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Gaudiebility Group Therapy in Depressed Patients: A Pilot Study

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Abstract

Gaudiebility is defined as a set of modulators that regulates enjoyable experiences. Depressed patients are unable to enjoy life experiences. The aim of this pilot study was to test the efficacy of a group therapy approach based on gaudiebility principles in patients with unipolar depression. The experimental group included 7 patients who were diagnosed with unipolar depression and who scored less than 50 points on the gaudiebility scale. The control group consisted of 10 patients with similar characteristics. The experimental group was treated with both a standard treatment and gaudiebility therapy. The control group was treated only with the standard treatment. Our results showed improvement in the experimental group as indicated by the clinical scales evaluated: the Beck depression scale (24.57 to 13.14, $p= 0.02$), the gaudiebility scale (32.71 to 49.57, $p= 0.04$), the quality of life scale (87.14 to 104.43, $p= 0.02$), and the psychological well-being scale (61.86 to 82.14, $p= 0.02$). This improvement was maintained after both 3 months and 2 years. The control group showed statistically significant differences only in the quality of life scale (87.1 to 97.6, $p= 0.014$). Our study suggests that gaudiebility therapy intervention is effective as an additional treatment in patients with unipolar depression. Further exploration of this finding is required, including testing with other disorders and the use of a randomized placebo control study design.

Key words: gaudiebility; depression; well-being; group therapy; enjoy; anhedonia.

Novelty and Significance

What is already known about the topic?

It has been suggested that an inability to enjoy life experiences is a feasible cause for depression.

Gaudiebility is a construct that encompasses all of the processes mediating the interactions between stimuli and the enjoyment people experience when receiving these stimuli.

What this paper adds?

Our study suggests that the gaudeability therapy that was developed to potentiate the individual's ability to enjoy life experiences, could improve clinical symptoms of depression and therefore it can be used, as an additional treatment to treat depressive syndromes.

A low level of positive affect has been proposed as a defining feature of unipolar affective disorders (Lewinson & Graf, 1973). This is particularly emphasized in the

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tripartite model (Watson, Clark & Carey, 1988; Clark & Watson, 1991), which describes depressive disorders as characterized by high levels of negative affect along with low levels of positive affect. Bouman and Lutejin (1986) have demonstrated a change in the frequency and intensity of enjoyment in depressed patients. Burns and Davis (1999) have suggested that an inability to enjoy life experiences is a feasible cause for depression. Gaudiebility (from the Latin Gaudiere) is a construct that encompasses all of the processes mediating the interactions between stimuli and the enjoyment people experience when receiving these stimuli. In other words, gaudiebility is the set of modulators that regulates subjective emotional responses that arise from gratifying experiences of enjoyment, which vary in their degree, the number of situations, and their duration (Padrós & Fernández Castro, 2008). Accordingly, high gaudiebility indicates that there is a high probability for a person to feel enjoyment. Thus, gaudiebility is the potentiality of enjoyment for every individual or the potential for experiencing gratifying sensations.

Because depressed patients are unable to enjoy life experiences (Burns & Davis, 1999), the development of an intervention to enhance gaudiebility (modulators of enjoyment) may be useful in addition to individual treatments (psychiatric and/or psychological) that address modulators of negative affect.

Therefore, this pilot study was aimed to assess the feasibility of a gaudiebility intervention protocol on patients diagnosed with unipolar depressive disorder who were simultaneously receiving individual treatment (psychiatric and/or psychological).

Method

Participants

The sample consisted of 17 adults diagnosed by a mental health professional as having major depressive, dysthymic, or non-specified depressive disorders according to the DSM-IV-TR (American Psychiatric Association, 2000) criteria. Also, the participating patients were required to have scored less than 50 points on the gaudiebility scale (GS). All subjects received individual ambulatory treatments (cognitive behavior therapy twice a week and pharmacological treatment with antidepressants and/or benzodiazepines) in the Adult Mental Health Center. The experimental group also participated in gaudiebility therapy; this group included 5 women and 2 men between the ages of 34 and 61 years (mean: 48.5 years, standard deviation [SD]: 9.6 years). The control group included 6 women and 4 men between the ages of 32 and 55 years (mean: 47.6 years, SD: 7.3 years).

Measures

The Spanish version of the Beck Depression Inventory (BDI) (Vázquez & Sanz, 1997) is widely used to detect and quantify depressive symptoms and has shown a high degree of consistency (Cronbach's alpha values between 0.73 and 0.93). It consists of 21 items in which various descriptions of a person's mood are evaluated by the examinee.

Only the items with the highest values (0-3) are scored. High scores, obtained by summing the highest values, indicate the presence of depressive symptoms.

The *Gaudiebility Scale* (GS) measures gaudiebility (Padrós & Fernández Castro, 2008) and consists of 23 items; for each item, the examinee must indicate his/her degree of agreement on a scale of 5, ranging from complete disagreement (0) to complete agreement (4). The final score is obtained by adding up the scores for all of the items; thus, the final score ranges from 0 to 92. A high score indicates high gaudiebility. The mean score for this scale in the general population is 57.5 (*SD* 10.2). There is satisfactory evidence of the validity, test-retest reliability and internal consistency of this scale (Cronbach's alpha coefficient ranges between 0.84 and 0.86; Padrós & Fernández Castro, 2008).

The *Quality of Life Questionnaire* (QLQ), designed by Ruiz and Baca (1993), is a questionnaire consisting of 39 items that evaluate the health-related aspects of an individual's quality of life. Each item is scored from 1 to 5, and the sum of all of the item scores produces the final score, which can range from 39 to 195. Higher scores on the questionnaire indicate a higher quality of life. Studies using this questionnaire indicate that it exhibits good internal consistency (Cronbach's alpha coefficient ranges between 0.94 and 0.95) and good concurrent validity.

The *Psychological Well-being Questionnaire* (PWBQ), designed and analyzed by Sánchez Cánovas (1994), is used to evaluate general subjective psychological well-being. It is a 30-item scale in which the respondent provides answers ranging from "never" (1) to "always" (5). A score is obtained by adding the values assigned to all of the items (values range from 30 to 150). A high score indicates a high level of subjective psychological well-being. This instrument shows good internal consistency (Cronbach's alpha: 0.93) and good concurrent validity.

Procedure

The study was approved by the Ethics Committee of the Hospital, and all of the patients participating in this study signed a written informed consent form. The participants were randomly assigned to either the experimental or the control group. The patients of the experimental group (n= 7) were invited to participate in the experimental intervention. The participants in this group filled out the self-administered GS, BDI, QLQ, and WBPQ scales on four separate occasions: after the first group treatment session, during the last session, three months after the last session, and at the two-year follow-up. The patients of the control group (n=10) received only the individual treatment. The same scales were administered once the unipolar affective disorder was diagnosed and three months later, which was the duration of the therapy given to the experimental group.

Gaudiebility Protocol Treatment. An intervention program was designed that included the majority of the modulators that appear in the gaudiebility construct (Padrós & Fernández Castro, 2008). This program was applied by a therapist and a co-therapist; it covered 9 weekly sessions, which were 90-minutes in duration. The contents of the sessions are described below.

Session 1. The therapist, co-therapist and patients introduced themselves. The rationale for and the characteristics of the intervention were fully explained, and direct instructions were given, including a description of the tasks to be done at home as homework between sessions. It was also stated that during the individual treatment, the patients must deal with situations that generate discomfort and that in the group sessions, factors regulating enjoyment would be discussed. The patient was taught that depression makes it difficult to experience enjoyment. "Máximo's case," a fictitious case of depression, was presented. It describes a person who enjoys most life circumstances (see the Appendix). A copy of the case was distributed to all of the participants, and written homework was given for the following session. The participants were asked to respond to the following: 1) What do you think is meant by enjoyment? (definition of various forms of enjoyment), and 2) Make a list of things that make enjoyment easier or more difficult (modulators).

Session 2. The completed homework was reviewed, followed by a discussion addressing different ways of experiencing enjoyment and factors identified as enjoyment "facilitators" or "hinderers." As homework, each of the participants (including the therapists) was randomly assigned another person in the group. The participant was asked to write a short essay about the person to whom he/she was assigned, including a brief, fictitious life history, a name, a nationality and a place in a historical moment different from the present one.

Session 3. The homework was reviewed, and a discussion followed that emphasized the ability to find gratification through use of the imagination. The internal locus of control of the imagination and its power to be activated with varying degrees of frequency were emphasized. At the end of the session, the issue of enjoyment "facilitators" and "hinderers" was readdressed, taking into account the factors that the patients previously identified. As a guided homework, the patients were told 1) to revise their list of factors identified as enjoyment "facilitators" or "hindrances" and 2) to remember personal anecdotes and/or jokes that he/she recalled as being particularly funny.

Session 4. The first homework assignment was reviewed, and a discussion was opened concerning enjoyment modulators. The participants were encouraged to tell their own personal funny anecdotes and/or to tell jokes (homework assignment 2). A discussion was opened on the topic of humor; common factors playing a role in humor were discussed, such as metacognition (to think about one's own thoughts and perceiving oneself as "another intelligent being"), surprise (the act must comprise, to a certain degree, an unexpected situation), and the lack of serious consequences. Irrational thoughts were identified and discussed (for example, a person who engages in humorous behavior is not incompetent, unreliable or insensitive), and behaviors commonly identified as ridiculous were identified. In most cases, these of thinking or aspects of behavior were associated with irrational fear. The following homework was assigned: each person must dance in front of a mirror for 5-10 minutes each day, making gestures while dancing to the radio without selecting a particular radio station.

Session 5. The assigned task was reviewed, and an activity was undertaken consisting of dancing and making gestures to music on the radio, without selecting a particular radio station. This was followed by a discussion on humor "facilitators" and "hinderers," emphasizing the internal locus of control, irrational ideas, and perceived competence. For homework, each patient was requested to use his/her imagination to generate humor, imagining hypothetical, but viable, funny situations (keeping in mind metacognition and surprise factors). It was also suggested that the patients try

to enact these situations if they were feasible.

Session 6. The homework from the previous session was reviewed and an activity followed that involved three common objects (a notebook, a black lead pencil and a paper hole punch). One patient was asked to choose one of the objects, and all of the participants were asked to write a list (as long as possible) of all of the topics on which this particular object might raise interest and anything this object might suggest. Then a discussion was opened on the topic of the capacity to enjoy a cognitive effort by connecting a specific situation to a person's acquired knowledge or by putting the person's imagination to work. The inner loci of interest and imagination were emphasized (two of the enjoyment "facilitators"/"enablers"). In addition, cognitive events identified as enjoyment "hinderers" (for example, "highly boring situations where no enjoyment is possible") and "facilitators"/"enablers" (for example, "the ability to enjoy a situation implicates mental activity that requires effort, but this effort is rewarded later") were addressed. The guided homework task was 1) to make use of one's imagination and humor or to connect with one's interests in seemingly boring situations and 2) to record the enjoyment level experienced during daily activities throughout the following week.

Session 7. The homework from the previous session was reviewed, and a discussion based on how the organization of time may influence the enjoyment that one may experience was opened. Psycho-educational techniques that encourage active idleness and gradually create a vision of enjoyment were stressed; it was noted that the latter seldom reaches its highest point of enjoyment. Other issues treated in the discussion were cognitive bias (an extreme appreciation of the enjoyment level) and lifestyle factors (such as a tendency toward passivity). The homework for this session consisted of each patient modifying his/her daily activities to increase the duration and frequency of situations that lead to a higher enjoyment level. With respect to the moments that provide low enjoyment levels, the patient must make suggestions for enhancing enjoyment and was encouraged to put them into practice.

Session 8. The previously assigned homework tasks were reviewed and were followed by a discussion on the modifications of daily activities performed by the patients. Each participant was invited to make suggestions for enhancing the level of enjoyment of the other members of the group. The homework at this point was to summarize the issues treated in all the sessions with a list of "facilitators"/"enablers" and "hinderers" and to generate a list of slogans to help keep these factors in mind; the participants were required to read this list three times a day.

Session 9. The homework was reviewed. All of the participants were encouraged to assess and share their slogans. An evaluation was conducted using self-administered questionnaires.

Results

The analyses were performed using SPSS software, version 15.0. The results showed that 85.7 % of participants in the experimental group and 100 % of controls completed the study. Furthermore, the experimental and control groups did not show any differences in gender (Fisher's exact test= 0.516), age (t= 0.238; df= 15; p= 0.815), or the basal assessments of BDI (t= 0.926; df= 15; p= 0.369), GS (t= 0.506; df= 15; p= 0.620), QLQ (t= 0.004; df= 15; p= 0.997), and PWBQ (t= 0.333; df= 15; p= 0.744). These results are shown in Table 1.

Table 1. Student's *t* test comparison between the two groups at pre-treatment of the descriptive variables and psychological scales.

	Exp Group		Control Group		*t* test	*p* (2-tailed)
	Mean	*SD*	Mean	*SD*		
Age	48.6	9.59	47.6	7.31	t= 0.238	p= .815
BDI	24.57	6.4	27.6	6.79	t= -0.926	p= .369
GS	32.71	14.41	35.7	10.04	t= -0.506	p= .620
QLQ	87.14	14.79	87.1	24.96	t= 0.004	p= .997
PWBQ	61.86	10.04	59.6	15.76	t= -0.333	p= .744

Notes: BDI (Beck Depression Inventory), GS (Gaudiebility Scale), Quality of Life Questionnaire (QLQ) and Psychological Well-Being Questionnaire (PWBQ).

The experimental group showed statistically significant differences between before and after treatment for the BDI score (*t*= 3.493; *df*= 6; *p*= 0.013), the Gaudiebility Scale total score (*t*= -3.305; *df*= 6; *p*= 0.016), the quality of life score (*t*= -2.801; *df*= 6; *p*= 0.031), and the psychological well-being score (*t*= -3.835; *df*= 6; *p*= 0.009). The control group showed statistically significant differences only in the quality of life score (*t*= -3.023; *df*= 9; *p*= 0.014; see Table 2). In addition, to assess the changes experienced by the subjects after the treatment, the differences between the pretreatment and post-treatment scores were calculated for each subject for each scale. The following transformation

Table 2. Student's *t* test to assess the statistical significance in the different psychological scales in experimental and control groups at pre-treatment and post-treatment.

	Exp Group				Control Group			
	Pre-T Mean (*SD*)	Post-T Mean (*SD*)	t test (P 2-tailed)	*r*	Pre-T Mean (*SD*)	Post-T Mean (*SD*)	t test (P 2-tailed)	*r*
BDI	24.57 (6.4)	13.14 (7.52)	t= 3.493 p=0.01	0.819	27.6 (6.79)	22.8 (11.75)	t= 1.361 p=0.21	
GS	32.71 (14.41)	49.57 (5.03)	t= -3.305 p=0.02	0.803	35.7 (10.04)	39.5 (15.56)	t= -1.127 p=0.29	
QLQ	87.14 (14.79)	104.43 (23.92)	t= -2.801 p=0.03	0.753	87.1 (24.96)	97.6 (25.63)	t= -3.023 p=0.01	0.7
PWBQ	61.86 (10.04)	82.14 (12.31)	t= -3.835 p=0.01	0.843	59.6 (15.76)	64.8 (17.09)	t= -1.017 p=0.34	

Notes: Pre-T = pre-treatment; Post-T = post-treatment; r = Effect size.

was thus applied to each variable: Difference= (post-treatment value - pretreatment value). This operation provided an estimation of the change in score with respect to the first measurement of each of the variables. We compared these changes between groups using the Student-Fisher's *t*-test. We obtained statistically significant differences for the GS scores (*t*= -2.231; *df*= 15; *p*= 0.041) and a trend toward significance for the PWBQ scores (*t*= -1.996; *df*= 15; *p*= 0.064). In both of these cases, the experimental group showed greater differences between the pretreatment and post-treatment scores than the control group (see Table 3).

The follow-up data indicated that the benefits of our intervention persisted or even increased. This improvement was sustained for three months after cessation of treatment. No significant changes were found between these post-treatment assessments for any of the four scales. There was also a sustained improvement two years later (Table 4).

Table 3. Student's *t* test to assess the statistical significance in the distance (post-treatment value-pre-treatment value) in the different scales in experimental and control group.

	Exp Group Mean (*SD*)	Control Group Mean (*SD*)	*df*	*t* test	*p* (2-tailed)	*r*
BDI	-11.43 (8.66)	-4.8 (11.15)	15	-1.315	0.208	
GS	16.86 (13.50)	3.8 (10.66)	15	2.231	0.041	0.499
QLQ	17.29 (17.21)	10.50 (17.53)	15	0.794	0.441	
PWBQ	20.29 (13.99)	5.2 (16.16)	15	1.996	0.064	

Note: r = Effect size.

Table 4. Mean, *SD* (in parenthesis), *t* values and significance (in parenthesis) of the different scales in experimental group at post-treatment (Post-T) and follow-up three months and two years.

	Three months of Follow-up			Two years of Follow-up	
	Post-T Mean (*SD*)	Mean (*SD*)	*p* (2-tailed)	Mean (*SD*)	*p* (2-tailed)
BDI	13.14 (7.52)	15.57 (8.1)	*t*= -2.189 *p*= 0.07	9.71 (9.72)	*t*= -2.21 *p*= 0.03
GS	49.57 (5.03)	54.57 (10.67)	*t*= -1.063 *p*= 0.33	60.29 (14.80)	*t*= -2.37 *p*= 0.02
QLQ	104.43 (23.92)	107.71 (25.66)	*t*= -0.603 *p*= 0.57	116.57 (22.63)	*t*= -2.37 *p*= 0.02
PWBQ	82.14 (12.31)	82.57 (17.69)	*t*= -0.119 *p*= 0.91	100.14 (24.30)	*t*= -2.37 *p*= 0.02

Note: r = Effect size.

Discussion

The result of our pilot study suggests that a gaudiebility intervention is feasible in patient with mild to moderate major depression episode and this intervention could be helpful to relief depressive symptoms when is administered as an adjuvant therapy to conventional antidepressant treatment. We found significantly greater changes in the GS score and a trend toward significantly greater changes in the PWBQ score in the gaudiebility intervention group with respect to the control group. These data suggest that a "dual" approach designed to modify the modulators of both negative and positive affect may be beneficial for the treatment of depressive disorders.

In addition, our data indicate that the improvement was sustained for three months and two years in the gaudiebility treatment group.

Gaudiebility therapy may encourage adherence to therapy; in this case, attendance was 100%, and 62.5% of assignments were completed. It should be noted that adherence

to treatment for depression is low (Regan & Livingston, 2006). Dropout rates are high in persons seeking help in centers offering psychotherapy to outpatients (Torres Torija & Lara Muñoz, 2002); these rates are approximately 50%. The high adherence and fulfillment of assignments in this study might be due, at least in part, to the characteristics of the therapy itself. Notice that this gaudiebility protocol encourages patients to escape from their inner selves; it is centered on the positive aspects of the self and its suggested activities have a playful quality that allows patients to enjoy the sessions. Further applications of this protocol will determine whether this high level of adherence can be replicated.

This is the first time that this gaudiebility protocol has been applied. Some elements have been detected that can be modified. First, in the text used in session 1 (see the Appendix), the character of Máximo was received negatively by three out of the seven patients. Therefore, some modifications to the text are necessary. An introductory paragraph is suggested to express that Máximo also experiences negative emotions and feelings, so that he as a character becomes more similar to a model for coping instead of an authority figure; a number of researchers have shown that the former is more effective (Kornhaber & Schroeder, 1975; Schunk, Hanson, & Cox, 1987; Zimmerman & Kitsantas, 2002). Another critical problem was detected in session 5, in which therapists and patients were required to dance and make gestures to broadcasted music. The patients were unwilling to partake in this activity. It is possible that, in some circumstances, a patient or some patients may refuse to participate. If this is the case, the patient's decision must be respected, and he/she should be permitted to participate only through observation and by participating in the discussions.

Among the study's limitations is the small sample size of the treatment group. Additionally, the subjects in the control group had no access to group therapy once a week and did not have the option to participate, but the gaudiebility therapy group demonstrated a willingness to participate in therapy. In further research, the control subjects should undergo placebo or conventional therapies because an individual's willingness to participate could significantly modify the outcomes for some patients.

Furthermore, it should be noted that there was no control for medication. The referring psychiatrists were given complete freedom in patient medication management. However, the patients in both the gaudiebility therapy and control groups were treated by the same mental healthcare professionals.

A posteriori mistakes were made with respect to the inclusion criteria. For instance, one patient in the experimental group scored 14 points on the BDI instrument prior to treatment, and this score made it difficult for a significant improvement to be detected. In future studies, a cut-off value of 20 points should be used to discriminate between depressed patients and healthy individuals (Vázquez & Sanz, 1999). However, a criterion of <50 points on the GS might be inappropriate because the standard deviation of the instrument is between 11 and 12 (Padrós & Fernández, 2008). Finally, in the future, a clinical assessment must be performed by professionals blind to the treatment that each patient received.

The Well-being therapy (Fava, 1999; Fava & Ruini, 2003), a treatment that showed favorable results in the treatment of depressive residual symptoms (Fava, Rafanelli,

Cazzaro, Conti, & Grandi, 1998), is similar to the gaudiebility therapy because both treatments try to promote the positive aspects of psychological functioning. Nevertheless, the gaudiebility therapy is focused on the modulators of enjoyment to increase the client's positive affect levels, which is a key component of subjective well-being (Diener, 1984). On the other hand the well-being therapy is based on Ryff's multidimensional model of psychological well-being (Ryff, 1989) and the goal of this therapy is to improve the patients level's of well-being according to these particular dimensions. Both therapies contain cognitive restructuration techniques and self-monitoring instructions for the clients, but the gaudiebility therapy emphasizes the development and practice of 3 important skills useful to enjoy life experiences: the capacity of imagination, the sense of humor, and the ability to enjoy non-amusing experiences.

In this pilot study, gaudiebility group therapy as an adjuvant treatment showed more effectiveness compared with individual treatment only. It is possible that other disorders characterized by low positive affect levels, such as substance abuse (Van Etten, Higgins, Budney, & Badger, 1998), schizophrenia (DiLalla & Gottesman, 1995; Blanchard, Horan, & Brown, 2001) and personality disorders (Millon & Davis, 1996), may benefit from gaudiebility treatment. Protocol modifications or the generation of new protocols must be undertaken depending on the type of disorder to be treated.

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Appendix

My acquaintance with Maximo

Maximo is a friend of a friend of mine that came along with a group of persons one day that we went to the cinema. The group consisted of eight or nine persons. During the movie I noticed that Maximo experienced very intense the events showed in the film, the plot clearly touched him. After the film, he expressed some comments and I noticed that he was still very emotional and excited. It was evident that he liked a lot film. In fact, I assumed the film had some special meaning for him and maybe the film had an emotional effect on him given his character and personal tastes.

Two weeks later, Maximo joined us again for going out. We were three in the group in this ocassion: Maximo, a friend of mine and me. We went to see a very different kind of film. During the projection no one made any comments but, from the corner of my eye, I saw that Maximo was completely captivated, almost transported to the screen. When we came out, Maximo said that the film had delighted him, he went over some of its details; there were parts of the film that I recalled but others passed inadvertently. He even enacted some of the scenes in the story; he was completely immersed in the film. The plot originated in him many interesting ideas. He spoke of the film's artistic, philosophical and political aspects. He extended on these issues adding pertinent appreciations. I concluded that the cinema was one of Maximo's greatest hobbies and that he enjoyed any kind of film. Afterwards, and after sharing more time with him I came to know him and became his friend. I have seen that even in the films he says he does not like, he is capable of making remarks on the photography, camera movement, music and various aspects of the script; he even propounds possible changes to the story. All this tells me that Maximo really enjoys going to the cinema. The surprising thing about him is that he draws pleasure from almost any situation, when doing sports, going camping or to a picnic, attending a concert, play or ballet. Even in those days in which we do not do anything special, he is happy and enjoys either being alone or with someone. Practically everything is interesting or entertaining. He seems to enjoy anything almost all the time. When he is at leisure, he frequently enrols in some sort of activity. It is odd when he is not doing something. He usually plans activities for his holidays or weekends. He is quite enthusiastic while making all this planning. He is eager to show us photographs taken during his outings, as well as to describe us the sensations he experienced and the situations he lived. Maximo can also talk of his worries at his job or with his family. Sometimes he can be sad while remembering his loved ones. At times he can be disappointed or frustrated.