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UNDERSTANDING USUAL CARE IN SCHOOLS: A MIXED METHODS APPROACH

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KATIE MOORE, PSY.M.

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APPROVED:

Jami F. Young, Ph.D.

Daniel B. Fishman, Ph.D.

DEAN:

Stanley Messer, Ph.D.

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ABSTRACT

Approximately 75% of youth who receive mental health services are receiving those services in schools, and yet a scarcity of research exists on the types, intensities, quality, and effectiveness of school-based interventions, creating a serious public health concern (Rones & Hoagwood, 2000). The few studies examining usual care (UC) services suggest that significant variability exists in the therapeutic process and effectiveness of those services (Weisz, Jensen-Doss, & Hawley, 2006). While over four decades of research have spurred the development of a number of evidence-based prevention and treatment interventions for youth and families (Weisz & Kazdin, 2010), transporting these protocols to real-world, community settings has been wrought with challenges (Southam-Gerow, Rodriguez, Chorpita, & Daleiden, 2012). The present study seeks to obtain a better understanding of the specific factors that impact intervention outcomes in schools by using a mixed methods approach. Systematic case studies of two school counselor-led groups focused on the prevention of depression symptoms in youth—specifically a positive outcome group and a negative outcome group—were examined. Qualitative data from video recordings and observational coding data of the interventions were used to examine the therapeutic processes of the selected groups during the intervention, and quantitative data from self-report measures were used to examine the outcomes through 6-month follow-up. Case study findings suggest that therapeutic strategies, including use of evidence-based strategies, adherence to identified goals, and repeated application of the group material, contributed to improvements in depression symptoms and functioning. Results also underscore the importance of establishing group cohesion and alliance as well as understanding logistical barriers that may interrupt important therapeutic processes. The implications of these variables are discussed for future research and training initiatives.

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I. Case Context and Method

Findings from randomized controlled trials (RCTs) comparing empirically-based treatments (EBTs) to those used in real-world community settings, or usual care (UC), have generally demonstrated that EBTs are better at ameliorating mental health difficulties in youth (e.g., Weisz, Jensen-Doss, & Hawley, 2006). However, some studies have shown that UC interventions are beneficial and can be superior to EBTs (Weisz, Jensen-Doss, & Hawley, 2006; Weisz et al., 2009). Unfortunately, these “horse race” comparisons in which EBTs are compared to control UC conditions yield little information about the procedures, interventions, and other relevant contextual factors that occur in the UC conditions. Understanding these factors is essential given the significant gap between science and practice, particularly difficulties with the transportability of EBTs to real-world settings (Southam-Gerow, Rodriquez, Chorpita, & Daleiden, 2012). Rather than continuing to build treatments in research vacuums, researchers and clinicians alike should focus on a different approach in which the complexities involved in implementing treatments in diverse ecologies are considered (Southam-Gerow & Dorsey, 2014). Given the significant heterogeneity of UC services, and subsequent variability in the outcomes of those services, a more granular analysis of the factors impacting outcomes is the key to improving the quality of care delivered in community settings.

UC in Schools

A growing mental health crisis in youth necessitates more in-depth research on the treatment processes and interventions that reduce psychiatric symptoms specific to this population. Approximately 15 million children and adolescents in the U.S. have a diagnosable mental health disorder (American Psychological Association, 2015 [APA]). This alarmingly high prevalence rate does not include youth at risk for developing a disorder or those with social,

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emotional, and behavioral difficulties that cause substantial distress and impairment, but do not meet the threshold for a disorder. Disrupting the process of typical development, these mental health difficulties are associated with a host of negative long-term academic, social, and psychiatric outcomes, including school failure, maladaptive interpersonal relationships, substance abuse, and suicide—the third leading cause of death in adolescents (Beauchaine & Hinshaw, 2013; Centers for Disease Control and Prevention [CDC], 2015; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). Given these long-term negative consequences, interventions that are aimed at the prevention and treatment of psychiatric symptoms and disorders are essential. However, the majority of adolescents with mental health needs are not receiving adequate services to meet those needs (Burns et al., 1995; Merikangas et al., 2011). Thus, the delivery of services in settings that reach a wider range of children and adolescents is crucial to the prevention and treatment of mental health issues.

Schools have presented as one critical avenue for addressing the mental health needs of youth. Of the 16% of children and adolescents receiving mental health services, 75% received these services in school (Burns et al., 1995). Greater use of mental health services in schools is likely attributable to the reduction of barriers that would otherwise prevent youth from utilizing more traditional services in the community. For instance, schools are a source of unparalleled accessibility as a majority of children and adolescents spend a significant portion of their time in schools. Thus, schools provide an optimal setting to identify at-risk youth and provide them with prevention and treatment interventions to enhance protective factors and prevent later emotional and behavioral difficulties (Adelman & Taylor, 1999; Masia-Warner, Nangle, & Hanson, 2006; Weist, 1999). Moreover, schools may alleviate the stigma common to help-seeking in other mental health service sectors (Pescosolido, Jensen, Martin, Perry, Olafsdottir, & Fettes, 2008)

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since many youth receive in-school services for factors unrelated to mental health (Weist, 1999). School mental health services may also reduce practical barriers, such as those concerning cost and transportation (Evans, 1999), and they may enhance the generalization of skills as they are located in real world settings among peers and teachers, which should theoretically increase the effectiveness of the intervention (Weist, 1999). Finally, schools may be ideal settings for prevention interventions as such initiatives target a large number of youth, many of whom may not be actively seeking treatment—a ubiquitous population in schools.

Empirical Support for UC in Schools

Despite the fact that schools are the primary providers of mental health services to children and adolescents, little is known about the details of the services provided and whether those services are effective (Adelman & Taylor, 1998; Masia-Warner, Nangle, & Hanson, 2006; Rones & Hoagwood, 2000). In the last four decades, researchers have developed a number of evidence-based prevention and treatment interventions for youth and families (Weisz & Kazdin, 2010). Although the number and breadth of EBTs proven effective for a variety of childhood disorders has grown in the last several years, schools and community settings have lagged behind in the implementation of these treatments (Evans & Weist, 2004; Fixsen, Naoom, Blase, & Friedman, 2005). Perhaps the most common barrier to the implementation of EBTs is the fit between interventions created in tightly controlled university settings with those in unique real world contexts (Durlak & DuPre, 2008; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Westen, Novotny, & Thompson-Brenner, 2004). As such, the extensive research available on EBTs is not representative of real world clinical practice. Subsequently, there is a dire need for systematic research on the types, intensities, quality, and effectiveness of UC in schools; however, such literature is rare, even at the descriptive level (Rones & Hoagwood, 2000).

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Some research has started this process by broadly identifying the most common types of mental health services delivered in schools. Foster, Rollefson, Doksum, Noonan, and Robinson (2005) surveyed a nationally representative sample of over 1,000 public elementary, middle, and high schools during the 2002-2003 school year. Overall, schools provided a broad range of social-emotional services, including assessment (63%), behavior management consultation (64%), individual counseling (54%), group counseling (61%), and preventive services (63%). While the study elucidated basic information on the types of services common to school-based mental health, no information was provided on the intensity of services, the types of interventions used, and the effectiveness of those interventions.

Whiston and Sexton (1998) attempted to address these gaps by reviewing school outcome research published between 1988 and 1995. Results suggested that group counseling was effective for children with social skills deficits and with elementary students facing a wide range of difficulties, particularly adjustment to family difficulties. Additionally, peer counseling programs were effective for a variety of difficulties. However, many of the studies included in the review had questionable methods and designs, and the restricted time period sampled may not be reflective of current practice and trends. Additionally, while the study found that the activities of school counselors tend to have a positive impact on students' wellbeing, the study did not identify the specific factors and interventions that are responsible for positive changes in student mental health.

Unfortunately, surprisingly little research exists on the specific interventions used in schools; however, there is a growing body of literature on the therapeutic procedures used in community settings. While there are some obvious differences between community clinics and schools, both settings are known to treat complex, heterogeneous youth with everyday clinical

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care that typically does not fit the strict standards of EBTs used in university settings. One study (Weisz, Jensen-Doss, & Hawley, 2006) completed a meta-analysis comprised of 32 randomized clinical trials that directly compared UC to EBTs in community clinics. All of the included studies were coded for several study characteristics, including therapist qualities, format of sessions, treatment participants, treatment dose, and use of homework. Results suggested that UC is a heterogeneous category comprised of a number of diverse interventions and treatment providers. However, the researchers were unable to elucidate most of the UC intervention procedures as such procedures were frequently not reported in the original studies. Overall, EBTs outperformed UC with a small to medium effect size of .30. While some studies showed large effects in favor of EBTs, five studies found that UC outperformed EBTs, suggesting that some forms of UC may be beneficial for certain target problems. Nonetheless, the implications of this finding lack practical utility because the effective UC procedures and interventions were not clarified, and therefore cannot be replicated in other settings.

Weisz and colleagues (2009) continued to work toward elucidating the characteristics of effective UC by using a coding system to classify interventions by therapeutic orientation. The researchers randomized community therapists to brief training and supervision in CBT for depression or UC. The study also randomized 57 youth with depression to receive CBT or UC. All UC sessions were coded for four subscales using the Therapy Process Observational Coding System for Child Psychotherapy—Strategies Scale (TPOCS-S; McLeod, 2001): CBT (e.g., cognitive distortions), Psychodynamic (e.g., transference), Family (e.g., parenting style), or Client-Centered (e.g., seeks client perspective). Findings indicated more use of psychodynamic and family approaches by UC therapists and more use of CBT by CBT therapists. Regardless of the type of therapy over 70% of youth no longer met criteria for a depressive disorder. However,

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those youth who received UC were more likely to have a longer duration of treatment (39 weeks versus 24 weeks), weaker therapeutic alliances as rated by their parents, and greater mental health service utilization than those who received EBT. The results suggested that EBT had greater overall benefits, but the variability of the interventions used by the UC therapists may have impacted outcomes. Thus, more in-depth analysis of the process and procedures of UC is warranted to clarify the factors that may contribute to outcome.

Garland and colleagues (2010) furthered this body of research by focusing their efforts on characterizing UC outpatient therapy for children with disruptive behavior problems. Participants were 191 children with disruptive behavior disorders (ages 4 to 13) and 96 UC therapists from community clinics. Over 1,000 randomly selected sessions were coded for therapy processes using the Therapy Process Observational Coding System for Child Psychotherapy—Strategies Scale (TPOCS-S; McLeod, 2001). Most of the sessions were eclectic, utilizing a great breadth of therapeutic strategies. Additionally, many of the interventions used were conceptually consistent with core aspects of EBTs for youth with behavioral difficulties. Indeed, a majority of sessions included affect education, problem solving skills, positive reinforcement, and psychoeducation; however, many of these and other strategies were used at a lower intensity or dose than would be expected in EBT models. While this study began elucidating common interventions used in UC, the impact of these interventions on outcomes remains unknown, reducing the practical utility of these findings in informing training and implementation models in real-world settings.

Overall, the dearth of research on school-based mental health services is a serious public health concern. Without information on the specific types of psychotherapeutic care used in schools and their effectiveness, it is difficult to understand how to target the improvement of

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services. The few studies examining the process of UC services in community mental health settings suggest that current interventions are broad and heterogeneous. Future efforts need to delineate which interventions are effective within specific contexts in order to better meet the mental health needs of youth in real-world settings.

A Mixed Method Approach to Understanding Usual Care in Schools

Significant variability exists in the therapeutic process and effectiveness of UC in schools. While many UC services have been found to be ineffective, some have shown positive outcomes, even outperforming EBTs in community settings (Weisz, Jensen-Doss, & Hawley, 2006). However, little information exists on which therapeutic procedures contribute to variability in outcomes. In order to obtain a better understanding of the factors that positively impact intervention outcomes in schools, research examining the therapeutic strategies used, group variables, and characteristics of the setting is warranted. Equally critical is an analysis of these factors in youth who do not respond positively. Understanding the impact of these variables on intervention outcomes requires combining both quantitative and qualitative research methods so that the weaknesses of one approach are rectified by the strengths of another—a process deemed “methodological triangulation” (Weisz, Weersing, & Henggeler, 2005).

Quantitative research, particularly RCTs, adhere to valid, reliable, and objective research methods, producing generalizable findings (Dattilo, Edwards, & Fishman, 2010). While such methods result in a breadth of understanding, they neglect to explain findings in terms of ideographic contexts—factors that are necessary to understand to improve care in real-world contexts. As such, quantitative data can be complemented with qualitative data, which can provide a “thick description” (Geertz, 1973) of process components, such as the therapeutic strategies used, group variables, and setting characteristics, at a depth of understanding that

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cannot be obtained by methods inherent in quantitative paradigms (Palinkas, 2014). Thus, this mixed methods approach integrates both quantitative and qualitative information by systematically examining positive and negative UC groups. Utilizing the mixed methods approach may help to synthesize information about the effectiveness of an intervention, while also identifying the complexities of the intervention process, without compromising scientific inquiry and rigor (Dattilo, Edwards, & Fishman, 2010). Thus, by combining information from an RCT with data from systematic, case studies, the factors that contribute to variability in outcome can begin to be clarified, thereby informing training initiatives to improve mental health care in schools (Fishman, 1999).

Study Aim

The present analysis examined two UC groups (one which was associated with more positive outcomes in participating youth and one which was associated with more negative outcomes) which were part of the Depression Prevention Initiative—an ongoing NIMH-funded RCT conducted by Dr. Jami Young that compares a school-based group depression prevention program, Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST), and usual group counseling (GC) in schools. GC groups were led by school mental health professionals—from a variety of educational and theoretical backgrounds—drawn from public middle and high schools from six school districts located in the Northeast. Two groups were chosen for the case studies, which allow for a more in-depth analysis of the factors that contribute to the variability in outcomes. Of particular interest were three variables: therapeutic strategies, group components, and setting characteristics. Details are provided on individual group members in order to provide a better picture of these factors. However, the focus of the analyses is on the therapeutic strategies, group leader, and group processes. Few studies have examined how these specific

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factors contribute to outcome in school-based mental health. By examining the impact of these variables using the case study method in concert with outcome and observational coding data at different time points, the present study has started elucidating how to improve the quality of mental care in schools.

Method

The clinical setting. Altogether, there were 16 GC groups—ranging in size from 2-8 adolescents—which were conducted during or after school in 10 public middle and high schools in New Jersey. Within the GC condition, the average age at first contact was 13.4 (SD = 1.2), and a majority of the UC participants were female (65.6%). Almost a third of the adolescents were racial minorities (17.8% African American, 5.5% Asian, and 7.8% who identified as mixed race); 40% were Hispanic and 40% were White non-minority, non-Hispanic.

The GC groups were led by school mental health professionals from a variety of educational and theoretical backgrounds. Most of the group leaders held Master's degrees in education, counseling or a related field; however, five were graduate students, and one was a doctoral level psychologist. The average experience in counseling was 9.5 years, but experience ranged from 1 year to 30 years.

Procedures. From November 2010 through February 2013, adolescents with subsyndromal depressive symptoms were recruited from ten schools in New Jersey using a two-step process. First, youth whose parents consented to the study participated in a classroom-based screening, which consisted of the Center for Epidemiologic Studies-Depression Scale (CES-D; Radloff, 1977), a 20-item measure that assesses depressive symptoms over the past week. A score of 16 or higher was used to identify adolescents who may be experiencing symptoms of

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depression. Research staff later contacted eligible participants, and interested families were invited to the school to learn about the project and complete consent and assent forms.

Adolescents with assent and consent participated in the second step of the eligibility screening, which included a semi-structured diagnostic interview using the Schedule for Affective Disorders and Schizophrenia for School-aged Children—Present and Lifetime Version (K-SADS-PL; Kaufman et al., 1997). This instrument was used to rule out youth without subthreshold depressive symptoms or those with more significant pathology. Adolescents were eligible for the intervention if they had at least two current subthreshold or threshold depression symptoms on the K-SADS-PL and did not meet criteria for a current depressive episode.

Adolescents were excluded from the project if they had a current diagnosis of major depression, dysthymia, bipolar disorder, psychosis, substance abuse, or conduct disorder. Adolescents who endorsed significant suicidal ideation or non-suicidal self-injury, or those with significant cognitive or language impairments were also excluded from the study.

The 186 eligible adolescents were randomized to either IPT-AST or GC. Adolescents were stratified on gender within each school and assigned to a group intervention using a computer-generated random numbers sequence. Once randomized, all participants were considered a part of the study, regardless of their participation throughout the study. Ninety-five adolescents were randomized to IPT-AST and 91 were randomized to GC.

Group leaders were instructed to provide an eight-session intervention that focused on the prevention of depression. For some schools, this was the first time group interventions were being conducted, whereas other schools had completed group interventions with different durations and frequencies as those used in the study. Group leaders were asked to complete a pre-group session, eight weekly group sessions (with sessions lasting as long as the IPT-AST

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groups in that school), a mid-group session , and four booster sessions (15-45 minutes) within six months of the completion of the last group session. Group sessions were the focus of this investigation as the individual pre-group, mid-group, and booster sessions were not audio or video recorded, and the exact duration and content of these sessions is unknown. In order to approximate typical practices in the school, no parameters were given in regards to the procedures and content of the intervention. After group sessions four and eight, group leaders completed the Therapy Procedures Checklist (TPC; Weersing, Weisz, & Donenberg, 2002), which assesses therapists' reports on the techniques they employed in group. According to group leaders' reports, cognitive techniques were used most frequently, followed by psychodynamic techniques. Both the positive and negative outcome groups reported using cognitive techniques most frequently. The positive outcome group leader created her own manual, which was based upon the Adolescent Coping with Stress Course—an eight session depression prevention curriculum for adolescents (Clarke, Lewinsohn, & Hops, 1990). The group leader shared her manual with the group leaders of the negative outcome group, who loosely followed this manual.

Assessment. Participants were scheduled to complete the study over a period of approximately two years. Data was collected at nine different time points: screening, eligibility, baseline, mid-group, post-group, and at 6-, 12-, 18-, and 24-month follow-up periods. However, for the purposes of the current investigation, only data up to the 6-month follow-up assessment were analyzed. Adolescents were compensated with \$20 for completing assessments at each time point. Evaluators who were trained, reliable, and blind to the intervention condition completed the battery of self-report measures and diagnostic interview. See Table 1 for a listing of the assessment instruments and Table 2 for the schedule and structure of contacts.

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Depressive symptoms were measured at screening, baseline, mid-group, post-group and all follow-up periods by the CES-D—a short self-report scale with strong psychometric properties that is commonly used to assess depressive symptoms in the general population. Depression diagnoses were assessed at eligibility, post-group, and all follow-up periods using the KSADS-PL. Adolescents' overall functioning was rated as part of the KSADS-PL using the Children's Global Assessment Scale (CGAS; Shaffer et al., 1983). The CGAS score assesses functioning at home, in school, and with peers on a 1-100 scale. Scores over 70 indicate minor impairments in functioning.

To identify the content and processes of the GC interventions, an adapted version of the Therapy Process Observational Coding System for Child Psychotherapy (TPOCS; McLeod, 2001)—an evidence-based observational coding system comprised of a diverse mix of therapeutic procedures—was used. The TPOCS maximizes relevance to community care as it assesses for a wide range of therapeutic interventions and content areas, spanning across theories and orientations and rating the frequency and dosage of the interventions used. Several research projects have used adaptations of the TPOCS to better understand the mental health care of youth attending individual therapy in community clinics (Garland et al., 2010; McLeod, Smith, Southam-Gerow, Weisz, & Kendall, 2015; McLeod & Weisz, 2005). Since most youth receive mental health care in schools, often in the form of group, the present study will extend the current body of literature by using an adapted version of the TPOCS which was developed for groups (Bearman, McLeod, & Weisz, 2009) to clarify the impact of specific interventions on outcomes of two groups of youth who received mental health care in schools as part of a larger RCT for youth with elevated symptoms of depression.

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The TPOCS-G is comprised of two scales: (1) the Therapeutic Process Scale and (2) the Therapeutic Content Scale. The Process Scale consists of the active methods or interventions used by the group leader (e.g., role playing), whereas the Content Scale addresses the substance or issue being addressed in the intervention (e.g., social skills). The original TPOCS-G included 25 items on the Process Scale and 11 items on the Content Scale; however, for use in the current investigation and as suggested by one of the developers of the coding system, three of the process items (i.e. “Warmth,” “Empathy,” and “Validation”) were collapsed into one code and one item (i.e. “Confidentiality/Rules”) was added to the Content Scale. See Table 3 for a listing of the Process and Content items. Each of the 35 items was coded for occurrence in five-minute increments and the extensiveness with which each strategy was delivered. Occurrence is a measure of whether the strategy was observed in the session, while extensiveness is a rating of the frequency of the intervention, the effort with which the intervention was pursued, and the scope of to whom it was directed. Extensiveness ratings were measured on a Likert scale ranging from 1 to 7 (1=“not at all”; 7=“extensively”). Additionally, two global ratings, Intervention Level, and Group Participation were coded. Intervention Level reflects the level of individuals that the interventions are directed towards, while Group Member Participation is defined as the extent to which members were involved, responsive, and/or interactive in the session. These items were similarly scored on a 1 to 7 Likert scale with 7 reflecting the best score. The author received a full day of training on the TPOCS-G by one of the developers of the system, Dr. Sarah-Kate Bearman, and coded several practice tapes prior to coding for the current study.

Case selection process. The selection process for qualitative analysis of the two groups began with an examination of the assessment data, focused on changes from baseline through

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post-intervention on the two primary outcomes in the DPI study: depression symptoms as measured by the CES-D and overall functioning as measured by the CGAS. In addition, the presence of a depressive episode as assessed by trained evaluators using the K-SADS-PL was also considered. Group mean CES-D and CGAS scores were calculated at each time point for each group. Groups meeting the following criteria were identified as negative outcome groups: those with (1) an increase in the mean CES-D score from baseline to post-group (indicative of a worsening of symptoms) or (2) a decrease in the CGAS score from baseline to post-group (which corresponds to a worsening of functioning). Four out of 16 groups in the GC condition met criteria for a negative outcome group. Positive outcome groups, on the other hand, were identified with the following criteria: those with (1) a decrease in the mean CES-D score from baseline to post-group and (2) an increase in the CGAS score from baseline to post-group. Twelve out of 16 groups met the criteria for a positive outcome group.

Groups led by graduate students were not chosen as the focus of the study is on GC as delivered by counselors embedded in schools. Furthermore, given the importance of completion of assessments (for quantitative analyses), groups with missing assessment data were not prioritized for the case studies. Finally, since groups are generally defined as a number of people classed together, groups with less than three people were not considered.

Out of the four negative outcome GC groups, three were eliminated due to missing data or atypical group leaders (i.e. graduate students), leaving one group left for selection. Out of the 12 positive outcome GC groups, seven were eliminated due to missing data (n=4), atypical group leaders (n=2), and an insufficient number of group members (n=1). Two important factors contributed to the selection of the positive outcome group from the five remaining choices. First, one of the positive outcome groups took place in the same school district as the negative

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outcome group. Matching the two groups on important factors, such as SES, would allow for a more rigorous examination of the therapeutic procedures and processes that influence outcomes by reducing confounds, such as school and student resources. Second, the group that was located in the same school district as the negative outcome group also had the greatest improvement in scores from baseline to post-intervention on the CES-D and CGAS out of the remaining groups. See Table 4 for the criteria for the case selection process.

Design. The current author was not a group leader for any of the groups; thus, video recordings and progress notes were used to analyze the qualitative data. These recordings were also used to identify the specific interventions and content of the group sessions using an observational coding system, the TPOCS-G. Finally, the therapy process coding and case studies were synthesized with data from self-report measures at different time points in order to obtain a complete understanding of the factors influencing intervention outcome.

Confidentiality. Some information was altered to further protect participants' confidentiality, including participants' names and quotes from the group sessions. While some of the content has been changed, the clinical authenticity of these cases has been preserved.

II. The Groups

The following is a brief description of each of the groups selected. The GC groups were part of a larger RCT aimed at reducing depressive symptoms, preventing the onset of a future depressive disorder, and improving overall functioning. As such, the CGAS, KSADS-PL, and CES-D were used over the course of the study to assess depressive symptoms and functioning.

Positive Outcome Group: Group A

Relevant background information. The demographic profiles of members in the selected group are summarized in Table 5. Members of Group A were all enrolled in a public

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middle school located in New Jersey. The town in which the middle school is located is predominately white (62.1%; 17.7% Asian, 8.6% African American, and 12.1% other or mixed race) and non-Hispanic (80%). Group A consisted of 6 members, predominately female (n=4) who identified as white non-Hispanic (n=5) and black Hispanic (n=1). The mean age at eligibility was 12.5-years-old. One group leader with a Master's Degree in Education led all of the eight group sessions. She identified as white, worked in the school as a school counselor for 9 years, and had 13 years of counseling experience in total.

Symptom profile. The baseline symptom profiles of members in Group A are summarized and compared to means of participants in Group B and the entire UC condition in Table 6. At the initial screening, the mean CES-D score of Group A was 24 (SD = 6.7; 60 is the highest possible score). This score, comparable to the GC mean (24.4, SD = 6.9), indicates clinical levels of depressive symptoms. However, at the baseline evaluation which occurred prior to randomization and the group intervention, the mean CES-D score was 13.6 (SD = 8.8), indicating subclinical levels of depressive symptoms. This spontaneous remission from screening to baseline (6-7 weeks) is a 43% decrease in mean depressive symptoms as rated on the CES-D, and a slightly greater decrease than the GC mean (38% decrease). Moreover, the mean CGAS score at baseline was 66.8 (SD = 7.2), which is comparable to the mean UC score of 67.5 (SD = 5.2). At baseline, three group members had current anxiety diagnoses, two had current diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), and two members had a past depressive disorder that was impairing but did not fit the criteria for a specified diagnosis (i.e., Depressive Disorder Not Otherwise Specified [DDNOS]). None of the group members had current depression diagnoses. Overall, this data suggest that group members had some difficulty

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with depression and had some minor impairment in functioning in family and peer relationships and school functioning, but were generally functioning well.

Negative Outcome Group: Group B

Relevant background information. The demographic profiles of members in the selected group are summarized in Table 5. Members of Group B were all enrolled in a public high school located in New Jersey in the same school-district as Group B. The town in which the high school is located is predominately white (62.1%; 17.7% Asian, 8.6% African American, and 12.1% other or mixed race) and non-Hispanic (80%). Group B consisted of four female members who identified as white non-Hispanic (n=2), white Hispanic (n=1), and black non-Hispanic (n=1). The mean age at eligibility was 15-years-old. Group B was led by a white male Educational Specialist and a black female with a Master's Degree in Education. The male counselor had worked in the school for five years with 13 years of counseling experience in total. The female counselor had worked in the school for three years with 6 years of counseling experience in total.

Symptom profile. At the initial screening, the mean CES-D score was 28.8 (SD = 7.4). This score is higher than the GC mean of 24.4 (SD = 6.9) and indicates clinical levels of depressive symptoms. At the baseline evaluation, the mean CES-D score was 19 (SD = 10.7), indicating clinical levels of depressive symptoms. This spontaneous remission from screening to baseline (6-7 weeks) is a 33% decrease in mean depressive symptoms as rated on the CES-D, and a slightly lower decrease than the GC mean (38% decrease) and the Group A mean (43%). Similar to the UC condition, the mean CGAS score was 68.5 (SD = 3.7), suggesting that group members had some difficulty with depression, but were generally functioning well. Moreover,

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one group member met criteria for current and past DDNOS. None of the group members had other current comorbidities.

III. Course of Intervention

Group A

Session 1. The group leader and all six group members were initially present for the first group session, which lasted approximately 82 minutes (see Table 7 for a summary of group attendance). However, Nate arrived two minutes late, and Gia left five minutes after the start of group due to a doctor's appointment. Each group member received a workbook to guide them through group activities and homework, and the leader clarified that the goal of group is to learn one or two skills that are helpful. The group members then engaged in a rapport-building activity in which they broke into pairs and asked each other questions provided in their workbooks. Next, they introduced each other to the group, including name, place of birth, hobbies, favorite movies, and dreams for the future. Only five group members were present; subsequently, one student was paired with the group leader. This activity, along with the leaders' warm demeanor, likely facilitated the immediate engagement and participation observed throughout the session.

Notably, the group leader presented as warm and welcoming to group members. She struck a balance between listening to group members' thoughts and opinions, while also providing factual information on the topic of stress and depression in interactive ways. Using their workbooks, members independently wrote down thoughts and feelings associated with stress. Members then shared their thoughts about stress with the group, focusing on triggers (e.g., school, parents, homework), feelings (e.g., mean, grumpy), and ways to cope with stress. Members then applied their knowledge of stress and triggers to a hypothetical story about a teen

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who developed depression in response to transitioning to a new school. Members identified the stressors in the story and discussed whether the story seemed realistic. When Aaron shared that he did not view the story as realistic, the leader appropriately related Aaron's ideas back to the character in the story and to the goals of group.

***Aaron:** I get that this guy has his problems and stuff, but when I'm upset I try to just flip a switch in my brain and then try to make myself just like happy... You just need to just stop yourself from being negative. If you're having a problem and like whatever the problem is, just try to like make yourself see it in a better light.*

***Leader:** Beautiful. And that's, Aaron, what we're going to learn and look at. [The character in the story] didn't have that switch and he didn't have the ability to look at the situation and say, "Alright, what am I doing here and how am I looking at the situation? How can I look at it differently?" So that's exactly what we're going to get into talking about.*

Using the workbook as a guide, the group read and discussed information about depression. First, group members discussed the differences between sadness and depression. The group leader then provided members with basic information on neuroanatomy using diagrams and information provided in the workbook in order to explain that while one is born with certain capabilities, one's brain can also be shaped and developed through life experiences. While the group leader may have provided overly advanced psychoeducation given the developmental level of the group members (e.g., synaptic pruning), she almost always directly related the material back to the goals of group. The group also worked together to identify symptoms and triggers of serious depression, and members took turns reading about the "depression spiral" in their workbooks. The leader briefly mentioned the "CBT triangle," explaining that thoughts, feelings, and behaviors are interconnected and can lead to a "depression spiral." Group members similarly learned that thoughts, feelings, and behaviors can contribute to an "upward spiral," using an example in the workbook. The group leader linked this

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information back to the goal of group—learning how to change thoughts in order to change how one acts and feels.

Lastly, members discussed homework, reviewed the importance of the group, and developed group guidelines. Each group member was encouraged to write in a journal provided by the group leader; however, no parameters about the frequency and content of the writing were given. The leader also oriented members to the mood diaries located in their workbooks as a way to increase their awareness of their mood states. For homework, the leader assigned members the task of identifying an example of a positive and negative mood. Additionally, members were asked to document their average mood rating each day. Finally, the group leader stated the group rules, including confidentiality and equal time to share.

The session was coded using the TPOCS-G Process and Content Scales, which were rated on extensiveness. Extensiveness ratings reflect a combination of the frequency, effort, and scope with which group leaders pursue the interventions, and are rated on a 1 to 7 Likert scale (1=“not at all”; 7=“extensively”). The most frequently occurring TPOCS-G Process Codes for the first session were Warmth/Empathy/Validation (coded 70.6% of the session), Psychoeducation (58.8%), Encourages Cohesiveness (35.3%), Establishes/Reviews Goals/Agenda (29.4%), and Uses Self-Disclosure (29.4%; see Table 8). Warmth/Empathy/Validation and Psychoeducation received the highest extensiveness ratings, while Encourages Cohesiveness, Establishes/Reviews Goals/Agenda, and Uses Self-Disclosure received moderate extensiveness ratings. Affect Content (17.6%), Cognitive Restructuring (11.8%), and Confidentiality/Rules (5.8%) were the most frequently coded Content Codes; however, each of these codes received low extensiveness ratings. Additionally, the session received high scores on the two global rating scales, Intervention Level (i.e., the level of

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individuals that the interventions are directed towards) and Group Member Participation (i.e., group member participation) as the group leader involved all of the group members in discussions and interactive activities, and most of the group members remained responsive and engaged (see Table 8 for a summary of the TPOCS-G codes).

Session 2. The group leader and four group members (Julia, Gia, Natalie, and Nate) participated in the second group session, which lasted approximately 78 minutes and occurred two weeks after the first group session. The session began with a detailed homework review, particularly for Gia who did not attend most of the first session. Natalie was the only member who consistently completed her mood diary; subsequently, she shared the patterns she documented in her mood diary, while the other group members retrospectively completed their mood diaries in session. Natalie noticed that her mood improved over the weekend, and other members echoed similar patterns in their moods, agreeing that these improvements were likely linked to having more free time to engage in hobbies and spend time with friends. The group leader also inquired about stressful situations that may have worsened their moods. Gia discussed an embarrassing moment in her French class, identifying negative thoughts that contributed to her embarrassment. The group leader assigned the mood diary for homework and asked Natalie to share how and when she was able to complete her mood diary each day to increase homework compliance among other members.

The group leader skillfully paired psychoeducation with a series of interactive activities to increase awareness and understanding of negative and positive thoughts, while maintaining a warm demeanor. The group leader used the “CBT triangle” learned in the previous session to explain the impact of negative thoughts on feelings and future behaviors. Through eliciting examples of instances when group members changed their minds in their ordinary activities (e.g.,

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tests and spending allowances), the group leader helped members understand that changing one's mind is not a new concept, and that changing one's thoughts influences how one feels and behaves. The group then completed a mindfulness breathing exercise for several minutes as a way to increase their awareness of automatic thoughts. Afterwards, each group member wrote the automatic thoughts they noticed during the mindfulness exercise on the chalk board. After categorizing their thoughts, the group agreed that their thoughts are both negative and positive. Using their workbooks as a guide, the group read the "general rule" aloud, which stated that happy people tend to have twice as many positive thoughts as negative thoughts. Group members discussed their tendencies to think negatively or positively in certain contexts. The leader reflected back their statements, stating that one goal of group is to increase the number of positive thoughts.

Next, group members used their workbooks to read a list of negative thoughts while checking off the thoughts that frequently pass through their minds. Group members then shared their most common negative thoughts with the group, such as "Why do bad things happen to me?" and "That was a dumb thing to do." By providing a list of common negative thoughts and disclosing personal examples, the group leader normalized negative thinking, which may have contributed to group members' sharing of personal examples. Group members were prompted to connect these negative thoughts to sad moods documented in their mood diaries. None of the group members were able to do so; subsequently, the group leader assigned this for homework. The group leader changed the focus to positive thoughts and engaged group members in similar activities explained above. The group counted the number of positive and negative thoughts they checked off. Most of the group members checked off more positive thoughts than negative, and

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the group leader praised the group, while cautioning that people tend to have greater difficulties thinking positively when they're under stress.

Next, the group leader facilitated a discussion on the function and consequences of negative thoughts. The group identified triggers (e.g., tragedies) and protection against negative emotions (e.g., disappointment, embarrassment and hurt) as reasons for negative thinking. Once members had a basic understanding of the function of negative thoughts, they learned about the negative consequences of thinking pessimistically. For instance, the group leader provided a common example of not trying in school in order to protect oneself from feeling like a failure. She clarified, "Over time it becomes a self-fulfilling prophecy and people can start to believe all those negative thoughts about themselves." The leader also addressed potential concerns about thinking too positively about oneself, by facilitating a discussion on the differences between self-confidence and bragging.

The group leader briefly assigned homework for the following week. Group members agreed to complete their mood diaries, linking their moods to their thoughts. The leader checked for understanding by asking one group member to explain the homework to the entire group.

The most frequently occurring TPOCS-G Process Codes for the second session were Warmth, Empathy, Validation (coded 75% of the session; extensiveness=7), Psychoeducation (50%; extensiveness=6), Between Session Assignment (31.3%; extensiveness=5), Information Gathering (31.3%; extensiveness=4), and Uses Self-Disclosure (29.4%; extensiveness=4). The most frequent Content Codes were Cognitive Restructuring (68.8%; extensiveness=7), Relaxation/Mindfulness (25%; extensiveness=5), and Previous Themes (i.e., discussing skills learned in previous sessions; 25%; extensiveness=4). Additionally, the session received the

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highest scores on the two global rating scales: Intervention Level and Group Participation (see Table 8 for a summary of the TPOCS-G codes).

Session 3. The group leader and five group members (Julia, Cora, Nate, Gia, and Natalie) participated in the third group session, which lasted approximately 80 minutes and occurred one week after the second group session. The session began with a brief review of the importance of positive and negative thoughts as discussed in the previous session. The group also reviewed the mood diary homework, focusing on identifying patterns in mood. All but one (Gia) of the group members completed their mood diaries. Group members linked their moods to particular events, such as spending time with friends and family, losing personal items, and a death in the family. The group leader praised members who completed their mood diaries and highlighted the minimal amount of time and effort required to complete this important task in order to increase homework compliance.

The group leader introduced the topic of activating events by using an example provided by Natalie during the mood diary review. Natalie identified the activating event as losing her phone; however she struggled with identifying negative thoughts that impacted her mood. Subsequently, the group leader modeled several possible negative thoughts until Natalie settled on “I’m an idiot.” In order to practice identifying activating events and negative thoughts, group members took turns reading a Bloom County cartoon about a penguin who thinks negatively about his age and appearance after hearing a song. Group members laughed at the cartoon and appeared engaged throughout this activity. Cora and Natalie were able to identify the activating event (i.e., humming an old song) and the negative thought (i.e., feeling ugly and old) in the cartoon. The group continued to practice this skill by reading another comic strip, and the leader

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assigned homework, which involved monitoring negative thoughts and activating events in the mood diary throughout the week.

Through a number of interactive activities, the focus of the group then switched to learning how to think more positively. First, the group leader encouraged group members to keep a gratitude list in the journals that they were given in the first group session. Group members shared numerous examples, including spending time with siblings, eating a good meal, and watching a movie with family. Next, using their workbooks group members independently completed a diagram representing supportive people in their lives, writing the names of close family and friends in the inner circle and more distant people in the outer circles. Group members took turns sharing the names of people in each circle, as well as positive things they gain from those relationships. During another positive thinking exercise, group members wrote positive statements about themselves and each group member on a notecard. After reading the positive statements on their notecards, group members discussed their reactions, generalizing this activity to their everyday lives:

Leader: *Do you find in talking with friends, that sometimes you are much harder on yourself than your friends are on you?*

Natalie: *Isn't that the way for everybody?*

Leader: *I don't know.*

Natalie: *Because everybody always like picks on themselves harder because it's them. It's you.*

Leader: *Right. Yeah, so you know I think, "Oh I'm so bad at running group." But then when I talk to people and hear what their experiences are I think, "No it's okay. It's good." You know, we laugh a lot and make people feel comfortable. So then I get to say, "Okay, alright. It's not as bad as I think." It's important to get that feedback. And plus it's just nice to hear nice things, isn't it? Because often times I think we just assume that, you know, we hear positive things so we don't actually say, "Cora I'm really glad you're in this group because you add a lot of fun and..."*

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Natalie: "...humor?"

Leader: "...humor and niceness to it."

Cora: Thanks!

Leader: And I could say that about every one of you. It would be a different group if we didn't have any one of you.

In this brief exchange, the group leader normalized having negative thoughts about oneself, modeled a counter thought, increased group cohesion, and emphasized the importance of positive thinking and communication with others. While group members continued to express concerns about communicating positive statements to others too frequently or superficially, they appeared to understand the importance of thinking more positively about others.

Lastly, the group completed an anchoring exercise together as a way to produce a positive feeling at any time of the day. The group leader explained how the exercise works by providing psychoeducation on classical conditioning, using the example of Pavlov's dog to illustrate this concept. Next, each group member silently thought about a happy memory they would elicit during the exercise and verbally identified a discrete and intentional signal they would use, such as tapping a knee, pulling an ear, or blinking an eye. With their eyes closed and through verbal instructions given by the group leader, members elicited their happy memories while performing their anchors. Afterwards, the group leader assigned additional homework of practicing this exercise twice daily, particularly during times when they are feeling anxious.

The most frequently occurring TPOCS-G Process Codes for the third session were Warmth/Empathy/Validation (coded 68.75% of the session; extensiveness=7), Psychoeducation (62.5%; extensiveness=6), Between Session Assignment (31.25%; extensiveness=4), Modeling (25%; extensiveness=4), and Conducts Interpersonal Inventory (25%; extensiveness=3). The most frequent Content Codes were Cognitive Restructuring (50%; extensiveness=4),

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Relaxation/Mindfulness (18.75%; extensiveness=4), and Previous Themes (12.5%; extensiveness=4). Additionally, the session received the highest scores on the two global rating scales, Intervention Level and Group Participation (see Table 8 for a summary of the TPOCS-G codes).

Session 4. The group leader and five group members (Natalie, Gia, Aaron, Cora, and Julia) participated in the fourth group session, which lasted approximately 75 minutes and occurred one week after the third group session. The group reviewed material learned in previous sessions, including examples of negative thoughts and the “general rule” of having twice as many positive thoughts as negative thoughts. The leader also reviewed the mood diary assignment with each group member, focusing on identifying activating events and negative thoughts. Aaron did not complete his homework because he missed the last group session; subsequently, the leader anchored him to the mood rating scale and explained the assignment to him. The group leader also reviewed the anchoring assignment with the group. Natalie stated that she practiced every day; however, when the group leader inquired further, it was unclear whether she fully understood the purpose of the assignment. The group leader then provided the rationale of the anchoring exercise—to elicit a positive emotion on cue—and led the group through the exercise for several minutes. By continuing to review and practice homework assignments in session, the group leader conveyed the importance of continued practice, which may have increased homework compliance and skill generalization.

Next, the group leader introduced the topic of unrealistic exaggerations by eliciting examples from the group and modeling more realistic ways of thinking. The group leader further illustrated exaggerations by reading a Garfield cartoon aloud (the same cartoon discussed during the previous group session), while group members followed along in their workbooks. Together,

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the group identified the activating event, negative thought, underlying and exaggerated belief, and the negative emotion resulting from these factors. The group leader used the analogy of an iceberg to illustrate the difference between “surface thoughts” and deeper, underlying beliefs. She also provided psychoeducation on the importance of creating counter thoughts that are more accurate. During this exercise group members struggled with identifying counter thoughts; subsequently, the group leader continued to model more accurate counter thoughts, checking for understanding along the way.

The group leader read another cartoon for additional practice, and the group identified the activating event, emotional reactions of both characters, negative thoughts, and underlying beliefs. Once again, the group struggled with identifying the underlying belief, and the group leader provided group members with additional examples. The group leader then provided psychoeducation on another category of negative beliefs—unrealistic expectations—using the example of the cartoon they just read and analyzed. The group leader quickly moved on and summarized the purpose of these activities, namely that negative beliefs are often inaccurate and are overreactions to a situation. She illustrated this point by describing two hypothetical people with the same activating event and two different interpretations (one realistic and one negative) of the event. Both Gia and Natalie seemed to easily understand this concept, providing examples of times when their thoughts about roller coasters influenced whether they enjoyed themselves at theme parks.

The group leader then introduced the concept of examining thoughts in order to determine their accuracy. The group leader walked the group through a series of six questions that can help them determine whether a thought is accurate, eliciting examples from group members along the way. The leader explained that some thoughts are only half-truths,

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emphasizing the importance of acknowledging the part of the thought that is exaggerated or inaccurate. Cora provided a detailed example about thinking that her sleepover was ruined because her cousins felt excluded and some of her friends were overly talkative and attention-seeking. The group had difficulty identifying the half-truth, and began tangential conversations. The group leader attempted to refocus the group by modeling that the conclusion that the party was a complete disaster is likely not the whole truth.

The group leader then explained that identifying positive counter thoughts may improve one's mood and happiness. As a group, members looked at unrealistic, negative thoughts provided in the workbook, and attempted to identify more realistic, positive counter thoughts. Despite modeling from the group leader, many group members struggled with identifying counter thoughts, and quickly got off topic. However, through their discussions of hypothetical negative thoughts, they worked together to identify common negative beliefs they hold about themselves as well as more realistic counter thoughts. For instance, the last unrealistic thought in the workbook was related to connecting one's self-worth to being popular.

Leader: So what's a more realistic statement or phrase?

Natalie: "I can try my best to feel like I'm worth something."

Leader: Yup, okay.

Cora: "As long as I have friends, then I'm worth something."

Leader: Yeah. "As long as I have friends, then I'm worth something." How about, "Being popular or smart..."

Natalie: "...really isn't all that?"

Leader: Yeah or "...doesn't really..."

Natalie: "...make you worth something?"

Leader: Yeah, "...make me worth something." Right?

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Gia: *If you really think about it, if you're popular or whatever, everyone will be in your business.*

Natalie: *You won't have any privacy.*

Gia: *Yeah and that's what I think of. If I'm ever down on myself and I just think, "I'm such a loser," I'm just like, "Well, everyone would be in my business if I'm..."*

Natalie: *"...all that."*

Gia: *"...all that." Yeah and "Nothing will be fun anymore if everyone knows everything."*

After this discussion, the focus of group then shifted from cognitive restructuring to members' negative experiences with popular peers in school. Everyone except Julia participated in this discussion. Even Aaron, who otherwise was very quiet in group, participated in this discussion. Members also shared their impressions of the factors that differentiate "normal kids" from popular kids, including their dress, self-confidence, and likeability. The group leader then reviewed the homework assignment of identifying mood ratings, activating events, negative beliefs, and counter thoughts over the next week.

The most frequently occurring TPOCS-G Process Codes for the fourth session were Warmth/Empathy/Validation (coded 100% of the session; extensiveness=7), Psychoeducation (93.3%; extensiveness=7), Modeling (66.7%; extensiveness=6), Addresses Non-Compliance (26.7%; extensiveness=3), and Monitoring (20%; extensiveness=3). The most frequent Content Codes were Cognitive Restructuring (93.3%; extensiveness=7), Previous Themes (20%; extensiveness=4), and Relaxation/Mindfulness (13.3%; extensiveness=4). Additionally, the session received high scores on the two global rating scales, Intervention Level and Group Participation (see Table 8 for a summary of the TPOCS-G codes).

Session 5. The group leader and four group members (Nate, Aaron, Gia, and Julia) participated in the fifth group session, which lasted approximately 66 minutes and occurred one

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week after the fourth group session. The beginning of the session was likely not video recorded as group members were well into a discussion at the outset of the video recording. Specifically, Nate was discussing a conflict with his mother in which she threatened to ground him for two days if he missed an hour of guitar practice. After much discussion, the group leader helped the group to engage in problem solving, identifying the problem as Nate getting less enjoyment from playing his guitar than when he first started his lessons. The group leader and Gia role played how Nate could ask his mother to stop guitar lessons and continue to play for fun. Next, the group leader and Nate role played the same scenario; however, Nate used poor communication skills and was unable to effectively communicate his needs. While the group leader continued to engage Nate in problem-solving strategies, Nate was resistant to suggestions, identifying many possible barriers (e.g., his mother will not make time to have a conversation with him). As such, the group leader moved on by reviewing and practicing the anchoring exercise that was discussed over the last several sessions. However, it is unclear whether she reviewed the other homework assigned in the previous session.

Next, the group used their workbooks to continue to learn about identifying unrealistic beliefs and counter thoughts. For example, group members read a comic strip aloud, identifying the activating event, negative thought, and underlying belief. Overall, the group seemed to have a better understanding of these factors than in the previous group, particularly Gia who readily identified the underlying belief in the comic strip. Through Socratic questioning, the group leader was also able to help group members understand the implications of believing negative underlying beliefs, including feeling negative emotions and behaving in unhelpful ways that lead to negative outcomes. The group continued to practice identifying these factors using another comic strip as an example. The group leader facilitated practice of creating realistic counter

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thoughts by asking group members to read a letter, underline the negative thoughts in the letter, and create realistic counter thoughts for two of the thoughts that they underlined. The group leader modeled how to create many of the counter thoughts as most of the group members struggled with this task.

Next, the group leader briefly provided psychoeducation on different types of unrealistic thoughts, including jumping to conclusions, over-reaction, all or nothing thinking, unreasonable expectations, and catastrophizing, by modeling and eliciting examples from group members. The group then learned about the importance of identifying non-personal thoughts, which the leader defined as disguised personal beliefs that often lead to negative emotions. Three group members attempted to provide examples of non-personal beliefs; however, the examples they provided were more like attacks on their siblings, rather than hidden beliefs about themselves. In response to this misunderstanding, the leader wrote two lists on the board: things one has control over and things one does not have control over. Group members agreed that they have control over their preferences for food and music and the decisions they make, while they do not have control over school, their parents, and other people. The group leader summarized that members can change the way they think about a situation and other people, but they cannot control other people or what's happening around them.

The group continued to practice identifying disguised personal beliefs by reading a comic strip located in their workbooks. Once again, the group identified the activating event and non-personal beliefs very quickly. However, rather than focusing on converting the non-personal belief to a personal belief, the group leader labeled the non-personal belief as all or nothing thinking or an exaggeration. The group then discussed personal examples of times when they have had unrealistic expectations about their parents or their parents have had unrealistic

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expectations about themselves. Subsequently, the task of learning how to identify personal beliefs in disguise was not completed in this session.

The session ended with assigning homework for the following week. The group agreed to complete their mood diaries and identify their mood rating, activating event, negative beliefs, consequences, and realistic counter thoughts. In reviewing the homework, the group leader realized that she forgot to review the six questions group members should ask themselves in order to determine whether a thought is accurate. She quickly reviewed the six questions, using examples from group members along the way.

The most frequently occurring TPOCS-G Process Codes for the fifth session were Warmth/Empathy/Validation (coded 85.7% of the session; extensiveness=7), Psychoeducation (85.7%; extensiveness=7), Modeling (57.1%; extensiveness=6), Explores Universality (21.4%; extensiveness=3), and Seeks Client Perspective (21.4%; extensiveness=2). The most frequent Content Codes were Cognitive Restructuring (85.7%; extensiveness=7), Relaxation/Mindfulness (14.3%; extensiveness=4), and Previous Themes (14.3%; extensiveness=3). Additionally, the session received a high score on Intervention Level and a moderate score on Group Participation (see Table 8 for a summary of the TPOCS-G codes).

Session 6. The group leader and five group members (Nate, Cora, Julia, Natalie, and Gia) participated in the sixth group session, which lasted approximately 74 minutes and occurred one week after the fifth group session. The group leader asked for feedback from group members as a way to improve future groups. Group members identified anchoring, mood monitoring, and cognitive restructuring as helpful tools that have improved their moods, and many appeared to use these tools to make positive changes in their everyday lives. For example, the following is an exchange between Natalie and the group leader:

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Natalie: *I've noticed now that before this group I used to kind of think negatively, so I never tried to do anything with my family at all. So I thought at one point, "Why should I even try? This is no fun." So I usually stayed in my room, but I've noticed that over the course of the last couple of weeks, I've actually been attempting to make some contact with my parents and my sister. The other day we actually, well part of my family, we actually went out shooting together.*

Leader: *Wow!*

Natalie: *Something we've never done.*

Leader: *You know what that makes me think of is, you know, we were looking at that triangle, right? So it's an action, a thought, and a feeling. Right? So you can change any one of those things and it's going to change the other points on the triangle. So if you change an action by doing something with your family, how did that change a thought and a feeling?*

During this exchange, the leader not only praised Natalie for using a new skill, but she also helped Natalie link these changes back to the cognitive behavioral framework using Socratic questioning.

Prior to discussing negative feedback, several group members temporarily left the session for various reasons (e.g., forgot items in other classrooms). In the interim, the group leader inquired about Nate's struggle in asking his mother to stop guitar lessons as discussed the previous week. Throughout group, Nate has had a tendency to focus on negative aspects of his family and to be rejecting of help or advice. As such, he reported that his difficulties with his mother worsened, and he tangentially discussed other significant difficulties with his sister. The group leader validated Nate's feelings, while simultaneously offering solutions, such as talking to his mother. Nate rejected assistance provided by the group leader, subsequently, the leader modeled an effective way of asking for help and returned to the topic of feedback once the group members returned from their errands. Gia commented that the sessions are boring. The group leader welcomed this feedback, stating that she will find more ways of making the material fun

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and interactive. The leader wrote down suggestions provided by Natalie to incorporate games, such as silent ball, much like teachers do in the classroom.

The leader quickly checked in about the mood diary, discovering that many students did not complete their assignments over the past week. The group leader reviewed the topic of unrealistic or inaccurate beliefs discussed during the previous session, eliciting examples from group members and identifying types of negative thoughts. Using their workbooks, group members then independently worked on describing an activating event that occurred over the past week and identifying the beliefs and negative emotional consequences linked to the activating event. The group leader asked them to use the “6 questions” to help them identify whether their beliefs were unrealistic. Depending on the outcome, group members were instructed to either problem solve and choose a different course of action or create a positive counter thought. After many of the group members asked clarifying questions or had difficulty getting started, the group leader walked the group through an example of failing a test and thinking “I’m so stupid, I’ll never get anywhere.”

After group members completed the assignment, the group leader paired them up to discuss and offer each other suggestions. Given the odd number of group members, the leader paired up with Cora and discussed a time when she had the thought “I’m bad at math.” The leader posed questions to challenge this thought; however, Cora and the group leader agreed that the thought was realistic. Together, they created a plan for Cora to receive tutoring services in the library. Group members then discussed their experiences using these coping skills as a large group. Natalie stated that the process did not help change her negative thoughts. The group leader then went through the process using her belief “I’m bad at shooting and they’re all going to laugh at me.” Throughout, the group leader attempted to challenge the member’s belief,

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emphasizing that her thoughts were based on a part truth, but her conclusion was an overreaction. The group leader also used examples of her own personal experiences to explain that one can't expect to be an expert when initially trying a new activity. The group leader quickly discussed other group members' experiences, helping them to identify their counter thoughts. The group leader assigned a similar activity for homework to facilitate additional practice.

The group then discussed problem solving as a tool to use when negative thoughts are realistic and should not be changed. The group leader provided the group with four ways to problem solve: changing the way one responds to the activating event, predicting and preventing the activating event, changing the activating event, or accepting the activating event and the emotional consequences. The leader provided an example of when one might accept the activating event (e.g., when a friend moves away), and she discussed a detailed and comical illustration of predicting and preventing the activating event (e.g., avoiding walking into a manhole); however the other strategies were discussed briefly and vaguely.

The most frequently occurring TPOCS-G Process Codes for the sixth session were Warmth/Empathy/Validation (coded 80% of the session; extensiveness=7), Modeling (73.3%; extensiveness=6), Psychoeducation (53.3%; extensiveness=6), Uses Collaboration (53.3%; extensiveness=5), and Information Gathering (33.3%; extensiveness=4). The most frequent Content Codes were Cognitive Restructuring (80%; extensiveness=7), Previous Themes (33.3%; extensiveness=5), and Problem Solving (26.7%; extensiveness=3). Additionally, the session received high scores on the two global rating scales, Intervention Level and Group Participation (see Table 8 for a summary of the TPOCS-G codes).

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Session 7. Initially, the group leader and four group members (Nate, Aaron, Julia, and Cora) participated in the seventh group session, which lasted approximately 78 minutes and occurred one week after the sixth group session. However, two group members left the session within the first 10 minutes, leaving two group members (Julia and Nate) who participated for the entire group session. The group leader began the session by providing psychoeducation on the importance of developmental assets, which she defined as the aspects of a person's life or personality that have long-term positive consequences, such as family, school, a neighborhood or personal values. Using their workbooks, the two remaining group members silently read through a list of assets, checking off the assets they possess. The group leader then read each statement aloud, asking which members identified as possessing each asset. Many of the initial assets pertained to parents and family members, which led to a discussion about who members can go to for support and advice. Nate expressed concerns about his mother's ability to take his problems seriously.

Nate: If it's just answering a question, she doesn't take it seriously, and if it's something bad she's just going to yell at me. It's usually yelling or her just being weird.

Leader: How could you present it to your mother so she knows that it's serious to you?

Nate: I could tell her to stop being an idiot.

Leader: (To Julia) Would you say that to your mom? I wouldn't say that to my mom, Nate.

Nate: "Stop being a weirdo." How about that?

Leader: How about something like, "Mom I have something to ask you..."

Nate: "... of serious importance."

Leader: "...it's really important and I need for you to take it seriously because it's something that I'm really concerned about."

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Nate: *Then she would be like, “What’s so important?” and all laughing. I would be like, “Mom? Just...no.”*

Leader: *Well, that would be disappointing.*

Nate: *Whenever I talk about something serious she makes these faces.*

Leader: *(To Julia) Hmm. If you have something serious to talk about with your cousin, does she take you seriously? Does she listen well, Julia?*

Julia: *Yes.*

Leader: *So maybe you have to find somebody else, Nate...who will take it more seriously. Who are other adults who are available?*

Julia: *It could be a grandma or grandpa.*

Nate: *My grandma and grandpa live in California. They all live in California.*

While Nate remained resistant to change, the group leader was still able to model how to effectively ask for help, collaborate with the other group member for ideas, and brainstorm ways to get support from other adults in Nate’s life. After Nate began to voice his concerns about other problematic relationships (without attempting to respond differently), the leader moved on to discuss other developmental assets, including church, school, the community, extracurricular activities, and values. Group members then counted their assets, each identifying a similar number. With the help of the group leader, members identified one asset that they would like to develop and problem solved the steps necessary to cultivate that asset. For instance, Nate problem solved how he could increase time spent reading, such as selecting a good book and scheduling times to read.

Next, the group discussed progress on their mood diaries. The two members neglected to complete their mood diaries over the past week. The group leader asked whether their moods are generally better in the winter or in the spring. Nate stated that his mood is better in the winter because he likes to play video games inside. Nate then began to tangentially discuss conflicts

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with his sister who has been making threatening, albeit empty, remarks to Nate. The group leader inquired about conflictual incidents between Nate and his sister, offering ways to improve the situation along the way. However, Nate was not receptive to feedback, at which time the leader pointed out his tendency to find excuses rather than engage in problem solving strategies. Once again, the group leader attempted to validate and provide appropriate suggestions for solutions. Nonetheless, she did take the opportunity to review the formal problem solving steps with Nate, which may have provided him with a concrete format and structure to think through conflicts in his relationships.

Subsequently, the group leader moved on to review the cognitive restructuring process, asking group members to provide examples. However, both group members had difficulties identifying activating events. The group leader suggested that Nate discuss his conflict with his sister, while Julia found an event by searching previous entries in her mood diary. As a group, they went through the cognitive restructuring steps in detail. Nate was unwilling to change his negative beliefs about his sister; subsequently, the group leader asked him to problem solve by using predict and prevent as discussed last week. Once again, Nate was resistant to accepting help or feedback; however, he ultimately admitted that his relationship with his sister has been improving. The group leader then reviewed the cognitive restructuring steps with Julia, focusing on challenging her negative thoughts about her mother when her mother denies her requests to play outside. Afterwards, the group discussed whether this method has proven helpful. The group members remained unsure; subsequently the group leader discussed the importance of challenging thinking and identifying a counter thought. Lastly, she assigned the homework of bringing in a song, poem, movie, or any object that helps group members stay positive.

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The most frequently occurring TPOCS-G Process Codes for the seventh session were Warmth/Empathy/Validation (coded 93.8% of the session; extensiveness=7), Seeks Client Perspective (37.5%; extensiveness=5), Information Gathering (37.5%; extensiveness=4), Psychoeducation (37.5%; extensiveness=4), and Modeling (31.25%; extensiveness=4). The most frequent Content Codes were Cognitive Restructuring (31.3%; extensiveness=4), Problem Solving (25%; extensiveness=3) and Previous Themes (18.8%; extensiveness=3). Additionally, the session received high scores on the two global rating scales, Intervention Level and Group Participation (see Table 8 for a summary of the TPOCS-G codes).

Session 8. The group leader and four group members (Nate, Julia, Gia, and Aaron) participated in the eighth and final group session, which lasted approximately 64 minutes and occurred one week after the seventh group session. The group leader introduced the topic of “maintenance” as holding onto the strategies discussed over the past eight weeks by anticipating stressors and creating emergency plans. As such, group members identified examples of major life stressors, while the group leader wrote them on the board. The group leader emphasized the importance of creating a plan to cope with these major life stressors in order to prevent the “downward spiral” discussed at the beginning of group. Using their workbooks, group members independently created prevention plans and shared their plans aloud with the group.

Next, the group discussed examples of daily hassles with family, friends, or at school. The group leader emphasized that when hassles build up, they can be overwhelming, leading to negative emotions such as anger, depression, and irritability. Using their workbooks, group members identified which hassles they are likely to experience in the future, and how they can cope with these stressors. While Nate appeared to struggle with creating a coping plan, other group members readily identified plans to think more positively, challenge thoughts, and

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problem solve. For instance, Gia shared her plan to cope with striving for popularity in school, stating, “I did being popular. For my plan I put I should convince myself, ‘You don’t need to worry what others think’ and ‘You have friends, so why does it matter what being popular means.’” While Gia previously questioned why others were more popular than her, in this session she appeared to be more accepting of her social status. Next the group leader facilitated a discussion on whether group members noticed any changes in their moods since the beginning of the group. Members did not continue to keep up with their mood diaries and had trouble remembering changes in their moods, which may be a result of the group leader neglecting to complete thorough homework reviews at the start of the session.

To conclude the group, members provided the group leader with anonymous feedback about the group and participated in an activity in which they identified positive attributes about one another. Through this activity, each group member, including the group leader, received awards about the qualities they brought to the group (e.g., team player, good listening skills). Each award was tied to a piece of string, so they could wear them around their necks. The group seemed to really enjoy this activity with one group member stating, “I’m proud to wear my awards.” The group leader ended group with one last anchoring exercise, stating that the idea of the exercise is not to change one’s mood, but rather to unlock oneself from negative thinking.

The most frequently occurring TPOCS-G Process Codes for the eighth session were Warmth/Empathy/Validation (coded 76.9% of the session; extensiveness=7), Psychoeducation (38.5%; extensiveness=5), Encourages Cohesiveness (23.1%; extensiveness=4), Monitoring (15.4%; extensiveness=2), and Uses Collaboration (15.4%; extensiveness=2). The most frequent Content Codes were Anticipates Relapse/Setbacks (69.2%; extensiveness=6), Previous Themes (38.5%; extensiveness=5), and Cognitive Restructuring (30.0%; extensiveness=2). Additionally,

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the session received high scores on the two global rating scales, Intervention Level and Group Participation (see Table 8 for a summary of the TPOCS-G codes).

Group B

Session 1. Two group leaders (Mr. B and Ms. L) and three female group members (Kelly, Sam, and Karmen) were initially present for the first group session, which lasted approximately 51 minutes (see Table 7 for a summary of group attendance). The session began with a rapport-building activity in which members broke into pairs, asked each other questions, and introduced each other to the group. One group member was paired with Mr. B because an odd number of members were present. Ms. L modeled the types of questions members could ask each other because no structure was provided, and members appeared confused about how to approach this task. Afterwards Ms. L highlighted the many similarities among group members, including favorite colors, interest in movies, and place of birth. Group leaders then discussed group rules at length, modeling and providing the rationale for each, including confidentiality, one person speaks at a time, respecting everyone's opinion, and sharing at one's own free will. Leaders checked for understanding and asked for input, although group members did not offer any more suggestions.

Next, the group discussed the topic of stress and depression. The group leaders attempted to facilitate a discussion on the triggers and symptoms of stress; however, the group leaders appeared to disagree on how to structure this discussion as evidenced by Mr. B apologizing to Ms. L for leading the discussion in a different direction than she intended. Group members minimally participated in this discussion; subsequently, the group leaders gave group members a handout describing the effects of stress, such as hair loss, insomnia, headaches, and shortness of breath. Once again, the group leaders attempted to elicit group members' thoughts on the

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handout with minimal success as group members did not participate. Mr. B then provided psychoeducation on factors that contribute to stress, such as poor nutrition, substance use, and lack of sleep. Group leaders asked each group member how many of hours of sleep they were getting each night. After Sam reported difficulties falling asleep, the group leaders attempted to problem solve ways Sam could relax before falling asleep. However, rather than fully exploring the problem and guiding Sam towards a solution, Ms. L interrupted Sam and advised her on some solutions. While Ms. L may have had valid suggestions, the way in which she offered her perspective may have stilted the discussion and hindered Sam's development of this skill:

Ms. L: Have you thought of some things that can kind of relax you before bedtime?"

Sam: Sometimes I try to read to like...

Ms. L: (interrupting) You could work out before you go to bed, take a shower, [and] just kind of slow yourself down.

Sam: Yeah.

Mr. B: How about warm milk?

Sam: I tried that. It doesn't work. I'm not a baby (laughs).

Ms. L: Reading is good, but sometimes reading can put you in a fantasy world. Sometimes you read and it kind of triggers what you've been thinking about all along and then your mind really starts racing. So I don't know if reading would be the best thing to do at night. But definitely working out will. Like working out a good, hard work out and a nice hot shower can put you out.

Next, the group leaders provided psychoeducation on the symptoms of serious depression, such as changes in sleep, appetite, and mood lasting two weeks or longer. The leaders incorporated group members into this discussion by inquiring about factors that contribute to serious depression. Leaders praised members for identifying factors such as trauma, conflicts in relationships, or losses. Mr. B also referenced genetic inheritance of depression, as well as problems in one's social environment. Next, Mr. B provided

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psychoeducation on the “depression spiral”, stating that multiple triggers, negative thoughts, and unhelpful behaviors all contribute to the development of depression. He then indicated that the goal of group is for members to learn how to examine their thinking and change their thoughts to prevent them from falling into the depression spiral. Finally, each group member shared with the group how they were currently feeling. Group leaders also shared their feelings, emphasizing that leading the group had a positive impact on their moods.

The session was coded using the TPOCS-G Process and Content Scales, which were rated on extensiveness. The most frequently occurring TPOCS-G Process Codes for the first session were Uses Self-Disclosure (63.6% of the session; extensiveness=7), Warmth/Empathy/Validation (63.6%; extensiveness=5), Psychoeducation (54.5%; extensiveness=4), Uses Collaboration (36.4%; extensiveness=4), and Encourages Cohesiveness (36.4%; extensiveness=4). The most frequent Content Codes were Affect Content (45.5%; extensiveness=4), Confidentiality/Rules (27.3%; extensiveness=4), and Cognitive Restructuring (9.1%; extensiveness=2). Additionally, the session received a high score on Intervention Level and a moderate score on Group Member Participation (see Table 9 for a summary of the TPOCS-G codes).

Session 2. The two group leaders and two group members (Karmen and Maya) participated in the second group session, which lasted approximately 45 minutes and occurred one week after the first group session. The session began with brief introductions as one group member was absent during the first group session. The group leaders reviewed the material covered last session, including the rapport-building activity, group rules, triggers for stress, and the “depression spiral.”

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The group leaders also reviewed the goal of group—to change one’s negative thinking to prevent the depression spiral. To illustrate the depression spiral, group members discussed a hypothetical story about a teen who developed depression in response to transitioning to a new school. The leaders attempted to facilitate a discussion among group members by asking them to identify triggers and relate the story to themselves. However, group members did not appear engaged in this discussion; subsequently, the group leaders led most of the discussion. When Mr. B asked members how the hypothetical teen’s stress spiraled into depression, Maya appropriately stated, “I think it turned into something more because he kept having thoughts and telling himself, ‘This is not good enough. This is not my best.’” Rather than linking Maya’s comments back to the goal of identifying and challenging negative thoughts, Ms. L provided a more interpersonally focused conceptualization:

Ms. L: It was his parents that said “This isn’t good enough. You can do better than that. Blah blah blah.” So when Mr. B said, “How did he end up experiencing these feelings?”, you could see how when you go to the person who’s protected you your entire life when you were sick, when you were afraid, when you were hurt, and these are the very people that are tearing you apart, who do you go to? Would you respond to your friends texts? If my mom and dad are telling me that I’m not doing well enough, certainly my friend can’t tell me anything that’s going to make me feel better. So I think that’s how he got to the point of withdrawing himself and feeling down and gloomy, and skipping school and all of that because his biggest support system was his challenge.

While this conceptualization of the story may be valid, it departed from the goals identified at the beginning of group.

After group members identified their sources of support, Mr. B briefly provided psychoeducation on depression and the impact of automatic negative thoughts by drawing the “CBT triangle” and the “depression spiral” on the board. Group members were asked to think of instances when they changed their minds in ordinary activities to introduce the idea of changing negative thoughts to positive thoughts. When members were unable to provide examples, Ms. L

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offered a possible example of a time when Karmen may have decided not to sit next to peers at lunch due to feeling self-consciousness about her English. While this was a clear example, it may have further stilted the conversation as Karmen's self-consciousness about speaking English and her comfort in sharing personal examples was unclear.

Next, group members completed a mindfulness exercise in which they focused their attention on their breath. Mr. B modeled the appropriate way to engage in deep breathing prior to the exercise, counting as he inhaled and exhaled. While Mr. B introduced this activity as a way to increase awareness of fleeting thoughts, he placed greater emphasis on using this activity to alleviate stress and relax. As such, afterwards when Mr. B inquired about thoughts that arose during the exercise, group members had difficulties identifying fleeting thoughts.

During the last several minutes of group, members discussed different types of negative thoughts, such as overgeneralizations, filtering, black and white thinking, personalizing, and catastrophizing, by reading a handout aloud and eliciting examples from personal experiences. Once again, group members had difficulties identifying examples; subsequently leaders shared examples from their personal lives, as well as interactions they have with students.

The most frequently occurring TPOCS-G Process Codes for the second session were Psychoeducation (88.9% of the session; extensiveness=7), Uses Self-Disclosure (66.7%; extensiveness=5), Modeling (55.6%; extensiveness=5), Information Gathering (55.6%; extensiveness=5), and Seeks Client Perspective (44.4%; extensiveness=4). The most frequent Content Codes were Cognitive Restructuring (66.7%; extensiveness=5), Relaxation/Mindfulness (33.3%; extensiveness=3), and Affect Content (22.2%; extensiveness=2). Additionally, the session received the highest score on Intervention Level and a moderate score on Group Participation (see Table 9 for a summary of the TPOCS-G codes).

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Session 3. Two group leaders (Mr. B and Ms. L) and three group members (Kelly, Maya, and Karmen) were present for the third group session, which lasted approximately 55 minutes and occurred three weeks after the second group session (Note: While the video recording showed three members in attendance, the progress note indicated that all four group members attended). The session began with a review of the factors that distinguish serious depression from sadness and examples of common reactions to stress, and the “depression spiral.” Group members did not actively participate in this discussion, which may be attributed to difficulties recalling this information given the three week lag between sessions.

Mr. B provided psychoeducation on the importance of identifying activating events that prompt negative thoughts in order to prevent the “depression spiral.” Kelly disagreed with some of this information, stating that one is bound to think negatively in response to some external events, such as tragedies or having conflict with friends. Mr. B agreed with Kelly, but clarified the difference between thinking realistically and catastrophizing by using the example of thinking “I have nobody left in my life” in response to a death in the family. Initially, Kelly did not appear to understand these differences as she tangentially spurred a discussion about feeling lonely in middle school. The leaders continued this discussion by asking group members about times they felt lonely. Sam and Kelly told the group about times when they blamed themselves for conflict between their parents, while Maya shared her ambivalence about potentially meeting her father whom she has never met. As each member shared, the group leaders gathered more information about these relationships, emphasizing the commonalities among group members. The group leaders also emphasized the importance of learning from one’s experiences and viewing adversity as a strength.

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Next, Mr. B intermittently refocused the group back to the topic on identifying negative thinking patterns and thinking more positively. To illustrate this point, Ms. L shared a story about a student who thought her boyfriend no longer loved her. After talking with this student further, it became clear that the student was dealing with her own family conflict, and the student's thoughts about her boyfriend were irrational. This story incited a discussion between the group leaders about the difficulties of being a teenager, particularly given the lack of agency in decision making. Once again, Mr. B attempted to bring the discussion back to the importance of positive thinking by providing examples that apply to school. However, the topic shifted to discussing the differences between high school and college. Ultimately, group leaders were able to link their discussions back to the importance of reframing one's experiences more positively, and group members agreed to start documenting their activating events and negative thoughts during the week.

Group leaders then introduced the idea of practicing positive thinking by thinking more positively about others. Group members were disengaged throughout this discussion. Subsequently, the group leaders carried the conversation and began a tangential discussion about the importance of accepting others for who they are, despite their flaws. During the last several minutes of group, members practiced thinking positively about others by writing down the names of supportive others using a visual diagram of their relationships. All of the group members, except Karmen, shared the names of the supportive people in their lives, as well as the reasons they find these people supportive.

The most frequently occurring TPOCS-G Process Codes for the third session were Psychoeducation (58.3% of the session; extensiveness=5), Uses Self-Disclosure (50%; extensiveness=6), Information Gathering (33.3%; extensiveness=4), Modeling (33.3%;

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extensiveness=3), and Seeks Client Perspective (33.3%; extensiveness=3). The most frequent Content Codes were Cognitive Restructuring (75%; extensiveness=4), Affect Content (33.3%; extensiveness=3), and Previous Themes (16.7%; extensiveness=2). Additionally, the session received a high score on Intervention Level and a moderate score on Group Participation (see Table 9 for a summary of the TPOCS-G codes).

Session 4. The two group leaders and two group members (Maya and Sam) participated in the fourth group session, which lasted approximately 37 minutes and occurred two weeks after the third group session (Note: While the video recording showed two members in attendance, the progress note indicated that all four group members attended). The session began with an interactive review of material learned in the last three group sessions, including the signs of stress and depression, the difference between stress and depression, and the importance of changing one's thinking and other coping strategies to prevent the "depression spiral." For the duration of the group, members wrote about a stressful event that occurred over the past several weeks as well as how they coped with it. After they finished writing, they drew a picture of the stressful situation and shared their pictures with the group while other group members used the illustrations to guess the stressful life event. Turning this activity into a game could have had the effect of trivializing group members' stressful experiences; however, group members were engaged, forthcoming, and empathic of other group members throughout this activity.

Maya shared her illustration first, which was a depiction of her feeling upset after students were talking so loudly in class that she missed the instructions for a project. Maya admitted that she was also stressed out by several impending tests, and indicated that her coping method was to "cram." The rest of the session was spent on Sam who drew a picture of her reactions to hearing that her aunt had recently passed away. In response to this stressor, Sam

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indicated that she cried, got support from her friends, and wrote a letter to her aunt to say goodbye. The group validated Sam's feelings of sadness and grief, and the leaders praised her for coping in healthy ways. The group leaders also emphasized the importance of focusing on the positive aspects of an event, such as remembering the things she gained from knowing her aunt.

The most frequently occurring TPOCS-G Process Codes for the fourth session were Play/Art (75% of the session; extensiveness=6), Warmth/Empathy/Validation (75%; extensiveness=6), Information Gathering (62.5%; extensiveness=5), Psychoeducation (37.5%; extensiveness=2), and Establishes/Reviews Goals/Agenda (25%; extensiveness=2). The most frequent Content Codes were Affect Content (62.5%; extensiveness=4), Previous Themes (25%; extensiveness=3), and Cognitive Restructuring (25%; extensiveness=2). Additionally, the session received high scores on Intervention Level and Group Participation (see Table 9 for a summary of the TPOCS-G codes).

Session 5. The exact duration and content of this session remains unknown as this session was not audio or video recorded. According to a progress note completed by the group leaders, three group members (Maya, Sam, and Kelly) participated in the session, which lasted approximately 45 minutes and occurred 9 days after session 4. Group leaders reported that the content of the session was focused on anxiety and sadness. However, the progress note should be interpreted with caution as some of the information detailed in other progress notes is inconsistent with observations from the video recordings.

Session 6. The two group leaders and three group members (Karen, Sam, and Kelly) participated in the sixth group session, which lasted approximately 51 minutes and occurred one week after the fifth group session. (Note: While the video recording showed three members in

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attendance, the progress note indicated that all four group members attended). Group began by reviewing negative thoughts and providing psychoeducation on underlying beliefs inherent in some negative thoughts. Mr. B inquired about the content and frequency of group members' negative thoughts. Sam reported that she has negative thoughts related to her family nearly every other day, such as "Why am I here?" and "Why are all these negative things happening to me or my family?" Rather than inquiring about activating events or the underlying beliefs behind her thoughts, group leaders normalized her thinking, stating that often times there are no answers to the "why" questions. While Karmen was reticent to discuss her negative thinking, Kelly was forthcoming about her negative thoughts, stating that she embraces negative and positive thoughts as they come and go because of her history of feeling numb to her emotions. While the group leaders asked multiple questions about her thought process to increase their understanding, they did not inquire about activating events or the content of specific thoughts, which may have allowed them to model identification and restructuring techniques. However, the leaders did inquire about whether Kelly's thoughts were about herself or others, which led to a discussion about the problems with having unrealistic expectations for others.

Next, Mr. B provided psychoeducation on creating counter thoughts once negative automatic thoughts and beliefs are identified. After the group leaders had difficulties eliciting examples from group members, Ms. L inquired about Sam's negative thoughts about having parents with a conflictual relationship.

Ms. L: Do you ever have negative thoughts of this is what your marriage could be like?

Sam: Sometimes I'm afraid, like when I get into a relationship, I'm afraid that I don't know what I'm doing and I might end up like them. Like how my parents are.

Ms. L: I mean I could understand you initially thinking that, but let's re-evaluate that and look at it realistically. Do you have a boyfriend now?

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Sam: *Yeah.*

Ms. L: *What's his name? (laughs) I'm just kidding. So you're in a relationship now so you feel like sometimes you worry about that. Are you acting like your mother in your relationship right now? Are you acting like your father in your relationship right now? And does your relationship mirror what you see every day at home?*

After asking questions to determine whether Sam was communicating and compromising with her boyfriend, which is in opposition to her parents' relationship, Ms. L continued:

Ms. L: *So it sounds to me that in order to be more realistic about the situation, you're doing the opposite of what you see at home. So does that support your negative thought of you feeling like you could potentially have a disastrous marriage?*

Sam: *I don't know.*

Ms. L: *No, you're proving in this relationship right now that it won't be the same way.*

Sam: *I'm just afraid.*

Group leaders then validated Sam's fears and cautioned her about being taken advantage of in her relationships. Validation is an important component in facilitating change; however, there was no exploration of Sam's fears (i.e., evidence for her negative thought), as well as no attempts to create a counter thought—the main reason for this discussion. As such, at the end of the exercise, Sam's beliefs remained unchanged, decreasing the likelihood that she will use these tools outside of group.

Next, the group leaders briefly reviewed an example of having unrealistic expectations for others and asked group members to create a list of characteristics that make a good friend. Each group member shared their list, which included the following: selflessness, trustworthiness, and sympathy. Group leaders then inquired about times when group member's expectations of friends created difficulties in their relationships. After group members stated that their lists of characteristics were not unrealistic, Ms. L shared a personal example in order to model that expectations can be so automatic that people do not always have awareness. This example likely

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resonated with other group members, as both Sam and Kelly shared similar examples. During the last several minutes of group, leaders asked group members how they want to spend the last two group sessions, stating that group members were not relating to the topic of unrealistic thinking. Group members agreed, but they could not identify other topics that would be helpful to the group.

The most frequently occurring TPOCS-G Process Codes for the sixth session were Warmth/Empathy/Validation (72.7%; extensiveness=7), Psychoeducation (54.5%; extensiveness=4), Uses Self-Disclosure (45.5%; extensiveness=7), Seeks Client Perspective (45.5%; extensiveness=4), and Modeling (36.4%; extensiveness=4). The most frequent Content Codes were Cognitive Restructuring (81.8%; extensiveness=4), Previous Themes (18.2%; extensiveness=2), and Affect Content (9.1%; extensiveness=2). Additionally, the session received high scores on Intervention Level and Group Participation (see Table 9 for a summary of the TPOCS-G codes).

Session 7. The exact duration and content of this session remains unknown as this session was not audio or video recorded. According to a progress note, all four group members attended session 7. However, according to a conversation in the session 8 video recording, only one group member (Maya) showed up for the session. Subsequently, it remains unclear whether a group session was completed and if so, how many group members attended.

Session 8. The two group leaders and three group members (Maya, Sam, and Karen) participated in the eighth group session, which lasted approximately 44 minutes and occurred one week after the seventh group session was scheduled to occur. Group members were provided with lunch in celebration of the end of group. The group began with a discussion of minor hassles and major stressors that group members may have to continue to cope with in the

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future. Group members initially provided examples of major life stressors that they have already gone through (e.g., changing schools) before discussing minor hassles, such as having less money to spend, having less time to spend with parents, getting up for school in the morning, and struggling in sports. The group leaders also shared detailed examples from their own lives (e.g., getting to work on time), emphasizing healthy ways to cope (e.g., time management). While group members appeared engaged throughout this discussion, they focused more on identifying types of stressors they have already been through, rather than creating coping plans for anticipated stressors in the future.

Next, group members took turns sharing the strengths and the unique characteristics they bring to their families, communities, and the group. Sam and Maya identified multiple talents and personality characteristics that make them unique and personable. However, Karmen struggled with this activity. Rather than moving onto the next group member, the group leaders identified several unique assets that Karmen possesses, including bilingualism, friendliness, and responsibility. Karmen appeared pleased with their responses as evidenced by smiling, laughing, and agreeing with the group leaders' comments. The group leaders also disclosed personal strengths about themselves and each other, such as their hobbies and sense of humor. This turned into a discussion about what talents group members wish they had, such as being a good singer and dancer. Once again, the group leaders disclosed a lot of information about themselves, which seemed to increase group members' participation and engagement. Next, group members discussed what keeps them inspired each day. Members identified classes in school, famous artists, and the summertime. During the last several minutes of group, members expressed their sadness about ending group. Group leaders offered to hold additional lunches

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with the group every once and awhile, and they reiterated that group members can reach out to them at any time.

The most frequently occurring TPOCS-G Process Codes for the eighth session were Warmth/Empathy/Validation (100%; extensiveness=7), Information Gathering (77.8%; extensiveness=7), Uses Self-Disclosure (77.8%; extensiveness=7), Seeks Client Perspective (33.3%; extensiveness=4), and Psychoeducation (33.3%; extensiveness=3). The most frequent Content Codes were Anticipates Relapse/Setbacks (44.4%; extensiveness=3), Previous Themes (22.2%; extensiveness=2), and Affect Content (11.1%; extensiveness=2). Additionally, the session received high scores on Intervention Level and Group Participation (see Table 9 for a summary of the TPOCS-G codes).

Summary of TPOCS-G Codes

Group A. Throughout Group A's eight sessions, a breadth of the Process (18 out of 23) and Content (10 out of 12) Codes occurred (see Table 10 for a summary of the average TPOCS-G codes across the eight group sessions and Figure 1 for extensiveness ratings of the most frequently coded TPOCS-G Process and Content Codes). On average, most of the Process Codes occurred infrequently (less than 25% of sessions) and at low extensiveness ratings with the exception of Warmth/Empathy/Validation (81.3% of the sessions), Psychoeducation (60%) and Modeling (35.7%), which received average extensiveness ratings of 7, 6, and 4, respectively (1="not at all"; 7="extensively"). On average, the most frequently occurring Content Code was Cognitive Restructuring, which received an average extensiveness rating of 5. The remaining Content Codes were similarly used infrequently and at low extensiveness ratings. The average Intervention Level and Group Member Participation across sessions was 6.5 and 6.6,

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respectively, suggesting that the interventions were frequently targeted to each group member, and members actively participated.

Group B. Throughout Group B's eight sessions, a breadth of the Process (15 out of 23) and Content (10 out of 12) Codes occurred (see Table 10 for a summary of the average TPOCS-G codes across the eight group sessions and Figure 1 for extensiveness ratings of the most frequently coded TPOCS-G Process and Content Codes). On average, most of the Process Codes occurred infrequently (less than 25% of sessions) with the exception of four codes that had moderate extensiveness ratings—Warmth/Empathy/Validation (65.8% of the sessions), Psychoeducation (54.5%), Uses Self Disclosure (52.7%), and Information Gathering (48.8%)—and two codes that had low extensiveness ratings—Seeks Client Perspective (30.6%) and Modeling (29.4%). The remaining Content Codes were similarly used infrequently and at low extensiveness ratings. The most frequently occurring Content Codes were Cognitively Restructuring (42.9%) and Affect Content (30.6%), which received low extensiveness ratings. The average Intervention Level and Group Member Participation across sessions was 5.3 and 6.1, respectively, suggesting that the interventions were targeted to each group member fairly consistently, and members actively participated. However, despite consistencies in Intervention Level, the ratings for Group Member Participation changed throughout group. The group received moderate ratings during sessions 1-3 and increases in ratings at session 4 and for the duration of the group (see Figure 2 for average TPOCS-G ratings for Group Member Participation across sessions).

IV. Evaluation of Therapy Process and Outcome

Quantitative Evaluation

The results on the CES-D, CGAS, and K-SADS for Group A, Group B, and the GC condition are summarized in Table 6. Figures 3 and 4 illustrate the change in depression symptoms and overall functioning from baseline through 6-month follow-up. Overall, the results indicated an improvement in depression symptoms and functioning for members of Group A throughout the intervention and over the next six months, and minimal improvements in symptoms for members of Group B.

Group A's positive outcome. At the mid-group assessment, the mean CES-D score decreased from baseline by 22% (CES-D = 10.7, SD = 4.5), which is greater than the average increase of .3% in scores for the GC condition. This improvement continued at the post-group assessment as the mean CES-D score fell to 6.8 (SD = 7.8), which is a decrease of approximately 50%. This change in CES-D score from baseline to post-group is significantly greater than the GC average change of 15.8%. While the mean CES-D score slightly increased during the 6-month assessment (CES-D = 9.2, SD = 6.4; indicating a worsening of symptoms), Group A showed a 32.9% decrease in symptoms from baseline to the 6-month assessment. The CGAS scores exhibited a similar pattern in which the mean scores showed improvement at mid- and post-group and slightly worsened during the 6-month assessment. At the post-group assessment, the average CGAS score (76.2) increased by 14%—which is greater than the GC mean increase of 7.8%—indicating that group members generally had no more than slight impairments in functioning. At the 6-month assessment, the mean CGAS score for Group A showed a slight decline (indicating a worsening of functioning), but showed a 12% improvement from baseline.

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Additionally, none of the group members met criteria for a depressive disorder during the post-group or 6-month assessments as measured by diagnostic interviews using the KSADS.

Group B's negative outcome. At the mid-group assessment, the mean CES-D score remained largely unchanged from the baseline assessment and was in the clinically significant range (CES-D = 18.8, SD = 8.8)—a finding comparable to rest of the GC condition. At the post-group assessment, the mean CES-D score slightly increased to 20.3 (SD = 10.2). This 6.5% increase from baseline indicates a worsening of symptoms and is in contrast to the GC average of a 15% decrease. The mean CES-D score showed the greatest decrease from baseline at the 6-month assessment (CES-D = 16.0, SD = 7.8); however the mean score remained in the clinically significant range. The average CGAS score at the post-group assessment was 69.3, a .8% increase from baseline (indicating little change in functioning), which is below the GC mean of a 7.8% increase. From baseline to the 6-month assessment the mean CGAS scores slightly increased 5%, which is less than the GC average change of 9.9%. Based on diagnostic interviews using the KSADS, none of the group members met criteria for a depressive disorder during the post-group assessment; however two members (Kelly and Sam) met criteria for DDNOS at the 6-month assessment. Thus, this data suggest that group members were continuing to experience some difficulties with depressive symptoms and functioning after the conclusion of the group intervention and six month afterwards.

Qualitative Evaluation: Contributing Variables to Intervention Outcomes

Therapeutic Strategies

Therapeutic approach. The leaders of Groups A and B similarly used a manual created by Group A's leader, which was based upon the Adolescent Coping with Stress Course (CWS)—an eight session depression prevention curriculum for adolescents (Clarke, Lewinsohn, & Hops,

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1990). CWS is a psychoeducational, cognitive-behavioral (CB) intervention that has been shown to be effective for adolescents with subthreshold symptoms of depression (Clarke et al., 2002; Garber et al., 2009). According to the observational coding, the leaders of both groups used a wide array of clinical strategies across sessions; however, the leader of Group A was more conceptually consistent with elements common to CWS and other evidence-based approaches for depression than the leaders of Group B. For instance, the leader of Group A used directive techniques—which are more typical of CB approaches—more frequently than the leaders of Group B, including psychoeducation (60% of sessions on average), modeling (35%), between session assignment (20%), and monitoring of thoughts, feelings, and behaviors (14%) as coded using the TPOCS-G. Additionally, these strategies were frequently used within a CB framework involving cognitive restructuring (56% of the sessions), content from previous sessions (e.g., thinking traps, “CBT triangle”; 20%), and relaxation or mindfulness (12%). While much of the content and strategies were superficially applied, some were used comprehensively (i.e., psychoeducation) or with moderate extensiveness (i.e., modeling and cognitive restructuring). Thus, the content and strategies of Group A, although somewhat eclectic, showed consistencies with the content and strategies common to CWS and other approaches that have been empirically supported.

In contrast, Group B’s leaders used evidence-based strategies and content less frequently, and their therapeutic approach was more eclectic than the leader of Group A. For instance, the leaders incorporated some directive techniques (psychoeducation: 55% of the sessions on average; modeling: 29%) and evidence-based content (cognitive restructuring: 43%; previous themes: 17%); however, they were applied with moderate to low extensiveness. Moreover, other

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strategies common to evidence-based interventions were applied infrequently and superficially (e.g., between session assignment and monitoring).

The leaders of Group B also incorporated other eclectic strategies and content areas, such as self-disclosure (53%), information gathering (49%), seeking the client's perspective (31%), and affect content (30%), more frequently than the leader of Group A. While the effectiveness of therapist self-disclosure is unclear, the research suggests that self-disclosure should be used infrequently and with the purpose of validating, normalizing, building rapport, or modeling adaptive behaviors (Norcross, 2002). The leaders of Group B used this strategy frequently, and many instances of self-disclosure involved leaders' insights into the personal challenges of other students they counsel in school. These instances often took the form of lengthy, detailed monologues, which appeared to stifle discussion and participation. Additionally, the leaders of Group B implemented information gathering and seeking group members' perspectives more frequently than the leader of Group A. These strategies were coded when 1) leaders inquired about factual information or the unique point of view of group members and 2) these strategies were not better accounted for by other codes (e.g., gathering factual information about an event to set the scene for problem solving). These strategies were occasionally used to encourage group members to reflect more deeply on their experiences; however, they were frequently applied precariously, often leading to tangential discussions that were not on the initial agenda. Thus, the leaders of Group B tended to implement more eclectic strategies than those in CWS or other evidence-based approaches, which may have contributed to poorer outcomes for group members.

Setting and achieving goals. The leaders of Groups A and B identified the same goal for the group intervention—to change negative thoughts in order to improve one's behaviors and

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emotions and to prevent the “depression spiral.” However, the leader of Group A implemented structured activities and discussions that were consistent with this goal, while the leaders of Group B did so inconsistently. Indeed, in each of the eight sessions, the leader of Group A carried out activities that aligned with the goals for the group, including implementing mindfulness exercises to increase awareness of thoughts, practicing positive thinking by writing positive statements about other group members, and introducing problem solving as a technique to use when negative thoughts are realistic and cannot be altered. Additionally, when group members’ comments digressed from the current topics, the leader of Group A almost always attempted to relate their comments back to the group material. Thus, the leader of Group A provided a structure for group that created plentiful opportunities for members to work toward their goals, increasing the likelihood of goal achievement.

In contrast, the leaders of Group B started each session with activities related to the identified goals for treatment, but through the course of the session, they facilitated discussions that were inconsistent with those goals. For instance, in session 4 the leaders introduced the importance of activating events in triggering negative automatic thoughts. As such, the leaders instructed group members to draw a picture of an activating event that occurred over the past week and write about the thoughts, emotions, and behaviors that were linked to the event. However, throughout this activity, the group leaders focused more on understanding the stressors in group members’ lives and less on identifying maladaptive cognitions in response to stress—the purpose of the activity. Additionally, when the group leaders provided conceptualizations for depression, they often borrowed from interpersonal or family systems approaches, even when group members offered suggestions consistent with the cognitive-behavioral framework. Furthermore, in session 6, the leaders of Group B initiated a discussion about which topics group

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members wanted to focus on in the future because they perceived group members to be disengaged from the cognitive material they were learning. This discussion, as well as leaders' inconsistent and superficial commitment toward the identified goals of the intervention may have inadvertently communicated to group members that the information they were learning in group was irrelevant and ineffective—decreasing the likelihood that group members would achieve their goals by the end of the group.

Skill acquisition and application. The leaders of both groups stated their commitment to teaching group members new coping skills that would help them better manage their stress. However, the differing ways in which they taught the skills may have impacted members' acquisition and application of those skills. For instance, the leader of Group A facilitated skill acquisition by providing detailed and concrete psychoeducation on each of the skills she taught, as well as the rationale for these strategies. Rather than providing information on all of the steps for cognitive restructuring at once—identifying automatic thoughts, labeling thinking traps, challenging thinking, and creating counter thoughts—she taught these skill gradually with each session building upon a new step of the process. Additionally, this material was provided didactically using workbooks, through discussions in which the leader used Socratic questioning to guide members toward their own discovery, and through interactive exercises. For instance, when learning about automatic thoughts, the leader provided psychoeducation on the material using the workbook as a guide, led a mindfulness exercise to increase awareness of thoughts, asked students to write different automatic thoughts on the board, and facilitated a discussion in which students categorized the valence of their thoughts. By providing detailed psychoeducation using a variety of teaching methods, the leader tapped into different learning styles and increased group member engagement, which likely improved members' acquisition of the material.

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In contrast, the leaders of Group B provided less psychoeducation on how, when, and why group members should use the material presented throughout the group. When the leaders provided psychoeducation on the material didactically by reading out of the manual, the information was clear, concise, and concrete. However, when the leaders discussed unscripted material—particularly on cognitive restructuring—they tended to stumble over their words, presenting vague and discursive information. This ineffective teaching style was not used when discussing less cognitive techniques, such as deep breathing in which the information was provided step-by-step and modeled by one of the leaders. Subsequently, one hypothesis for this observation is that the group leaders may have had less experience in teaching cognitive restructuring techniques. Additionally, while some of the material was presented in an engaging manner (e.g., discussing activating events by drawing pictures), much of the information was provided through discussions in which group members were not actively participating. Subsequently, the vague, and at times confusing, presentation of the psychoeducational material coupled with the uniform teaching style may have negatively impacted group members' engagement and understanding of the material.

Furthermore, the leader of Group A provided more opportunities for practicing the skills through in-session activities and between-session homework assignments than the leaders of Group B. Indeed, the leader of Group A helped group members apply the material they learned in session to hypothetical stories and comic strips, which facilitated rehearsal of the skills, while maintaining members' interest and engagement. Additionally, the leader of Group A used some personal examples to model how to effectively use skills, and she implemented Socratic questioning to help group members discover how to apply these skills to difficulties in their lives. Perhaps most importantly, the group leader also assigned homework between sessions

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(e.g., monitoring of mood, activating events, and negative thoughts, the anchoring exercise, using counter thoughts), which helped members gather new information about themselves, apply the skills in the context of negative affective arousal, and generalize information learned in session to the range of everyday difficulties. Moreover, the leader frequently reviewed the homework in order to problem solve barriers and provide corrective feedback.

The leaders of Group B also facilitated some practice of skills by discussing hypothetical vignettes. However, rather than using Socratic questioning to collaboratively help members discover how to effectively apply the skills, the group leaders often provided the answers for group members or explored the problem with little reference to material learned in group. At other times, the leaders of Group B attempted to apply the skills to relevant examples in group members' lives. However, much of the time—particularly in the first half of the group sessions—members appeared reticent to share their experiences. Subsequently, the group leaders used self-disclosure of personal or professional experiences to illustrate different applications of the skills, which often took the form of lecturing or discussions between group leaders with little participation from group members. Additionally, the leaders of Group B infrequently used homework assignments to facilitate mastery and generalization of the skills. This therapeutic technique was mostly frequently coded on the TPOCS-G when the group leaders encouraged members to practice outside of group. However, the assignments were vague, and they were not reviewed at the next session, decreasing the likelihood of homework completion among group members. Overall, the leaders of Group B provided limited opportunities for group members to practice applying the information they learned in group, which may have negatively impacted how much information group members retained and whether they perceived this information as relevant to their specific difficulties.

Group Components

Group psychotherapy is founded on the idea that groups of people experiencing similar difficulties can provide support and empathy to one another. As such, group cohesion or the extent to which group members form rapport and strong bonds with one another and group alliance are important factors that impact outcome. While both groups received similar average ratings on Encourages Cohesiveness on the TPOCS-G, the groups differed in terms of participation, dialogue between group members, and sharing of personal information—indirect indicators of group cohesion and alliance. For instance, in Group A, the mean group participation as coded on the TPOCS-G was 6.1 (SD = .8; 1=“no participation”; 7 = “majority participation”), achieving high levels of participation since the start of the group. Additionally, members consistently shared personal information (e.g., death of a family member, struggles with popularity) and discussed difficulties among each other during the first several sessions of group.

Members of Group B, however, showed a different pattern. Group B’s mean participation was 5.3 (SD = 1.2) with moderate scores in group participation during the first three sessions and consistently higher scores after session 3. Indeed, it was not until session 3 that group members began to divulge personal information about themselves, and session 4 that they began to have spontaneous member to member interactions. Given these observations, it appears that Group B developed elements of cohesion and alliance at a slower pace than Group A, which may have negatively impacted outcomes, particularly in a brief, time-limited group. Group size and inconsistencies in attendance are two factors that likely contributed to these observations.

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Throughout the eight group sessions, the attendance rate for Group A was 70.8% and 62.5% for Group B. This inconsistency in attendance may have had a larger impact on Group B because the group started with two less members than Group A. Subsequently, the mean number of group members across the eight group sessions was 4.2 for Group A and 2.5 for Group B. Furthermore, due to inconsistencies in attendance, the members of Group B were not fully acquainted with one another until session 4, whereas all of the members of Group A were introduced to one another at the start of the group. Thus, lack of familiarity with one another and a small group size may have prolonged the development of Group B's cohesion and alliance.

Additionally, factors associated with the group leaders may have impacted group cohesion and alliance. For instance, the leader of Group A assisted in creating the manual used for the group intervention. As such, she likely had a better understanding of the material than the leaders of Group B. Indeed, from the first session, the leader of Group A presented as a knowledgeable and confident group leader, and because of her competency with the material, she was able to focus her efforts on providing a warm demeanor and tending to the needs of the group members. In contrast, the leaders of Group B (who did not create the manual they used for the group intervention) presented as less confident in their knowledge of the material as evidenced by lengthy pauses between activities, jokes about their lack of competency as group leaders, and minor disagreements about which topics to talk about next. The leaders, preoccupied with attending to the structure and content of a session, had less resources devoted to important group processes, such as establishing comfort and facilitating interactions among group members.

Interestingly, in session 4 the leaders of Group B collaborated together to create an interactive group activity that was initially consistent with the content in the manual. During this

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session, the leaders appeared more confident in teaching the material as evidenced by complementing one another and showing overall more enthusiasm about the material they were presenting. Thus, the leaders were able to focus more on the group as a whole, providing members with more opportunities to interact with one another as a cohesive unit. Indeed, during this session, the leaders of Group B received higher frequency and extensiveness ratings in Warmth/Empathy/Validation and group members' mean participation also increased. However, only two members were present for this group session. Thus, group cohesion and alliance, and the many factors comprising this construct (e.g., participation, engagement, and interactions among group members) appeared to be impacted by multiple components, such as attendance, group size, competency of the group leader, and opportunities for group interaction.

Setting Characteristics

Logistical factors may have impacted the implementation of the group intervention. For instance, while Group A completed sessions after school, Group B held sessions during school hours, which allowed for longer group sessions. Indeed, the mean session length for Group A was 73 minutes, which is significantly longer than Group B's mean session time of 47 minutes. Since Group B completed sessions during school hours, the length of the session was determined by the length of a class period, which appeared to be less than an hour. Additionally, the length of time between sessions was slightly greater in Group B (10 weeks altogether) than in Group A (9 weeks altogether), partly due to a three week gap between session 2 and 3, which was not accounted for by holidays or school-wide closures. Delaying the time between sessions, particularly at a time when group members are becoming acquainted with one another, may have disrupted the process of group cohesion and contributed to difficulties remembering the material. Additionally, the timing and process of getting notified to come to sessions may have negatively

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impacted attendance rates, which were lower in Group B (see Table 7 and Figure 5). Group A consistently occurred at the same time and on the same day of the week. However, Group B occasionally occurred on different days of the week, alternating between lunch and another school period, and members received passes the day before the group was scheduled to occur. Subsequently, multiple factors may have contributed to poor attendance rates, including being absent the day passes were sent out, forgetting to bring passes to school the next day, skipping group to eat lunch in the company of friends, and forgetfulness resulting from inconsistent meeting times. Any combination of these factors may have decreased attendance rates, disrupting important therapeutic processes. Many school-based prevention programs implemented during school hours have been shown to be effective (e.g., Young, Mufson, & Gallop, 2010); thus, the duration, and process of scheduling sessions may be more important in enhancing attendance and intervention outcomes than the timing per se.

V. Synthesis of Findings

Discussion and Recommendations

The aim of the present investigation was to elucidate factors that may positively and negatively impact intervention outcomes of UC in schools, particularly given the significant variability in outcomes of UC services and the dearth of information available on the factors contributing to this variability (Rones & Hoagwood, 2000). As such, the present investigation used a mixed-methods analysis to examine differences in therapeutic strategies, group processes, and setting characteristics among two school-based depression prevention groups showing differential outcomes on depression symptoms and functioning.

Overall, the leaders of both groups used a wide variety of strategies and therapeutic content at low extensiveness ratings, some of which were consistent with evidence-based

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approaches. However, the leaders of Group A used some of the evidence-based strategies and content more frequently and at greater extensiveness levels than the leaders of Group B. On average, the leader of Group A incorporated psychoeducation, modeling, and cognitive restructuring at moderate to high extensiveness ratings, while between session assignments and monitoring were used less frequently and less extensively. The leaders of Group B not only used these strategies less frequently and at lower extensiveness ratings than the leader of Group A, but they used other strategies (i.e., self-disclosure, information gathering and seeking members' perspectives) and content areas (i.e., affect) at a greater frequency than the leader of Group A.

These findings suggest that 1) community clinicians can employ evidence-based interventions to successfully intervene with adolescents with mild depressive symptoms and 2) utilizing a few key elements of EB approaches with moderate to high levels of therapeutic technique can lead to positive therapeutic outcomes. Several RCTs have found EBTs to be superior to UC in reducing depressive symptoms in adolescent youth (Clarke et al., 1999; Garber et al., 2009). However, many of these studies were implemented in tightly controlled university settings with clinicians who received intensive and comprehensive training. Subsequent research has tried to address these gaps by providing brief training for UC therapists in CB interventions, which were implemented with heterogeneous community samples (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Kerfoot, Harrington, Rogers, & Verduyen, 2004). Studies found no differences in outcomes between participants that received CB interventions provided by trained community therapists and those receiving UC, concluding that community clinicians cannot learn to employ CB techniques effectively.

A more recent and methodologically sound study found advantages for CBT delivered by community clinicians, including reduction of service utilization, overall cost, and time to

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symptom reduction, despite significant differences in therapist skill in executing the CB interventions (Weisz et al., 2009). The present investigation offers a more nuanced explanation of these findings: the mere occurrence and frequency of CB interventions may not directly impact symptom reduction. Rather the application and level of skill with which the CB interventions are delivered may have a greater impact on outcomes. Additionally, focusing on implementing “the right” CB interventions at a great depth may have more beneficial effects than delivering the entire CB package with varying levels of extensiveness. Thus, future research aimed at elucidating the potency of specific interventions through dismantling studies may clarify which interventions have the greatest impact on intervention outcome. This information is essential for future training initiatives of community clinicians as learning and mastering several core elements of an evidence-based treatment may be more practical and cost-effective than learning and utilizing multiple complex treatment protocols with adequate therapeutic technique.

Moreover, the qualitative analyses emphasized differences in the extent to which leaders completed activities and discussions which were consistent with their treatment goals. While the leaders of both groups identified their goals as teaching skills to change or cope with unrealistic thoughts, only the leader of Group A remained consistent in working toward this goal. Indeed, the leaders of Group B strayed from their activities, and they offered conceptualizations to problems that were inconsistent with the intervention model they were providing. Discrepancies between identified goals and structured activities, along with discussions about the ineffectiveness of the intervention, inaccurate record keeping, and inconsistent videotaping also suggest that the leaders of Group B may not have been invested in the intervention they were delivering.

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Conversely, the leader of Group A chose and amended the goals, activities, and structure of each group session, increasing her investment in the group and adherence to the therapeutic goals she created. Thus, investment in the development of the intervention protocol may have impacted leaders' beliefs about its effectiveness and adherence to activities consistent with its underlying theory. Differences in leaders' beliefs and behaviors may have influenced group members' beliefs about and compliance to the intervention. Providing and adhering to the intervention rationale and generating positive expectations for change have long been recognized as nonspecific factors which account for some variability in the psychotherapy outcome, no matter the treatment approach (Frank, 1971; Illardi & Craighead, 1994). The leaders of Group B did not consistently utilize these nonspecific factors, which may have negatively impacted outcome. Thus, future research should focus on operationalizing nonspecific factors into teachable clinical skills and increasing clinicians' buy-in in order to maximize outcomes.

The case study findings also convey the importance of acquiring and applying information learned in session. The leader of Group A provided clear, graduated psychoeducational material on cognitive restructuring using a variety of engaging teaching strategies, and she assisted members in applying material learned in group to clinical vignettes and events occurring between group sessions. In contrast, the leaders of Group B provided vague and discursive psychoeducational material, primarily through a discussion format. Additionally members of Group B were provided with limited opportunities to apply the material in group, and they were not assigned homework between sessions. These findings are in agreement with the large body of research showing that homework assignments facilitate improvements in therapy (Addis & Jacobson, 2000; Burns & Spangler, 2000; Neimeyer & Feixas, 1990; Stice, Shaw, Bohon, Marti, & Rode, 2009). One study found that participants'

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willingness to complete homework assignments, homework compliance, and cognitive restructuring skill acquisition mediated the relationship between homework assignments and improvement in symptoms (Neimeyer, Kazantzis, Kassler, Baker, & Fletcher, 2008). While it is clear that the members of Group B did not complete homework (as they were not assigned such tasks), the extent to which members of Group A were compliant with their homework throughout the eight weeks remains unclear. Given the importance of homework completion on intervention outcome, future research investigating the relative effectiveness of different types of homework assignments as well as therapist behaviors that may enhance the effects of homework compliance is essential.

Qualitative analyses also revealed the impact of group cohesion and alliance on outcome—a finding consistent with research suggesting that cohesion and alliance predict outcome in short-term group psychotherapy (Joyce, Piper, & Ogrodniczuk, 2007). While Group A appeared to have elements of group cohesion and alliance at the start of group—increased participation, disclosures of personal information, and member to member interactions—members of Group B developed these factors at a slower pace. A smaller group size and inconsistencies in attendance are two factors that likely contributed to these observations. One meta-analysis of 40 studies found that groups comprised of five to nine people excluding leaders resulted in greater cohesion and better outcomes than groups with less than five members (Burlingame, Theobald McClendon, & Alonso, 2011). One hypothesis for this finding is that smaller groups are at greater perceived risk for potential alienation from the group; subsequently members are more likely to avoid possible disagreements, decreasing the benefits they may have otherwise received (Fulkerson, Hawkins, & Alden, 1981). These results indicate that group size

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may be an important factor in maximizing the benefits of group cohesion and alliance, and should inform future therapeutic practices.

Additionally, therapist behaviors may also enhance group cohesion and alliance and impact outcomes. For instance, the leader of Group A received consistently high average TPOCS-G ratings on Warmth/Empathy/Validation from the start of the group, while leaders of Group B did not achieve high levels of this process code until session 4—the session at which group member participation and discussions amongst group members increased. Empathy, warmth, and the therapeutic relationship are nonspecific factors that have been shown to correlate with client outcome in both child and adult populations (Karver, Handelsman, Fields, & Bickman, 2006; Martin, Garske, & Davis, 2000). As such, these nonspecific factors are important elements in the therapeutic process of change that should be incorporated throughout all phases of treatment. While these factors are assumed to be intuitive and innate, it appears that they are carried out less frequently when clinicians are implementing an intervention with which they have less familiarity—a conceivable problem for many community clinicians implementing EBTs. Thus, once again, operationalizing and teaching nonspecific therapeutic skills that contribute to the therapeutic relationship may increase cohesion and alliance, thereby improving outcomes for youth.

Lastly, the case study findings suggested that the setting characteristics, particularly those pertaining to the scheduling, timing, and consistency of group sessions may impact attendance and disrupt important therapeutic processes. Little research exists on the impact of logistical barriers on the implementation and outcome of therapeutic programs in schools. One study, however, explored clinicians' perceptions of the factors influencing the implementation of an evidence-based intervention for trauma in schools (Langley, Nadeem, Kataoka, Stein, & Jaycox,

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2010). Both successful and unsuccessful implementers of the program identified limited time and space, hectic student schedules, teachers not allowing children to leave class, and school-wide drills and assemblies as barriers toward implementing the intervention. These barriers were ranked as more disruptive by the unsuccessful implementers than the successful implementers, indicating that these seemingly innocuous factors may have a significant impact on effectively implementing therapeutic programs in schools.

Relatedly, research suggests that both organizational factors (e.g., school structure, administrative leadership, school resources, and policies) and the implementation climate (i.e., the organization's perception of the intervention and the level of leadership and support for its implementation) are relevant factors to successful implementation of therapeutic programs in community settings (Langley et al., 2010; Shoenwald & Hoagwood, 2001). While these organizational factors were not formally assessed in the present study, they may have impacted the implementation of the group interventions for both groups, particularly since both interventions were being implemented in the school for the first time. Indeed, the leader of Group A acted as a champion for depression prevention by voluntarily taking a large role in the development and implementation of the group intervention. The intervention was then later disseminated to the high school in the same district. While the counselors of Group B were interested in the project, they did not appear to have as much investment in the intervention—an informal observation that appeared to mirror the attitudes of many of the school personnel in the high school. Thus, not only should future research examine the impact of specific organizational and logistical barriers on implementation and outcome, research should also clarify the conditions that allow organizations to overcome such barriers.

Limitations of the Present Study

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A number of limitations of the study should be noted. First, because the case study analyses were focused on group level processes, other important factors impacting outcome, such as client characteristics, were not examined. The two case studies were not matched on severity of depressive symptoms, age, gender, and comorbidity, which may have accounted for differences in intervention outcome. For instance, Group B had a higher mean CES-D score at screening and less spontaneous remission from the screening to the baseline assessment than Group A and the rest of the GC sample. This suggests that members of Group B may have had more entrenched depressive symptoms, which may have been less amenable to a short-term prevention program. Moreover, research has found larger effects for programs targeting samples with more females, older adolescents, and less comorbidities (Stice et al., 2009). Nonetheless, while Group B had a favorable composition of group members—high school females who reported less comorbidities at eligibility—this group had poorer intervention outcomes at post-group and 6-month follow-up. Future studies should more closely examine other factors that contribute to symptom improvement, as this was not the focus of the current study. Indeed, an analysis of the individual client characteristics may help to clarify moderators of intervention outcomes.

Second, it is important to emphasize that the two case studies are better described as “enhanced GC” and may not perfectly mirror practices occurring in community settings. The group leaders, participating in a larger RCT, were asked to provide an eight-session therapeutic intervention, and neither of the school counselors had previously implemented these group interventions. Subsequently, the interventions may not have occurred in the absence of the larger RCT. Nonetheless, in order to approximate typical practices in the school, no other parameters were provided in regards to the structure and content of the interventions, and groups delivered

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by non-school affiliated personnel were not selected for the case studies. Given these limitations, additional case studies examining group interventions that are more regularly implemented in schools is warranted.

Lastly, the findings were based on data obtained from relatively few time points. Measurement of depressive symptoms after each session may have allowed for a deeper analysis of the specific links between therapeutic processes and symptom change. Additionally, because the leaders of both groups chose to use a manual focused on reducing negative cognitions about the cause, consequence, and self-worth implications of activating events, measuring change in group members' cognitive style over the course of the project may have provided more insight into potential mechanisms of change.

Conclusion

The two case studies highlight the importance of specific and non-specific therapeutic strategies, group components, and setting characteristics that may impact depression outcomes of adolescents in school-based group counseling. The leader of Group A chose and amended a manualized cognitive-behavioral intervention. Despite some deviations from her hybrid manual, she frequently utilized a few directive, cognitive-behavioral strategies and content areas with high levels of extensiveness. Her investment in choosing and revising her protocol, likely increased her beliefs about its effectiveness and her consistency in structuring activities and discussions that were aligned with the overarching goals of the intervention. Moreover, she repeatedly provided opportunities for group members to review and practice skills in a variety of engaging formats, which likely increased their mastery and generalization of the material. Notably, her apparent investment in the group, warm demeanor, and approachability appeared to positively impact group members' participation, self-disclosure, and open dialogue between one

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another—factors indicative of group cohesion and alliance. Additionally, logistical factors such as the timing, scheduling, and duration of Group A may have impacted attendance and group processes.

Conversely, the leaders of Group B appeared to have an eclectic and non-directive approach to therapy, and many of the strategies observed were used superficially or incompletely. Their use of eclectic strategies may have been indicative of their overall therapeutic approach, limited competency with cognitive-behavioral techniques, and/or their apparent lack of investment in the group. Regardless of the reason, the leaders at times appeared to commit to activities described in the protocol, while other times they strayed from their identified goals, offering conceptualizations and providing psychoeducation that were inconsistent with the cognitive-behavioral framework they were using. This erratic approach, coupled with discussions about the lack of effectiveness of the cognitive-behavioral approach, may have negatively impacted members' expectations for change. The leaders also provided limited opportunities for group members to apply the material learned in group, which may have impacted skill acquisition and generalization. Moreover, the leaders' inconsistent use of nonspecific factors (e.g., warmth, empathy, and validation) as well as poor attendance rates and a small group size, may have contributed to greater difficulties in developing group cohesion and alliance. These issues, coupled with logistical problems—holding sessions at inconsistent times, difficulties getting passes to members and shorter session length—appeared to lead to greater difficulties in attendance, interrupting the therapeutic process and outcome.

While exploratory in nature, these analyses were inspired by the paucity of research studies linking therapeutic processes in usual care to variability in outcomes. The case study method provided a structure for examining factors impacting therapeutic change at a level of

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detail missed by RCTs. These case studies serve as the first step toward informing future research and therapeutic practices aimed at improving the quality of care delivered in community settings.

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Tables and Figures

Table 1

Assessment Instruments

General Information
<ul style="list-style-type: none"> • Demographics
Depressive symptoms and Functioning
<ul style="list-style-type: none"> • Schedule for Affective Disorders and Schizophrenia for School-aged Children – Present and Lifetime Version (K-SADS-PL) • Center for Epidemiological Studies-Depression Scale (CES-D) • Children's Global Assessment Scale (CGAS)

Table 2

Structure of Contacts

Contact Type	Time from Initial Contact	Assessment or Intervention	Group or Individual	Duration (minutes)	Instruments Administered
1. Screening	0 weeks	Assessment	N/A	15	CES-D
2. Consent Meeting	1-2 weeks	N/A	Individual	30-60	Demographics
3. Eligibility Assessment	4-5 weeks	Assessment	Individual	90-120	K-SADS-PL, CGAS
4. Baseline Assessment	6-7 weeks	Assessment	Individual	30-60	CES-D
5. Individual Pre-group Sessions	8-9weeks	Intervention	Individual	15-45	N/A
6. Groups	9-17weeks	Intervention	Group	45-90 (8x)	N/A
7. Mid-Group Assessment	13 weeks	Assessment	Individual	30-60	CES-D
8. Mid-Group Session	13 weeks	Intervention	Individual	30-60	N/A
9. Post-Group Assessment	18 weeks 4.5 months	Assessment	Individual	60-120	K-SADS-PL, CES-D, CGAS
10. 6-month Assessment	42 weeks (10.5 months)	Assessment	Individual	60-120	K-SADS-PL, CES-D, CGAS

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Table 3

TPOCS-G Process and Content Codes

The Therapeutic Process Scale	
1. Addresses Non-compliance	13. Makes an Interpretation
2. Addresses In-session Relationships	14. Modeling
3. Advising	15. Monitoring
4. Between Session Assignment	16. Play/Art
5. Communication Analysis	17. Psychoeducation
6. Conducts Interpersonal Inventory	18. Role Play
7. Encourages Cohesiveness	19. Seeks Client's Perspective
8. Establishes/Reviews Goals/Agenda	20. Uses Consequences/Sets Limits
9. Explores Universality	21. Uses Collaboration
10. Exposure	22. Uses Positive Reinforcement/Rewards
11. Warmth/Empathy/Validation	23. Uses Self-Disclosure
12. Information Gathering	
The Therapeutic Content Scale	
1. Affect Content	7. Principle Interpersonal Model
2. Anticipating Relapse/Setbacks	8. Problem Solving
3. Behavioral Activation	9. Relaxation/Mindfulness
4. Cognitive Restructuring	10. Social Skills Training
5. Explores Past	11. Confidentiality/Rules
6. Previous Themes	12. Other

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Table 4

Case Selection Process

Group	Met positive outcome criteria	Met negative outcome criteria	Complete CGAS and CES-D data	More than 2 members	No graduate students as leaders	Same school district
1	X		X	X	X	X
2	X		X	X	X	
3	X		X	X	X	
4	X		X	X	X	
5	X		X	X	X	
6	X		X	X		
7	X		X	X		
8	X		X			
9	X					
10	X					
11	X					
12	X					
13		X	X	X	X	X
14		X	X	X		
15		X				
16		X				

Table 5

Group A and B Demographics

Group Member	Age at Baseline	Sex	Grade	Race	Ethnicity
Group A					
Natalie	13	F	8	White	Not Hispanic
Nate	12	M	7	White	Not Hispanic
Julia	13	F	7	African American	Hispanic
Gia	12	F	7	White	Not Hispanic
Cora	13	F	8	White	Not Hispanic
Aaron	12	M	7	White	Not Hispanic
Group B					
Karmen	15	F	9	Mestizo	Hispanic
Kelly	15	F	10	White	Not Hispanic
Sam	15	F	10	African American	Not Hispanic
Maya	15	F	10	White	Not Hispanic
GC					
Group Means	13.4 (SD=1.2)	65.6% F	55% 7 th or 8 th grade	68.9% White	60% Not Hispanic

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Table 6

Quantitative Data of Group Means Compared to Means of UC Participants

	Group A	Group B	GC
CES-D			
Screening	*24 (6.7)	*28.8 (7.4)	*24.4 (6.9)
Baseline	13.7 (8.8)	*19.0 (10.7)	15.1 (8.6)
Mid-Group	10.7 (4.5)	*18.8 (8.8)	15.3 (9.6)
Post-Group	6.8 (7.8)	*20.3 (10.2)	12.7 (9.2)
6-Month	9.2 (6.4)	*16.0 (7.8)	11.2 (7.6)
CGAS			
Baseline	66.8 (7.2)	68.5 (3.7)	67.5 (5.2)
Post-Group	76.2 (8.1)	69.3 (6.4)	72.8 (6.7)
6-Month	74.8 (4.4)	70.5 (9.1)	74.3 (5.8)
K-SADS Depressive Diagnosis			
Eligibility	None	1 DDNOS	11
Post-Group	None	None	4
6-Month	None	2 DDNOS	5

*Clinically significant

Table 7

Group A and B Attendance

Members	Group Session							
	1	2	3	4	5	6	7	8
Group A								
Natalie	X	X	X	X		X		
Nate	X	X	X		X	X	X	X
Julia	X	X	X	X	X	X	X	X
Gia		X	X	X	X	X		X
Cora	X		X	X		X		
Aaron	X			X	X			X
Group B								
Karmen	X	X	X			X		X
Kelly	X		X		X	X		
Sam	X			X	X	X		X
Maya		X	X	X	X		X	X

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Table 8

Group A Most Frequently Occurring TPOCS-G Codes

Session	Top 5 Process Codes	% of Session	Extensiveness Rating	Top 3 Content Codes	% of Session	Extensiveness Rating	Intervention Level	Group Participation
1	Warmth/Empathy/Validation Psychoeducation Encourages Cohesiveness Uses Self-Disclosure Establishes/Reviews Goals/Agenda	70.6 58.8 35.3 29.4 29.4	7 6 4 5 5	Affect Content Cognitive Restructuring Confidentiality/Rules	17.7 11.8 5.9	3 2 2	7	6
2	Warmth/Empathy/Validation Psychoeducation Between Session Assignment Information Gathering Uses Self-Disclosure	75 50 31.3 31.3 29.4	7 6 5 4 4	Cognitive Restructuring Relaxation/Mindfulness Previous Themes	68.8 25 25	7 5 4	7	7
3	Warmth/Empathy/Validation Psychoeducation Between Session Assignment Modeling Conducts Interpersonal Inventory	68.8 62.5 31.3 25 25	7 6 4 4 3	Cognitive Restructuring Relaxation/Mindfulness Previous Themes	50 18.75 12.5	4 4 3	7	7
4	Warmth/Empathy/Validation Psychoeducation Modeling Addresses Non-Compliance Monitoring	100 93.3 66.7 26.7 20	7 7 6 3 3	Cognitive Restructuring Previous Themes Relaxation/Mindfulness	93.3 20 13.3	7 4 4	6	6
5	Warmth/Empathy/Validation Psychoeducation Modeling Explores Universality Seeks Client Perspective	85.7 85.7 57.1 21.4 21.4	7 7 6 3 2	Cognitive Restructuring Relaxation/Mindfulness Previous Themes	85.7 14.3 14.3	7 4 3	6	5
6	Warmth/Empathy/ Validation Modeling Psychoeducation Uses Collaboration Information Gathering	80 73.3 53.3 53.3 33.3	7 6 6 5 4	Cognitive Restructuring Previous Themes Problem Solving	80 33.3 26.7	7 5 3	7	6
7	Warmth, Empathy, Validation Seeks Client Perspective Information Gathering Psychoeducation Modeling	93.8 37.5 37.5 37.5 31.3	7 5 4 4 4	Cognitive Restructuring Problem Solving Previous Themes	31.3 25 18.8	4 3 3	7	7
8	Warmth/Empathy/Validation Psychoeducation Encourages Cohesiveness Monitoring Uses Collaboration	76.9 38.5 23.1 15.4 15.4	7 5 4 2 2	Anticipates Relapse/Setbacks Previous Themes Cognitive Restructuring	69.2 38.5 30.8	6 5 2	6	5

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Table 9

Group B Most Frequently Occurring TPOCS-G Codes

Session	Top 5 Process Codes	% of Session	Extensiveness Rating	Top 3 Content Codes	% of Session	Extensiveness Rating	Intervention Level	Group Participation
1	Uses Self-Disclosure Warmth, Empathy, Validation Psychoeducation Uses Collaboration Encourages Cohesiveness	63.6 63.6 54.5 36.4 36.4	7 5 4 4 4	Affect Content Confidentiality/Rules Cognitive Restructuring	45.5 27.3 9.1	4 4 2	6	4
2	Psychoeducation Uses Self-Disclosure Modeling Information Gathering Seeks Client Perspective	88.9 66.7 55.6 55.6 44.4	7 5 5 4 4	Cognitive Restructuring Relaxation/Mindfulness Affect Content	66.7 33.3 22.2	5 3 2	7	4
3	Psychoeducation Uses Self-Disclosure Information Gathering Modeling Seeks Client Perspective	58.3 50 33.3 33.3 33.3	5 6 4 3 3	Cognitive Restructuring Affect Content Previous Themes	75 33.3 16.7	4 3 2	6	5
4	Play/Art Warmth, Empathy, Validation Information Gathering Psychoeducation Establishes/Reviews Goals/Agenda	75 75 62.5 37.5 25	6 6 5 2 2	Affect Content Previous Themes Cognitive Restructuring	62.5 25 25	4 3 2	6	7
6	Warmth, Empathy, Validation Psychoeducation Uses Self-Disclosure Seeks Client Perspective Modeling	72.7 54.5 45.5 45.5 36.4	7 4 7 4 4	Cognitive Restructuring Previous Themes Affect Content	81.8 18.2 9.1	4 2 2	7	6
8	Warmth, Empathy, Validation Information Gathering Uses Self-Disclosure Seeks Client Perspective Psychoeducation	100 77.8 77.8 33.3 33.3	7 7 7 4 3	Anticipates Relapse/Setbacks Previous Themes Affect Content	44.4 22.2 11.1	3 2 2	7	6

A MIXED METHODS ANALYSIS OF USUAL CARE

Table 10

Average TPOCS-G Ratings across Group Sessions

TPOCS-G Process Codes	Group A		Group B	
	Average % of Session	Average Extensiveness Rating	Average % of Session	Average Extensiveness Rating
Addresses Non-Compliance	9.0	1.6	0.0	1.0
Addresses In-Session Relationship	0.0	1.0	0.0	1.0
Advising	3.3	1.5	3.4	1.3
Between Session Assignment	20.2	2.9	6.7	1.5
Communication Analysis	2.5	1.4	0.0	1.0
Conducts Interpersonal Inventory	6.2	1.6	4.2	1.3
Encourages Cohesiveness	9.6	2.0	15.3	1.8
Establishes/Reviews Goals/Agenda	10.3	2.3	14.1	1.8
Explores Universality	5.8	1.6	11.6	2.0
Exposure	0.0	1.0	0.0	1.0
Warmth/Empathy/Validation	81.3	7.0	65.8	5.5
Information Gathering	21.0	2.9	48.8	4.5
Makes an Interpretation	0.8	1.1	0.0	1.0
Modeling	35.7	4.0	29.4	3.2
Monitoring	13.9	2.9	2.8	1.2
Play/Art	0.0	1.0	12.5	1.8
Psychoeducation	60.0	6	54.5	4.2
Role Play	1.8	1.1	0.0	1.0
Seeks Client Perspective	14.6	2.4	30.6	3.2
Use Consequences/Set Limits	0.0	1.0	0.0	1.0
Uses Collaboration	13.4	2.1	12.7	2.2
Uses Positive Reinforcement/Rewards	0.0	1.0	0.0	1.0
Uses Self-Disclosure	15.2	2.8	52.7	5.8
TPOCS-G Content Codes	Average % of Session	Average Extensiveness Rating	Average % of Session	Average Extensiveness Rating
Affect Content	3.8	1.5	30.6	2.8
Anticipate Relapse/Setback	8.7	1.8	7.4	1.3
Behavioral Activation	5.6	1.4	0.0	1.0
Cognitive Restructuring	56.4	5.0	42.9	3.0
Explores Past	0.0	1.0	1.4	1.6
Previous Themes	20.3	3.5	17.4	2.0
Principles of Interpersonal Model	2.5	1.3	8.0	1.5
Problem Solving	9.3	1.8	1.5	1.0
Relaxation/Mindfulness	11.7	3.1	6.9	1.5
Social Skills Training	5.6	1.5	0.0	1.0
Confidentiality/Rules	0.7	1.1	6.4	1.7
Other	0.0	1.0	1.4	1.2
Global Rating Scales	Group A Average		Group B Average	
Intervention Level	6.5		5.3	
Group Member Participation	6.6		6.1	

A MIXED METHODS ANALYSIS OF USUAL CARE

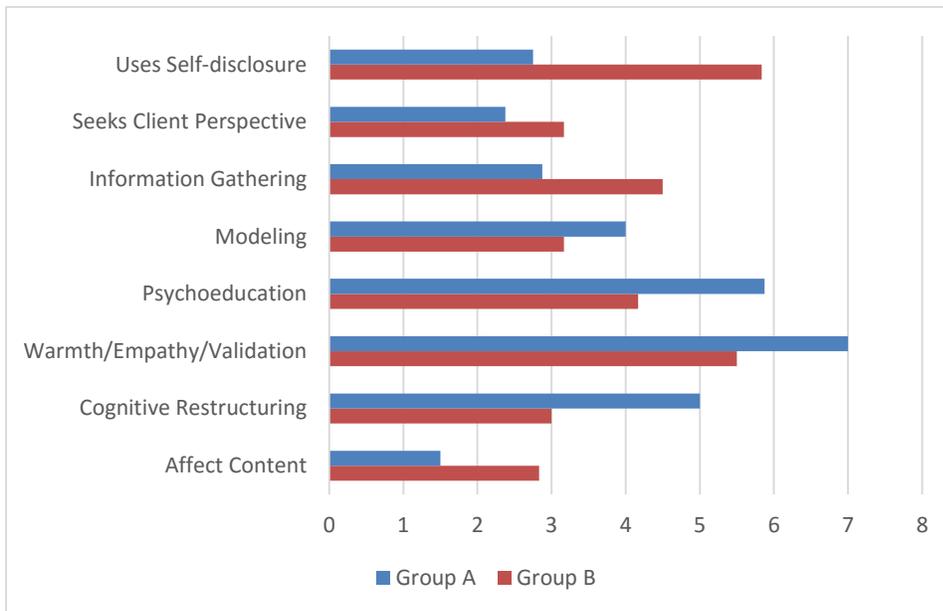


Figure 1. Average Group Extensiveness Ratings of the Most Frequently Coded TPOCS-G Process and Content Codes for Groups A and B

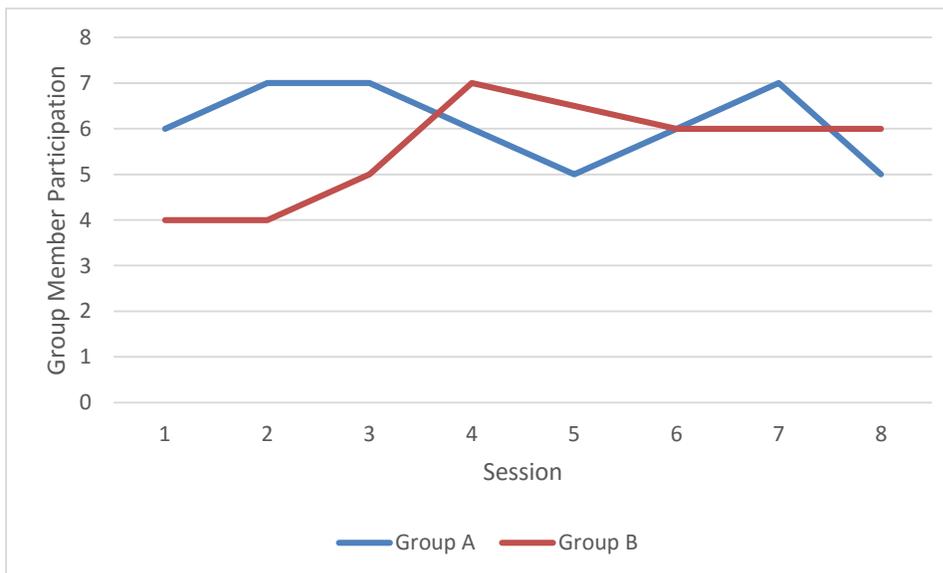


Figure 2. Average TPOCS-G ratings of Group Member Participation by Session for Groups A and B

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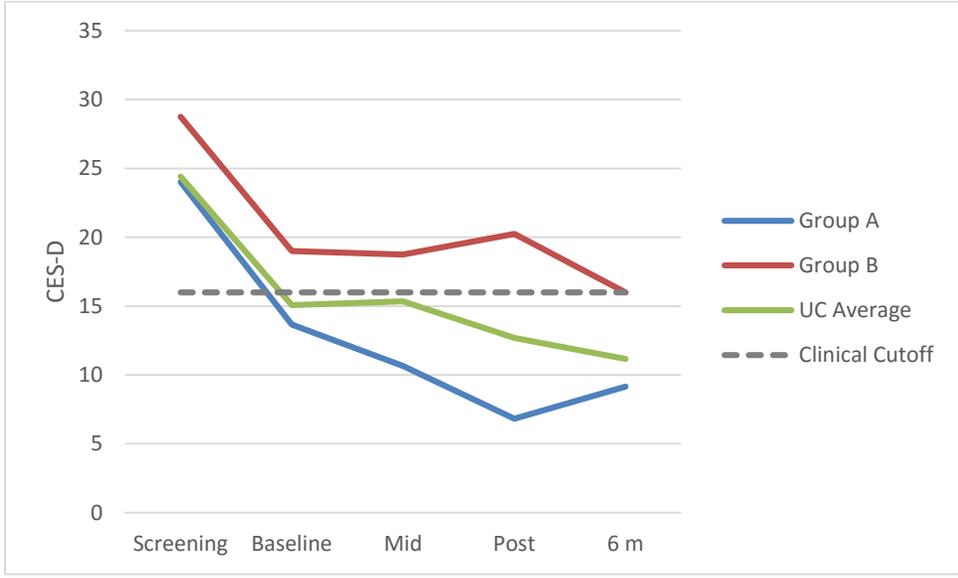


Figure 3. Profile Plots for the Center for Epidemiologic Studies-Depression Scale (CES-D)

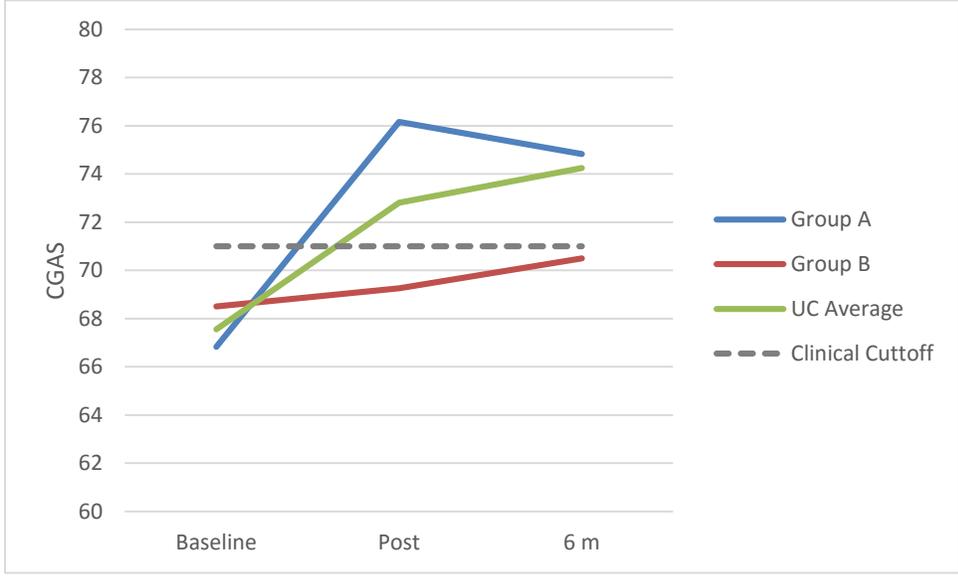


Figure 4. Profile Plots for the Children's Global Assessment Scale (CGAS)

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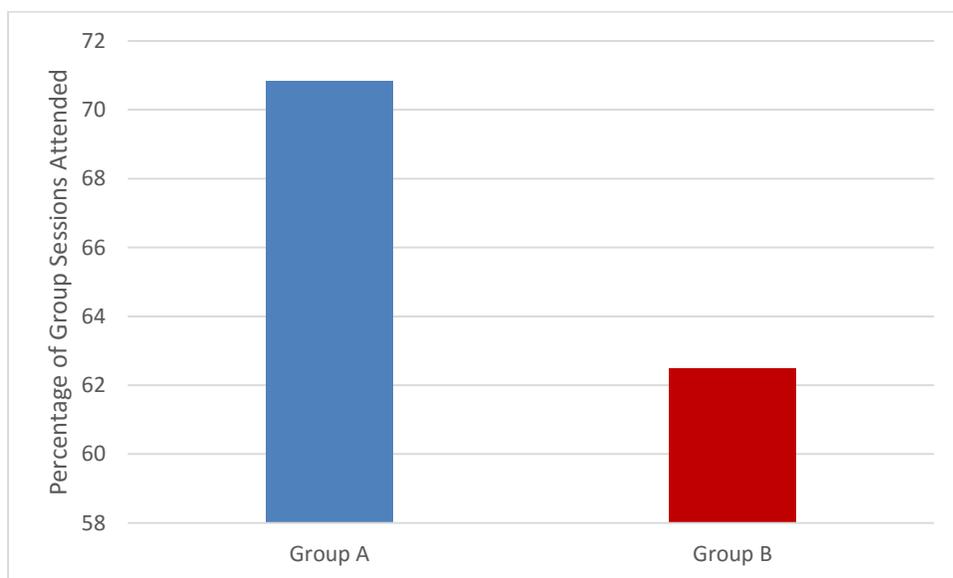


Figure 5. Percentage of Group Sessions Attended