Patient experiences with group behavioral activation in a partial hospital program

**Ethical Statements:** The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. This research was exempt from IRB approval by McLean Hospital because the data was anonymously collected as part of a quality improvement initiative.

**Conflicts of Interest:** All authors declare that they have no conflicts of interest with respect to this publication.

**Financial Support:** This research received no specific grant from any funding agency, commercial or non-for-profit sectors.

Abstract

**Background**: Behavioral activation (BA) is an evidence-based treatment for depression that has been primarily delivered in individual outpatient treatment. Prior research supports a positive participant experience in individual therapy; however, less is known about the patient experience in group therapy, which is common in acute psychiatric settings.

**Aims**: The present study examined the patient experience of Brief Behavioral Activation Treatment for Depression (BATD) delivered in group acute psychiatric treatment.

**Method**: We used thematic analysis to extract themes from feedback surveys administered as part of quality improvement practice at a partial hospital program. Survey questions explored what patients learned, liked, disliked, and thought could be improved in the BATD groups. Three individuals independently coded survey responses and collaboratively developed categories and themes.

**Results**: Themes included several helpful content areas (e.g., value-driven activities, increasing motivation, goal setting, activity scheduling, cognitive-behavioral model, self-monitoring) and learning methods (e.g., group format, experiential exercises, worksheets). Patients also identified unhelpful content (e.g., specific focus on depression and listing activities by mood). There was mixed feedback regarding the repetition of material and balance of lecture versus group participation.

**Conclusion**: Overall, these findings suggest a mostly positive patient experience of group-delivered BATD and support the acceptability of group-delivered BATD as a component of short-term intensive treatment.

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Behavioral activation (BA) is an evidence-based treatment (APA Presidential Task Force on Evidence-Based Practice, 2006) for depression that aims to increase activity as a means of expanding an individual’s contact with rewarding experiences (Hershenberg & Goldstein, 2019). As it was originally conceived by Lewinsohn, behavioral treatment for depression focused primarily on (1) understanding contingencies maintaining the individual’s behaviors that contribute to depressed mood and (2) increasing engagement in behaviors that are naturally reinforcing and contribute to improved mood (Lewinsohn & Shaffer, 1971). Following the results of a dismantling study that suggested that the behavioral component of Cognitive Behavioral Therapy (CBT) was as effective for depression as full CBT, Jacobson et al (1996) termed this set of behavioral skills “Behavioral Activation” (BA). The treatment protocol for BA included a variety of behavioral skills such as self-monitoring, graded activity scheduling (with a focus on pleasure and mastery), cognitive rehearsal, problem solving, and social skills training. Martell and colleagues have continued to expand on the behavioral skills incorporated within BA (e.g., adding mindfulness practice) with increased focus on targeting avoidance (Martell et al., 2001, 2013). Subsequently, Lejuez and colleagues (Lejuez et al., 2001, 2011) developed Brief Behavioral Activation Treatment for Depression (BATD), which focuses more specifically on activity monitoring and scheduling. Based on research on Acceptance and Commitment Therapy (ACT; Hayes et al., 1999), BATD includes a values-driven framework for activity selection as a means of increasing the likelihood that scheduled activities will be positively reinforcing.

Meta-analyses support the efficacy of BA treatments (including BATD) for reducing depressive symptoms in adults (Cuijpers et al., 2007; Ekers et al., 2014; Mazzucchelli et al., 2009). Similarly, a meta-analysis by Ekers et al. (2014) supports the utility of group delivered BA for reducing depressive symptoms, with comparable effect sizes across delivery modes (individual, group, self-help). Prior studies have evaluated group-delivered BA in depressed community volunteers (Fuchs & Rehm, 1977; Rehm et al., 1981), depressed outpatients (Hout et al., 1995), university students (Shaw, 1977), older adult caregivers (Gallagher-Thompson et al., 2000; Lovett & Gallagher, 1988), and community mental health clients (Porter et al., 2004).

BA, and specifically BATD, is an appealing intervention for acute psychiatric settings, such as inpatient and partial hospitalization (Hopko, Lejuez, et al., 2003). Major depression is one of the most prevalent primary diagnoses in acute settings (Heslin et al., 2012; Hsu et al., 2019). Additionally, patients in acute settings experience high rates of comorbidity (Forgeard et al., 2018). Although there is not robust data to support the use of BA in in other conditions, case studies support the potential use of BATD in individuals with comorbid conditions, such as borderline personality disorder (Hopko, Armento, et al., 2003), anxiety (Hopko et al., 2004), and posttraumatic stress disorder (Mulick & Naugle, 2004). In acute settings, psychosocial treatment is primarily delivered via group therapy led by mental health counselors without post-graduate degrees; thus, treatments that can be reliably administered by non-specialists, such as BA (Richards et al., 2016) and BATD (Magidson et al., 2015), are appealing for such settings. Moreover, BATD has been adapted across a range of different time frames, settings, and disorders. For example, while the initial protocol includes 10-12 sessions (Lejuez et al., 2001), BATD has also been successfully implemented as a single session intervention (Gawrysiak et al., 2009; Nasrin et al., 2017). However, to our knowledge, no studies have examined group-delivered BA or BATD in acute psychiatric settings.

Most of the BA protocols for group settings mirror individual treatment manuals. For example, existing group BA protocols are generally structured so that they take place approximately once per week, with the same group of participants for several weeks (e.g., Porter et al., 2004). This is very different from the structure of treatment in acute psychiatric settings. In many inpatient and partial hospital programs, stays are very short in duration and the composition of the groups change from day to day. In addition, depending on the day of admission, and meetings with individual providers (e.g., social worker, psychiatrist, etc.), patients are often not able to attend groups in a specified sequence.

To address these limitations, we developed new group treatment protocols for BATD based on the manual by Lejuez et al. (2011). We retained core elements of BATD, including psychoeducation, self-monitoring, values-assessment, and activity scheduling. Based on clinical expertise of clinicians working in acute psychiatric settings, we also considered the unique demands of our specific CBT-based partial hospital program. For example, because individuals attending these groups also attend other CBT-based groups, efforts were made to explain to attendees how BATD fits within the overarching cognitive behavioral model. In developing these protocols, we strove to create a set of groups that could be flexibly implemented in a wide variety of settings. Each of the four group sessions stand alone and is designed to have therapeutic value independent of participation in other group sessions, while also building off possible attendance of previous groups. In addition, these new protocols incorporate research emphasizing value-driven activities as a means of increasing response-contingent positive reinforcement.

The aim of the current study was to examine the acceptability of a group delivered BATD in a partial hospital program. Specifically, we sought to understand the individual experiences of group members regarding what they learned, liked, and disliked about the group sessions. We used thematic content analysis to extract themes from feedback surveys administered as part of ongoing quality improvement practice. Based on prior qualitative studies of individual BA (Finning et al., 2017), we expected patients to find BATD generally helpful. We did not have any a priori expectations about which aspects of the group protocol patients would find helpful or unhelpful.

**Method**

**Treatment setting and BATD protocols**

We obtained patient feedback on the new BATD group protocols at McLean Hospital’s Behavioral Health Partial Hospital Program (BHP). Similar to other partial hospital programs, the BHP serves as a step-down transition from inpatient care or as a step-up from outpatient care in lieu of inpatient treatment. The program runs weekdays for seven hours each day, and the typical length of treatment is three to ten business days. All patients have the opportunity to participate in up to five groups per day in addition to individual meetings with a program therapist, case manager, and psychiatrist.

We developed four distinct 50-minute BATD groups: (1) “*What is it?*” (offered twice per week), (2) “*Practice*”, (3) “*Weekend Preparation*”, and (4) “*Weekend Review*”. An overview of the main components of each group can be found in Table 1. The full group protocols and handout are available upon request from the corresponding author. The “*What is it*?” group provided an overview of the treatment rationale and components. Additionally, patients worked to identify and plan one value-driven activity. The “*Practice*” group aimed to experientially demonstrate the practice of BATD and taught individuals to set specific, achievable goals. Further, it provided patients with strategies to overcome barriers to activation. The “*Weekend Preparation*” group provided a brief conceptual overview of BATD and value-driven activity for those who did not attend the “*What is it?*” group, and taught patients how to monitor activity and pair it with a mood rating. Group leaders also worked with patients to brainstorm patient values and potential ideas to increase activity. During the group, patients scheduled value-driven activity into their weekend schedule. Finally, in the “*Weekend Review*” group, patients discussed their experiences regarding their scheduled goals from the weekend. Additionally, group leaders reviewed the rationale behind engaging in behaviors despite one’s mood, taught patients how to use data from self-monitoring to plan their next schedule, and reviewed strategies to overcome barriers to activation. The series of groups could be taken in any order, as each group made an effort to underscore the basic principles of BA. All patients participating in a BATD group were eligible to participate in the current study. Responses were collected across 23 BATD groups delivered from March to April of 2019 as part of a quality improvement initiative. In total, 130 anonymous responses were obtained. Due the anonymity of survey responses, it is possible that some patients completed the survey more than once.

Data was collected anonymously and therefore demographic and clinical information was not collected. Prior research from this partial hospital indicates that the patient population is mostly White (85%) and approximately half female (52%). The majority of patients present for treatment in the context of a Major Depressive Episode (~ 75% either in a full episode or partial remission). The most common diagnoses at admission are Major Depressive Disorder (57%), Generalized Anxiety Disorder (42%), Social Anxiety Disorder (35%), and Bipolar Disorder (25%). Additionally, comorbidity is highly prevalent, with 70% of patients meeting criteria for at least two disorders. For a more detailed description of this population and setting, please see Forgeard et al. (2018)

**Measures**

At the completion of each BATD group, patients were asked to provide feedback about their group experience. The survey consisted of four questions: 1) In a few sentences, briefly summarize what you learned in today’s group, 2) What about this group did you find helpful? 3) What about this group was not helpful? and 4) Is there anything else we can do differently to improve this group moving forward?

**Coders**

We identified three coders with varying levels of experience with BA.Two coders (the first and third author) were doctoral students in clinical psychology and one coder (second author) was an undergraduate research assistant. The first author is experienced in the development of treatment protocols of BA and has conducted research in this area. Additionally, the first author is experienced in delivering BATD treatment protocols. The third author is also experienced in delivering BATD in group and individual settings. The second author did not have prior experience with this treatment.

**Analysis Plan**

Qualitative analysis was conducted using the principles of thematic analysis. Thematic analysis has shown to be an effective method for evaluating this type of qualitative data (Miles & Huberman, 1994; Patton, 1990). The coding team was led by the first author. All survey responses were coded by the first, second, and third authors. The first and second author separately created an initial code list for the first and second item on the survey, and then collaborated to create the initial codebook. Through collaboration between the three coders, they adapted the codebook from a close read of a subset of ten surveys. After, team members separately used the codebook to analyze the first question of the remaining surveys and to confer about their suggested codes; they repeated this process with question two and, at that point, determined that they likely had identified the full range of relevant codes for questions three and four. The team used the resulting codebook to code a portion of the remaining surveys, working to resolve discrepancies through consensus and to organize the most robust themes conceptually, and then coded all of the transcripts. Any discrepancies were discussed with coding team and consensus (100% agreement) was reached over the application of a given code. Throughout the coding process, the team adjusted the codebook to reflect emergent data from the patient responses.

**Results**

We identified three overarching themes in patients’ feedback about the groups: 1)helpful, 2)unhelpful, and 3) mixed feedback (lack of consensus). Within each of these themes, responses generally addressed either BATD group content or the implementation/learning methods of said content.

**Helpful Content**

Table 2 presents the findings from the coding for helpful content. Patients reported appreciation for many group components, and each subtheme emerged from having at least 20 relevant responses, with the exception of “the utility of self-monitoring and reflection.”

The catchphrase “*action precedes motivation*” seemed especially effective, as it was most commonly mentioned or paraphrased (especially in response to question 2). Patients found **learning about motivation** helpful because many discussed being a naturally “low energy individual” or having a “lack of motivation.” Therefore, “troubleshooting ways to put action before motivation” gave patients ideas about how to overcome these barriers. Patients connected these skills to their own life, in learning how to motivate “for next weekend,” “to do things I don't want to do,” or “to accomplish my desired behaviors.”

In addition, patients found it helpful to learn about the overall relationship between **thoughts, feelings, and behaviors** (CBT Model). Patients demonstrated knowledge of the central idea that “behaviors influence our feelings and thoughts and vice versa” and that “behaviors are a catalyst for how you think/feel.”

Patients found **scheduling and structuring time** to be helpful components of the groups. In addition to learning the utility of planning in and of itself, many self-compassionate responses emphasized being “flexible” with your schedule and learning “how valuable your time is.” Patients saw scheduling as an effective method to “feel good” and “combat depression.”

Regarding **goal-setting**, specifically SMART (Specific, Measurable, Attainable, Realistic, Time-bound; Doran, 1981) goals, patients reported that breaking the process down into small, “manageable” steps made things “easier to complete.” Patients found it beneficial to learn how “to do ‘little’ activities to make a ‘big difference.’”

**Discussion of values** in the context of goal-setting was helpful. Many survey responses noted the significance of “doing important activities that contribute to your values.” Multiple patients mentioned the balance between enjoyment and importance, with one saying that they learned to “make time for fun activities” and also “try to value it more if it’s a tedious task.”

Reflecting upon “how to improve” and “how to analyze what I did well” were **self-monitoring** concepts that patients found useful. By applying the method of self-monitoring taught in groups, patients reported “understanding where and how BA[TD] was successful over the weekend” and one stated that he/she could use self-monitoring to “recognize what and when makes me happy/what is important to me.”

**Helpful Learning Methods**

Patients also commented on the **learning methods**, or methods of implementing the material that they found most helpful (seen in Table 3). Many expressed satisfaction with the **group format** because it allowed patients “to talk, hear from others, brainstorm.” They found it helpful to have an open format where they could ask group members and leaders about “advice on how to tackle tough obstacles” or discuss their goals. In addition to learning from the instructors, patients appreciated “hearing about the activities others engaged in, and how they were often flexible.” As one patient said, it was useful “finding what strategies work for people that I may not have considered myself.” In fact, the most common suggestions for the group were to “ensure everyone shares” and “include more participation opportunities.” Patients gained exposure to new perspectives but also felt validation of their own experiences through relating to others. “Knowing that almost everyone struggles with anxiety in relation to family and post hospital reaction” evoked feelings of solidarity within the group. Many patients emphasized the sentiment that “it was encouraging to hear other people have the same fear.”

Patients also found **structured, experiential group activities** helpful in demonstrating BA concepts. Patients noted that the group exercises (e.g., two truths and a lie) helped them “learn the theory and put into practice with the exercise.”

The “*What is it?*” and “*Weekend Prep*” groups used a **worksheet for activity planning**. This handout broke down the steps of planning a value-driven SMART goal. Patients noted that this worksheet provided a concrete way to “spend some time making goal[s]” during the group. We categorized feedback that described the utility of “the breakdown of BA[TD],” “going through examples,” and “setting a goal” as pertaining to this worksheet even when not explicitly specified. Overall, comments suggested that the worksheet provided the structure for implementing skills during the group.

**Unhelpful Aspects of the Groups**

Responses within **t**his theme primarily emerged from the questions “What about this group was not helpful?” and “Is there anything else we can do differently to improve this group moving forward?” These results are presented in Table 3. The vast majority of replies to this question did not discuss anything negative or unhelpful; many people wrote “Nothing” or “Not sure.” Of the remaining responses, many were too vague or specific to an individual to derive broader themes. Some people responded to the survey with questions they had, such as: “When do you DECIDE not to do something? And never make it a goal? No one can always say yes?” and “how do I do something if I have zero motivation” showing that not all patients found the treatment rationale satisfactory. Additional individual factors impacted the patients’ satisfaction and learning in the group. For example, one person noted that they, “did not specifically get to address an issue I had this weekend (really my fault though).” Comments like these suggested that patient experiences are impacted by a variety of personal factors that are difficult to control.

The coders agreed on two broader themes for what multiple people found unhelpful. First, patients did not find **listing activities by mood** (i.e.,discussing what they do when they are sad versus happy) helpful**.** Second, some patients believed that the group was unhelpfully “only based on depression,” with one participant suggesting “different groups for different problems but on the same skills.” Although only a few people expressed concerns on these topics, out of the small sample of negative feedback, these responses were prominent enough to warrant attention.

**Mixed Feedback**

Patient feedback varied regarding the **repetition of material** and **balance of lecture versus group participation**. These two themes, shown in Table 4, received a significant amount of both positive and negative feedback, with at least six responses for both opinions. Some patients appreciated a repetitive teaching style because they “always forget things” and the repetition “reinforced the material.” Others found the group unhelpful with “how repetitive it was about what BA was; it was a bit tedious.” Thus, repetition, while “tedious” for some, “clarified how to implement this skill [BATD]” for others.

There was also disagreement about the **balance between lecture and group participation**. While many believed that the group had a helpful “mix between lecture and active participation,” others believed that there was “too much talking by clinician,” so “it felt 1-sided (lots of lecturing).”

**Discussion**

The current study examined patient perceptions of BATD delivered in a time-limited, dosage-varying, group-based format as part of a CBT-based partial hospital program. Using qualitative methods, this study highlighted helpful group content and learning methods as well as unhelpful aspects of group protocols. Patients perceived the core elements from the original BATD protocol (Lejuez et al. 2011) as helpful in this adapted format, including values-driven activities, activity scheduling, and self-monitoring. Consistent with prior qualitative findings from individual BA (Finning et al., 2017), patients also noted that setting effective goals was helpful. These findings provide preliminary evidence that the adapted protocol sufficiently conveys critical aspects of BATD to patients.

There were also subthemes that emerged in the current study that were not identified in qualitative analyses of individual BA protocols (Finning et al., 2017). Themes unique to this study include the importance of value-driven activity and the importance of understanding that “action precedes motivation.” The emphasis on values is unique to BATD, which explains why this theme did not emerge in qualitative reviews of BA protocols (Lejeuz et al., 2001). Notably, these two subthemes were among the most consistently identified helpful concepts on patient surveys. One aspect of our BATD protocol that differed from the originally published manual was that we included psychoeducation on the CBT model of thoughts, feelings, and behaviors. This aspect of the protocol was unique to the partial hospital program and was designed to integrate BATD concepts into the overall CBT-dominant framework of the program. As such, prior research has not examined the utility of this concept in BATD protocols. Patient feedback suggests that it was helpful to incorporate BATD into their understanding of how thoughts, feelings, and behaviors are connected. This feedback implies that it may be helpful to provide conceptual connections across groups in similar settings that provide multiple treatment modalities.

Consistent with the findings of Finning et al. (2017), patients generally reported they found completing worksheets and practicing skills helpful. Interestingly, however, some patients in both studies found it aversive to focus on aspects of behavior that relate to negative mood. One possible explanation for this relates to emotion regulation theory. Avoidance and suppression of thoughts, feelings, and behaviors associated with negative mood states are common emotion regulation strategies across multiple psychopathologies (Aldao et al., 2010). It is possible that patients in BATD are uncomfortable engaging in exercises that require approach rather than avoidance of negative mood. Another possible explanation for this finding in the current study is that patients in a partial hospital program already spend a substantial amount of time each day engaging with activities that require the identification of thoughts, feelings, and behaviors associated with negative mood states. Given the limited time allotted for BATD treatment in a partial hospital setting and other groups that highlight negative thoughts, feelings, and behaviors, it may be beneficial to replace this exercise with one that is more focused on practicing concrete, change oriented BATD skills. Future research might explore the reasons why a focus on thoughts and behaviors associated with negative mood are perceived as unhelpful.

Patients in the current study also identified that the group format was helpful in learning BATD skills. To our knowledge, there are no prior qualitative studies that have examined patient experiences with BATD in a group format. However, one feasibility study surveyed focus groups of clinicians (*n =* 12) and patients (*n* = 9) to assess perceptions about different elements of a proposed group-based BA program (Samaan et al., 2016). Clinicians predicted that group members would act as mutual supports during treatment. Patients predicted that they would benefit from learning how their own experiences relate to others and that it would be helpful to build relationships with other patients who share the experience of depression. While these focus groups were limited to identifying potential benefits of a proposed group format, the current study provides some initial evidence to support these predictions from patients who have completed adapted BATD groups. Patient feedback from the current study suggests that delivering BATD in a group format enhances patient perceptions of community support, shared experience, and self-exploration, even in adapted settings where group membership is not consistent or recurring on a regular basis.

As alluded to above, several patients identified the groups’ focus on depression as unhelpful. Although three-quarters of patients are admitted to within the context of a depressive episode, there are many patients who do not meet criteria for a current major depressive episode (Forgeard et al., 2018). Likewise, there may be patients who have comorbid diagnoses that they identify as more distressing than their depression symptoms. One potential way to highlight the benefits of BATD for non-depressed patients might be for group leaders to emphasize overlapping symptoms and behaviors across common psychiatric disorders and include examples that extend beyond depression. Specifically, many patients with anxiety disorders, trauma/stressor disorders, and mood disorders share symptoms (e.g. difficulty concentrating, disrupted sleep) and maladaptive coping strategies (e.g. emotional avoidance, rumination; Aldao et al., 2010). Preliminary clinical research indicates that BA skills can reduce shared symptoms across disorders and target maladaptive coping strategies (Chen et al., 2013; Gros et al., 2012; Hopko et al., 2006).

With regard to group structure, patients expressed differing opinions about the proportion of group time allocated to lecturing versus group participation. Some patients benefited from listening to group leaders talk, while others preferred to hear from other group members. This may reflect the fact that patients have different learning styles. In addition, different group leaders had different teaching styles, and this likely influenced patient experiences. Group leaders should be encouraged to take a balanced approach in order to maximize benefits to patients with any learning style.

Results should be interpreted in the context of several limitations. Feedback was collected immediately following each group. While this was helpful in gathering initial patient perceptions, it is unclear how perceptions might change over an entire course of treatment. It is also not clear how patient perceptions of what is helpful relates to symptom outcomes. Future research should examine whether patient experiences with treatment are associated with treatment outcome. In addition, the surveys were short and limited in scope, which limited the themes that could be extracted from participant responses. The surveys utilized in this study asked the same four questions across four different BATD groups. The questions asked for broad perceptions about helpful and unhelpful content but did not ask specific follow-up questions to facilitate an extraction of richer themes. Interview data would have allowed for richer extraction of themes. In addition, the lack of quantitative measures or analyses limits the interpretation of these findings. Finally, while we provide information on the broad demographic and clinical composition of the patients in the partial hospitalization program, we did not collect this information for participants in BATD groups who filled out the survey, which limits our understanding of the respondents and whether they are representative of the program population. Furthermore, the lack of demographic data limits the generalizability of these findings to other groups of patients that may not share the same demographic features.

Patients in hospital settings receive intensive care for brief periods of time; existing BATD group protocols require regular weekly attendance and thus do not fit well into the hospital model of care. This study suggests that an adapted BATD protocol can provide patients in such settings with an understanding of core concepts and clear examples of how to put these skills into practice, even when groups are not attended regularly over a period of weeks. Patient feedback suggests that, overall, patients find BATD helpful. BATD groups should continue to emphasize value-driven activity and how these concepts influence motivation.

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Table 1. Overview of group components

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | What is it | Practice | Weekend Prep | Weekend Review |
| Content | |  |  |  |  |
|  | In-depth treatment rationale | X |  |  |  |
|  | Brief treatment rationale |  | X | X | X |
|  | Activity planning | X | X | X |  |
|  | Experiential exercise |  | X |  |  |
|  | Anticipate hurdles and roadblocks |  |  | X |  |
|  | Assign self-monitoring |  |  | X |  |
|  | Review self-monitoring |  |  |  | X |
| Worksheets | |  |  |  |  |
|  | BA Practice Worksheet | X |  |  |  |
|  | Examples of Values | X | X | X |  |
|  | Daily Schedule | X |  | X |  |
|  | Identifying Meaningful Activities |  | X |  |  |
|  | Weekend Monitoring |  |  | X | X |
|  | Weekend Prep |  |  | X |  |
|  | Weekend Activity Review |  |  |  | X |

Table 2: Feedback on Helpful Content and Learning Methods

|  |  |  |
| --- | --- | --- |
| Main theme | Subthemes | Example Quotations |
| Helpful  Content | The importance of value-driven activities | *- It's best to choose activities that are important to you - i.e. in support of your values and goals.*  *- Doing important activities that contribute to your values creates happiness* |
|  | How BATD can be useful for increasing motivation | *- Action precedes motivation*  *- I learned that there are times you need to initiate behaviors even if you do not feel motivated. By doing so, you will increase your motivation, which in turn makes you feel better and have more positive thoughts about yourself.* |
|  | How to set effective goals | - *SMART goal setting technique [was helpful]*  - *I learned to break down activities that I enjoy or have to do into smaller more manageable pieces* |
|  | The importance and utility of structure and activity scheduling | - *[I learned] How to structure my time/schedule wisely enough to strike a positive or "feel good" reaction*  *- [I learned] How critical it is to be flexible/forgiving about the schedule you establish - to take 'failures' as opportunities to learn about what works* |
|  | The relationship between thoughts, feelings, and behaviors | *- Behaviors are a catalyst for how you think/feel. Even if you don't feel like doing something, it may be helpful to do it because it may change the way you feel.*  *- We learned that our behaviors influence our feelings and thoughts and vice versa.* |
|  | The utility of self-monitoring and reflection | *- Using the prior weekend's activities as a learning tool for future weekend planning [was helpful]*  *- [I learned] The concept of self-monitoring to realize/recognize what and when makes me happy/what is important to me.* |
| Helpful learning methods | Group format | *- Sharing our ideas with the group and getting feedback and suggestions [was helpful]*  *- I found it helpful that other people had similar difficulties that I've encountered* |
|  | Participation in experiential group activities intended to demonstrate BATD concepts | *- Learned that my fatigue went down after the activity with the class. ACTION -> MOTIVATION*  *- The exercise in which we had to get up and engage with others in the session [was helpful]* |
|  | Worksheet for integrated activity planning | *- The practice exercise where we thought about something we are going to do this weekend [was helpful]*  *- The breakdown of BA[TD] and explanation of each step [was helpful]* |

Table 3: Feedback on Unhelpful aspects of groups

|  |  |  |
| --- | --- | --- |
| Main theme | Subthemes | Example Quotations |
| Unhelpful | Focus on depression | *- [Unhelpful because] It’s only based on depression*  *- [Suggestion on what to do differently:] Maybe different groups for different problems but on the same skills* |
|  | Listing activities by mood | *- It wasn’t helpful to talk about activities that make one more/less depressed* |

Table 4: Mixed Feedback on aspects of groups

|  |  |  |
| --- | --- | --- |
| Main theme | Subthemes | Example Quotations |
| Mixed Feedback | Repetition of Material | *- I found it helpful that he reviewed what BA[TD] was. I always forget things.*  *- [It was unhelpful] How repetitive it was about what BA[TD] was, it was a bit tedious* |
|  | Balance of lecture versus group participation | *- The mix between lecture and active participation [was helpful]*  *- Too much talking by clinician/not involving group enough [was unhelpful]* |