.4.1.4 Community involvement

1.4.2 Meaningful action steps .....

1.4.2.1 Attend a church service today.

1.4.2.2 Go and see a movie with my daughter.

1.4.2.3 Complete my science project for school.

1.42.4 Prepare the next group therapy session for my patients.

1.4.2.5 Visit my elderly neighbour.

What do you view as "meaningful" in your life? We will also discuss this aspect during a group discussion. This exercise will also form part of a homework assignment.

"My Personal Meaning Worksheet".



What do I consider as the most meaningful areas of life:

1. .....
2. .....
3. .....
4. .....



Meaningful action steps I will take .... Today:

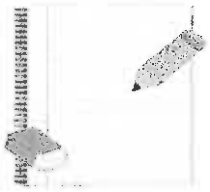
1. .....
2. .....
3. .....
4. .....
5. .....

(Source: Riggenbach, J. 2013:245 & 246)

Remember!

- You should establish what **you** consider as **meaningful** in **your life.**

- You have to determine actions steps you are willing to take in order to establish **"meaning"** in your life. **NB! We cannot wait for others to re-activate this aspect of our lives!**



My Notes: .....

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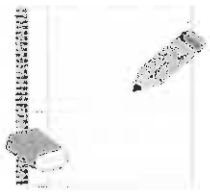
1.5 Reality ..... Acknowledging your pain:

The purpose of attending group therapy; in particular cognitive behaviour therapy is not to disregard loss, pain and hurt. CBT group therapy is seated in the "here and now" of our lives.

In order to grow in therapy and enhance therapeutic change we need to acknowledge our pain and despair. Therefor it is important that you validate your feelings of pain and grief. These emotions experienced; are "real" and "valid".

There is nothing as **demotivating** as the **spoken or unspoken message – "Just move on".** When depressed it is vitally important to express our feelings as well as feel that we are validated as a person.

It is only when we can acknowledge loss and pain by expressing our feelings; that we can start moving towards a more positive stance of acknowledging pain without constantly dwelling on negative aspects only. Use the worksheet below as a tool to acknowledge your feelings of pain and despair.



My Notes: .....

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1.5.1 Worksheet: "Acknowledging my pain"



Painful situations in my life ....

1. ... My husband belittles me in front of our friends. .....
2. ... I am being bullied at school. .....
3. .....
4. .....
5. .....



Losses I am ..... currently dealing with:

1. ... My husband is leaving me. .....
2. .....
3. .....
4. .....

Positive ways in which I can validate my feelings .....



1. ... Attend group therapy. .....

2. ... Speak to a counsellor / teacher at school. .....

3. .....

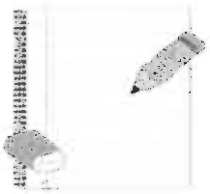
4. .....

5. .....

(Source: Riggenbach, J. 2013:248)

Note: The purpose of the **"My feelings: How do I ..... Feel today?" whiteboard** in Mafube where **you** have to **indicate** your **mood** by **selecting** an appropriate **"emotion cartoon" character** and **place** your **name accordingly; are part and parcel of acknowledging your feelings.**

Moving to a more functional / positive frame of mind not only implies acknowledging your pain. It also entails considering what is good about your life. It is therefore imperative that we also **acknowledge** our **blessings** even though we are currently experiencing difficulties.



My Notes: .....

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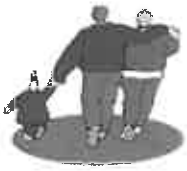
Use the tool on the next page to shift your focus towards **positive things** in your life.

Example: "Counting my blessings!"

Example: Counting my Blessings ..... !

(Things I have to be thankful for even though I'm struggling with some issues)



1. ... My mother. .....
2. ... My pet. .....
3. ... My support group. .....
4. ... My garden. .....
5. ... Knitting. .....

(Source: Riggenbach, J. 2013:249)

Worksheet: "Counting my blessings!"

Counting my Blessings ..... !

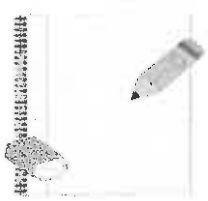
(Things I have to be thankful for even though I'm struggling with some issues)



1. .....
2. .....
3. .....
4. .....
5. .....
6. .....

I once knew a person who was born with physical disability. He compared life with a poker game. Most people think poker is all about how to best play a hand of "good" cards. In actual fact it is rather about how to play a hand of bad cards to the best.

Now, how do we do this? Another way to facilitate coping when we are feeling overwhelmed; is to make use of **"positive cue"** cards. The facilitator will provide you with **"positive cue cards"** hand-outs in order to initiate this process.



My Notes: .....

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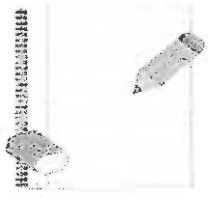
You can utilize these cards when reality seems to be overwhelming. The purpose of **"coping cards"** is to assist you in the **"heat of the moment"** When things just seem **to be too much! Coping cards** help us to actually "do" / focus on something specific when things "just seem too much"! (See example below).



My Notes: .....

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Example: "Activity – Coping Card!"

Activity – Coping Card ..... !

When I feel ..... Stressed out!



I can .....

1. ... Water my garden. .....
2. ... Take a relaxing bath .....
3. ... Call my friend .....

(Source: Riggenbach, J. 2013:250)

"My activity – Coping Card!"

My activity – Coping Card ..... !

When I feel .....!



I can .....

1. .....
2. .....
3. .....

(Source: Riggenbach, J. 2013:250)

"Coping cards" focus on **behavioural** aspects as well as **cognitive** aspects. Whilst **activity – coping cards** help you to focus better by doing a specific task; **cognitive cue cards** assist you with **"how"** to **"think"** when **feeling overwhelmed** (See example below).

Example: "Cognitive Cue Card"

My Cognitive Cue Card ..... !

When I feel ..... Overwhelmed and Think .....



Just because ... I didn't ..... doesn't mean .....

.....

I know ..... is true because .....

.....

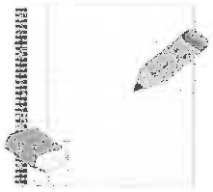
(Source: Riggenbach, J. 2013:251)

You will be expected to complete at least X2 "Activity coping card" as well as at least X2 "Cognitive cue card" within the group. Additional cards can be completed as part of homework.

Remember!

- Our thoughts; feelings and behaviour are shaped by how we make sense of / understand our world.

- However, the good news is: We can learn how to control / master our thoughts and behaviour. By making use of practical interventions / actions we actually start to take control of our lives again.



My Notes: .....

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C. Summary: Session 7

During this session we focussed on re-activating our lives pertaining to daily necessary tasks as well as pleasant activities. Can you remember - "Why it is necessary to re-activate these areas in your life?" "How is this relevant to depression?"

We discussed the importance of acknowledging our pain. We explored how to establish "meaning" and "mastery" in our lives. The value of activity – coping cards and cognitive cue cards were highlighted in order to facilitate coping and control when we feel overwhelmed.

D. Homework:

- Complete adjusted adapted "daily mood monitoring scale"

- Complete Beck Depression inventory.

- Complete worksheet: Acknowledging my pain, as well as worksheet: How can I validate my feelings?

- Complete: Activity – Coping cards.

- Complete: Cognitive Cue cards.

- Read notes for next session (Session 8).

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).

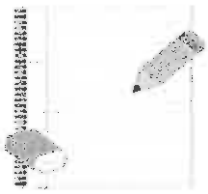
SESSION 8: HOPELESSNESS, UNHELPFUL THINKING / BEHAVIOUR AND SUICIDE

A. INTRODUCTION - SESSION 8:

This session serves to empower you when faced with strong emotions resulting in suicidal ideation and / or contemplating self-harm. Remember! The issue of suicide is a sensitive topic, but also a very real one. When requested to quote personal examples; you need to only disclose issues / aspects that you feel "emotionally safe" and comfortable with.

Purpose / goals of this session:

- To define the concepts "suicidal ideation" and "suicidal behaviour".
- To identify the link of suicidal ideation and behaviour as related to Beck's cognitive model of depression (Negative Cognitive Triad).
- To explore the theme of "hopelessness" as related to suicidal behaviour.
- To explore the role of negative thinking styles in hopelessness / suicidal behaviour (A – B – C model).
- To identify the devastating effects of attempted suicide / suicide on yourself; your life as well as significant others.
- To plan steps that can assist you in the "heat of the moment"- **"When feeling overwhelmed".**
- To develop your own "Individual Crises / Risk plan." (What do I do?).



My Notes: .....

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B. DEFINING SUICIDAL BEHAVIOUR:

What is your understanding of suicide?

1. Definitions:

Suicidal ideation & behaviour:

Literature refers to different concepts related to suicide. Suicide has a cognitive component (thinking styles) as well as a behavioural component.

- **Suicidal ideation: Thoughts** of engaging in suicidal-related behaviour
- **Suicidal attempts (behaviour):** Deliberate **acts of self-harm** with or without intend.

Hope:

- Hope implies positive expectations related to achievement of goals as well as towards the future.

Hopelessness:

As previously discussed when depressed we have a negative view of the self; our environment as well as or future. Hopelessness specifically revolves around this negative theme pertaining to the future.

Depressed patients with suicidal ideation / behaviour view themselves in a significant negative manner. For example: We see ourselves as .....

- Worthless
- Undesirable / unlovable
- Inadequate



My Notes: .....

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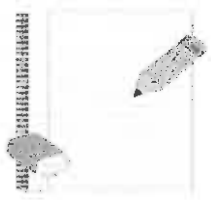
We often feel rejected by other people and belief that others do not support us. We also belief we do not have the capabilities (internal resources) or the external resources to cope with adverse events / trauma or everyday life problems. This results in feeling helpless. Thus, also feeling hopeless pertaining to the future.

During previous sessions you were introduced to the theory of cognitive behaviour therapy and how depression is viewed. You were also made aware that it is not necessarily the things that happen to us, but rather how we perceive and interpret these events that cause us to feel depressed. Our beliefs regarding ourselves; our environment; other people as well as the future have a vast impact on our mood.



My Notes: .....

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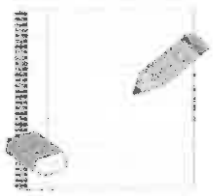
Dysfunctional thought patterns were also explored in terms of contributing to being depressed. When looking at suicidal ideation and behaviour the same principles seem to feature. When considering cognitive distortions; specific thought patterns seem to apply.

When suicidal the following mal-adaptive thought patterns feature:

- **"Black and White thinking"** e.g. thinking my life is a total disaster – leading to now hope regarding future expectations.
- **"Overgeneralization"** e.g. just considering one specific bad event as portraying whole situation as bad.
- **"Fortune telling" e.g.** believing that things will be bad / **"Catastrophysing"** can also lead to severe feelings of misery.

- **"Minimization"** e.g. failing to ignore positive aspects that may contribute to a sense of hope.
- **"Selective attention"** e.g. only concentrating on negative events that reinforce unhelpful thoughts.



My Notes: .....

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When feeling hopeless, thinking that: "Things will never get better!", we are especially vulnerable to indulge in harmful behaviour. Inappropriate harmful behaviour usually results from the abovementioned thought patterns as well as a lack of coping / mastering skills. This only aggravates feelings of worthlessness and despair.

Therefore this session will attempt to empower you when faced with suicidal ideation as well as self-destructive behaviour.



My Notes: .....

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2. Triggers – My feelings ..... My beliefs!

Think back to the last time when you felt overwhelmed; hopeless and considered hurting yourself). "How did you feel?"; "What were you thinking?" Use the sheet below to examine your own individual triggers.

"My Triggers – My Feelings ..... My Beliefs!



When ..... happens

(trigger) and I feel .....

What am I thinking / telling myself? .....

.....

Disputing / Talking back to my thoughts: .....

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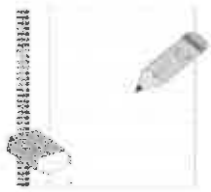
(Source: Riggenbach, J. 2013:327)



My Notes: .....

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3. My impulsive / ineffective "In the Moment ..... coping behaviour!"

"My ..... "In the moment" coping behaviour!



The last time I felt .....,

I did (hurt myself) .....

Other harmful things I did which only served to hurt me in some way .....

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What were the consequences (myself / my life)? .....

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What were the impact on significant others in my life (family / friends)? .....

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(Source: Riggenbach, J. 2013:329 – Adjusted for Mafube Affective Ward only)

4. Safeguarding my environment!

Now that we have identified harmful **triggers / buttons,** we need to plan to **safeguard** our **environment.**

Complete the worksheet below in order to facilitate this process.

Safeguarding my environment!

Areas I need to consider to safeguard in my environment:

.....

.....

.....

Pre-emptive steps I need to take to safeguard my environment ahead of time (Remember! Be specific):

.....

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Things I could do in the heat of the moment; when I might give in to harmful behaviour:

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(Source: Riggenbach, J. 2013:345)

2. Socratic questioning:

Challenging thoughts & perceptions by means of Socratic questioning!

Socratic questioning is used as a means to facilitate ***cognitive restructuring.*** The aim is to investigate underlying assumptions and evidence that formulate the basis of our thoughts and beliefs pertaining to problems experienced. When feeling overwhelmed try asking yourself the questions listed below.

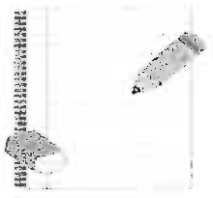
5.1 ***Revealing the issue:*** "What evidence supports this idea? And what evidence is against it being true?"

5.2 ***Conceiving reasonable alternatives:*** "What might be another explanation or viewpoint of the situation? Why else did it happen?"

5.3 ***Examining various potential consequences:*** "What are worst, best, bearable and most realistic outcomes?"

5.4 ***Evaluate those consequences***: "What's the effect of thinking or believing this? What could be the effect of thinking differently and no longer holding onto this belief?"

5.5 ***Distancing:*** "Imagine a specific friend/family member in the same situation. Would they view the situation in the same manner? What would I tell them?"



My Notes: .....

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B. OTHER TECHNIQUES THAT MAY BE HELPFUL:

There are several other techniques that can assist you when you are faced with thoughts and / or an urge to hurt yourself.

1. Distracting techniques:

When thoughts seem to be overwhelming to the point where you feel "stuck", it becomes difficult to analyse and evaluate your thoughts. In this case it is easier and more practical to "distract" one's mind. This technique does not assist with cognitive restructuring and should only be applied in the "heat" of the moment when other more functional options do not seem to apply. Use the list below to identify your own personal "distraction techniques".

My distraction techniques:

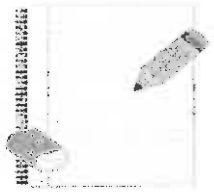
1.1 .....

1.2 .....

1.3 .....

1.4 .....

1.5 .....



My Notes: .....

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2. Soothing techniques:

When emotions are intense and running high, people often resort to impulsive or harmful behaviour. Therefore it is vitally important to develop coping skills which can be implemented to combat traditional dysfunctional coping skills. You need to be able to

"sooth" and **"comfort"** yourself when experiencing intense emotions. Soothing techniques will differ from person to person. The following can be examples:

- Taking a warm relaxing bath;

- Drinking a hot cup of tea;

- Listening to calming music;

Indicate your own personal soothing strategies in the lines below.

1. .....

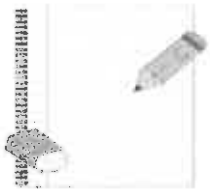
2. .....

3. .....

4. .....

5. .....

In conclusion you will also develop a **"Personal Safety / Risk Plan"** in order to act pro-actively in managing your suicidal ideation and behaviour.



My Notes: .....

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B. "MY PERSONAL SAFETY / RISK PLAN"

During this part of the session you will explore the value of a **"Personal Safety / Risk Plan"** in order to empower you when feeling overwhelmed and hopeless. Please see example below. You will need to complete your own individual safety plan as part of a homework assignment.

MY PERSONAL SAFETY / RISK PLAN



This tool will apply when you feel totally overwhelmed and hopeless and consider hurting yourself. It is important to note that suicidal ideation can be very prominent. You may feel that these thoughts will last for ever. However, given time and appropriate interventions these thoughts will become less prominent. When feeling suicidal you may have difficulty in focussing. Therefore this safety plan should feature where it is readily available and visible.

General precaution: Always ensure that your immediate environment is safe by removing all possible lethal methods. For example: Remove fire-arms and hand them over to authorities (When at risk a friend / family member can assist you). Ensure that treatment (medication) is controlled by a responsible person.

When having suicidal ideation start at the first step and go through them all until you are safe!

Step 1: Engage in the following activities that will calm / sooth and comfort me:

.....

.....

.....

.....

Step 2: Explore reasons for living / aspects of meaning in my life:

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Note! If religion plays a significant meaningful role in your life; you can call a supported member of the church / ministry.

Step 3: Call a supportive friend / family member:

Name: ..... Contact no: .....

Step 4: Call a back-up person if the person stated above is not available:

Name: ..... Contact no: .....

Step 5: Go to a place where I am safe e.g. friend / family member.

Step 6: Call a member of support group / crises line.

Step 7: Call a care provider (therapist / psychiatrist / psychologist).

Name: ..... Contact no: .....

Name: ..... Contact no: .....

Step 8: Go to the emergency room at the nearest hospital.

Step 9: If I think I will not be able to make it to the nearest hospital; call emergency services to transport me. Contact no: .....

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).

C. Summary: Session 8

The purpose of this session was to investigate your own thoughts and behaviour as related to suicide. This session also served to empower you to be able to challenge harmful thoughts and behaviour, with the end result seated in acting pro-actively when faced with suicidal ideation / behaviour.

D. Homework assignments:

- Complete adjusted adapted "Daily mood monitoring scale"

- Complete Beck Depression inventory.

- Complete worksheet: "My personal safety / risk plan"

- Read notes for next session (Session 9).

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).

SESSION 9: BRINGING IT ALL TOGETHER ..... PLANNING FOR THE FUTURE!

A. REVIEW OF PREVIOUS SESSION:

During the previous session you explored the concepts of suicidal ideation and behaviour. Beck's cognitive model of depression was reviewed as related to the phenomenon of suicide. You were also familiarized with specific cognitive distortions relevant in suicidal ideation. Personal triggers were identified / investigated. Relevant positive coping strategies were explored. You also had to attend to "Safeguarding your personal environment". Finally you had to develop your own "Personal Safety / Risk Plan".

1. Purpose of Session 9:

- During session 9 we will highlight and summarize the core concepts of cognitive behavioural therapy as applied to depression.

- The aim of this session is to empower you to be able to maintain and sustain therapeutic growth even after discharge.

- To gain insight in your own personal weaknesses in order to prevent relapse.

- To developing your own individual "Relapse Prevention Plan"

B. Introduction Session 9:

1. Bringing it all together:

Briefly revisit Beck's cognitive model pertaining to depression. Can you remember the Negative Cognitive Triad? Think back to the session related to the A – B – C model in emotions. Most people think it is the things that happen to us that cause us to feel depressed. However, during group therapy we realized that it is actually our thoughts (how we think about and perceive the event) that cause us to feel depressed. You were also familiarized with the significance of the A – B – C – D model (Disputing your thoughts).

Emotions; thoughts and behaviour are interrelated. Therefore change in one area; evokes changes in the other related areas.

B. My Therapeutic Journey ..... Does it end here?

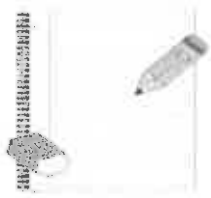
At the beginning of group therapy sessions you committed yourself to a specific therapeutic path involving a process of change. However, this process does not end here. In fact, when

feeling better it may seem irrelevant to keep up with implementing newly acquired information and skills.

On the contrary, we need to continue looking after ourselves! We need to keep on working on our thoughts and behaviour. Remember, thinking styles as well as certain behavioural patterns were developed and maintained throughout our entire lifespan up to the "now and here moment". When experiencing stressful life events it may be very easy to slip back to our previous thinking styles as well as old harmful / dysfunctional behavioural patterns.

As mentioned during previous sessions, cognitive behavioural therapy as a treatment model, focus on our reality in the "here and now" Everyday life is not without stress or trauma. Once we have experienced a depressive episode, we may be especially vulnerable towards depression when faced with stressful events. Hence we may or may not develop another depressive episode.

However, we can take specific actions in order to make it less likely, less severe and less frequent. It is therefore imperative to prepare in advance for such circumstances.



My Notes: .....

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1. My Journey of Change ..... What is different? – Reflecting back!

Your admission to the unit as well as your attendance of group therapy had a significant relevance in your live. During this process you committed yourself to engage in a therapeutic process of personal growth and change. However, the therapeutic journey does not end here! You need to stay focussed on the healthy path chosen. It is therefore important to remind yourself of the following:

- What were your reasons for engaging in this process?

- Why is it important to continue with the process after discharge? What are the benefits involved?

Self-reflection will enhance and maintain continuous self-development and growth. Thus, you are empowering and preparing yourself for facing possible difficulties after discharge.

Use the worksheet below to reflect back on your own individual therapeutic process.

My Journey of Change .... What is different?



What is different from before? What have changed in the following areas?

"In my thoughts": .....

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"In my feelings (emotional and physical": .....

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"In my behaviour": .....

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"How has these changes made a difference in my life?"

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(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).

2. Having direction ..... What really matters in my life?

Remember! – During session 7 you had to identify specific aspects of "meaning" in your life. One basic theme which surfaced throughout group therapy sessions was to instil a "sense of hope" in your life. Hopefully, by now your perception pertaining to your future has changed to a more positive / hopeful stance.

Reflecting back on what is important in your life will facilitate direction towards your future goals. Ask yourself why these aspects are important to you and remember this differ from person to person! These areas need to include significant others; looking after yourself as well as contributions you can make in other people's lives. Use the worksheet below to reflect on what really matters to you.

What really matters ..... in my life?



The most important thing currently for me is .....

.....

What do I want for my future? .....

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The people I value most in my life are .....

.....

Why are these people of value? .....

.....

What can I teach other people? .....

.....

What do I need to do for myself? .....

.....

This is important because .....

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(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).

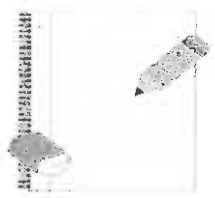
3. Relapse prevention ..... What if?

We live in a real world and at times we are confronted with stressful or painful events. Therefore a most frequent as well as important question asked is: ***"What happens after discharge? ..... What if?"***

Once you have experienced a depressive episode and / or are recovering from depression you may be especially vulnerable during stressful events. It is therefore imperative to increase self-awareness and to equip yourself with the necessary skills to deal with potentially difficult situations after discharge. This brings us to - ***"relapse prevention".***

Empowerment pertaining to relapse prevention involves knowing yourself (self-awareness), specifically related to your own individual vulnerabilities (weaknesses). Being aware of these vulnerabilities will assist you to plan in advance on how to deal with such circumstances. People differ, therefore difficult or vulnerable situations will also differ from person to person.

First of all you need to reflect on and identify your own individual vulnerabilities or what you perceive as difficult situations. You can consider a few practical examples listed below.



My Notes: .....

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3.1 A few practical examples:

I am especially vulnerable .....

- When I feel overwhelmed.

- When it seems that things are spinning out of control.

- When I feel rejected e.g. when I'm having relationship problems.

- When I feel that things are going wrong or will not work out for me.

Use the space below to explore and identify your own individual vulnerabilities.

Possible vulnerable situations / times in my life are .....

1. .....

2. .....

3. .....

4. .....

What new skills have I learned during group therapy? How can I use these skills during difficult times?

1. .....

2. .....

3. .....

4. .....

What can I do differently; when encountering these situations? .....

1. .....

2. .....

3. .....

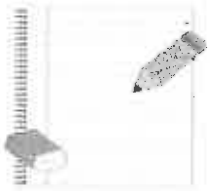
4. .....

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).

During the course of group therapy you were made familiar with the following links pertaining to depression: - altered thinking; altered feelings; altered behaviour; altered physical symptoms as well as the role of external events. Furthermore, you were also enabled to

explore your own individual thinking styles; behavioural patterns; related emotional / physical experiences as well as external life events and the significance there-of.

It is therefore significant to consider alterations in these spheres when considering relapse prevention. Changes in these domains can serve as ***early warning signs.*** Use the diagram below to identify your own individual warning signs (also see example below). This exercise will help you to reflect back on the symptoms you have experienced whilst being depressed. Thus, you will be reminded about – ***"What to look out for in future".*** The diagram on the next page serves as a practical example. You will complete your own diagram **(My early warning signs)** on page 64.



My Notes: .....

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Worksheet: Early warning signs (example).

Situation, relationships & practical problems:

* Feeling overwhelmed by circumstances.

Altered thinking.

* Extreme unhelpful thoughts dominating your mind (Remember faulty thinking / cognitive errors).



Altered feelings.

* Mood feeling down.
* Feeling more anxious.

Altered behaviour - unhelpful / harmful activities.

* Drinking more to block out feelings.

Altered behaviour – reduced or avoidant activities.

* Withdrawing from others.
* Avoiding activities by staying in bed.
* Reduction in activities.

Altered physical symptoms.

* Restlessness.
* Growing tension.
* Sleep disturbances / change in appetite.

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).

My early warning signs!

Situation, relationships & practical problems:

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Altered thinking.

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Altered feelings.

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Altered behaviour - unhelpful / harmful activities.

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Altered physical symptoms.

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Altered behaviour – reduced or avoidant activities.

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The purpose of the abovementioned exercise is to enable you to detect a possibility of relapse at an early stage before your symptoms get worse.

Remember! We do not always have control over our external environment. However, during group therapy sessions you became aware of your ability to exercise better control over your thoughts and behaviour. This aspect can have a significant impact on your emotional experiences.

After identifying your own individual ***"early warning signs",*** you need to plan pro-actively on how to act when warning signs occur. Thus, therefore you are going to develop your own individual ***emergency plan.*** Your own personal emergency plan also needs to include support resources. Supporting systems can involve appropriate significant others; close friends as well as professional organizations.

3.2 Emergency plan (Source: Rosoman, C. 2008:260):

Note! Be specific when developing your emergency plan".

What do I do?

What do I need to do when I notice any of the abovementioned warning signs?

When I resort back to unhealthy thinking styles, I can .....

.....

When I engage in altered behaviour (e.g. stop doing pleasant activities), I can .....

.....

When I consider engaging in unhealthy or harmful behaviour, I can .....

.....

When I experience altered physical symptoms (e.g. low energy), I can .....

.....

When I experience altered feelings (emotions), I can .....

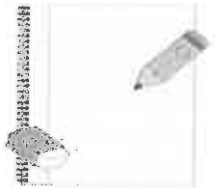
.....

The purpose of the abovementioned action plan is to allow you the opportunity to reflect back on the skills you have acquired during group therapy.

For example:

When resorting back to unhealthy thinking styles, you should identifying particular unhelpful thoughts involved. These thoughts should be challenged / disputed in the same manner as it was practiced during group therapy. You can use your work book as well as the relevant worksheets to challenge and chance these thought patterns.

When altered behaviour occurs (unhelpful behaviour or harmful behaviour); you can implement the principles of behavioural activation. The same applies to experiencing altered physical symptoms. For example when your energy level is low; activity scheduling may assist you. For example: Focussing on small, limited tasks.



My Notes: .....

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Social support systems:

When vulnerable; we often tend to seek support from sources which may not always be as beneficial as expected. Some might even be unhelpful and / or harmful. This may result in feelings of discouragement, hopelessness and helplessness.

Use the worksheet on the next page to identify possible appropriate support systems in your life. The most important relevant support systems are to be indicated in the larger figures, nearer to the centre of the sheet. On the other hand less important support systems can be reflected in the smaller diagrams, further from the centre of the worksheet.

What do I do?

My support systems:

Who can I go to for support if I need support?



If symptoms worsen in spite of actions taken, I need to .....

Get professional help!

1. Name of institution where follow-up was arranged .....

   .....

   Contact no: .....

2. Psychiatrist (name): .....

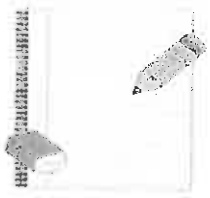
   Contact no: .....

3. Psychologist (name): .....

   Contact no: .....

(Muñdoz & Miranda, 2000; Riggenbach, 2013; Rosomon, 2008; Yalom & Leszcz, 2005).

Important note! When experiencing severe suicidal ideations / and or the intense urges to harm yourself; **you should report to nearest casualty / 24 hour emergence services.**



My Notes: .....

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3.3 Reflecting back: How do I see ..... Myself / My future / My environment?

During earlier sessions you were introduced to Beck's cognitive model of depression, namely: A person with depression views themselves; their environment as well as their

future in a negative manner (Negative Cognitive Triad). You also had to indicate how you saw yourself; your environment as well as your future. We are going to repeat this exercise using the table on the next page.

3.3.1 Worksheet: How do I see ..... myself / my environment / my future now?

How do I see		
Myself.	**My environment.**	**My future.**

Compare these two similar exercises with each other and ask yourself the following questions:

- Is there any difference in how I saw myself; my environment as well as my future as compare to how I view these aspects now?

- If so, what has changed?

Now, let us look at the ***"The Healthy Me!"***

5. In summary - Healthy me!

This worksheet need to be completed by yourself. The aim of this exercise is to reflect back on your process of change. At the same time it also serves as goal setting pertaining to a more ***"healthy / functional you"***.

(Source: Centre for Clinical intervention)

Healthy me!

Thinking:

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Relaxation / Exercise:

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Healthy



ME

Behaviour:

Pleasant activities

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Social activities.

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Behaviour:

Mastery

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Meaning:

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APPENDIX I

- **FIELD NOTES: PATIENTS EXPERIENCE OF NURSE-LED CBT GROUP THERAPY – A REFLECTIVE REPORT**

Patients' experience of nurse-led cognitive behavioural group therapy and changes in mental health care nursing practice resulting from the implementation of this study: A reflective report

The focus of group psychotherapy is rooted in interpersonal relationships and related mechanisms of change. Therefore the researcher compiled notes on group interactions and group dynamics during sessions with the objective of assessing the effective implementation and outcomes of specific group therapeutic principles which served as the core of the therapeutic group processes, and also to monitor the effects of the CBT groups on nursing practices and the therapeutic milieu.

Session 1: Understanding Depression

Session one commenced with an overview of ground rules pertaining to the group sessions. The benefits of attending group therapy were also highlighted. Irrespective of the possible advantages posed by group therapy, patients were reserved during the initial stages of session 1. The content of session 1 focused on understanding depression in terms of symptoms and available treatment options. Biological medical treatment options and psychosocial interventions were explored within the session. Providing psycho-educational information related to symptoms of depression and the availability of appropriate treatment interventions represented important therapeutic factors significant to the therapeutic group process as described by Yalom & Leszcz (2005:9.). Imparting of information aimed at assisting patients to gain a better understanding of depression.

Providing psycho-educational information was followed by an overview of Beck's cognitive model of depression; also known as the negative cognitive triad of depression. A practical group exercise facilitated this process. During this exercise patients were asked to mention within the group context how they viewed themselves, their world as well as their future. Most patients reported a negative view of themselves, thus representing a low self-esteem. Patients further indicated feeling worthless, hopeless and doubtful about ever feeling better.

Cognitive behavioural therapy was introduced which relates to the theoretical framework as well as the treatment intervention of choice for the intervention. Patients were introduced to daily mood monitoring including the concept of functional and dysfunctional thought patterns. This aspect formed part of a homework assignment which led to leisure time being utilised in a more constructive, functional and therapeutic manner. Homework assignments aimed at re-enforcing the learning process and providing the opportunity to reflect back at newly acquired information and skills.

Patients were also orientated regarding the advantages of group therapy in general. The following benefits of group therapy has been well documented in literature: Learning new skills for example socialisation in a safe environment, supporting each other, patients also

became aware of other members' improvement, establishing support systems even after discharge etc. Some participants were able to identify specific advantages related to participation in group therapy. Patients initially appeared reluctant and seemed guarded during the first session. This could be attributed to feelings of anxiety experienced regarding group interaction. When requested to reflect back on their experience of group therapy, patients mentioned initially feeling anxious due to not being used to discussing personal issues in a group context.

Irrespective of being wary during the first session patients were able to relate to symptoms of depression as the group progressed. Patients realised that they were not the only ones experiencing depression and associated depressive symptoms and thus became more open. This aspect represents an important therapeutic principle related to the therapeutic group process of universality as described by Yalom & Leszcz (2005:6). Some examples of symptoms mentioned by patients included feelings of sadness, hopelessness, worthlessness as well as physical symptoms for example headache, fatigue etc.

These expressed feelings of hopelessness and worthlessness relates back to Beck's cognitive model of depression, also known as the negative cognitive triad. According to this model people with depression have a negative view of themselves, their world and their future. Worthlessness represents a negative view of the self, whilst hopelessness relates to a negative view pertaining to future expectations. One participant very early on identified supportive protective factors which assisted in coping with depression and gave meaning to her life. The aspect of mastery and meaning were addressed as the core of session 7.

Towards the end of session 1 some patients managed to express a slight increase in feelings of hope and future expectations. This could be ascribed to realising that they were not alone; the availability of effective treatment as well as seeing patients admitted prior to them already showing improvement. Therefore, confirming group therapy as an important therapeutic tool in the installation of hope.

Session 2: Socialisation of Cognitive Behavioural Therapy (CBT) Model

The purpose of session 2 was to socialise patients with regards to the theoretical model underpinning cognitive behavioural therapy. This session in particular aimed at instilling a better understanding of the relationship between thoughts, emotions and behaviour as related to depression. Patients were introduced and familiarised to the A – B – C model of emotional reactions. This aspect was complimented with a practical group exercise. It provided patients with the opportunity to explore how different people had different perceptions (thoughts), experienced different emotional responses and reacted differently to the very same scenario (activating agent).

During this session some patients managed to express emotional experiences with ease, whilst some still remained slightly guarded especially when discussing perceptions and inner thoughts. Some patients even mentioned specific thought patterns which actually represented cognitive errors. Thus, the researcher could utilise the opportunity to observe specific thought patterns which played a significant role in emotional reactions and behavioural responses. These aspects could therefore be related to the session specifically dealing with cognitive errors (Session 4).

Group therapy sessions proved to provide mental health care professional nurses with an excellent opportunity to observe patients clinically pertaining to cognitive functioning, emotional responses as well as behavioural responses. For example: One patient was observed to have a sudden change in clinical symptoms. This patient initially presented with symptoms of depression as observed on admission and confirmed during session 1. However, during session 2 symptoms similar to symptoms of hypomania were observed. This was reported to the psychiatrist of the unit as well as other members of the multi-disciplinary team. The patient was referred for neurological assessment and organic pathology was identified. Thus, professional mental health care nurses were able to provide valuable clinical information to the multi-disciplinary team and clinical management of the patient could be adjusted appropriately and accordingly.

Session 3: It's all about Thoughts (How Thoughts Affect My Mood)

Session 3 focussed specifically on how thoughts affect the mood of patients. During this session Beck's cognitive model of depression were explored. Depressive thoughts versus non-depressed thoughts were discussed as related to emotional experiences. Discussions on different styles of thinking were included in this session and patients were guided to identify their own styles of thinking. Patients had to utilise a worksheet related to self-labelling – My bad thoughts in order to identify dysfunctional styles of thinking.

The majority of patients were able to identify thoughts related to how they viewed themselves, their world and their future. Interestingly, patients were more open during this session and managed to challenge each other's thoughts within the group setting in a non-threatening manner. It was obvious during this session that a therapeutic relationship between patients, professional mental health care nurses and the facilitator had been established. This was based on mutual trust between patients and the nursing staff as well as amongst the patients themselves.

The process of therapeutic change was also introduced during this session. The principle of change represents a core principle in Beck's cognitive theory of depression. According to this principle change in one domain will introduce change in another domain. This implied that by changing a person's thoughts regarding themselves, their world and their future will lead to change related to emotional experiences and behavioural responses. The possibility of change fostered hope within the group, which is an important factor in the management of depression.

Information processing pertaining to the self, the world and the future were discussed. The concepts of cognitive structures, schemas, assumptions and automatic thoughts were introduced and further explored. Patients had to identify their own individual automatic thoughts. Examples of adaptive and maladaptive schemas had also been explored within the group.

Notably, one patient returning from a therapeutic weekend leave reported that she managed to practise some of the skills acquired during group therapy at home. The patient verbalised that she previously viewed herself as a bad mother and felt guilty when not taking responsibility for her already adult children. However, by session 3 she was able to identify

dysfunctional thoughts related to this, as well as resulting emotional experiences and associated behavioural responses. According to the patient she was able to restructure her thoughts to a more functional stance which resulted in a decrease of guilt feelings. She subsequently also refrained from taking full responsibility for the actions of adult children. Thus, change occurred pertaining to emotional experiences as well as behavioural responses.

During this session daily mood monitoring charts of patients showed an improvement in mood. Patients' functional thoughts also increased and patients were able to identify the link between improved mood and adapted functional thought patterns.

Session 4: Cognitive Errors (Mistakes in Thinking)/ Challenging Unhelpful Thoughts

During session 4 cognitive errors were discussed in-depth. The following cognitive errors were explored: Catastrophizing, overgeneralization, mental filtering, minimisation, black and white thinking, emotional reasoning, jumping to conclusions, labelling, should or musts, mind reading, personalising and blaming. This was followed by a practical group exercise during which patients had to mention practical examples of their own individual cognitive errors. Patients also had to complete a homework assignment related to this aspect.

Complimentary to session 4 was the A – B – C – D model: A (activating agent) – B (belief) – C (consequence) – D (disputing the thoughts). This model introduced the principles of cognitive restructuring. Cognitive restructuring had been practised within the group by means of a practical exercise. This was followed by exploring additional strategies for example, thought stopping which could assist patients in decreasing dysfunctional thoughts.

During this session group cohesion was evident and patients managed to verbalise practical examples. Patients were also able to identify cognitive errors as observed in each other and managed to assist each other in restructuring of these thoughts.

After concluding this session, professional mental health care nurses remarked that observing patients and participation in group sessions contributed to their development on a professional as well as personal level. The concepts of cognitive errors and cognitive structures (schemas, assumptions and automatic thoughts) were new to the nursing staff. More than one professional mental health care nurse mentioned applying the principles of cognitive behavioural therapy in their own lives.

Professional mental health care nurses were also able to report important information obtained from group sessions to members of the multi-disciplinary team. These observations included for example, specific symptoms related to emotional and behavioural responses. Professional nurses could also report on the clinical improvement of patients. In addition, members of the multi-disciplinary team reported patients grasped therapeutic principles easier and this was probably the result of attending group therapy.

In summary the first 4 sessions orientated patients to the cognitive approach of cognitive behavioural therapy when dealing with depression.

The first 4 sessions of the nurse-led cognitive behavioural group therapy programme were followed by sessions focussing on the behavioural approach of cognitive behavioural therapy as related to depression.

Session 5: Behaviour and Depression

Session 5 specifically focused on behavioural responses related to depression. The following 5 links of depression were explored and discussed as a vicious circle: Altered thinking; altered emotions; altered physical feelings and altered behaviour. Patients had to provide examples of altered physical feelings as well as altered behavioural responses. Altered behaviour included referring to two components, decrease in activity level as well as engaging in harmful behaviour (self-sabotage). During this session patients initially seemed at ease with discussing the concept of a decrease in activity level and could identify their previous level of activity compared to their level of activity whilst experiencing depression.

Session 5 was facilitated with a group activity during which patients had to identify harmful behavioural responses. The impact of engaging in harmful behaviour was further explored. However, when discussing harmful behaviour patients once again became guarded. One patient for example, mentioned in retrospect that it was extremely difficult to confide and mention within the group that she attempted suicide by cutting her wrists, although she actually felt better when she realised that she was not being judged by the other members. Another patient shared the devastating effect of an interrupted suicide attempt. Discussing harmful behaviour within the group proved to have positive outcomes. When one patient shared that she had resorted to substances whilst feeling depressed, it led to another user also admitting to substance abuse. However, this patient did not share this with any other team member and provided the opportunity to treat patient appropriately.

This session was concluded by giving a homework assignment related to harmful behaviour (How do I sabotage myself?). Patients had to make a list of the things they stopped doing as an introduction to session 6 which addressed behavioural activation.

Session 6: Behavioural Activation

Session 6 gave a brief overview on dysfunctional behavioural responses and patterns. Patients had been introduced to the principles of behavioural activation. The following components of behavioural activation were discussed: Important functional areas of everyday life, engaging in pleasurable activities and socialising with others. This was linked with activity monitoring. Patients were provided with an activity log worksheet and had to monitor their daily activities accordingly. The purpose of this exercise was for patients to assess the amount of time they spend on constructive activities and how much time and energy was actually spend on dysfunctional activities.

Activity monitoring was followed by a discussion on activity scheduling. The aim was to assist patients in reactivating their lives whilst still being admitted in the unit. In addition, the benefits of engaging in pleasurable activities were explored. Patients had to list at least one functional necessary activity such as feeding the fish. Thereafter, patients had to list at least one pleasurable activity which they stopped doing and had to commit themselves to reactivate this specific activity for example, reading, gardening, etc.

During this session patients were introduced to the adapted daily mood monitoring chart and were asked to record their mood, thought patterns and behavioural activities as a homework assignment. Session 6 was followed by session 7 which focused on mastery and meaning in patients' lives. Patients managed this aspect of group therapy effectively and were able to relate to the principles of behavioural activation including the importance of engaging in pleasurable activities. Interestingly, some patients reported realising that they will have to take responsibility for reactivating their lives.

Session 7: Mastery and Meaning

Whilst session 6 largely focused on activity monitoring and scheduling, this session focused on taking charge of your life. The core of this session centred on three specific aspects of behavioural activation, namely pleasure, mastery and meaning. Pleasure was yet again highlighted as an important factor in emotional wellbeing. Patients were also made aware of the importance of the need to experience a sense of achievement, fulfilment and belonging. This was followed by a practical group exercise during which patients had to identify important areas of mastery being neglected whilst being depressed. Patients were provided with a personal mastery card (to-do-list), indicating at least two activities of mastery which they had to commit to.

Patients were reminded that depression involves and influences the following important areas: thoughts, emotions, physical feelings, actions and physical functioning. These components are interrelated and therefore change in one area will result to change in another area. The purpose of re-enforcing this principle was to instil feelings of hope.

The discussion on mastery was followed by exploring meaning in patients' lives. Patients were made aware that all people have certain values and a unique manner in which they interpret their lives as being meaningful. Possible examples of meaningful areas were explored and patients were asked to identify meaningful areas in their own lives.

The value of group therapy was evident during this session, since patients could assist each other in identifying specific areas of mastery and meaning. One patient for example, was reminded that he previously conducted voluntary work at his church and mentioned feeling less worthless after the others acknowledge his contribution to society.

Session 7 was concluded with a discussion on the importance of acknowledging emotional distress and pain, in a constructive manner. In addition, painful situations and personal losses formed part of the group discussions. Validation of feelings was facilitated by utilising a mood board – How do I feel today. This was followed by discussing positive coping mechanisms and patients had to indicate these strategies on activity cards which included behavioural as well as cognitive aspects.

Patients subsequently explored the positive aspects in their lives. This was accommodated by means of activity cards – Counting my blessings. Patients managed to participate actively and some patients once again assisted each other in this regard. However, in retrospect this session utilised a large number of activity cards, leading to the session being too compact.

This session included further exploration on the benefits of reactivation.

Session 8: Hopelessness, Unhelpful Thinking / Behaviour and Suicide

Session 8 focused on hopelessness, dysfunctional thoughts, dysfunctional behaviour and suicide. It was specifically included in the programme due to the fact that suicide increases the mortality risk in depression and aimed to provide patients with the necessary skill to counteract suicidal ideation and self-destructive behaviour.

Patients had to explore the concepts of suicidal ideation and behaviour, relating back to Beck's cognitive model of depression. Suicidal ideation and behaviour were explored on the basis of Beck's negative cognitive triad. Depressed patients usually have a negative view of the self, their environment and their future. Hopelessness specifically revolves around a negative view of the future. The way in which patients viewed their future represented an important link with future expectations and hope. A negative view of the self on the other hand often resulted in feelings of worthlessness and inadequateness.

Patients experiencing suicidal ideation tend to have specific dysfunctional thoughts patterns. Negative automatic thoughts included for example 'I'm unlovable". When exploring suicidal ideation specific cognitive errors were highlighted in the group. Black and white thinking, for example, thinking that the circumstances in life were disastrous seemed to negatively impact future expectations and hope. Fortune telling and catastrophizing further resulted in severe feelings of misery and distress.

Patients had to identify specific triggers involved in suicidal ideation and suicidal behaviour. The content of this session represented sensitive information and some patients verbalised it being difficult to discuss these aspects within the group. However, the patients managed to participate and one patient specifically made a valuable contribution by mentioning the devastating effects of attempted suicide on her life. This patient previously attempted suicide which resulted in having cognitive impairment and shared the impact thereof on her life.

After identifying personal triggers, patients had to explore safeguarding their environment. Discussions on additional therapeutic techniques that could assist patients when experiencing suicidal ideation and urges, were included. It entailed Socratic questioning which could be used in challenging specific thoughts and perceptions. Others included distracting techniques and soothing techniques. In conclusion, patients had to compile their own personal safety plan.

During this session patients were provided with the opportunity to analyse specific thoughts and behaviour patterns pertaining to suicidal ideation and suicidal behaviour. This session aimed to empower patients to act proactively when experiencing suicidal ideation and urges to engage in suicidal behaviour.

Session 9: Bringing it all Together ..... Planning for the Future

Session 9 included an overview of the principles of cognitive behavioural therapy. Beck's cognitive model of depression was reviewed and patients had to reflect back on the negative cognitive triad of depression. This aspect was addressed in a practical group exercise and patients had to indicate in a worksheet how they viewed themselves, their world and their future at this point in time compared to the first session. Patients also had to reflect back on what was different compared to previously. Patients reported viewing themselves in a more positive manner and expressed hope pertaining to future expectations. Group members however reflected that they will have to continue to implement the new acquired skill in order maintain emotional wellbeing.

Relapse prevention were also addressed and possible relapse triggers explored. Patients also had to list appropriate skills which could assist them when feeling vulnerable. This was followed by a discussion on early warnings signs which could indicate possible relapse. The aim of this session was to prepare patients for discharge. Thus patients had to compile a relapse prevention plan which could assist them when feeling overwhelmed. Previously discharge planning in the unit only entailed scheduling a follow-up appointment and providing medication for a specific period after discharge. During this session the researcher in collaboration with the professional mental health care nurses identified that this session should feature as part of the formal discharge plan in the unit.

This session was concluded by completing a worksheet allowing patients to reflect back on their process of change in experiencing emotional wellbeing. Patients were also provided with the opportunity to express their experience regarding participation in nurse-led cognitive behavioural group therapy.

PATIENTS' EXPERIENCE OF NURSE-LED COGNITIVE BEHAVIOURAL THERAPY

The following information was obtained with regards to patients' experience of nurse-led CBT group therapy.

Group therapy assisted the patients in gaining a better understanding of depression and the available treatment interventions. This aspect represented the provisioning of educational information. The goal of imparting information was to eliminate any misconceptions pertaining to mental health illness as well as treatment interventions. This aspect fostered hope and patients realised that help is available. Patients reported experiencing disclosure of personal distress within the group as quite difficult. However, participation in group therapy made them realise that they were not alone. Patients actually felt relief when others reported similar problems regarding life experiences. Patients became more open in disclosing information when they realised that other members of the group experienced similar symptoms. Patients thus experienced a sense of universality.

Group therapy sessions were designed to accommodate the acute admission setting and therefore the intervention made use of open group format. Different patients joined the group therapy at different times. The implication thereof was that new patients with severe levels of depression were allowed to observe fellow patients describing their feelings on admission compared to after having participated in a certain amount of nurse-led CBT group

sessions. This experience induced a sense of hope. According to literature hope is an important therapeutic factor in the process of change (Yalom & Leszcz, 2005:4). Experiencing a sense of hope is also important in maintaining emotional wellbeing.

Although the intervention did not address anxiety as such, group sessions assisted patients with this aspect. One patient for example, mentioned experiencing social anxiety and participation in the sessions assisted her with addressing this problem in a safe therapeutic environment. Participation in group therapy also provided an opportunity to observe how perceptions, thoughts, affective responses and behavioural responses differ from person to person. One patient stated that she felt irritated when another patient complained about physical symptoms. In group therapy group members will eventually act in the manner in which they react in society and in their family. Group members in this case made the patient aware that they experience her lack of empathy with others as distressing. This was addressed in the group context whilst being facilitated by the group leader. Group sessions therefore also assisted in the recapitulation of the primary family group (Yalom & Leszcz, 2005:15).

Most patients with depression admitted to the unit described intense feelings of worthlessness. Participation in group sessions made them realise that they can make valuable contributions to other members of the group. This process is descriptive of the therapeutic factor altruism, as described by Yalom & Leszcz, (2005:13). According to these authors human beings have a deep sense of receiving through the process of giving. Realising that they are important to others and that they can help others improved the self-esteem of patients.

Patients reported that the most difficult aspect of group therapy was discussing intimate information in the group. They found it especially difficult to discuss self-destructive behaviour. However, realising that other patients sometimes resorted to the same kind of behaviour helped and not being judged helped with feeling less guilty.

APPENDIX J

- **STANDARD NURSING PROGRAMME**

DAYS:	TREATMENT INTERVENTIONS:	ALLOCATED TIMEFRAMES:	TEAM MEMBER/S INVOLVED:
MONDAY till Friday	Bathing & hygiene	07:00 (1hr)	PMHCN
	Medication	08:00 (45min/session) 13:45 21:00	PMHCN
	Occupational therapy	09:00 till 10:00 14:00 till 15:00 (excluding Wednesdays & Fridays)	Occupational therapist
	Recreational activities	Adhoc (not scheduled formally)	PMHCN
	Dr's rounds	10:00 till 12:00	Registrar Psychiatrist
	Individual psychotherapy	10:00 till 12:00 13:00 till 14:00	Psychologist interns
	Recreational activities	Adhoc (not scheduled formally)	PMHCN
	Physiotherapy	14:00 till 15:00 (Wednesdays only)	Physiotherapist (on referral base)
	Social work interventions	In between	On referral base only
	Nursing care assessments / Nursing care progress writing / counselling.	1hr : 16:30 till 17:30 1hr	PMHCN
WEEK-ENDS	(No structured programme)		
NOTE:	Times not indicated in the abovementioned table are utilized for additional daily activities of living, recreational activities facilitated by MHPNs' or structured by the patient him/herself.		

APPENDIX K

- **PLAGIARISM DECLARATION**



Postgraduate Office, Faculty of Health Sciences

Wits Medical School, 7 York Road, PARKTOWN, 2193, Johannesburg • Tel: (011) 717 2240 • Fax: (011) 717 2110 • email: [illegible]

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I Herta Maria Petronella Vidugie (Student number: 1002184) am a student registered for the degree of MSc Nursing in the academic year 2014.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this in not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature: [signature] Date: 15/8/14

HMP Vidugie

APPENDIX L

- **TURN-IT-IN REPORT**

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by Hester Visagie

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5	wiredspace.wits.ac.za Internet Source	<%1
6	pirun.ku.ac.th Internet Source	<%1
7	Gandhi, Smiti. "Faculty-Librarian Collaboration to Assess the Effectiveness of a Five-Session Library Instruction Model", Community & Junior College Libraries, 2005. Publication	<%1
8	espace.curtin.edu.au Internet Source	<%1
9	psychiatryonline.org	