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A Support Group for Depression

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Introduction

My project was to participate for three months as a co-facilitator in a support group at the Whatcom Counseling and Psychiatric Clinic. As a psychology major at Western, I learned theory behind disorders and treatments from textbooks. However, I wanted some actual experience in a clinical setting.

Support groups allow people who are dealing with similar issues to get together and talk about their experiences. Support groups form for a variety of issues ranging from depression and anxiety to groups for patients with breast cancer or groups for caregivers of Alzheimer's patients. The goals of these groups are not necessarily to cure or fix one's problems. Rather, these groups aim at giving support to members, thereby relieving some of the weight of the problems. This support may serve as a stepping stone allowing members to step out and regain some control in their lives.

Groups may also increase feelings of normalcy. When people face problems alone, they often feel deviant because their emotional reactions are different from others' around them. When they see these others feeling fine while they themselves are not, they feel abnormal. By participating in groups where others have similar reactions, they have an opportunity to realize that they are normal and responding appropriately.

Groups can also increase members' understanding. Borkman (1976) identifies experiential knowledge as the understanding of people who have experienced problems the group is discussing. When a client talks to a professional who has learned the issues of a problem from schooling, the information that is given is different from the information that clients get by talking to other clients who have experienced the

phenomenon. This experiential knowledge can be more practical for individuals dealing with common issues.

I participated as a co-facilitator in a depression support group for three months. I was with a trained facilitator who was working on her master's degree. There were seven clients in the group, although attendance varied and sometimes as few as three clients participated. Groups met weekly for ninety minutes. We began with a check-in where each member had time to talk about how their week had been since the last meeting. During this time however, they could talk about any of the issues with which they were dealing. This could include childhood abuse, interpersonal problems, or difficulties coping with their present situation.

Part of our job as facilitators was to draw connections between participants' problems and issues. We looked for commonalities in individual experience. This helped members see that they were not alone and not deviant or abnormal for reacting the way they were. It also facilitated discussion as members saw that they had a lot in common.

Our job was also to encourage interaction between members. There is a tendency for participants to talk to facilitators and ask for advice at the exclusion of the group. We tried to return discussion to the group by deflecting attention to other group members. After check-in, which could last for up to 45 minutes, the second half of the group was open. The clients wanted a fairly unstructured format, allowing for the dialogue to follow the current issues being discussed. However, sometimes we had daily themes that we focused on throughout the discussion. Examples are normalcy, automatic thoughts, and the inner critic. Normalcy refers to the idea that there is some normal group of the

population to which the clients were comparing themselves, increasing feelings of deviance. We also discussed automatic thoughts, which arise from underlying attitudes and beliefs. These thoughts often surface before stressful events and can undermine one's performance. Examples include: "everyone will laugh at me if I try," or "I will make mistakes as soon as I start." Finally, we tried to raise awareness about the inner critic that constantly judges and condemns clients faced with depression.

Theory Behind the Isolation of the Depressed

Oftentimes people dealing with trauma, abuse, or loss do not necessarily have solid social support networks. This isolation in victims can lead to feelings of deviance. Furthermore, social support can perpetuate deviance in victims (Coates and Winston, 1983). Friends and relatives try to help by saying "cheer up, things aren't so bad" or "don't worry" and "don't dwell on it." Yet victims can't just cheer up and they begin to feel like something is wrong with them. Also, friends and relatives want to help but they become disturbed by the sadness, crying, and despair. The result is that they make supportive statements accompanied by negative nonverbal behavior such as less smiles, increased avoidance, and occasional outbursts of hostility and derogatory remarks due to the stress they are under. This incongruency between friends' words and actions make the victim feel even more strange and abnormal. Furthermore, while victims are feeling a host of emotional reactions, those around them seem to be functioning fine. Therefore, the social support has the effect of making the victims feel deviant.

Deviance has been linked to depression (Coates & Winston, 1983). First, deviance increases feelings of isolation and loneliness. Deviants feel like they are unique

and therefore have to face the world alone. Second, according to Kelley's (1967) Attribution Theory, people who see less consensus for their feelings and behaviors tend to make internal attributions for them. In this case, depressed people who see others around them functioning fine attribute the cause of their depression to something wrong with them, such as incompetence.

Coates and Peterson (1982) actually correlated depression with feelings of deviance. They administered questionnaires to 432 undergraduate psychology students. Questions measured their preferences in arbitrary situations such as if subjects would prefer buying broccoli or asparagus at the supermarket. They also had subjects record the percentage of their peers they thought would do the same thing. They found that the more depressed subjects were, the less they thought others would agree with their choices. Therefore, the depression of the subjects was correlated with their feelings of deviance.

How Groups May Help

Support groups may counteract these feelings of deviance. By being around other people with similar experiences, individuals may feel less alone and isolated. They may also get a sense of being understood, along with feeling validated through the support of others.

Latane, Eckman, and Joy (1966) paired subjects in groups of two and divided groups into three experimental conditions. Either none, one, or both subjects received painful electric shocks. After subject pairs were given time in a waiting room to discuss their experiences, researchers found that pairs in which both subjects received the electric

shocks posed more personal questions of each other, made more personal statements about themselves, were better judges of their partner's level of disturbance, and liked each other more than either of the other two conditions. Therefore, people undergoing similar problems appear to form closer immediate connections with each other.

This same process may apply to members of support groups who are undergoing similar problems. Furthermore, groups may counteract negative internal attributions such as incompetence when others around them are reacting in similar ways and they perceive greater consensus for feelings and behaviors. Therefore, groups may validate and normalize their members.

However, rather than feeling less deviant, group members may just identify with a deviant subculture (Coates & Winston, 1983). Members may have felt different from what they considered normal in the past, but after participating in a group of other "deviants", members may feel a part of this deviant group.

There is also the potential for a downward spiral in depressed groups (Yalom & Lieberman, 1971). As members become more comfortable talking about their problems and feelings, they may begin to realize more depression and describe it more deeply. The result may be that members actually feel more depressed. In the study by Latane, Eckman, and Joy (1966), while pairs where both subjects received electric shocks liked each other more, they liked the shocks less than those in the other two conditions where one or both subjects did not receive shocks. Researchers reported that after talking to each other, subjects re-evaluated their experience of the shocks based on the other's comments and found the experience to be more aversive overall.

The same may be true for support groups. Members may feel deeper depression after discussing and re-evaluating their experiences. The question then arises, do group members feel more deviant and depressed after contact with other depressed members? Or do they feel more understood, validated, and normal? A review of the evidence helps answer this question.

Evidence

There is some evidence for support groups' ability to counteract feelings of deviance. Barrett (1978) studied the effects of a widow's support group. They found one of the main changes reported by participants was feelings of "unique experiences" in an open-ended, self-report questionnaire. This may be closely related to deviance. Furthermore, Coates and Winston (1983) devised a 10-item deviance questionnaire for a rape victims' support group. They found a significant drop in perceived self-deviance in participants after finishing a support group. Therefore, though studies are limited and lack control groups for comparison, support groups appear to combat feelings of deviance among participants of groups.

In order to assess feelings of support and belonging Fiedler (1993) measured levels of cohesion, using the Group Climate Questionnaire-Short Form (GCQ-S). This questionnaire measures feelings of cohesion and connectedness rated by members, group leaders, and external observers. Group cohesion was found to increase over time in both depression support groups and cognitive-behavioral therapy (CBT) groups for depression. Furthermore, greater cohesion correlated with lower levels of depression. However, since correlation does not necessarily equal causation, the data was analyzed further.

Cohesion scores showed a nearly significant trend in predicting the subsequent week's depression scores ($p<.056$). However, this trend was not reversible, since one week's depression score did not predict the following week's cohesion score. Therefore, cohesion does seem to play a role in reducing depression. and this cohesion is a characteristic of groups.

In my observations, this cohesion was easy to see. As the group began, members stayed distant. When they spoke, they used more of a monologue style without giving or looking for input from others. There was also less emotional involvement in what they chose to disclose. However, after time went on, cohesion greatly increased. Members offered and sought more support and validation of each other. They also offered solutions to problems other members were dealing with. They would offer actual physical help in the form of giving rides or helping others move to a new apartment. Some members began meeting outside of group for activities such as roller skating or bowling. Finally, they remembered each others problems and asked about the status of the problems during future meetings, providing a sense of being understood and remembered. This support and cohesion developed in the depression support group in which I was volunteering.

Typical of depressed clients, most of the members I worked with were highly inactive. They had difficulty maintaining social relationships and were often too inactive to even get out of bed or maintain basic hygiene such as showering. Therefore, to see members reaching out by supporting and validating each other stood out as a sharp contrast to their normal lifestyle. Therefore, this quality of cohesion speaks as a great testimonial for groups' ability to activate and involve its members.

Groups also show some ability to reduce members depression. The most comprehensive review I found was on CBT group work. This style of group is more structured than traditional support groups and involves cognitive exercises. The most comprehensive review was by Peterson and Halstead (1998). In 17 studies, they found a 57% reduction in depressive symptoms among group participants as measured by the Beck Depression Inventory (BDI), a self-report questionnaire. In studies that included waiting list controls, there was an overall 11% reduction in depressive symptoms. This waiting list is important because depression is a highly dynamic phenomenon and many of those who suffer from it feel better simply with the passage of time. However, the group format reduces depression as measured by the BDI 46 % more than what can be expected with no treatment.

While the group in which I volunteered used some cognitive techniques, it was primarily a support group. In my review, support groups did not favor as well as CBT groups in general depression. Maynard (1993) reports that women showed significant reductions in depression (measured by the BDI) after participation in a CBT group. Support groups also lowered scores but not significantly more than the waiting list control. Therefore, while support groups showed a definite trend in reducing depression, the effects were not significantly lower than no treatment.

However, a number of studies have shown a great benefit of support groups with depressed people that are dealing with tangible problems. Kelly et al. (1993) found that depressed subjects infected with HIV responded equally well to a CBT group as they did to a support group. Tutty, Bidgood, and Rothery (1993) evaluated 12 support groups for battered women. While they didn't measure specifically depression, they did find

significant improvements in self-esteem measured by the Coopersmith Self-Esteem Inventory (SEI), a self-report questionnaire. This increase in self-esteem may be related to a decrease in depression. Edelman, Bell, and Kidman (1999) studied depression in patients with breast cancer using the Profile of Mood States (POMS), a self-report questionnaire. They found significant improvement for both CBT and support groups. Furthermore, groupwork with elderly depressed has been shown to be effective. Gorey and Cryns (1991) conducted a meta-analysis of studies for groupwork for the elderly and found 42% of participants showed a change for the better. Elderly typically have less major depressive disorder diagnoses and more tangible problems such as bereavement and adjustment disorder (Ladish, 1993). Therefore, the success of groupwork for elderly depressed supports the possibility that groupwork is more effective for depression stemming from more tangible problems.

Overall, depression is a complex and multifaceted phenomenon making certain conclusions difficult. However, the group format appears to help in depression, especially when the depression is related to some tangible circumstances. My personal observations strengthen my belief in the efficacy of group therapy. At first I was skeptical. I came from a school environment that teaches different approaches and techniques to be applied. However, support groups are often highly unstructured. Furthermore, it is difficult to assess depression levels since clients talk more about their depression as they got to know each other better and possibly realized more deeply how their depression affected their lives. So at times they sounded like they were getting worse rather than better. However clients would talk about the importance the group had for them. It was something to which they looked forward to each week. For some, the

group served as motivation to get out of bed. Some clients said the group was their only chance for interaction with others, as they were almost completely isolated. The group was definitely meaningful for its members.

However, the group was no cure. Only one of the seven clients discontinued participation after completing the 16-week group. The other six clients enrolled in the next depression support group after the completion of the last. Furthermore, not all treatments work for everyone. Personality characteristics may determine which people are helped by groups. There were definitely different personalities within the group that I participated. Some people were more supportive and outgoing. These people may find groups most beneficial, since people derive a sense of meaning and worth by helping others (Salem, Bogat, & Reid, 1997). Some people were more introverted. These people may also benefit more since groups increase their ability and opportunities to be social. Some participants may even be hurt by groups. Yalom and Lieberman (1971) reviewed 18 encounter-groups, a more confrontive style of group. They found 7.5% of members were casualties of the group, where their symptoms actually got worse because of group participation. Therefore, it may be important to find which personalities are most benefited by groups for better placement and subsequent results.

Conclusion

Overall, there are many issues people face that their support networks cannot deal with. Groups provide an opportunity to receive support and validation to help members feel more normal and increase their understanding of issues they face. In the literature I reviewed, groups have decreased feelings of deviance, increased feelings of cohesion and

support, and reduced depression, especially when the depression is related to some tangible circumstances. Furthermore, individuals expressed the meaning and worth that the group experience provided for them.

The group experience had considerable meaning for me. It meant engaging people on a real and honest level. If one gives insincere empathy to a depressed client, the client will sense the lack of authenticity and feel condescended. I felt challenged to truly feel empathy for others in pain and express it with sincerity.

The group experience also meant seeing people beyond labels. I have learned in school about different diagnostic criteria for a bipolar or a major depressive. In group I felt challenged to see the clients as real people beyond their diagnoses.

This experience even meant getting depressed myself at times. I listened to people who had gone through severe abuse and had very difficult lives. It was difficult to listen to such pain and feel powerless to change it.

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