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Extending CBT to Groups

Cognitive behavioral group therapy (CBGT) can play an important role in making effective therapy for mental health problems more accessible and less costly—whether paid for by individual clients or governments. Within governmental mental health systems, CBGT offers significant cost savings and efficiencies without compromising effectiveness (Bennett-Levy, Richards, & Farrand, 2010). Groups run out of private offices or agencies are less expensive for clients because private group therapists do not charge the equivalent of an individual fee when they treat more than one person at the same time. This chapter provides an overview of how individual cognitive behavioral therapy (CBT) has gained momentum and why a group format is a logical extension of this success. Adapting an individual CBT protocol to a group setting is, however, not straightforward. A panic disorder group example illustrates some of these challenges. The chapter closes with a discussion of the unique therapeutic benefits offered by CBGT compared to individual CBT and how to be off to a good start with a CBT group.

Why CBT Is Increasingly Used for Common Mental Health Problems

The number of individuals who suffer from mental health problems is steadily increasing. Depression and anxiety disorders account for the majority of these mental health problems, with North American lifetime prevalence rates estimated at 16% for adult depression and 28% for anxiety disorders (Kessler, Chiu, Demler, & Walters, 2005). There are several reasons for this upward trend. Some likely reflect increased awareness of mental health problems and treatment options. However,

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even after taking better public education into consideration, rates of anxiety and depression are still on the rise. Larger socioeconomic trends may be operating, leading some health researchers to argue convincingly for a strong association between higher rates of mental illness and socioeconomic inequality. Rates for almost all mental health problems, but especially anxiety disorders, increase as socioeconomic status decreases, making poor mental health both a cause and consequence of poverty and inequality (White, 2010). Interestingly, inequality may also hurt the more affluent. In countries where the gap between rich and poor is large and widening, such as the United States (US), we see higher rates of depression and anxiety even among the financially comfortable members. Conversely, Japan has a relatively narrow income gap, and rates of mental illness across socioeconomic status are lower (Wilkinson & Pickett, 2010). Over and above socioeconomic factors, having a well-integrated family, friendship, and community network may be even more critical than previously thought for the psychological well-being of both men and women (Cable, Bartley, Chandola, & Sacker, 2013); conversely, any breakdown of family and community structure and support has been linked to increases in mental health problems (Alexander, 2010).

Medication can be helpful for many kinds of anxiety and depression and is usually the first treatment offered when a person talks to their family doctor about feeling anxious or depressed. For depression, the advent of the selective serotonin reuptake inhibitors (SSRIs) antidepressant medication in the 1980s was welcomed by family physicians because of their milder side effects compared to the "older" types of antidepressants, the tricyclics, such as imipramine. SSRIs are also routinely prescribed for anxiety. Research suggests that CBT and medication may be roughly equally effective for treating the acute phase of depression (DeRubeis, Siegle, & Hollon, 2008) but that CBT is more likely to help people stay free of depression after discontinuing treatment, whereas ceasing medication has a higher likelihood of relapse (Hollon, Stewart, & Strunk, 2006). A combination of medication and CBT may be especially helpful for depression. A recent randomized controlled trial involving 469 United Kingdom (UK) patients treated for depression with medication by their family physicians showed that only when CBT was added to their usual care did patients begin to improve. At 6 months follow-up, 46% in the CBT group had responded well to treatment compared to only 22% in the care as usual. The treatment gains were maintained at 12 months follow-up (Wiles et al., 2013). It is our experience that people with more severe depression, who respond to antidepressant treatment, are in a better position to commit to regular group attendance. In particular, we notice that those group members benefit from better sleep regulation and increased levels of energy after starting medication and are therefore less likely to miss group sessions due to inertia and low motivation.

Still, regardless of effectiveness, many people prefer not to take medications for various reasons. For depressed people, antidepressants often include side effects such as weight gain and diminished sexual interest, which can lead to a further decrease in social and interpersonal confidence and well-being. For older people with depression, lower rates of metabolism create a necessity for lower dosages which may

not even be therapeutic. Others simply prefer to learn sustainable self-help skills rather than relying on external agents such as medication, which can also be costly (Cooper et al., 2007; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000). For people who prefer to take a more active role in their own health, CBT is an attractive option. Clinicians present CBT as a symptom- or problem-focused psychological treatment with an emphasis on personal change in behaviors and patterns of thinking about oneself, other people, and one's day-to-day living environment. Clients are informed that CBT is a shorter-term treatment, typically 8–16 weeks, and that a commitment to practice new skills between sessions is necessary if treatment gains are to be sustained over time.

CBT is available in most Western countries and increasingly also in other parts of the world such as China. Indeed, clinical guidelines in Canada, outlined by the Canadian Network for Mood and Anxiety Treatments (CANMAT), recommend CBT as a first-line treatment for both depression (Ravindran et al., 2009) and anxiety (Swinson et al., 2006) due to the steadily growing body of evidence supporting the effectiveness of CBT. In the United Kingdom the National Institute for Health and Clinical Excellence (NICE, 2009) also recommends CBT for anxiety and depression, including for people who may not meet all diagnostic criteria, that is, minor or sub threshold depression. Not only is CBT helping individuals enjoy a better quality of life, but it is also cost-effective. Before highlighting the cost-effectiveness of CBT, I briefly summarize what CBT is.

Principles of CBT

CBT as we know it today has evolved from the original behavioral therapies developed in the 1960s as a result of the experiments by B.F. Skinner, Joseph Wolpe, Hans Eysenck, and I.P. Pavlov among several other physiologists and medical scientists. These early behaviorists conceptualized psychopathology as simple learning processes either involving *classical* or *operant* conditioning (Hawton, Salkovskis, Kirk, & Clark, 1989). They reacted to the notion in psychodynamic theory, as formulated by Sigmund Freud and his followers, of psychopathology being the result of unresolved intrapsychic conflict caused during the first 5 years of life. Instead of focusing on mind phenomena such as dreams, memories, and free associations, the early behavioral therapists focused exclusively on environmental determinants of behavior. They demonstrated that environmental factors lead to two basic forms of learning, classical conditioning and operant conditioning. We are all familiar with the classical conditioning of Pavlov's dogs.

Initially, the dogs exhibited an unconditioned response of salivation to the smell of food (unconditioned stimulus). However, over time, the presentation of food was systematically paired with a bell. Simply hearing the sound of the bell therefore led the dogs to salivate even though no food was present. The bell (conditioned stimulus) had thus produced a conditioned response. We see other versions of classical conditioning in the modern CBT office. A woman may show a strong anxiety

reaction to, and avoidance of, cats. She is puzzled because she is not afraid of cats per se. It becomes apparent that she had a first panic attack in a friend's home where there were several cats around. Seeing a cat becomes a conditioned stimulus because of its association with the extreme unpleasantness of a panic attack. Avoiding cats as much as possible becomes the conditioned response. Treatment would in part involve exposure to cats and other places associated with panic attacks. Operant conditioning involves manipulation of environmental factors in order to shape a person's behavior. For example, as will be reviewed in Chapter 17, people who receive treatment for an addiction may agree to receive vouchers that can be used to purchase goods as rewards for decreased engagement with their addictions. The presence of a reward thus serves to positively reinforce the desired behavior.

By the 1970s, behavioral therapy working within the paradigm of classical and operant conditioning was widely used for treating a number of problems, mostly anxiety and specific phobias. However, observations from the cognitive sciences challenged the strict behavioral models of learning. CBT psychotherapist pioneers such as Albert Ellis (psychologist) and Aaron Beck (psychiatrist) emphasized the role of mediating cognitive factors. They found that specific thoughts or interpretations of a stimulus influenced the person's behavioral response (Hawton et al., 1989). For example, the woman who avoids cats fearing she will have a panic attack in their presence will likely have powerful thoughts increasing her fear, thoughts such as "I cannot cope with a panic attack" or "having a panic attack means I'm going crazy." For people with depression, the importance of self-critical and exaggerated thoughts in maintaining symptoms of depression (e.g., "everyone else is so smart, and I have nothing to say") became a major focus for Beck. His groundbreaking cognitive theory of depression continues to inform CBT for depression (Beck, Rush, Shaw, & Emery, 1979).

Most CBT practitioners vary their relative focus between environmental and cognitive determinants of behaviors. As we will see throughout this book, some mental health problems call for more behavioral interventions, others for more cognitive, and most for a mix of both. The key treatment principle in behavioral therapy is *exposure* (facing one's fears), which always aims to extinguish the conditioned fear response through *systematic desensitization*. Central to cognitive therapy is *cognitive restructuring* (changing one's thoughts and interpretations). Cognitive restructuring involves gently helping clients become more flexible in their thinking and not lock in to "the first" interpretation or understanding of what is happening around them (e.g., "I'm convinced my boss wants to fire me") or within their bodies (e.g., "my racing heart means I'm having a heart attack").

More recently, CBT has undergone another transformation often referred to as the *third wave* after the initial behavioral wave and, secondly, the cognitive. Mindfulness training and acceptance and commitment therapy (ACT) characterize this newest branch on the CBT tree. Mindfulness training can be described as a continual practice of *awakening* to the present-moment experience (Bishop et al., 2004). Mindfulness-based cognitive therapy (MBCT) differs from traditional CBT in that it is less concerned with the kinds of thoughts people have but more with the

acceptance of the thought and the way the person *relates* to their thought. Chapter 5 shows how MBCT was developed in response to a need for better maintenance therapy to prevent relapse after successful CBT for depression (Lau, 2010).

Today, CBT is a broad term including a wide array of distinct yet often overlapping approaches to the optimal treatment of a range of mental health problems. After six decades of empirical validation, CBT has proven to be a highly effective treatment for numerous psychiatric disorders (e.g., depression, panic disorder, obsessive–compulsive disorder (OCD), generalized anxiety disorder (GAD), social anxiety disorder (SAD), phobias, posttraumatic stress disorder (PTSD), addiction, and psychosis), medical disorders (e.g., disorders related to sleep, sexual functioning, diabetes, chronic pain, and heart disease), and nondiagnosable problems in living (e.g., lack of assertiveness, low self-esteem, and anger). CBT is also helpful for personality disorders (Beck, Freeman, & Davis, 2004), although particularly challenging to administer in a group format (Bieling, McCabe, & Antony, 2006).

Cost-Effectiveness of CBT

The benefits of CBT as a cost-saving measure may be especially well understood and recognized in the United Kingdom. In 2007, the then Labour government led by Prime Minister Tony Blair made improving public access to CBT a government priority based on a major study, The Depression Report, from the London School of Economics (2006) showing that the societal cost of lost productivity was estimated at approximately US$ 19 billion per year, about 1% of the total national income. In 2006, according to The Depression Report, a million people in the United Kingdom received *Incapacity Benefits* because of mental disorders, at a cost of US$ 1,200 a month per person. A Canadian report estimated that employers saved US$ 4,000–$9,000 a month in average wage replacement, sick leave, and prescription drug costs for every employee with a mental health problem—including drug and alcohol addiction—who received effective treatment (Mood Disorders Society of Canada, 2009). The Depression Report in Britain further showed that less than 5% of the population had access to effective psychotherapy. Informed by this economic report, the Tony Blair government dedicated US$ 280 million per year to train therapists in CBT in order to improve access to effective psychotherapy—at no cost to the individuals receiving the therapy. This project is referred to as the British Improving Access to Psychological Therapy (IAPT). The present UK coalition government led by David Cameron has continued the funding by committing another US$ 652 million for 2011–2015. This continuation is based on evidence of improved outcomes and accountability for how funds are spent (Clark, 2011; Clark et al., 2009).

Although it is heartwarming to think of the UK government placing such high value on citizens receiving government-funded therapy, its reasons are highly pragmatic. This government realized that it could not afford to avoid improving the function of its citizens, especially when lack of treatment results in missed work days and extended leaves of absences. Australia is another example of a jurisdiction

that has taken steps to increase access to effective psychological treatment such as CBT. The Australian *Better Access* initiative allows physicians to refer a person to a psychologist for up to 10 government-paid therapy sessions (Australian Department of Health and Aging, 2009).

If offered in a group setting, CBT is even more cost-effective given that, compared to individual therapy, a single therapist or two cotherapists can treat up to four times as many clients within the same number of hours. The group format also optimizes use of costly psychotherapy. If a client fails to attend an individual hour of psychotherapy, the therapist's time is wasted, whereas if someone fails to show for a group, it does not impact the therapist's ability to provide services for those who attend. Furthermore, in a real cost analysis, Otto, Pollack, and Maki (2000) estimated absolute costs for the treatment of panic disorder using CBT and arrived at US$ 523 for CBGT, US$ 1,357 for individual CBT, and US$ 2,305 for pharmacotherapy (medication). With CBGT being the least costly, it is easy to see why CBGT is becoming increasingly popular in publicly funded outpatient community mental health settings. At the same time, it is also puzzling why CBGT is not even more popular to the point of being mandated by health-care departments and authorities. Some of the reasons for the relative lack of public access to CBGT may have to do with insufficient number of trained therapists and the challenges this can lead to in terms of developing and maintaining CBT groups. Getting enough people with the same problem to form a group in a timely manner is another problem in smaller communities. These and other reasons for lack of access to and engagement with CBGT are discussed in Chapters 6, 7, and 10.

Transporting Individual CBT to a Group Setting

Even for the well-trained CBT therapist, transporting individual CBT to a group setting requires careful planning and attention. Not only are there practical challenges regarding how to take the content from an individual CBT protocol and turn it into a group protocol but also with how to manage the group dynamic. In the following text, I address first the content challenge—using a panic disorder group as a specific example—and then the group process challenge from a general CBGT perspective.

CBT protocols delivered in an individual context have successfully been translated into group CBT. Clinical research provides "good-to-excellent" evidence for the effectiveness of CBGT for a number of disorders including OCD, depression, SAD, eating disorders, psychosis, and substance abuse (Burlingame, Strauss, & Joyce, 2013). Despite these good results, protocol translations are not straightforward. The proliferation of available individual CBT protocols, and the fact that most are highly disorder specific, means that specialized training is needed for at least one of the group leaders if the implementation is to be effective. Even for anxiety, there is a distinct protocol for each of the roughly 10 different anxiety

disorders. Because protocols used in CBT groups tend to be adaptations of individual CBT protocols, some reorganizing of treatment components may be needed given the fixed number of sessions in CBGT. This panic protocol is just one example. Individual CBT protocols for other disorder such as OCD and depression will similarly require various adaptions to a group setting.

Adapting CBT to CBGT: panic disorder illustration

Panic disorder with or without agoraphobia is a common anxiety problem often rendering otherwise high-functioning people unable to drive or take public transit outside of their immediate neighborhood. According to the *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (DSM-5) (American Psychiatric Association [APA], 2013),[1] panic disorder is characterized by recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and during which time four (or more) symptoms occur: pounding heart, sweating, trembling or shaking, sensations of shortness of breath or smothering, feelings of choking, chest pain or discomfort, nausea or abdominal distress, feeling dizzy, light-headed or faint, tingling sensations, derealization (feelings of unreality) or depersonalization (being detached from oneself), fear of losing control or "going crazy," or fear of dying. At least one attack must be followed by 1 month or more of one or both of the following: (1) persistent concern or worry about having another attack and/or (2) a significant maladaptive behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations). Panic disorder may or may not involve agoraphobia. *Agoraphobia*, according to the DSM-5 (APA, 2013), involves marked fear or anxiety about two (or more) of the following five situations: (1) using public transportation (e.g., automobiles, buses, planes), (2) being in open spaces (e.g., parking lots, marketplaces), (3) being in enclosed places (e.g., shops, theaters, cinemas), (4) standing in line or being in a crowd, and (5) being outside of one's home alone.

In more extreme cases, people with panic disorder avoid leaving their homes and become nearly housebound. In public treatment settings where there is pressure to prioritize more serious mental illness, panic disorder is often considered less severe. The loss, however, of human and societal potential in regard to untreated panic disorder is profound. It is costly to society to have educated, high-functioning employees on sick leave for a disorder that is highly treatable with CBT.

A panic disorder CBT group typically meets for 1.5–2 hours per week for 10 weeks. In a homogeneous panic disorder group, up to 12 people can be accommodated, even though the usually recommended optimal number for a CBT group is eight people. A panic group usually involves both people with agoraphobia and those without. A panic disorder group is the most structured and "classroom"-like of all

the CBT groups. Clients tend to be highly motivated and relatively free of other problems, including significant family of origin issues. This allows the facilitators to take more of a teaching role as they go through the standard protocol. A panic group is generally considered to be the easiest to run. Treatment manuals do not differ that much, and the one by Barlow and Craske, *Mastery of Your Anxiety and Panic*, Fourth Edition (2007), is excellent. It offers a 12-session CBT program for treating panic disorder. Similar to many other CBT manuals, it requires adaptation to a group setting. Mainly, certain treatment components need to be introduced earlier in the group compared to the outline in the Barlow and Craske manual.

A typical panic disorder group session starts with a *go-round* where all members in turn report back on how many panic attacks they had, or how many times they came close to panicking in the past week, and how they used their coping skills. This go-round is followed by a didactic component such as information about the physiology of breathing and the importance of the CO_2/oxygen balance. Or the didactic component could be instruction on how to build a personal exposure hierarchy (more about this in Chapter 9) or how to challenge misinterpretations of bodily sensations. All these different treatment components for panic disorder are outlined in the Barlow and Craske therapist guide. The session concludes with another go-round where facilitators ensure that all clients have set realistic and appropriate tasks for homework. The main task for facilitators of a panic group is to manage time, which can be a challenge when the group is large, and ensure that all the material is covered. We have found it to be especially challenging to have enough time for people to work through their *exposure* to both internal body sensations and actual feared situations, in vivo (real life) exposure. The practice of these exposure exercises does not begin until around sessions 6–8 in the Barlow and Craske client manual (and even later in earlier versions of this manual). Unlike individual CBT for panic, for which the Barlow and Craske manual was developed, the group has a finite number of sessions—usually 10—and extension to complete exposure work is usually not possible.

Deliberately bringing on the feared bodily sensations—such as a sense of restricted air intake by breathing through a straw—is a key CBT principle in treating panic disorder. By actually producing the feared body sensations, clients begin to realize that while the sensations are certainly uncomfortable, they are not life-threatening. This challenge is also called interoceptive exposure. It is critical in treating people with panic attacks whose sensitivity to body sensations is extremely heightened. It is not fear of, for example, a shopping mall in and of itself but fear of the body sensations such as accelerated heart rate that keeps people away from the shopping mall. We recommend group therapists work flexibly with manuals and introduce this practice in session 4 and then support clients in setting weekly exposure goals. The Barlow and Craske manual recommends about eight interoceptive exposures (e.g., over breathing, running on the spot, restricted breathing through a straw, spinning), and they can all—and ought to—be practiced together in the group with the therapists leading. If therapists start this practice earlier, such as in session 4, they can introduce two or three interoceptive exposures over 3–4 weeks.

Similarly, in vivo exposure can also be started around session 4 for those members who have agoraphobia. The therapists need to be aware of who these members are and ensure they get homework related to facing places and situations they avoid. For example, a client Amir, who had a fear of panicking in crowded places, had a top exposure hierarchy item of "go on a 4-hour airplane flight" to his favorite vacation place. Knowing that he was not likely to meet this goal and report back to the group within the 10-week duration, we attempted to get Amir—and other group members with agoraphobia—started on exposure goals earlier in the group. Starting in session 4, Amir set weekly goals to drive to the local airport and hang out in it and to discuss travel plans with his wife and a travel agent. As for interoceptive exposure, Amir was guided through restricted breathing using straws during the group sessions. His fear of panic attacks in the plane was to a large extent driven by his oversensitivity to a feeling of not getting enough air and thus dying of lack of oxygen. Similar to many people with panic disorder, Amir was not particularly afraid of the airplane crashing. His continued practice of tolerating restricted air intake helped Amir become more confident about tolerating being in an enclosed space such as an airplane for a prolonged period of time. In vivo exposures to being in a crowded room and on buses also helped him prepare for going on an airplane.

The cognitive components of *overestimation* and *decatastrophizing* in the Barlow and Craske protocol are introduced according to the outline in the manual. Group discussions on how to challenge overestimations of the likelihood of dying of a heart attack or decatastrophizing fears of, for example, other people noticing one has symptoms of anxiety, are rich and productive. Group facilitators will use the board to work through individual member's examples. As I point out later in this chapter, any group discussion or exercise requires that the facilitators engage the whole group as much as possible. They do this by not providing the answers themselves, but instead by deferring to the group. They also encourage more quiet members by gently including them without putting them on the spot. For example, a therapist may say: "We now have three pieces of evidence suggesting it is extremely unlikely, if not impossible, for Jennifer's heart to reach a dangerous level of beating (no evidence of heart disease, accelerated heart rate is safe for the heart, a faster heart rate eventually slows down). Linda, do these reasons make sense to you too, or is there something you'd like to add?." Linda, an extremely quiet member, may simply say "yes it makes sense to me, I get it" and thus enjoy the experience of being included and practicing speaking up. Or Linda may add an additional piece of evidence such as "for me, I've learned to notice that my heart rate changes quite a bit all the time for no particular reason." Jennifer may reply: "Thanks for that, Linda, I guess our hearts are not these perfect little machines and the more we try to just let them 'do their thing,' the calmer we are."

Managing the group process across CBGT

Clinicians trained in psychodynamic therapy understand the many complicated manifestations of the emotional connection between an individual patient and therapist. It is dizzying to try to map out the multiple connections in a group of eight

clients plus two facilitators. Not only are group members reacting to the group therapists and vice versa but also to each other. The group therapists themselves also have their own dynamic, which in turn is projected onto the rest of the group. The sum and quality of all these interactions is usually referred to as the *group dynamic*, the *group climate*, or the *group process* and is the equivalent to the nonspecific factors referred to as the *therapeutic bond or alliance* in individual therapy. The term group process will be used throughout the rest of this book. The group process involves a number of separate factors, which I will describe in Chapter 2.

The complexity of the group process places additional demands on therapists' expertise. They wrestle not only with implementation of specific CBT techniques but also with all the interpersonal interactions and processes taking place in any group. It is not uncommon to hear CBGT cotherapists agree to divide their roles with one delivering the material and the other keeping an eye on how individual members are doing, that is, the process. Although this makes some practical sense, my experience is that the nature of CBGT work does not lend itself well to such a division of labor. The unexpected always happens, as the following examples illustrate.

The credibility of the group leadership is easily undermined if one cotherapist answers that he is "not really here to explain how *exposure and response prevention* (ERP) works [in case of OCD], but to make sure everyone is OK." This may be interpreted by some group members to mean that the therapist who presumably knows about ERP may not keep everyone safe.

Here is another situation where the therapists could be perceived as less competent and engaging. In this example, one cotherapist was intensely focused on working with a group member, Susan, who was asked to produce evidence countering her self-denigrating *negative automatic thought*: "I am a disorganized scatterbrain." The therapist working with Susan got carried away in asking her for examples of when she may not be disorganized, and this became more of a mini one-to-one therapy encounter, which is inevitable in group CBT and certainly permitted to some extent. But, in this case, the "group process" facilitator was trying to monitor another group member, Tom, who was crying and making attempts to leave the room. The rest of the group began to feel disconnected, drifting into their own moods and thoughts. This loss of group cohesion could have been prevented if the "content delivery" therapist had taken steps to engage the rest of the group by asking their perceptions of Susan as a group member. Someone might have said that Susan always arrives on time with her folder, a good piece of evidence against the idea that "I am disorganized."

While there is much that can be effectively imported from individual therapy into CBGT, protocols for disorder-specific group CBT that explicitly address how to pay attention to the group process are essentially nonexistent; I have come across one, *Group Cognitive Therapy for Addictions* (Wenzel, Liese, Beck, & Friedman-Wheeler, 2012). Chapter 2 will continue this discussion on the distinction between, and integration of, process and content.

Before I review how to start a CBT group and the importance of the first session, I present some of the unique benefits of CBGT compared to individual CBT.

Unique Benefits of the Group Format

Any kind of therapy becomes more effective when three conditions are met. The *bond* between the client and therapist, or the group *process*, must be strong. The *goals* for therapy must be clear and agreed upon by both client and therapist, and the client must have a good understanding of which *tasks* will be the focus of therapy in order to meet the goals. CBGT offers a unique opportunity to create a strong group bond or group dynamic, to develop skills, and even to strengthen the standard CBT procedural aspects *because* of the group format (Coon et al., 2005). These procedures include review of homework, in-session tasks such as exposure and thought challenging, and setting new homework.

Groups have the potential for providing participants with a sense of belonging, which counters social isolation and the common feeling of being stigmatized or marginalized in society. Sometimes, a remarkable improvement in social confidence develops even though most CBT groups do not explicitly address self-esteem. We are often aware of clients continuing to meet over coffee, walks, or even day trips after the group has ended. I continue to be struck—but not surprised—by how much it means to human beings to have a sense of being in "the same boat." One of the rewarding aspects of group therapy is to walk into a first session—for example, with a group for people with OCD—and be witness to how quickly the initial atmosphere of anxiety and shame changes to one of relaxed openness, acceptance of oneself and others, and lots of hope. During only 2 hours, some not readily explicable group magic has taken place.

Agreeing on goals for therapy is less of a problem in CBGT because each group usually has a name that clearly indicates what the group is about, for example, panic disorder group, depression group, or traumatic stress group. Pregroup assessment and group orientation sessions further help to ensure clients have a good understanding of whether their chosen group can help them achieve their goals. The first session offers a kind of additional check when each member states what they hope to get from the group. Members may say they seek to understand their problems better and develop skills to manage their anxiety or depression more effectively. Hearing other people desiring similar outcomes strengthens the overall goal of the group and increases motivation for everyone.

A principal component in CBT is the emphasis on learning adaptive coping skills by engaging with various behavioral and cognitive tasks. This focus on learning new skills and replacing less helpful ones (avoidance is an example of a common maladaptive coping skill for people seeking CBT) may be the most important rationale for conducting CBT in groups as much as possible. The group format allows clients to learn together from the facilitators but also to learn from each other. CBGT therapists teach that it is possible to have more control over one's thinking—and

therefore over one's emotions and behaviors. In many cases, CBGT may provide the first opportunity for clients to obtain feedback on their behaviors from peers. A group offers a unique opportunity for both receiving and giving constructive feedback. The CBT concept of *Socratic dialogue*[2] or *guided discovery* takes on a new meaning in the group setting.

Guided discovery in CBT means that therapists do not offer quick answers or solutions but rather engage the client in a series of questions to uncover relevant information outside the client's current awareness (Padesky & Greenberger, 1995). The therapist listens, reflects, and summarizes. Through this process, clients come up with a new way of understanding their problems. Because they arrived at an alternative view through their own reasoning, their new understanding seems more believable. In CBGT, group therapists encourage group members to offer this kind of supportive questioning to one another. Here is an example of how the group therapists defer to the group to support Mandeep, who has panic disorder, in increasing his ability to understand and cope with his fear of certain body sensations.

MANDEEP: I'm not going to go the retirement party for my boss because it would be ridiculous and embarrassing if I fainted.

THERAPIST: Sounds like your fear of fainting is a key factor in why you prefer to stay home and avoid social events?

MANDEEP: It is. I know someone in our last session said something about how it is almost impossible to faint during a panic attack, but that does not seem true for me.

THERAPIST: Does anyone have some suggestions for how Mandeep can address his fear of fainting?

NADIA: I'm curious about how many times you have fainted when feeling panicky?

MANDEEP: Well, I haven't actually fainted if you mean loss of consciousness, but I've come really close.

LEE: How do you know when you're really close?

MANDEEP: Well, my legs feel like jelly, my mind goes blank, and I sometimes have blurred vision, so I know I'm close to fainting.

LARRY: Remember when we talked in our first two sessions about all the symptoms that can happen in a panic attack? Seems to me you're experiencing some of them, especially the wobbly legs. I get that too and I used to be terrified of fainting

LEE: I can't quite remember how it goes, but something about blood pressure being either high or low when we panic

MANDEEP: I think we learned that our blood pressure tends to go up a bit when we panic.

NADIA: Yes, and when we faint, our blood pressure is actually down. It has to do with the different impact of our sympathetic and parasympathetic nervous systems. The sympathetic gets activated when we panic, right? [Looks at the facilitators]

MANDEEP: Oh, so it feels similar to fainting but it is actually very different from real fainting?

LARRY: I just want to say, that I really hear you, Mandeep, but it seems to me that both you and I mistakenly think that our anxiety symptoms mean we're about to faint, when physiologically that is not really possible.

MANDEEP: I'm going to remind myself that all the scary feelings of light-headedness and wobbly legs are uncomfortable but not dangerous. They have to do with the adrenaline rush in the fight-flight-freeze reaction we talked about in the first sessions.

LARRY: Yeah, and even if you or I were to faint, that's not really dangerous either. But the chance of that is so low, so I'm not going to worry about it anymore.

NADIA: I wonder if our therapists would mind just reviewing again the fight-flight-freeze response when we panic?

THERAPIST: Sure we can do a review. Is there perhaps someone in the group who would like to start this review?

With the help of questioning and summary statements from the group, Mandeep was supported in developing an alternative perspective or interpretation of his panic symptoms that made sense to him. Going through this group process of questioning and exploring usually makes the answers more credible compared to the therapists simply telling the group members what to think or do.

Lastly, the CBGT setting can also strengthen the standard CBT procedural aspects of running a group. These include review and setting of homework as well as in-session tasks. The Mandeep example showed how the therapists let the group support a member in challenging his overestimation of fainting. Individual group members who struggle with homework can benefit from learning how other group members succeed at their chosen homework. As the group develops, therapists are often impressed with how group members help each other set new and relevant homework. Members may even gently tease each other to set more challenging homework. Therapists encourage humor whenever possible and appropriate to strengthen the procedural aspects of CBGT. Even depression groups are known for outbursts of laughter when the group process is strong. We find that group members collaborate with both the group leaders, and each other, to maximize their individual treatment plans including planning their homework.

In the following sections, I go into some detail about how to start a CBT group. The important issues of the bond (group process), goals, and tasks are addressed right from the beginning of the group.

How to Start a CBT Group

CBT is a time-limited, goal-focused, and highly structured form of therapy. CBGT does not differ from this general description. CBT groups tend to be closed groups, meaning that everyone starts and finishes together. However, open groups in which one or two new clients enter each week can be effective too, and I review some examples in Chapters 5 and 17. Toward the shorter time end of the spectrum are groups for anxiety, such as panic disorder (typically 8–10 sessions). At the longer end are

groups for moderate to severe depression, PTSD, problems with hoarding, and addictions (typically 16–20 sessions).

Setting up the group room

Prior to the first session of a new group, facilitators ensure that the room is set up. It is important that this is done ahead of time so that clients feel welcomed—and not imposing themselves on therapists who they would see busily running around moving tables and chairs. Typically, a CBT group involves clients sitting around a square- or horseshoe-shaped table. The facilitators can sit next to each other, but do not have to. Sitting together reinforces the fact that CBGT facilitators do function in large part as teachers and it thus seems helpful to have all group members turn their head toward the leaders as opposed to constantly moving their head depending on which leader is talking. Other therapists prefer to sit across from each other and develop nonverbal gestures for communication about process issues, such as a light tap on the table as code for "you're talking too much—let me help out." On the other hand, sitting next to each other allows for nonverbal communication variants of "kicking under the table." I will keep referring to *the therapists* with the assumption of their being two. It is, however, not uncommon that a CBT group is run by only one therapist. Some groups lend themselves better to a solo therapist than others. Groups with intense in-session exposures such as social anxiety and OCD are best conducted with a pair of therapists. Most CBGT programs agree that two cotherapists are preferred but that at times this is not possible due to insufficient staff resources.

The room usually also has a whiteboard with markers, or a flip chart, or a projector for Power Point slides. It is important not to forget to have some boxes of Kleenex on the tables. Sharpened pencils should also be available. In busy work settings, it is a good idea to put a notice on the door stating: "Group in process—please do not disturb." We made such a sign even more visible after a large man who was part of the engineering team for the hospital flung the door open and loudly asked about the location of the fan. The timing was unfortunate in that a female group member was just in the middle of offering a verbal account of her sexual assault as part of her exposure in *a cognitive processing therapy* (*CPT*) group (Chapter 7 discusses this approach to trauma).

The first session

The first session is critical. It sets the framework by explaining the structure of the group, the ground rules, the CBT treatment rationale, and the creation of hope and positive expectations. The therapists also set a tone of transparency, warmth, and collaboration. We rarely allow clients to miss the first session (acceptable reasons would be family or home emergencies) and, if they do, we ask that they go on the wait list for the next group.

In the first group session for all CBT groups, clients are given a folder, which has the outline of the group sessions including dates and topics (see Appendix A for an example of a depression group). This is followed by handouts pertaining to the first four sessions. Clients are instructed to insert new handouts as the group progresses. Clients are told to bring the folder, which can also be called the client's self-help manual, to each session. If budgets allow, some programs give each client a copy of a published manual, such as *Mastery of Your Anxiety and Panic*, Fourth Edition (Barlow & Craske, 2007).

Everyone is given a name tag with his or her first name, including the facilitators. The facilitators first offer their welcome plus a few words intended to validate nervousness about coming to a group of strangers with only a vague idea of what to expect. The facilitators state the agenda for today's session, as they do at the beginning of every subsequent group session. They may say: "For our first session today, we have a lot to accomplish. First, we facilitators will introduce ourselves. We will then review some ground rules and expectations for this group before hearing about your hopes for this group. This will be followed by a discussion of what panic disorder (or other disorder depending on the type of group) is. We will discuss a model showing why it is difficult to break free of panic attacks. We will end our session by describing what this group treatment involves, and get you started with your first homework. How does that sound? Anything you would like to add to this agenda?"

After the agenda has been set, the facilitators introduce themselves, emphasizing their area of specialty and experience. Students should be honest about their lack of training, and for some, it may be their first group. The manner in which the facilitators introduce themselves matters as they model respect, honesty, and openness. Sometimes, clients will ask if the facilitators have personal experience with a particular problem or disorder. It is best to avoid therapist self-disclosure of this nature. There are a number of ways in which to genuinely respond to such a question. Group therapists may say that they understand human struggles as falling on a continuum and do not believe anyone is immune to mental health problems.

We then review ground rules as well as expectations for attendance, how to handle absences and arriving late to the group, confidentiality, socializing outside of the group, and, lastly, a general introduction to CBT, including its focus on active participation and homework. As for ground rules, programs will develop their own, and there are no strict guidelines within the CBGT practice community. Some programs allow clients to bring food or even offer tea and refreshments. Others only allow clients to bring a beverage into the group room. Generally, CBT groups are more permissive compared to non-CBT groups in terms of what can be brought into the group room. My suggestions for how to handle a number of issues pertaining to the organization and structure of the group reflect my preference and may be somewhat different from other experienced CBGT therapists. By being quite specific, I hope to help more junior CBGT therapists with getting groups off to a good start.

Absences and being late

Absences in a CBT group are a problem because the groups tend to be shorter term and each session includes new didactic information. We ask that clients make a commitment to not miss more than two sessions. Clients are made aware that if they miss more than that, we may ask them to leave the group and start over again in a next group. Clients are usually cooperative with this and see it as being in their own best interest. Arriving late to group is another issue that should be addressed from the start. CBT groups, just like other kinds of psychotherapy groups, work best if they start and end on time as this reinforces the importance of keeping a structure and respecting everyone's time. Group facilitators are free to develop their own lateness "rules" so long as they state them clearly. There are of course many reasons for why group members might not arrive on time, with avoidance being a common one. Symptoms can get in the way too, as they did with a school teacher whose washing compulsions necessitated she spend 30 minutes in the school washroom and therefore often arrived late for group with hands and lower arms red and swollen.

It is understandable that people may feel ambivalent about coming to a program where they are asked to confront some of their strongest fears or emotions. We speak about this using exactly those terms. While we validate group members' fears and ambivalence, we also make it clear that the group room door will be closed 5 minutes after we start and that those who come late should quietly enter and take their seat. (If somebody will be more than 30 minutes late, we ask they call the program in advance if at all possible.) If members miss the go-round (the first part of the group where each member in turn reports on their previous week and homework), we may not give them an opportunity to review their week. With the risk of coming across as slightly punitive, we also attempt to extinguish this problematic behavior by not rewarding late coming with positive attention. Brushing up on CBT learning principles is highly recommended for the CBGT therapist!

Confidentiality and socializing outside the group

Confidentiality is universally a rule in any mental health therapy group. While clients usually nod and say they get it, they often indicate confusion about what confidentiality does not mean. To lessen this anxiety, we tell clients that they are free to talk about their own experience in the group as much as they want to whomever but that they simply do not mention by name or describe any other person in the group. Similarly, there is sometimes confusion about why the group facilitators ask people not to meet outside of the group when we also encourage people to make strong connections. When we explain about the possibility of some people feeling left out if they hear others are meeting outside of the group, everyone usually gets it. Interestingly, it can take repeated reminders and therapists need to pay attention throughout the group. In a group for older adults, one woman had a

hard time understanding why she could not invite another group member for Christmas dinner when he was otherwise going to be alone. Not wanting to appear inhuman, the facilitators decided in their debriefing to have the whole group discuss this issue and come to a group decision about this, including agreed-upon limits to the invitation. This example shows how rules are not inflexibly imposed by the therapists but can be negotiated by participation of all group members.

There is another wrinkle to confidentiality. Occasionally, in smaller communities, two people in the same first group session realize they know each other. Their children may be on the same sports team; they may attend the same church or live in the same apartment building. There is no way to prevent this as the identity of group members obviously cannot be shared before the group or at any time. When this happens, the facilitators express their concern, saying that it does happen. We explain that the two people can stay in the group so long as they are both absolutely comfortable with this, or one can choose to withdraw and go on the list for the next group. It usually gets sorted out but may require some individual discussion with the group facilitators. In one case, two people working as volunteers for the same organization clearly had a strong negative reaction upon recognizing each other. One said: "I don't want to leave, but she definitely needs therapy!" It is awkward and frustrating to lose a group member who cannot easily be replaced but also something facilitators learn to deal with in a matter-of-fact way.

Member introductions

Group members are then asked to introduce themselves. Empathizing with how terrifying this can be even for people who do not have social anxiety, we lessen this by structuring the introductions. We ask clients to answer three questions written on the board: (1) What is your favorite food? (2) What brought you to this group? and (3) What is one thing you hope to get from this group? The first question is obviously meant to break the ice and strengthen the group process by creating a more personal, light atmosphere. The second question is a sort of double check on whether the group matches each member's goal for their improvement. If a group member in an OCD group says she is hoping to overcome abuse from her childhood, this goal is not likely to be met. In response to the third question, members tend to say "to learn how to handle my anxiety better" or "to understand why I keep falling into the same patterns." These answers offer an opportunity for the therapists to reinforce what tasks and skills will be presented in the group.

It is important that the facilitators not engage in lengthy one-to-one dialogues during these introductions. Some members are eager to "tell their stories." The facilitators firmly but gently connect what the members say to the purpose of the group and to what other members have said. For example, if Sam is going on about how unfair his many bosses have been, the facilitator will say: "You will have many opportunities to address your concerns in this group over the next several weeks, Sam, and we're glad you came to this group. Similar to Mary, your

challenges at work seem to have contributed to your depression. In this group, we hope to offer you a number of skills to help you cope better." If facilitators are not sure how to keep introductions fairly short, they will be unable to accomplish what they stated in their agenda. This undermines confidence in the group and especially in the facilitators.

Expectations for CBGT commitment

It is imperative that all clients leave the first session with a strong sense of what to expect from the CBT group, how the treatment will proceed, their commitment to daily homework, and, just as importantly, an experience of the group as safe and led by competent facilitators whom they can trust to guide them through the difficulties of facing their challenges. While the facilitators acknowledge their expertise, they also remind the group that all sessions will be a combination of presentation of new material as well as working together as a group on helping one another. Facilitators explain that they do most of the talking in the first sessions but increasingly expect group members to support each other by asking questions, offering suggestions and feedback, as well as being able to receive feedback. They further explain that feedback must be respectful. They may comment on how some group members will find it easier to talk than others, and they encourage those who are more comfortable with talking to attempt to bring out the more quiet members. It is worth emphasizing that gains from a CBGT group do not depend on how much a member talks. Some very quiet people gain a lot from CBGT.

The second-to-last part of the first session is dedicated to education about the particular problem or disorder, often augmented by a video. The very last part involves handing out a set of outcome measures relevant to the particular CBT group. The therapists explain the benefits of tracking individual progress and also overall comparisons for program evaluation purposes. Group members are asked to complete the measures at home and bring them to the next session. Chapter 6 includes more information on various outcome measurements.

Note-taking by CBGT therapists

CBGT therapists tend to have a notepad or clipboard with note paper in front of them in the group. This allows them to make brief written notes during the go-round where group members report back on their homework. They also make notes during the checkout go-round where new homework is assigned. CBGT groups include various work sheets and forms for tracking anxiety or creating behavioral experiments. Group therapists can make copies of these work sheets at the end of the session so that clients can keep them in their folders. After the session, group therapists use their notes for making formal progress notes in their clients' charts. Having careful documentation from each session is

mandatory in most mental health programs and also helps therapists summarize clients' progress in treatment in their final discharge notes. Although note-taking during CBGT sessions is permissible, it is important that it does not interfere with the group process. If a therapist writes extensively, seems absorbed, and is not looking up and around that much, this obviously sends a message of disengaging from the group. It may also make group members suspicious of what the therapist is writing down about them. My practice is to explain why I take a few notes and how I use them and add that clients are welcome to see what I note about their work in the group.

Subsequent sessions

After the first session, all subsequent sessions follow the same structure of (1) welcome and go-round with review of each member's week and their homework, (2) presentation by the facilitators of new material or review of previously introduced material, (3) in-session practice of tasks such as exposures or cognitive restructuring and (4) go-round where new homework is set for each member based on what they worked on in the session.

At the beginning of each session, the facilitators welcome everyone, announce who may have called in to say they are unable to attend or will be late, and set the agenda by stating what new material will be introduced or what will be practiced in the session. They ask if there is any addition to the agenda, and if there is, this is added. For example, a member may say that she had a bad week because of being fired from her job and would like some support from the group. The facilitators may suggest that the go-round ends with this member and that the group takes some time to support her before moving to other tasks.

Summary

This chapter reviews the historical development, principles, and common applications of CBT. CBT is the treatment of choice for a number of mental health problems across the world. CBT is cost-effective, and if delivered in a group format, even more so. Some of the challenges with transporting individual CBT protocols to a group setting are discussed and illustrated with a panic disorder protocol example. This is followed by a review of the basic common components in the first group session no matter what kind of problem. Despite the limitation to group CBT of less individualized treatment plans, the group format has the potential for offering clients a sense of belonging and validation above and beyond symptom relief. The very format of the group, with its rich possibilities for support and connection, is a critical strength of CBGT. In the next chapter, we take a closer look at how to work with the uniqueness of the group format and especially at how to infuse process factors into basic CBGT.

Notes

1. The diagnostic criteria for panic disorder have not changed from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) (APA, 2000) to the DSM-5 (APA, 2013).
2. The CBT term Socratic dialogue credits the Greek philosopher Socrates (470-399 BC) with his ability to help people understand they already have the insight or solution to their problems within them; it is more a matter of drawing this out by asking good quetions.

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