

CHAPTER I

Cognitive-Behavioral Therapy Groups

POSSIBILITIES AND CHALLENGES

Cognitive-behavioral therapy (CBT) is an empirically validated form of psychotherapy that has been shown to be effective in over 350 outcome studies for myriad psychiatric disorders, ranging from depression to the anxiety disorders, and more recently to personality and psychotic disorders (Beck & Weishaar, 2000). Despite its relatively young age, both as a theory and treatment, the cognitive-behavioral approach has generated unparalleled volumes of research data. There is widespread support for both the therapy itself and many of its theoretical explanations for psychopathology (Bieling & Kuyken, 2003; Clark, Beck, & Alford, 1999).

Traditionally, CBT was described and practiced in an individual format. However, even the original, now classic text on treatment of depression by Beck, Rush, Shaw, and Emery (1979) described the use of a group format. The reasons for this exploration of a group approach then was simple and is as applicable now as in 1979: “More patients can be treated within a given period of time by trained professional therapists than can be treated individually” (Hollon & Shaw, 1979, p. 328). Some authors have found that in terms of therapists’ time, groups offer as much as 50% greater efficiency when compared to individual treatment (N. Morrison, 2001). There may also be overall financial savings for the health care system when a group format is used (N. Morrison, 2001; Scott & Stradling, 1990). Efficiency may have been a factor when group CBT was first proposed in the late 1970s, but consideration of costs has since become paramount in health care. In some settings it is now all but impossible to deliver CBT in anything but a group approach due to limited funding.

Beyond the clinician efficiency argument, the efficacy of the group CBT approach has also been confirmed by carefully conducted research that started in the 1970s. For example, in the area of depression, small early studies by Hollon, Shaw, and other collaborators found that a CBT group was superior to several other treatments, but not as effective as individual CBT (Beck et al., 1979). Subsequent reviews and at least one meta-analysis since that time suggest a high level of efficacy, even to the point of equivalence between group and individual CBT for depression (Burlingame, MacKenzie, & Strauss, 2004; Robinson, Berman, & Neimeyer, 1990). In other clinical areas, for example, many different anxiety disorders, considerable evidence for the efficacy and effectiveness of a group approach has emerged (N. Morrison, 2001). The state of evidence for specific disorders is reviewed in the chapters that follow, but there is little doubt now that CBT groups are efficacious and effective.

Importantly, there is also a subset of clinical problems that lends itself to group work, and conceptually at least, would seem to be better treated using a group approach. Social phobia is a prime example, because the focal fear of other people, social evaluation, and concern about how one is perceived are readily tested in a group environment (Heimberg, Salzman, Holt, & Blendell, 1993). Group CBT for social phobia provides ample opportunities to practice exposures to a variety of social situations, to engage in role plays, and to provide different members with feedback about social interactions. Considerable data have since accumulated to support the efficacy of group CBT for social phobia.

The apparent success of the group approach in CBT based on efficacy and cost-effectiveness suggests that over time, more and more disorders are likely to be treated in this modality. Thus, it will be important to continue to refine and develop methods specifically designed for a group approach. Luckily, numerous CBT group protocols are now available in the literature, many based on carefully designed efficacy studies. A collection of approaches for specific disorders, including depression, panic, obesity, eating disorders, and work in specific populations, has also been published (e.g., White & Freeman, 2000). Thus, the literature on how to deliver group CBT continues to expand, with more and more resources becoming available.

Despite the success and availability of group approaches to a variety of disorders, the literature on group CBT contains a number of significant omissions. Because group protocols for CBT tend to be based on individual treatment strategies, it is understandable that such protocols tend to emphasize the adaptation of very specific teaching of principles and strategies of CBT techniques to a collection of individuals. However, this also results in too little attention paid to the simple fact that such strategies are being delivered to an interacting, evolving group. Some authors certainly have recognized that a group modality offers unique therapeutic opportunities. For example, CBT group approaches to depression and social phobia emphasize that patients may more readily recognize cognitive errors made by others than errors made by themselves, and that a group can produce many more examples of links

between thoughts and feelings than would be possible in individual therapy (Hollon & Shaw, 1979; Heimberg et al., 1993). However, traditional CBT protocols for groups also imply that group CBT is similar to individual CBT, only the audience has grown from a single person to a handful. Few CBT group approaches meaningfully contemplate the ways in which group members interact with one another, and with the therapist(s). Moreover, when there are two therapists, they are likely to interact with one another, not just with group members. Finally, there is a sense in which “the group” interacts with each individual member throughout treatment. All of these interactions are more than incidental; they involve significant learning opportunities and exchange of information, and clearly involve an inherently “relational” component that is rarely addressed in traditional CBT protocols. The traditional CBT group approach by and large neither recognizes nor takes advantage of the fact that the group itself can create a milieu that either supports or undermines the overall goals of learning and using cognitive and behavioral strategies.

Training group therapists with extant protocols offers dozens of examples of important quandaries and dilemmas that evolve out of a group interactional context that have thus far been difficult to address with currently available treatment protocols. Learners (and some senior therapists!) of group CBT approaches find themselves asking questions such as the following:

- What do I do if one group member seems to not understand a point about evidence gathering but all the others do?
- What should I do if one group member gives nonconstructive, or even mean-spirited, feedback to another member?
- What can I do if the group as a whole seems to be doing less homework because a couple of members never do theirs?
- How can I involve a group member who never offers any examples?
- How can we stay on track when two of the people in group have a second disorder and keep talking about symptoms that no one else has?
- Should we offer an alternative approach to one group member who is clearly not doing well and not keeping up?

These questions, which clearly fall into the “troubleshooting” category, are rarely addressed in group CBT protocols. At an even more basic level, issues such as how best to use group discussion to illustrate the central point of a session or how to maximize the efficiency of reviewing or assigning homework are often not addressed in the CBT group literature.

These important issues can be addressed only by acknowledging that such groups are more than techniques delivered “simultaneously” to multiple clients. The group process issues must also be considered and leveraged for success, but from the foundation that the principal mechanism of change is based on a cognitive-behavioral model. Indeed, a consideration of group process should not in any way conflict with or suggest a choice between expend-

ing time and effort on enhancing process versus focusing on teaching and implementing CBT strategies. Process and technique can and should ideally be symbiotic and rarely in direct competition. The focus of this volume is therefore, to a large extent, the integration of CBT strategies, and the understanding and enhancement of group process to aid in learning and understanding cognitive and behavioral strategies. We also offer specific protocols for disorders, as well as trouble shooting guides, integrating both techniques and the process of applying those techniques in real-world settings.

Interestingly, a similar pattern of evolution can be discerned in the literature on individual CBT in which the early work tended to focus on specific techniques and principles, followed over time by more and more emphasis on enhancing or optimizing the techniques by also considering the therapeutic alliance and interpersonal factors. In their well-known volume on interpersonal processes in CBT, Safran and Segal (1990) advocated for both a theoretical and practical integration of CBT techniques and the therapeutic relationship in which those techniques are communicated. This work added a number of dimensions to CBT, emphasizing the moment-to-moment experiential aspect of cognitive strategies for the patient, attunement of the therapist to the patient's interpersonal schema, as well as the affective, behavioral, and cognitive responses of the therapist to the patient. It is now common practice to emphasize, as the basis for productive CBT, that a strong collaborative therapeutic alliance and attention to both the internal and external reaction of the therapist to the patient are critical factors in individual CBT (Beck, 1995).

Similarly, our aim in this book is to integrate group process factors and CBT techniques. Just as Safran and Segal (1990) suggested that consideration of interpersonal factors in individual CBT should be construed as an evolution toward integration, we believe that considering group process factors in CBT represents the development of a more sophisticated and inclusive model of intervention. We believe that this integration can provide the answers to the several sample questions we posed earlier, and that focusing on such integration will help to set the stage for more clinical developments, research questions, and a richer understanding of the "effective ingredients" in group CBT.

THE GROUP PSYCHOTHERAPY LITERATURE

To begin this integration task, we first turn to the group psychotherapy literature, which has a long tradition of its own that predates CBT. The group psychotherapy movement, with its roots in psychodynamic models of pathology, focus on experiential (or encounter) groups, and historical antithesis to research, appears to be diametrically opposed to the scientist-practitioner mind-set of CBT. Moreover, data on the effectiveness of such generic groups are less clear, and not all aspects of group process can be readily investigated in the same manner as aspects of cognitive-behavioral models or their efficacy.

Stated most plainly, the well-proven techniques in a CBT group are seen as the intervention, and the group is simply the delivery system for those techniques. In the group psychotherapy literature, on the other hand, the group process itself is the intervention. Summarizing this perspective, Burlingame and colleagues (2004) write that in the traditional group approach, “high value is placed on interpersonal and interactional climate of the group, undergirded by the belief that the group is the vehicle of change and that member-to-member interaction is a primary mechanism of change” (p. 647). Writers from the group psychotherapy tradition focus not only on group process over techniques, but may also advocate for groups with heterogeneous diagnoses and an “open” format in which group membership changes as individuals enter and depart the group.

Certainly this process-based theoretical foundation is indeed a stark contrast to the CBT model and group approach. Pragmatically too, few CBT groups are run with an open format, and no empirically supported protocols suggest diagnostic heterogeneity as matter of course. Yet despite the readily apparent differences between these two clinical traditions, work on group process factors does offer many important insights that are useful for CBT. The group literature offers not only a carefully thought out, detailed perspective on the functioning of groups but also a more highly evolved set of strategies for troubleshooting when groups are not functioning optimally. In some cases, knowledge of group process can also be construed as atheoretical, based more on observation and inductive process than on a particular theory. For example, seminal writers such as Yalom attempt to distill from many different kinds of groups, ranging from large didactic groups to small and intense therapy, the effective ingredients that result in change processes in group members.

Indeed, perhaps the most comprehensive perspective in the group psychotherapy field has been offered by Irvin Yalom (1995) in *The Theory and Practice of Group Psychotherapy*. Yalom describes nine relevant therapeutic factors that groups offer, and how each of these can be fostered in the group environment to produce change. These factors are: (1) instillation of hope, (2) universality, (3) imparting information, (4) altruism, (5) the corrective capitulation of the primary family group and interpersonal learning, (6) development of socializing techniques, (7) imitative behavior, (8) group cohesion, and (9) catharsis. Each of these factors is seen to be important in a unique way and more or less present in almost any type of therapeutic group. Burlingame and colleagues (2004) offer a complementary theoretical model that extends this work, yet offers a very concise and specific model of groups that can be adapted to different modalities. These two complementary perspectives on group effectiveness and functioning are briefly described below, followed by an examination of how these factors are relevant to CBT delivered in groups, followed by the beginnings of an integration between CBT and the group factors literature.

Yalom's Group Factors

Yalom (1995) describes *instillation of hope* as a necessary ingredient in all psychotherapies, including group therapy. Yalom suggests that it is important for therapists to reinforce directly the potency of a group approach and to emphasize positive outcomes in members of other groups. Instillation of hope, including narratives of “overcoming” provided by members, appears to be an important component of many self-help groups, including Alcoholics Anonymous (Yalom, 1995).

Universality describes the discovery that others suffer from similar difficulties, often despite patients' conviction that their problems are unique and hence isolating. This factor is more unique to groups than instillation of hope, because it can often be difficult for patients in individual therapy to recognize that their disorder(s) have been experienced by others. Yalom (1995) describes the palpable relief that group members can experience when they, perhaps for the first time, recognize that they are not alone in their suffering.

According to Yalom, the *imparting of information* is a central feature of most groups. This can be further broken down into two specific categories of information, didactic instruction and direct advice. Didactic instruction can be in the form of psychoeducation about the nature of a particular diagnosis or problem, specification of a treatment plan, and a description of how a specific technique might alleviate suffering. At an implicit level, learning about the nature of interpersonal processes and the patient's own interpersonal impact can also occur (Yalom, 1995). The central source of change is seen to be provision of an explanation, a narrative to help the patient understand why and how problems came to exist. Direct advice from the therapist or a copatient may also provide new and helpful information for the patient. Yalom emphasizes the process of advice giving, rather than the content, as offering the most critical learning.

The interpersonal factor of *altruism* refers to the opportunity that group members are given to help one another in the group. If a group member benefits from advice given by another member, then both members benefit. The person receiving the advice obtains helpful information, whereas the person providing the advice benefits from helping another. Groups offer individuals who are often demoralized and marginalized many opportunities to provide others with help, whether by giving advice or offering support, empathy, or understanding. In this way, the group members learn that they can make valuable contributions and have much to offer. Yalom also describes altruism as a sort of antidote to the morbid self-preoccupation that often characterized distressed individuals (Yalom, 1995).

Groups, because they involve peers and “leaders,” can also offer opportunities for *corrective recapitulation of the primary family group and interpersonal learning* (Yalom, 1995). Based on the work of attachment theorists such as John Bowlby, and Harry Stack Sullivan's emphasis on interpersonal relationships, the group is thought to constitute a *social microcosm*, a crucible in

which the interpersonal patterns of each member will emerge and interact. This offers many opportunities, but in the case of particularly problematic interpersonal styles, can also cause significant strife between members and disrupt the group as a whole. Group leaders are important for helping to moderate rather than amplify these dysfunctional patterns. For example, excessive dependency may express itself as an unusually strong attachment to the group leaders and reliance on their advice and feedback. Similarly, individuals with early experiences of mistrust may have difficulty becoming meaningfully engaged with other group members. The corrective aspects of the experience are provided by both the group members and the leaders, who are able to observe objectively these interpersonal patterns in others. Rather than responding in a way that increases the dysfunction, the group should respond in a way that makes the individual aware of this pattern, so that his or her interpersonal functioning becomes more flexible and adaptive. The interpersonal learning is therefore thought to occur at a fully conscious level; individuals become aware of how they are constructing their interpersonal world and that they have the power to change it. Yalom also emphasizes affect and consequences of this learning. The more affect involved in this realization and behavior change, the more potent the experience (Yalom, 1995). Also, when patients attempt a behavior change and realize that the new behavior has better consequences than their former, more dysfunctional style, the new approach they have learned becomes part of an “adaptive spiral” (Yalom, 1995, p. 43) in which the new behavior gains strength both within and outside the group.

At a more basic interpersonal level, a group can offer *socializing techniques* that involve the development of more basic social skills, either implicitly or through direct exercises including role plays. Groups can give members opportunities to “try out” a variety of new skills or approaches and, unlike many real-world situations, receive direct feedback on the consequences of those actions.

Another area emphasized by Yalom from a traditional group perspective is *imitative behavior*. This factor is based directly on the work of social learning theorists, including Albert Bandura, who identified the process of vicarious or observational learning. In a therapy group, a group member can learn by observing other models of behavior, potentially including both the leaders and group members, from which he or she can gain important information about appropriate and effective interpersonal strategies.

Paralleling the importance of the therapeutic alliance in individual therapy, *group cohesiveness* is seen as a critical ingredient in the process and outcome of any group (Burlingame, Fuhrman, & Johnson, 2002; Yalom, 1995). Operationally, “cohesiveness” is defined as the attraction the members have for the group and for the other members. The ingredients of cohesiveness include acceptance, support, and trust. Similar to unconditional positive regard in individual therapy, the group ideally provides its members an environment in which they can disclose their most private emotions and thoughts,

and know in advance that the group will understand and empathize. Yalom (1995) suggests that attendance and, in “open” groups, lower levels of turn-over are indicators of cohesion. Cohesion is typically described as an overarching condition under which groups operate, and level of cohesion is seen to affect almost all other interpersonal aspects of group process.

Group cohesion has also been among the most studied aspects of group process, even though proponents of group approaches still lament the gap between clinical and research literatures in this area (Burlingame et al., 2004). Reviews of this cohesion research point to a number of discrete principles and practices to create a group with high levels of cohesion (Burlingame et al., 2002). These principles involve factors including pregroup preparation in which members are informed about group functions and roles, high levels of structure in early sessions, consideration of group membership to balance interpersonal and clinical factors, and leadership with a balance of control and expression of regard for all group members and their contributions. Clearly then, cohesion is itself a complex and dynamic grouping of factors, likened to a complex chemical reaction for which all conditions must be right (Burlingame et al., 2002).

Like cohesion, *catharsis* is seen to be a critical variable in groups but one that defies simple categorization as a single type of event that occurs under specific conditions. Virtually any verbalization made by group members to the leader or to one another can involve an aspect of unburdening, sharing something that has not previously been articulated or even part of self-awareness. However, catharsis is also seen as necessary but not sufficient for a positive outcome: “No one ever obtains enduring benefit for ventilating feelings in an empty closet” (Yalom, 1995, p. 81). Equally important then is the response to the cathartic event, and obviously this could involve information or other kinds of feedback that fit the particular situation. Nonetheless, according to Yalom, a group that does not involve catharsis is unlikely to provide the proper conditions for change.

Burlingame, MacKenzie, and Strauss Group Model

Burlingame, MacKenzie, and Strauss utilize a different framework that is informed on the one hand by Yalom’s work and on the other hand by the developing literature on treatment outcome that supports the efficacy of a group approach in many disorders (Burlingame et al., 2004). The results of this dualistic approach are represented in Figure 1.1. With therapeutic outcome as the overarching “fact” to be explained, Burlingame and colleagues include a number of evident contributing factors. One of these is the “formal change theory,” in other words, the treatment modality. In the case of CBT, this would correspond to a protocol or session plan describing the CBT principles and techniques to be worked through. The modality occupies an important but by no means primary position in the Burlingame model. The second critical component in the model, the principles of small-group process, corre-

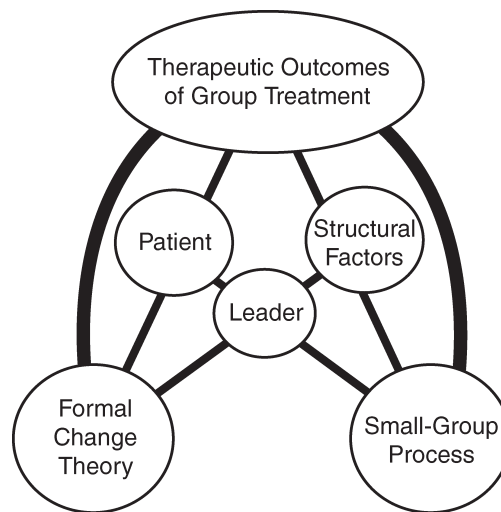


FIGURE 1.1. Forces that govern the therapeutic outcomes of group psychology. From Burlingame, MacKenzie, and Strauss (2004). Copyright 2004 by John Wiley & Sons, Inc. Reprinted by permission.

sponds in many ways with the processes described by Yalom, essentially the various interpersonal relationships that come into operation when a group of individuals gather in a “therapeutic” context.

The other three components are more specific but are seen to have a powerful and unique effect on outcome (Burlingame et al., 2004). One is the patient, in terms of not only his or her specific disorder but also personal and interpersonal characteristics. Various factors, such as the individual’s ability to be empathic to other group members, as well as a host of basic social skills, are believed to have a strong potential to interact with the specific treatment modality (Piper, 1994). Group structural factors make up another component that “explains” the positive impact of a group. This includes factors such as length and number of sessions, frequency of meeting times, group size, and the setting in which treatment takes place. Also considered here is the number of group therapists, and whether or not there exists a hierarchy of leadership.

The final component of the model is at the nexus of the other components (Burlingame et al., 2004). To a great extent, all aspects of group experience are seen to flow through a single source, the group leader(s). The model points out that the style and practice of leadership determine exactly how the formal change techniques are delivered in a group setting. Also, the leader helps to direct and redirect a host of group process variables throughout the moment-to-moment interactions for the duration of the group. The interpersonal approach taken by the leader and levels of warmth, openness, and

empathy have been shown to predict cohesiveness and outcome, and are seen to parallel the importance of the therapeutic alliance in individual therapy (Burlingame et al., 2002).

APPLICABILITY OF TRADITIONAL GROUP FACTORS IN CBT GROUPS

We take the view that many of the factors we have described can be adapted or are readily evident within CBT groups, even though few writers have explicitly focused on both group process and CBT. Of course, there are also considerable points of divergence between the traditional group process literature and CBT models of intervention. Below we first consider the process factors as described by Yalom and how they can be related or adapted to a typical group CBT protocol. We then consider the Burlingame et al. model, which already includes a specific modality component, and discuss the implications of choosing CBT as a modality for various aspects of group structure, leadership, and selection of patients.

Yalom's Factors and CBT Groups

Usually as a first step, CBT protocols for specific disorders present participants with a model of their difficulties that emphasizes the possibility for change. In many clinics, information about the efficacy of CBT is also described either in written literature or in early discussions with therapists. From a group perspective, this process is consistent with both *instillation of hope* and *imparting didactic information*. Participants are provided with a model of their difficulties, one that both explains their condition and offers a systematic way to relieve their suffering. Traditionally in CBT, psychoeducation is intertwined with change strategies; for example, explanations of a biopsychosocial model of depression emphasize that changing one system, thought content, can change affect, behavior, and physiology (Greenberger & Padesky, 1995). Within a group context, the possibilities for positive change offered within the group should be consistently emphasized. Instillation of hope can also be enhanced through discussion of case examples, for example, describing other people who have overcome similar problems using the same type of interventions.

Another aspect of group process that likely plays a significant role in CBT is *universality*. The gathering together of individuals with specific disorders is often the first time one sufferer has ever met, let alone gotten to know, another sufferer. This is especially true for those disorders that are less common, for example, obsessive-compulsive or personality disorders. Similarly, some individuals, given the nature of their difficulties, are reluctant to discuss their inner experiences with others except in this new group circumstance. Individuals with social phobia often feel isolated in this manner not only

because, like many people with psychiatric disorders, they perceive their problem to be unique, but also because they are the least likely to share their experiences or talk with others in everyday social situations. In the initial phases of CBT group work, individuals often openly express their surprise that other individuals, at this time and this place, have the same problems and have chosen to work on those problems in the group. *Universality* can also be enhanced when group members describe their own difficulties and some background about themselves. After a round of introductions and some autobiographical information, group members often express incredulity that individuals with such different backgrounds could suffer from the same kinds of problems. Such recognition, and the sense of belonging this experience of other group members provides, appears to be very useful in setting the stage for the introduction of more specific CBT strategies and helps to create a milieu that supports cohesion in subsequent sessions.

Once the group begins to focus on specific CBT strategies, for example, thought monitoring and examination of evidence for thoughts, other group factors come into play and can be used to support learning and change. A group can offer many opportunities for its members to express *altruism* whenever a new strategy is introduced. In the case of evidence gathering, therapists typically demonstrate the Socratic approach using one group member's example. Therapists ask questions about both the facts that support a particular thought and evidence that does not support that thought. Group members could and should be encouraged to participate in this questioning process, and this sets the stage for altruism. By asking such evidence-gathering questions of one another, group members can help each other obtain new information or see the events and thoughts in their lives in different ways. The group member whose example is being discussed clearly benefits from these multiple perspectives, but the group members asking these helpful questions also will feel that they are making valuable contributions to one another. Also, by seeing the beneficial impact of asking questions of others, the group members are more likely to ask themselves similar, useful questions. Moreover, it is not uncommon for therapists to discover that the best questions about a thought record examined in the group come from other group members. This important process of group members contributing to the Socratic dialogue needs to be encouraged early on in sessions, for both the altruistic benefit it offers and the diversity of questioning strategies for automatic thoughts that result from broad group participation.

As a CBT group progresses through the discussion of various behavioral strategies, *socializing techniques* and *imitative behavior* become more and more important. A group may offer many opportunities for group members to practice new behaviors with one another. The most obvious application of these is with interpersonal behavior, for example, in practicing to be assertive or to engage in a social interaction that previously engendered anxiety. More broadly, most CBT groups would discuss experiments and action plans within areas that a group member may need to explore in more detail. As in contrib-

uting to Socratic dialogue, group members should be encouraged to offer input into developing more adaptive behavioral approaches to their problems. Moreover, if one group member is able to stop a self-defeating behavior, reduce reliance on a dysfunctional compensation strategy, or engage in an anxiety-reducing exposure, other group members have access to a model that has succeeded. When handled optimally, such examples of positive change can engender more hope and purpose in other group members. Encouraging group members to be pleased about one another's successes and to discover how such successes help others to make progress is an important task for therapists to consider. Finally, because the completion of homework tasks is so critical in CBT, therapists need to focus on socializing the group, as a whole, toward the importance and benefit of working on homework. Completion of homework by members offers many opportunities to reinforce the importance of this therapy task, thereby supporting the desire of the other members to imitate homework completion.

As in Yalom's analysis, group *cohesion* in CBT is a factor that combines a sense of trust in and support from other group members. As described earlier, the creation of cohesion is itself a complex "chemical" process; the addition of the specific CBT approach is yet another variable to be considered in that mix. Cohesion has traditionally been seen to occur around the group, but it could be extended to encompass the CBT approach itself. Group members and therapists who share a sense of enthusiasm for the active change strategies of CBT are likely to reinforce each other. However, group cohesion is clearly a varying and variable product and process of CBT groups. When cohesion is high, it is not uncommon for members of CBT groups to exchange phone numbers with one another, to offer each other support around the tasks of treatment. Sometimes groups will continue to meet even after the therapy has ended. This is a clear indicator of attraction of group members to the group, and it is important also to consider the "attraction" to a CBT model. If group members choose to meet or speak outside of group time, therapists may wish to consider to what extent such contact can encourage use of cognitive and behavioral strategies, and reinforce principles taught in treatment. Also important, the trust and support aspects of cohesion set the stage for important self-disclosures. In almost any specific category of disorder, an individual may have "secrets" or cognitive-emotional material that they have rarely, if ever, disclosed to anyone else, let alone to a group. All other things being equal, the higher the level of cohesion, the more likely group members will regularly disclose important affective and cognitive content. The presence of cohesion also increases the probability that highly private revelations will be well received, even if such disclosures have the potential to be upsetting to others. When group members have an affinity and unconditional regard for one another, they are more likely to accept one another throughout the therapy process.

Cohesion can also be low, and this tends to be a particular problem when there is an associated lack of progress toward important clinical goals. There

are examples of CBT groups that “fall apart” when a significant number of members drop out. Just as in groups with high cohesion, the reasons for a lack of cohesion are complex and may be difficult to alter, especially if group members are in direct conflict with one another. Putting into place carefully considered measures to increase cohesion, for example, the composition of group members, choice of leaders and leadership style, and preparation of members for the group, will reduce the likelihood that the group will disband prematurely. Cohesion clearly is not static. A group that seems cohesive in early sessions may become less so if progress for some or all members becomes difficult, or if group members have a negative interaction in some way. Troubleshooting and “midcourse” corrections are often necessary to stay on track and in step with the treatment protocol.

Two other group factors described by Yalom may be less relevant to CBT, largely because these factors are, at a theoretical level, antithetical to CBT models and therapeutic strategies. First, *catharsis* alone is unlikely to be seen by most CBT practitioners as useful. Certainly disclosure of private and troubling affect, cognition, and behavior is critical to CBT. However, this disclosure is usually seen only as a first step toward modification of these problems, not an end in itself. Thus, a CBT group should create a forum in which individuals are comfortable and encouraged to reveal private information, even if catharsis is not the ultimate goal of such revelations.

The second group factor that may be less relevant in CBT is *corrective recapitulation of the primary family group*. Because CBT focuses largely on the “here and now” and does not view most problems as rooted in problematic attachment experiences, CBT group protocols are unlikely to focus on this area. Traditional group psychotherapy is more likely to involve a “working through” of early developmental experiences, focusing on recollections of parenting and members’ expressing affect and discussing these experiences with one another. However, there are two less direct ways in which CBT groups do relate to early learning, if not recapitulation. First, CBT strategies concerning core beliefs are likely to involve an examination of the origins of such beliefs. This is done to aid understanding of how such beliefs were learned rather than to create a reexperiencing or interpretation of such experiences. Nonetheless, a CBT group should foster an environment in which early experiences can be shared and discussed when needed. Second, just as beliefs about the meaning of situations are uncovered in CBT, these same strategies often result in the discovery of problematic or self-defeating beliefs about other people. Those “interpersonal” beliefs or schemas are likely to be brought to the group experience, as to other relationships in the individual’s life, and are often brought to bear in interactions with group members and therapists. For example, a depressed patient who has difficulty trusting others may experience difficulties in trusting fellow group members and the therapists. Not only should this belief itself be targeted in treatment, but it also has the potential to undermine learning from the therapy experience, because the individual doubts whether others are genuinely motivated to help him or her. As a result, the patient may

withhold information, not express doubts, or not be motivated to follow up on strategies he or she has learned. Clearly, creating an environment in which such beliefs can be shared and then “tested” through experiments with other group members would be very useful for someone with mistrust beliefs.

Importantly, not all group CBT treatments are likely to deal with interpersonal beliefs or core beliefs in this manner. For example, in some anxiety conditions, such as panic disorder, there may be little focus on interpersonal relationships by design of the protocol. However, in groups for depression, social phobia, and certainly personality disorders, beliefs about others are an important focus of the treatment. A supportive and trusting therapeutic milieu will help participants to share their beliefs about others. How the group receives and responds to these beliefs is an important and very real source of learning for participants. In that sense, a CBT group is indeed an important “micro” social environment that can go a considerable distance toward correcting interpersonal distortions.

The Burlingame et al. Model

The approach advocated by Burlingame and his colleagues adds three factors not considered explicitly by Yalom: the structure of the group context, patient characteristics, and leadership. Each of these areas is certainly touched on by group writers, but the Burlingame model separates these factors into discrete entities since they have been targets of research and conceivably can be linked to outcome in specific ways (Burlingame et al., 2004).

Structure of the group context is typically specified in most CBT protocols, though not necessarily with an explicit rationale. Many common themes emerge across protocols. First, most CBT groups are closed; that is, there is no regular provision for people to join or depart from a group in progress. There are important reasons for this choice, mainly that CBT is a set of skills that should be taught and learned in a linear manner. This choice makes plain that a CBT group emphasizes content of the modality over process. Frequency of meetings is another near-constant factor; most CBT groups meet once per week for between 1 and 2 hours. Again, this choice likely reflects the notion that learning can only take place when intervals between sessions are relatively small, and that optimal learning cannot occur when the duration of any one session exceeds 60–120 minutes. One potentially compelling area of clinical and research interest involving structure is provision of booster groups (Burlingame et al., 2004). Once the acute phase of treatment has ended, it may be desirable to provide occasional booster groups to support wellness, or stated differently, to help the patient avert relapse.*

*Emerging studies suggest that maintenance individual psychotherapy promotes stability and prevents relapse in depression (Jarrett et al., 2001; Lenze et al., 2002). Whether this is also the case in the group approach would be important to discover.

The second factor in the Burlingame model considered here is patient characteristics and individual differences. Certainly these do come into play in CBT groups, most obviously based on the primary Axis I diagnosis of the patient. Extant and efficacious protocols for CBT are largely built for a single diagnostic category, and in many cases, efficacy of these approaches is established in individuals with a single Axis I disorder. However, in real-world applications of such protocols, it is likely that significant Axis I and, possibly, Axis II comorbidity and heterogeneity may occur. This may be the case even in settings where patients are selected for a group based on their *primary* diagnosis. These adaptations to a true “effectiveness” context have implications for not only the CBT protocol being used but also the group process. Particular types of diagnoses, especially on Axis II, will have important implications for each individual’s predominant interpersonal style, ability to have insight into that impact, and ability to be empathic to others. Also, patients with multiple Axis I disorders will present a different set of complaints, symptoms, affects, and thoughts compared to patients with a single Axis I disorder. Group therapists therefore need to consider the level of flexibility in their protocol and the impact of working with any single individual’s unique set of symptoms and functional impairments. A large degree of diagnostic heterogeneity can overwhelm almost any protocol, forcing therapists to invoke such a variety of techniques that group therapy begins to resemble individual CBT with 10 diverse people at once! Clearly this is not ideal from a technique or process perspective; thus, we consider many of these questions explicitly in this volume.

Beyond Axis I and II disorders lies the issue of an individual’s “suitability” for CBT. Safran and Segal (1990) pioneered an approach to suitability for CBT in individual therapy that consisted of an interview to determine the level of fit between client and the treatment modality. The 10 specific dimensions considered consisted of a number of broader factors, including abilities to describe affect, emotion, and cognition, compatibility with the rationale of CBT, a desire to engage in an active treatment, and the ability to form therapeutic relationships. The scores on this instrument have shown moderate correlations with both client and therapist ratings of success in treatment (Safran & Segal, 1990). It may be important to consider whether similar factors are useful in a group context, and potentially to add several dimensions of group process; that is, how will this particular person interact with other group members, and what interpersonal impact will he or she bring to the group experience?

Another issue regarding patient-related characteristics concerns patient motivation or potential to change in CBT group. Preparation of a patient for CBT has certainly been considered in individual treatment and may also be considered for group treatment. In individual CBT, emerging “preparatory” approaches have been based on the transtheoretical model of change and motivational interviewing (Rowa, Bieling, & Segal, 2005). Also, the traditional group approach emphasizes the importance of informing group mem-

bers about the functioning of the group, and their roles and responsibilities, but whether such preparation is necessary or useful in a more didactic group has not been well considered up to this point.

Finally, the Burlingame model places leadership at the nexus of the different group factors. In the area of leadership and leadership style, few CBT group protocols make explicit recommendations despite leadership's presumed importance in the group's experience. In the absence of that recommendation, it tends to be assumed that the interpersonal "style" of a group leader would be very similar to the approach taken in individual CBT. The prerequisites would therefore include empathy, an emphasis on collaborative empiricism, and the ability to foster guided discovery through Socratic dialogue (Beck, 1995). However, beyond these basic requirements, we postulate that leaders of CBT groups also need additional skills that arise from the unique features of the group context. Some have likened the role of the CBT group therapist to that of an orchestra conductor or film director, a person who helps control the action but is clearly not a part of the production (White, 2000). Indeed, group leaders need to be sensitive to a host of group factors, balancing attention to in-session process and affect in each member on the one hand with the need to cover the necessary material in the time available on the other. Thus, there will be times when leaders must make difficult decisions about both process and techniques. Group leaders need to consider connections between patients' experiences with one another, and especially those group interactions that foster learning. In a sense, the best leadership style is one that allows technique to be enveloped in a healthy group process, or allows process to make the techniques feel "live" through the groups' examples.

In many ways, leaders of CBT groups face challenges above and beyond those faced by leaders of more traditional group psychotherapy. Whereas the latter can devote all of their energy toward emphasizing and deepening process, CBT therapists must balance their attention to group relationships with the need to teach certain principles and associated techniques. This requires many difficult decisions throughout the group experience, and often leads to necessary compromises. Thus, there is little doubt that leadership style is an important variable in conducting a CBT group.

DEFINING "PROCESS" FOR CBT GROUPS

One of the clearest challenges that arise from any attempt to integrate the traditional group approaches with CBT is the distinction between group process and techniques. As described earlier, the notion of "process" dominates the approaches of Yalom and other group theorists. However, despite the importance of this concept in group approaches, it often lacks an operational definition; there is a tendency for the general notion of process to be attached to almost every group event. This tendency muddles and confuses the

extent to which certain theoretical frames underlie “process.” On the one hand, for example, didactic education seems more like a technique anchored in theories of learning than a process. On the other hand, recapitulation of the primary family group relies heavily on a psychodynamic formulation of psychopathology, and it too is often construed as an aspect of “process.” This lack of clarity may account for the difficulty with advancing a systematic research agenda for group theories that others have observed (Burlingame et al., 2004).

For our purposes, we distinguish between “process” and “technique” within a CBT group. The latter refers to the commonly understood learning tools and strategies by which patients are educated about their disorder, or are taught to examine their behaviors, thoughts, and feelings, and any strategy designed to change this cognitive-behavioral system. We define “process” as the interpersonal interactions among group members, and between group members and group leaders, and lay out a specific description of these factors in Chapter 2.

PROBLEMS IN CBT GROUPS

Thus far, we have focused on critical group factors and the role these factors can play in the process and learning that occurs in CBT. CBT group therapists also readily acknowledge that every group they treat is different, and that there are clear differences in how “well” groups function. This complex judgment can be based on lack of progress on outcome variables, a low rate of homework completion or, as described earlier, lack of cohesion. Some groups overcome such obstacles; homework completion is targeted with problem-solving strategies by therapists and compliance increases, or group members, with the aid of the therapists, resolve a disagreement and find common ground. When difficulties in a group occur, group factors, rather than the CBT model of intervention, are often responsible. When a group is deemed to be not going well by therapists (or members), this should trigger an examination of what factors are in play. This identification process also points to potential solutions, again, likely related to group process rather than CBT techniques per se.

Aside from specific process variables, CBT groups can function poorly due to the other factors considered here: patient factors, structure, and leadership. Perhaps the mix of patient characteristics in a particular group has impaired the ability of members to make connections with one another. In some instances, a single group member who stands apart from others on some dimension can impede the formation of cohesion in the other members. Structure factors can also impede learning of CBT skills. For example, in groups that reach a certain size (i.e., $n > 12$), leaders quickly run into difficult decisions about involving each group member and being able to “cover” the material in the protocol. Such groups risk becoming underinvolving for their mem-

bers and more didactic than experiential. Finally, group leaders may have to reexamine their approach when a group is not going well. Is the leadership style too rigid or not focused enough? Is time being effectively managed to cover material and explore group members' examples? All of these factors may need to be considered when running a CBT group, perhaps more so when the group members seem to be struggling or making no forward progress.

CONCLUSIONS

Understanding and working with group process variables can have two significant advantages. First, facilitating these factors may enhance outcome and set the stage for more change, greater levels of intra- and interpersonal learning, and a sense of lasting benefit for group members. We would argue that bringing these models of group process to the CBT context would significantly enrich a clinician's understanding of how to work effectively and optimally in a group setting. Second, awareness and attendance to such factors may help to resolve problems that inevitably arise in a group context. Optimal CBT groups involve a carefully constructed protocol that includes the critical information and exercises to support specific cognitive and behavioral techniques. But these techniques should also be embedded in a comprehensive understanding of group process factors that, in every possible sense, are constantly interacting with the delivery of techniques to influence the overall experience of the group for its members.

The rest of this book is devoted to a further, detailed exploration of these ideas. Rooted in a CBT model, we consider process, patient factors, structure, and leadership style, both generically and for specific disorders. In the remaining chapters of Part I we describe the generic techniques, interventions, and process factors that are likely common to nearly all CBT groups. Chapter 2 more explicitly explores group processes in CBT, focusing on how to marshal these process variables to enhance the group members' experiences, learning, and changes to symptoms and functioning. Chapter 3 provides an overview of specific cognitive strategies for educating patients about the importance of different levels of cognition and the consequences of cognitive processes for affect and behavior. Chapter 4 shifts the focus to behavioral strategies and how these are best communicated and illustrated in a group context. These chapters serve as foundations for the integration of techniques with the process variables introduced here. Chapter 5 focuses on issues that are not always described in specific protocols but are critical for setting the stage for a successful group. In Chapter 6 we describe common pitfalls and obstacles to running successful groups and strategies to resolve these common problems. These issues include ways to structure and lead CBT groups, and we present a number of methods for determining what type of group to conduct and possible leadership configurations.

In Part II we present protocols and methods for treating specific disorders in CBT groups, focusing on both techniques and group processes unique to that type of group. The treatments for disorders described here represent the most common types of difficulties treated with CBT, as well as disorders for which some amount of efficacy data exists. Included in Chapters 7–15, respectively, are panic disorder and agoraphobia, obsessive–compulsive disorder, social phobia, depression, bipolar disorder, eating disorders, substance abuse, personality disorder, and schizophrenia. Unlike the chapters on techniques that are common across a number of disorders, the chapters in Part II focus on techniques and interventions that are unique to a specific disorder. In addition these chapters consider the group process factors that are most critical for that specific disorder, offering troubleshooting and suggestions for optimizing outcomes.

Part III focuses on two additional areas that need to be considered in CBT group work. Co-occurrence of Axis I disorders is the norm in most tertiary care or specialized clinics. Unfortunately, extant protocols for CBT groups rarely take comorbidity into account. Chapter 16 describes the impact of comorbidity on both the application of CBT techniques and group process. Finally, Chapter 17 describes some of the unresolved issues in the clinical and research literature on Group CBT and offers some directions for future work.