second edition

Cognitive-Behavioral Therapy in Groups

Peter J. Bieling
Randi E. McCabe
Martin M. Antony

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SECOND EDITION

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For Audrey and Olivia
—P. J. B.

For Liam and Brendan
—R. E. M.

For Cynthia
—M. M. A.

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Preface

Good ideas last, but time moves on. The original idea for this book was hatched in a small favored restaurant, Bronzie's Place, almost 20 years ago. Back then we sometimes had time to go out for lunch, and that's changed. Bronzie's is still amazing, and now beloved by our growing families as the go-to place for Italian comfort food. Back then each of us was in our own way responsible for running cognitive-behavioral therapy (CBT) groups in our clinics, including training students and junior therapists, and each of us was trying to get every drop of effectiveness that we could out of what we were doing. Writing the first edition was as much an exercise for ourselves to collect wisdom from the literature as it was to share with readers, but we also found we had to contribute a degree of originality and make our own judgments. The book was well received and became part of our own teaching approach in workshops and courses. This in turn led to thoughts about further tweaks and ways to make the work flow better—to make it more cohesive, if you will. So, much like CBT group therapists looking to make groups function at the highest possible level, as authors we began to think we could have another go at an improved version of a book about CBT groups. So, here we are. The Guilford Press were enthusiastic supporters of our efforts and shaped this book for the better.

In this edition, we attempt to bridge the gap between the typical, sometimes technical, CBT protocols and the real world of clinical application. We have rewritten every chapter, not just to update the literature but to bring to life the clinical work and make the discussion more approachable. We have tried to do more distillation and synthesis of the literature. While teaching clinicians in our workshops it became clear to us that this

work is less about reviewing all possible references, including long lists of group process factors, but more about what to do when specific things happen in a group. What is the consensus? What works best? And we thought extensively about how to deliver these messages in reasonable chunks. The world is moving faster and faster, and we attempted to move with it. But the essence remains and we bring group process factors that have been written about for many decades to bear on CBT. This part of the book is the "ain't broke" part, so we tried not to fix it!

A book like this is not possible without a great team helping along the way. We gratefully acknowledge the organizational skills and editing of Duncan Cameron, who carefully went over each chapter. We also thank Kathleen Stewart and Melina Ovanessian for their assistance in updating several of the chapters. Our invited chapter authors—Jenna E. Boyd, Tahira Gulamani, Janice R. Kuo, Tania Lecomte, Emily MacKillop, Bailee Malivoire, Peter M. Monti, Tracy O'Leary Tevyaw, and Amanda A. Uliaszek—were wonderful not only in sharing their expertise in areas outside of our own but also in supporting the overall mission of the book. Jim Nageotte and Jane Keislar provided terrific feedback, as did several peer reviewers who went well beyond critique to share some excellent ideas from their own perspectives. This feedback rounded out the book and provided key clinical and academic questions that help to close this second edition. Finally, it's impossible not to mention the context and world situation as this book was being finished. Much of this work was done during the COVID-19 pandemic. This sometimes made work on it impossible, as we were "redeployed" to tasks particular to containing the virus and dealing with its consequences. In other moments, the pandemic gave us time to write when one might almost say it was actually too quiet (another lockdown!). The pandemic may have informed our work in ways that were both conscious (like the discussion of virtual groups) and unconscious. Still, what it mainly did was underline the efforts of coauthors and all the people mentioned above who got this done during such a difficult year(s).

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PART I

General Principles and Practice of Cognitive-Behavioral Therapy Groups

CHAPTER 1

Possibilities and Group Dynamics

Cognitive-behavioral therapy (CBT) is an empirically validated form of psychotherapy that has consistently been shown to be effective in over 300 meta-analyses published to date, covering myriad psychiatric disorders, ranging from depression to the anxiety disorders, and more recently to personality and psychotic disorders, among others (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012).

For the nearly half-century that CBT has been used and researched, its main form has clearly been one-on-one psychotherapy. However, in the last decade in particular, CBT has leapt from that individual, face-to-face tradition into forms and methods that are increasingly varied. These include, of course, virtual or online, peer led, dramatically shortened, and other approaches for which there is sometimes less evidence but for which the impetus is clear—broadening the spread, scale, and impact of an evidence-based treatment. In the original, now classic text on treatment of depression by Beck, Rush, Shaw, and Emery (1979), the use of a group format was described. Then, as now, the reasons were very much scale and spread: "[In group therapy,] 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). The group format may offer significant treatment advantages—such as relatability, reduction of stigma, and vicarious learning—over individual treatment (Whitfield, 2010), and there may also be overall financial savings for the health care system when a group format is used (Tucker & Oei, 2007), depending on the disorder. The efficacy of group CBT has also been studied and reviewed, and in the subsequent chapters on specific problems, we summarize this work. What emerges

though is solid evidence of efficacy, without which the efficiency factor would be moot.

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 anxiety disorder (SAD) 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. Group CBT for social anxiety 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. All considered together, the efficiency, efficacy, and appropriateness dimensions to group CBT have contributed to a burgeoning field of study and clinical writing—of which this book is a part.

And yet, 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 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. In our view, not enough 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 each other, 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. Training group therapists with extant protocols, handbooks, and other technique resources offers dozens of examples of important quandaries 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 the 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. Indeed, a consideration of group process should not suggest a choice between expending 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 book 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 troubleshooting guides, integrating both techniques and the process of applying those techniques in real-world settings.

Put simply, our aim in this book is to integrate group process factors and CBT techniques. 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 above, and that focusing on such integration helps 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. There is little question that, historically at least, the group psychotherapy movement had strong psychodynamic roots and tended to eschew the scientific method. But the essence of that movement was that the group itself was the intervention, and much was written about the group process. 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).

Certainly, this process-based theoretical foundation is a stark contrast to the CBT model and group approach. In group CBT, the collection of individuals is simply the vehicle by which the techniques are delivered. 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 Irvin 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.

Yalom's Group Factors

Yalom (1995) describes nine relevant therapeutic factors (presented in Table 1.1) that groups offer, and how each of these can be fostered in the group environment to produce change. Each factor 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 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. Table 1.1 briefly describes each of these nine process factors, both as they are traditionally defined and how they might be recast within a CBT framework.

Burlingame, MacKenzie, and Strauss's Group Model

Burlingame et al. (2004) 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. 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. The second critical component in the model, the principles of small-group process, corresponds in many ways with the processes described by Yalom, essentially the various interpersonal

TABLE 1.1. Yalom's Group Factors

Factor label	Description	In CBT groups
Instillation of hope	• Necessary ingredient in all psychotherapies. • Important to reinforce directly the potency of group approach; to emphasize positive outcomes of other groups. • Includes narratives of "overcoming."	• Enhanced by presentation of successful case examples. • Tied to imparting information—positive education provides hope. • Consistently emphasize possibility for positive change within group.
Universality	• Realizing that others suffer from similar difficulties. • Can be unique to each group; differs for each disorder. • Members may experience relief to know they are not alone in their suffering.	• Might be the first time one sufferer has ever met another. • Demonstrates that people of different backgrounds can suffer from the same problems. • Recognition and belonging can be essential foundation for cohesion.
Imparting information	• *Didactic instruction* (e.g., psychoeducation, forming a treatment plan, description of treatment techniques) can help a client understand why and how problems came to exist. • *Direct advice* can be from a therapist or group member, with emphasis on the process of advice giving, rather than specific content.	• Present participants with model of disorder, or information about CBT. • Psychoeducation and change strategies (e.g., discuss biopsychosocial model of depression, where change in one system can affect change in another; Greenberger & Padesky, 2016).
Altruism	• The opportunity for group members to help one another in treatment. • Recipient of advice obtains helpful information; person giving advice benefits from helping another. • Group members learn they can make valuable contributions and have much to offer.	• Employ Socratic dialogue—sharing example of one group member offers opportunity for that person to gain multiple perspectives, while those giving feedback feel they are making a valuable contribution. • Encourage in early group sessions.
Corrective recapitulation of the primary family group and interpersonal learning	• Based on attachment theory—the interpersonal patterns of each member will emerge and interact. • Can cause strife between members with problematic interpersonal styles, disrupting group but creating opportunity for learning. • Group leaders may have to mollify traits, such as dependency or mistrust, but corrective aspects are also provided by group members. • More affect involved in behavior change leads to more potent experience.	• Strategies concerning core beliefs can involve examination of origins of such beliefs. • Aid understanding of how beliefs were learned, not to reexperience or reinterpret. • Interpersonal experiences in personal life are often reflected within the group—self-defeating beliefs should be targeted to not affect learning in therapy.

(continued)

TABLE 1.1. *(continued)*

Factor label	Description	In CBT groups
Development of socializing techniques	• May be implicit or through direct exercises (e.g., role playing). • Group setting offers opportunity to try new behaviors and get direct feedback.	• Embodies practice of many interpersonal behaviors, such as assertiveness, social interaction, engaging in exposures, offering input, or discussing homework examples.
Imitative behaviors	• Learning by observing other models of behavior. • Can include group leaders and other group members. • Important source of information about interpersonal strategies.	• Encourage members to be positive about one another's successes. • Seeing one person succeed offers model for success to all members. • Positive discussion of homework provides incentive to imitate homework completion.
Group cohesiveness	• The attraction members have for the group and one another. • Acceptance, support, and trust akin to unconditional positive regard in individual therapy. • Affects most other interpersonal aspects of group process. • Among most studied aspects of group process.	• Includes therapists and group members. • Better cohesion increases probability of important self-disclosures. • High dropout, lack of progress toward goals, or conflict between members can result in low cohesion.
Catharsis	• Broadly, any act of unburdening or sharing something previously unsaid. • Necessary but not sufficient for positive outcomes. • Group response or feedback to cathartic event is equally important.	• Important for modification of problems, but not to be considered a resolution of them. • Group should encourage sharing of private information, even if not the end goal of therapy.

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 client, in terms of not only their specific disorder but also personal and interpersonal characteristics. 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.

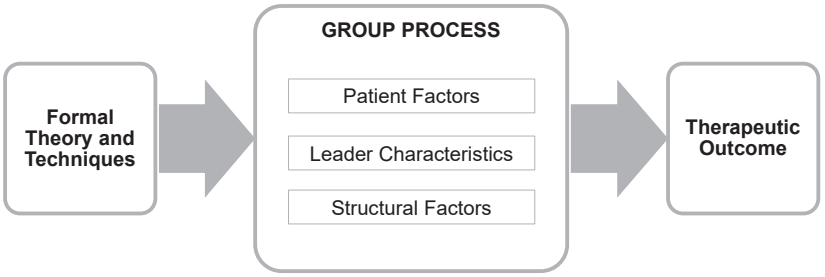

FIGURE 1.1. Forces that govern the therapeutic outcomes of group psychology. Based on Burlingame, Strauss, and Joyce (2013).

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. 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, Fuhriman, & Johnson, 2002).

Applicability of Traditional Group Factors in CBT Groups

We take the view that many of the factors we described can be adapted or are readily evident within CBT groups, even though few writers have explicitly focused on both group process and CBT. Keeping in mind the Yalom factors, and especially how these can be conceived of in CBT terms (see Table 1.1) and with the Burlingame et al. (2004) model, we next attempt an integration of these various models to arrive at a CBT-specific group process approach.

As a careful reading of Table 1.1 shows, a number Yalom's (1995) factors are complementary and the presence of one often aids in the fostering of others. Offering *instillation of hope* in the early sessions of therapy provides a positive environment for learning and can encourage greater attendance, participation, and homework completion. Instilling hope requires *imparting information,* which is also a necessary component both from group leaders and members throughout all sessions, and can take the form of psychoeducation, sharing homework examples, or providing feedback on homework.

Also essential to the creation of a productive group atmosphere is the concept of *universality*. The realization that group members are suffering from similar problems creates a sense of belonging, which can be useful in setting the state for the introduction of other CBT strategies later in treatment. Eventually, group members will have many opportunities to express *altruism* whenever one of these strategies is introduced, and as the group works through various behavioral strategies, *socializing techniques* and *imitative behavior* become increasingly important.

Although not as frequently thought to be essential to CBT, *corrective recapitulation of the primary family group* can arise through strategies concerning core beliefs by examining their origins to understand how they were learned, and the group environment should encourage sharing of such examples. The emphasis on sharing and interpersonal learning should not exclude *catharsis*, but the implementation of this factor in CBT should be a step toward the modification of problems, rather than as the ultimate goal of therapy.

Finally, it is apparent that each of these factors plays a vital role in *group cohesion*. When group members have an affinity and high regard for one another, they are more likely to accept one another throughout the therapy process. Cohesion is not static and must be monitored throughout all sessions.

The approach advocated by Burlingame and colleagues (2004) adds three factors not considered explicitly by Yalom: the structure of the group context, client 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.

The second factor in the Burlingame model considered in this book is client characteristics and individual differences. Certainly these do come into play in CBT groups, most obviously based on the primary diagnosis of the client. 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 disorder. However, in real-world applications of such protocols, comorbidity is often the norm. Particular types of diagnoses, including personality disorders and features of these

disorders, 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, clients with multiple disorders present a different set of complaints, symptoms, affects, and thoughts compared to clients with a single 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.

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). In fact, some studies have found that while leader support is an important predictor of group outcomes, too much leader support can also lead to unfavorable outcomes (Oei & Browne, 2006). 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 clients' 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 the process to make the techniques feel "live" through the groups' examples.

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."

For our purposes, we distinguish as clearly as we can between process and technique within a CBT group. The latter refers to the commonly understood learning tools and strategies by which clients 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 next.

We posit that therapeutic outcome in a CBT group is determined by both the formal CBT strategies and the small-group process present in the group context. The group leader plays a pivotal role in determining whether the treatment proceeds essentially as individual therapy within a group setting or from the perspective of enhancing the CBT by recognizing and building on group process factors.

Defining Group Process within a CBT Framework

Becoming even more precise, we put forth a definition of group process that aims to operationalize the variables involved. Group process is the set of factors that arise from conducting therapy within a group setting. Factors that we considered in our definition of process in CBT groups include the following:

- The effects of group members' symptoms on one another.
- The effects of group members' personality styles on one another.
- The effects of improvement/worsening in one group member on the others.
- The ways in which group members interact with one another.
- The therapeutic relationship between the therapist and group (e.g., whether they like and trust one another).
- The therapeutic relationship among group members (e.g., whether they like and trust one another).
- The therapeutic relationship between cotherapists (if cotherapist is present).
- The effects of dropout and absenteeism on the group.
- The effect of individual variables on the group:
  - Client expectations
  - Client satisfaction with treatment
  - Client variables that predict outcome
  - Client suitability for group treatment
- Group mechanisms of change:
  - Inspiration
  - Inclusion

- Group learning
- Shifting self-focus
- Group cohesiveness
- Emotional processing in the group setting

We suggest in this book that these factors interact with the delivery of the specific cognitive-behavioral intervention to influence treatment outcome. Next, we recast the relevant aspects of group process in CBT terms, followed by appropriate examples and sample dialogues that illustrate this factor in action.

Optimism

Positive expectations and associated feelings of hopefulness toward recovery are related to better therapeutic outcome—the group setting offers unique opportunities to kindle positive feedback among members. Initially, the therapists provide motivation by discussing the effectiveness of the group approach—from actual group data or the research literature. In early sessions, group leaders can exemplify positive reinforcement when discussing homework or in-session practice of strategies, attendance, progress toward goals (e.g., using an exposure hierarchy), and by encouraging member engagement. As treatment progresses, more and more of this positive feedback is typically provided from one group member to another, based on modeling done by therapists in the initial phases of treatment. For example:

THERAPIST: Let's go around and hear what each group member has planned for exposure practice this week. Also, let us know where your exposure practice ranks in terms of your exposure hierarchy and ratings.

TONY: I am planning to drive to the city. It is number 3 on my list. My anxiety rating is 70 and my avoidance rating is 85.

THERAPIST: Looking back to just before you started group, what were your ratings like?

TONY: My anxiety rating was 95 and my avoidance was 100. That has come down a lot. Before I started this group, I would never have driven to the city.

THERAPIST: What do people think about the progress Tony has made?

POLLY: I think it is wonderful. I can see that others have already made changes and it has only been four sessions. It makes me more hopeful that this treatment will work for me too.

In this example, the therapist has used exposure hierarchy ratings to highlight Tony's progress, both for him and for other group members.

Inclusion

In the group setting, clients realize that they are not in isolation with their problem—rather, group members have been included in the group for the very fact that they have a shared problem. The CBT therapist can promote a group member's feelings of inclusion by drawing links between the client's symptoms and experiences, and promoting dialogue among group members on their feelings about having a specific disorder and their attempts to overcome it. For example:

THERAPIST: Now that we have gone around and heard from group members about their symptoms and experiences, we can see that although each person has a unique experience, there are certain similarities that you all share. What do people think or feel about what they have heard?

RON: I feel a great sense of relief. I have been struggling with this anxiety for so long, and I always thought I was alone in this.

KATIE: I have to say I feel like you are all actors, because what you have said is so much exactly like what I have been living with, it is hard to believe that you haven't been planted here to say exactly what I have been experiencing.

GROUP: (*Silence.*)

THERAPIST: What about for others?

POLLY: It is nice to feel that I am not alone in this, but I do worry that hearing about other people's anxiety might make mine worse.

THERAPIST: I am glad you shared that, Polly. Although people may find that their anxiety does increase as we start to work on it directly in therapy, our data tell us that it is exceptionally rare for us to have a group member actually get worse. You have raised a normal concern that is good for us to talk about.

In this example, we can see that checking group members' thoughts and feelings in the here and now is important for not only helping them build a sense that they are not alone but also in giving each group member an opportunity to process doubts that may have interfered with their therapeutic progress.

Group-Based Learning

Learning through the group can happen through a number of pathways, including didactic means by the therapist, advice and feedback received from other group members, and observational learning of both the therapists and group members. Psychoeducation is a cornerstone of CBT, but

so is experiential, problem-based learning. In the group setting, the CBT therapist should present material in an interactive way that encourages active participation by group members. If a whiteboard or screen is used to present models or information, the CBT therapist should use Socratic questioning to help group members discover new information or provide examples to individualize the model to their own unique experiences. In terms of advice and feedback from other group members, the CBT therapist can facilitate provision of feedback and advice so that it is given in a helpful way, ideally through guided discovery between group members. CBT therapists can encourage modeling behavior in the group setting through therapist- and group member-assisted exposure, role plays, and sharing of strategies and approaches to problem solving among group members. For example:

> KATIE: I didn't do very well this week. I was able to go to the grocery store, but I wasn't able to go alone. I took my daughter with me. I got very anxious in the store but was able to stay there until my anxiety came down. I am kind of disappointed that I wasn't able to do it by myself.
>
> THERAPIST: What do people think about how Katie did this week?
>
> RON: Even though you took your daughter with you, it is still a major accomplishment that you went and stayed.
>
> POLLY: I agree, even though you felt anxious, you stayed. It seems like you are focusing on the negative—what you wanted to do but couldn't—and not on what you actually did.
>
> THERAPIST: Katie, what do you think about what people are saying?
>
> KATIE: It is helpful to have that perspective; it's true that I need to focus on what I did do. I was focusing on the negatives, and that really brings my confidence down. I feel better about what I was able to do this week.

In this example, the therapist uses the group to provide feedback, giving Katie a different perspective. As a result, Katie has learned to evaluate her progress in a more evenhanded fashion. Using the group in this way is a more powerful way to learn, because the group provides the key ingredients of the "lesson," which is likely to be more meaningful and persuasive than if the therapist alone had emphasized that same point.

Shifting Self-Focus

The benefit of being able to help other group members is an important aspect of the group experience. In addition, the group provides an atmosphere that

shifts the focus from the self to focus on other group members and on the group itself. CBT therapists can promote this shift by facilitating group members in providing support, giving reassurance, and sharing strategies with the group. In a sense, support provided to others reflects back, benefiting each individual. For example:

> TONY: I found that I was so stressed at work this week I felt too anxious to do the exposures I had planned. I was worried that if I did them, I would really have a bad week.
>
> THERAPIST: Do others find that you are worried about doing exposures when you're already stressed or not feeling well, and if so, how do you manage?
>
> POLLY: I can totally relate. I just tell myself that whether I do the exposure or not, I am going to feel anxious. At least if I do it, then I know that I will feel much better afterward.
>
> TONY: That is true. I did feel even worse that I didn't do the homework I had planned, and I felt anxious anyway.
>
> RON: Tony, is there a way that you can cut back on your stress at work so that you have more time to work on your exposures? I know, for me, I need to save some energy for doing the homework, so I've rearranged some other things until after the group.
>
> TONY: You're right. I probably need to do the same thing.

In this example, we not only see that Tony benefits from the input of group members but also that the group members are able to derive a sense of effectiveness from being able to help a fellow group member.

Modification of Maladaptive Relational Patterns

The group provides a corrective social learning experience for maladaptive interpersonal patterns that have developed through early experiences. As Yalom (1995) noted, the group represents a social microcosm, in that group members interact with one another the way they would interact with others in the external world. The CBT therapist can facilitate awareness of interpersonal patterns and the effect that a group member's style may have on other group members. The therapist can then elicit feedback, modify maladaptive appraisals, and encourage different ways of behaving that may be more adaptive or in line with personal goals and values.

Group Cohesiveness

"Group cohesiveness" may be defined as the conditions that hold group members within the group (e.g., feelings of comfort and belonging, valuing

the group, and unconditional acceptance by other group members; Bloch & Crouch, 1985) and is the most heavily studied relationship construct in group therapy (Burlingame, McClendon, & Alonso, 2011).

The CBT group therapist can use a number of strategies to increase cohesiveness, including:

- Increase homogeneity of the group in pregroup selection.
- Encourage consistent attendance.
- Provide a safe environment for self-disclosure, largely through modeling of acceptance, empathy, and helpful feedback.
- Promote sharing of information.
- Make connections between two or more group members' experiences.
- Attend to group process in the here and now.

Emotional Processing in the Group Setting

The group setting promotes open expression and processing of emotion. By balancing the agenda of each group session with processing thoughts and feelings among the group members in the here and now, the CBT group therapist can promote expression and processing of feelings in a way that is in line with the goals of the group. In addition, processing in the here and now may help to elicit important automatic thoughts, assumptions, beliefs, and behaviors that become a target for intervention. In the example that follows, the therapist is introducing the concept of cognitive distortions when she notices that a group member is doodling on a paper in front of him and appears disengaged. The other group members appear interested and attentive. It may be that some members of the group have also noticed the disengaged member. Instead of continuing with the discussion of cognitive distortions in the group, the therapist shifts to the here and now to process what is happening.

THERAPIST: Before we go on to talk about examples each of you may have, I just want to check in with the group. Tony, I noticed that you seem distracted. Can you tell us what is going on for you?

TONY: Nothing.

THERAPIST: Oh. How does what we were covering fit for you?

TONY: Well, I am just feeling like it doesn't fit. I'm discouraged because I don't think this therapy will help me. It seems like a lot of work, and I don't see how it can ever make this anxiety go away.

THERAPIST: Does anyone else ever feel discouraged about overcoming their anxiety?

POLLY: (*Nods her head.*)

KATIE: Yes, I sometimes feel that way too.

THERAPIST: What do you do to stay hopeful, Katie?

KATIE: I just try to keep an open mind. I mean, what do I have to lose by trying this treatment? If I don't try, then how will I ever get rid of this anxiety?

THERAPIST: Tony, what is it like for you to know that other people also feel discouraged sometimes?

TONY: Well, I guess it makes me feel more normal. Maybe I can give this a try. Katie's right. I really don't have anything to lose, because my life has already been ruined by this anxiety.

In this example, the therapist has shifted from introducing a CBT concept to processing a group member's feelings about the treatment in the here and now. The therapist has both refocused and validated the individual by drawing support from the entire group. As a result of this intervention, group cohesion has likely increased; group members have been invited to support one another and have also learned that their therapist is responsive to their emotional state and not just solely interested in teaching strategies. The therapist was also able to elicit the discouraged group member's automatic thoughts about treatment ("Treatment will not work"), as well as his beliefs about the future ("This anxiety will never go away"). They have now accessed "live" material that can be used to illustrate the concepts that were introduced in the session as part of the agenda (cognitive distortions).

In this section, we attempted to capture the major factors representing mechanisms of change unique to group therapy from a CBT perspective. These are summarized and operationally defined in Table 1.2. Whether we have been over- or underinclusive in our attempt is an empirical question, and one that we hope will be a focus of future inquiry. In any case, the purpose and goals of the group determine the therapeutic factors that may be a focus of attention. In any single group, there may be certain factors at the forefront. It is up to the CBT group therapist to identify those factors that are operating and to then work with these processes in parallel with the CBT-specific group agenda.

Attending to Group Process within a CBT Structure

It is helpful to think of these same group process factors within the technique-specific structure of CBT group therapy sessions. The structure of these sessions often includes the following components: homework review, presentation of new information, practicing skills (e.g., examples, role play, exposure), and planning homework for the week.

TABLE 1.2. Group Process Factors: Mechanisms of Change from a CBT Perspective

Process factor	Description	Therapeutic strategy
Optimism	The group provides an atmosphere that promotes an optimistic, hopeful outlook on overcoming the problem, as well as motivational activation.	• Provide data on effectiveness of approach. • Provide positive reinforcement of group participation. • Facilitate group members to provide positive reinforcement of other group members. • Highlight improvement and progress. • Use group members' experience to promote positive expectations. • Utilize the group to promote cognitive shifts in expectations.
Inclusion	The group raises awareness of a shared problem and provides a sense of belonging and reduced isolation.	• Link group members' symptoms and experiences. • Promote dialogue among the group members about having the specific problem and attempts toward recovery.
Group-based learning	The group provides an opportunity for learning on a number of levels.	• Provide psychoeducation in an interactive manner. • Use Socratic technique to help group members to discover new information. • Facilitate provision of feedback and advice from other group members. • Use group to provide a range of perspectives and appraisals. • Utilize therapist- and group member-assisted exposure and role plays.
Shifting self-focus	The group promotes helping of other group members, shifting emphasis from the individual to the group.	• Facilitate group members to provide support, share information and strategies, and give reassurance.
Modification of maladaptive relational patterns	The group provides a corrective learning experience for maladaptive interpersonal interactions.	• Facilitate awareness of interpersonal patterns and the effect one has on other group members. • Focus on current interactions in the group. • Elicit feedback. • Modify maladaptive appraisals. • Encourage alternative ways of behaving. • Utilize specific CBT techniques to facilitate corrective experience: exposure, role play, identification of appraisals and core beliefs.

(continued)

TABLE 1.2. *(continued)*

Process factor	Description	Therapeutic strategy
Group cohesiveness	The attractiveness of a group to its members facilitates cognitive and behavioral change.	• Encourage consistent attendance and commitment to group. • Promote a safe environment for self-disclosure. • Promote sharing of information. • Make connections among group members' experiences, thoughts, and feelings. • Attend to other group process factors in the here and now.
Emotional processing in the group setting	The group provides a place for open expression and working through of emotions, thoughts, and behaviors, allowing for the identification of therapeutic targets for intervention.	• Encourage expression of feelings in real time. • Examine feelings associated with specific thoughts and courses of action. • Encourage processing among the group members.

Homework Review

Homework review is an important part of each CBT group therapy session in which group members relate their experiences practicing the skills or strategies that they learned from the previous session. This is an opportunity to reinforce CBT principles, provide encouragement and positive feedback, and problem solve obstacles or challenges that may have gotten in the way.

In CBT group therapy where there is an inattention to group process, the homework review looks like individual therapy moving along a circle as each group member reviews their week and how the homework went. Often, this can take up to 5 or 10 minutes per group member, with the therapist and cotherapist asking questions of each person. If one were to look around the group during such an instance, one would likely see that some of the other group members have "zoned out," are doodling on a paper, looking out the window or at their phone, or generally appear "disengaged" from what is going on within the group. Such an approach casts an explicit and implicit spotlight on one group member, literally excluding all of the others. Consider the two examples that follow:

Lack of Attention to Group Process

THERAPIST: Who would like to tell us how their week went with the homework?

GROUP: (*Silence.*)

THERAPIST: Katie, would you like to fill us in on how things went for you?

KATIE: Sure, I guess. This week went pretty good. I found that I tried to stay in some situations that usually I wouldn't, so that I could experience some anxiety.

THERAPIST: That's great! Can you tell us about one of those situations?

KATIE: Well, I went to the grocery store, and when I got anxious I stayed where I was and kept going down the aisle even though I felt like bolting. I took a basket instead of a cart, so I was feeling really nervous, because usually I feel less anxious with a cart.

THERAPIST: Why is that?

KATIE: Well, if I have the cart, then I feel safer, like if I get nervous, I will have something to hold on to.

COTHERAPIST: That is really good, Katie. It sounds like you really challenged yourself, so that you could experience some anxiety. Who would like to go next?

Attention to Group Process

THERAPIST: Who would like to tell us how their week went with the homework?

GROUP: (*Silence.*)

THERAPIST: Katie, would you like to fill us in on how things went for you?

KATIE: Sure, I guess. This week went pretty good. I found that I tried to stay in some situations that usually I wouldn't, so that I could experience some anxiety.

THERAPIST: (*Nods head.*)

KATIE: Well, I went to the grocery store, and when I got anxious, I stayed where I was and kept going down the aisle even though I felt like bolting. I took a basket instead of a cart, so I was feeling really nervous, because usually I feel less anxious with a cart.

THERAPIST: That's great! Did anyone else find that they had to challenge themselves a bit so that they experienced some anxiety?

RON: Yes, I let my wife drive when we went out, which triggered quite a bit of anxiety, as I usually like to be in control and be in charge of driving.

THERAPIST: That's excellent, Ron. Polly, I saw that you were also nodding your head.

POLLY: I had a very similar experience to Katie. I went to a store by myself. Usually I take my children, which makes me less anxious.

COTHERAPIST: That is interesting, Polly. It sounds like both you and Katie practiced eliminating a safety behavior so that you would experience some anxiety. Katie, what happened when you were at the store without your cart?

KATIE: Well, I did get quite anxious, because I had nothing to hold on to if I felt lightheaded. I kept going down the aisle even though I felt like bolting.

THERAPIST: That is really great. Who would like to go next?

With either of these approaches, the therapist reviews homework and how the week went. In the first approach, the therapist's style is efficient and gets the job done. However, the lack of attention to group process fails to marshal the power inherent in the group. In the first example, group members assume that they are not part of the interaction and therefore will not learn anything, while in the second example, group cohesion is built by highlighting similarities among members' experiences. This keeps the other group members engaged and interested. These participants are likely to learn, over time, that homework review is relevant for the entire group, and that they can learn from similarities and differences between themselves and others, even when they are not being questioned directly themselves.

Presenting New Information

Often, a portion of the group session is focused on the presentation of new information, whether this is psychoeducational in nature or laying the groundwork for learning a new strategy or skill. In CBT group therapy where there is a lack of attention to group process, this portion of the session often resembles what takes place in a classroom. In that scenario, the therapist and cotherapist are the teachers working on a blackboard and the group members are the students. Typically, the therapists actively present the new information and the group members absorb it passively. In contrast, when there is a focus on group process, the therapist and cotherapist present new information in a more interactive style whereby material is solicited from the group and then processed within the group. Consider the following two examples:

Lack of Attention to Group Process

THERAPIST: Today we are going to talk about our thoughts and how they can be distorted. People with anxiety tend to distort their thoughts by overestimating the probability of a bad thing happening and underestimating their ability to cope. They also tend to think that these scary outcomes will be much worse than they realistically are. This first type of distortion is called probability

overestimation. The second type of distortion is called catastrophizing. Does that make sense to people?

GROUP: (*Members nod their heads.*)

THERAPIST: Okay, does anyone have any questions or thoughts about these two types of distortions?

GROUP: (*Silence.*)

THERAPIST: Okay, why don't we all look at your homework and see if any of your thoughts would be good examples of probability overestimation or catastrophizing.

Attention to Group Process

THERAPIST: Okay, today we are going to talk about our thoughts and how they can be distorted. When you think about the word *distortion,* what do you think it means?

TONY: It means that it is shifted from the truth.

THERAPIST: Exactly. We all see things in our own way, which is often a distortion from the way things really are. Can anybody think of an example of this?

POLLY: In my family, my brother always thinks that he does all the work around the house but really he doesn't. His thoughts are obviously distorted! (*Group members laugh.*)

COTHERAPIST: That is a great example! Now let's think about when you all are feeling anxious. How are your thoughts distorted?

RON: I tend to be focusing on the "what ifs"—like, what if I have a heart attack? What if this numbness down my arm is a sign that I am going to die? Maybe I should go to the hospital.

THERAPIST: And why are those thought distortions, Ron?

RON: Because I always have them but nothing ever happens.

COTHERAPIST: That is a nice example. So it sounds like, based on your own experience, you have felt these physical sensations many times but nothing bad has ever happened. However, every time you have them, you focus not on what is realistically likely but rather on the potential danger.

RON: Exactly.

THERAPIST: Do other people find that they tend to do that as well?

GROUP: (*Members nod.*)

THERAPIST: Okay, we actually have names for the types of anxiety distortions that people with anxiety tend to make. The first one is called probability overestimation. Who wants to guess what that is?

POLLY: Well, that sounds like what Ron was describing. Overestimating the chances of a bad thing happening. I do that when I think I am going to pass out every time I am anxious, even though I never have.

THERAPIST: Exactly. That is a good example too. The second type of distortion that anxious people tend to make is catastrophizing. Who can guess what that is?

KATIE: Well, I guess it is like it sounds—thinking that something is a catastrophe.

COTHERAPIST: Exactly. And what does that mean?

KATIE: Well, thinking it is worse than it really is?

THERAPIST: Can anyone think of an example for this?

TONY: Yeah. I think that when I am anxious, people will notice and it will be awful.

THERAPIST: Right. When you are anxious, it feels really horrible and people may notice. But is it really a big deal if people notice?

TONY: Not when I really think about it. In fact, even though I worry about people noticing, I am not even sure if people really can tell when I am anxious.

By focusing on group process and presenting the new material in a more interactive manner in the second example, the group is more engaged and participative in the process of learning the information rather than absorbing it passively. Both approaches have the therapist asking at least some Socratic questions, but in the second example, the questions are much simpler and phrased in an open-ended manner, so that many more people are likely to contribute. The therapists also carefully build the information from multiple perspectives, doing a much better job of guided discovery. In the second example, the therapists are far more likely to hold the attention of the group members and have group members looking for opportunities to contribute to the dialogue.

Practicing Skills/Exposure

After group members practice new skills, exposures, or role plays in the group, it is important to process the experience with the group as a whole before moving on in the session. Therapists should focus on members' thoughts and feelings about the experience and try to make connections between group members' experiences. This helps build group cohesion and also provides important feedback. Consider the following example, which took place in a therapy session after the group returned from doing exposures at a shopping mall:

THERAPIST: How do people feel about how the exposures went?

TONY: I feel good about it. Although I was anxious taking the bus on the way down, I felt less anxious on the way back.

THERAPIST: That is great. (*Looks around at the group.*)

RON: I had a different experience. Although I was anxious about going to the mall, when I got there I wasn't really anxious at all. My anticipatory anxiety was much worse than the actual situation.

COTHERAPIST: That is interesting. Did other people find that?

POLLY: Yes, although I was really anxious when we were walking around the mall, it wasn't as bad as I thought it would be before we got there.

THERAPIST: What about for you, Katie?

KATIE: Well, I am not doing as well as everyone else. I felt anxious the whole time.

THERAPIST: What do other people think about Katie not doing as well as everyone else?

TONY: Katie, you did a good job just even going. It was really hard for me too, when I did this for the first time a couple of weeks ago. We are all at different stages. I think it will go better for you next time.

COTHERAPIST: That brings up a great point. Often in the group people tend to compare themselves to how others are doing. It is important to remember that everyone is starting at a different place and will be working at a different pace.

In this example, it is clear that if the activities were not discussed in the group, Katie would have gone home feeling that she was not progressing as well as everyone else. This could also make her vulnerable to dropping out. In addition, having a group member tell Katie that she was doing a good job is much more powerful than if the therapist had told her. Processing CBT exercises in the group context enables other group members to provide feedback, help one another, and learn from one another's experiences.

Planning Homework

Homework can also be planned with attention to group process. Instead of having each member go around and plan their homework with the therapist, group members can be involved to help think of potential homework practices and problem solve potential obstacles. This helps keep the group engaged in the process and uses the group to its potential. It also serves to increase the motivation of group members when they return to group

the following week, because they know that the other group members are interested in how things went.

Therapeutic Strategies within Session and Across Treatment

The previous examples reveal a number of interventions and strategies that the group therapist can use to conduct CBT effectively, while also paying attention to and using group process. Other issues of process that need to be attended to in a CBT group to maximize the potency of the group experience include the following:

- Achieving a balance between group members and therapists in terms of "air time."
- Ensuring that each group member receives a similar amount of attention from the group.
- Achieving a balance between focusing on the individual, particularly during guided discovery, and taking issues back to the group for general feedback.
- Managing group members who miss sessions and processing the effect this may have on the group.
- Addressing the fact of "dropouts" in a group and the effect this has on the group's sense of cohesion.
- Balancing interaction between cotherapists and supporting each other's interventions.
- Balancing working on specific skills/agendas and group members' thoughts/feelings in the here and now.
- Processing progress in the group (how members feel about being in the group, particularly at the start of treatment, how treatment is going, etc.).
- Allowing group members to provide feedback or answer questions posed to the therapist.
- Using Socratic questioning and interactive methods to present new information and elicit relevant material from group members.

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. 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, and these chapters serve as foundations for the integration of techniques with the process variables introduced here. 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.

CHAPTER 2

Structure, Process, and Challenges in CBT Groups

The delivery of group CBT involves many details related to client selection and therapist stance and style, as well as within-session and between-session structure; considerable energy must go into the planning and organization of CBT to achieve maximum efficiency and clinical effectiveness. Therapists who move from working with individuals to a group format are often surprised to discover the number of factors that are introduced when therapy relies on the presence of more than two individuals for a therapy hour. Gathering a group of people in one time and place for regularly scheduled meetings for the length of a treatment protocol may seem like an easy task, but it actually requires that many specific elements work in concert. This chapter aims to cover this territory and provide information about some of the basic underpinnings of any CBT group. Time spent in thinking through these issues carefully before conducting any group pays dividends; when structural issues are not planned or anticipated well, these components can distract from or even undermine the delivery of the treatment.

We describe four factors that are critical to the organization and structure of CBT groups: client selection, therapist factors, between-session structure, and within-session structure. There are certainly other concrete considerations to running groups: physical space, scheduling of groups, clinical documentation, outcome measurement, and approaches to treatment noncompliance or dropouts that are not considered here. These issues vary widely from one clinical setting and problem focus to another, but they are still important details to be considered. A room that is too small (or too

large) for the number of occupants, lack of client handouts when needed, follow-up with clients who do not attend sessions, and client scheduling problems (e.g., a client needs to leave a group because child care arrangements fall through) can all impact significantly on the group experience for therapists and clients.

Furthermore, the onset of the global COVID-19 pandemic in 2020 necessitated a rapid shift to providing mental health care in a virtual setting. The provision of virtual groups brings with it a host of issues that therapists must consider. (The last section of this chapter is focused on discussion of these issues.)

And yet, the four factors we highlight in this chapter will consistently be of critical importance to a group's success. The four themes are also reiterated in Part II of this book where specific presenting problems and disorders are described—each of these chapters has a similar pattern, for the most part, following this outline:

- Description and features of the problem or disorder
- Evidence-based treatment of the problem or disorder
- Assessment and eligibility for group CBT for the problem or disorder
- Structuring group CBT for the problem or disorder
- Key treatment components for the problem or disorder
- Sample CBT group protocol for the problem or disorder
- Group process factors in CBT for the problem or disorder
- Conclusions

Client Selection

As in any psychotherapy pursuit, accurate and complete diagnosis using a *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or International Classification of Diseases (ICD) framework is likely to be useful prior to any CBT group. That said, there are settings where this is not an immutable law, settings where clients self-select (e.g., a group on problematic perfectionism), or where diagnosis may matter but not be determining for group participation (e.g., a CBT group in a hospital setting, with a variety of diagnoses represented). Where possible, it is also desirable to have a group suitability interview. Suitability interviewing provides an assessment that is not only useful in making treatment decisions but may also have the added benefit of enhancing a client's readiness for a brief, focused treatment, such as CBT.

Such interviews need not be exhaustive, and indeed we are not aware of any high-quality evidence that one type of screening tool produces uniquely positive results. Useful questions for therapists to ask themselves about potential group members include the following:

1. "What kind of relationships will this person wish to form with other group members?"
2. "What kinds of interpersonal behaviors of this person will support group cohesion and process?"
3. "What kinds of interpersonal behaviors have the potential to undermine group cohesion and process?"

It may also be useful to contemplate commonly used techniques, such as thought record work or behavioral activation, and consider how the individual might interact with other group members working collaboratively on their own examples and examples offered by other participants.

In terms of "fit" with the CBT model, ideally the model of intervention resonates with the client. For example, clients who are ready and willing to make changes in their "normal" means of coping or dealing with their difficulties are more likely to respond to suggestions made in group. Clients with an exclusively biological view of their difficulties, or those who believe it is imperative to focus on insights about their early life, will not be well served in a CBT group. Similarly, clients who take little responsibility for helping themselves with their problems may not be successful in a CBT group. On the other hand, suitable clients tend to more readily understand the CBT model and have less difficulty seeing how the model fits them. Such clients may, with little or no prompting, fit their particular difficulties with the generic model described in the interview.

Therapists can discover clients' level of compatibility with the CBT approach in suitability interviewing by discussing sample techniques, such as thought records or behavioral exposures. Although it cannot be assumed that clients will completely understand these procedures, their desire to learn more, or their level of acceptance of these interventions, can be important indicators. At a more practical level, clients need to be informed about the expectations for the group, including duration, length of sessions, nature of the group process itself, and the need for homework. Clients who know what the group involves, and who state a commitment to those expectations, are less likely to drop out of treatment later.

Client Demographics

In addition to diagnostic and suitability variables, the group modality also requires that consideration be given to other client factors, including age, culture, language, and gender. There are no universal rules for dealing with these issues; some types of problems and settings might lend themselves to more or less heterogeneity. For example, a CBT group for performance anxiety in a college counseling center will draw from a more homogeneous group than an inpatient CBT program for depression. This leads to a natural question: Is it preferable for group members to share features such as age and gender? In general, we advocate for not only allowing but indeed

selecting for some amount of heterogeneity in group members, although with some limits. At the outset of a group, heterogeneity can sometimes be seen as an impediment. Certainly, individuals who, superficially, have a great deal in common are more likely to get along spontaneously and identify with a similar-"looking" group. However, in a more heterogeneous group, other beneficial factors are also operative—for example, clients learn that their problem is shared by people from apparently different walks of life. This facilitates group processes, such as universality. On the other hand, very large differences in age can result in a gap that is difficult to overcome. Indeed, the evolution of CBTs for different populations, such as adolescents or older adults, suggests a need for attention to specific details depending on age (e.g., Cox & D'Oyley, 2011; Keles & Idsoe, 2018). If cultural factors and differences make it difficult for group members to relate in even the most basic ways, such as differences in fundamental values, it may be preferable to aim for somewhat more homogeneity. Also, language can be problematic if a group member has trouble speaking or understanding the chosen language of the group. In individual therapy, language issues are more readily overcome, because the therapist can take this into account and take the necessary time to explain concepts. This is unlikely to be possible in group treatment.

Therapists

Because of the challenges and complexity that the group format adds to CBT, therapists who take primary responsibility for conducting a group should first have adequate training in individual CBT and previous exposure to group CBT as well. Given the success of CBT in randomized controlled trials (RCTs) and various systems pressures to implement evidence-based treatments, many new practitioners from various mental health professions continue to be trained in this approach. Often this occurs in relatively short workshops or through self-directed learning. Indeed, given the specificity of most group protocols and the prevailing notion that CBT is a straightforward approach that is readily learned, it is possible to foster the illusion that group CBT is simple to learn and do, and requires minimal training. We advocate that group therapists have a combination of previous experiences in CBT before leading a group. Ideally this would consist of the following elements:

1. Didactic training/coursework in CBT models and techniques.
2. Direct (ideally hour-for-hour) supervision on multiple individual cases of CBT.
3. Observational participation in a CBT group led by another therapist.
4. Taking on the role of a coleader.

Each of these elements adds a distinct type of knowledge, first establishing a basis for a CBT orientation to treatment and then experiencing, observing, and finally working with group process issues as well. Also noteworthy is that preparation for CBT in treating one kind of disorder does not necessarily prepare a group therapist to treat another kind of disorder. For example, the relative weighting of different strategies in anxiety and mood disorders requires different skill sets and experience, and may not be sufficient for another area without more specialized training.

Therapist Stance in Treatment

Relatively little has been written about the interpersonal style or leadership qualities required for CBT group therapists. Clearly though, group CBT requires a combination of both didactic and process work, and each requires a distinctive style. The didactic portion (e.g., presenting the concept of an automatic thought or the nature of an exposure hierarchy) draws heavily on the public speaking/presentation skills of therapists. Communication must be simple, clear, and direct, and it is imperative that therapists stay "on message" to complete these tasks, so that the agenda is fulfilled in a timely fashion. Once the more process-oriented portion of a session begins (e.g., helping clients to articulate their automatic thoughts or to develop their own hierarchies), the therapist can take a much more traditional, less directive CBT therapeutic stance, using questions and feedback to deepen understanding and disclosure in clients. This also translates into nonverbal behavior; most therapists stand when presenting didactically and are more likely to sit when an example is being discussed and group process is coming to the fore.

Thus, therapists in CBT groups should observe the following general principles, and competence in this area should be defined accordingly:

1. The CBT group therapist embodies the CBT principles of collaborative empiricism, guided discovery, and Socratic learning.
2. The CBT group therapist is sensitive to process factors observing important connections between group members, encouraging openness and encouraging supportive (and therapeutic) feedback among group members.
3. The primary CBT group therapist is responsible for keeping the group on track through the agenda, and redirecting the group as needed to stay on that agenda.
4. The CBT group therapist uses a warm, empathic, directive style that balances group cohesion with group learning.
5. The CBT group therapist observes any obstacles or problems in process and structure, and actively attempts to solve these issues within the group (see Chapter 14).
6. The CBT group therapist is sensitive to the stage of group

development, respecting the evolution of group dynamics and allowing the group enough autonomy for members to work with one another.

Number of Therapists

Generally, two therapists are preferred in most applications, and most often the arrangement involves a primary therapist and a cotherapist. The primary therapist takes a greater share of responsibility for leading the group discussion and making the central decisions about following the agenda and process issues. The cotherapist, who has fewer immediate responsibilities, can cover some of the material, and, importantly, offers a second set of clinical "eyes and ears." While the primary therapist is occupied with presenting material and working examples, the cotherapist is able to note group interactions and process factors about which the primary therapist may need to be informed.

Typically, therapists meet briefly before each session to discuss what material each will be responsible for and to anticipate any potential issues with the material and group members. Equally important, therapists should debrief for a short time after the session. Here the cotherapist and therapist can share any important observations related to the use of techniques or process and plan for whatever necessary corrective action that is needed. For example, the cotherapist may be observing a group member who is struggling to keep up with the material, something the group leader may not yet know. It may then be determined that the cotherapist follow up with a phone call to the client to determine what the difficulties are. This raises a second benefit of having two therapists. The workload of calling clients who miss sessions, assessments, progress notes, and termination reports can also be split. Debriefing can also be useful as a form of peer supervision relative to using techniques, optimizing strategies, or examining whether important opportunities were missed in the session.

The context of CBT groups also has much to offer in terms of training. Advanced trainees can be effective cotherapists, and acting in such a role is often the final preparation for becoming a primary group therapist. It may also be desirable, especially in teaching settings, to have a third therapist/learner who is a participant/observer in the group. This role will likely be more flexible; some learners may need simply to observe the model in action, whereas others may wish to present some material formally or lead the questioning to gain a working familiarity with the techniques. The learner would participate both in preparation and therapist debriefing, and perhaps would also be involved in an additional period of supervision with the primary therapist to discuss their own learning.

A final consideration in examining the number and makeup of therapists is the extent to which this context changes CBT practitioners into a CBT team. It is imperative that the two or more therapists involved in

a CBT group see themselves as, and act like, a team—that is, therapists should display a unified front and message to the group at all times. This can be challenged when the two therapists have different ideas about where a group should go—for example, in a Socratic dialogue, the primary therapist and cotherapist may each have a different sense of which questioning strategy is ideal. While it is sometimes possible for each therapist to take a turn in the questioning, therapists need to be careful about contradicting, or even appearing to contradict, each other. This can send a confusing message to the group and possibly undermine the group's esteem for one, and often both, therapists. The debriefing is the proper forum for therapists to have a full discussion of any differences about the direction of the group or approach to any specific clinical scenario. In many cases, the two therapists might reach a similar conclusion once a full discussion takes place; such discussions obviously cannot happen during the group itself. Resolution of therapist differences can sometimes require taking additional, new information back to the group, especially if it is determined that some countertherapeutic, or at the very least nonoptimal, information or process has taken place.

Group Structure

Group sessions tend to be either 90 minutes or 2 hours in length. The former can be more efficient, whereas the latter allows for more time. A 2-hour group session can allow for a brief break, whereas a 90-minute session typically does not allow for a break. We suggest a 2-hour length for several reasons: first, because it allows for needed flexibility in starting the group; it can often take extra time to start the group as members assemble and complete their symptom checklists. Also, a 2-hour length allows for more opportunities to include as many individuals as possible in the discussion and examples—this length may also be necessary for groups doing exposure exercises. Groups that last for more than 2 hours can seem overlong, both from the therapists' and clients' perspectives.

Selecting a Protocol

The most common approach to selecting a protocol is to determine the predominant or primary diagnosis of group members. These protocols have tended to be developed for RCTs and thus have considerable specificity for only one disorder. However, it is also possible to create more general protocols—for example, in the case of groups that include members with comorbid conditions. In other clinical applications (e.g., community mental health settings), group members have a variety of primary disorders that therapists must consider when determining what techniques should be implemented. This may involve selecting specific techniques from

single-disorder protocols and adapting these to a broader range of difficulties. For example, any anxiety condition will benefit from some type of controlled exposure, elements of which could be taken from social phobia, obsessive–compulsive disorder (OCD), or panic treatments.

Before a group begins, a session plan should be laid out to describe the overall plan for what techniques will be taught and to what level of detail and depth. In creating "customized" protocols, special attention needs to be given to the flow of material, so that it is logical and provides a steady progression of learning. One important area to consider is homework, because homework gives clients an opportunity to practice skills learned in one session and at the same time serves as the basis for new learning in the subsequent session. Once this process is completed, it is useful to create a package of materials to be distributed to group members. This can be as formal as constructing a comprehensive manual or as informal as a set of handouts that includes homework sheets. This package should also include any necessary contact information for therapists, dates, and times of sessions.

Group Rules

An important point of departure, usually covered in the first session, is to discuss group rules. These rules cover important areas, including confidentiality, attendance, compliance with homework, and what to do if unable to attend the group. Consideration should also be given to a therapy "contract" that outlines an agreement for group members to attend a minimum number of sessions and a commitment to completing homework. The rules of confidentiality, which may be slightly different in various jurisdictions, should be explicitly discussed in the group, just as they would be in individual therapy. Members should be aware that much of their learning will likely include examples involving other clients and that these should remain confidential when discussing the group experience with others in their lives. Usually this involves a compromise in which clients agree that, when discussing group with others, they allude only vaguely to others' anecdotes or to any of their own discussions with co-clients, and most important, that no identifying information (i.e., co-clients' professional status, place of residence, marital status) be discussed outside the group.

Discussion of group rules is also an excellent time to introduce and socialize group members to the model of intervention and expectations about group interaction. Members enter groups with widely varying assumptions and expectations about what the group will be like, ranging from a process-oriented group (e.g., 12-step programs) to something resembling a "course," in which learning is the only goal. The introduction to group rules should thus make plain that a CBT group combines elements of learning, like a course, with elements of experience and group support. The group rules should be explicit about the desire for group members to

provide feedback to one another and ask questions of one another. This process will certainly evolve as the group develops, but it is helpful to establish from the outset that group members can and should interact among themselves, not just with and through the leader.

Individual Needs

It is necessary in any group to address the different needs of individuals, but it is also important to emphasize clinical issues in the group whenever possible. Sample scenarios in which individuals need attention include times when clients must miss a group session and would benefit from an update, or when clients have concerns that they prefer to express privately to the therapists. When clients do need to miss a session, planned or not, one of the cotherapists should at least make telephone contact with the client, if possible, providing an update on what occurred in the group and a summary of new material.

Homework

Given the importance of homework in CBT outcomes (Mausbach, Moore, Roesch, Cardenas, & Patterson, 2010), an absolute priority before beginning a group is to have a structured plan for the assignment and review of homework, as well as preparation of any handouts, worksheets, and exercises that go with the homework. When the homework assignment is left until the last minute or is otherwise cursory or ambiguous, compliance rates fall sharply. We also advocate that at the beginning of each session homework be handed directly to the therapists, who quickly review it. This procedure has several advantages. First, when clients are made aware that homework is to be "handed in," they are more motivated to attempt to complete it. Second, therapists can ascertain directly how well each group member understands the material, because they review each individual's work. Third, by surveying the homework, therapists can make a preliminary plan around which examples they will use in the group. Once the homework has been surveyed, and this is often done while participants complete their symptom inventories, it can be returned to each person for use during the session. Also, before openly discussing any homework example in the group, the therapist should ask the permission of the group member to use their example.

Choosing Examples

An everyday but important decision that group therapists face is selecting which of many possible examples they might use from the group to illustrate a new technique or to make some other important therapeutic point.

For example, if the group as a whole completed 15 thought records, which thought record(s) should be explored in further detail and receive the feedback of the entire group?

Three factors are important to consider. First, group members should be asked whether they have an example that they struggled with or one that they found particularly useful. This reflects a collaborative approach, and allows clients to follow up on examples about which they have important unresolved questions.

A second factor to consider when selecting an example is the intent behind the discussion that the therapist hopes to trigger. In some instances, examples are chosen because they illustrate a point particularly well, or were completed by the client and had a successful outcome. We term these "positive examples"; they help model how a technique can work well or demonstrate a successful outcome of a problem using a CBT technique. Positive examples should be chosen to emphasize the benefits of strategies being taught, because this encourages other group members to use the same strategies in their own situations. However, it should be noted that these examples do not necessarily lead to in-depth discussion, because of the very fact that they do involve an issue that is already fully and positively resolved. A second kind of example that we term "in progress" involves an item that is as yet unresolved or on which the client is stuck. These examples can take more time and be more challenging—however, they demonstrate to the group important aspects of working through techniques using Socratic dialogue and other specific CBT techniques, and tend to deepen group process, adding to cohesion and the group's ability to work together. In-progress examples illustrate the therapeutic principles in action and help to move the person toward a successful resolution. A third kind of example, the "transition example," is similar to in-progress examples because it is unresolved—however, transition examples are chosen because they illustrate how the new material for the session can be applied in a specific instance. To return to the thought record homework example, if the goal of the session is to discuss underlying beliefs for the first time, the therapist might select an example in which a belief, more than an automatic thought, seems to be maintaining negative affect or impairment. Good transition examples help group members to understand why a new strategy is being taught and illustrate these new techniques in action in a "real" situation encountered by a group member.

A third factor to consider is "generalizability" of an example. All other things being equal, the examples that generate the most useful discussion are those that are most likely to be shared experiences for many, or most, group members. For example, in depression, examples that involve self-deprecating themes are most likely to resonate with all group members. Such examples are more useful than idiosyncratic, or complicated, scenarios that lead to difficulties for only one group member.

Within-Session Structure

CBT can be distinguished from many other therapeutic approaches simply by the fact that each session of a course of therapy follows a rational and comprehensive sequence. Even as the content of each group session advances, the basic structure of the sessions is predictable for both therapists and group members. This structure is of central importance for two main reasons. First, the effectiveness of CBT is based primarily on the extent to which the client learns to use the skills conveyed in therapy. Thus, CBT places a priority on creating an interactive learning forum. Also, an emerging body of research evidence supports the notion that structural elements of CBT, particularly homework, are important as "effective ingredients" in therapy. If learning is to occur, what is the best means by which to facilitate it? Two extremes probably define the spectrum of possibilities, and these can also be found in approaches to education in general. At one extreme would be highly structured, rote exercises; education-based examples would be drills to teach spelling or multiplication tables. At the other extreme would be a highly unstructured and undirected, experiential approach, in which principles are said to be discovered rather than learned. Both of these extreme approaches have drawbacks. The former is mechanistic and repetitive—perhaps even boring—and is experienced as a chore rather than learning; a CBT group that is too structured would resemble a course with lectures. On the other hand, the experiential extreme is inefficient and could result in overlooking important principles; a CBT group based on experiential learning would resemble an encounter group. The approach to group CBT sessions we advocate represents a middle ground between these two extremes. The therapists ensure that during each group session, and over sessions of therapy, the important skills and principles of CBT are covered. At the same time, real problems are discussed and integrated in a way that is not preplanned, and that allows for flexible learning. This approach represents the concept of "guided discovery," a term that describes both the directive and explorative nature of CBT.

The structural elements of CBT sessions described here include seven distinct components that are also present in individual CBT: status check, clarification, the session bridge, the agenda, capsule summary, session summary, and homework. Table 2.1 outlines each of these and how they can be applied in group therapy.

Challenges and Problems in Group Structure

Conducting CBT group therapy may appear straightforward in terms of following a preset format and protocol—however, putting protocol into practice, particularly in a group setting, is a dynamic, evolving process that changes with each group as a function of the group members, the clinical

TABLE 2.1. The Structural Elements of CBT Sessions

Structural element	Purpose	Application in group
Status check	• Starting point of each session. • Understand clients' clinical status relative to previous session and determine whether there has been improvement.	• Provide self-report measure of symptom severity. • Gather feedback about experiences with homework. • Complete a "go-around" with group members, sequentially discussing the previous week's experiences. • Therapists to gather information relevant to the upcoming session content.
Clarification	• Identify clarifications needed from previous session's material.	• Ensure that clients who do not understand are not left behind. • Therapists to inquire whether members have questions about last session.
Session bridge	• Encapsulation of previous session with indication of upcoming session content.	• Essential to make sessions feel connected. • Particularly effective when examples from group members' homework are included.
Agenda	• Set up the "plan" for the session.	• Material from previous three structural elements can inform an agenda relative to members' needs. • Can record on whiteboard and leave up throughout session. • New material largely determined by treatment protocol, balanced with clients' wishes. • Therapists can use discretion regarding how much to deviate from agenda.
Capsule summary	• Summarize points just covered to facilitate and check learning.	• Distinct from Socratic dialogue. • Best done after a concept has been introduced and applied to a group member's life. • Didactic exercise interweaving CBT concepts and members' experiences to make therapy "real."
Session summary	• Recapitulation of most important points from the session.	• May involve questions to and from group members—test understanding. • Therapist to translate principles into understandable language, including group member examples.
Homework	• Homework discussion and assignment for upcoming week.	• Based on content of the session and the protocol. • Not to be considered an afterthought—all other business to be closed with 10 minutes left to discuss homework. • Blend concepts learned in therapy with clients' unresolved problems. • Members encouraged to provide feedback to one another about what strategies would be most helpful.

picture, and therapist style and skill. In this section, we review a number of these challenges alongside potential solutions.

Challenging Clients

In our experience, each group a therapist conducts is likely to have at least one client who presents a challenge to group process, to other group members, and to group leadership. Consider the following examples of statements made by clients in a group:

> Paul: I don't have anything to share. Nothing good happened this week.
>
> Wayne: (*interrupting another group member who started to speak*) I know exactly what that is like. For me, I always have to stop whatever I am doing when I get anxious.
>
> Traci: We are all putting on a persona. Every one of us is fake and we put on an act to others, so that they don't know what we are dealing with inside. We can only do that for so long before something gives.
>
> Lesley: I have tried this type of treatment before and it hasn't been helpful. It has only been three sessions, but I don't find this group helpful either. I am wondering what other group members feel.

These real examples of group dialogue are likely to trigger some degree of recognition for all CBT group therapists, and are clear indicators of trouble that make therapists have their own "hot thoughts!" But more than being examples of group members' ambivalence or resistance, these examples challenge group leadership and can undermine good group process, and thereby undermine effective treatment. Inspired by Yalom's work and our own clinical experience, the common prototypes for challenging group members within a CBT group are presented in Table 2.2, along with strategies for management.

Note that these categories are not likely mutually exclusive. For example, the disbelieving member may be either quiet or overbearing. Although these descriptive categories are based on clinical experience and not on empirical data, they are useful in that they provide the group leader a set of strategies that may help to guide clinical intervention and to manage group function.

The Quiet and Silent Type

The "quiet and silent" prototypical group member is the individual who prefers to sit quietly, providing minimal participation in the group. This individual may be shy and uncomfortable in a group format. Alternatively,

TABLE 2.2. Challenging Group Member Prototypes and Strategies for Management

Typical behavior	Description	Therapeutic management
Quiet or silent	• Group participation is minimal. • Prefers to sit in silence.	• Use group to help draw out. • Ask direct questions to help facilitate interaction. • Try to link experiences to other group members' experiences. • When appropriate, process thoughts and feelings about being in the group.
Overbearing	• Monopolizes group time. • Has no difficulty sharing information.	• Use containment strategies to help balance group time. • May use subtle management strategies (i.e., not reinforcing continued talking with questions or eye contact). • May eventually require more overt management strategies, such as stopping the person midstream (e.g., "I am going to stop you there so we can hear from others").
Helper	• Always giving advice that may or may not be helpful. • May talk in generalities using "we" and not "I." • May focus on others and not on own issues.	• Encourage the person to reflect on personal experience and speak in the first person. • If advice is helpful, then reinforce and direct the person to how they can focus on their own issues. • If advice is not helpful (e.g., "If you are anxious about going, then don't go"), then process within the group (e.g., "What do group members think about that idea?" or "How does that idea fit with the goals of the group?").
Disbeliever	• Makes pessimistic statements. • Ambivalent about treatment. • May have already tried CBT a number of times. • May challenge the therapist and the therapy.	• "Roll with resistance" (Miller & Rollnick, 2002): Do not engage in argument; agree/validate member's feelings, then shift direction to emphasize personal responsibility and choice. • Ask the group member (can include other members if desired) to enumerate why this won't work and why the status quo is okay. Then support the entire group in exploring why there's a possibility that change could happen and may have benefits.

(continued)

TABLE 2.2. *(continued)*

Typical behavior	Description	Therapeutic management
Drifter	• Sometimes shows up and sometimes does not. • Does not appear to be committed to the group.	• Address in group. • May need to have an individual meeting.
Not-appropriate-for-group member	• Problematic in group because their issues may be different from those of the rest of the group. • Often due to problematic personality features (e.g., paranoia) or other conditions that require immediate attention.	• Use management and containment strategies. • Acknowledge that their needs may be different from those of the group and shift focus to what the individual may gain from group participation. • May need to discontinue group and find alternative treatment option if the person is too disruptive or treatment needs have shifted.

and presenting a greater challenge, is the individual who is silent because of a lack of openness to the treatment, as reflected in guarded participation and involvement in the group. It is helpful for the group leader to ascertain the underlying reason for the lack of participation based on obsvervation or through gentle probing in the group. In many cases, as the group sessions progress, the shy group member may become more comfortable and participation may increase. Similarly, the guarded group member may become more open to the therapy and more involved in the group over time.

There are a number of interventions the group leader may use to facilitate the involvement of a quiet- and silent-type member. The group leader can use the group to help draw the person out. For example, when the individual shares something, the group leader can link that experience to other group members' experiences, with the aim of increasing the comfort level in the group. Alternatively, the group leader may use direct questions to help facilitate interaction. Consider the following example:

THERAPIST: Paul, we haven't heard from you yet. How was your week?

PAUL: I don't have anything to share. Nothing happened this week.

THERAPIST: Did you have any anxiety this week?

PAUL: No, not really.

THERAPIST: So that sounds like it was a good week.

PAUL: No, it wasn't. I just didn't go out of the house.

COTHERAPIST: It sounds like it was not a good week. Paul, can you tell us what made it difficult for you to leave the house?

PAUL: I just didn't feel good.

COTHERAPIST: (*taking it to the group*) Have other people had that experience of not feeling good and having trouble going out?

Here, the coleader is attempting to highlight the similarity between Paul and the other group members, so that Paul feels more comfortable.

Another intervention for facilitating participation by a quiet group member is to process the individual's thoughts and feelings about being in the group. This strategy may raise issues that other group members can relate to, thereby increasing cohesion and comfort in the group.

The Overbearing Type

The "overbearing" group member is the individual who continually tries to monopolize group time with their own experience. This type of member shifts the balance of group participation and may also sidetrack the agenda of the group leaders. Strategies for managing this type of group member may involve subtle or overt containment strategies. Subtle strategies may be used at first, such as not reinforcing continued talking by asking questions, nodding, or making eye contact. If these subtle strategies are not enough, then more overt management strategies may be required. More overt strategies require a considered approach that balances the needs of the individual with that of the group. For example, in each of the following cases, the group leader jumps in, midstream:

"Jack, I am going to stop you there. You have raised a good point and I want to see how others have managed."

"Susan, I need to jump in here. Those are interesting issues you have raised. We have a few more things to get through and I am just aware of the time, so we need to move on."

"Katie, let me stop you there. Why don't we hear from others on that point?"

Although waiting for the individual to pause is a better place to jump in, sometimes this does not happen, and interrupting the person is necessary. Letting the person continue on without containment is not good for group process because other members may disengage or become frustrated with the overbearing, dominant group member. In addition, the group leaders may not be able to cover the items on the agenda for the group if too much time is taken up by one group member. Development of containment strategies is an important skill for the group leader, and one that takes practice and comes with some experience. These are the most challenging

of interventions, and trainees often struggle to become comfortable and skilled in their use. Consider the following example:

> WAYNE: (*interrupting Paul, another group member, who started to speak*) I know exactly what that is like. For me, I always have to stop whatever I am doing when I get anxious.
>
> THERAPIST: Paul, can you tell us what you did at that point?

In this example, the therapist uses a subtle containment strategy by not responding to Wayne and by reinforcing his point, which might lead Wayne to continue his personal focus. Instead, the therapist redirects the group's attention back to Paul, so that he has time to discuss his experience.

The Helper

The "helper" is the group member who is always giving advice to other group members and in some cases to the group leaders as well (how to run the group better, etc.). Consider the following example:

> TRACI: We are all putting on a persona. Every one of us is fake and we put on an act to others so that they don't know what we are dealing with inside. We can only do that for so long before something gives.
>
> THERAPIST: Is that how it feels for you, Traci?
>
> TRACI: Yes, it feels like I am wearing a persona.
>
> COTHERAPIST: Can you tell us a bit more about what you mean when you say that "something gives"?
>
> TRACI: Well, I feel like I could just freak out from the pressure. I mean, to everyone around me I look normal and confident. They don't know the struggle that is going on inside me every day trying to fight this anxiety.
>
> THERAPIST: I wonder what other group members think about this?

In this example, we see that Traci is trying to be helpful by summing things up and making statements that generalize to the whole group. The group leaders could have let this go, without addressing it, but doing so would have passed up the opportunity to encourage Traci to focus on her own thoughts and feelings.

It is important to socialize group members early on to share their experience from their own personal perspective and to avoid speaking in generalities. Another issue that may arise is not so much that a person takes on the "helper style" but rather that, invariably, in each group, some group members may provide "help" that is not helpful in many cases, and even

worse, is detrimental or counter to the therapeutic aims of the group. This problem may arise whenever a group leader or group member takes an issue to the group for suggestions or feedback. For example, in anxiety groups, a common piece of "unhelpful advice" is one group member's suggestion that another group member avoid an anxiety-provoking activity, thus encouraging behavior that reinforces anxiety and is counter to the aims of the group. In such a case, the group leader can take the advice back to the group by asking group members what they think about it, or how the suggestion fits with what they have learned in the group so far. In this way, the "unhelpful" or countertherapeutic suggestion is dealt with in a constructive manner that is processed in the group to enhance or reinforce the underlying principles or objectives of the therapeutic approach. The group leader could also ask the member who volunteered the suggestion what they thought the benefits or costs of taking the advice would be (e.g., reducing anxiety in the short term, but reinforcing it in the long term).

The Disbeliever

The "disbeliever" is the pessimistic group member who does not really buy into treatment. They may have previously tried CBT or many other different approaches. The disbeliever may be a silent member or an overbearing member. In either case, this individual may challenge the therapist and the therapeutic approach, undermine the treatment, and have a negative effect on the group. Consider the following example:

LESLEY: (*in an angry voice*) I have tried this type of treatment before and it hasn't been helpful. It has only been three sessions, but I don't find this group helpful either. I am wondering what other group members feel.

THERAPIST: (*jumping in before group members can respond*) It is too bad that you aren't finding this treatment helpful, Lesley. It sounds like you have tried a number of treatments before and haven't had relief. That must be very frustrating for you. We know that although this treatment is effective for many people, it does not work for everyone. We would completely understand if you decided that you did not want to continue with the group.

GROUP: (*Silence.*)

LESLEY: Well, I didn't mean that this group wasn't helpful. I am actually enjoying the group, and I do want to continue. I just sometimes feel like I will never get better.

THERAPIST: Do other members sometimes feel discouraged about ever feeling better?

WAYNE: Yes, I sometimes feel that way.

THERAPIST: What about for others?

TRACI: No, I am just hoping that this treatment will work.

COTHERAPIST: That is good, Traci. That is what we ask from people—that they keep an open mind and try the strategies. It is normal to feel discouraged or hopeless at times, and it is helpful for us to talk about these feelings in the group. Why don't we find out how everyone did this week with the homework?

In this example, although it is entirely acceptable for group members to express their feelings in the group, the issues of timing and type of expression were relevant in this case.

The leaders had two options in this situation. One option would have been to let the group respond to Lesley directly, without any intervention on the part of either group leader. Although this is what Lesley wanted, the group leaders felt that it would not be helpful for the group for the following reasons: it could serve to contaminate the group with negativity; once started, it could sidetrack the group from focusing on more productive material; and it could send the message that this type of aggressive expression within the group was acceptable. The second option, and the one that the group leader chose, was to utilize specific containment interventions. As one can see from the interchange, this option effectively defused Lesley's anger and shifted her toward expressing her feelings in a more appropriate manner (i.e., instead of attacking the group, she was able to voice her feelings of hopelessness about recovery). Instead of potentially contaminating the group with negativity, this exchange promoted group interaction on the feelings of frustration associated with recovery. The group leader then normalized these feelings and shifted back to the task of homework review.

The Drifter

The "drifter" is the group member whose attendance at the group is inconsistent. Sometimes the drifter shows up, and sometimes not. The presence of a drifter can interfere with the therapeutic process by affecting group morale and cohesion. The rest of the group demonstrates commitment by making the group a priority and attending each session, save for an emergency. The drifter may miss sessions for a number of reasons, including lack of commitment to the group (e.g., motivation, doubts about treatment, "disbeliever"-type personality), symptom severity (e.g., severe agoraphobia, such that the individual relies on another person to accompany him or her to each session), practical issues (e.g., transportation, child care, work schedule), and social anxiety (discomfort in the group).

It is important for the group leader to address the issues of a drifter early on. It is of no benefit to the drifter to let them participate in the group in such a manner, missing important material on which future sessions are

based. The drifter will likely realize little therapeutic benefit upon group completion. More important, if a drifter completes treatment in this manner, they may do so with the belief that CBT group treatment was received and was a failure, when in fact an adequate trial of therapy was not completed. In addition, other treatment providers will be led to the conclusion that the individual did not respond to CBT, when in fact this determination is not substantiated.

At the start of the group, the issue of attendance and commitment to the group should be emphasized when reviewing group norms. If a group member misses a session and does not notify the group leaders, it is important for the group leaders to follow up with a phone call to check in. If a missed session is ignored by the group leaders, it undermines the importance of participation in the group. Periodically, it is helpful to ask the group as a whole about thoughts and feelings about the group experience (e.g., "How are people feeling about being in the group? What do people think so far?"). In this way, group members can relate to one another and expectations can be clarified.

The Not-Appropriate-for-Group Member

The "not-appropriate-for-group" member is an individual who has made it through the screening and into the group, but once the group is underway, it becomes evident that the individual is not appropriate for the group, or that the group is not appropriate for the individual. This occurs primarily due to issues of diagnosis and personality. With the exception of more recent advances in CBT targeting comorbidity (e.g., Norton & Paulus, 2016), traditional CBT is based on protocols designed to address single disorders. Thus, it is not surprising that problems may arise when comorbidity is present.

When a coexisting condition becomes a primary concern, the group may no longer be the appropriate treatment intervention. In addition, occasional misdiagnosis may lead to inclusion of a member who is not appropriate for the group. Consider the following example: Ellen presented for treatment at an anxiety clinic, and following the assessment it was determined that panic disorder (PD) and agoraphobia was her primary diagnosis. An additional diagnosis of posttraumatic stress disorder (PTSD) was assigned. Ellen was placed in a group treatment for PD. In the third session, it became quite clear that Ellen's panic attacks really were not out of the blue but were triggered by thoughts that she could be in danger or be assaulted. Her panic attacks were really encompassed by the diagnosis of PTSD, and a diagnosis of PD was not supported. This posed a dilemma for the group leaders. It was clear that Ellen found it difficult to relate to the other group members because her experience was quite different. In turn, it was also hard for the other group members to relate to Ellen for the same reasons. After the third session, the group leaders met with Ellen to discuss options. They decided

that Ellen would benefit more from individual treatment for her PTSD. Ellen agreed that this option made more sense for her and she discontinued her participation in the group. This issue was addressed at the next group session. Ellen came to say good-bye to the group, which allowed her closure. Following her departure, group members were given the opportunity to discuss any thoughts or feelings they had about having a group member leave early.

Challenges to Group Process in CBT

The presence of any of the prototypical problem members discussed earlier may interfere with group process and the smooth facilitation of the group. In this section, we discuss additional factors that may present a challenge to group process.

Didactic Components of CBT

Presentation of the educational components of CBT has the potential to challenge group process when material is presented didactically, without the opportunity for group interaction. It is important for group leaders to present educational material in a way that is interactive, and ideally discovered through Socratic questioning of group members and group dialogue. When the group leaders are too didactic, the group takes on the feeling of a classroom rather than a therapy setting that promotes open expression of thoughts and feelings.

Structure of CBT

Having structure and an agenda within the group sessions is an important component of the CBT approach. However, if a session is overly structured to the point that there is little or no opportunity for silence, time for reflection, and spontaneous group interaction, then group process is compromised. Group leaders should budget additional time outside of the structured agenda items to address issues that may arise outside of the anticipated discussion. It is also helpful to plan time at the beginning or end of each session to check on how group members are feeling overall, and any thoughts or feelings they have about the group and how it is progressing. Allowing for unstructured group time promotes feelings of group responsibility and ownership in individual members.

Outside Sessions

In a number of CBT groups, and in anxiety groups in particular, some group sessions may be held outside of the therapeutic setting to provide

opportunities for exposure, behavioral experiments, and modeling. For example, a PD group may have a session while riding the bus or going to the mall. An eating disorder group may go to a food court to practice eating risky foods. Sessions held outside the therapeutic setting can be a challenge to group process, because the group may need to split into smaller subgroups to carry out individual exposures (e.g., one subgroup may ride the elevator and another may practice standing in lines). To maintain group cohesion it is helpful to plan the excursion in advance within the whole group, then to reconvene the whole group at the end of the session, so that each subgroup can report back and progress can be discussed within the group.

Presence of Observers and Trainees

The presence of observers and trainees may also affect group process, because members may feel too inhibited to share when outside individuals are present. It is recommended that group members be informed of observer/trainee participation up front and that the observer/trainee commit to attending each group session in its entirety. In this way, group members become accustomed to the presence of the observer/trainee, and disruption is minimized. It is also a good idea to limit the number of observers/trainees present, so that group members are not outnumbered. For example, in a group of five to eight group members and two group leaders, a maximum of one trainee/observer is recommended.

Leadership Challenges

Not surprisingly, one of the more common obstacles encountered in CBT groups occurs not because of difficult client or intervention factors but because conducting groups involves two or more therapists. Therapists working together may have different approaches to the difficulties they treat, stylistic differences, or different instincts about what is the best intervention for a particular example. We review here some of the common issues encountered and potential solutions.

Ideally, coleaders work together, balancing their interactions, backing each other up, and helping each other out in difficult situations. However, sometimes the styles of coleaders may not be a good fit. For example, you may wonder where your coleader is going with a certain line of questioning or feel like you are doing all of the work and your coleader is along for the ride. In some cases, there may be a coleader conflict due to disagreement on the management of the group. In the worst-case scenario, there may be open disagreement between coleaders in the group. The smooth running of the group requires active participation by both coleaders. It is recommended that part of the time used for planning before and after a group be

spent on reviewing coleadership issues and working toward development of a balanced coleadership style. Lines of responsibility should also be clear. When there is a primary therapist, that therapist needs to be empowered to curtail an intervention offered by a cotherapist when the leader is no longer able to recognize the benefit of the intervention or understand where that intervention is going. Cotherapists also need to discuss how to handle a "botched" example. No group we have ever run has gone flawlessly; all therapists can find themselves lost within an example, or have an intervention go awry. It is helpful if cotherapists share a language, code, or nonverbal signal for the other therapist to "rescue" or help redirect the group. It is sometimes necessary for group therapists to acknowledge when they are lost, or when an intervention has not gone in the expected direction. Sometimes it is helpful to take this back to the group, especially in later sessions, to have group members help to troubleshoot an intervention that did not work well initially. Most important, cotherapists should at all costs avoid any overt or covert communication of conflict or dissatisfaction with each other. Finally, in our experience, the more often the same therapists work together, the smoother and more problem-free the experience of the group becomes, in part because therapists begin to have a "case formulation" of each other that allows them to better predict their cotherapist's intentions, behaviors, and ways of working with group process.

Conducting Virtual Groups

The global COVID-19 pandemic of 2020 has catalyzed mental health care, including group therapy, to transition primarily to virtual platforms. The literature on conducting virtual group therapy is not surprisingly small with a few preliminary studies examining clinical outcomes of virtual group therapy (Chirită, Ilinca, Chiriță, Bîşcă, & Chele, 2006), chapters (e.g., Colón & Friedman, 2003), and online non-peer-reviewed articles providing practice guidance (e.g., Whittingham & Martin, 2020). Preliminary research consisting of open trials and pilot/feasibility studies suggests that virtual CBT group therapy may be as effective as in-person therapy for depression (Chirită et al., 2006) and for reducing symptoms of public speaking anxiety (Yuen et al., 2019) and insomnia (Gehrman, Shah, Miles, Kuna, & Godleski, 2016).

There are numerous benefits to providing CBT in a virtual group therapy format. Most impressive is the ability to transcend physical boundaries and enable access to quality care for individuals living in the far reaches of a geographical area, an area that may have had limited or no resources locally. Further, by transcending geographical boundaries, virtual group therapy connects individuals with common concerns who would never have met in a face-to-face environment, allowing access to a supportive therapeutic group that is both convenient and comfortable, as individuals do not

have to leave their house or take time to travel to an appointment. Prior to initiating a CBT group on a virtual platform, there are a number of considerations that must be addressed. Many of these considerations are practical in nature and others relate to process and technique.

Choosing a Secure Virtual Platform

First and foremost, when preparing to conduct group therapy in a virtual format, one must consider how the privacy and confidentiality of group members will be maintained. Choosing a platform that is secure and compliant with jurisdictional privacy requirements (e.g., the Health Insurance Portability and Accountability Act [HIPAA]) is a critical element for maintaining security for group members (Whittingham & Martin, 2020).

When considering what platform to use for conducting virtual group CBT, one should consider features that could be useful in enhancing various therapeutic strategies. For example, the sharing of the screen feature of some platforms enables the therapist to show worksheets, record on them, and discuss interactively with the group. The sharing screen feature may also facilitate showing materials for exposure practices, including videos or a virtual whiteboard. Platforms with the ability to form subgroups using "breakout rooms" is especially conducive to facilitating therapists to divide the group to work on issues or exposures that are relevant to different group members. In addition, having some way for participants to share homework with the therapists using a secure network is preferred over sending back and forth through email.

Informed Consent

Ensuring informed consent is a key requirement prior to embarking on any therapy. In the group context, one must ensure that group members recognize that other group members will also be aware of their information and must maintain the privacy and confidentiality of other group members and what is expected behavior outside of the group context (e.g., if group members were to run into one another in the community). In the virtual context, informed consent also requires acknowledgment of potential breaches in confidentiality if the individual participating in the group session lives in a shared environment where others may intrude inadvertently into a session by walking through the room, for example. Thus, it is important prior to the group starting for group leaders to emphasize the importance of all group members to have a private space/room where they will participate in the virtual group session. They should consider using headphones or closing the door to the space so that no one else hears the group discussion. The ideal location should also consider the lighting—for example, ensuring you are not sitting with a window behind you that obscures other group members and the therapists from seeing your face. In addition, the space should

be private and every effort should be made to minimize intrusions by others. It is recommended that group members be expected to share their video feed so that all group members can see one another and feel safe that no one else is present during the group session. In addition, group members should sign into the platform with just their first name to protect their privacy.

Ensuring a Reliable Internet Connection

One must consider the quality of the Internet connection for both the client and the group facilitators. Both clients and facilitators must have a sufficient Internet connection to participate in the virtual group using their video feed and the connection must be reliable such that the clients and facilitators maintain connection for the entire session. Having reliable Internet is especially important for the facilitator who is leading the session, because if the Internet goes down, the group could be left hanging. It is recommended that the group have two facilitators for each session so that in the event of an unstable Internet signal, the other group leader can take over. A dry run with each group member to ensure they are oriented to the platform and able to engage is highly recommended to ensure that all group members are able to connect for the session. If a group member has difficulty connecting during a session, it is advised that they notify the group leader through the platform being used or through email rather than bringing in someone in their environment to assist, which could violate other group members' privacy.

Establishing Group Norms

Establishing norms for the group about expectations for behavior are always important but are especially critical for virtual group therapy, which may take place outside of an office setting and most often in the home. Ensuring that everyone is in a private space, dressed appropriately, and focused on the session is critical. If these expectations are not emphasized, group members may be engaged in all manner of tasks during the session. When we surveyed therapists who were active in conducting virtual groups, we heard about many instances where group members were engaged in multitasking in various forms, including eating, folding laundry, lying on their bed, walking around their house, cooking, and playing with their children. Distractions should be minimized (e.g., keep pets out of the room). Participation using a computer screen is preferred over a phone as it allows the group member to see all of the group members at the same time, as well as the screen share of the therapists if they show worksheets. It is recommended that all group members arrive 5 minutes early. Some platforms have a waiting room feature where group members can connect while they are waiting. This simulates the experience of live group therapy. In addition, no group members should record the session,

as this would violate the privacy of other group members. It is also helpful to discuss what measures are in place to ensure the safety of group members should the need arise.

Orientation to the Virtual Platform

The first group session should include an orientation to the platform if this was not covered prior to the group starting. The group leadership should demonstrate various features to assist group members in their participation, including the view that they see on their screen (gallery vs. speaker), how they communicate in the group (raising their hand vs. using a chat feature), how to mute when not speaking, and how to ensure that the camera and volume are on when entering the group. Side chatting between group members (like side talking) is discouraged to minimize distraction for other group members from the person currently speaking. Unlike live group therapy, virtual therapy requires more control of how group members engage in the session with consequent impact on group process and natural flow/interactions among group members, as we discuss below.

Orienting group members to how to speak and participate is important. It is recommended that group members physically raise their hand if they want to contribute or if they have a question so that the therapist can then invite them to speak. This reduces multiple people speaking at the same time or not knowing when they should speak. Although some platforms offer other options, such as raising a virtual hand or a chat function, these options are less desirable as the therapists may not notice if they are focused on the group members' video feeds. Of course, this requirement interferes with the natural flow of group interaction that occurs during an in-person group and research is needed to determine whether levels of group cohesion are lower for a virtual group than an in-person group. Anecdotally, we have heard varying accounts from participants in virtual group therapy. Some individuals report that they really like attending group virtually, as it is more accessible and convenient. Others, however, report that they feel less engaged and have difficulty speaking up and contributing in the virtual format, preferring to discontinue and wait for an in-person group. Research is needed to examine the comparative efficacy of virtual versus in-person CBT groups and to identify which individuals may benefit more from one format over another.

It is also good to inform group members of troubleshooting options if they run into technical difficulties with their feed, such as turning off the video and then resuming if they find they are freezing. Group members should also all have a group manual and a pen to record information from the session. Group members and group leaders may find it more challenging to maintain focus through a straight 2-hour virtual CBT session. Thus, considerations of having a shorter session or taking a structured break is advised.

Conclusions

We have highlighted the issue of client selection, offering specific suggestions for evaluating the suitability of clients for a group. We also discussed some issues regarding therapist training and stance, keeping in mind that all CBT is provided through the conduit of the group leaders. The approach they take dictates a great deal about the success of the group. Finally, it is important for therapists to construct protocols and plans for a group carefully, paying special attention to the flow of concepts, session structure, and creating homework that ties sessions together.

In this chapter, we also proposed that good group CBT expertly balances the learning objective of a protocol with the experiential needs of group members. In some cases, therapists must choose between spending more time to explore and deepen understanding, and making sure that they get through the planned didactic material. The key question here is "Do the advantages of staying with the 'experience' or affect outweigh the costs of falling behind in the protocol?" We also reviewed some of the common obstacles and challenges to group treatment. Although our list is not exhaustive, we tried to capture some of the main issues that arise across CBT groups with respect to group membership, group process, and leadership. We have provided specific strategies that may be useful for overcoming these challenges and ensuring that the group is facilitated smoothly.

In the final section of this chapter, we covered both practical and process considerations for conducting CBT groups in a virtual setting. Although there are many benefits to a virtual format, there are also challenges and research is needed to determine whether there is any differential efficacy when comparing the two formats. Part II homes in on specific problems and disorders, sharpening the focus of these important but generic structure and process concepts for a specific application.

CHAPTER 3

Behavioral and Cognitive Strategies in CBT Groups

This chapter reviews the use of behavioral and cognitive strategies in group treatment. We begin with the advantages and challenges of delivering CBT in groups. We then introduce behavioral strategies, such as *in vivo* exposure, role plays and simulated exposures, skills training, and problem solving. We then turn to cognitive strategies, including connecting thoughts to situations and mood, identifying and challenging cognitive distortions, using experiments to test thoughts, and using the downward-arrow technique to uncover conditional and core beliefs. For each skill we aim to describe the basic technique for the reader, and then elaborate on how the technique can best be presented in a group context. It is important to note that while a number of these CBT strategies are nearly universal, the chapters on specific disorders in Part II contain more targeted methods for specific problems.

Overall, there is considerable evidence supporting the use of CBT treatments in groups. A number of studies and meta-analytic reviews have reviewed the relative effectiveness of group and individual treatments for particular disorders (see Part II of this book). Both appear to be effective, with little consistent evidence to suggest that either individual or group therapy is more effective. However, comparative studies have often ignored variables other than efficacy, such as the cost of treatment, rates of treatment refusal and dropout, and treatment satisfaction. In addition, little is known about predictors of who is likely to benefit most from group versus individual treatment. Despite the lack of empirical research on the

relative costs and benefits of delivering behavioral and cognitive treatments in a group format, clinically, group treatment seems to have a number of strengths and liabilities relative to individual therapy.

Advantages of Delivering CBT in Groups

Some advantages of delivering cognitive and behavioral treatments in groups are similar to the advantages for any group treatment. For example, because they take less therapist time per client, groups often provide an opportunity for CBT treatment to be offered at a lower cost compared to individual treatment. Furthermore, group treatments allow for behavioral practices that would be difficult to arrange in the context of individual treatment. One occurrence of this can be seen in exposure exercises for social anxiety disorder (SAD), which require opportunities for social interaction—a group format provides such opportunities readily. Groups also allow clients to get a wider range of feedback on their performance during social skills training (SST) . In a group, there are also more "heads" in the room for the purpose of brainstorming solutions to one another's problems or helping challenge maladaptive beliefs. When using cognitive techniques in groups, group members may help one another come up with evidence against maladaptive appraisals that may not be immediately apparent to the individual. Often, group members suggest homework practices for one another that might not have occurred to either the therapist or other group members. Groups also provide opportunity for shared learning. Clients can model nonfearful behavior for one another and also learn from one another's experiences. Listening to a discussion about another group member's exposure homework, for instance, can help other members to think differently about how they might plan their own homework for the coming week. Group members may also hold similar distorted appraisals and hearing one member share a more balanced appraisal with the group may influence the thinking of other members.

Group treatment also provides peer support that may not be present in individual treatment. Being part of a group reminds clients that they are not alone in their struggle; they often value the support and inspiration they get from other members in the group. Although support from the therapist is important, support from others who share a particular problem is a unique feature of group treatment. Hearing from another group member that their fear eventually decreased as a result of exposure may be more credible than a similar message coming from a therapist. It is not unusual for group members to push one another to try more challenging exposures, or to catch one another relying on subtle avoidance strategies. Group treatment may foster a sense of responsibility among clients to not let one another down (a positive form of peer pressure or expectation).

It also helps to reduce the "therapist versus client" dynamic that sometimes arises during individual therapy with a client who is noncompliant. Finally, conducting CBT in groups can also be a lot of fun compared to individual treatment.

Challenges in Delivering CBT in Groups

As with some of the advantages of group CBT discussed earlier, several of the main disadvantages of administering cognitive and behavioral therapy in groups are challenges that are likely to arise in any group treatment. For groups in which clients differ in their levels of motivation, comprehension, or symptom profiles, it may be necessary to "pitch" the group for the "average" member. As a result, clients with poor motivation, difficulty comprehending the material in the group, or unusual symptom presentations may not get as much out of the group as they might from individual therapy. Such clients may benefit from a few individual sessions in addition to the group. In addition, some participants may be reluctant or embarrassed to bring up issues (e.g., symptoms having to do with sexuality, past experiences that they regret, core beliefs) in front of group members that they might have brought up in individual therapy. In addition, just as positive experiences among some group members can be a source of inspiration to others, negative experiences among group members (e.g., a bad exposure experience) can affect other group members negatively. Finally, it may not be possible to review all group members' homework, and some clients may not relate to another group member's homework being discussed.

Behavioral Strategies

Exposure-based strategies (e.g., situational exposure, role play and simulated exposure, imaginal exposure) are at the heart of many CBT groups. Also described are other behavioral strategies, including self-monitoring, SST, and problem solving. Behavioral strategies that are most often used for a specific problem (vs. across multiple problems) are discussed in Part II. For example, symptom exposure (interoceptive exposure) for PD is covered in Chapter 6 and behavioral activation for depression is covered extensively in Chapter 9. Mindfulness and acceptance-based treatments are discussed in Chapter 4. Additional discussion of these approaches is also available elsewhere (e.g., Antony & Roemer, 2011; Germer, Siegel, & Fulton, 2016; Hayes, Strosahl, & Wilson, 2016). Although this chapter provides some general descriptions of each strategy discussed, the emphasis is on how these methods can best be presented and implemented in a group format.

Exposure-Based Strategies

Exposure is perhaps the most established strategy for combating fear. It is often a key component of treatment for anxiety disorders, OCD, and posttraumatic stress, and is also often used when treating other disorders in which fear and avoidance are important features (e.g., eating disorders, body dysmorphic disorder, illness anxiety disorder). In this section, we discuss general methods for implementing exposure-based treatments in a group format. Strategies for integrating exposure into the treatment of particular conditions are also discussed in Part II. A more detailed discussion of exposure is found in *Exposure Therapy for Anxiety: Principles and Practice, Second Edition* (Abramowitz, Deacon, & Whiteside, 2019).

Types of Exposure

In Vivo Exposure

In vivo exposure involves confronting a feared object or situation directly (i.e., in reality, as opposed to in the imagination). Examples include practicing driving to overcome a fear of driving; attending parties, meetings, and other social gatherings to combat SAD; and eating "forbidden" foods to combat a fear of gaining weight in anorexia nervosa. When an individual is fearful of a particular object, situation, or activity, *in vivo* exposure is typically the most effective exposure approach. Studies comparing *in vivo* exposure to imaginal exposure for situational fears have generally found situational exposure to be the most effective (e.g., Emmelkamp & Wessels, 1975), with some exceptions discussed later in the chapter.

Conducting situational exposures in groups can be a challenge, particularly when group members fear different types of objects and situations. In fact, when treating groups, it is not uncommon for group time to be spent reviewing homework and planning future exposures, and to have the actual *in vivo* exposure practices occur between group meetings. In these cases, it may be useful to suggest that clients work with a supportive family member or friend during exposure practice, if they need extra support or coaching.

Although exposure practices between group sessions are important, conducting exposures during group time can be a valuable experience. We recommend trying to do some exposures in group, if possible, to successfully model how to conduct an exposure practice. If it is not possible for the group to complete a practice together, one way to accomplish this is to break a group up into smaller groups that comprise individuals with similar concerns who can practice exposure together for part of the group session. If the group has multiple therapists, each therapist can take responsibility for coaching several group members during their exposure practices. If group practices are impractical (e.g., in the case of driving fears), some group members can practice exposures individually during group time.

For example, in a group for OCD, three participants could work on contamination exposures, while several others work on imaginal exposures to frightening words (see the section below on imaginal exposure), and one remaining client works on leaving rooms without checking for possessions that may have been left behind. In a group focused on overcoming agoraphobia, several members could practice being at a mall, while others practice standing in line at a supermarket or driving alone on the highway. Before splitting up the group for exposures, it is often helpful to begin the session together to review homework and plan the practices, then meet as a group again after the practices are completed to discuss the outcome and assign new homework. In a 2-hour group session, that should leave up to an hour for the exposure practices. Longer meetings (e.g., 2.5 hours) may be necessary in some cases to accommodate in-session exposures.

Simulated Exposures and Behavioral Role Plays

Simulated exposures are a form of *in vivo* exposure in which an individual practices confronting a situation that approximates the actual feared situation but is not quite the real thing. Examples include role-playing a job interview, with the therapist or another group member playing the part of the employer, or practicing a presentation, with group members playing the part of the audience. Exposures to stimuli in photos, videotapes, or virtual reality are also examples of simulated exposures, and are used most often for treating certain types of specific phobias (e.g., phobias of blood, needles, spiders, snakes, and some other animals), primarily on an individual basis (see Antony & McCabe, 2005; Antony & Watling, 2006). Simulated exposures or role plays are useful when (1) the client initially finds it too difficult to practice exposures in the actual situation, or (2) when it is inconvenient or impractical to practice exposure in the actual situation.

Simulated exposures are often used for in-session exposure practices during group treatment for SAD (Heimberg & Becker, 2002). Practices typically involve having group members role-play various social or performance-related scenarios. Some practices may involve the entire group (e.g., having group members role-play engaging in casual small talk at a party). Other practices may involve breaking the group up into smaller groups, so that members can practice exposures that are relevant to them. For example, two group members might role-play a job interview, while several others practice eating in front of one another. A possible disadvantage of role playing in front of other group members is that the role-play situation may be quite different from the real-life situation that is being simulated. In real life, conversations tend to occur in isolation, whereas a role-played conversation in group therapy may have the added component of an audience. Clients may feel pressure to make a good impression on not only the person they are talking to but also the audience. Also, clients may "minimize" a positive performance and good feedback because it occurred

in the protected setting of a therapy group. Nonetheless, an observant CBT therapist could point out that a group situation with an audience may actually be more pressure than the same "real-world" situation without several potential critics looking on. Role plays may also serve as a motivating first step before approaching *in vivo* exposures.

Imaginal Exposure

As mentioned earlier, *in vivo* exposure is generally preferred to imaginal exposure, particularly when treating situational fears. However, there are a number of situations in which imaginal exposure may be appropriate. First, imaginal exposure is appropriate if an individual is afraid of their thoughts, images, or urges. For example, a client with OCD who fears thoughts and images having to do with Satan might be encouraged to practice thinking about, writing about, and talking about images that trigger the fear (Rowa, Antony, & Swinson, 2007). Similarly, imaginal exposure is often used for treating people with PTSD who are fearful of memories following a traumatic event (e.g., Foa, Hembree, Rothbaum, & Rauch, 2019). In some cases, imaginal exposure may also be useful for fears of external objects or situations. For example, if a client refuses to practice *in vivo* exposure due to extreme fear, imaginal exposure may be a good initial step before trying *in vivo* exposures. Also, imaginal exposure may be useful when regular *in vivo* exposure practices are impractical or when a feared situation is impossible to create on a regular basis (e.g., if a client is anxious about their upcoming wedding, a situation that is difficult to simulate).

Imaginal exposure may involve (1) having a client describe a feared memory or image out loud, (2) having a client write about a feared outcome, (3) having the therapist read a description of a feared image or scenario to a client, or (4) having a client silently bring a feared image to mind. Regardless, the process of imaginal exposure is very much a private experience. Different clients typically need to work on different images, and for many clients in the group (i.e., those who are not afraid of their thoughts, images, or urges), imaginal exposure may not even be relevant. At our clinic, we typically do not practice imaginal exposure in groups. If imaginal exposure is warranted for one or more group members, therapists spend some group time describing the procedures and may demonstrate the process with one or more clients. However, clients are expected to do most of their imaginal exposure practices for homework, between group sessions.

Developing an Exposure Hierarchy

An exposure hierarchy is a list of situations that an individual fears or avoids, rank-ordered with the most frightening items at the top, easier items at the bottom, and moderately difficult items in the middle—generally, exposure hierarchies include 10–15 items. Hierarchy items should be as

detailed and descriptive as possible, specifying the variables that impact upon an individual's fear in each situation on the list. For example, "riding a bus alone at rush hour, sitting away from the door" is a much more descriptive item than simply "riding a bus."

In individual therapy, items are typically generated collaboratively, with the therapist and client each proposing possible items based on their discussions about feared situations, as well as the client's responses to items on standard questionnaires, such as the Mobility Inventory for Agoraphobia (Chambless, Caputo, Jasin, Gracely, & Williams, 1985) or the symptom checklist from the second edition of the Yale–Brown Obsessive–Compulsive Scale (Y-BOCS; Goodman, Rasmussen, Price, & Storch, 2006; Storch et al., 2010). After an initial list is generated, the therapist and client refine the items, ensuring that they are sufficiently detailed to describe situations relevant to the client's goals, that they are practical to assign for exposure practices, and that they cover a range of difficulty levels and a range of situations representative of those feared by the client. Once the item list is finalized, the clients rate their fear level (using a 0- to 100-point scale, where 0 = *no fear* and 100 = *maximum fear*) and the extent to which they would be inclined to avoid the situation, using a 0- to 100-point scale (0 = *never avoids* and 100 = *always avoids*). Alternatively, because fear and avoidance ratings tend to be highly correlated, a single fear/avoidance rating can be generated for each item. The final step is to reorder the list, putting the items with the highest fear ratings at the top and those with the lowest ratings at the bottom.

At our clinic, we typically develop the hierarchy during an individual session with each client, before a group begins. An advantage is that this approach ensures that each client has a carefully constructed hierarchy and the therapist has had a chance to have some individual time with each client before the group starts. Also, the individual meetings provide each client with an opportunity to address any last-minute concerns or questions about the group. It is also possible to develop the hierarchies during one of the group sessions. This can be done in one of two ways: (1) to provide detailed instructions (both verbally and in writing) during the group session, or (2) to request that clients develop their hierarchies for homework before the next session. In the former situation, clients can develop their hierarchy in the group session; while clients work on their hierarchies, the therapists can move around the room, answering questions and providing feedback. Group members may also help one another come up with items for their hierarchies. Alternatively, the therapist can send clients home with several sample hierarchies to facilitate the process. Feedback can then be provided to each client at the next group session.

Guidelines for Effective Exposure

The following guidelines should be considered when helping group members to plan exposure practices. We recommend reviewing them with the

group when exposure is first introduced and reminding clients about these principles from time to time over the course of treatment.

Perceived Control

Studies on the effects of controllability (i.e., the extent to which the client has control over the rate of exposure and the ability to end the exposure, if necessary) have yielded mixed findings, with some showing that control by the client leads to better outcomes and others finding no differences (see Antony & Swinson, 2000, for a review). light of these findings, as well as other studies suggesting that a lack of perceived control contributes to anxiety problems (Barlow, 2002), it is generally recommended that clients never be forced to do anything that they have not agreed to do. Exposure is believed to work best when clients have a sense of control over the process.

Spacing of Exposure Practices

Exposure sessions spaced closely together (e.g., daily) have been found to work better than exposure sessions that are more spaced out (e.g., weekly; Foa, Jameson, Turner, & Payne, 1980). Furthermore, spreading out the last few sessions of exposure may lead to even better long-term outcomes (Tsao & Craske, 2000), though other studies have found no advantage in expanding the space between later sessions (Lang & Craske, 2000). Given that CBT groups typically meet only once per week, the best way to ensure frequent exposures is to encourage clients to practice between sessions. However, it is useful to note that the quality of homework compliance may be more important than the quality of homework completed (Cammin-Nowak et al., 2013; Kazantzis et al., 2016).

Duration of Exposure Practices

Stern and Marks (1973) showed that a single exposure session lasting 2 hours leads to more fear reduction than four 30-minute exposures occurring over the course of an afternoon. Ideally, exposures should last long enough for clients to learn that their feared outcome does not occur. If an exposure is inherently brief (e.g., a social anxiety exposure that involves asking someone for directions), the practice can be repeated again and again, until the individual has learned that the situation is safe. In group treatment, it may be difficult to set up in-session exposures lasting more than an hour due to time constraints. Although fear reduction within a session may be a helpful proxy for learning, it does not appear to be essential in order to see improvements across exposure practices (e.g., Craske et al., 2008; Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014). Practically, therapists may want to advise group members to stay in an exposure until fear reduces *or* they believe they have learned something valuable from the

exposure (e.g., that they can tolerate the fear, that their feared outcome does not come true).

Graduated versus Rapid Exposures

Evidence regarding the best rate for progressing through the exposure hierarchy items has been mixed, with one direct comparison finding few differences in outcome following gradual versus more rapid exposure or flooding (Everaerd, Rijken, & Emmelkamp, 1973), and another finding that rapid exposure is more effective than a more graduated exposure schedule (Fiegenbaum, 1988). In practice, exposure seems to work regardless of whether steps are taken gradually or more quickly. An advantage of taking smaller steps is that anxiety is not as overwhelming during the practices. However, if steps are too small, gains occur more slowly, which can increase the length and costs of treatment, and be a blow to the client's motivation (often, nothing is more motivating than seeing quick improvements). Generally, we recommend that clients take steps as quickly as they are willing to; if they find a particular practice more difficult than they can handle, they can always try something easier.

Preventing Safety Behaviors and Rituals

People with anxiety problems often engage in a wide range of behaviors designed to protect themselves from threat. These may include subtle avoidance behaviors (e.g., distraction, wearing extra makeup to hide blushing, or wearing gloves to avoid contact with a potential source of contamination), carrying safety objects (e.g., carrying medication in case of a panic attack), overusing alcohol or drugs (e.g., having a few glasses of wine to manage anxiety at a party), or engaging in compulsive rituals (e.g., checking, cleaning, or counting in OCD). Generally, these behaviors can undermine the effects of exposure, and eliminating them often leads to improved outcomes (Craske, Street, & Barlow, 1989; Morgan & Raffle, 1999; Wells et al., 1995). In fact, in the case of OCD, ritual prevention is generally viewed as an essential component of treatment. However, studies on the effects of safety behaviors on exposure outcomes have been mixed, and some investigators have suggested that including safety behaviors during practices may be helpful under certain circumstances, especially early in treatment (Rachman, Radomsky, & Shafran, 2008). Although therapists will likely encourage group members to work toward reducing the use of safety behaviors, this process can occur gradually and can be built into the exposure hierarchy. In addition, some "safety behaviors" may be required as part of normal living (e.g., washing hands before preparing a meal), and eliminating all types of safety behavior may not be realistic.

Intensity of Exposure

Typically, we recommend that the intensity of fear experienced during exposure start in the moderate to high range (e.g., a rating between 70 and 100), though a practice need not be a horrific experience to be of benefit (Foa, Blau, Prout, & Latimer, 1977). In fact, if fear levels are too high (to the point of being overwhelming), the individual will be less likely to stay in the situation and may start to engage in a variety of subtle avoidance behaviors. Of course, if fear levels are two low, exposures will not be all that useful either.

Importance of Varying Context and Exposure Stimuli

People with anxiety disorders often fear the environments in which they encounter their feared objects and situations, in addition to fearing the objects themselves. Gunther, Denniston, and Miller (1998) found that conducting exposure practices in a variety of contexts protected clients from experiencing a return of fear after treatment had ended, relative to exposure in only one environment. Therefore, it is recommended that clients practice exposure in a variety of places, such as at home, at work, or in other environments where they tend to encounter the situations they fear. In addition, varying exposure stimuli (e.g., practicing driving on a number of different bridges rather than on just one bridge, practicing exposure to several different spiders instead of just one) has been found to be associated with better long-term outcomes (Rowe & Craske, 1998).

Modeling Nonfearful Behavior

Just as fear can be learned through observational learning or modeling (Mineka, Davidson, Cook, & Keir, 1984), clients often find exposures easier when a therapist or other trusted individual shares in the exposure experience or demonstrates the exposure task first. For example, a client with OCD might find it easier to touch a contaminated object after seeing their therapist touch it initially. Though some studies have confirmed better long-term outcomes for exposure treatments that include a modeling component (e.g., Menzies & Clarke, 1993), others have failed to find any benefit of adding modeling to exposure (e.g., Bourque & Ladouceur, 1980). Though findings have been inconsistent, in our experience, modeling is often a useful component of exposure-based treatments, and we recommend including it when possible.

Minimizing Danger

Though it is important to conduct exposure practices that are likely to trigger a fear response, it is at least as important to ensure that the actual risks during exposures are in fact minimal. Clients may not always be the best

judges of whether a particular practice is in fact safe. Before planning an exposure, it may be helpful for clients to ask themselves whether the average person without an anxiety problem would consider the practice to be dangerous. If the answer is "yes," then it is probably a good idea to try a different practice.

Assigning and Reviewing Exposure Homework in Groups

Each group session typically begins with a review of homework. Each client takes a turn at describing their experience with the homework from the previous week. When a particular client is speaking, the other group members should be encouraged to participate in the process by asking questions and making suggestions. Homework is assigned at the end of each session in much the same way. Each client describes their homework plan for the following week. The therapists and other group members provide feedback on the plan, which may lead to some changes in the homework that is finally assigned. Therapists should record each client's homework assignment, so it can be checked on at the next session. In addition, clients should be encouraged to record their homework assignments on paper, so that they are sure to remember what they agreed to do.

Behavioral Self-Monitoring

A hallmark of behavioral treatment is careful monitoring of symptoms in behavioral diaries. Self-monitoring helps clients to become more aware of their behaviors, as well as the triggers for, and consequences of, their behaviors and emotional responses. In addition, completing diaries encourages clients to stay engaged in treatment throughout the week rather than just during their therapy sessions. Finally, diaries can be used to document progress during treatment.

Typically, diaries allow clients to record their symptoms, either in particular situations (e.g., during an exposure practice) or throughout the week. For example, individuals with bulimia are often asked to monitor their food intake during the week, as well as any purging episodes that occur. Similarly, people with PD are typically encouraged to monitor their panic attacks, recording the intensity of each attack, the circumstances under which it occurred, and the symptoms that were experienced.

When using monitoring forms in groups, it is important to spend an adequate amount of time teaching group members how to complete the forms. We recommend that clients turn in their monitoring records at the start of each session (particularly during the first few treatment sessions), so therapists can provide corrective feedback on how the forms were completed. Once clients have a good understanding of how to complete their diaries appropriately, handing in the diaries is less important. Instead,

clients can hold on to their diaries, using them to prompt their memories as they describe their experiences with the previous week's homework.

Social Skills Training

SST (e.g., communication training, assertiveness training) is often included as a component of behavioral treatment for a number of different problems, including SAD, depression, schizophrenia, and couple distress. Essentially, the process involves teaching clients to identify particular social skills deficits or communication-related behaviors that they would like to change, then targeting those social skills directly in treatment. The goal of SST is to improve the client's functioning in social and performance situations in order to increase the likelihood of a positive response from others, which in turn may lead to other positive consequences (successfully interviewing for a job, getting along better with others, becoming an effective presenter, etc.). Table 3.1 includes a list of behaviors that may be worked on in

TABLE 3.1. Behaviors Targeted in SST

General category	Examples
Nonverbal communication	• Eye contact • Body language (e.g., personal space, posture) • Facial expressions
Conversation skills	• Tone and volume of speech • Strategies for starting and ending conversations • Asking open-ended rather than closed-ended questions
Presentation skills	• Refraining from reading a presentation to an audience • Developing effective slides and audiovisual aids • Using humor in the presentation • Strategies for answering audience questions without seeming defensive
Dating skills	• Asking another individual out for lunch or dinner • Strategies for following up after a date
Assertiveness skills	• Asking for something in a direct manner, without coming across as overly passive or aggressive • Asking another individual to change their behavior • Refusing an unreasonable request
Conflict skills	• Learning how to defuse an argument • Learning how to deal with situations that may lead another individual to become angry
Listening skills	• Listening to other people instead of planning what one is going to say next in a conversation • Asking for clarification when a statement is unclear

SST. Detailed strategies for improving social and communication skills are available elsewhere (e.g., McKay, Davis, & Fanning, 2018).

In some ways, presenting the rationale for SST is more straightforward in a group setting than in individual therapy. In individual therapy, a client may respond negatively to the suggestion that they need to work on their social skills. However, in a group setting, these strategies can be brought up more generally, so that no particular client is likely to take the suggestion personally. In addition, it is helpful to begin by having clients identify social behaviors that they would like to work on, rather than having the therapist point out social skills deficits of which the client may not even be aware. As treatment progresses, the therapist can suggest additional behaviors that group members may wish to target.

SST is often accomplished in the context of exposure practices or behavioral role plays. After identifying particular behaviors to change, clients are encouraged to practice replacing problem behaviors with more adaptive behaviors, perhaps after modeling by the therapist or other group members. For example, clients may be taught to make appropriate eye contact or to give a presentation without having their voice drop off. It is often helpful to video record the role-play practices, and to play the recordings back, so clients can evaluate their performance and group members can provide objective feedback.

Problem-Solving Training

Impaired problem solving is a common feature in certain psychological problems, such as depression (Davila, Hammen, Burge, Paley, & Daley, 1995) and schizophrenia (e.g., Xia & Li, 2007). In addition, although problem-solving impairment may not be a prominent feature of generalized anxiety disorder (GAD; Ladouceur, Blais, Freeston, & Dugas, 1998), frequent worry may be associated with impaired confidence in one's problem-solving abilities (Belzer, D'Zurilla, & Maydeu-Olivares, 2002) and difficulty implementing solutions to problems, as opposed to difficulty generating solutions (Davey, 1994). Because of the possible relationship between impaired problem-solving skills and various psychological disorders, treatments for these disorders sometimes include problem-solving training as a component (e.g., Martell, Dimidjian, & Herman-Dunn, 2022; Robichaud, Koerner, & Dugas, 2019). Importantly, problem solving is a strategy that is best used for *current* problems, where an actual problem is at hand, rather than potential *hypothetical* problems (Robichaud et al., 2019). Clinicians may direct clients to use problem solving rather than worry when facing a current problem (Robichaud et al., 2019). Problem-solving training involves teaching clients to use a structured, step-by-step approach to solving problems that typically

involves four steps (e.g., D'Zurilla & Nezu, 2006; Wenzel, Dobson, & Hays, 2016):

1. *Defining the problem and the goals of problem solving.* The first step involves identifying the specific problem to be solved. Clients are encouraged to replace problems that they describe in vague or general terms (e.g., "I hate my job") with a list of more specifically defined problems (e.g., "I would like to find a job that will allow me to use my background in design"). If the client identifies multiple problems, they are encouraged to use the problem-solving strategies to work through each problem, one at a time, starting with the most important problem.

2. *Brainstorming possible solutions.* This stage involves having the client list as many solutions to the problem as possible, without filtering, censoring, or judging solutions that come to mind. All possible solutions (good and bad) should be recorded at this stage. When teaching problem solving in groups, all clients in the group should be encouraged to generate possible solutions to problems raised.

3. *Evaluating possible solutions and deciding on a solution.* At this stage, clients are taught to evaluate the advantages and disadvantages of each solution generated in Step 2. Through this process, clients work at reducing the length of their lists by eliminating solutions that are impossible or impractical to implement, that are unlikely to work, or that can only be implemented at great cost. The remaining list should include only those solutions that are reasonable options. Next, clients should select the best solution (or solutions) from their list, based on the evaluation completed in this third step. Clients may be concerned with finding the "perfect" solution, which provides an opportunity for clinicians to help clients tolerate uncertainty (Robichaud et al., 2019).

4. *Implementing the solution.* The final step involves implementing the selected solution. Upon implementing the solution, the client may encounter various obstacles. If this occurs, the client should use the same problem-solving approach to get around any problems that arise along the way.

In group treatments, problem-solving skills are usually introduced didactically. The entire group may then participate in working through one or two sample problems presented by the therapists, followed by some actual problems that group members may be experiencing in their lives. It is generally recommended that clinicians introduce a problem-solving module as learning to *master* these skills rather than as learning a new skill, given the intuitive nature of the steps (e.g., Robichaud et al., 2019). Clients should then be encouraged to practice their problem-solving skills throughout the week, as problems arise in their day-to-day lives.

Conclusions about Behavioral Strategies

This section provided an overview of how to administer behavioral strategies in a group format. Much of this section focused on exposure-based treatments. In addition, suggestions for implementing other strategies (e.g., behavioral self-monitoring, SST, problem solving) were provided. We now turn to cognitive strategies, which are typically interwoven with behavioral strategies in most groups. The proportion of time spent in a group on behavioral and cognitive strategies varies with the presenting problems being treated. Part II of this book offers more specific guidance on particular disorders.

Cognitive Strategies

Next, we describe some of the most frequently used cognitive therapy (CT) techniques and how they can be adapted and applied to a group setting. One obvious challenge in presenting these strategies is that there likely exists no absolute or correct way to determine how many cognitive techniques are essential in CBT and how to classify the different strategies. Previous authors describing CBT have opted for different presentations, some using a relatively delimited number of domains (e.g., Beck, 2011) and others using a "compendium" approach featuring numerous specific strategies (e.g., Neenan & Dryden, 2015).

We have grouped the techniques into four broad categories: (1) connection between thoughts, situational triggers, and the elicitation of negative affect, including depression and anxiety; (2) use of evidence gathering to become more objective about one's negative or maladaptive thoughts; (3) use of experiments; and (4) exploration of underlying beliefs and assumptions. Throughout, we also focus on the three fundamental concepts of CT that underlie each of these domains: collaborative empiricism, Socratic dialogue, and guided discovery (Beck & Weishaar, 2000). The group modality alters each of these fundamental precepts of cognitive techniques in very specific ways. We next define each of these terms, taking into account group process factors.

Collaborative empiricism is achieved when therapist and client join forces to investigate thoughts and experiences in a manner that is reminiscent of the scientific method. This requires developing hypotheses about thoughts and testing these through logical analysis and collection of factual evidence. Importantly, this partnership helps to demystify the process of change since the techniques for change are shared openly and step-by-step (Beck & Weishaar, 2000). Of course, in a group, the essential elements of this definition are left intact—however, the relationship must necessarily expand to include interactions between therapists and group members, and interactions among group members. In a sense, group members

become therapists for one another, asking questions rather than providing direct advice or feedback. The role of therapist also becomes more complex because collaborative empiricism needs to be cultivated not only between therapist and client but also between clients. This requires direct modeling and feedback about the need to ask questions and more subtle forms of socialization—for example, making sure that clients in the group do not simply "blurt out" what they perceive as helpful advice to one another. Therapists also need to reflect on that process through summaries describing concretely how collaborative empiricism was used. These kinds of "meta" summaries are useful for ensuring generalization of the empirical approach when group members are applying the approach, by themselves, between sessions.

Socratic dialogue is a series of interconnected questions that lead to a more logical, objective conclusion about one's inner experiences, and is also a common theme for all cognitive techniques (Beck & Young, 1985). In fact, asking open-ended and open-minded questions is probably one of the most critical and distinguishing features of CBT. Four basic steps in this questioning process have been described: (1) characterizing the problem specifically and accurately; (2) identifying the associated thoughts, beliefs, and interpretations; (3) understanding the meanings of the thoughts for the client; and (4) assessing the consequences of thoughts and their basis in evidence (Beck & Weishaar, 2000). Although the questions in a Socratic dialogue should neither lead nor trap the client into agreeing with the therapist's view (which is, of course, inevitably biased), the questions are intended to stimulate consideration of alternative perspectives and uncover information that was not previously considered.

In individual therapy, the clinician has the task of asking questions that help to illuminate new information and new perspectives. Cognitive therapists can quickly become adept at formulating questions, anticipating possible answers, and even considering the question that might follow the one currently being asked, or at least considering possible answers and where these might lead. However, this process becomes much more complex in a group. Multiple individuals, including cotherapists and other clients, will ask questions of the client whose example is being considered. Thus, therapists must not only keep up with the questioning strategy they are using but they must also process, in an "online" manner, where questions asked by others will lead the discussion. Therapists must also evaluate the usefulness, or therapeutic value, of questions group members ask of one another. Although this seems like a difficult, even impossible task, it is important to remember that Socratic dialogue can also sometimes be unproductive in individual therapy. In all CT, multiple lines of questioning must very often be used to discover useful information, and unless an example runs well over the allotted time, there is no harm in using multiple types of questioning or starting over using a new questioning approach. Nonetheless, an important component of the therapist's work is to teach group members to ask useful and therapeutic questions of one another, in

addition to being ready to ask themselves useful questions. This is a process that readily develops over time.

In early sessions, therapists are more likely to ask most of the questions, while group members observe and learn strategies. Over time, more of the questioning strategies can be left to the group, with occasional "course corrections" from therapists. For therapists, this can also be illuminating and surprising, because group members very often ask highly useful questions that the therapists may not have considered. This only reinforces the value and power of Socratic dialogue and the importance of multiple perspectives inherent in a group of individuals.

The final concept, common to many cognitive techniques, is *guided discovery*. Here, the therapist helps to illuminate the meaning of thoughts and problems in logic, or helps to create situations from which the client learns new information and different ways of thinking, acting, and feeling. In a group setting, guided discovery takes on the additional dimension that there are multiple possible guides in addition to the therapist. Although therapists undoubtedly retain a considerable portion of authority and lead the group through exercises and examples, the group significantly influences that process. For example, if a therapist wishes to help a group member to create an experiment to test the validity of a thought, the therapist might suggest a basic approach, with group members making additional suggestions or modifications. The advantage of having the group help to guide discovery is that this often makes the process more creative. However, therapists as leaders must retain the option of not heeding group suggestions that are not helpful or valid for the specific example being considered. Group members often make helpful suggestions, but this is not universal, and at times the input of the group may impede guided discovery.

The three change strategies in CT—collaborative empiricism, Socratic dialogue, and guided discovery—are evident in each of the four technique content areas we describe next. We recognize that our presentation of those four stages of CT technique is somewhat arbitrary and caution therapists that we do not intend for these techniques to always be presented exactly as described here. Instead, we suggest that therapists regard collaborative empiricism, Socratic dialogue, and guided discovery as a set of philosophical principles or values. Keeping these principles of the intervention in mind, therapists can construct an infinite number of specific techniques that might be suited to a particular group in a specific instance.

Cognitive Techniques I: Connecting Thoughts to Situations and Affect

Eliciting automatic thoughts and educating clients about the connections between their "inner dialogue" and their affective reactions to events are often the first areas examined by the group. In some instances, group

members will have had an opportunity to record events that changed their mood or other symptoms and to have made an initial attempt to record what they recall thinking or saying to themselves. Other times, group members may be asked to recall a recent situation that elicited strong negative feelings, anxiety, or other symptoms they are seeking to change.

In either case, group members are sensitized to the idea of "shifts" in their emotional state, and are encouraged to take the opportunity to record what was happening at that time, and what they were feeling and thinking. This may seem straightforward, and it is in many instances—however, some group members have considerable difficulty identifying mood shifts or articulating their thoughts. There are other ways to elicit thoughts, initially by asking questions about what was happening in the person's mind, or by providing generic examples that might parallel the client's experience. Another alternative is to have the person imagine the situation as if it were happening again; this allows group members who have some initial difficulties with the process to remember their thoughts.

This process, the recording of thoughts, is usually done on something that resembles the Daily Record of Dysfunctional Thoughts (DRDT). Many different and specific forms of this record exist, usually customized for the specific disorder of interest. However, almost all forms have columns to represent the situation encountered, the emotion or symptoms, and the recorded thoughts. If using a full thought record, group members are often asked to complete only those three columns of the record to start, so as to sensitize them to the idea of recording their thoughts. This can take some practice; some group members will find the idea of writing down their internal, often negative dialogue to be somewhat unusual and even acutely uncomfortable. Even those group members who have no difficulty with this recording are unlikely straightaway to record those thoughts that contain the most emotional content, which we would term the "hot" thought (Greenberger & Padesky, 2016). Through further questioning and dialogue, the group helps each member refine the ability to record thoughts and become more and more aware of which thought is hot and of central importance to their experience.

The group therapist's goals in this stage of therapy are to:

1. Help the client connect the event with a certain set of thoughts that have important consequences for affect.
2. Lay the groundwork for "shaping" the group's thought records so that all members become more likely to record the hot thoughts they are experiencing.
3. Model questions one can ask oneself (or others) to specify thoughts and their connections to events and emotions.
4. Emphasize the importance of understanding one's thoughts as an initial step to change emotional responses.
5. Maintain positive group processes, particularly inclusion,

cohesiveness, and emotional processing, so that group members experience the group as a welcoming, supportive environment in which to share and explore their private thoughts and affect.

Cognitive Techniques II: Use of Evidence Gathering

Once group members are able to identify their "automatic thoughts," the group can begin to focus on reexamining potentially biased negative conclusions. Employing a Socratic approach, the group members learn to question their thoughts and take a more wide-ranging, objective view of the facts involved in a situation that they found emotionally distressing. This dialogue typically consists of many informational questions and then synthesizing questions that help clients to integrate the new information in a way that differs from their original conclusion (the hot thought). Critical questions in this process typically involve having clients think about their experience from another perspective, considering factors that they did not at first consider, and pointing out any logical leaps that might not be warranted by the actual facts. It is important to emphasize that evidence gathering and examination for distortion do not represent "positive thinking," nor should questions be used to trap clients or invalidate their thoughts. Instead, the questions enable clients to look at the situation objectively, flexibly, and nondefensively.

A common way to determine whether a negative thought might be distorted is by eliciting the "evidence" for and against the negative thought. First, all the facts—not interpretations or suggestions, but the objective facts that support the negative conclusion—need to be listed. Next, group members learn to ask questions that identify factual information that is not consistent with the original conclusion. The kinds of questions therapists ask vary according to the situation. Broadly defined, questions that gather evidence against the automatic thought usually (1) ascertain all the situational parameters related to a negative thought, especially those outside of the client's control or responsibility; (2) ask clients to shift perspective on the situation by having them perceive the situation "through" another person; and (3) have clients focus on information that is incomplete or unsubstantiated. Once a more complete picture of the situation emerges, clients are asked to formulate a "balanced" thought that takes into account all of the evidence from the questioning process. This process usually helps to illuminate the kinds of cognitive errors, or distortions, clients made when they did not take into account all of the information. Typically, the group takes an example from one of its members, and both therapists and group members are encouraged to participate in asking questions of the person supplying the example. In addition, therapists summarize and highlight questioning strategies that will be useful beyond the context of the current

example, so that group members consider such questions for their own thoughts.

Systematic errors in cognitive processing, or *cognitive distortions* (Beck et al., 1979), are often the basis for negative thoughts. Various lists of cognitive distortions exist, and different distortions are seen in different kinds of disorders. Most generally, cognitive distortions include the following:

- *Arbitrary inference*—drawing a specific conclusion without supporting evidence or even in the face of contradictory evidence. An example of this is a harried worker who cannot accomplish all of their tasks in one day, thinking, "I'm a horrible employee."
- *Selective abstraction*—conceptualizing a situation on the basis of a detail taken out of context, ignoring other information. An example is the person who takes one piece of negative feedback from an evaluation with 10 pieces of positive feedback and becomes sad and hopeless.
- *Overgeneralization*—abstracting a general rule from one or a few isolated incidents and applying it too broadly and to unrelated situations. After having difficulty with an unruly child in a class, a teacher concluded, "All of these children are ill-mannered."
- *Magnification and minimization*—seeing something as far more or less significant than it actually is. After a woman on a date unintentionally mentioned that her former boyfriend had left her, she thought, "Now I've done it. He knows there's something wrong with me."
- *Personalization*—attributing external events to oneself without evidence supporting a causal connection. At a party, a woman overheard someone saying that there were not enough interesting people at the gathering, and she thought, "I know he's talking about me."
- *Dichotomous thinking or black-and-white thinking*—categorizing experiences in one of two extremes (e.g., as complete success or total failure). A woman who was cooking a family dinner felt that one of her dishes had not turned out perfectly, and she thought, "The entire dinner is ruined."
- *Mind reading*—this error occurs when someone believes they know what another person is thinking, without any direct evidence. A woman's friend did not return her call about plans for the weekend, and the woman thought, "She's fed up with my depression and doesn't want to be around me."

Teaching group members about these distortions in conjunction with evidence gathering is extremely useful, because once these concepts are understood, clients can quickly tackle their own cognitive errors. Once

clients have identified their "usual" cognitive errors, they are able to correct their thinking more efficiently. Use of these cognitive strategies in group follows the usual pattern for presenting techniques. Therapists provide a brief but careful didactic overview, describing both the need to gather evidence around one's thoughts and possible distortions. Next, an example is provided by one of the group members. The therapist initially walks through the example, taking a leadership role in the process as the group learns the technique. Gradually, and over the course of further examples, the group leaders take on a less directive role, potentially helping the group to initiate questions, and correcting the course of questions only as needed. Eventually, each group member will have multiple opportunities both to ask questions of others and to have their particular example examined by the group.

Cognitive Techniques III: Experiments

Aside from identifying a distortion and gathering useful evidence, a DRDT may also point to a lack of information or leave the individual with unanswered questions about the meaning of a situation. A powerful way to change thinking is through direct experience, and conducting an *experiment* provides such an experience. An experiment is essentially a plan to gather new information needed to reach a conclusion about the accuracy of a negative thought. The experiment in CT embodies collaborative empiricism and asking questions in an open-minded manner. Many experiments involve some form of returning to the situation and gathering more information, but the essence of any experiment is to form a hypothesis about a thought and a way to test that hypothesis. For example, where a group member has been "mind reading," the group member could be encouraged to check their conclusions with the other person involved in the situation.

The key to a powerful experiment is to create two hypotheses that are credible and important, and that can be proven by facts to be either true or false. In individual treatment, often the client's hypothesis is related to their automatic thought—that is, a negative conclusion about a situation. The therapist, at least initially, typically offers an alternative hypothesis that represents a more balanced, evenhanded view of the situation. Therapist and client then work together to develop a simple methodology to "test" each of their ideas. Before any exploration is carried out, discussion should take place about what information is likely to emerge and what that information means for each hypothesis. Both the therapist and the client are likely to have an attachment to their hypotheses, but both commit to allowing the evidence that emerges to influence their view.

In a group setting, the hypotheses and methods of the experiment are influenced in a more complex way by the entire group. However, group members can also contribute novel and useful suggestions for testing ideas.

The group therapist focuses on the following objectives for creating useful experiments:

1. Clarification of the client's hypothesis and an alternative, balanced hypothesis.
2. Development of a method for testing those ideas that is compelling for not only the client but also for other group members.
3. Maximization of learning by reminding group members about how they can use experiments themselves.
4. Focus on group factors, including cohesion and shifting self-focus.

Cognitive Techniques IV: Exploring Underlying Beliefs and Assumptions

For most clients, problematic situations and thoughts occur repeatedly, and certain "cognitive themes" emerge over the course of many thought records. Such themes are indicative of clients' more deeply held beliefs about themselves, others, and the world. These beliefs, which are thought to be rooted in early life events and learning, are variously called core beliefs or schemas (Beck, 2011; Leahy, 2017). The process of understanding early learning and how it leads to clients' beliefs and current problems is a more fluid and open-ended process compared to the DRDT. However, helping clients to understand their underlying beliefs helps them to change the factors that give rise to many of their troubling automatic thoughts and provides alternatives to self-defeating coping strategies.

Conditional Assumptions

One of the most common strategies for identifying beliefs is the downward arrow (Greenberger & Padesky, 2016). This approach begins with an automatic thought, and rather than disputing that thought with evidence gathering, clients are encouraged to deepen their level of affect and explore the thought with questions such as "What would it mean if this thought were true?" This typically leads to the emergence of an underlying conditional assumption, a level of cognition that typically takes the form of "if . . . then" statements. These "rules" often specify a circumstance and an emotional consequence that is dysfunctional. For example, a client whose thought records reflect concern, time after time, with letting others down might have the belief "If I cannot please everyone around me, it is awful."

Largely, these rules exist at a level of awareness such that the client has rarely been able to reflect on them. In these instances, it is often the therapist who picks up on a kind of "emotional rule" that seems to reoccur in the client's difficulties. A number of situations may share some features and

cause similar emotional responses. Often, this means that similar rules are in operation across these situations. The therapist might initially verbalize this rule and then a collaborative effort can be made to modify the specific wording of the conditional assumption. Other times, clients may be aware of their conditional beliefs and are able to state "the rules" that seem to govern their emotional and behavioral responses to situations.

Another useful conceptual issue is the distinction between "positive assumptions" and "negative assumptions." A positive assumption is an if . . . then statement in which the outcome, the "then," is positively valenced from the client's perspective. In other words, a positive assumption is a case where the client, if they satisfy some condition, can gain a positive outcome. The difficulty with these beliefs is that the condition is often rigidly defined and difficult to maintain. For example, a client may have the belief "If I do everything right all the time at my job, I will be all right." A negative assumption is also an if . . . then statement, but in this case, the outcome is negatively valenced from the client's perspective. In some instances, negative assumptions can be seen as the "flip side" of positive assumptions. In the previous example, a negative assumption version might be "If I make a mistake at my job, I will be a failure." Here, the precedent (a mistake) leads to a negative consequence (sense of failure).

In a group setting, it is useful first to present the concept of conditional assumptions or emotional rules didactically and provide examples similar to those presented above. Usually, the examination of beliefs occurs after many group sessions, by which time group members are highly cohesive and also have considerable knowledge of one another's difficulties. Thus, group process plays a very important role in uncovering beliefs, since group members have some understanding of one another's typical ways of emotional responding to situations. The group therapist's goals when focused on condition assumptions are:

1. Exploring any emotional rules that underlie particular automatic thoughts.
2. Illustrate the "if . . . then" nature of these emotional rules or assumptions.
3. Discuss the negative emotional consequences of the assumption and the need to modify this.
4. Focus on emotional processing, group learning, and modifying maladaptive relational patterns, particularly when conditional assumptions are interpersonal.

Associated with conditional assumptions or rules are compensatory or coping strategies. The ultimate goal of these coping strategies is directly related to a conditional assumption. These strategies can logically be defined as the behavior a person selects in order to ensure that (1) the

positive assumptions are made true, and (2) the negative assumptions are made false. Thus, pragmatically, this means that clients are motivated to engage in any behavior that satisfies their assumptions in an attempt to regulate affect. For example, if a group member holds a belief about needing to always help others, they may overextend themself and sacrifice to considerable lengths to provide help to anyone who asks. In most cases, the key consideration is to determine what behaviors are associated with conditional assumptions and then to specify what these behaviors are intended to do.

Most often, the behaviors that result from extreme beliefs are problematic, and this is usually quickly recognized by the group, if not always the client whose example is being discussed. For example, someone with high standards or perfectionism will often engage in behavior that seems illogical or even self-defeating to observers. Having the group, as gently as possible, reflect these responses back to the client is often very meaningful to the client who feels "trapped" in this cycle of high standards and behaviors designed to keep up with those high standards. The next step in working with conditional assumptions and coping strategies is creating alternative beliefs and reducing reliance on unhelpful coping strategies. More balanced and less rigid beliefs often emerge in the Socratic dialogue, though initially, more therapist direction may be required. For this component of CT, the group therapist's overall goals are to:

1. Identify an alternative conditional assumption that is more functional.
2. Examine the consequences of the new conditional assumption for behavior.
3. Facilitate group learning and emotional processing.

Core Beliefs

The deepest form of cognition that most groups focus on is the concept of core beliefs. These represent extreme, one-sided views of self, other, and the world that give rise both to the conditional assumptions and coping strategies described earlier. Core beliefs are believed to be primitive, extreme views formed as a result of early experiences (Clark, Beck, & Alford, 1999). Content for these beliefs varies for each individual, but it is important to emphasize that core beliefs are ways of understanding the world and are often "rational" in the circumstances under which they form. The most important precursor to identifying core beliefs is to explain these concepts in therapy. Clients are encouraged to see their automatic thoughts as outgrowths of something deeper and that more profoundly affects their interpretations of events over time. The rationale, early learning, should also be provided, because it is important for clients to understand that their

negative core beliefs are not accidental or random but rather are understandable outcomes of their experiences. Core beliefs often take the form of absolute statements, such as "I'm a failure," "I am unlovable," or "I am in constant danger." Clients usually experience considerable affect when exposed to their core beliefs; they can often become tearful, sad, or very anxious. This is usually a sign that a highly salient type of processing has been tapped.

Many of the techniques used for changing automatic thoughts (e.g., examining distortions, evidence gathering) can be applied to working with deeper levels of cognition, although changing beliefs takes longer and requires more effort than altering a negative automatic thought. In addition to these techniques, three other processes help to change core beliefs, all of which are facilitated by the group and group processes. First, clients need to have some narrative concerning the development of these beliefs. Second, clients need to view these experiences more objectively and sympathetically, acknowledging that they learned something negative and potentially damaging. Third, it is important to engender hope that these kinds of beliefs can be "relearned" with the help of the group experience. Once clients have acknowledged the need to change core beliefs, they can be encouraged to create an alternative core belief, just as they worked on an alternative thought to their automatic thought and alternative conditional assumptions. Once the alternative belief is identified, clients are encouraged to gather evidence for the old core belief and the more adaptive alternative core belief. This encourages clients to see their subsequent experiences through a new filter and assess which of the two beliefs is a better fit to their current reality.

As with other cognitive techniques, the therapist first provides an overview of the rationale for working on core beliefs and examples to illustrate the point. Next, the therapist selects a suitable example, keeping in mind the high level of affect that can sometimes accompany this discussion. The goals of the group therapist in working with core beliefs are:

1. Identifying a core belief and its historical context.
2. Identifying a potential alternative belief.
3. Developing strategies for strengthening that alternative core belief.
4. Facilitating group learning and emotional processing.

Conclusions

This chapter provided an overview of important behavioral and cognitive "building blocks" that are present in nearly all types of group CBT. These critical techniques are combined in various ways that are often based on the presenting problems in the group. The emphasis or proportion of the

two broad themes can vary considerably—many anxiety disorder protocols use a high proportion of behavioral strategies, while mood and personality protocols are more likely to rely on cognitive techniques. In Part II, we specify how these broader "B" and "C" strategies are brought to life in groups for specific problems. This includes sample dialogues to illustrate how, more exactly, to discuss these strategies in groups. In Part II, we also describe some common obstacles that can arise around these techniques. The essence of behavioral and cognitive intervention in group is to keep the traditional CBT principles in mind, while at the same time considering process factors. An ideal behavioral and cognitive intervention in a group mixes teaching of technique with the activation of process factors that deepen and enrich the learning and change experiences for all group members.

CHAPTER 4

Mindfulness-Based Cognitive Therapy

In this chapter, we describe a form of treatment that has been rapidly evolving from a CBT root and involves a distinct mindfulness component. It could also be said that mindfulness treatments have evolved to include a CBT component, depending on the perspective of the writer—a testament to how intertwined these interventions have become, particularly in the area of mental health and its disorders. Partly for this reason, mindfulness-based CBT (MBCBT; for efficiency, we shorten this to MBCT in this chapter) groups deserve special attention: Are such groups really CBT with mindfulness added on or are they meditation groups with CBT added? Readers may find that the answer is both of the above. This work also deserves special consideration for other more specific reasons. First, the tradition of teaching mindfulness within "Western" medicine dates to the 1970s and from Day 1 involved a group format for teaching and learning (Kabat-Zinn, 1990). Second, an MBCT intervention is not a simple add-on or tweak to standard treatment; it produces a profound shift in structure, content, and group process that merits distinct consideration. Third, this remains a rapidly evolving field and while the seeds of this movement were certainly present in the 1990s, many of the interventions have been described only in recent years and continue to develop—in a 2018 meta-analysis (Goldberg et al., 2018), only 30% (50/171) of included studies had been published prior to 2012.

The merging of CBT and mindfulness began in the area of depression with a specific focus on relapse prevention (Segal, Williams, & Teasdale, 2013). At the time in the mid-1990s, this approach filled a specific and critical niche. A treatment was needed for working with individuals who had recovered from depression and had almost no symptoms, but who

had a known risk of relapse and were interested in a treatment that would offer a degree of protection against another episode of depression, and ideally, an approach to "wellness." The developers of this approach began a collaboration with Jon Kabat-Zinn, who had been the "father" of mindfulness in North America and had been teaching mindfulness in a medical setting since the late 1970s. The treatment that was developed, called MBCT, was both efficacious and impactful, and the approach in treating depression relapse was adopted and reshaped to treat many conditions in the mental health and addiction spectrum. It has likely become impossible to list all possible applications of mindfulness–CBT hybrids, but a recent meta-analysis of mindfulness therapies for psychiatric disorders (Goldberg et al., 2018) describes protocols for attention-deficit/hyperactivity disorder (ADHD), anxiety, bipolar disorder, depression, pain, PTSD, schizophrenia, sleep, smoking, and weight/eating, among a number of other mindfulness-based approaches.

In this chapter, we describe an overall approach to CBT mindfulness groups. Although it would have been possible to describe mindfulness interventions for specific disorders in Part II of this book, we chose this alternative approach to focus on "generic" CBT mindfulness because as a group of interventions, they likely have more in common with one another, even across different disorders. Moreover, we would make the claim that mindfulness-based interventions, while fitting alongside standard CBT, are rather unique interventions. Finally, running such groups offers distinct rewards and challenges for therapists—and indeed there are a number of clear differences and more subtle differences in approach. It may indeed be true that some therapists are a better fit for CBT versus MBCT, and that the converse would also be true: that some will be artful practitioners of MBCT but be relatively less comfortable as a CBT group leader.

In the next section, we review a number of facets of a "generic" MBCT approach. We begin with client eligibility and suitability; address structural factors, mindfulness, and CBT strategies in the group setting; and discuss the process factors common to these groups.

Assessing Eligibility for MBCT

For this section, it is important to note that in an actual clinical application, much would depend on the specific MBCT protocol and population the group is aimed at. Nonetheless, some general observations are certainly possible.

First, it is important to explain openly what MBCT is and what might be different about it compared to other treatments. This is particularly true when MBCT is offered to clients who may have already undergone other treatment (including CBT) for a more acute phase of their illness. Indeed, in the original application of MBCT for depressive relapse, most clients who

sought this treatment did so only after successful treatment using another modality. MBCT looks and feels very different to clients than a more active treatment to reduce symptoms; important points to emphasize to clients include the more experiential aspect of mindfulness, and assessing their comfort with considering what, at first, will seem to clients like a slightly more philosophical or existential stance.

Second, depending on the client's treatment history, it can be important to point out that the look and feel of an MBCT group can be somewhat different from most other psychotherapy groups. Examples that can be helpful is that in most MBCT groups there is not necessarily an opportunity at each group for open-ended self-disclosure or even a review of the week's events (so typical of CBT groups). Instead, the therapist might point out that MBCT resembles more of a skill-learning group, where both the experiences and group discussion are focused on the development of that skill. In this discussion with the client, therapists also point out, somewhat implicitly, that in an MBCT group, more of the responsibility for the experience rests with the client. It might be argued that a CBT group is something that is done for clients by therapists trained in a specific modality; in MBCT, therapists offer something the client can choose to participate in and take on. Practicing mindfulness cannot be done to a person.

This leads to the third and final theme that is important to emphasize as clients decide whether or not to participate in MBCT—namely, that the commitment to between-session work is large and probably much more important than actual participation in the weekly group. MBCT asks for a daily commitment of up to 1 hour to meditate on days the group is not in session. This is critical and often an important decision point—for example, where clients' current symptoms and functional limitations may not indeed allow for that kind of energy and time commitment. For other clients, they may agree that they have the capacity to invest such time, but may also not have fully thought through what this means in real terms. It can be useful to point out that such a commitment, while laudable, is not trivial. Spending this kind of time commitment is equivalent to following exercise guidelines or good nutrition guidelines; many people seek to make such a pledge but, in practice, doing these things on a daily basis can quickly become overwhelming. Direct discussion about when and how time for meditation might be found is helpful groundwork for when the group commences.

Finally, a word about comorbidity: because MBCT treatments are often offered in a context where someone has struggled with a chronic problem for some period of time, there may be additional diagnoses present. MBCT is typically broadly applicable, precisely because less time is spent on psychoeducation about specific diagnoses and symptoms than in other CBT-based treatments for depression. Indeed, much of the process of skill building and developing mindfulness practice is agnostic to underlying diagnoses. When mindfulness was first applied by Kabat-Zinn

as mindfulness-based stress reduction (MBSR), it was provided to individuals with a broad range of medical and other chronic conditions—thus there is a long tradition of inclusion in this approach. As a group progresses, the work and process emphasize basic human qualities of the mind, such as emotions, behaviors, and thoughts that are common to nearly everyone. Despite this broad bandwidth, two conditions that could be comorbidities deserve special mention or consideration. We have found that an MBCT setting is sometimes not sufficiently structured for individuals with borderline personality disorder (BPD), especially at the more severe end of this difficult diagnostic category. Often the powerful emotion dysregulation aspect of this problem derails the process for the group. Mindfulness components offered in a dialectical behavior therapy (DBT) format are likely a better fit for this population. Second, individuals with PTSD, especially those who have endured physical trauma or injury, should be cautioned that some aspects of the practice, body scanning in particular, can produce strong reexperiencing sensations and emotions (e.g., flashbacks) that can be distressing. This is unlikely to be any kind of absolute exclusion but is something a person electing to take part should consider.

Structuring Group Treatment

Number of Participants

Given that mindfulness is a more "skills"-based approach, it might be assumed that MBCT groups could comprise more participants than other CBT groups. Indeed, it is true that during the meditation practices themselves, almost any number of participants could be meditating in silence and following along with the group leaders' instructions. However, there are many other phases to the group, including inquiry (described below), that are aided when the group size is more modest (10–12 participants) so that everyone has an opportunity to respond to questions and offer their input. Moreover, when doing other kinds of practices, including yoga (or mindful stretching) and walking meditation, it is advantageous for the group leader or coleader to be able to have oversight of everyone and, where needed, give some gentle feedback. Also, to some extent MBCT allows more room for participants to speak and share—for example, in some groups, the guide for participants explicitly states that "sharing" is fully optional. An utterly silent group member in a traditional CBT group is a clear warning sign and requires follow-up. In an MBCT group, silence from a group member is much more acceptable, especially if in other ways that group member is participating in the meditations and showing no particular signs of distress. Finally, as in other CBT groups, heterogeneity of group members is a valuable asset and in MBCT, the opportunity to broaden membership is especially welcome. Again, this has to do with the skill-building basis of such groups—individuals from many walks of life, age groups, or other

backgrounds will have incredibly similar experiences as they learn to meditate and grapple with mindfulness as an approach to their difficulties.

Structure of Group Sessions

Most MBCT groups are designed to support twin goals. Broadly, these are the development of mindfulness practice and CBT principles. Following the design of MBSR, most groups are 8 weeks (eight sessions) and typically 2 to sometimes 2½ hours in length. Some groups will have a distinct, additional half-day or day "retreat" near the completion of the group. For most groups, just over half of each session is taken up by a mindfulness practice and discussion of that practice—called inquiry. More detail about inquiry is described subsequently. Devoting half of all group time to mindfulness practice also results in a change to how many of the CBT psychoeducation, behavioral activation, and strategies are thoughts and beliefs that are conveyed. Much less time is spent exploring a group member's specific examples or sharing examples in the group—for example, there is unlikely to be a time when a group member is describing an automatic thought and other group members are engaged in Socratic dialogue around evidence gathering or distortions. Rather, these kinds of techniques are described to the group as a possible method for working with difficult thoughts that might arise during meditation. For therapists with a background in "standard" group or individual CBT, this difference in therapist stance and depth of exploration can be profound. However, conceptually, this shift in focus is natural in the context of mindfulness, which places a much greater emphasis on the client's own choices, abilities, and wisdom as a nascent practitioner of meditation. To some extent, therapists who are skilled in CBT for groups might find the CBT portions of MBCT quite straightforward; the concepts are familiar and tried and true. What will be less familiar is the teaching of mindfulness strategies and the process of inquiry, which we discuss next, with one significant caveat.

Teaching mindfulness skills to group participants and conducting inquiry is premised on an important factor we have not yet discussed. Therapists who conduct MBCT groups must have a personal practice of mindfulness. There is simply no way to meaningfully lead meditation practices if the group leader does not have their own practice, or worst of all, is reading from a prepared script. This will always come off as disingenuous, not least because mindfulness is a skill and it makes no sense to learn a skill from someone who does not themselves possess the skill. This is both different and similar to CBT groups—there would be broad agreement that all group leaders need to develop, advance, and hone their skills over time. The same is true for mindfulness except that here the skill is being a practitioner (and human being) who attempts to meditate, knows what this takes, and has experience with all the possible distractions (in Buddhism referred to more often as hindrances) and thus can fully relate to clients who are beginning

to practice for the first time. At the same time, MBCT therapists must have other CBT group skills, so that does set the bar high.

A seasoned meditator will not always be able to be a group therapist but an MBCT therapist must be a meditator. Less clear is what is meant by "meditator" beyond a personal practice. For many MBCT therapists, their initial experience of being a meditator is signing up for otherwise being part of an MBCT group themselves. This is also how MBSR therapists are taught—that is, they are "trainees" who first participate in an MBSR group. Beyond the personal practice, there is no clear standard or certification, though of course the same is true of being a CBT group therapist in general. Nonetheless, the issue is hardly trivial—therapists who wish to do MBCT interventions need to consider how, when, and where to build skills for their own practice.

Personal practice then becomes a gateway for learning how to lead others in mindfulness practices. It is one thing to follow along with a body scan or sitting meditation provided by an instructor or a recording; leading group members in such practices is another. In a single chapter, it is not possible to describe all aspects of developing MBCT leadership expertise but at a high level, the phases of a therapist's development are worth describing. First, establishing a personal practice exposes the developing therapist to a number of practices and how those practices are led, ideally by a variety of individuals, or through reference material (e.g., Segal & Teasdale, 2018; Teasdale & Segal, 2007; Teasdale, Williams, & Segal, 2014). Indeed, we encourage multiple sources—which now include apps and readily googled Internet resources; mindfulness teachers from different traditions and perspectives can provide a rich source of inspiration. Supervision, as in other training contexts, can also be important because there are, at times, unseen limits on what can be said and how during mindfulness instruction. Finding a balance of saying too much or being too directive versus not providing enough guidance is one issue. Another potential pitfall in an activity like body scanning is to become too detailed or anatomical; this can be a common problem for training therapists who may prefer more structure and scripting than is ideal. The key in leading practices is to embody the practice and to simultaneously lead and be engaged in the practice at the same time. Finally, as is clear in the sample protocol below, there are a variety of practices that need to be led. Body scanning and sitting/breathing meditation feature frequently; additional components include eating, walking, and yoga (stretching) meditations. Few therapists are adept at all of these in equal measure and, since this is almost universally true, it is not a particular problem. In a situation where a group is coled, ideally the cotherapist's skills complement the group leader's skills. Distinct from leading mindfulness practices is the process of inquiry. Generally, inquiry is a period of group participation that follows any formal mindfulness practice and it is intended to deepen participants' experiences and understanding of mindfulness practices. Inquiry can be thought of as occurring in three

nested circles, as represented in Figure 4.1. The first circle reflects clients' experiences and observations, concretely and in the practice that just concluded; the second expands that experience of mindfulness by contrasting it with similar experiences when not engaging in mindfulness; and the third links this mindful experience more directly with improving health or mental health. Inquiry at times can resemble a Socratic dialogue, and for many CBT therapists has some familiar patterns and approaches. However, it is also distinctly different. In inquiry, therapists may engage in active listening, much more than directly answering a question or offering a solution, and almost never give direct advice. For example, if after a body scan a client indicated that they became preoccupied with a part of the body where they noted pain and felt it difficult to move on, in a more CBT framework, such a statement might be addressed by the therapist or taken to the group so that the client no longer gets "stuck" during a body scan. In MBCT inquiry, this is a highly unlikely response—more typically the client would be asked what else they noticed about the pain and if it had a color or other sensory aspect (circle 1). This pattern holds throughout inquiry—the group leader's major role is to listen, connect clients' experiences to one another,

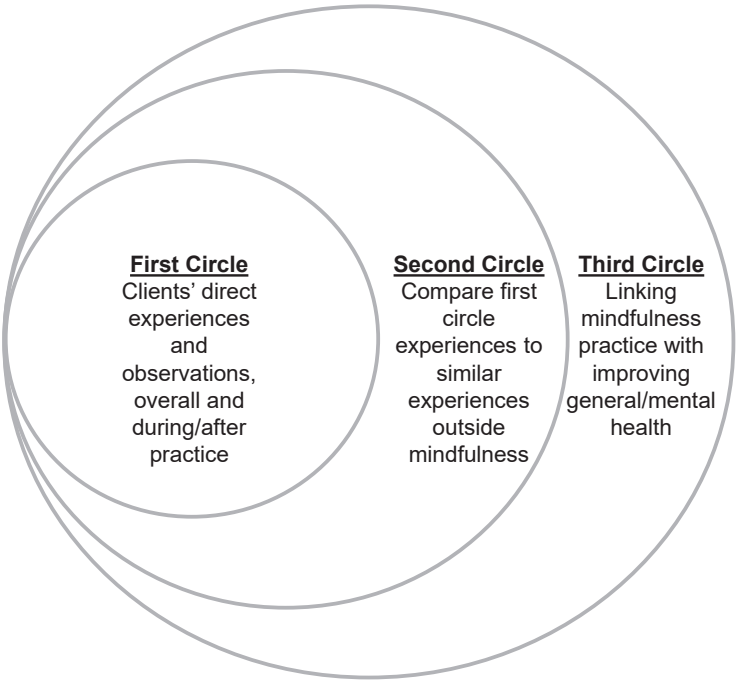

FIGURE 4.1. Representation of the inquiry process in mindfulness training as three nested circles, each expanding upon the last.

and as much as possible keep the discussion on one of the three circles. Thus, whereas inquiry can certainly resemble group dialogue in other CBT groups, it is quite distinctly different. The leaders, frankly, lead less and facilitate more. Of all the challenges of leading MBCT, inquiry is likely the most difficult skill for therapists to master, and the one in which a group leader will be the least confident. A full "curriculum" related to inquiry is beyond the scope of this book; in-depth discussion can be found in Teasdale et al. (2014).

Finally, in most MBCT applications, a lead and a cotherapist model, as in other CBT groups, is ideal. As mentioned above, a team of therapists with complementary skills in leading practices can be useful. Further, the group leader should be identified as such; that person will lead most of the practices and inquiry, while the cotherapist assists during some practices, and adds an important set of eyes and ears within the group.

Overview of MBCT

A sample MBCT group protocol is presented in Table 4.1. It is useful as a general guide and to facilitate discussion in this chapter about generic group process issues. It is also likely to require further specificity—for example, if the group is being conducted for individuals with chronic anxiety problems, the CBT and psychoeducation portions in each session can be adapted to focus on those kinds of symptoms, emotions, and thoughts.

As is clear from reviewing each of the sessions, a large proportion of content each week consists of mindfulness practices, inquiry, and incorporating mindfulness into everyday living (a key aspect of every week's homework discussion both at the beginning and end of each session). Relatively less emphasis is placed on the CBT skills, and indeed these are taught in a distinctive way. For example, while negative or anxiety-provoking "hot" thoughts might be described and various methods for working with those thoughts pointed out, the group does not engage in Socratic dialogue related to disputation, a linchpin of many CBT groups. MBCT focuses more on the client's decision to use what strategy emerges for them, ranging from evidence gathering to acceptance and acknowledgment. A truly key theme in this work, at least relative to a CBT group, is that troubling thoughts do not need to be "solved" in some fashion, but might arise periodically and can be dealt with by using mindfulness skills.

Somewhat informally, the 8-week group can be divided into three distinct phases. The first three sessions can be thought of as "basic training," and are largely focused on a variety of mindfulness skills that will be new to clients. Body scanning, eating meditation, breathing meditation, sitting meditation, mindful walking, and mindful movement are all covered in this phase. Also, practices that are shorter in duration are helpful; mindfulness in everyday life is introduced in this phase. This helps build bridges and

TABLE 4.1. Sample MBCT Group Protocol

Session 1

- Establishing orientation to the class and setting the tone
- Raisin exercise
- Inquiry
- Body scan meditation
- Inquiry
- Homework discussion and distribution

Session 2

- Review homework practice
- Sitting-with-the-breath meditation
- Inquiry
- Thoughts and feelings exercise
- Three-minute breathing space
- Homework discussion and distribution

Session 3

- Review homework practice
- Seeing and hearing meditation
- Inquiry
- Longer sitting meditation and walking meditation
- Inquiry
- Homework discussion and distribution

Session 4

- Review homework practice
- Mindful stretching
- Inquiry
- Symptoms and thoughts associated with troubling emotions
- Homework discussion and distribution

Session 5

- Review homework practice
- Silent meditation
- Inquiry
- Cultivating a different relationship to experience—allowing/letting be
- Sitting meditation with open awareness
- Inquiry
- Homework discussion and distribution

Session 6

- Review homework practice
- Sitting meditation with awareness of reactions to difficulties
- Inquiry
- Discussion: Thoughts are not facts
- Homework discussion and distribution

(continued)

TABLE 4.1. *(continued)*

Session 7

- Review homework practice
- Sitting meditation with awareness of breath, body, sounds, and thoughts
- Nourishing and depleting activities discussion, exploring links between activities and emotions
- Discussion of developing early warning system and relapse prevention kit
- Homework discussion and distribution

Session 8

- Review homework practice
- Body scan
- Inquiry
- Discussion: keeping momentum going
- Discussion: reflections on program
- Closing meditation

consistency between practicing intently for longer periods and the notion that at many points in the day a person can "drop in" to mindfulness on a more as-needed basis.

During this first phase of treatment, new skills and positive habits are being learned and ingrained. Many clients also encounter various obstacles and are likely to have many questions about practices; there can be questions about where, when, and how to practice; what to do if one is interrupted; struggles to remain mindful because of distractions; or falls asleep or finds some of the practice aversive. Broadly, these concerns from a meditation and Buddhist perspective are considered hindrances to mindfulness. Inquiry often focuses on how common these experiences are for all people new to mindfulness, that more experience and practice can be helpful, and at the same time, practices are best conducted in some circumstances (e.g., a quiet room but a well-lit room without electronics) than others. For some clients, despite careful screening and selection, the first phase of treatment will be a struggle; it is now that clients will truly confront the difficulty of carving out an hour a day, despite other struggles to practice mindfulness. For some this leads to a discussion of staying in the group to continue, or choosing another time to participate. Finally, during this first phase of treatment clients will have a lot of questions and concerns about "the point" of all this meditation practice. Questions are typically about what the experience of mindfulness meditation is supposed to be; experiencing peace and inner happiness, transcending to another place of existence, cleansing the mind, and so on. For the therapist, it is important to emphasize that the point of mindfulness is simply to be aware of the present moment, nonjudgmentally. As the work in the group progresses, this becomes more and more clear to participants, and the variety of hindrances (and good experiences too) are all part of developing a mindfulness practice.

In the first phase of treatment, the CBT strategies tend to focus on psychoeducation about symptoms, thoughts, and emotions that are commonly experienced, and to an extent, participants are shown the "generic" cognitive model. This often builds a bridge between the mindfulness meditation practices they are just starting, and the difficulties they experience that motivated them to participate in the group. During practices, it is common that participants encounter difficult emotions, negative thoughts, worries, or other problems. The psychoeducation component helps to explain why this is happening and sets the stage for the second phase of treatment.

In the second phase of treatment, approximately from Session 4 through 6, the mindfulness skills that participants have developed now begin to be used for another purpose. A somewhat gradual but still clear direction emerges that when considering the CBT model, and what has been developing as mindfulness skills, the notion of acceptance is raised—that is, instead of (or in addition to) challenging thoughts or gathering evidence, a person can also accept when a negative thought, emotion, or belief arises. As is pointed out explicitly in the protocol, acceptance is not resignation or some admission that the negative thought is true—instead, it is treating negative experiences as mindfulness treats good experience, or any experience, to acknowledge what is happening in the present moment, be nonjudgmental about the experience, and indeed open to exploring how it feels (or where it is in the body).

This can be somewhat startling, especially so for group participants who have had formal CBT before. And indeed, it is something of a departure from a standard CBT model that, arguably, does focus on "answering" negative thoughts with evidence gathering, labeling distortions, and usually sees success as a reduction in the number and intensity of negative thoughts. During this phase of treatment, all of the "basic" mindfulness skills from Phase 1 begin to be marshaled in the service of helping the person to better anticipate, cope with, and respond to usual ways of thinking, feeling, and behaving. Understandably, group members progress at slightly different rates through this phase. Some immediately accept acceptance, so to speak, as a reasonable approach and totally consonant with mindfulness practice and inquiry that came before; just as one accepts that during a body scan, an itch or skin irritation arises, so they might try to accept a moment of emotional discomfort, and return to breathing. For others, this move in the direction of acceptance seems at first less desirable—much less desirable than getting rid of unwanted negative emotional experiences. Group therapists require patience during this phase, and protocols tend to support this by using a number of means to relay the acceptance message, including poetry and specific practices that underscore the value of acceptance.

One particular challenge that might arise during this phase of treatment, and also because group members have now begun to have a sense of group cohesion and belonging, is that the conversation in inquiry turns

toward truly emotional and more difficult topics. Rather than discussing the right conditions for conducting a body scan, or what to do if one falls asleep during a practice, the conversation about acceptance quite naturally pulls for some self-disclosure about emotions, thoughts, and situations that group participants struggle with. However, much of these themes are familiar to therapists who have conducted CBT groups, where these conversations might be considered "bread and butter." What is different about MBCT, as elsewhere, is that these conversations both between participant and therapists, and between participants, is not to presume that a CBT technique is the best method for dealing with these issues. In MBCT, much more choice is provided about ways to cope with negativity, including the many mindfulness and acceptance strategies participants have been learning.

The final phase of treatment, certainly Sessions 7 and 8, shift some of the focus to "action." Here, techniques like behavioral activation find a home—whereas in CBT they often are seen at the start of treatment, in MBCT they arrive closer to the end of treatment. This becomes important because on the foundation of Phase 1 (mindfulness skills) and Phase 2 (acceptance), participants in the group will find that they are seeking alternative ways of acting and coping. These themes naturally arise because participants are beginning to fully disentangle the automatic connections in the past between certain negative emotional states and behavior, and they realize that these patterns are cyclical. Now integrating behavioral alternatives, participants are making another important shift and realization: that meditation and acceptance are not consistent with inaction. Much as in Phase 2, the more behavioral strategies in Phase 3 are not as directive as they likely would be in standard CBT; every technique is offered as a suggestion or a possibility that a person might choose. Often participants have the experience that problems that have arisen during meditation appear to have different possible solutions than any they have used in the past. In this phase of treatment, group leaders find themselves talking more about behavioral choices: actions including those aimed at wellness and pleasant events. For group therapists experienced in standard CBT, this is something of a reversal: in most standard CBT, behavioral activation comes early in the group; in MBCT, taking action comes nearly last in the treatment protocol.

At the end of treatment, especially in Session 8, which is focused mostly on closing, a summary of the group experience is shared by each member with the group. This is where the three components of the group ("basic mindfulness," "acceptance," and "action") are understood better by participants and it is not uncommon for participants to describe the experience, not just as helpful but as transformative in many ways. Again, somewhat unlike CBT where the goal might be to reduce symptoms and increase functioning and quality of life, the overall MBCT experience pulls for a greater emphasis on empowerment, self-determination, self-compassion, and

continuing to develop as a mindfulness practitioner beyond the group. For many participants it can be helpful to describe local resources and supports to continue practicing—in that sense, and unlike CBT, which has a clearer beginning and end, mindfulness or Vipassanā meditation is intended to become part of a person's lifestyle and choices.

One analogy that may be helpful for MBCT group therapists to contemplate across the phases of treatment is the so-called serenity prayer, which has a long but somewhat uncertain history. It is most commonly expressed as "Grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference." Group leaders embody this whether teaching meditation, conducting inquiry, or making gentle but clear cognitive or behavioral suggestions. These are not always simple concepts in practice; any group therapist is probably humbled by the notion that group participants need to "learn" wisdom. However, for many, if not most, group participants, the course of therapy does involve better understanding of their own internal world and different choices about how and when to take action.

In the next section, each session in the sample protocol is described in some detail. Also integrated into the discussion of each session are the likely group process issues that arise for that particular content. It is important to point out that specific applications, for example, different primary diagnostic groups tend to determine the specific cognitive and behavioral strategies taught; the mindfulness components are likely to be more consistent across different groups. For example, if the group is for individuals who have recovered from depression, discussion of negative automatic thoughts might be supported by reviewing standard rating scales of such thoughts. If the group is for individuals who have recovered from an anxiety disorder, inventories specific to those conditions can readily be substituted. Similarly, in MBCT for depression, the behavioral components bear strong similarity to behavioral activation strategies, and in anxiety, the group is more likely to add at least some exposure strategies. To aid the specificity of the discussion here, the session-by-session description is simplified to follow the sample protocol shown in Table 4.1.

Sample Protocol: Session-by-Session Review

Session 1

This initial session naturally sets the tone for the sessions to follow and, as one might expect, establishes the ground rules for the group. It introduces notions that are important throughout the group: that the group is to a great extent skill based, and focuses intensely on mindfulness that is supported within the group itself and between-group sessions by the individual's commitment to practice. Unlike in CBT, where all group

members would be encouraged to participate throughout, MBCT gives more choice to the participants, including saying nothing at times. An ice-breaker exercise in which group members introduce one another is also often included. Next, the theme of "automatic pilot"—the notion that many of our everyday activities are performed without a persistent conscious effort—is discussed, and the first mindfulness practice begins in earnest using the raisin exercise. Here, participants are encouraged to touch, see, smell, and indeed use all the senses to experience a common object, a raisin, as if for the first time. Inquiry often exposes unique features of a raisin that, in the usual way of eating raisins many at a time, are not at all apparent but become so when much attention and focus is devoted to experiencing a raisin. Group leaders suggest that just as there are experiences available to us when we encounter a raisin mindfully, so too are a variety of new and deep experiences available when we become mindful about all things, and more generally.

The raisin exercise highlights an important distinction between typical CBT and MBCT exercises. Group leaders might choose to take note of diagnosis-specific symptoms in mindfulness practices that might affect the client experience. For example, a client with OCD and prominent contamination concerns might have reservations about participating in the raisin exercise if a bag of raisins is being passed around the group for each person to take one prior to beginning the exercise. The goal of mindfulness practice, particularly at this stage, is not to be simultaneously engaging in exposure and response prevention, and group leaders should keep this in mind when dealing with specific psychiatric populations. More discussion of symptom-related thoughts and how they can be addressed in the context of mindfulness begins in Session 4.

The most time-intensive activity of the first session is the body scan, a fairly intensive and directed exploration of bringing full awareness to parts of the body, in sequence, from the toes to the top of the head. Participants typically complete the body scan lying on a mat, for many that in and of itself is a new experience, and may not be what they expected in a "therapy group." Again, the body scan during inquiry reveals contrasts between the usual relationships we have with our body, and what can be experienced by bringing focused awareness. Also revealed by this in-depth scan is the beginning of the difficulty involved in taming one's focus—that is, the tendency of the mind to wander and quickly lapse into usual habits of jumping from one topic to another and again without any seeming logic or direction. The body scan inquiry then transitions to homework, particularly the importance of practice to develop the skills to bring, even if for a few moments, the mind under voluntary control to stay with breath or body.

From a group process perspective, participants are often taking on board, for real this time, the challenge and commitment to practice to which they have agreed. However, much of this subtext may not yet be

discussed. Questions that participants likely harbor are "What is the real goal of being mindful?"; "How difficult will it be to practice this much"; and "How can doing these practices help me with whatever challenge brought me to the group?" However, these questions usually do not arise in this format, and often take the guise of more practical questions about when, how, and where to practice.

Session 2

The second session begins with a significant contrast to the first—rather than rules and introductions, participants immediately move into the body scan—which presumably they have been practicing all week. Inquiry after this body scan is usually rich, and blends seamlessly with the homework. Session 2 can be thought of as identifying barriers as participants will surely have struggled to do as much practice as they were expected to (or hoped to do) and will have had a variety of responses during the practice. These amount, in different, sometimes colorful words, to the five hindrances to meditation described in Buddhism: sensory desire (seeking happiness through the five senses of sight, sound, smell, taste, and physical feeling), ill will (negative thoughts and feelings), sloth and torpor, restlessness and worry, and doubt. Even for those who say the week's practices have gone well, these obstacles or impediments are universal. It will also be clear that experience and practicing matters, and that these obstacles can be overcome, if briefly, to experience true moment-to-moment awareness without judgment. For some, Session 2 is also a watershed moment about their commitment and ability to take on this much practice at this time. Indeed, some group members may choose to leave the group at this point, much more so than after the first session. It is common for some group members to feel discouraged at this stage, and group leaders can reinforce the notion that mindfulness practice is a skill that is built over time. A helpful analogy is that of exercising a muscle. One does not—generally speaking—begin to lift the heaviest weights in the gym with no training. Rather, the novice begins with 2 pounds, then 5, 10, 15, and so forth, and follows a gradual progression over time.

The second component of this session is to use an example of the generic cognitive model, referred to mainly as a "thoughts and feelings exercise," to illustrate how, when we are not mindful, certain ambiguous experiences can be judged quickly and lead to all kinds of potentially challenging and emotional conclusions. It is likely in fact that these experiences have already been noted, to some extent, during the homework practices. Finally, in this session the 3-minute breathing space is introduced; usually using an hourglass metaphor, participants learn to take 1 minute to tune into whatever their present experience is, a second minute to narrow their awareness to just their breath, and a third minute to be aware both of the breath and any sensations, thoughts, and feelings. This much shorter

exercise (3 minutes vs. nearly 10 times that amount for a body scan!) helps build a bridge between concerted practice and "moments" of mindfulness that can be spread over the course of the day. This is then translated into the homework, which includes both formal practice, as well as smaller moments of mindfulness while doing a 3-minute breathing space or an everyday activity, like a morning ablution, for example.

Session 3

Session 3 involves a variety of new mindfulness practices, including a seeing meditation, a sitting meditation focusing on the breath, and a mindful walking meditation. The shift toward a breathing-focused meditation is subtle and not entirely novel since the breath is used in both body scanning and more obviously in the 3-minute breathing space. Nonetheless, in inquiry about the longer sitting meditation, themes will start to arise related to where the mind is drawn, including difficulties, when there is less instruction—particularly compared to the body scan that by now participants are highly used to. Mindful walking is an additional practice that can afford, depending on the situation, the ability to be mindful outside and not just in a "meditation circle." For some participants, these new practices are a boon—the variety offers something that they can look forward to. For others, judgment can arise about preferences, along the lines of "I love . . . ," "I hate . . ."—filling in the blank with breathing meditation, walking meditation, and so on. It is important for therapists to use these opportunities to focus participants on these strong responses as another experience in the moment around which they can become more aware, allowing for the experience and then let it go, recognizing it as a judgment. Over time, most participants will attenuate in their seeming likes and dislikes of various practices, recognizing that each one has something subtle and different to offer.

Session 4

Session 4 continues the theme of expanding the mindfulness repertoire with mindful stretching (a less intimidating concept than mindful yoga) to add yet another variation to possible practices. Here, too, the work participants have done with body scanning comes into play as moving the body can elicit particularly strong reactions in body parts that are more difficult to notice in a lying still position. The cognitive-behavioral content of the session also focuses on "strong" sensations in the form of emotions and thoughts that are associated with the symptom pattern the group is focused on. There is a direct discussion, resembling psychoeducation, about symptoms and syndromes, including potentially, depression and anxiety, as well as exemplars of the kinds of thought content most associated with conditions the group is aimed at. In this exercise, it is important to emphasize that such symptoms and thoughts (and emotions) are not

inevitable, and may not always arise during every meditation, balanced with the notion that such experiences are common, part of being human, and that there are various ways to cope with such thoughts. Moreover, an important discussion point is that each person has their own "signature" thoughts and feelings, those that are familiar and return again and again. The question then posed to the group is how to best respond to such thoughts that can seem so aversive, and yet arise again and again. Individuals who have had CBT in the group often raise strategies that they have learned to cope with such things: thought records, or other worksheets to identify distortions or gather evidence. It is important to point out that this is one approach, the other being premised in meditation—accepting the experience, being open to it, and then seeing if it can "let go," just as was done with sensations from various body parts during a body scan or stretching. This initial discussion is important for many reasons: for one, it signals that while there is much to be gained from meditation in terms of wellness, it is taught in the context of MBCT for a much more specific purpose—changing one's way of relating to negative experiences that may have been troubling for years. Second, the message to participants, with a degree of sensitivity, is that the best way to deal with such struggles is something other than what they might have expected—that accepting, acknowledging, and moving toward such experiences is a strategy that is as powerful, if not more so, than usual problem solving or disputing the truth of such thoughts. Of course, this message will be paradoxical to some; most people would say that reducing the frequency of negative experiences would be their fondest wish. Accepting such experiences is not, at first, a message that makes immediate sense.

Session 5

In Session 5, the theme of acceptance comes even more to the forefront. During or after the initial sitting meditation, a poem like Rumi's "The Guest House" can seed a conversation with participants about accepting, allowing, and letting be all experiences, including their most common negative ones (Banks & Moyne, 1997). This notion, which might have seemed so paradoxical in Session 4 (i.e., as the poem suggests, welcoming any experience as a visitor in your guest house), will likely meet with more understanding. Likely, participants in their home practices will have already attempted some mindful strategies when the mind, inevitably, turns to some difficulty. Having experienced the benefit of acceptance, in Session 5 there is often a deeper discussion of how to allow for acceptance and let experiences be as they are. This session is as close as MBCT comes to suggesting a specific mantra—and steps for dealing with strong negative emotions and thoughts. These steps include deliberately bringing a gentle, friendly awareness to negativity of any sort; notice what the response to this negativity is, in the body or mind; then accepting the experience, allowing space for it and not trying to make things different;

and focusing on the breath. This is supported by phrases such as "It's okay. Whatever it is, it's okay. Let me feel it" and "Soften" on an in breath and "Open" on an out breath.

This typically leads to rich discussion with participants volunteering the kinds of things they struggle with, and coparticipants and leaders evaluating what acceptance might bring to this experience. It is also explicitly stated that acceptance is not the same as resignation or passivity but about not simply reacting in ways that tend to maintain negativity, and using a variety of skills to respond to negativity as needed. It is also important to discuss what happens when we do not accept negativity, and instead try to always fight or suppress it. Ideally using some participant examples, the point to be made is that this risks returning to usual routines that could actually strengthen negative responses and emotions. Attempting to pay attention to the negativity and letting it go breaks this chain of responses.

Session 6

In Session 6, after a sitting meditation with only minimal direction (participants at this point will have developed considerable abilities to engage in breathing meditation for longer periods), the therapists return to this theme of acceptance and go one step further: stating explicitly the powerful notion that thoughts are not facts. Returning to an exercise that is similar to Session 2 in which an ambiguous scenario is presented, on this occasion there can be more elaborate discussion about how small differences in circumstance, the history a person brings to the scenario, or the preexisting mood one is in can heavily influence the interpretation of the event and therefore thoughts and feelings. There may be an explicit opportunity to point out that, at a least for some, there is now the "usual" way of responding to such an event, and a newly discovered "mindful" way of coping. This session has strong themes of standard CBT, but always with a mindfulness component. The material emphasizes the many options someone might have in coping with negative emotional or thought experiences, including simply watching thoughts come and go in the field of awareness, viewing thoughts as mental events and not facts, and writing down thoughts and feelings, as well as disputation—and also asking questions about whether the thought fits the known facts. Above all, the central issue is attempting to help participants change their relationship to their thoughts.

Session 7

Session 7 begins with a mindfulness meditation and then shifts to content that has more to do with behavioral interventions—particularly, behavioral activation. In mindfulness terms this is reframed as "skillful means"

and ought to include certain specific actions aimed at staying well and enhancing quality of life. This is a very important element, underscoring that acceptance of certain negative experiences does not mean that mindfulness involves some kind of overall passive stance, in which the meditator is fixed in one place while all around the world carries on. Material from the session suggests that not all activities are created equal, that some activities can be pleasurable or give a sense of accomplishment (or both) and thus are nourishing, while other activities might not provide either of these and thus are experienced as depleting. Participants list parts of their average day and categorize these as nourishing or depleting and they are asked to examine the quantity and balance of these, followed by direct discussion about modifying their routines to add more nourishing activities, as well as two options for dealing with depleting activities, including spending less time, where possible, on these, or changing their relationship to these necessary events. Next, participants develop a list partly based on their experiences in practicing, that they see as early warning signs of stress, anxiety, or depression (and possible other symptoms depending on the specific intent of the group). This information can be put together in a written format, even a letter to oneself, that describes negative things a person might be experiencing in the future and what they might do about including doing nourishing activities, mindful practice, or mindful action. Participants are encouraged to ask themselves "What do I need for myself right now?" and "How can I best take care of myself right now?" These questions can set the stage for a somewhat distinctive homework assignment that involves further elaborating on the notion of a letter to oneself—in a sense their "healthy self"—writing a preemptive note to their "struggling self" that might be shared with the group. This sharing is by no means required of any particular group member, but it is a powerful intervention in its own right. Session 7 can be a busy but rewarding session for participants and therapists. To an extent it is the most like a CBT session, with therapists making more than the usual number of suggestions and directions, as well as group members helping one another with ideas and feedback.

Session 8

The final session is something of a review and certainly a wrap-up of the group. While nothing brand new is shared, this session often underscores all that has changed for participants from the first session. The body scan is repeated, and whereas in Session 1 participants might have seemed uncertain, agitated, or fell asleep (including snoring, a real feature of the first session), the body scan now happens with everyone in a kind of mindful synchrony. Inquiry after that body scan often focuses on "how far we've come" since that first touch-and-go body scan experience. The written material from Session 7 and homework can be shared by those

willing—this is often poignant, but positively so. Some of this work usually borders on the poetic and inspirational. Next, the group transitions to a pairs exercise in which group members interview one another using questions, such as why they came originally, what they were hoping for, what did they learn, but above all, how can the material covered and the practices be supported and continued. Finally, and in some contrast to how a CBT group might end, there is a closing exercise in which participants each receive a unique stone (a parallel to the raisin from Session 1) and silently gaze at the stone, and then look at the person to their left and wish him or her well and thank the person silently; then gaze again at the stone, followed by looking at and thanking the next person to the left. This process is repeated for some minutes until everyone has wished everyone else well. This exercise is often followed by a brief sitting meditation that underscores again the importance of mindfulness practice.

Comparing CBT and MBCT

There is little doubt that MBCT has numerous similarities with CBT. Nonetheless, the differences are considerable. In this section, we briefly review these distinctions by highlighting first what might be considered particular "strengths" of group CBT, followed by relative weaknesses, and then "strengths" of MBCT, followed by weaknesses. We appreciate that for a specific population at a specific stage of a disorder, there might be more than one reasonable choice—it is entirely possible that CBT and MBCT could have equal pro and con lists. On the other hand, it may be that when considering strengths and weaknesses, a "best fit" will appear more clearly to the reader.

We begin with group CBT strengths—Part II will highlight these themes as well. First, CBT promises and is known to impact positively the intensity of difficult emotional experiences. If there are prominent and acute symptoms of depression and anxiety, and associated maladaptive behaviors, CBT promises a rapid and effective remedy. Second, for many clients the action and activity of CBT feels gratifying; even before symptom relief occurs clients will likely feel they are doing something active to help themselves. Third, CBT promises that with the effort of doing behavioral activation, thought records, exposures, and so on, progress will be made. In other words, there is a direct correlation (mostly) between effort and outcome. Fourth and finally, CBT groups have space for a considerable amount of direction, including from group leaders; suggestions can be made, questions answered directly or through Socratic dialogue, but each question clearly drives the group toward an answer.

On the other hand, a CBT group can include a degree of disappointment—specifically when the purported action strategies in

either the behavioral or cognitive domain do not inexorably lead to positive changes. Because CBT has a kind of improvement demand characteristic, it can struggle (and have the client struggle) when problems are particularly thorny or intractable. Second, CBT tends to promise, but not always achieve, a person having fewer and less intense negative thoughts. In some cases, what clients gather from CBT is that negative thoughts are to be expunged or eliminated. It is not clear that this is possible when some degree of distress and suffering is part of human existence. Third, some clients find the CBT approach superficial, even obvious, and may be looking for something more profound or philosophical. Finally, there is the flip side of directiveness: CBT leans heavily on group leaders in particular to have answers to difficult questions, but that can be especially difficult when a client or clients are facing difficult-to-control stressors, moral dilemmas, and truly complicated important life choices.

In MBCT, between-session homework, while time-consuming, is much more experiential than what is asked of CBT clients, and for many people that homework brings about at least some immediate benefits. Struggling with writing out a thought record can be perceived by clients as tedious work whose benefit is clear only in the longer run; doing a 3-minute breathing space while waiting for a potentially stressful appointment can produce an immediate sense of present-moment awareness and even peacefulness. Second, MBCT offers what can best be termed as an approach to living that is not confined to improving symptoms or deficits and functioning. While it is obviously not a stated goal of MBCT for participants to refashion their lives around Buddhist principles and practices, there is little doubt that for some participants this introduction to Vipassanā meditation (and contemplative practice generally) begins a process of self-discovery and even reinvention. Group therapists can even anticipate this. In Session 8 in particular, it can be helpful to share community resources related to mindfulness activities, events, and "sitting groups" that are open. MBCT "alumni" who engage in this ongoing deepening of their practice often report far more profound changes after the group than during it. In contrast, once a CBT group is concluded it is unusual to see participants using even more CBT strategies.

Finally, MBCT focuses more than CBT on participants' inherent strengths and abilities to find their own conclusions and solutions; the flip side of being less directive. This can be particularly meaningful for participants who have been clients in the mental health system for some period of time. Often those clients will have a strong sense that services are done "to them," like prescriptions and drug regimens, structured psychotherapy, and other supportive interventions. MBCT for this population is perceived as more empowering and allows for greater self-determination. For many participants, the MBCT group experience can feel like something of a turning point, with the therapeutic conversation flipping from what is wrong or what deficits exist, to focusing on ability and positive potential.

Weaknesses of MBCT relative to CBT include the intense time commitment to practice and homework. There is some debate about which approach demands the greater time commitment, but the 6 hours of homework practice required for MBCT is most likely more than what CBT would require for exercises and worksheets. (Indeed, most CBT group therapists would be thrilled if participants were spending 6 hours a week completing thought records.) Second, because MBCT is less directive and focused, some participants (perhaps especially those with more acute symptoms) will find that MBCT does not offer a direct solution to their problems, and it may not even be clear that MBCT offers a strong change strategy. Finally, MBCT places particular demands on therapists and therefore group leaders, as described earlier. The need for therapists to develop their own mindful practice has no countervailing, parallel weakness in CBT; indeed, it would be unclear and unheard of to say a CBT group leader would have a CBT "practice" for themselves. This requirement likely will always place a cap on the number of practitioners who are willing and able to lead MBCT groups, and may ultimately affect the growth of this modality.

Although group CBT and MBCT have advantages and disadvantages, the foregoing discussion really is about matching the chosen treatment with the particular client and context. In fact, one could easily picture the same client choosing either modality at different stages of their disorder, both in terms of symptoms and functioning, and life stage.

A person who has struggled repeatedly with depression and finds him- or herself acutely depressed, possibly with active suicidal ideation, is likely a better fit for a standard CBT approach. In such a group, their daily routines and self-care activities could be enhanced by behavioral activation, negative thoughts and hopelessness reduced by thought records and worksheets, and suicidal ideation discussed frequently in group while receiving direct support from other group members, and later in the group exploring their assumptions and beliefs about self, the world, and others. That same person who has made a recovery from depression but months or years later struggles with occasional lapses or relapses might be a better fit for an MBCT group. Here they would learn about the habits of being on automatic pilot and what it means instead to focus on just the present moment nonjudgmentally. The person would learn many skills to quiet and focus their awareness, while at the same time gaining an entirely new approach to the familiar themes that arise in their negative thinking. And instead of gathering the evidence and disputing, they could explore acceptance. Later, the person might reshape and remake their behavioral patterns based on what they learned from meditation.

In short, clients with more acute symptoms and functional deficits might be a better fit for a CBT-based group, whereas clients with some degree of improvement in their acute condition struggling with chronicity may be a better fit for MBCT. Some therapists may choose to offer MBCT as an adjunctive treatment, offered to those who have already completed a

course of standard CBT and have learned some strategies to address their most impairing symptoms, but who are looking to gain additional techniques for improvements upon or maintenance of gains already made.

Last, it is important to observe that MBCT is different enough from CBT that the attributes of group leaders likely are not identical. A high-energy, directive leader with a great deal of positive affect may be ideal for a CBT group. In MBCT, the group leader is not the diametric opposite, but the role does call for other leader aspects, like a soothing but calm demeanor, as well the ability to be comfortable with more silence and more ambiguity. It is possible to imagine a truly excellent MBCT group therapist who would struggle in leading a CBT group, and a CBT group therapist who is quite uncomfortable with MBCT. Luckily, most professionals exposed to both kinds of opportunities will likely choose the approach best suited to their strengths as practitioners.

Conclusions

In this chapter, we reviewed group MBCT, a rapidly growing approach that evolved from both CBT and MBSR—two traditions that themselves have strong roots in group work and group learning. While often thought of as a "third wave" of CBT, we noted here that this approach is quite distinct. Indeed, distinct enough that this chapter was formatted somewhat differently than the chapters that follow in Part II. It remains notable that even when compared to CBT, MBCT is more naturally a group format. The alternative is rarely done, easily illustrated in a thought experiment. Imagine the sample group protocol in Table 4.1 being done in individual therapy, it would be both intensely awkward for a dyad to meditate in this way, and the process of inquiry would be all but irrelevant. This area is evolving quickly; it is probably still true that most practitioners first learn to do CBT or CBT groups, and then move on to "add" mindfulness or MBCT. The experiential difference as a therapist leading these is not to be understated; while the approaches are related in the ways in which one leads mindfulness compared to a CBT group are substantial. This likely would not be fully apparent from a single reading of this chapter but is nonetheless true. Certainly, the addition of MBCT to the family of CBT-based group interventions expands the possibilities for clients, and these interventions are likely to continue to grow.

CHAPTER 5

Structuring and Delivering Group CBT in Acute Inpatient Settings

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In this chapter, we review the barriers to delivering inpatient psychotherapeutic treatment and then present a novel approach to delivering a transdiagnostic group CBT intervention in an acute, diverse inpatient setting with varied psychiatric comorbidities based on empirical foundations and clinical experience.

Acute and short-stay inpatient units are principally charged with providing care for the most severely unwell and, as a result, the focus is management of harm reduction, stabilization, and coordination of postdischarge care (Bowers et al., 2005). Clients in mixed and diverse short-stay inpatient settings have long been considered too unwell or lacking in the insight necessary to engage effectively in therapeutic interventions, which can contribute to an overreliance on medication management and nonintervention programming as the standard of care in these environments (Bowles, 2000). Similarly, there appears to be an emphasis on monitoring and observing clients rather than engaging clients or understanding more about the clients' situation (Mullen, 2009). Nursing staff provide frontline and direct symptom management through programming, while intervention-based programming by registered health professionals is less common, despite evidence suggesting registered providers with training in CBT are more effective in delivering CBT on inpatient units (e.g., see Clarke & Wilson, 2009). Accordingly, the standard practice in acute and tertiary inpatient settings has been to provide CBT and group interventions as an afterthought rather than a pivotal component to the admission,

despite evidence supporting its efficacy. These factors may result in a missed opportunity to provide the best care for clients in short-term inpatient settings where there is significant psychiatric symptom heterogeneity and comorbidity—that is, in settings where individuals have multiple overlapping diagnoses or complex symptom presentations.

Individuals are often admitted to inpatient mental health units during an acute crisis. Pervasive patterns of symptoms and client experiences transcend across crises and psychiatric diagnoses. For example, many individuals become overwhelmed by severe mental illness and/or situational distress and have acted in a maladaptive way or are attempting to escape from the distress. Interventions focused on these common characteristics can be extremely important, yet accessibility to therapeutic programming is limited due to logistical barriers and client considerations that are not typically considered in the treatment protocols currently available. This chapter introduces a novel approach to providing group CBT within acute inpatient settings, which tend to be highly diverse and heterogeneous in terms of diagnoses and symptom presentations. Whereas this chapter focuses on acute inpatient settings, the procedures utilize frameworks and methodologies from both traditional and newer CBT models. In this regard, the intervention was designed to be structurally flexible and modular in nature to accommodate the unique logistical and client factors found across many types of inpatient settings.

Evidence for Group CBT in Inpatient Settings

Several noteworthy barriers contribute to the limited psychotherapeutic programming available on psychiatric inpatient units. First, conventional CBT therapy interventions (e.g., CBT for depression) often contain set content parameters and requirements for clients with specific diagnoses that are not well suited for application in many inpatient settings, given the diversity of diagnoses and the high comorbidity rates in these settings (Durrant, Clarke, Tolland, & Wilson, 2007). In addition, when providing psychological services on inpatient units, environmental and client characteristics arise as a barrier to treatment delivery, such as rapid turnover rates, high occupancy rates with high staff to client ratios, variable stays, mental status instability, fluctuating psychiatric symptom severity, and a diagnostically and demographically heterogeneous client population. These characteristics are not considered in many treatment protocols, as they are not often observed in settings where protocols were designed (Mullen, 2009). Of the interventions available, the mechanisms and impact on outcomes is not well understood given the limited empirical research in this area due to the aforementioned barriers. As a result, there are no clear guidelines on how to adapt currently available evidence-based CBT interventions within acute and diagnostically heterogeneous inpatient contexts.

Although research demonstrating the benefit of CBT interventions is promising in tertiary and specialty inpatient settings, there is limited research investigating CBT in demographically and diagnostically heterogeneous inpatient settings, and there are no known clinical outcome studies investigating group CBT (Baker, 2000; Bowers et al., 2005; Durrant et al., 2007; McCann & Bowers, 2005). There is an abundance of CBT-type interventions available, many of which have been radically adapted for use on acute or heterogeneous inpatient units. These approaches focus on basic strategies, which are more consistent psychosocial and educational programming (e.g., coping, sleep, nutrition), rather than interventional. Finally, many interventions available do not directly address or provide techniques to manage the psychiatric symptoms that the clients are experiencing because many of the interventions focus on coping strategies and tend to come from nursing and occupational therapy, rather than from the psychological literature.

The upshot is that CBT has been adapted successfully in many environments and with varied populations, suggesting a basis for its utility in acute and heterogeneous inpatient settings. For example, CBT has been adapted to target specific needs or issues, including a transdiagnostic approach for insomnia (Sheaves et al., 2018) and an approach for suicide prevention (Ghahramanlou-Holloway, Cox, & Greene, 2012) in inpatient settings. CBT has also been adapted for individual therapy with a diagnostic-specific approach in inpatient settings, such as in schizophrenia and CBT for psychosis, including some group CBT applications (e.g., Bernabei, Murtinu, & Chiaie, 2016; Haddock, Tarrier, et al., 1999; McCann & Bowers, 2005; Munro, Baker, & Playle, 2005; Owen, Speight, Sarsam, & Sellwood, 2015). CBT has also been demonstrated to be an effective intervention for depression in inpatient settings by reducing clinical symptoms and contributing to higher remission rates when combined with pharmacotherapy, relative to standard interventions (Köhler et al., 2013; Page & Hooke, 2012). Despite encouraging research investigating CBT utility for specific behaviors or diagnoses, relatively few studies have been conducted on the utility of group CBT in settings where individuals have multiple overlapping diagnoses or complex presentations in acute settings. In one study, individual CBT was adapted and demonstrated utility in heterogeneous acute inpatient settings (Paterson et al., 2019). In another study, manualized group CBT was integrated into routine care provided on an inpatient unit with clients who had mixed diagnoses (schizophrenia, major depression, bipolar disorder, and personality disorders) and was associated with improvements in client satisfaction and ward atmosphere, as well as reduction in the readmission rate over a 4-year follow-up period (Veltro et al., 2008).

There are also logistical barriers to implementing the adapted existing interventions in short-stay settings. Many available treatments require adherence to a manualized protocol that is longer than feasible given the

rapid turnover rates and variable lengths of stays on acute units, such as individual interventions targeting CBT for psychosis (e.g., Veltro et al., 2006). Group-based interventions are the most practical and improve accessibility for clients on inpatient units due to the high client to staff ratios, but the majority of inpatient CBT protocols available are designed for individual psychotherapy. Traditional group CBT interventions may also require a certain level of psychiatric stability in order to initiate in a higher level of discourse and to engage in the components of treatment effectively. However, there is typically not enough time to deliver a structured linear treatment intervention before discharge once the clients are stabilized, due to the costs associated with inpatient stays. Raune and Daddi's (2011) pilot study demonstrated practice-based evidence for delivery feasibility and promising efficacy in a group CBT intervention implemented on acute psychiatric inpatient units, but outcomes research is clearly needed. The reality is that most inpatient settings include a diverse and complex client population with environmental barriers, and the group CBT interventions available are not well suited for delivery in these environments.

Overcoming the Barriers to Providing Group CBT in Acute Inpatient Settings

In this next section, we troubleshoot some of the mentioned barriers to delivering group CBT within acute settings that can also be applied to most inpatient settings.

Group Composition

Logistics and group cohesion are fundamental considerations in any setting when constructing a group CBT intervention, as described in Chapter 2. In most outpatient and many inpatient settings, groups are constructed by soliciting referrals, screening individuals, and determining viable members based on specific inclusion and exclusion criteria to meet a particular therapeutic intervention program. In other forms of inpatient group CBT (e.g., Clarke & Wilson, 2009) and traditional group CBT, assessment and screening have been shown to be key components predicting treatment success (e.g., "Is this intervention the correct fit for this individual?"). Screening also seeks to enhance group dynamics to produce a supportive and cohesive environment (e.g., "Does this individual have characteristics or symptoms that may interfere in the treatment of other individuals?"). Client and demographic factors are considered critical and individuals are screened using measures to determine suitability and stability to participate (e.g., CBT suitability interviews). Screening is also encouraged when delivering group CBT on inpatient units, as group processes are also considered a key factor to delivery of the intervention (e.g., Clarke & Wilson,

2009). However, the needs of the individuals are different in acute and heterogeneous psychiatric inpatient units—therefore, traditional screening approaches can become a barrier to accessing care in such inpatient settings. In addition, nursing staff may not have time to engage in screening due to other clinical care demands (e.g., clinical monitoring).

Accessibility barriers can be overcome by constructing a low-barrier, drop-in group with content designed to be relevant to most individuals on the unit. Regarding the open and flexible component of the structure, the group CBT program we present in this chapter was designed to deliver an effective intervention to any given individual on the unit, as opposed to screening for individuals who fit the type of intervention being delivered.

While screening still occurs, it is limited in scope. For example, individuals who have been identified as being a particularly good fit for the group are encouraged by the facilitators or their treatment team to attend. Rounds to the rooms and an overhead announcement can be made before every group to gently call attention to the group start. Screening also occurs within the session by the group leaders. Some less psychiatrically stable individuals will self-screen after they determine they are not interested in the group, and an open-door policy provides the individual with agency to attend and leave without disruption. Participants are allowed to come and go as they like because of a number of factors specific to inpatient settings, such as fluctuating tolerance levels, symptom severity, interruptions due to appointments, or unexpected behavior driven by internal and external distractions. Individuals are asked to follow the same standards of decorum in the group that is required on the unit. Participants can be asked to leave if they become disruptive—just as they would in any other program or event that occurs on the unit. Examples of this type of behavior include threatening other group members and engaging in distracting behaviors that interfere with the delivery of the content or encroach on the experience of other members. Externalizing behaviors are common due to the heightened active psychiatric symptoms in this environment (e.g., mania or psychosis) and behavioral management during session should be anticipated. The presence of a coleader is also helpful for managing disruptions so that one leader can continue group facilitation while the other leader can step away with a client if needed. In brief, predetermined screening and behavioral management plans can reduce disruptions significantly.

Group Structure, Content, and Frequency

In a traditional CBT approach, a protocol is chosen and followed in a linear fashion, each session building on the previous. Between-session work, such as homework, is a necessary element because it shapes the direction of the therapy through consolidation and practice of the content. Traditional linear structure is not well suited for inpatient delivery. Indeed, the

simple act of delivering homework would prove to be too overwhelming for most individuals. Further, most clients are discharged when they are stable, often without notice and regardless of their involvement in a therapeutic treatment program. In addition, involvement in traditional group CBT programming requires a high level of engagement and motivation from the participants. On acute and other inpatient units, the ability and motivation to engage is variable due to disrupted attention, level of symptom severity, cognitive ability, and potential medication effects. Clients may feel well enough to attend a group session one day and then too unwell to attend the next. In this regard, following a 12- to 16-session protocol that is structured and linear is neither realistic nor often achievable.

The structure of the inpatient group CBT described in this chapter is modular and flexible so that any individual can attend any module at any given time. While the modules have a cumulative effect and work together as a cohesive unit, each module is independent of the other. The modules share the same standard psychoeducation component involving the understanding of the CBT framework, from which an intervention component is then elaborated. The program is also modified in real time during the session through a flexible approach, which is described in greater detail below.

Worksheets using visual aids and simple language are available and provided to group participants who wish to use them. The worksheets are utilized flexibly during the session. At the most basic level, informational sheets are provided—however, completing the activities on the worksheets is voluntary. The ability to attend future sessions is not contingent on homework completion. For those interested, the worksheets should include basic information about the content of the group session and they also may involve an activity to do at a later time, if desired. Additional worksheets and supplementary resources should also be available for individuals who would like them either during session or during another time while they are on the unit.

In inpatient settings, individuals often have variable attention and cognitive engagement; delivery of information does not necessarily involve uptake or learning from all group members. Repetition of content from the sessions and the worksheets can also assist with managing fluctuating engagement and attention span. Thus, individuals who have longer stays can repeat the modules, as the content may resonate more with the individual when it is repeated at a later time in their admission, such as when they may be more stabilized and receptive to engaging with the content.

In terms of frequency of delivery, weekly or twice-weekly sessions are best, with session duration averaging around 45 minutes. Individuals tend to lose or maximize interest when the group CBT is offered more frequently during the week. Although slightly counterintuitive, it has been our experience that when the group is run daily it can be harder to engage clients because they may feel less compelled to take advantage of the group on any

given day knowing they can attend the following day. Accordingly, keeping the session time relatively brief helps participants maintain attention and motivation to stay in the session for the entire duration.

Mixed and Multiple Diagnoses

As noted, individuals on acute units are heterogeneous in terms of their backgrounds and symptom presentations, and many carry multiple psychiatric diagnoses. Despite this heterogeneity, common unifying themes emerge leading up to many acute and short-stay admissions. Many individuals act and react maladaptively following destabilization of their mental state and feel overwhelmed, confused, angry, and fearful of the future. This destabilization may be due to medication mismanagement or following a significant psychosocial stressor. In a review, Bowers (2005) illuminated seven themes contributing to and precipitating inpatient admissions: dangerousness, assessment, medical treatment, severe mental disorder, self-care deficits, respite for carers, and respite for the client. During the admission, symptomatic themes also tend to emerge across clients and can be effectively targeted using modified empirically supported cognitive and behavioral interventions (e.g., low distress tolerance, maladaptive coping strategies, low self-worth, cognitive distortions, and heightened negative affect). These common themes and symptoms contributing to admissions can be targeted effectively in the interventions to reach a symptomatically diverse audience.

Barriers to Engagement

Regardless of the therapeutic approach, client engagement is often considered to be crucially important when delivering an intervention. Client motivation and therapeutic alliance are two common factors observed that contribute to engagement and treatment success. Individuals on inpatient units may have fluctuating cognitive engagement due to psychiatric, intellectual, or physiological barriers. Motivation may fluctuate between and within sessions due to clinical symptoms, acute psychosocial stressors, or medication side effects. The content and approach of the intervention we present here is modified to address fluctuations in arousal, stability, and attention span.

Engagement barriers are overcome in a few different ways. Foremost, the cotherapist's most important role is to foster therapeutic engagement and alliance by drawing the more reserved and quiet participants into the discussion, while also assisting in managing the potentially disruptive engagement style of other group members. To assist with cognitive and intellectual engagement barriers, the cotherapist also helps individuals follow along or complete the worksheets, if desired. In addition, the cotherapist encourages

some individuals to attend the sessions to increase the likelihood of attendance based on knowledge of the individual's condition and situation. The door can be left open to ease the comfort level for some participants to attend the group. Given that arousal levels may be affected by medication changes, individuals are not ostracized if they fall asleep or appear aloof. Finally, attending the session is encouraged and considered positive client engagement regardless of whether or not the client participated in the discussion or completed the worksheets.

Facilitator Roles and Expectations

Although not an explicit barrier, carefully considered facilitator roles can assist with managing the aforementioned barriers and is an important aspect to consider when constructing any group CBT intervention (see Chapter 2). For best results, it is recommended that two facilitators be present during each group: a primary therapist and a cotherapist. It is very helpful when at least one of the facilitators has a good relationship with the individuals on the inpatient unit and this individual can take on the role of the cotherapist as this can assist with building the therapeutic alliance. It is also equally important for this facilitator to manage the behavioral or symptomatic issues that arise from the group members while also not trying to deliver the intervention—that is, when there is a disruptive issue (e.g., angry outburst) or a psychiatric concern (e.g., client begins sobbing and leaves the room), it is the cotherapist who manages these individuals as professionally and discreetly as possible so as to not interfere with the other group members' experience. It is best for the cotherapist to have a respected presence on the unit so that clients see them as someone they can trust and from whom they will accept directives. The cotherapist's role is also crucially important in terms of understanding the makeup of the group from day-to-day in terms of personality characteristics and symptom severity. Issues can be managed and better predicted when therapists are aware of individuals who may be particularly distressed or triggered by certain discussions, or of individuals who may pose behavioral challenges. In addition, it is the role of the cotherapist to identify individuals who may benefit from the group, but who may need a nudge of encouragement to attend. Finally, the cotherapist assists the primary therapist in delivering the content of the session, such as helping with examples, assisting in role playing, and/or eliciting responses from group members when appropriate and therapeutically beneficial. The cotherapist can be any type of health professional with a background in mental health.

The primary facilitator's principal role is to deliver the session content, manage group processes, and know when to change direction of the content using a flexible format. It is not necessary for this individual to have a strong familiarity with the clients on the unit. However, the individual

should be a registered mental health professional with appropriate training in the delivery of CBT, including having familiarity with the delivery of interventions on inpatient units (e.g., Clarke & Wilson, 2009). If the primary therapist and cotherapist have equal backgrounds and/or roles on the unit, then they should determine the facilitator roles in advance. Undefined roles or too much switching of roles between therapists may complicate the organization and flow of the sessions.

Potential Positive Impact of Group CBT in Acute and Short-Stay Settings

Despite the potential barriers, conducting group CBT in heterogeneous inpatient settings can be a rewarding and worthwhile endeavor. In an interesting study investigating client experiences on inpatient units, Chevalier, Ntala, Fung, Priebe, and Bird (2018) found that clients' subjective positive experiences on inpatient units predicted clinical outcome, such as response to pharmacotherapy, alleviation of symptoms, and reduction of future admissions. Further, negative experiences during inpatient admissions were linked to poorer engagement with community services and an increased likelihood of relapse. It was concluded that reducing the impact of uncertainty and promoting good relationships may help services to improve the initial experience of hospital admission and ultimately improve future outcomes for clients (Chevalier et al., 2018). Thus, using group programming as a tool to assist in enhancing nonspecific factors, including building relationships and/or increasing contact with mental health providers to reduce uncertainty, may contribute to more positive experiences and better outcomes. In addition to serving as a treatment, group CBT is an activity to foster engagement with other individuals. There are often many hours of the day without structured programming and interventions, and individuals may spend a great deal of time in solitary activities (e.g., sitting, sleeping, watching television), which can contribute to restlessness, boredom, and potentially escalating agitation. As a consequence, many clients often feel isolated on inpatient units—sharing a human connection while managing a challenging experience can be highly beneficial. Indeed, human experience and connection are cited as client benefits when individual CBT is delivered on acute inpatient units (Small, Pistrang, Huddy, & Williams, 2018).

Clients often lack direct access to registered mental health providers outside of scheduled appointments with members of their treatment team in the inpatient setting, despite having complex needs. Much of the direct contact they have during the day is with nursing staff or other health professionals checking in on their basic needs or delivering perfunctory programming. While these services are beneficial and necessary for providing validation, empathy, and support, they are not therapeutic treatment. Group

CBT leaders are a point of access to mental health services and contribute to the clients' care while on the unit. As noted, the primary therapist should be a registered mental health provider so that when pressing client issues arise during the group sessions, the issues can be managed appropriately and therapeutically as part of continuity of care. Accordingly, the primary therapist acts as a treatment provider for the individuals in the group by documenting status changes and issues that arise in the session, which can be informative for the treatment team.

Finally, attending the group introduces CBT in a nonthreatening format while providing tangible takeaways (e.g., worksheets and lists of resources). The group content can plant seeds for future treatment, as individuals may not have sought out treatment independently due to stigma or anxiety about what to expect. Or it can simply serve as a way to pass the time in the form of a constructive distraction or socialization.

The Case of John

John attended group CBT treatment during his inpatient admission. He had previously not been successful in attending outpatient treatment due to the severity of his anxiety and avoidance related to a past traumatic event. He was initially unable to attend any programming while on the unit. Medication was stabilizing for the anxiety and physiological arousal, but he continued to struggle with a paralyzing fear related to feeling unsafe when he left his room. He was encouraged to attend the CBT group in the first couple of weeks during his inpatient admission. The first time he came to group, he could not tolerate the group for more than a few minutes and left the session. The importance of the open-door format was essential for him. During the next session, he sat next to the door and the door was left open, which was a compromise the facilitators suggested. He was told that he could leave at any time, and did after several minutes. He was also granted a request to be the last person to enter the room, and be seated in a way where nobody could walk up behind him. Over the next couple of weeks, he continued to experience intolerable fear with heightened arousal, including startle responses to certain noises that reminded him of the traumatic event—however, he tolerated more of the session each time before leaving. By his last group, he was capable of sitting through the entire session away from the door despite continuing to show overt signs of distress. Soon thereafter, he was discharged and able to attend outpatient trauma-informed CBT. Notably, the primary therapist was able to consult with the outpatient treatment provider by providing information about John's time on the unit, including his determination to attend the sessions on the unit. It is unclear what, if any, content he was able to grasp from the group CBT sessions, particularly in the initial couple of sessions—however, the intervention was at the appropriate level for his symptomatology, provided

exposure for managing anxiety and the acute fear, and contributed to improved outpatient engagement.

The Modified Group CBT Intervention for Heterogeneous Inpatient Settings

The current adaptation of group CBT presented here, and summarized in Table 5.1, was designed to deliver an effective transdiagnostic therapeutic intervention based on the traditional foundations of CBT and group CBT, as well as third-wave CBT approaches that have been gaining in popularity and empirical support in recent years. The modification focuses on stabilization and acute management of symptoms. As noted, outcome studies are

TABLE 5.1. Session-by-Session Description of Strategies and Content Covered in Group CBT for Heterogeneous Inpatient Settings

Session (45 minutes)	Session content and strategies covered
Module 1: Identifying and Challenging Cognitions	• Psychoeducation and introduction to CBT framework • CBT framework worksheet and example • Discuss group examples • Identifying and challenging thoughts • Review of cognitive distortions worksheet • Discussion of challenging thoughts using worksheet
Module 2: Modifying Behaviors	• Psychoeducation and introduction to CBT framework • CBT framework worksheet and example with focus on behavioral responses and finding the middle ground • Diaphragmatic breathing is introduced as a strategy for addressing elevated emotion/arousal • Role of avoidance in maintaining symptoms is discussed
Module 3: Working Through Emotions—Anger and Fear	• Psychoeducation and introduction to CBT framework • CBT framework worksheet and example • Focus on understanding the role of emotions • Anger is used as an example to highlight surface emotion and underlying emotions with discussion facilitated using a worksheet • Discussion of coping techniques used for managing strong emotions
Module 4: Cultivating Self-Compassion and Mindful Coping	• Psychoeducation and introduction to CBT framework • CBT framework worksheet and example with focus on physical sensations • Introduction to concepts of mindfulness and self-compassion • Three-minute body scan • Discussion of relationship between physical and emotional self • Loving-kindness meditation (10 minutes) followed by discussion

limited and there is no widely used group CBT treatment protocol for acute and diagnostically heterogeneous inpatient settings—thus, the intervention was developed using an iterative process directly from clinical experience while working with individuals on acute inpatient units. The modules were designed to target a diverse client population using a transdiagnostic approach, and thus can easily be generalized across audiences and environments.

Group CBT Basic Framework and Sample Modules

Presentation of the Group CBT Framework

The core feature of the inpatient group CBT protocol is the psychoeducation component. Each module begins with an explanation of the CBT framework. During approximately the first 5 minutes, the definition of CBT is explained along with the concepts of how thoughts ("what we tell ourselves"), behaviors ("what we do"), and emotions ("how we feel") are related. For this particular group CBT intervention, it is helpful to add the fourth component: physical sensations. Many individuals receiving care in inpatient settings experience significant physical and somatic symptoms related to their serious mental illness. This fourth element is described by stating "how our physical body reacts." Although these are behavioral responses on some level, strong physiological reactions can be unsettling and triggering for individuals with severe mental illness who may not otherwise have access to their inner cognitions or emotions.

After the basic framework is presented, the next 10–15 minutes are spent using a worksheet (see Figure 5.1) to review the CBT model, focusing on a specific example through a facilitated discussion. This is an important step, because it is used later in conjunction with the module theme. Having a few go-to examples is important, as this helps group members identify a specific situation or an example for their own practice, and it also helps to find something that is generalizable to the group—for example, "Someone cuts in front of you in the lunch line" or "When you said hello to your friend/neighbor, they did not say hello/wave back." These are both specific situations, but common enough for most individuals to be able to draw upon a personal reference. In addition, the examples can be generalized to something the group member may be experiencing. For example, if group members have not had the experience of someone jumping ahead in the lunch line on the unit, the example can be generalized to being cut off when driving or someone jumping the line in a store. The general theme is *feeling upset when someone tries to get ahead in some way that many may find threatening or unfair.* The second example offered can be generalized to *feeling lonely or disrespected* (e.g., a loved one not calling/texting). Many individuals experience feelings of isolation

while they are on inpatient units and if not there, have felt this way at some time in their life.

Using a large whiteboard, chalkboard, or posterboard, the primary therapist solicits examples from the group, moving through thoughts, feelings, physical sensations, and behavioral responses to the example. The group members are asked to follow along either by working through the exercise using a more specific example that they are experiencing (highest level); with the more general example on their worksheet (midlevel); or they can follow along without writing, if they prefer (lowest level). The engagement level is flexible and adapts to the client.

Troubleshooting

It is not uncommon for individuals to be unable to report on particular negative cognitions, behaviors, or emotions. For example, many clients may not have good insight into their internal process or show complete alexithymia (i.e., the inability to identify their feelings). The cotherapist and the primary therapist may choose to role play or provide examples

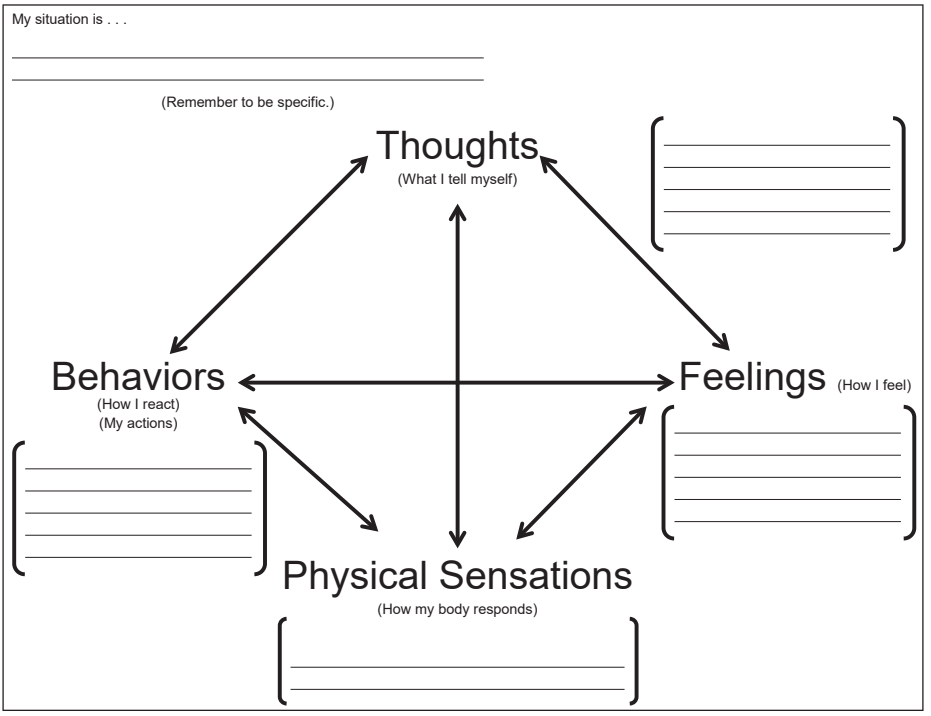

FIGURE 5.1. The CBT feedback cycle.

for the group if this becomes a sticking point. Further, individuals may express or hold a firm belief that these types of situations would not bother them and report on using only adaptive cognitions and behaviors. We once had a client in a group, who was admitted to the unit after a domestic assault on a spouse during an argument, say something like "I don't let other people anger me." Rather than confront the discrepancy directly, this comment was addressed by asking the individual, "Do you think it's possible that smaller examples might build up and then cause problems?" or "Might frustration ever be displaced by overreacting to a different, seemingly unrelated, situation?" The individual was being concrete by suggesting that a particular example would not affect him, but then acknowledged that there might be situations during which he could become angry.

Another sticking point presents when clients struggle to generalize, or become focused on problem solving to the exclusion of self-exploration. Clients may respond with something like "I'd just think that the other person was having a bad day." This could be encouraged as an example of a coping strategy or a way to better understand and access our automatic thoughts. It can also be challenged by drawing on another area of the CBT framework: "I wonder if it's possible to have that thought, but also feel hurt at the same time?" If someone is argumentative, then it is helpful to redirect the client and challenge him or her to think of finding something that is causing distress to him or her at this moment in time. The cotherapist can also be useful in this situation, particularly if the client is motivated to monopolize the discussion.

Choice Point

After the delivery of the CBT framework and worksheet, the facilitators will have a good idea of the group processes, any behavioral issues, and the cognitive level of the group for that day. At this time, it may be decided to end the group session. Or the psychoeducation component may be extended several minutes to continue a discussion. Or the facilitators can decide to deliver the content for the day. When continuing, the leader will revert to the model and highlight which specific area the lesson will target. Ultimately, the approach is a flexible one that is guided by the group members present in the session.

Module 1: Identifying and Challenging Cognitions—"Unhelpful Thinking"

Content from this module is adapted directly from traditional CBT approaches and focuses on the concepts of automatic negative thoughts and cognitive distortions. The primary therapist directs a discussion about

how cognitions (i.e., "what we tell ourselves") affect and evoke emotions, behaviors, and physical sensations. At this time in the session, a worksheet is provided that reviews common maladaptive thinking styles. The group members are given a few minutes to consider which styles resonate most closely with them. Pictures and graphics on worksheets are often more effective than wordy paragraphs. In addition, the simpler the lesson, the easier it is for uptake by group members. A good basic rule of thumb is to keep content at about the sixth-grade reading level. There are many materials and resources readily available online and in CBT workbooks that highlight cognitive distortions and maladaptive thinking styles. After pausing to review the worksheet, the group members are encouraged to volunteer thoughts about which thinking styles resonate most strongly with them. Examples are solicited during a facilitated discussion about how these styles affect their physical body, emotions, and reactions to situations. During this time, the therapists may draw attention back to the CBT framework to seek examples, ask participants to come up with their own examples, or role-play examples with one another if the discussion stalls. Next, an activity of breaking down or challenging these thoughts is explained. There are several ways to do this, but simpler is better in this setting.

During the example provided, individuals identify a situation, write down a few negative automatic thoughts, and then determine which cognitive distortions they used. Then, they may come up with alternative ways to think about the situation. They also review how much they believe in each automatic thought before and then after the exercise. The facilitators can draw attention back to the first activity when they discussed the different negative thoughts associated with the situation (CBT framework) if the group members are stuck. Depending on the group participation, this activity can be completed as a group using an example of an automatic negative thought that was shared by a group member. Or it can be done with a general thought that is role-played and discussed by the facilitators. Alternatively, it can be done independently with the therapists assisting the members of the group with completing their worksheets.

Choice Point

The group session can conclude after the delivery of the maladaptive thinking styles if it is evident at this point in the treatment that individuals do not have the cognitive ability to challenge these thoughts and determine alternative thoughts. For example, it is probably best to end the session if many responses involve reasoning that is out of touch with reality, or if there is disengagement from the group members (e.g., stalled discussion). Conclude the session by stating that all individuals experience unhelpful thoughts and many of these follow a particular pattern across

challenging situations. Encourage group members to use the worksheet to better understand and think about which patterns of thought they identify with most strongly, and ask the attendees to try to apply them to situations they experience later in the day. Importantly, however, as long as there are one or two group members who are engaged in the content, this is typically enough to complete the session. Individuals who are not well engaged can self-excuse or continue on in the session as they have been.

Module 2: Modifying Behaviors

The purpose of this module is twofold: (1) to help participants better understand how patterns of their own behaviors affect, and are affected by, thoughts, emotions, and physical sensations; and (2) to provide very basic problem-solving techniques to identify more adaptive behavioral strategies.

Using the CBT framework, the primary therapist introduces the idea of "what we do" in situations and the effects of these actions. Sometimes, the effects are positive and sometimes how we react can contribute to an escalation of symptoms and problems. It is likely that many participants have heard the idea of "coping," but it is equally likely that they may not be able to describe what that means for them and that it actually means to change our behavior to react in an adaptive way to a stressor.

In this module, behavioral responses are discussed in terms of "too much or too little" reactions to situations—both spectrums can have negative consequences. Finding a "middle ground" is often how the discussion can be directed, even when there are challenging comments or sticking points in a discussion. The middle ground is often an easily understood and well-tolerated message, and draws loosely from distress tolerance and interpersonal effectiveness dialectical behavior therapy (DBT) skills (Linehan, 1993).

After approximately 5 minutes of discussion regarding the effects of maladaptive behavioral responses, the concepts of problem-solving and coping strategies are introduced. While most individuals have heard of deep breathing, many fail to understand how to use it effectively as a therapeutic tool. Deep breathing (e.g., diaphragmatic breathing) should be introduced as a behavioral response to combat "too much" emotion or elevated physiological arousal. The concept of applying deep breathing to counter a "fight-or-flight" physiological arousal reaction is often well understood in acute settings. Group members may want to share whether they tend to be "flee-ers," "fighters," or "freeze-ers" in response to threatening situations; describe examples of each; and determine when the response is too much or too little in amplitude. The facilitators may want to draw out basic examples from their own lives or situations to get the conversation going (e.g., "When I see someone who hurt my feelings,

I try to avoid eye contact with them the next time I see them but it might also make me feel angry. Do other people react the same way? Or differently?").

In addition, the primary therapist may also wish to introduce the idea of avoidance, through the phenomenon of the paradoxical "white bear" (Wegner, 1989; Wegner & Schneider, 2003). The concept suggests that when one attempts to not think about something, or suppress a reaction, they may be more likely to have that thought or reaction (e.g., "don't think about a white bear"). Just as when people are told not to think about a white bear, we have a similar reaction when we tell ourselves or are told not to have certain thoughts or feel a certain way, which can promote the negative behavioral reactions of avoidance or desire for "flight." Exposure to those thoughts and emotions can be powerful and can contribute to making positive behavioral changes and reducing avoidance.

After a brief discussion, the concept of an adaptive behavioral action as something that elicits a positive response, reduces physiological arousal, calms emotions, and changes or diverts the spiraling thoughts is illuminated. Deep breathing and tense-and-release exercises are then presented. Again, there are many open-access breathing and progressive muscle relaxation tools available (see some examples in the resource list at the end of this chapter), and a list of useful websites with audio should be available as resources for the clients to take with them after the session to practice on their own.

In a related approach, the concept of "habits" can be introduced as a mechanism to describe how to change typical behaviors and responses. The ripple effect on thoughts, emotions, and bodily sensations based on "habits" or "patterns" of responses is highlighted. One may want to use a metaphorical notion that is similar to Newtonian's physics concept of "an object at rest tends to stay at rest versus an object in motion tends to stay in motion" to describe how we find ourselves in the same patterns of behaviors across situations. The particular pattern followed by the clients will continue on in that motion (or action) until change occurs. For example, clients can be acknowledged for engaging in action/motion by attending group to initiate change. This tangible example is accessible to clients in the moment and can be encouraging for individuals who are feeling discouraged or worried about whether they will be able to make behavioral changes.

Choice Point

There are several exercises and activities that can be used within this module. Sometimes, the module stops after a discussion of fight-and-flight responses and the introduction of deep breathing. Other times, group members are encouraged to make a list of responses or things to

do instead of the maladaptive behavior along with a discussion of adaptive coping and distraction strategies. Still other times, the group may be better suited for a discussion about how their behaviors may be in response to, or have an effect on, their thoughts, feelings, or physical sensations using the CBT framework. The flow of the conversation by group members during any particular session often dictates the direction and specific activities.

Troubleshooting

Perhaps the two most significant maladaptive behavioral responses are self-harm and substance abuse, which are common precursors to admissions on acute and other inpatient units. These should be addressed directly, when warranted. A productive and nonconfrontational note about substance abuse as a coping strategy can be made (e.g., it does change the cycle of thoughts, feelings, and physical sensations). However, the focus should then be directed toward the potentially long-term negative consequences far exceeding any perceived short-term benefits. Self-harm can also be explored in a similar way, focusing on other techniques to use (e.g., distraction tasks, self-soothing, calling a friend, calling 911). These topics are discussed in the general sense and should never be specifically directed toward any group member. If an individual self-discloses during the session, the primary therapist validates the client and also attempts to direct the discussion to a more general framework. Given the nature of the group, it is not typically appropriate to go into greater detail about these topics with individual group members during the session, but individuals with concerns should be offered time to independently discuss them with the facilitators after the group or at another time.

Drawing from the stages of change transtheoretical model (Prochaska, DiClemente, & Norcross, 1992), it is important to meet each member where they are in terms of making changes. Asking for too much behavioral change during a therapeutic intervention at this acute stage is a common mistake. Not all group participants will be at the action stage. Indeed, the *idea* of change can be overwhelming and may not be easily accessible or well understood by all members of the group during a single session (i.e., precontemplation stage). This group CBT intervention is not meant to be a comprehensive treatment intervention, and the facilitators should take great care not to imply incorrectly that clients should be able to make (or want to make) significant behavioral change without more comprehensive treatment (e.g., stop substance abuse, remove amotivation from depression, cure suicidal ideation).

Finally, whereas behavioral activation is a standard treatment approach for depression, the approach is less useful as a transdiagnostic intervention tool. Therefore, it is often useful to explain the concept

and keep behavioral activation records available for those interested—however, in our experience, the concept does not work well as a primary intervention tool in heterogeneous settings.

Module 3: Working Through Emotions—Anger and Fear

The goal of this module is to introduce the topic of understanding emotions by focusing on the most stigmatized emotion: anger. Individuals who are on inpatient units suffering from psychological distress often have a poor understanding of their emotional state and how to regulate emotions effectively. Individuals with severe mental illness can also be detached from their emotions and exhibit alexithymia. Emotions become a means of managing the relationship with self, individuals close to him or her, and the greater society, which can be problematic if an individual does not have a good understanding of their emotional state (Durrant et al., 2007). The important relationship between the person and their emotions is a central focus of this module.

The module starts with a brief discussion about the universal emotions (e.g., anger, sadness, disgust, surprise, happiness/joy, and fear). It is often encouraging for individuals to take notice that most of these universal emotions have a negative connotation in today's society. It can be comforting and validating to explore the reactions they have had when they have been told not to be angry, sad, or fearful.

The concept of anger as a "surface-level" emotion is then discussed. Anger is usually easily expressed and observable, but the underpinnings are not as easily accessible. Using a worksheet, a facilitated discussion about anger and the other underlying emotions is explored.

Finally, the session ends with a discussion about coping techniques when faced with strong emotions (e.g., deep breathing, grounding techniques, and distraction techniques). The discussion can also include the idea of making a plan on how to react and how to identify warning signs. Worksheets are provided about grounding techniques and coping strategies, which are also readily available online (e.g., *www.TherapistAid.com*, *www.PsychologyTools.com*) and in most CBT workbooks.

Troubleshooting

Sometimes during this module, heightened anger surfaces. It is helpful for facilitators to be prepared for this reaction and have a plan of how to respond to it and any other strong emotion that emerges. Individuals who are particularly vulnerable are those who have been admitted against their wishes or those who are displeased with their care. This can be addressed by validation and also by breaking down the anger to discuss the long-standing hurt and fear that is contributing to the anger during the specific situation. When targeting anger is modeled appropriately,

it can be disarming because individuals expect others to react negatively toward them. Empathizing with a client's anger, helping him or her to better understand it, and then addressing alternative strategies to express it can help diminish it acutely.

Module 4: Lowering Arousal by Cultivating Self-Compassion and Mindful Coping

This module draws from "third-wave" or "third-generation" CBT approaches to address the area of physical sensations (e.g., Hayes, Follette, & Linehan, 2004; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes et al., 2016). In more traditional CBT approaches, the relationship among thoughts, emotions, and behaviors is highlighted by targeting core beliefs and identifying automatic thoughts. Then a number of strategies are taught to help the individual change these dysfunctional thoughts, emotions, and behaviors. The third-wave CBT approaches seek to facilitate change by altering the person's inner experience, which increases awareness of their relationship to self. Mindfulness and meditation exercises are utilized to emphasize the important relationship to one's physical body.

Initial research in this area demonstrated the efficacy of mindfulness-based stress reduction in chronic pain (e.g., Kabat-Zinn, 1990). In the past three decades, mindfulness has been broadly applied and shown to be effective in targeting transdiagnostic processes across various forms of psychopathology (e.g., Greeson, Garland, & Black, 2014). The concept of mindful self-compassion, or the compassionate inner voice, is reflected in the relatively more recent line of work on self-compassion (e.g., Gilbert, 2010; Neff & Germer, 2013). Such research has demonstrated the importance of kind and compassionate relationships in regulating mental states, pointing to key processes that undermine many mental health difficulties. It is from these concepts that compassion-focused therapy has been drawn and self-compassion has been demonstrated as a mechanism for change across psychiatric diagnoses (Gilbert, 2010; Keng, Smoski, Robins, Ekblad, & Brantley, 2012; Neff, 2015). In a recent systematic review, Inwood and Ferrari (2018) provide support for self-compassion as a pertinent preliminary treatment target for individuals who avoid the experience of emotions and feelings of physical distress. This approach has been successfully piloted in an individual CBT approach in acute settings with individuals with severe mental illness (Durrant et al., 2007).

In this module, the concepts of mindfulness and self-compassion are explored and utilized as the intervention strategy to improve body awareness and calm the physiological arousal system. This is introduced by examining the cultivation of nonjudgmental thoughts, positive self-emotions, and meditation to foster inner reflection. The concept of a nonjudgmental approach can be introduced by discussion or through the

easily accessible RAIN mnemonic (see below). A discussion about meditation is also helpful if individuals have questions about the concepts or show hesitancy to engaging in the practice (e.g., the client is worried that focusing on the body will increase anxiety). There are many open-access tools that can be found by searching using the keywords *mindfulness* and *self-compassion*. One helpful tool to use is the RAIN acronym for introducing and practicing the concept of mindfulness, which was first introduced as part of meditation and mindfulness practices several years ago, but later widely popularized by Tara Brach (2013; *www.tarabrach.com/rain*). RAIN stands for *R*—*R*ecognize what is going on; *A*—*A*ccept *or A*llow the experience to be there, just as it is; *I*—*I*nvestigate with kindness, interest, and care; and *N*—*Non*identification with the experience or *N*urture with self-compassion. Across the past two decades, variations of the RAIN mnemonic have been broadly applied in psychotherapeutic interventions, such as the Mindfulness Awareness Practices (MAPs) program for ADHD (Zylowska et al., 2008), among others.

After the concept of mindfulness and cultivating positive emotions is presented, a brief body scan (approximately 3 minutes) is played to introduce the concept of body awareness and understanding the effects of heightened arousal (e.g., heart rate, muscle tension, shaking). The importance of understanding the relationship between the physical and emotional self is stressed. Then, a brief loving-kindness meditation is then played (less than 10 minutes). There are many open-access loving-kindness meditations available (e.g., *www.uclahealth.org/marc/mindful-meditations*). A loving-kindness meditation was selected based on the effectiveness of this core construct in the mindful self-compassion intervention (Neff & Germer, 2013). After the meditation is played, a debrief discussion (less than 5 minutes) ensues, either by way of guided worksheet or via a guided group discussion that draws upon bodily sensations and nonjudgmental reactions to inner reflections that emerged during the guided meditation. Finally, group members are given a worksheet that has a script of the meditations used during the session. As a bonus, the facilitators may wish to put together a list of useful websites and other tools that can be accessed openly online or printed for the group participants.

Troubleshooting

A paradoxical reaction is one of the most common barriers when introducing mindfulness or meditation techniques. This concept has been described in older studies as having potentially negative therapeutic consequences, such as producing uncomfortable awareness to the inner self (e.g., Shapiro, 1992). However, research examining the newer applications in controlled trials demonstrates that cultivation of mindfulness facilitates adaptive psychological functioning and is a generally safe and

effective practice (e.g., Greeson et al., 2014; Keng, Smoski, & Robins, 2011). Choosing brief meditation activities also increases tolerance to the exercises. For the few individuals whose ability to engage is low due to severe emergent psychiatric distress or discomfort, they may choose to leave the session when mindfulness is introduced. Those individuals are offered a written mindfulness script with a list of other resources that they may want to access at a later time.

The environment can be a barrier to delivering mindfulness and meditation interventions on acute units. Often, the units do not evoke a sense of calm, peace, and tranquility. Turning down the lights, lowering the shades on the windows in the room, or blocking windows on the door from individuals peering in from the hallway are all ways to help set the tone. A sign on the door asking others to limit hallway noise around the room during the meditation time can also be helpful. There may also be flexibility in where the session is held, such as at the end of a corridor rather than beside a common room. Blankets, sleep masks, or other aids to increase comfort can also be provided.

Outcomes and Limitations

This chapter sought to provide the reader with a basic framework for delivering group CBT in an accessible format in heterogeneous inpatient settings. It also provided an approach to using group CBT to target nonspecific factors that are helpful in recovery, such as reducing isolation and improving engagement and alliance while on the unit (e.g., providing empathy, camaraderie with other members, and face time with mental health providers). Despite these positive benefits, the intervention approach has notable limitations. Foremost, the approach is not well suited for individuals in acute crisis because the intervention does not deliver a specific or individualized approach to meet the acute needs of an individual (e.g., safety). Further, it does not offer a psychotherapy intervention program for a specific disorder or diagnosis. Clients, when possible, are encouraged to continue to pursue comprehensive CBT or other empirically supported therapies to address symptoms associated with their diagnosis (or diagnoses) for long-term stability.

Although the elements are based on empirical literature, it is not an empirically validated treatment protocol. While anecdotal and qualitative information available is overwhelmingly positive, more empirical evidence to support modified group CBT interventions is needed (e.g., Raune & Daddi, 2011). As with most interventions utilized on inpatient settings, the impact of group CBT treatment on client outcomes and symptom reduction is not well understood. However, it is evident that individuals seek out the programming and find it beneficial to their health when it is provided.

Conclusions

The goal of this chapter was to highlight the empirical literature that provides support for the utility of delivery of group CBT in inpatient settings; examine and troubleshoot the barriers for delivery on heterogeneous inpatient units; and also provide an example of an adapted, flexible, and modular group CBT framework that is appropriate to use in complex heterogeneous inpatient settings. Although much work is still needed, the evidence available supports the value and potential efficacy of group CBT as part of therapeutic programming in inpatient settings.

Resources

Online Resources for Group Content

Psychology tools: *www.psychologytools.com*

Therapist aids: *www.therapistaid.com*

Progressive muscle relaxation: *https://anxietycanada.com/articles/tense-and-release*

Deep breathing: *https://anxietycanada.com/articles/calm-breathing-audio*

Free Guided Meditations

www.uclahealth.org/marc/mindful-meditations

www.mindful.org

https://msw.usc.edu/mindful-living-resources

http://self-compassion.org/category/exercises

www.freemindfulness.org/download

https://positivepsychology.com/loving-kindness-meditation

https://health.ucsd.edu/specialties/mindfulness/programs/mbsr/Pages/audio.aspx

www.tarabrach.com/the-rain-of-self-compassion

www.mindfulness-solution.com/DownloadMeditations.html

https://insighttimer.com (free smartphone app)

PART II

CBT Groups for Specific Populations and Presenting Problems

CHAPTER 6

Anxiety Disorders

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Anxiety disorders are characterized by excessive and debilitating fear and anxiety that is out of proportion to the level of danger posed by the object or situation. The anxiety is accompanied by avoidance of the feared stimuli and is distressing, and/or interferes with daily activities. Anxiety disorders are among the most prevalent disorders, affecting up to one-third of the population at some point in their lives (Bandelow & Michaelis, 2015). Despite the high prevalence of anxiety disorders, it is estimated that only one-quarter of individuals with anxiety disorders receive treatment, with even fewer receiving adequate treatment (Alonso et al., 2018). Further, anxiety disorders are found to be one of the most burdensome health issues, due to the substantial use of primary care services and difficulty detecting the presence of anxiety disorders in primary care settings (Deacon, Lickel, & Abramowitz, 2008; Rice & Miller, 1998).

CBT is the most studied psychological treatment for anxiety disorders and appears to be efficacious regardless of whether it is provided in an individual or group format. An advantage of providing CBT for anxiety disorders in a group format is that it increases the accessibility of treatment and therefore helps to decrease the societal and economic burden associated with anxiety disorders. This chapter (1) provides an overview of anxiety disorders and common maintenance factors; (2) reviews the literature on individual and group CBT (including both disorder-specific and transdiagnostic CBT); and (3) details key treatment components for anxiety disorders, including a session-by-session group CBT treatment protocol for anxiety disorders.

Selected Anxiety Disorders

This chapter focuses on group treatment for panic disorder (PD), agoraphobia, social anxiety disorder (SAD), and generalized anxiety disorder (GAD)—these are the anxiety disorders in DSM-5-TR (American Psychiatric Association, 2022) that have been predominantly studied in the context of group CBT for adults.

PD and Agoraphobia

Individuals with PD experience repeated, unexpected panic attacks, which are surges of fear accompanied by symptoms of autonomic arousal. These panic attacks can become cued over time, and individuals tend to experience persistent anxiety about having another panic attack, concern about the possible consequences of panic attacks, or changes in their behavior to reduce the likelihood, intensity, or consequences of possible future panic attacks (American Psychiatric Association, 2022). A number of cognitive and behavioral approaches to understanding PD have been developed (e.g., Barlow, 2002; Clark, 1986; Margraf & Ehlers, 1988). Cognitive models, such as Clark's theory, emphasize the key role played by catastrophic misinterpretations of physical symptoms (e.g., interpreting dizziness as a sign of fainting) and interoceptive anxiety or fear of physical sensations. For example, an individual who misinterprets a random heart palpitation as a sign of a heart attack is likely to become anxious. The experience of anxiety leads to more physical sensations of arousal (e.g., dizziness, lightheadedness, sweating) that are then misinterpreted as further evidence of an impending catastrophe. Thus, a vicious cycle of anxiety is created, such that catastrophic misinterpretation leads to fear and anxiety, which in turn leads to increased physical symptoms that provide further evidence for the initial misinterpretations. This cycle of anxiety may escalate into a full-blown panic attack.

Individuals with agoraphobia often experience elevated fear and anxiety in situations where they believe they may have a panic attack or other incapacitating symptoms, and are in a location where they feel they might not be able to get away (American Psychiatric Association, 2022). Examples of situations commonly feared by individuals with agoraphobia may include transportation, large open spaces, enclosed places, crowded places or long lines, and leaving one's home alone.

Social Anxiety Disorder

Individuals with SAD (also known as social phobia) experience extreme fear of social and performance situations in which a person feels as though they may be scrutinized or judged by others, embarrassed, or humiliated (American Psychiatric Association, 2013). Examples of situations feared

by people with SAD may include those involving interpersonal interaction, such as dating, meetings, parties, and conversations, as well as performance situations, such as being the center of attention; public speaking; and eating, drinking, or writing in front of others. It is noteworthy that some people with SAD may also fear positive evaluation, perhaps because they believe performing well will raise others' expectations of them and that they are incapable of sustaining this improvement in performance (Heimberg, Brozovich, & Rapee, 2014). Individuals with SAD also fear that others will notice their anxiety symptoms (e.g., blushing, sweating) and criticize or reject them. According to CBT models of SAD, individuals with SAD assume that others have high standards for them and expect them to come across perfectly (Heimberg et al., 2014; Rapee & Heimberg, 1997), they believe that they are likely to behave in a way that will be perceived as incompetent and inappropriate, and they perceive the consequences of their behavior in social situations to be catastrophic (Clark, 2001; Clark & Wells, 1995). As such, individuals with SAD worry and ruminate about what might happen in social situations and avoid social events and interactions. Avoiding social events and interactions maintains anxiety as the individual is unable to disconfirm their feared consequences. When faced with a social situation, individuals with SAD may focus on their own physical reactions (e.g., shaky hands, sweating), behaviors (e.g., slumped posture), and negative beliefs (e.g., "This person does not care about what I am saying"). In addition, they may monitor others' reactions for signs of disinterest or rejection and focus on the perceived discrepancy between their distorted beliefs about others' expectations and their social performance. This internal focus impairs their ability to read social cues and increases the likelihood of poor social performance. Further, people with SAD engage in safety behaviors to manage their anxiety (e.g., avoiding maintaining eye contact)—however, these behaviors may elicit the feared outcome (e.g., others losing interest or forming a negative impression). Following a social event, the person dwells on the negative aspects of their performance, having likely missed any signs of social approval due to their inward focus while in the situation (Clark, 2001; Heimberg et al., 2014).

Generalized Anxiety Disorder

Individuals with GAD experience excessive and uncontrollable worry. Unlike individuals with social anxiety, those with generalized anxiety may worry about any number of things, ranging from simple everyday tasks to the health and well-being of self and others, finances, school or work, or community or world affairs. The worry they experience is often future oriented and related to issues over which they have little control. Individuals with GAD may also experience a number of associated symptoms, including difficulties with sleep, poor concentration, muscle tension, fatigue, restlessness, and irritability (American Psychiatric Association, 2022).

According to prominent CBT models of chronic worry and GAD, individuals with GAD have a high intolerance of uncertainty and use worry as a strategy to prepare for all potential outcomes and to reduce anxiety (e.g., Borkovec, Alcaine, & Behar, 2004; Dugas, Gagnon, Ladouceur, & Freeston, 1998). In this way, worry acts as a dysfunctional form of problem solving in an effort to reduce potential threat and uncertainty. Further, the verbal-linguistic process of worry enables emotional avoidance by reducing exposure to threatening mental images involving potential catastrophes and one's worst fears, and the associated aversive arousal. However, this cognitive avoidance prevents the emotional processing needed to reduce worry in the long term. The worry process is reinforced through decreased exposure to anxious arousal, the absence of catastrophic outcomes, and positive beliefs about worry, including the belief that worry is an effective problem-solving strategy (Borkovec et al., 2004). Further, given that uncertainty is inherent in everyday life, individuals with GAD perpetually engage in worry to prepare for and solve problems, and the process of reviewing the many potential outcomes engenders more worry.

Features of Anxiety Disorders

On the surface, the presenting features of each anxiety disorder may appear somewhat different, considering the distinctive stimuli that elicit anxiety and fear, and how the individual copes in response to these experiences. However, despite the differences in the content, the core factors that initiate and maintain fear and anxiety are similar across anxiety disorders. This section summarizes key features that are shared across anxiety disorders.

Anxiety Cues and Triggers

Across anxiety disorders, anxiety is typically triggered by a cue that elicits a threat appraisal (Ehring, 2014). Even unexpected panic attacks, which occur in the absence of any obvious or conscious trigger, are believed to be responses to feared physical sensations, at least from a cognitive perspective (e.g., Clark, 1986). When faced with a perceived threat, people with anxiety tend to overestimate the danger and underestimate their ability to cope (Ehring, 2014). Anxiety cues can be internal or external and take many forms, including situations, cognitions, and physical sensations (Antony & Rowa, 2005). Situational triggers of anxiety can include situations and circumstances or even a particular object. For instance, a situational trigger for an individual with SAD could be a meeting room at work where the boss frequently calls on employees to provide their opinion. An individual with agoraphobia might be triggered by crowded spaces, and a situational trigger for someone with GAD could be waiting for a loved one who is late coming home. In addition to situational anxiety cues, anxiety can be

triggered by cognitive experiences, such as memories, urges, beliefs, predictions, and assumptions. For instance, a client with SAD may become anxious thinking about giving a poor presentation at a work meeting the next day. Anxiety can also be triggered by physiological sensations that accompany fear (Antony & Rowa, 2005). For instance, individuals with PD may fear an increase in their heart rate while walking quickly. Last, people high in anxiety can also interpret their own symptoms negatively. For example, people with GAD report negative appraisals about their worry (e.g., that it is detrimental to their health; Ehring, 2014).

Cognitive Biases and Processes

According to cognitive theories (e.g., Beck, 1976), anxiety disorders are characterized by the tendency to overestimate threat and its consequences. In other words, people with anxiety disorders hold exaggerated beliefs about the likelihood and level of threat posed by a stimulus and the negative consequences that may come from confronting the stimulus (Abramowitz & Blakey, 2020; Aue & Okon-Singer, 2015). Threat overestimation is attributable, in part, to cognitive biases, including hypervigilance toward threat and making threat-laden judgments (e.g., Williams, Mathews, & MacLeod, 1996). Consistently, there is evidence across anxiety disorders that individuals demonstrate heightened attention for threatening information (Bar-Haim, Lamy, Pergamin, Bakermans-Kranenburg, & van IJzendoorn, 2007; see de Jong, 2014; Koster & Bogaerde, 2019, for reviews) and have the tendency to appraise ambiguity in a threatening or catastrophic manner (Beard, 2011; Harvey, Watkins, & Mansell, 2004; see de Jong, 2014, for a review). Given that these processing biases orient people toward threat, they are posited to act as maintaining factors common across anxiety disorders (Beard, 2011; Williams, Watts, MacLeod, & Mathews, 1997). Although cognitive biases are found across anxiety disorders, the content of the biases may be different. For instance, when delivering a presentation, an individual with SAD may focus their attention on negative facial expressions, and any facial expressions that are difficult to read are likely to be interpreted negatively (e.g., "They were bored," "They thought I was stupid"). In contrast, individuals with PD have heightened attention toward bodily sensations and demonstrate the tendency to catastrophize that the bodily sensation is a sign of an impending medical problem.

Another cognitive process common across anxiety disorders is the tendency to engage in negative repetitive and inflexible thinking patterns in response to intrusions—that is, uncontrollable and unwanted thoughts, images, or urges (Ehring & Watkins, 2008; McEvoy, Watson, Watkins, & Nathan, 2013; McLaughlin & Nolen-Hoeksema, 2011). Two commonly observed inflexible thinking patterns proposed to contribute to the development and maintenance of anxiety disorders include worry and rumination (Ehring, 2014). Worry refers to a future-oriented negative thought and

involves analyzing future possibilities and consequences (e.g., the "what ifs . . . ?"; Borkovec, 1994; McEvoy et al., 2013). In contrast, rumination refers to negative thoughts and reflections on the causes, meaning, and implications of past problems and past experiences of negative emotions (McEvoy et al., 2013; Nolen-Hoeksema, 1991). Specifically, rumination involves analyzing why negative events happened and their consequences (e.g., "Why am I this way?"; "Why did my life turn out this way?"). These thoughts can prompt other negative thoughts and begin a chain of maladaptive thinking. Both worry and rumination are characterized by abstract and overgeneralized thinking styles that contribute to difficulties with concentration, attention, and problem solving (Ehring & Watkins, 2008; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Further, intolerance of uncertainty (IU; Gentes & Ruscio, 2011), which refers to difficulty enduring the aversive emotions triggered by situations in which the outcome is unknown, is suggested to be a cognitive vulnerability factor for worry and anxiety disorders (Carleton, 2016). For individuals high in IU, exposure to uncertainty is associated with elevated arousal, which, in turn, elicits cognitive (e.g., rumination, worry) and behavioral processes (e.g., safety behaviors, avoidance) to reduce this arousal and gain a sense of control.

Avoidance and Safety Behaviors

CBT theories of anxiety disorders posit that avoidance and escape play a central role in the persistence of fear and anxiety. By avoiding the feared stimuli or escaping the situation to prevent a feared outcome, the individual misses out on opportunities to challenge their anxiety-related beliefs and predictions. Further, escaping feared situations establishes a negative reinforcement contingency, where the urge to escape becomes greater as the frequency of escape increases, and it becomes more difficult for the individual to stay in the situation and tolerate the anxiety. For example, if an individual with PD is in a movie theater and it starts to get crowded, they might experience some panic symptoms (e.g., increased heart rate, sweating) and leave the situation for fear of having a panic attack. Leaving the theater decreases the person's anxiety and provides short-term relief. However, the fear of having panic attacks in crowded places is likely to persist because the individual did not stay in the theater long enough to learn that the anxiety-related prediction did not come to pass. Avoidance behavior may also take more subtle forms—for instance, an individual with SAD may avoid making eye contact with others to avoid feeling scrutinized. In addition to overt avoidance, people can engage in cognitive avoidance. As discussed earlier in this chapter, worry has been conceptualized as a form of cognitive avoidance that precludes the emotional processing of feared, often hypothetical, outcomes (Borkovec et al., 2004). Further, worry has been suggested to serve an avoidant function, as the act of worrying and thinking about all possible future outcomes in the absence of a real threat

may lead to the nonoccurrence of that threat being attributed to the worry (Borkovec et al., 2004).

In addition to avoidance of anxiety triggers, individuals with anxiety disorders often engage in *safety behaviors* designed to help manage or reduce anxiety in an effort to feel more comfortable or to prevent anxiety symptoms. Similar to avoidance, safety behaviors maintain fear and anxiety as the nonoccurrence of the feared outcome is often attributed to the safety behavior (Abramowitz & Blakey, 2020; Salkovskis, 1991). Examples of safety behaviors include carrying certain items (e.g., cell phone, water, medication), repeatedly seeking reassurance, distraction, checking (e.g., scheduled appointment times, that appliances are turned off), entering anxiety-provoking situations accompanied by a familiar person, always offering to drive to maintain control and to avoid being a passenger, and taking a substance to prevent physical symptoms (e.g., antidiarrhea or antinausea medication) or to reduce anxiety (e.g., alcohol or other recreational drugs, such as cannabis). Individuals may not be aware of their safety behaviors, so these may be difficult to detect upon initial assessment. Careful assessment requires asking specifically about the presence of various safety behaviors, which typically become more evident as treatment progresses and the individual develops an awareness of the function of certain behaviors. For example, if an anxious person is afraid of making a mistake during a presentation, they may be inclined to engage in excessive preparation and memorization to minimize the likelihood of their feared outcome (e.g., answering a question incorrectly, stumbling) occurring. However, in the event the presentation goes well, the individual is likely to attribute their success to their preparation and memorization. Or if someone is worried about the safety of a loved one, they may feel compelled to call to check in on the loved one to make sure they are safe. In calling, the individual is likely to develop a sense of responsibility for the loved one's safety (e.g., "They are safe because I check up on them").

Physical Symptoms and Elevated Arousal

The experience of anxiety involves the activation of the autonomic nervous system, which leads to both physical (e.g., increased heart rate, breathlessness, dizziness) and affective (e.g., restlessness, frustration) symptoms. Individuals with anxiety disorders demonstrate elevated levels of autonomic arousal, which is due, in part, to their exaggerated perceptions of threat and their perceived inability to cope (Barlow, 2002; Ehring, 2014). Further, anxiety disorders are associated with heightened levels of anxiety sensitivity, which refers to the tendency to make catastrophic interpretations regarding the physical symptoms of arousal (Baillie & Rapee, 2005; Naragon-Gainey, 2010; Reiss & McNally, 1985). Heightened physiological arousal and increased reactivity to physical symptoms lead to hypervigilance and increased attention to threat, which contribute to

the maintenance of anxiety (Barlow, 2002; Brown & Barlow, 2009). For instance, in PD, heightened physiological arousal increases the likelihood of catastrophic misappraisals of physiological symptoms and panic attacks. Individuals with SAD are concerned about showing anxiety symptoms in public and being hyperaware that changes in their physical symptoms (e.g., sweating, blushing) can lead to escalations in anxiety (Hope, Heimberg, & Turk, 2019b). Further, individuals with GAD report chronic muscle tension, which puts them at greater risk of worry.

The Maintenance Cycle of Anxiety

In summary, fear and anxiety are typically triggered by external and internal cues, and are maintained through associated physical symptoms, cognitive features, and avoidance strategies. Specifically, individuals with anxiety disorders hold catastrophic beliefs about the likelihood of a negative outcome or its consequences, which are associated with heightened arousal and hypervigilance toward potential threat. Heightened awareness of and attention toward threat increases the likelihood of detecting anxiety triggers or of attending to the feared outcome coming true. As a result of the anxiety and negative arousal associated with the threat, the individual is likely to engage in various strategies (e.g., situational avoidance, escape, safety behaviors) in an effort to avoid or minimize exposure to anxiety triggers, prevent feared outcomes, and decrease anxiety. The nonoccurrence of the feared outcome is attributed to the avoidance and safety behaviors, and consequently, the anxious and catastrophic beliefs remain untested, the avoidance and safety behaviors are reinforced, and the anxiety persists. Accordingly, CBT is assumed to improve anxiety through identifying anxiety triggers, facilitating cognitive reappraisal of anxiety triggers and their consequences, and extinguishing fear through exposure to threatening stimuli.

Evidence-Based Treatment of Anxiety Disorders

Recent reviews on evidence-based treatments for anxiety disorders support the efficacy of both psychological treatments (Hofmann et al., 2012; van Dis et al., 2020), pharmacotherapy, and their combination (Bandelow et al., 2015). Given the focus of this book, this section focuses primarily on CBT. Evidence regarding both individual and group CBT for specific anxiety disorders is reviewed briefly, as is evidence regarding transdiagnostic treatments.

Individual CBT for Specific Anxiety Disorders

The efficacy of CBT delivered in an individual format for anxiety disorders is well established in research and clinical settings (Bandelow et al., 2015;

Carpenter et al., 2018; Hofmann et al., 2012; Stewart & Chambless, 2009; Watts, Turnell, Kladnitski, Newby, & Andrews, 2015). According to meta-analyses that compared effect sizes across anxiety disorders, several have suggested that the efficacy of CBT is comparable across GAD, SAD, and PD (e.g., Cuijpers, Cristea, Karyotaki, Reijnders, & Huibers, 2016; Hans & Hiller, 2013; Hofmann & Smits, 2008)—however, some studies have found that the effects are largest for GAD (Carpenter et al., 2018; Norton & Price, 2007).

Group CBT for Specific Anxiety Disorders

Given the higher costs of providing individual treatment combined with scarce resources, group treatment is often a more cost-effective and practical option. Group CBT has been found to be efficacious for PD and agoraphobia (Roberge, Marchand, Reinharz, & Savard, 2008; Sharp, Power, & Swanson, 2004), SAD (Barkowski et al., 2016; Mayo-Wilson et al., 2014; Powers, Sigmarsson, & Emmelkamp, 2008), and GAD (Dugas et al., 2003), compared to wait-list control conditions. Group therapy has been found to be equally efficacious as individual therapy for PD and agoraphobia (Hans & Hiller, 2013; Sharp et al., 2004)—however, the evidence is less clear for SAD and GAD. For SAD, some researchers have found that individual and group CBT have comparable effects (Barkowski et al., 2016), whereas other researchers have suggested that individual therapy leads to better outcomes for SAD compared to group CBT (e.g., Carpenter et al., 2018; Hedman et al., 2013). In a meta-analysis of the effectiveness of CBT for anxiety disorders in outpatient settings, there were no significant differences between individual and group therapy formats at improving SAD or in the dropout rates (Hans & Hiller, 2013). There are surprisingly few research studies comparing group and individual CBT for GAD. One study that investigated group CBT for GAD (Dugas et al., 2003) concluded that group CBT is as effective as individual CBT for GAD, suggesting that the treatment formats are clinically equivalent. However, some researchers have speculated that CBT for GAD may be more effective when provided one-on-one compared to a group setting, as individual treatment can be more easily tailored to the client's presentation (Covin, Ouimet, Seeds, & Dozois, 2008). Further research investigating the optimal treatment format for GAD is needed.

Transdiagnostic CBT

The shared underlying features of anxiety disorders and the commonalities across treatments have steered researchers to develop a single protocol that can be used across anxiety disorders. Two transdiagnostic treatments with the most empirical support include Norton's (2012) *transdiagnostic treatment for anxiety disorders* and Barlow and colleagues' (2017a, 2017b)

Unified Protocol (UP) for transdiagnostic treatment of emotional disorders. Although Norton's treatment was originally developed as a group intervention and the UP was developed to be delivered individually, both approaches have been used in both individual and group formats.

Transdiagnostic CBT protocols for anxiety disorders are practical for a number of reasons. It is proposed that transdiagnostic treatments are more efficient because they target common maintaining processes across anxiety disorders (Conklin & Boettcher, 2017; Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010; Norton & Barrera, 2012). Further, transdiagnostic treatments are suggested to be more cost-effective to implement than disorder-specific treatments, as clinicians need to be trained on only one protocol and clients can access group treatments more quickly in settings where there may not be large numbers of clients with any one anxiety disorder diagnosis (Conklin & Boettcher, 2017). Moreover, some have argued that transdiagnostic treatments can treat comorbid anxiety disorders concurrently, which decreases the need for the client to receive multiple rounds of treatment for comorbid conditions (Norton & Philipp, 2008; Wilamowska et al., 2010). However, there is evidence to suggest that transdiagnostic CBT and CBT for single disorders are equally effective at improving comorbid conditions (Steele et al., 2018).

The efficacy of transdiagnostic group CBT protocols for anxiety disorders has been supported by numerous studies. Meta-analyses of transdiagnostic CBT for anxiety have found that transdiagnostic CBT is more effective than wait-list and treatment-as-usual conditions (Newby, McKinnon, Kuyken, Gilbody, & Dalgleish, 2015; Reinholt & Krogh, 2014). More specifically, the UP has been found to lead to significant changes in both anxiety and depression symptoms for anxiety disorders relative to a wait-list control condition, and these effects were maintained at a 6-month follow-up (Farchione et al., 2012). Norton's transdiagnostic group therapy for anxiety disorders has been found to be more effective than a wait-list control (Norton, 2008; Norton & Hope, 2005) and equally effective as a relaxation training program (Norton, 2012). Further, both the UP and Norton's transdiagnostic group therapy have been found to lead to comparable outcomes as anxiety disorder-specific protocols (Barlow et al., 2017; Norton & Barrera, 2012; Pearl & Norton, 2017), with preliminary evidence of less attrition (Barlow et al., 2017). Norton and colleagues (2013) also investigated the influence of transdiagnostic CBT on comorbid diagnoses in anxiety disorders and found that of those with comorbid diagnoses at pretreatment, 67% did not show evidence of clinically significant comorbidity at posttreatment. Although transdiagnostic protocols have been found to lead to decreases in comorbid symptoms (Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010; Farchione et al., 2012), the improvements in comorbid conditions have been found to be comparable to disorder-specific treatment (Steele et al., 2018). Last, research suggests that there is no difference in outcomes across anxiety

disorders in transdiagnostic treatments (Ellard et al., 2010; Farchione et al., 2012; Norton, 2008).

Assessment and Eligibility for Group CBT in Anxiety Disorders

Comprehensive assessment should be used to establish an accurate diagnosis, to plan treatment, to assess eligibility for group CBT, and to determine treatment outcome. Comprehensive clinical interviews, such as the Structured Clinical Interview for DSM-5 (SCID-5; First, Williams, Karg, & Spitzer, 2015) and the Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5; Brown & Barlow, 2014), are excellent measures for obtaining the information required to make diagnostic decisions and to assess comorbidity. In addition, two emerging diagnostic interviews for DSM-5 that are brief, easy to administer, and free to access are the Diagnostic Interview for Anxiety, Mood, and Obsessive–Compulsive and Related Neuropsychiatric Disorders (DIAMOND; Tolin et al., 2018) and the Diagnostic Assessment Research Tool for DSM-5 (DART; McCabe et al., 2017). There is preliminary psychometric support for the DIAMOND (Tolin et al., 2018) and research is being conducted to assess the psychometric properties of the DART (Pawluk et al., 2022; Schneider et al., 2022).

Self-report questionnaires can also be used to assess different anxiety symptoms and supplement the diagnostic assessment. Discussion of symptom measures for each anxiety disorder is beyond the scope of this chapter. Table 6.1 provides examples of symptom measures for specific anxiety disorders, as well as transdiagnostic anxiety measures. A comprehensive review of assessment measures can be found in the *Handbook of Assessment and Treatment Planning for Psychological Disorders* (Antony & Barlow, 2020).

The information gathered from the initial assessment should be used to formulate an exposure hierarchy with the client, which will guide treatment. The exposure hierarchy consists of the client's most common anxiety triggers, as well as ratings of how anxious these triggers make the client. As part of the assessment, common safety behaviors should also be identified. Responses from the diagnostic assessment and the self-report questionnaires can be used to generate items for the hierarchy. In addition, the exposure hierarchy can be used as an outcome measure by asking group members to start each session by providing current fear/avoidance ratings for each item on their hierarchy (Katerelos, Hawley, Antony, & McCabe, 2008). Additional tools to assess treatment outcome include monitoring diaries (e.g., thought records) and behavioral assessments (e.g., behavioral observation, behavioral approach tests). Further, the self-report questionnaires discussed earlier can be administered throughout treatment to assess improvement and outcome.

TABLE 6.1. Examples of Transdiagnostic and Disorder-Specific Self-Report Measures

	Examples of measures
Transdiagnostic anxiety	Indices of anxiety severity • Beck Anxiety Inventory (BAI; Beck et al., 1988) • State–Trait Inventory for Cognitive and Somatic Anxiety (STICSA; Ree et al., 2008) Transdiagnostic screening tools for anxiety pathology • Anxiety Disorder Diagnostic Questionnaire (ADDQ; Norton & Robinson, 2010) • Overall Anxiety Severity and Impairment Scale (OASIS; Norman et al., 2006) Measure of anxiety, depression, and related symptoms • Depression Anxiety Stress Scales (DASS; P. F. Lovibond & Lovibond, 1995)
Panic disorder (PD) and agoraphobia	Measures of the severity of the core features of PD and agoraphobia • Panic Disorder Severity Scale (PDSS) self-report version (Houck et al., 2002) • Mobility Inventory for Agoraphobia (MIA; Chambless et al., 1985) Measure of catastrophic thoughts associated with PD and agoraphobia • Agoraphobic Cognitions Questionnaire (ACQ; Chambless et al., 1984) Measures of interoceptive anxiety • Body Sensations Questionnaire (BSQ; Chambless et al., 1984) • Anxiety Sensitivity Index (ASI; Peterson & Reiss, 1993)
Social anxiety disorder (SAD)	Measures of SAD features and general severity • Social Phobia Inventory (SPIN; Connor et al., 2000) • Ryerson Social Anxiety Scales (RSAS; Lenton-Brym et al., 2020) • Social Phobia Scale (SPS) and Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998) abbreviated versions, SPS-6A and SIAS-6A (Peters et al., 2012) • Brief Fear of Negative Evaluation Scale (BFNE; Leary, 1983) Measure of cognitive features • Social Thoughts and Beliefs Scale (STABS; Turner et al., 2003)
Generalized anxiety disorder (GAD)	Overall index of GAD severity • Generalized Anxiety Disorder Questionnaire–IV (GAD-Q-IV; Roemer et al., 1995) Measure of worry severity • Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990) Measures of intolerance of uncertainty • 27-item Intolerance of Uncertainty Scale (IUS-27; Freeston et al., 1994) or its 12-item short form (IUS-12; Carleton et al., 2007)

(continued)

TABLE 6.1. *(continued)*

	Examples of measures
Generalized anxiety disorder (GAD) *(continued)*	Measure of cognitive avoidance • Cognitive Avoidance Questionnaire (CAQ; Gosselin et al., 2002) Measure of metacognitive beliefs about worry • Meta-Cognitions Questionnaire (MCQ; Cartwright-Hatton & Wells, 1997) and its short form (MCQ-30; Wells & Cartwright-Hatton, 2004) Measure of positive beliefs about worry • The Why Worry–II (WW-II; Gosselin et al., 2003)

Structuring Group CBT for Anxiety Disorders

Structure of Group Sessions

For a course of group treatment, we recommend at least 12 sessions, each 2 hours in duration, and that sessions generally be held on a weekly basis. Each session should begin with setting an agenda. Therapists should take 5 minutes to provide an overview of the topics to be covered, and clients should be given an opportunity to add items to the agenda. Next, homework from the previous week is reviewed by group members. The review of homework is important, because it reinforces the expectation that homework be completed. When reviewing homework, therapists should be sure to look at each participant's monitoring forms, so feedback can be provided, and appropriate questions can be asked to follow up on the material from the forms. Each group member should take about 5–10 minutes to provide an update on their progress and to review the week's homework. Following the review of homework, sessions early in the treatment often include some psychoeducation, which may involve, for example, teaching participants about the role of cognitions in triggering anxiety, or about how to use particular CBT strategies (e.g., how to complete a thought record). As treatment progresses, more of the session is spent applying and practicing skills. For example, group members may spend increasing amounts of time engaging in exposure practices during group sessions. Each meeting ends with assigning new homework. Homework should be planned jointly by the therapists and participants. The therapists should note any planned exposure homework practices, so they can be checked on at the start of the next session.

Group Composition

Clinical studies on group treatment for anxiety disorders typically include small groups, with eight to 10 participants. We recommend that groups be

led by two therapists, so that there is always backup for dealing with any difficulties or issues that arise, and sufficient support to split the group into smaller subgroups for exposure practices. The presence of two therapists also ensures continuity of leadership in the case that one therapist is absent from a session. Effort is made to balance the contributions of the two therapists, so that group members do not respond more to one therapist than to another. To promote group process and cohesiveness, certain factors are important to consider when determining group composition, including demographic characteristics, symptom profile, and fit.

Demographic Characteristics

When possible, group leaders should take into account demographic characteristics (e.g., age, gender, race/ethnicity, socioeconomic status) when determining group composition. Balancing the group composition may increase group cohesiveness and lower the risk of dropout. However, if demographic characteristics cannot be balanced, there are other ways to foster group cohesiveness, such as linking group members' experiences with one another. In the event that a client's engagement is affected by lack of fit, then it may be beneficial to address this issue directly with this person. In some cases, it may be ideal for the client to be transferred to another group or to recommend individual treatment.

Diagnosis and Clinical Severity

Ideally, it is best either to have a range of clinical severities among group members or to have members with a similar severity of symptoms. Problems may arise when a group is fairly homogeneous with respect to severity, with the exception of one member. If one member has significantly greater symptom severity or is functioning at a significantly higher level than other group members, they may have different needs than the rest of the group or may view themself as not fitting in. Individuals at the most severe end of the spectrum or with severe comorbidity often do less well in group treatment (or any treatment, for that matter). In our experience, such clients may be served best by individual treatment, which allows for closer therapist attention, the opportunity to address issues that may not be addressed during group treatment, and the ability to devise a more tailored treatment plan that addresses comorbidity. In the event of a transdiagnostic group, similar considerations should be given. In addition, balancing anxiety disorders and the types of fears being reported helps to increase group cohesiveness. For instance, a client with SAD may experience even greater difficulty attending a therapy group comprising individuals with other anxiety disorders who do not fear negative judgment and evaluation.

Group Treatment for Anxiety Disorders

Key Treatment Components for Anxiety Disorders

This section provides an overview of the main CBT treatment components in the treatment of anxiety disorders. For more information on the treatment components and therapy protocols for PD and agoraphobia, SAD, and GAD, see the resources suggested in Table 6.2.

Psychoeducation

Psychoeducation is an important component of treatment for several reasons. Through psychoeducation the client's experience of anxiety is normalized; the group is provided with common language to discuss presenting problems during treatment; and it increases buy-in to treatment, as clients are shown how the CBT model applies to their anxiety symptoms (Norton, 2012). Psychoeducation tends to comprise a larger portion of the earlier sessions compared to later sessions, which focus more on practicing new skills.

To the extent possible, psychoeducation should be an interactive process in which the therapists evoke key points from the group members using prompts and Socratic questioning. Important concepts that should be conveyed through psychoeducation include information on the nature of fear and anxiety, and the components of anxiety. For example, there would

TABLE 6.2. Examples of Treatment Protocols for Specific Anxiety Disorders

Anxiety disorder	CBT protocols
Panic disorder and agoraphobia	• *Mastery of Your Anxiety and Panic* (5th ed.; therapist guide, Craske & Barlow, 2022; client workbook, Barlow & Craske, 2022) • *Panic Disorder: Manual for Improving Access to Psychological Therapy (IAPT) High-Intensity CBT Therapists* (Clark & Salkovskis, 2009)
Social anxiety disorder	• *Managing Social Anxiety: A Cognitive-Behavioral Therapy Approach* (3rd ed.; therapist guide, Hope et al., 2019b; client workbook, Hope et al., 2019a) • *The Shyness and Social Anxiety Workbook: Proven, Step-by-Step Techniques for Overcoming Your Fear* (3rd ed.; Antony & Swinson, 2017)
Generalized anxiety disorder	• *Cognitive Behavioral Treatment for Generalized Anxiety Disorder: From Science to Practice* (2nd ed.; Robichaud et al., 2019) • *The Generalized Anxiety Disorder Workbook: A Comprehensive CBT Guide for Coping with Uncertainty, Worry, and Fear* (Robichaud & Dugas, 2015)

typically be a discussion about how fear and anxiety are normal and adaptive emotions that alert us to something in the environment can protect us from threat. Therapists may evoke examples from group members to illustrate this point. For instance, if a car is driving toward people crossing the street, most people would experience fear and would run out of the way. Anxiety is discussed as existing on a continuum, in which problems can arise if anxiety is too low (e.g., low levels of anxiety may reduce motivation and lead to not caring about the consequences of one's actions) or too high (i.e., high anxiety may lead to avoidance or impaired functioning). As such, being somewhere in the middle of the continuum is ideal to maximize functioning and performance. It is important to highlight that the goal of therapy is not to eliminate worry and anxiety altogether but rather to decrease anxiety to a level that is more manageable and less interfering.

In addition, the group should be socialized to the three components of anxiety (cognitive, behavioral, and physiological) based on the CBT model. The therapists should invite the group to provide examples of cognitive, behavioral, and physiological reactions they experience when anxious. Next, the therapists should highlight how these three components interact to maintain anxiety and invite the group members to consider which of these components they have the most control over (i.e., behaviors and cognitions). The therapists can then discuss the main treatment components, which typically include cognitive restructuring and exposure.

Cognitive Strategies

A detailed discussion of how to use cognitive strategies in a group setting is provided in Chapter 3 of this book. In this section, we provide a brief review of how these strategies can be applied in group treatment for anxiety disorders in particular. Cognitive strategies are typically introduced in the second and third sessions and continue to be discussed throughout treatment (particularly during the review of homework). During the early treatment sessions, participants should be encouraged to discuss the triggers for their anxiety, as well as the variables that influence their fear upon entering these situations. In addition, they should be encouraged to become more aware of the thoughts, beliefs, and predictions that occur in anticipation of encountering these situations (as well as during and after such encounters). Through careful monitoring and discussion in the group, participants learn to become more aware of the situations that trigger anxiety, and the thoughts that are believed to mediate the relationship between these situations and anxiety. It is important to highlight that anxiety is not really a reaction to situations and other triggers but rather how we appraise or interpret situations and triggers. As such, people may misinterpret events, situations, objects, and internal experiences to be threatening or dangerous when objectively the actual danger or threat is low. By emphasizing the

relationship between appraisals of situations and anxiety, the rationale for cognitive restructuring should become clear.

In the anxiety disorders literature, it is common to describe two main types of cognitive distortions: probability overestimations and catastrophic thinking. *Probability overestimations* involve overestimating the likelihood of something bad occurring (e.g., "Nobody will talk to me at the party"). Probability overestimations can be challenged through examining both the evidence supporting the thought and evidence disconfirming it, as described in Chapter 3. *Catastrophic thinking* involves overestimating how unbearable or unmanageable a particular outcome would be, if it were to occur ("It would be terrible if I lost my train of thought during a presentation"), or underestimating one's ability to cope with the outcome. Catastrophic thinking can be challenged by asking questions designed to assume a more balanced perspective—for instance, by asking questions like "Would that really be as bad as I expect?" or "Would it matter the next day? . . . the next week? . . . the next month?" A powerful strategy for challenging both probability overestimations and catastrophic thinking is the behavioral experiment. Essentially, this strategy involves setting up a mini-experiment to test the validity of a belief in the way that a scientist might test a research hypothesis. Ultimately, the goal of cognitive restructuring is not to convince clients that their beliefs are wrong, nor to get them to think more positively. Rather, the goal is to cultivate an open and flexible mindset that considers all of the available information when interpreting anxiety triggers and evaluating potential outcomes.

Exposure-Based Strategies

In Chapter 3, detailed instructions for conducting group exposures are provided. Exposure-based strategies involve having group members gradually experience feared situations, physical sensations, and mental experiences repeatedly, until they no longer trigger fear. Exposures may be self-directed (completed individually as part of homework) or therapist/group assisted (completed as part of the group experience). The rationale for exposure is similar across anxiety disorders. However, the content and structure of exposure depends on the client's individual fears and, as such, may vary across group members. Exposure formats are reviewed below.

In Vivo Exposure

In vivo, or "real-life," exposure involves the systematic and repeated confrontation of feared situations, and is guided by an exposure hierarchy that comprises individually tailored items. Safety cues should be incorporated into the hierarchy. Sample exposure hierarchies for PD and agoraphobia, SAD, and GAD are provided in Figure 6.1. Note that the hierarchy items

SAMPLE EXPOSURE HIERARCHY FOR AGORAPHOBIA

Item	Fear/avoidance (0–100)
1. Go out without Ativan.	100
2. Go to the movies and sit in the middle of the row.	100
3. Stay alone at home in the morning.	99
4. Drive to the city alone.	95
5. Go to the mall when crowded.	90
6. Go out without a cell phone.	80
7. Drive on the highway alone outside of the safe zone.	80
8. Go to the gym.	70
9. Drive to the city as a passenger.	70
10. Go to the mall when it is uncrowded.	70
11. Go to the movies and sit on the aisle.	60
12. Wait in a line.	50

SAMPLE EXPOSURE HIERARCHY FOR SOCIAL ANXIETY DISORDER

Item	Fear/avoidance (0–100)
1. Have a party and invite everyone from work.	100
2. Give a 15-minute presentation to my department at work.	100
3. Ask someone from my art course to have dinner after class.	90
4. Attend a party being thrown by a coworker.	90
5. Eat dinner in a nice restaurant with a group of six or more coworkers.	80
6. Eat dinner in a nice restaurant with one or two coworkers.	70
7. Ask a question in a meeting at work.	65
8. Tell my boss about my weekend on a Monday morning.	50
9. Have lunch in a casual restaurant with one or two coworkers.	50
10. Tell Rick (a coworker) about my weekend on a Monday morning.	40
11. Arrive late for an art class.	35
12. Make small talk while standing in line at the supermarket.	30

(continued)

FIGURE 6.1. Sample exposure hierarchies for agoraphobia, SAD, and GAD, including pretreatment ratings.

SAMPLE EXPOSURE HIERARCHY FOR GENERALIZED ANXIETY DISORDER

Item	Fear/avoidance (0–100)
1. Imagine partner dies in an accident while away for work.	100
2. Refrain from calling partner to check in with them while they are away on a business trip.	90
3. Imagine getting fired from work.	90
4. Send email to boss that includes an intentional mistake.	90
5. Visit a new town without preplanning the day.	80
6. Invite an unfamiliar coworker out for lunch.	70
7. Send email to boss without rereading the email for mistakes.	65
8. Go to a new restaurant without looking at the menu beforehand.	50
9. Give a presentation at work without seeking reassurance from colleagues.	50
10. Imagine making a mistake in an important document at work.	40
11. Send email to coworker without rereading the email for mistakes.	40
12. Leave on time (instead of early) for a doctor's appointment.	35

FIGURE 6.1. *(continued)*

for PD with agoraphobia and SAD all refer to *in vivo* exposure practices, whereas the GAD hierarchy includes some *in vivo* exposure items, as well as items that might be practiced through imaginal exposure or written exposure (discussed later in this section).

The majority of exposures throughout the group sessions are self-directed. Each group member selects the situations that they will practice in between the group sessions. Frequent exposure practices (ideally daily) are encouraged. Group members are encouraged to try more difficult practices as soon as they are willing to. For some people, this pace may be more gradual, as they work their way up the exposure hierarchy. Other people may be willing to try more difficult practices sooner, selecting items closer to the top of the hierarchy. If warranted, group members are encouraged to have a helper (e.g., family member or friend) assist them in more challenging exposures. At least one or two group sessions are used for therapist-assisted exposure, especially in the treatment of agoraphobia and SAD. For instance, a SAD group might include having the group purposely draw attention to themselves in a public place. In an agoraphobia group, members might practice riding the elevator together.

Role-Play Exposures

Role-play exposures are a type of simulated exposure in which someone else (e.g., family members, the therapist, or other group members) engages with the client to create a feared situation. Role-play exposures are often included in the treatment of SAD. For example, a client who is fearful of going on job interviews can practice interview role plays before practicing exposure to actual job interviews. Or for an individual who is fearful of public speaking, the entire group can play the role of "audience." Similarly, group members can mingle at a simulated party for a client who is fearful of making small talk. During role-play exposures, the client and other participants are encouraged to stay in character and props can be used, as necessary, to simulate the feared situation.

Interoceptive Exposure

Interoceptive exposure involves having clients bring on the physical sensations they fear in a controlled and repeated manner, so that fear reduction is achieved. It is typically used in cases where clients are fearful of their physical arousal symptoms, which is common in clients with PD and agoraphobia. After review of the rationale for interoceptive exposure, the therapists lead the group through a series of exercises to determine which exercises provoke anxiety-related symptoms for each group member. Examples include hyperventilating (to induce breathlessness and light-headedness), breathing through a small straw (to induce a suffocation feeling), spinning in a chair (to induce dizziness and nausea), using a tongue depressor (to induce a gag reflex), and running on the spot (to induce a racing heart and breathlessness). After briefly demonstrating each exercise, the therapist leads the group through the exercise. Group members are encouraged to continue the exercise until they experience intense physical sensations (typically 1–3 minutes, depending on the exercise). After each exercise, group members share their experiences (e.g., symptoms, anxiety, similarity of symptoms to panic). After symptom testing, group members are encouraged to practice the exercises that were most powerful for them in triggering physical sensations similar to panic. As these exercises are repeatedly practiced, the fear response tends to decrease in intensity.

Imaginal Exposure

Imaginal exposure is used when a cognitive process (e.g., a thought, urge, or memory) is the trigger for a client's anxiety, and involves repeatedly imagining the fear in great detail until the thought no longer evokes anxiety. Imaginal exposure can be used when an unlikely feared outcome is particularly salient for a client. Although standard protocols for PD and SAD typically do not include imaginal exposure, it is often included in the

treatment of GAD (e.g., Robichaud et al., 2019). In the treatment of GAD, imaginal exposure can target hypothetical fears (e.g., "I will get fired and I won't be able to find another job, so I will run out of money, be unable to pay my bills, and will end up homeless"). The procedure for imaginal exposure is described in Chapter 3. Another form of imaginal exposure that may be easier to conduct in a group setting is "written exposure," where the client repeatedly writes about the worst-case scenario in first-person, present tense, including sensory details and vivid imagery, and referencing how the client feels throughout the story. It is recommended that the client writes about the same worst-case scenario continuously for 30 minutes three to five times per week. In the case of a GAD group, it may be useful to spend a session introducing imaginal or written exposure. However, in the event that only select members of a group would benefit from this type of exposure work, therapists could consider describing the procedures to these clients outside of the group.

Additional Treatment Strategies for Consideration

Depending on the group composition, the group members may benefit from other strategies, such as relaxation training, social skills training (SST), and problem-solving training. These skills are reviewed below.

Relaxation Training

Although relaxation training is rarely used in the treatment of PD and SAD, it is included in some GAD treatments (e.g., Zinbarg, Craske, & Barlow, 2006) and has demonstrated efficacy for improving anxiety (Kim & Kim, 2018; Montero-Marin, Garcia-Campayo, López-Montoyo, Zabaleta-del-Olmo, & Cujpers, 2018). Relaxation strategies may be particularly useful for individuals who experience muscle tension and physical restlessness, which are commonly associated with chronic worry. Reducing tension decreases the likelihood of making threatening appraisals and being anxious. Further, relaxation training can foster present-moment awareness, which is particularly beneficial for clients with GAD who are often engrossed in future-oriented worry. Progressive muscle relaxation (PMR) training is a technique that specifically targets muscle tension by teaching clients how to identify and reduce muscle tension using tension-release strategies. At the start of treatment, clients learn to systematically tense and relax 16 specific muscle groups. Over time, the series of exercises is gradually shortened until the client is able to reach the same level of relaxation by just recalling the relaxed state. Other important components of PMR include early cue detection, regular practice, and applying the skills in everyday life. PMR is described in detail by Bernstein, Borkovec, and Hazlett-Stevens (2000). Some researchers have expressed concern that teaching relaxation training may facilitate avoidance by teaching clients that anxiety is harmful and should be avoided.

As such it is important to emphasize that the purpose of relaxation training is not to avoid anxiety but rather to cope with discomfort and respond differently in stressful situations.

Social Skills Training

In some cases of SAD, the client's fears and anxiety may be maintained, in part, by one or more social skills deficits (e.g., difficulties with assertiveness). Specifically, the way the client acts and responds in social situations may actually increase the likelihood of their feared outcome coming true. SST typically begins with a discussion about how particular types of social behaviors (e.g., poor eye contact, coming across as angry or aloof) can sometimes lead to the negative reactions from others that clients often fear. Clients are encouraged to identify the types of social skills that they might want to work on, sometimes with gentle suggestions from the therapists or other group members. Role-play exercises (often conducted during the course of exposure practices) provide an opportunity both to obtain feedback on social behaviors and to practice new skills. Social skills practices may be video recorded to provide an opportunity for clients to see how they actually come across and to give group members an opportunity to provide feedback. Clients should be reassured that it is not essential for them to come across perfectly during the practices. Examples of social skills that could be targeted include nonverbal communication (e.g., eye contact, body language, personal space, facial expressions, volume and tone of voice), assertiveness training, dealing with conflict, dating skills, and presentation or interview skills. By improving the client's social skills, this should increase positive interactions with others and have other benefits, such as making friends, getting hired for a job, participating in meetings at work, and so on.

Problem-Solving Training

Individuals with GAD view problems as threatening, perceive their problem-solving skills to be poor, and doubt the effectiveness of potential solutions (Robichaud & Dugas, 2005). Although there is limited evidence to suggest that individuals with GAD have problem-solving deficits, holding these negative beliefs about problems and problem solving can act as a barrier to effective problem solving. As such, challenging clients' negative problem orientation is often incorporated into treatment for GAD, which includes recognizing opportunity in problems. Further, problem-solving skills are instructed, including how to identify and define problems, identify clear goals, generate solutions, make a decision that is consistent with one's goals, and implement the solution while monitoring its effectiveness and making changes accordingly (see Robichaud et al., 2019, Chapters 4 and 5, for further details).

Sample CBT Group Protocol for Anxiety Disorders

The sample protocol described in this section is a generic group protocol that can be used for transdiagnostic group treatment or tailored for disorder-specific groups. Considerations on how to tailor the protocol for specific disorders are provided. For additional information on how to tailor the protocol for specific disorders, see disorder-specific protocols (examples provided in Table 6.2). Further information on transdiagnostic CBT group treatment can be found in *Transdiagnostic Treatment for Anxiety Disorders* (Norton, 2012), which includes a similar group protocol. The treatment begins with an individual pretreatment session, followed by 12 group treatment sessions. A brief description of what occurs in each session (elaborating on the summary provided in Table 6.3) follows.

Pretreatment Individual Meetings with Group Members

This session involves a meeting between the individual group member and either one or both of the group therapists. The session provides an introduction to the group, the treatment schedule, an overview of what to expect in sessions, issues related to group confidentiality, the importance of attendance, and expectations for homework. This session also provides an opportunity for group members to have their questions addressed and for the therapist to normalize anxious apprehension about commencing treatment with a group of strangers. The pregroup meeting also increases the comfort level of prospective group members by ensuring that they know at least one person who will be in the room at the first session (the therapist).

Session 1: Presenting the Treatment Rationale

Introductions and Group Rules

Session 1 is the first opportunity for group members to meet one another and the group leaders. Because the therapists have a lot of ground to cover in this session, it is important that they aim for a balance between presenting information and allowing space for group interaction and discussion. Promoting group discussion can take place with the introductions. It is helpful to begin by having group members introduce themselves and share some information about themselves (e.g., where they grew up, where they live, favorite hobby or leisure activity) as a way to break the ice.

Following the introductions, the therapists should review the structure of the group, including the group format (12 sessions, 120 minutes per session) and typical session format (e.g., homework review, presentation of new material, application of skills, homework planning). Key

TABLE 6.3. Sample Outline of Treatment Protocol for Group CBT for Anxiety Disorders

Session	Strategies covered
Pretreatment individual meeting	• Explain how the group will work and what to expect. • Introduce norms and rules for the group, and provide practical information (e.g., location and times for group). • Develop an exposure hierarchy. • Answer any questions and address concerns.

Session 1	• Introduction to group members (group members share experiences about what brought them to the group).
	• What to expect from treatment.
	• Review rules for the group (e.g., confidentiality).
	• Psychoeducation: CBT model of anxiety and overview of treatment strategies.
	  ○ For a SAD group: Emphasize the role of avoidance, safety behaviors, and postevent processing in maintaining anxiety.
	  ○ For a PD group: Include psychoeducation on the nature of panic.
	  ○ For a GAD group: Include psychoeducation on the role of IU and its manifestations.
	• Homework: Complete monitoring forms and read introductory chapters from self-help readings.

Session 2	• Homework review. • Psychoeducation: Review CBT model of anxiety and introduce automatic thoughts and cognitive distortions. • Discussion of group members' examples of their cognitive distortions. • Homework: Monitor emotions and thoughts, and identify cognitive distortions.
Session 3	• Homework review. • Psychoeducation: strategies for countering anxious thoughts. • Group members practice challenging and countering anxious thoughts with the goal of realistic thinking. • Homework: Practice challenging anxious thoughts using thought records.
Session 4	• Homework review. • Psychoeducation: introduction to exposure. • Review guidelines for conducting exposures. • Each group member chooses an exposure practice from the exposure hierarchy. • Homework: Conduct exposure practices daily and continue challenging anxious thoughts.

Sessions 5–9	• Homework review.
	• Group members discuss challenges in conducting exposure practices.
	• In-session exposures and role plays.
	  ○ For a SAD group: Consider introducing role plays or exposures that can be conducted as a group (e.g., playing Charades in a public place to draw attention).
	  ○ For a PD group: Introduce and present guidelines for conducting interoceptive exposures. The group can be guided in an interoceptive exposure.
	  ○ For a GAD group: Consider introducing imaginal/written exposure.
	• Homework: cognitive restructuring, completion of thought records, exposure practices.

(continued)

TABLE 6.3. *(continued)*

Session	Strategies covered

Sessions 10 and 11	• Homework review.
	• Continued practice of cognitive restructuring and exposure.
	• Introduce additional skills as needed.
	  ○ For a SAD group: Introduce social skills training and combining exposures and role plays with rehearsing particular social skills.
	  ○ For a PD group: Combined interoceptive and situational exposure is introduced.
	  ○ For a GAD group: Consider introducing progressive muscle relaxation (PMR) or problem-solving skills.
	• Homework: cognitive restructuring, completion of thought records, exposure practices.

Session 12	• Homework review. • Psychoeducation: Discuss triggers for relapse and recurrence and review strategies for preventing relapse and recurrence. • Homework: Practice relapse prevention strategies.

aspects of the pretreatment meeting, such as confidentiality, should be reviewed, and group norms should be discussed, including expectations for attendance, the importance of punctuality, advance notice for missed sessions, and the integral role of homework in treatment outcome.

Group members may expect the group to help them get rid of their anxiety. Thus, it is important to clarify expectations for the treatment process and inform group members that they may experience an increase in anxiety before experiencing a reduction, as they start to confront feared situations instead of avoiding them. Because of this, treatment can be stressful, so group members should be encouraged to set time aside in their schedules to focus on treatment and to reward themselves for meeting goals along the way. It should be emphasized that treatment does not eliminate anxiety entirely, though it will provide skills to manage anxiety and worry, and change the way clients react to their anxiety, so that it does not control their lives. Therapists can build motivation by encouraging group members to consider all of the reasons they have for seeking treatment as motivation to challenge their anxiety.

Introducing Anxiety

The key features of anxiety disorders can be reviewed by having group members share their experience with anxiety, including common anxiety-related thoughts, situations avoided, subtle avoidance strategies, and safety behaviors. Therapists should make an effort to identify common themes across group members' experiences to build cohesion. In a transdiagnostic group, it is useful to highlight commonalities across disorders—for example, that every group member fears certain triggers, experiences

threat-related thoughts in response to these triggers, and consequently avoids these triggers or endures them with distress.

Therapists should review information on the nature of anxiety, highlighting the fact that anxiety is a normal emotion, anxiety is not dangerous, and anxiety will peak and pass. Participants are taught that anxiety is a natural and healthy response to threat, and that it is designed to facilitate survival. Having no anxiety in threatening situations can be a detriment. Within this context, a discussion of treatment goals should emphasize that the goal of treatment is to help group members manage their anxiety, not to eliminate fear and anxiety altogether.

The three-component model of anxiety should be presented as a way for group members to understand their anxiety and fear in terms of their components: physical sensations (e.g., dizziness, breathlessness, racing heart), thoughts (e.g., beliefs, assumptions, predictions), and behaviors (e.g., avoidance, escape, subtle avoidance). It is helpful to describe the components on a whiteboard and have group members share their symptoms for each component. Therapists can then ask group members for some examples to illustrate how the three components interact with one another to escalate anxiety.

If group members experience panic attacks, the nature of panic (e.g., the role of the fight–flight system, that panic attacks are time-limited) and the role of interoceptive conditioning in the development of PD following the initial panic attack should be presented. In GAD groups, the therapists should discuss the role of IU in maintaining worry and its manifestations (e.g., safety behaviors to decrease uncertainty). Finally, therapists present a CBT model for understanding the maintenance of anxiety, which can be general or specific to a particular anxiety disorder.

Homework for this session includes having group members monitor their daily anxiety. The monitoring forms should facilitate thinking about anxiety in terms of the three components (e.g., for each episode of anxiety or fear, recording any physical sensations, cognitions, and behavioral responses that occur). In addition, a reading on the nature of anxiety can be assigned for homework.

Sessions 2 and 3: Cognitive Strategies

Session 2 begins with setting an agenda, addressing any questions from the previous week's readings, and reviewing the completed monitoring forms. Group members should be encouraged to pull out their self-monitoring sheets and review examples. The therapists should identify common themes among group members' experiences. It is also useful to go over a few group members' experiences as examples on the whiteboard to review the CBT model and illustrate how the three components interact to trigger, maintain, or intensify the anxiety experience. The CBT model can be used to illustrate the treatment rationale—that although we often

have little control over our physical sensations, we can modify how we respond to them (i.e., how we think and behave). Group members should be encouraged to share their thoughts about this model and any questions or concerns that they have about how the model relates to their experience.

The importance of thoughts and the role they play in determining emotion is reviewed, with an emphasis on approaching thoughts as hypotheses rather than facts. It is important to highlight that it is not the stimuli (e.g., situations, events) that cause the anxiety but rather the individual's interpretation of these cues and triggers. To illustrate this point, consider providing an example in which two different people face the same stimulus (e.g., a large dog), in which one becomes anxious and the other does not; then have the group consider why the emotional response might differ between these two individuals, and how their thoughts might have influenced their emotions. Following this discussion, the therapists should introduce the notion of automatic thoughts and how people with anxiety disorders tend to have automatic thoughts related to threat and danger when faced with something they fear. Once the group demonstrates an understanding of automatic thoughts, the topic of cognitive distortions (or unhelpful thinking styles) is introduced. Group members are encouraged to identify cognitive distortions for homework during the week. In GAD groups, members should be encouraged to identify both negative thoughts and predictions, as well as positive beliefs about worry. For instance, group members may believe that their worry helps them solve problems and prevent negative outcomes, which can be challenged by asking group members to explore the evidence. Homework includes monitoring emotions and thoughts, and identifying biased thinking.

Session 3 of this protocol begins with a review of the self-monitoring homework. Group members are asked to share examples from their self-monitoring records. The therapists should then introduce the concept of cognitive restructuring. It is important to emphasize that the goal is not to think more positively but rather to learn skills to challenge the accuracy of one's thoughts and to consider alternative, more accurate, balanced, and flexible ways of thinking about feared situations. Anxiety-related thoughts can be challenged by asking group members to generate alternate appraisals and interpretations. One commonly used strategy is the thought record. The group members can be introduced to the thought record, and then a thought record should be completed on the whiteboard using a group member's example. The group should be encouraged to contribute to completing the columns of the thought record. Homework in this session includes using the thought record to track anxiety-related thoughts and practicing use of countering strategies. The goal of realistic, balanced, and flexible thinking versus positive thinking is highlighted. It is common for some group members to state that they have done this before, or that they already know that their negative predictions are not true, and

yet they still feel anxious. Therapists should normalize these concerns and feelings, and encourage group members to keep an open mind and to continue using the strategies, because countering anxiety-related thoughts is a skill that tends to improve over time. With practice, group members generally find that their anxiety-related beliefs become less intense and their alternative appraisals become stronger. Participants are also encouraged to conduct behavioral experiments to test out the validity of their anxiety-related beliefs and predictions. Homework includes completion of thought records and instructions to complete at least two behavioral experiments over the coming week.

Sessions 4–9: *In Vivo* Exposure

For Sessions 4–9, an agenda is first generated, followed by up to 30 minutes reviewing homework, providing corrective feedback, and helping participants to challenge anxiety-related thinking. Participants are also encouraged to help one another to examine evidence for anxious thoughts that arise during the course of the group. At Session 4, following the review of homework, the rationale for exposure is presented. It is helpful to use an example unrelated to group member anxiety to illustrate the concept of exposure (e.g., ask group members the specific steps that they might take to help a child overcome a fear of dogs), and draw a graph on the whiteboard to illustrate what typically happens to anxiety during repeated exposure practices. The guidelines for conducting exposure are reviewed (see Chapter 3). If exposure hierarchies were completed in advance during the assessment, group members should choose one exposure practice from their hierarchies as the focus for homework. However, if exposure hierarchies were not developed in advance of group therapy, then the group should be introduced to the exposure hierarchy and invited to brainstorm some items for their hierarchies. We recommend using the hierarchy as a rough guide to exposure, rather than a strict list of steps to be taken. Clients do not need to start with practices from the bottom of their hierarchies. Rather, they can attempt practices that are as challenging as they are willing to try. It is fine to skip steps on the hierarchy and move on to more difficult items. It is also fine to practice items that are not on the original hierarchy. Taking steps more quickly may lead to more anxiety during practices but it will also likely lead to a quicker reduction in fear over time.

Group members should be encouraged to make predictions about what they expect to happen during each practice, and to evaluate the actual outcomes after the practice is complete. Clients should also monitor urges to use safety behaviors when completing exposure practices. In general, we recommend that the clients gradually decrease the use of safety behaviors as they move through treatment.

Although the rationale for exposure is similar across anxiety disorders, the exposure practices will vary across clients and will depend on

the client's anxiety-provoking stimuli and triggers (see the "Exposure-Based Strategies" section of this chapter for more information). Clients are encouraged to choose exposures that will help them to achieve their therapy goals. For instance, if the client's therapy goal is to worry less about the future, then the exposures may involve increasing the client's tolerance of uncertainty through exposure to unpredictable situations. If the client's anxiety triggers involve bodily sensations, then they might benefit from interoceptive exposures. In some cases, the client's anxiety is triggered by their own thoughts, memories, or urges, in which case, imaginal exposure may be the most appropriate approach.

In Sessions 5–9, the review of homework is followed by in-session exposures. Each session ends with an assignment of homework for the following week (i.e., continuing to practice the cognitive strategies and exposure).

Sessions 10 and 11: Continued Practice of CBT Strategies

Sessions 10 and 11 are used for continued practice of CBT strategies. Homework review is completed as usual, with therapists facilitating the group in reviewing concepts, highlighting common themes, providing positive reinforcement and encouragement, and identifying and troubleshooting obstacles. Depending on the composition of the group, additional practices could be introduced at this time. For instance, for individuals with PD or agoraphobia, the therapists could introduce the combining of interoceptive and situational exposures. For SAD, these sessions might introduce SST, and clients might be encouraged to combine social skills rehearsal with their exposure practices. In a GAD group, effective problem-solving skills could be introduced (see the "Additional Treatment Strategies for Consideration" section of this chapter for more information). At the end of the session, therapists facilitate homework planning, encouraging group members to set specific homework goals, and identify steps for meeting these goals and overcoming anticipated obstacles.

Session 12: Termination and Relapse Prevention

Homework from the previous session is reviewed. The focus of the remainder of this meeting is on reviewing the progress made by each participant, identifying possible triggers for relapse and recurrence (e.g., life stress, a negative experience in a previously feared situation, falling back into old avoidance habits). Clients are encouraged to be vigilant for these triggers and to notice any changes in their anxiety before it becomes overwhelming. They are also encouraged to continue occasional exposure practices and to challenge their anxiety-related thoughts on a regular basis. Part of the session allows time for group members to share what they have learned from the group and what important experiences they will take with them, following the worksheet displayed in Figure 6.2. Time is also

1. Think back to when you first started treatment. What gains or accomplishments have you made over the past 14 weeks? What goals have you achieved? What obstacles have you overcome?

2. What do you need to keep working on after the group ends? What are the situations or experiences that you would like to tackle?

3. What key information or phrases did you learn in the group that you need to take with you to keep you going?

FIGURE 6.2. Posttreatment planning form.

spent processing group members' thoughts and feelings around termination. Relapse prevention is discussed, and the group generates strategies for managing any future anxiety flare-ups.

Posttreatment Evaluation and Planning

At the end of the treatment, group members complete a posttreatment evaluation, including all of the measures that were completed at the start of the treatment. For those who continue to experience significant anxiety, we recommend a number of options. At our clinic, we offer a monthly booster group for clients who have been through one of our treatments and would like a forum to discuss issues that arise as they continue to work on their anxiety. If the person's anxiety continues to be a significant problem, we sometimes offer individual CBT following the group, or a medication consultation.

Group Process Factors in CBT for Anxiety Disorders

A number of issues may present a challenge to group process and require management by the group leaders. Heterogeneity in group membership may reduce group cohesiveness and present a challenge to group process. Individuals who do not feel included in the group may be at risk for dropout. During group, heterogeneity can be minimized by therapists' highlighting of commonalities among group members.

Group members who have experienced negative events during exposures (e.g., fainting or vomiting during a panic-related exposure or being rejected following a social anxiety exposure) also present a challenge to group process because they may contradict information presented by the therapists and trigger fear in other group members. In these cases, there are a few possibilities that can be considered. One option is to direct the conversation to exploring the thoughts underlying the fear. Therapists can acknowledge the fact that negative events may sometimes happen, and shift the group focus to realistic probabilities (e.g., "You fainted once in 200 panic attacks. What is the likelihood of you fainting during a panic attack based on your own experience?" [0.5%]) and decatastrophization (e.g., "What was the outcome of the experience? How bad was it? What are the long-term consequences?"). A second option is to use motivational interviewing (MI) strategies to help resolve the group's "resistance" (Wagner & Ingersoll, 2013). For example, rather than challenging the beliefs, it may be more therapeutic in that moment to reflect the group's concerns back to them.

Participants whose anxious thoughts are resistant to change may also pose a challenge to group process when group members who may be ready to move on become frustrated by a "stubborn" group member. In such a case, it is helpful for the group leaders to encourage the individual to keep an open mind and continue practicing the cognitive strategies. The most powerful change agent is behavior, so moving the group along to the behavioral strategies may help the "stuck" group member.

Noncompliance with exposure homework is also an issue for the group. Noncompliance may be due to motivational factors, lack of understanding of the rationale, or symptom severity (e.g., exposure practice is too overwhelming). Group leaders need to ascertain the reasons for noncompliance, and then manage it accordingly by boosting motivation, reviewing the treatment rationale, or troubleshooting exposure practices. As mentioned earlier, MI strategies can be useful for boosting motivation for change and resolving ambivalence regarding treatment. Although MI is beyond the scope of this chapter, readers are encouraged to consult one of several general resources on the topic (e.g., Miller & Rollnick, 2013), or resources specifically focused on MI for anxiety (Westra, 2012) or for groups (Wagner & Ingersoll, 2013).

In some cases, a group member may require individualized attention for issues that cannot be managed in the group (severe agoraphobia interfering with group attendance, exacerbation of comorbid disorders, etc.). This may be handled by having an individual session, in addition to the group session, to address the issues and to reassess treatment needs, including the appropriateness of continuing in the group. For individuals with severe anxiety, providing additional sessions after the group has ended for those who need further exposure assistance may be beneficial.

Over the course of the group, individual group members are bound to experience a setback at one time or another. This experience should be reframed as a learning experience and discussed within the group in terms of strategies to manage setbacks. Being able to handle a setback with the support of the group is good preparation for handling setbacks that may occur once the group is over.

Conclusions

Collectively, anxiety disorders are among the most prevalent mental health conditions, affecting up to one-third of the population at some point in their lifetime. From a cognitive-behavioral perspective, anxiety disorders are characterized by the tendency to overestimate threat and its consequences, and are maintained through threat misappraisals and avoidance of the feared stimuli. Anxiety disorders respond well to CBT, pharmacotherapy, and combinations of these approaches. Transdiagnostic and disorder-specific CBT groups provide a cost-effective, efficient format for treatment. This chapter reviewed the key CBT components and provided a sample CBT group protocol for anxiety disorders.

CHAPTER 7

Obsessive–Compulsive Disorder in Adults

The hallmark feature of obsessive–compulsive disorder (OCD) is the presence of obsessions, compulsions, or both. Diagnosing OCD can often be challenging due to the overlap in features with other conditions, including tic disorders, impulse control disorders, obsessive–compulsive personality disorder, somatoform disorders, GAD, phobias, eating disorders, psychotic disorders, and depression. Given the overlap with other disorders, we recommend readers review recommendations for diagnosis and classification of OCD elsewhere before they select and treat patients in a CBT group (Abramowitz & Jacoby, 2015; Van Ameringen, Patterson, & Simpson, 2014). DSM-5-TR provides official symptom criteria that qualify an individual to receive a diagnosis of OCD, the core features of which include obsessions and compulsions.

Obsessions may be described as cognitions, urges, or mental images that occur over and over that are unwanted, upsetting, or intrusive, and that individuals try to avoid (see American Psychiatric Association, 2013, for a definition of obsessions). Common obsessions include concerns about contamination (e.g., fear of germs, diseases, detergents, chemicals, toxins, and various other perceived contaminants); doubts about actions (e.g., whether doors are locked, appliances have been left on, there are errors in one's written work, one has hit a pedestrian while driving); religious beliefs (e.g., thoughts of a religious nature that are distressing, such as blasphemous images or thoughts about being possessed by the devil); sexual thoughts and images (e.g., irrational doubts about one's sexual orientation, irrational thoughts about sex with a child or some other inappropriate

partner); aggressive thoughts (e.g., intrusive thoughts of hurting a loved one); thoughts of accidentally harming oneself or others; and impulses to have things exact, in a particular order, symmetrical, or just right (Antony, Downie, & Swinson, 1998).

Individuals with OCD may also experience compulsions, which are repeated behaviors that are done to reduce discomfort caused by obsessions or according to rigid rules (see American Psychiatric Association, 2022, for a definition of compulsions). Typical compulsions include excessive washing, cleaning, checking, reassurance seeking, repeating actions, counting, praying, hoarding, and restating things (Antony, Downie, et al., 1998).

OCD is a heterogeneous condition. Although symptom overlap is common, symptoms sometimes shift from one cluster to another over time, and most individuals with OCD do not experience all of the symptoms described in this section. For example, some individuals have symptoms focused exclusively on concerns related to contamination and washing, whereas others may have symptoms that cut across several content areas.

Cognitive and Behavioral Features of OCD

Cognitive Features

Cognitive-behavioral models of OCD emphasize the importance of beliefs, appraisals, and other cognitive features in the cause and maintenance of OCD. The Obsessive Compulsive Cognitions Working Group (2001, 2003) identified six belief domains that are relevant to OCD: (1) inflated responsibility, (2) overimportance of thoughts, (3) excessive concern about the importance of controlling one's thoughts, (4) overestimation of threat, (5) intolerance of uncertainty (IU), and (6) perfectionism. In this section, we consider a number of these domains, as well as several related cognitive features (e.g., attention and memory biases, magical thinking, thought–action fusion [TAF]) that are relevant to the understanding and treatment of OCD. A comprehensive review of the role of cognition in OCD is available elsewhere (e.g., Radomsky & Alcolado, 2012; Taylor, Abramowitz, McKay, & Cutler, 2012).

Metacognition

The term "metacognition" refers to a belief that an individual has about their beliefs (e.g., the belief that one must control or prevent intrusive thoughts, the belief that one's thoughts are dangerous or very important in some way). Most cognitive models of OCD emphasize the role of metacognitions, arguing that it is clients' beliefs about their obsessions that maintain the disorder. Researchers have begun to generate data confirming the importance of metacognitive factors for understanding OCD (e.g., Wells, Myers, Simons, & Fisher, 2017).

Attention and Vigilance

Although the literature is somewhat inconsistent, overall there is little evidence that individuals with OCD are biased to attend to *general* threat cues more closely than individuals without OCD (e.g., Moritz, Wendt, & Kluwe, 2004). However, there is evidence that individuals with OCD (particularly those with contamination concerns) may be vigilant for information related to their specific obsessions (Armstrong, Sarawgi, & Olatunji, 2012; Sizino da Victoria, Nascimento, & Fontenelle, 2012).

Memory Biases

Research results on memory and OCD have also been mixed. Although some studies have failed to find general memory deficits in OCD, meta-analytic reviews have concluded that individuals with OCD are impaired on tasks requiring working memory (Snyder, Kaiser, Warren, & Heller, 2015) and episodic memory (Shin, Lee, Kim, & Kwon, 2014). There is also evidence that people with contamination obsessions tend to have better memory for contaminated objects than for clean ones (Radomsky & Rachman, 1999), and that individuals with OCD have difficulty forgetting threat-related information when instructed to do so (Wilhelm, McNally, Baer, & Florin, 1996) compared to people without OCD. Regardless of whether people with OCD actually have memory deficits, it is fairly clear that individuals with OCD have a lack of cognitive confidence (i.e., distrust of attention, perception, and memory; Ouellet-Courtois, Wilson, & O'Connor, 2018). Furthermore, repeated checking seems to reduce confidence in one's memory even further (Radomsky & Alcolado, 2010).

Magical Thinking

Magical thinking involves assuming that there are associations between events that in reality are not related. Though not everyone with OCD engages in magical thinking, OCD symptoms do tend to be correlated with measures of magical thinking (Einstein & Menzies, 2004). Examples of magical thinking include beliefs such as "If I do everything seven times, I can prevent bad things from happening" and "If I step on a sidewalk crack, I'll break my mother's back."

Thought–Action Fusion

TAF refers to the tendency to view thoughts and actions as equivalent. Examples of TAF include the belief that thinking about harming a loved one is the moral equivalent of actually doing it, or the belief that thinking about doing something horrible increases the likelihood of acting on the belief. TAF is a common feature of OCD (Bailey, Wu, Valentiner, & McGrath,

2013; Rachman & Shafran, 1999) and, in our clinical experience, is particularly relevant in people with religious, aggressive, and sexual obsessions. Conceptually, TAF may be best thought of as a subtype of magical thinking (Einstein & Menzies, 2004). Recent research suggests that TAF can be corrected through standard CBT techniques, such as psychoeducation or behavioral experiments (Zucker, Craske, Barrios, & Holguin, 2002).

Perfectionistic Thinking

"Perfectionism" may be defined as a tendency to set standards that are both rigid and unattainably high, and is a feature of several disorders. Individuals with OCD tend to show higher levels of perfectionism compared to people without anxiety disorders. In particular, they are overly concerned about making mistakes, and they also report excessive doubts about whether they have done things correctly (Hood & Antony, 2016; Pinto et al., 2017). Clinically, some clients also present with excessive attention to detail and a need to have things "just right."

Inflated Responsibility

A growing literature suggests that individuals with OCD often have an inflated sense of responsibility (see Neal, Alcolado, & Radomsky, 2017, for a review), meaning that they tend to be overly concerned that their actions and thoughts will lead to negative consequences, or that failing to act will lead to negative consequences. The construct of inflated responsibility is closely related to some of the other cognitive features of OCD discussed earlier, including perfectionism, TAF, and magical thinking. Examples of OCD presentations that may reflect a sense of inflated responsibility include the following:

- A person who repeatedly asks for reassurance that others are not offended by something they said.
- A lawyer who spends hours reviewing reports and letters to ensure that everything is accurate, so harm will not come to their clients.
- A new mother who avoids spending time with her baby for fear of acting on intrusive sexual obsessions.

Overestimation of Threat

As with all anxiety-related disorders, people with OCD often judge situations to be much more dangerous than they really are. For example, perfectly safe objects may be viewed as contaminated, or the perceived consequences of making mistakes may be exaggerated. The tendency to overestimate threat has been found to be correlated with the severity of symptoms, such as washing, checking, doubting, obsessing, mental neutralizing, and

hoarding (Tolin, Woods, & Abramowitz, 2003). In addition, compared to people without OCD, people with OCD tend to request more information and tend to spend more time deliberating before making decisions about low-risk situations and about situations relevant to their OCD (Foa et al., 2003).

Intolerance of Uncertainty

The inability to tolerate ambiguity and uncertainty is pervasive across anxiety and related disorders, such as GAD, SAD, and OCD. Research has shown that IU is an important feature of OCD (Sarawgi, Oglesby, & Cougle, 2013; Tolin, Abramowitz, Brigidi, & Foa, 2003). The heightened desire for certainty is especially problematic given the tendency for OCD clients to be uncertain about things. As reviewed earlier, doubts about actions and a lack of confidence in memories are common features of OCD.

Behavioral Features

The most common behavioral features of OCD may be conceptualized either as avoidance behaviors or as compulsions, both of which are used to prevent harm or to reduce discomfort. The distinction between avoidance behaviors and compulsions is often blurred. For example, suppression of intrusive thoughts (an example of an avoidance behavior is listed below) can just as easily be conceptualized as a cognitive compulsion.

Avoidance Behaviors

People with OCD often avoid situations that trigger their obsessions and fear. For example, people who fear contamination avoid objects that are perceived as contaminated, and individuals who fear hitting pedestrians while driving may avoid driving, particularly in areas with pedestrian traffic. Avoidance may also be more subtle. For example, people with OCD engage in various forms of cognitive avoidance, including distraction, suppression of intrusive thoughts, and replacing intrusive thoughts with neutral ones (e.g., Purdon, Rowa, & Antony, 2007; Starcevic et al., 2011). Like other forms of avoidance, cognitive avoidance is thought to be counterproductive, serving to maintain anxiety and distress over the long term (Purdon, 1999).

Compulsions and Other Protective Strategies

One of the hallmark symptoms of OCD is compulsive rituals, the most common of which include checking, washing and cleaning, counting, repeating actions, and repeating phrases. Frequent reassurance seeking is another common compulsion used to reduce anxiety triggered by doubts

about one's actions, intrusive thoughts, or memories. Reassurance is often sought from family members, therapists, books, and other sources.

People with OCD often engage in other protective behaviors as well. For example, people with contamination fears may wear gloves to prevent contaminants from getting on their skin. People who fear leaving their small appliances on may unplug them and bring them to work each day, just to be sure. Reliance on safety cues (objects or people whose presence engenders a sense of safety) is also common in OCD and other anxiety disorders. Finally, some clients with OCD tend to overrely on substances as a way of managing their discomfort (Blom et al., 2011; Mancebo, Grant, Pinto, Eisen, & Rasmussen, 2009), though alcohol and drug use may be less of a problem in OCD than in certain other anxiety disorders.

Cognitive-Behavioral Approaches to Understanding OCD

Early behavioral models of OCD (e.g., Meyer, 1966) were based on traditional learning theories, such as Mowrer's (1960) two-factor model for the development of fear. According to Mowrer, fear is initially triggered through classical conditioning, in which a previously neutral stimulus (e.g., a dog) is associated with some negative event or experience (being bitten), and subsequently becomes an object of fear. Fear is thought to be maintained through operant conditioning processes (specifically, negative reinforcement), in which the avoidance of the feared object or situation maintains the problem over time by reducing the uncomfortable feelings of fear and anxiety, and providing a sense of relief. In the case of OCD, learning models assume that obsessive–compulsive symptoms begin after some sort of classically conditioned negative event. For example, developing food poisoning might lead to a fear of contamination, or losing something important might lead to excessive checking. By engaging in various avoidance behaviors and compulsive rituals, the individual with OCD increases the likelihood that their symptoms will continue over time.

Despite their intuitive appeal, learning models of OCD have not been well supported by research (e.g., see Jones & Menzies, 1998). Therefore, theorists have turned their attention to cognitive and cognitive-behavioral approaches to better understand OCD (e.g., Rachman, 1997, 1998, 2002; Rachman & deSilva, 1978; Salkovskis, 1985, 1998). Two core features of current cognitive-behavioral models of OCD are the notions (1) that individuals with OCD have an exaggerated sense of responsibility for causing or preventing harm, and (2) that metacognitions (i.e., beliefs about intrusive thoughts) are key to understanding this condition.

For example, Salkovskis (1998) reviewed research showing that almost 90% of individuals in the general population experience intrusive thoughts that are similar in content to clinical obsessions, and argued that what distinguishes normal intrusive thoughts from clinical obsessions is not the

nature of the thoughts but rather the way in which the individual interprets the thoughts. According to Salkovskis, intrusive thoughts become a problem when they are interpreted as an indication that an individual may be responsible for either causing or preventing harm to oneself or others. For example, if a person believes that the thought "I will stab my child" increases the chances of doing so, they might be inclined to make efforts to suppress the thought and to avoid sharp objects, such as knives. Behavioral compulsions, attempts to suppress thoughts, and efforts to neutralize obsessions are thought to reinforce the individual's fear of the intrusive thoughts by preventing them from learning that the thoughts are not dangerous. The model appears to be best suited to explaining OCD profiles that involve an intense fear of one's intrusive thoughts (e.g., sexual, aggressive, and religious obsessions).

As another example of a cognitive theory, Rachman (2002) published a model of compulsive checking. According to this theory, compulsive checking occurs when people believe that they have a heightened responsibility to prevent harm and are unsure whether the perceived threat has been removed. For example, a pharmacist who has obsessions about giving customers the wrong medications, and who doubts his memory about what medications he has dispensed, may check his work repeatedly. According to Rachman, three factors that contribute to the intensity of checking are (1) the level of perceived responsibility, (2) perceived likelihood of harm, and (3) perceived seriousness of harm. The Obsessive Compulsive Cognitions Working Group (2001, 2003) further extended the cognitive model of OCD by identifying six domains of beliefs (discussed previously), although more recent research has called into question whether these beliefs are inherently pathological and whether they are central to OCD pathology (Cougle & Lee, 2014). However, these cognitive features remain central to the conceptualization and treatment of OCD.

Evidence-Based Treatments for OCD

Evidence-based treatments for OCD include pharmacotherapy and psychological treatments, such as behavior therapy and CBT. In addition, several long-term follow-up studies suggest that up to half of clients with treatment-refractory OCD report significant benefit following psychosurgery (e.g., cingulotomy, anterior capsulotomy), with relatively few side effects (e.g., Dougherty, Rauch, & Jenike, 2012). However, because of the intrusive nature of psychosurgery and a lack of controlled studies, these procedures are currently used only in the most severe, refractory cases. Recent research has also shown that deep-brain stimulation (DBS) may show promise for treatment-resistant OCD, as evidenced by a meta-analysis showing clinically significant reductions in OCD symptom scores for individuals treated with DBS (Kisely et al., 2014). This section provides a brief review of the current status of pharmacological and psychological approaches to treating

OCD. More comprehensive reviews may be found in a number of sources (e.g., Abramowitz & Buchholz, 2020; Berman, Schwartz, & Park, 2017; Grancini et al., 2020; Öst, Havnen, Hansen, & Kvale, 2015; Stewart & Loh, 2017; Van Ameringen et al., 2014).

Pharmacotherapy

Numerous studies have shown that the selective serotonin reuptake inhibitors (SSRIs), such as sertraline, fluoxetine, fluvoxamine, paroxetine, and citalopram, as well as the tricyclic antidepressant clomipramine, are effective in reducing OCD symptoms (e.g., Fineberg, Reghunandanan, Brown, & Pampaloni, 2013; Skapinakis et al., 2016). In general, although SSRIs are considered to be the first-line pharmacological treatment for OCD, there is some support for SSRI augmentation with other agents, such as risperidone (see Dougherty et al., 2012, for an extensive review). Further, despite the relative paucity of support for alternative pharmacological monotherapies, there is emerging evidence that suggests that glutamatergic agents and serotonin norepinephrine reuptake inhibitors may be a promising avenue for OCD treatment (Dougherty et al., 2012).

There is no evidence that any single SSRI works better than any other. In addition, although effect sizes have tended to be largest in studies using clomipramine, head-to-head comparisons of SSRIs and clomipramine have found them to be equivalent (see Fineberg et al., 2013, for a review). The decision of which medication to use typically involves considering the evidence regarding efficacy, as well as available information on side effects, interactions with medications that the individual may be taking, possible effects on medical conditions from which the person suffers, previous response to medications taken by the client, and previous response to medications taken by family members of the client. Because SSRIs have a more favorable side effect profile than clomipramine, medication treatment for OCD typically begins with an SSRI. If the chosen medication does not lead to the desired reductions in symptoms after 12 weeks of treatment at an adequate dose, it is reasonable to switch to another SSRI and then to clomipramine (see Grancini et al., 2020, for recommended guidelines).

Psychosocial Treatments

Over the past few decades, exposure and ritual prevention (ERP) has emerged as the psychological treatment of choice for OCD. "Exposure" involves gradually confronting feared situations (e.g., touching contaminated objects; purposely making errors in one's written work; doing things the "wrong" number of times; exposing oneself to anxiety-provoking words, thoughts, or images). "Ritual prevention" (or "response prevention") refers to the process of eliminating compulsions, rituals, and protective behaviors.

Research supporting the use of ERP for OCD goes back more than 40 years, beginning with the work of Victor Meyer (1966). A large number

of controlled outcome studies have demonstrated that ERP is an effective treatment for OCD (see Berman et al., 2017; Blakey, Reuman, Jacoby, & Abramowitz, 2017, for a review). Generally, studies support the use of either intensive treatment (consisting of daily sessions for about 3 weeks, administered in either a day treatment or inpatient format) or a less intensive, outpatient-based treatment (often with two or three sessions per week). More recently, a 4-day concentrated exposure treatment was found to be effective, with a 6-month remission rate of nearly 70% (Hansen, Hagen, Öst, Solem, & Kvale, 2018). In one review of 12 ERP studies including about 330 participants, Foa and Kozak (1996) identified 83% of clients with OCD as responders. Furthermore, gains were generally maintained over time, with 76% of clients (from a group of 376 clients in 16 studies) still being considered responders at a mean of 2.4 years following the end of treatment (Foa & Kozak, 1996).

A meta-analysis by Abramowitz (1996) identified several factors that contribute to improved ERP outcomes. Generally, protocols in which strict ritual prevention instructions are given (as opposed to gradual or partial ritual prevention), protocols that include therapist-assisted exposure (as opposed to only self-exposure), and protocols that include both imaginal and *in vivo* (i.e., situational) exposure (as opposed to only *in vivo* exposure) lead to the best results. However, of note, in a subsequent meta-analysis of 16 controlled studies of ERP, Abramowitz, Franklin, and Foa (2002) found that the average OCD symptom reduction across studies was 48%, suggesting that most people continue to struggle with their OCD to some extent, even after successful treatment.

In light of recent cognitive models of OCD, and because ERP leads only to partial improvement in many clients, investigators have begun to examine the benefits of using cognitive strategies. Cognitive therapy (CT) involves teaching clients to identify and challenge unrealistic anxious beliefs by examining the evidence regarding the beliefs and conducting behavioral experiments to test whether negative beliefs are true. To date, studies have mostly focused on comparisons of CT to traditional behavioral treatments, and in most cases, CT has been found to be an effective alternative to ERP (e.g., McLean et al., 2001; Öst et al., 2015; Ougrin, 2011; Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008; Whittal, Thordarson, & McLean, 2005), though a recent study has shown faster symptom reduction with ERP than CT (Olatunji, Rosenfield, et al., 2013). Whereas there is a dearth of research investigating the question of whether adding cognitive strategies to ERP leads to improved outcomes compared to ERP alone, some recent research suggests that the addition of CT to ERP leads to medium to large symptom reductions at posttreatment and 6-month follow-up compared with ERP alone, following a 14-week protocol (Rector, Richter, Katz, & Leybman, 2019).

There is also emerging support for other psychosocial treatments. Acceptance and commitment therapy, which teaches clients to reduce maladaptive avoidance of obsessions through acceptance of intrusive thoughts,

as well as changing the relationship one has with unwanted thoughts, has been demonstrated to be an effective treatment for OCD (see Smith, Bluett, Lee, & Twohig, 2017, for a review). There is also support for other mindfulness and acceptance-based treatments for OCD (e.g., Key, Rowa, Bieling, McCabe, & Pawluk, 2017; Külz et al., 2019). Eye movement desensitization and reprocessing (EMDR) may be effective for OCD (Marsden, Lovell, Blore, Ali, & Delgadillo, 2018), though whether eye movements play a role in the effectiveness of EMDR requires further study. In addition to stand-alone treatments, adjunctive treatments, such as MI, may enhance the efficacy of ERP (McCabe et al., 2019). Last, transdiagnostic treatments are promising for OCD symptom reduction. Controlled trials of transdiagnostic treatments, including clients with OCD, have demonstrated improvements in clinical severity (e.g., Barlow et al., 2017), although outcomes were not broken down by disorder. In summary, there are a variety of cognitive and behavioral treatments that are likely to be effective for OCD.

Group Treatments

Although most studies of psychological treatments for OCD have been based on individual treatment protocols, a number of studies have found that OCD can be treated effectively in a group format (see Bulut & Subasi, 2020; Schwartze, Barkowski, Burlingame, Strauss, & Rosendahl, 2016, for a review). Group treatments that have been described in the literature include cognitive treatments (McLean et al., 2001), behavioral treatments (e.g., ERP; Fals-Stewart, Marks, & Schafer, 1993; Himle et al., 2001), treatments that combine ERP and CT (Belotto-Silva et al., 2012; Cordioli et al., 2003; Jónsson, Hougaard, & Bennedsen, 2011), groups for family members of individuals with OCD (Van Noppen, Steketee, McCorkle, & Pato, 1997), and support groups (e.g., Black & Blum, 1992).

Cordioli et al. (2003) demonstrated in a controlled study that the percentage of improved clients was 69.6% for those treated with 12-session group CBT and 4.2% in a wait-list control condition, providing evidence in support of group treatments. Himle and colleagues (2001) compared a seven-session group ERP treatment to a 12-session group ERP treatment and found both 2-hour groups to be equally effective. McLean et al. (2001) compared 12 sessions of 2.5-hour cognitive and behavioral group treatments for OCD. The percentage of individuals considered *recovered* at posttreatment was 16.0% in the CT group and 38.0% in the ERP group. At 3-month follow-up, the percentages were 13.0 and 45.0%, respectively, which represented a statistically significant difference. More recently, a controlled trial demonstrated that both group CBT and group metacognitive therapy were effective for OCD, with metacognitive therapy outperforming CBT (Papageorgiou et al., 2018).

There have also been preliminary reports on the effectiveness of group interventions for families of clients with OCD. A recent meta-analysis found

that group family-integrated CBT for OCD was effective for reducing adult OCD severity (Stewart, Sumantry, & Malivoire, 2020). For example, Van Noppen et al. (1997) compared two types of group treatment for OCD: one that included groups of six to eight clients on their own, and another that included groups of six to eight clients along with at least one family member each (usually a spouse or parent). Treatment consisted of 10–12 two-hour sessions. Both group formats led to comparable gains (with 70–80% of clients improving by at least 20% on symptom severity). Gains were at least as strong as those in previous studies based on individual therapy. Group therapy was associated with a low dropout rate and with relatively large treatment effects compared to those reported in previous individual treatment studies. Gomes et al. (2016) found that 12 two-hour sessions of family-integrated group CBT reduced OCD symptoms compared to a wait-list control.

A limited number of studies have compared individual and group treatment for OCD. For example, O'Connor et al. (2005) compared group and individual treatments for clients with OCD who had primarily obsessions without compulsions. The group treatment condition included four individual sessions, followed by 12 group sessions lasting 2 hours each. The individual treatment condition included 16 sessions (14 lasting 1 hour, and 2 lasting 90 minutes). Treatment in both conditions included psychoeducation, cognitive strategies, and ERP. Overall, both treatments were effective, though individual treatment produced the greatest changes in OCD symptoms, as well as anxiety and depression. The small number of therapy groups (a total of two), and the large size of each group (on average, 13 participants in each therapy group), may have accounted for the weaker effects of group treatment in this study. Follow-up findings were not presented. A meta-analysis by Eddy, Dutra, Bradley, and Westen (2004) found that individual therapy leads to larger changes than group treatment for OCD. Specifically, among those who completed treatment, a mean of 44% of clients (averaging across studies) who received individual therapy were considered recovered, compared to an average of 28% for those who received group treatment. These percentages as computed for all clients (based on "intent-to-treat" analyses that also included clients who did not complete treatment) were 37 and 22%, respectively.

Anderson and Rees (2007) compared the delivery of CBT for OCD individually or in a group. Individual CBT consisted of 10 sessions lasting 1 hour each. Group CBT consisted of 10 sessions that were 2 hours in length and were facilitated by two therapists. Both treatments were found to be effective. However, those receiving individual treatment showed a more rapid response to treatment, though by 10-week follow-up, participants across both treatments demonstrated equal rates of recovery. A meta-analysis by Olatunji, Davis, Powers, and Smits (2013) examining the efficacy of CBT for OCD showed no significant differences in effect size between group and individual treatment. In addition, a recent meta-analysis by Öst

et al. (2015) found there was no significant difference between group and individual treatment for OCD. Last, there appears to be no difference in dropout rates between group and individual treatments (Pozza & Dèttore, 2017). However, more studies comparing the effectiveness of group and individual treatment are required prior to making definitive conclusions about which approach is most effective.

Combining Pharmacological and Psychosocial Treatments

Though older research comparing ERP to pharmacotherapy has generally shown both approaches to be about equally effective (e.g., Abramowitz, 1997; van Balkom, van Oppen, Vermeulen, & van Dyck, 1994), a recent meta-analysis by Skapinakis et al. (2016) showed that psychosocial treatments (i.e., ERP, CT, and CBT) were more likely to lead to a larger effect, as measured by a reduction in mean self-reported symptom severity, than were medications. These findings have been supported by other more recent meta-analyses (Öst et al., 2015; Romanelli, Wu, Gamba, Mojtabai, & Segal, 2014). In addition, studies examining the combination of pharmacotherapy and psychological treatment (mostly ERP) have generally failed to find any advantage of combining treatments (see van Balkom & van Dyck, 1998; Öst et al., 2015, for reviews).

However, some studies have identified particular conditions under which combined treatments may be warranted. Hohagen et al. (1998) found that the combination of ERP and an SSRI was more effective than ERP alone for reducing obsessions (but not compulsions), and for clients who had depression along with their OCD. O'Connor, Todorov, Robillard, Borgeat, and Brault (1999) found that the combination of CBT and medication was more effective than either alone, particularly when the CBT was added after a period of medication use (rather than introducing both simultaneously). Finally, Kampman, Keijsers, Hoogduin, and Verbraak (2002) found that adding CBT can be useful for clients who do not respond to an SSRI alone. Relatedly, Skapinakis et al. (2016) showed that the combination of SSRIs or clomipramine with psychotherapy was useful for clients with severe OCD.

Assessment and Eligibility for Group CBT in OCD

A thorough discussion of issues related to the assessment of OCD is beyond the scope of this chapter. The reader is referred to Taylor, Abramowitz, McKay, and Garner (2020) for a detailed review. In addition, Rapp, Bergman, Piacentini, and McGuire (2016) reviewed the details on more than 20 different instruments (psychodiagnostic interviews, clinician-administered symptom severity scales, self-report measures, and parent/child measures).

In the context of group treatment for OCD, assessment has two main functions. First, a detailed assessment should be completed to indicate the degree to which the individual is suitable for group treatment. Second, appropriate measures should be used to assess treatment outcome. The issue of suitability for group treatment is discussed in various sections throughout the remainder of this chapter, including a review of recommended inclusion criteria for group treatment. Therefore, this section focuses more on measuring symptom severity before and after treatment.

Summerfeldt (2001) reviewed several obstacles in the assessment of OCD. These include comorbidity and symptom overlap (e.g., distinguishing between OCD and obsessive–compulsive personality disorder), heterogeneity of symptom content, upsetting or embarrassing symptom content (e.g., clients may be reluctant to admit to having sexual obsessions), symptom shifting over time, clinical features that affect response style (e.g., avoidance, need for exactness, doubt, obsessional slowness), and lack of insight. Because of these obstacles, it is important that the assessment take a multimodal format, including information from standard self-report and clinician-administered scales, behavioral assessments, and detailed interviews with clients and perhaps their family members.

With respect to standard scales, we recommend including the Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) second edition as part of the assessment battery (Storch et al., 2010). Ideally, the standard clinician-administered version should be used, though there is a self-report version that may be considered if therapist time constraints are a problem. The Y-BOCS provides not only detailed information regarding the breadth of symptom content but also information about other aspects of severity, including the time taken up by symptoms, distress, and functional impairment. In addition, one or two brief symptom measures may be useful for measuring initial severity and treatment outcome. In our work, we use the Obsessive–Compulsive Inventory—Revised (OCI-R; Foa et al., 2002)—a number of other options are available (see Rapp et al., 2016; Taylor et al., 2020, for reviews), including the Obsessional Beliefs Questionnaire (OBQ; Steketee & Frost, 2001).

Structuring Group CBT for OCD

The following section focuses on OCD-specific groups rather than the treatment of OCD within transdiagnostic groups.

Group Composition and Format

Table 7.1 provides details from several studies on group treatment for OCD that relate specifically to group composition and treatment format. In this section, we make specific recommendations based on existing research, as well as on our own clinical experience.

TABLE 7.1. Format and Composition for Group OCD Treatments

Study	Number of sessions	Group composition	Length of sessions	Strategies
Cordioli et al. (2002, 2003)	12 weekly sessions	8 clients, 2 therapists	2 hours	ERP, CT, group techniques
Fals-Stewart et al. (1993)	24 sessions over 12 weeks	10 clients	2 hours	ERP, imaginal exposure (when appropriate)
Himle et al. (2001)	7 or 12 weekly sessions	Not reported	2 hours	Behavior therapy
McLean et al. (2001)	12 weekly sessions	6–8 clients, 2 therapists	2.5 hours	ERP, CT, behavioral experiments
O'Connor et al. (2005)	16 sessions over 20 weeks	Mean of 13 clients (26 clients in two groups)	2 hours	ERP, CT
Anderson & Rees (2007)	10 weekly sessions	20 clients, 2 therapists	2 hours	ERP, CT
Jónsson et al. (2011)	15 weekly sessions; booster sessions at 1, 3, and 6 months	Not reported	2 hours	ERP, CT, behavioral experiments
Belotto-Silva et al. (2012)	12 weekly sessions	6–8 clients, 2 therapists	2 hours	ERP, CT
Hansen et al. (2018)	4 sessions over 4 days	3–6 patients, 3–6 therapists	3–10 hours	ERP
Papageorgiou et al. (2018)	12 weekly sessions	123 clients in CBT, 95 clients in MCT, 2 therapists per group	2 hours	CBT: ERP, CT; MCT: metacognitive therapy, mindfulness, exposure

Note. Neither Fals-Stewart et al. (1993), O'Connor et al. (2005), nor Jónsson et al. (2011) reported the number of therapists in each group. Himle et al. (2001) did not report the number of clients and the number of therapists in each group. Note that the treatments in many of these studies also included psychoeducation or relapse prevention strategies, though these are not included in the table. MCT = metacognitive therapy.

Number and Frequency of Sessions

The length of group treatments for OCD across research studies ranges from seven to 25 sessions, with an average of around 13 sessions (Whittal & McLean, 2002). The protocol described in this chapter is based on the treatment used in our clinic, which lasts 14 sessions (weekly at first, with the last two sessions occurring every other week). We recommend that

treatment typically last between 10 and 15 sessions. Most group treatment studies are based on weekly sessions. Though it is often most practical to schedule weekly sessions when working with groups, scheduling more frequent sessions may be useful, particularly early in treatment. Studies based on individual treatment protocols are often based on a more intensive schedule (e.g., several sessions per week), and some clients may do better when sessions are scheduled closer together.

Composition of Groups

OCD group treatment studies typically include six to 10 clients and two therapists. In our experience, the larger the group, the more likely participants are to feel inhibited socially, and early dropouts may be more likely to occur. Smaller groups also allow for more individual attention to participants' needs. An advantage of larger groups is that clients are more likely to have others in the group with similar symptom profiles. As we discuss later, symptom heterogeneity can be a problem in group treatments for OCD, and anything that can be done to help clients to not feel alone in the group is helpful.

Group treatment usually involves two therapists. One therapist takes a primary role in delivering the treatment, and the extent of the second therapist's involvement depends on their level of experience (because we are a training clinic, the second therapist is often a student). Including a third therapist can sometimes be useful for larger groups, especially when conducting in-session exposures. At our clinic, the third therapist is typically a more junior student whose main role is that of observer. Later in the treatment, when the group splits up for in-session exposures, the third therapist may play a more active role in coaching clients through their practices.

Inclusion Guidelines

Diagnosis and Clinical Severity

In our clinic's OCD groups, we require that OCD be the principal diagnosis of each participant. In other words, if multiple problems are present, we select for groups only participants for whom OCD is the most distressing or impairing problem. Finally, most research studies require that participants have clinically significant symptoms, based on a Y-BOCS score of at least 16. However, individuals with less severe symptoms may still benefit from group treatment.

Symptom Profile and Fit

Generally, the more homogeneous groups are with respect to symptom profile (e.g., sexual obsessions, contamination obsessions), the better. If group

members have different symptom profiles, they are less likely to see the similarities between their symptoms and those of others. In practice, it is often difficult to assemble homogeneous groups. Still, treating some clients individually may be worth considering if their symptoms are very different from those of other group members.

Comorbidity

Comorbidity is the norm in OCD, and most participants in group treatment have other difficulties in addition to just OCD. Depression and anxiety disorders are particularly common comorbid conditions. Generally, comorbidity should not be a rule out for group treatment. However, if a comorbid condition is likely to interfere significantly with a client's response to treatment, or with the response of other group members, the therapist should consider treating the client individually. For example, a client who has very severe depression, severe borderline personality disorder (BPD), or significant problems with substance dependence may be better treated individually than in a group format.

Insight

Although no data address the issue of whether individuals with poor insight should be treated individually or in groups, there are reasons to believe that both approaches may have benefits. Some clients with poor insight may respond best to individual treatment because it provides a better opportunity for more intensive therapy and to tailor the intervention to the individual's needs (individuals with poor insight often respond less well to treatment). In other cases, individuals with poor insight may benefit more from group treatment. Meeting others who have similar symptoms (except with more insight) may help individuals to recognize that their symptoms are excessive. The decision of whether to include a client with poor insight in a group treatment should be made on a case-by-case basis, taking these and other factors into account.

Client Motivation and Preferences

Some clients with low levels of motivation may not do as well in group treatments. In such cases, individual treatment may provide more opportunities for the therapist to target issues surrounding motivation more directly. The client's preference for group versus individual treatment should also be considered when deciding whether a particular individual is included in a group, though the therapist should recognize that individuals who are initially apprehensive about group treatment often still respond well in the end.

Interpersonal Skills

Individual treatment should be considered for clients who seem unlikely to be able to function effectively in a group (e.g., those who tend to be very hostile toward others). Clients who do not function well with other people may benefit less from group therapy and may also have a negative impact on the treatment response of other group members.

Structure of Group Sessions

Group sessions typically last between 2 and 2.5 hours. Sessions should begin with setting an agenda. The therapists should provide a brief overview of what is to be covered in the meeting, and participants should be given an opportunity to contribute to the agenda if there are specific issues they want to discuss. Next, homework is typically reviewed. Each participant is asked to take 5 or 10 minutes to discuss progress with homework and any issues that arose during the week. Therapists should decide whether to have clients hold on to their monitoring diaries during this part of the session (so clients can be prompted with respect to what happened during the week) or to have the therapist collect participants' diaries and monitoring forms (so that corrective feedback can be provided).

Part of the session may also be spent providing psychoeducation to group members. For example, in the early sessions, participants are provided with a rationale for the treatment and are taught various strategies for dealing with their OCD symptoms. In addition, once ERP has been introduced, part of each session is spent practicing exposure.

Finally, most sessions end with assignment of new homework, which typically involves assignments to practice ERP. In addition, participants are reminded to complete their monitoring diaries, as well as any recommended readings.

Key Treatment Components for OCD

This section provides an overview of the main components of CBT for the treatment of OCD, including psychoeducation, ERP, and CT. For readers seeking a more detailed description of these treatments, there are a number of excellet books that describe cognitive strategies (e.g., Wilhelm & Stetekee, 2006), exposure-based strategies (e.g., Foa, Yadin, & Lichner, 2012), and their combination (e.g., Bream, Challacombe, Palmer, & Salkovskis, 2017; Clark, 2020; Rego, 2016) for treating OCD. Table 7.2 provides a summary of what might be included in each session, based on standard CBT approaches to OCD treatment.

TABLE 7.2. Sample Outline of Treatment Protocol for Group CBT for OCD

Session	Strategies covered
Pretreatment individual meeting	• Explain how the group will work and what to expect. • Introduce norms and rules for the group and provide practical information (e.g., location and times for group). • Develop an exposure hierarchy. • Answer any questions and address concerns.
Session 1	• Introduction to group members (group members share experiences about what brought them to the group and describe OCD triggers and key symptoms). • Explain what to expect from treatment. • Review rules for the group (e.g., confidentiality). • Psychoeducation: model of OCD, define key terms, overview of treatment strategies, recommend self-help readings. • Discuss concerns around treatment and explore motivation for change. • Homework: Complete monitoring forms, read introductory chapters from self-help readings. • Discuss potential obstacles to completing homework.
Session 2	• Homework review. • Psychoeducation: Review cognitive model, introduce cognitive distortions. • Homework: Monitor cognitive distortions.
Session 3	• Homework review. • Psychoeducation: Review strategies for challenging cognitive distortions. • Homework: Practice challenging cognitive distortions on thought records.
Session 4	• Homework review. • Psychoeducation: introduction to exposure and ritual prevention. • In-session exposures and ritual prevention. • Homework: cognitive restructuring, completion of thought records, exposure practices, and prevention of rituals.
Sessions 5–13	• Homework review. • In-session exposures and ritual prevention. • Homework: cognitive restructuring, completion of thought records, exposure practices, and prevention of rituals.
Session 14	• Homework review. • Psychoeducation: Discuss triggers for relapse and recurrence, review strategies for preventing relapse and recurrence. • Homework: Practice relapse prevention strategies.

Psychoeducation

CBT is very much a skills-based approach to treatment, and psychoeducation is almost always included as a component of CBT. In the context of group treatment for OCD, education may occur in the form of didactic presentations, facilitated discussion among group members, demonstrations, assigned readings, or video presentations. Examples of education topics that are often included are as follows:

- Information about the nature and treatment of OCD.
- Guidelines for conducting ERP.
- Theories regarding the causes of OCD.
- CBT models of OCD.
- Information regarding the impact of OCD on the family.
- Family factors that can influence treatment.
- Making lifestyle changes (e.g., diet, exercise, sleep habits).
- Strategies for improving quality of life (e.g., employment, relationships).

Some of these topics (e.g., CBT models of OCD, causes of OCD) are routinely covered at the beginning of treatment. Others (e.g., lifestyle issues) may be covered later.

Exposure

Exposure to feared situations is believed by many experts to be an important, if not essential, component of treatment for phobic disorder and OCD. Hundreds of studies have demonstrated that exposure consistently leads to a reduction in fear, and much is known about the variables that influence the outcome of exposure-based treatments. In the case of OCD, prevention of the compulsive rituals (discussed after this section on exposure) is an important component of any exposure-based treatment.

Because of the wide range of fear triggers that occur in clients with OCD, it is often impossible to generate exposure ideas that are relevant to all group members. Therefore, during in-session exposures, groups are typically divided up, and members practice exposure either in smaller groups or individually. For example, two members may practice touching contaminated objects (e.g., elevator buttons, money, doorknobs), while another practices writing a letter that contains spelling errors.

Exposure practices may occur in the same room as the group sessions, or group members may leave the room to practice elsewhere, depending on the situations that tend to trigger their obsessions and fear. Therapists typically move around the room to check on clients' progress. In some cases, one therapist may accompany one or more clients on an exposure excursion

(e.g., going for a drive with an individual who is fearful of hitting pedestrians while driving), while the other therapist(s) stay behind to work with the remaining clients.

Before exposure begins, it is important to present the rationale for the procedures in a coherent and convincing way. Clients are asked to make a commitment to conduct exposure practices despite feeling uncomfortable and frightened. A model is presented to explain how exposure works, and clients are taught about the best ways to implement exposure practices. Chapter 3 reviews the most important guidelines for maximizing the benefits of exposure. As a reminder, exposure practices should be predictable, controllable, prolonged, and frequent. Clients should not distract themselves during exposures, and the use of safety behaviors should be minimized. The context of the exposure, as well as the types of stimuli used, should be varied. For example, a person who is fearful of becoming contaminated by certain foods should practice eating a wide range of feared foods, in a wide variety of contexts (e.g., at home, in restaurants, in friends' homes). Finally, clients should be encouraged to take steps as quickly as they are willing to progress. The sooner they move on to more difficult practices, the more quickly they see a reduction in the impact of their OCD.

In vivo (i.e., situational) exposure is most appropriate for individuals who are fearful of particular situations, places, objects, or activities. Examples include obsessions about contamination, losing things, and making minor mistakes. Exposure in imagination is most appropriate for clients who are frightened of experiencing particular images or thoughts (e.g., religious, sexual, and aggressive obsessions). Often, a combination of imaginal and *in vivo* exposure can be useful. Table 7.3 provides examples of exposure practices for a wide range of OCD presentations.

Developing an Exposure Hierarchy

In Chapter 3, we review the process of developing an exposure hierarchy. In OCD, it is not unusual for individuals to have a wide range of situations that trigger anxiety or lead to avoidance. In such cases, it can be helpful to generate more than one hierarchy. For example, a client with obsessions concerning contamination, as well as aggressive impulses, could have a separate hierarchy for each of these two domains. For another client (e.g., one who experiences different symptoms at home and at work), it may make sense to have one hierarchy for work-related symptoms and another for home-related symptoms. Hierarchies can be generated collaboratively between the client and therapist in an individual meeting that occurs before the group begins. However, it is also fine to spend time in the group teaching participants to develop their hierarchies, having them generate hierarchy items as a homework assignment, then providing feedback on hierarchies at the next session.

TABLE 7.3. Sample Exposure Practices for Particular OCD Presentations

OCD presentation	Examples of ERP practices
Contamination obsessions and excessive washing	• Touch contaminated objects for an extended period (e.g., rub the object over one's hands and face). • Touch food (e.g., a candy) to a contaminated object and then eat it. • Set a timer in the bathroom to ensure that showers last no more than 5 minutes. • Turn off the main water source in the basement, so water is not available for washing. • Contaminate everything in the home.
Fear of particular words or images (e.g., religious symbols, colors, numbers, names)	• Stare at the feared word or image. • Repeat feared words or phrases out loud. • Bring a feared image to mind and keep it there for an extended period. • Write out feared words and phrases. • Describe a feared image in detail, either out loud or in writing.
Fear of running over pedestrians	• Drive on bumpy roads. • Describe an image out loud, or in writing, of having hit a pedestrian while driving. • Do not check for bodies after hitting a bump or experiencing a thought of having hit someone. • Avoid watching the news or listening to accident reports (if one's natural inclination is to engage in these activities excessively). • Purposely watch the news or listen to accident reports (if one's natural inclination is to avoid these activities).
Aggressive or sexual obsessions	• For fear of stabbing a loved one, practice handling knives and other sharp objects with loved ones in the room; describe out loud, or in writing, images of stabbing a loved one. • Consider imaginal exposure to images of hurting a loved one. • Be around children (e.g., change one's baby) despite irrational intrusive thoughts of harming children sexually. • For intrusive thoughts involving doubt about one's sexual orientation, practice looking at photos of same-sex individuals, change in a public changing room, and so forth.
Need to repeat actions	• Prevent oneself from repeating actions (e.g., leave the situation before having the opportunity to repeat). • If activities have to be repeated a certain number of times or in a specific way, try repeating them in the wrong way for the wrong number of times.
Need to check one's work (e.g., writing)	• Prevent oneself from checking work. • Purposely make mistakes in one's work (but not mistakes that will lead to serious consequences).

(continued)

TABLE 7.3. *(continued)*

OCD presentation	Examples of ERP practices
Compulsive reassurance seeking	• Instruct family members and other sources of reassurance not to provide reassurance anymore (they can reassure the client that the anxiety will decrease over time, but they should not reassure the client about the content of the obsessions). • Tolerate discomfort without asking for reassurance. • Practice imaginal exposure to feared images that trigger the desire to obtain reassurance.
Perfectionism	• Purposely make minor mistakes that trigger anxiety (e.g., pronounce words incorrectly, fold the towels incorrectly, make spelling errors). • Encourage others to make minor mistakes that trigger one's anxiety.

Figure 7.1 provides an example of an exposure hierarchy for an individual who is fearful of encountering objects, situations, or words having to do with the occult, the devil, or other related constructs. As reviewed in Chapter 3, an exposure hierarchy should contain 10–15 items. Items should be as detailed as possible, specifying variables that influence the person's fear. In the case of OCD, hierarchy items and their ratings should include (either explicitly or implicitly) an assumption that the exposure to the item will not be followed by a compulsion.

Ritual Prevention

Complete versus Partial Ritual Prevention

As reviewed earlier, ERP appears to work best when strict ritual prevention instructions are given. In other words, it is best to prevent all rituals rather than to implement ritual prevention in a gradual or partial way. For example, in some intensive treatment programs (e.g., inpatient treatment, day treatment), clients are asked to stop all washing except for a brief shower once per week. In outpatient programs, including most group treatment programs, such restrictions may be impractical, but it is still preferable to eliminate all rituals where possible, and to reduce the frequency of normal behaviors that are similar to the compulsion. For example, for someone who washes excessively, a 5-minute shower every day or every other day may be permitted, but all other washing should still be discouraged. If eliminating all compulsion-like behaviors is dangerous, then the goal should be to decrease the frequency of the behaviors as much as possible. For example, a pharmacist who is afraid of giving customers the wrong medications should be encouraged to check once or twice, if that is the standard of practice, but should be discouraged from excessive checking.

Name: _____ Session: Pretreatment Date: _____

Item	Fear (0–100)	Avoidance (0–100)
1. Go out without Ativan.	100	100
2. Go to the movies and sit in the middle of the row.	100	100
3. Stay alone at home in the morning.	99	100
4. Drive to the city alone.	95	90
5. Go to the mall when crowded.	90	80
6. Go out without a cell phone.	80	80
7. Drive on the highway alone outside of the safe zone.	80	60
8. Go to the gym.	70	90
9. Drive to the city as a passenger.	70	40
10. Go to the mall when it is uncrowded.	70	0
11. Go to the movies and sit on the aisle.	60	100
12. Wait in a line.	50	0

FIGURE 7.1. Sample exposure hierarchy with initial ratings.

Presenting the Rationale for Ritual Prevention

Clients should understand that using compulsions to decrease their fear undermines the effects of exposure. The purpose of exposure is to teach the individual that feared objects, situations, thoughts, and images are in fact safe. When clients use compulsions, they are likely to attribute any positive outcomes to the fact that they engaged in a ritual, rather than to the idea that there was no risk in the first place. There are a number of analogies that therapists sometimes use to make this point.

First, OCD can be compared to a car, and rituals to gasoline. When an individual completes a ritual, it is comparable to putting gas into a car.

Compulsions keep the OCD alive. It is not until we allow the car to run out of gas that it finally stops running. The same is true of OCD. It is not until rituals are completely prevented that the OCD symptoms die. Even occasional rituals may be enough to keep the OCD alive.

Another analogy involves comparing OCD to a spoiled child, and comparing compulsions to the act of giving in to the child (e.g., giving the child candy when they throw a tantrum). When a parent gives in to the child, the child learns that throwing a tantrum is a way to get what they want. If a parent does not give in, the child has an opportunity to learn that using temper tantrums does not result in getting their way. The same is true of OCD. When rituals are stopped, the anxiety will eventually burn itself out, and the urge to do the ritual will die down, as well.

Dealing with Resistance

It is not unusual for clients to express apprehension about stopping all rituals. If this occurs, the therapist should try to alleviate the concerns by helping the individual to look at the situation in as balanced and realistic a way possible (e.g., using cognitive strategies). In addition, the client should be reassured that the therapist will be there for support. In addition to the weekly group meetings, some clients may need extra support by phone or through additional, individual sessions. Group members may also be able to support one another between sessions (e.g., it is not unusual for group members to exchange phone numbers). Clients should also be encouraged to rely on family members for support. At moments when the urge to do the ritual is overwhelming, clients should be encouraged to do whatever they can to prevent the ritual (go for a walk, get away from the situation, talk to a close friend, etc.). Although distraction is generally discouraged during exposure practices, it is preferable to distract oneself than to do the ritual. MI strategies are effective when implemented in the context of CBT (McCabe et al., 2019). For example, it may be of benefit to have clients complete a decisional balance worksheet in session, where they can reflect on the pros and cons of stopping rituals. Harnessing client values may help clients focus on reasons to change (e.g., being able to spend more time with their children if they reduced rituals).

If clients cannot commit to preventing their rituals, there are a few options to consider. One option is to have clients agree to delay their rituals. A client who can delay a ritual for 15 minutes and then reevaluate the situation may find that they can then delay the ritual for another 15 minutes, and so on. Sometimes, agreeing to delay the ritual for 15 minutes at a time, until the urge finally subsides, is more tolerable than the thought of promising to not do the ritual at all. Clients may also be willing to eliminate only some rituals (e.g., washing but not checking, home rituals but not work rituals, evening rituals but not daytime rituals), at least to start. If the most a client will agree to do is eliminate rituals partially, it is better to

tie the decision of which rituals to eliminate to factors such as the type of ritual, the location, or the time, rather than tying the decision to the severity of the person's anxiety or urge to do the compulsion.

Eliminating Cognitive Rituals

In addition to eliminating overt rituals, cognitive rituals should be circumvented. For example, if a client tends to count in 3s, they should be encouraged to stop counting. If necessary, the client can be encouraged to perform a behavior that competes with the cognitive ritual (e.g., counting in 2s) temporarily, but the therapist should be vigilant for the possibility that the competing behavior can itself become a ritual.

Undoing the Effects of Rituals

If the client cannot resist the urge to do the compulsion, they should be encouraged to undo the effects of the compulsion by engaging in additional exposure. For example, after a shower, clients should make an effort to come into contact with contaminated objects. In addition, a number of strategies can be used to circumvent the urge to do the compulsion. For example, eating a candy that has come into contact with contamination may help to prevent the urge to wash (there is no point in washing if the contamination has already been taken into the body). Similarly, purposely making mistakes in a letter and then mailing it may circumvent urges to check the letter for mistakes.

Cognitive Strategies

There are cases in which cognitive strategies should be used with caution. First, cognitive restructuring may function for the client as a form of reassurance. If the client's compulsions include reassurance seeking, some types of cognitive restructuring may serve to maintain the need for reassurance. Second, some clients tend to think in a very detailed, compulsive way, and they sometimes get "lost" in their thoughts (ruminating about a wide range of thoughts that enter their heads). For these clients, cognitive restructuring may simply be impossible, and the most effective way to change their beliefs may be through less cognitive means, such as ERP alone.

Despite these issues, evidence has emerged in recent years that cognitive strategies can be useful for the treatment of OCD. CT emphasizes strategies such as normalizing intrusive thoughts, correcting faulty appraisals, generating alternative beliefs, examining the evidence for particular beliefs (e.g., beliefs concerning responsibility), preventing efforts to neutralize intrusive thoughts, and testing beliefs through behavioral experiments. In addition, CT for OCD often emphasizes changing metacognitive beliefs (i.e., beliefs about obsessions), such as the belief that one's intrusive

thoughts are dangerous and should be controlled, as well as beliefs about the overimportance of one's thoughts. In general, the intrusive thoughts themselves are not challenged directly.

When using cognitive strategies in groups, it is useful to have members of the group help one another with the process of cognitive restructuring. For example, all members of the group can be invited to generate alternative beliefs to challenge a particular group member's intrusive thought. Group members can also be encouraged to role-play how a therapist might respond to a particular concern raised by a client in the group. By helping clients to develop their skills at challenging one another's intrusive thoughts, they may become better able to apply the skills to their own obsessions.

Sample CBT Group Protocol for OCD

This 14-session group treatment protocol borrows from a number of standard treatments for OCD (e.g., Clark, 2020; Rego, 2016; Yadin, Foa, & Lichner, 2012a). The first 12 sessions occur weekly, and the last two sessions, every other week. After a thorough assessment, and before the treatment begins, each client meets individually with one or more of the group therapists to provide an opportunity for the client to have any concerns or questions addressed and to develop an exposure hierarchy. Therapy begins with presenting the rationale for treatment, which is mostly based on an ERP model. In addition, some sessions emphasize cognitive strategies. All sessions last 2 hours. The content of each session is summarized in Table 7.2.

Pretreatment Individual Meetings with Group Members

This session involves an individual meeting between one client and one or more of the group therapists. In this session, a basic introduction to the group is presented, including the group schedule (location, times, and dates), a brief overview of what will occur during the group sessions, the importance of maintaining confidentiality, the importance of regular attendance, and expectations regarding homework. Clients are given an opportunity to ask questions and to have their concerns addressed. Next, an exposure hierarchy is generated using items previously endorsed on the Y-BOCS, as well as any feared objects or situations mentioned by the client during the appointment.

Session 1: Presenting the Treatment Rationale

This session has several purposes. First, it is an opportunity to introduce group members and therapists to one another. In addition, ground rules for the group are reviewed to remind participants of some of the issues raised during the pretreatment meeting. Clients are provided with a model

of OCD and an overview of the treatment strategies. Possible obstacles to improvement, and ways of overcoming these obstacles, are discussed. Homework for the first session typically involves reading introductory chapters from an ERP-based self-help book (e.g., Abramowitz, 2018; Yadin, Foa, & Lincher, 2012b). Components of the first session are as follows:

1. Introduction of group members and therapists.
2. Group rules and overview: confidentiality, group structure, importance of regular attendance, expectations regarding homework (60–90 minutes per day), importance of being honest about symptoms and completed homework, reminder to have realistic expectations, reminder to expect treatment initially to cause increased discomfort.
3. Definitions of key terms: "obsessions," "compulsions," "OCD," "cognitive rituals," "cues," "triggers," "avoidance," and "neutralization."
4. Presentation of the cognitive-behavioral model of OCD, including the effects of compulsions and neutralizing on maintaining obsessions over time.
5. Having each client review their key obsessions and compulsions, followed by discussion to ensure that all group members understand how their symptoms fit into an OCD profile, which of their symptoms are obsessions, and which are compulsions (including mental rituals).
6. Discussion of treatment procedures, including cognitive strategies, exposure, and ritual prevention.
7. Discussion about the role of the family, including ways in which family members may be able to help (stopping accommodation, being supportive, being present during homework practices, etc.).
8. Discussion about the costs and benefits of overcoming the problem, as well as obstacles that clients expect to encounter over the course of treatment.
9. Homework: introductory readings on the CBT model and on an overview of treatment strategies.

Sessions 2 and 3: Cognitive Strategies

Session 2 begins with a discussion of the readings from the previous week. Next, the cognitive model for OCD is reviewed. During Sessions 2 and 3, participants are taught to identify examples of anxious thinking (e.g., TAF), and strategies for combating cognitive distortions are presented. Clients are instructed in how to complete cognitive monitoring forms. Homework includes challenging intrusive thoughts (e.g., examining the evidence, conducting behavioral experiments) over the next week rather than neutralizing or suppressing unwanted thoughts. In addition,

participants are encouraged to complete self-help readings related to the cognitive strategies.

Session 4: Introducing ERP

The first 45 minutes of this session are spent reviewing cognitive monitoring forms from the previous week. The rationale for ERP is then presented and guidelines for exposure are reviewed (e.g., the need for exposure practices to be predictable, prolonged, and frequent). Clients are instructed in how to use exposure monitoring forms. They are also encouraged to stop their rituals immediately. Strategies for dealing with intense urges to engage in compulsions are discussed. In addition to continuing to complete cognitive monitoring records, clients are encouraged to engage in at least 1 hour of exposure per day over the coming week, starting with an item from the bottom half of their hierarchy. They are also encouraged to complete self-help readings on ERP.

Sessions 5–13: In-Session Exposures

Each session begins with a review of homework, lasting about 45 minutes. During the homework review, the therapists take advantage of any opportunities to challenge anxious appraisals that arise. The next hour is spent on in-session exposures, individually tailored to the clients in the group. The final 15 minutes are spent assigning homework for the next week, including exposure to feared situations, objects, and images; prevention of rituals; and cognitive restructuring. Throughout treatment, clients should be vigilant for any new rituals that emerge, as well as any new avoidance behaviors.

Session 14: Termination and Relapse Prevention

After a review of the homework, issues related to relapse and recurrence are discussed. Participants are reminded that the severity of OCD normally fluctuates over time. They are encouraged to tolerate periods of increased severity, without falling back into old habits of avoidance and rituals. Instead, they should engage in occasional exposures to help maintain their gains. Being vigilant for possible triggers of recurrence, including increased life stress, helps to alert clients to the possibility of symptoms worsening, so they can be better prepared.

Posttreatment Evaluation

Clients are invited to complete a posttreatment evaluation. At this stage, the main outcome measures are repeated. Clients who require additional treatment may be offered a series of individual sessions, pharmacotherapy,

family sessions, self-help interventions, support groups, or other interventions, depending on their needs and preferences. In addition, we offer all clients the opportunity to participate in a monthly booster group designed to help previously treated clients at our clinic maintain their improvements.

Variations on the Protocol

There are a number of ways in which this protocol can be modified. First, there are data supporting group treatments of longer (e.g., 25 sessions) and shorter (e.g., seven sessions) durations. The length of each session can also be extended (e.g., some clinics have group sessions lasting 2.5 hours). Session frequency can be altered as well. Although we recommend against meeting less often than once per week, there may be benefits of increasing the frequency of meetings to more than once per week. If possible, including family members (e.g., a spouse or parent) in one or more sessions may be useful, particularly for clients who report that their family members "don't understand," or in cases where family members engage in counterproductive behaviors, such as accommodation. Finally, if practical, there may be cases in which group and individual treatments can be combined. For example, it is possible to deliver the early sessions (e.g., psychoeducation, CT) in a group format, and the later sessions (e.g., exposure) in an individual format.

Advantages of Treating OCD in Groups

Group treatments are often more cost-effective than individual treatments. They take up less therapist time (on a per-client basis), and the reduced cost per session is often passed on to the client. Group treatment is particularly useful in settings where the number of client referrals is simply too large to manage on an individual basis. However, the benefits of group treatment are not simply financial. There are many other benefits to clients, some of which are difficult to measure objectively.

Clients often describe a sense of relief when they discover that they are not alone. They often say that it is very comforting to meet others with OCD and to discover that they seem so "normal." This helps clients realize that to the average person, an individual with OCD would probably not stand out as being unusual in any way. It also helps them to be less embarrassed and secretive with respect to their own symptoms.

In most cases, clients tend to be very supportive of one another during the course of group treatment. For example, they are empathic when a client is discussing painful symptoms, and they may express worry about a client who does not show up for a given treatment session. When group

cohesion is strong, clients may exchange phone numbers and develop lasting friendships with other group members. It is not unusual for some clients to get together between treatment sessions and to do their homework together. Group members often value suggestions and feedback received from other group members, whose personal experience with OCD gives them a special ability to empathize with clients' symptoms.

Overall, group members should be encouraged to participate in group discussions and to share their experiences. In addition, it is often useful for participants to take a more active role in one another's treatment, as they become more familiar with the strategies. For example, group members can help with the process of cognitive restructuring and may suggest to one another exposure practices that might be completed for homework.

Group Process Factors in CBT for OCD

Heterogeneity in Group Membership

OCD is a heterogeneous condition, and clients often present with very different symptom profiles. For example, an individual who is fearful of contamination may seem to have little in common with an individual who is constantly thinking about stabbing family members. Heterogeneity among group members can lead to a number of different problems. First, clients who feel different from other group members or whose symptoms are more "socially unacceptable" may be reluctant to discuss their symptoms in front of the group. In fact, they may refuse group treatment completely. This is particularly a problem for individuals who have aggressive, religious, or sexual obsessions. Therefore, it is useful to have more than one person in each group with these kinds of thoughts. Second, clients sometimes trivialize the concerns of others. For example, a client might say, "I wish my fear was just of making mistakes at work. I could live with that! My fear of killing my children is much more of a problem." Finally, some clients may not be understanding or supportive toward the other group members. They may give others strange looks or make insensitive comments.

To deal with these issues, it is important early in treatment to educate the group about the various ways in which OCD symptoms are expressed. Right from the start, therapists should emphasize the commonalities across OCD presentations, particularly with respect to the cognitive and behavioral influences. Clients should also be reminded that the distress and impairment associated with OCD can be severe, regardless of the specific symptom profile, and that it is important for group members to be supportive.

A final issue to keep in mind is that because clients tend to have different symptom profiles, parts of the group necessarily have an individualized focus. For example, during exposure practices, clients may end up working on their own.

Symptom "Contagion" among Group Members

Clients who receive group treatment for OCD are often concerned about "catching" OCD symptoms from other group members. In reality, this is something that we have never actually seen occur. What may happen, however, is a tendency for some clients to reinforce avoidance behaviors in others. For example, some clients may suggest ways in which others can neutralize their obsessions (e.g., suggesting a new cleaning product to an individual with contamination concerns). People may also share information that strengthens one another's beliefs about the feared situations (e.g., sharing a story about a friend of a cousin who became ill by forgetting to wash her hands after handling raw chicken). However, after participants have become more familiar with the treatment rationale, they learn to stop encouraging one another's avoidance. With corrective feedback, this issue can usually be dealt with early in treatment.

Other Disadvantages of Group Treatment

A number of other problems may arise during the course of group treatment. First, clients who are progressing more slowly than others may become discouraged and drop out of treatment prematurely. Also, a group format minimizes the amount of individualized attention that each client receives. As a result, some participants end up having to listen to discussions that are not relevant to their own situations. Others may not receive as much individual attention as they need. In these cases, having the client attend a few individual sessions, in addition to the group, may be useful, if it is practical and the individual can afford it.

Other Special Considerations in Treating OCD

Although the focus of this chapter is on group treatment, there are a number of obstacles and special considerations that often arise while treating OCD either in groups or individually. Although these obstacles are not unique to group treatment, they often arise when providing treatment in groups, so they are discussed briefly in this section.

Breadth of Symptoms

Data from our clinic (Antony, Downie, et al., 1998) suggest that most people with OCD experience obsessions and compulsions of more than one type (washing, checking, repeating, etc.). A challenge that often confronts therapists is how to decide which symptoms to focus on first. Generally, this decision should be made after considering which symptoms cause the most distress and impairment, and which symptoms the client is interested in working on first. In selecting symptoms to work on, it is useful to consider

obsessions (i.e., intrusive thoughts), compulsions (including overt behaviors and mental compulsions), and avoidance behaviors. It is often not practical to have the client work on all symptoms at the same time. Rather, selecting those problems that are most important to overcome first may be a more useful approach.

Symptom Shift

In addition to having a wide range of symptom types at any given time, some clients with OCD report having symptoms that shift from one type to another over time. In some cases, symptoms may change over the course of months or years. However, in other cases, shifts may occur on a daily or weekly basis. For example, an individual may report being concerned about contamination one week, and then return the next week and explain that the exposure homework assigned was not relevant because contamination concerns were no longer an issue. Instead, during the previous week, the obsessions might have shifted to a focus on appliances being left on, for example. In such cases, the symptoms may seem like a moving target, and it may be difficult to find appropriate strategies to deal with them. For clients whose symptoms shift over time, it is especially important for them to understand the general principles of treatment and how they apply to a wide range of symptoms. In addition, clients may have to adapt planned homework practices to deal with new symptoms as they emerge.

Noncompliance with Exposure Homework

Antony and Swinson (2000) reviewed the following possible reasons why clients may not complete their exposure homework assignments: (1) not understanding the assignment, (2) not understanding the relevance of the assignment to their goals, (3) homework assignments that are too difficult, (4) other demands on clients' time (e.g., young children to take care of, busy work schedule), and (5) the therapist not checking on homework at the start of each session. To improve compliance, it is important to identify the factors that interfere with completion of homework for each client in the group for whom noncompliance is an issue.

Depending on the reason for noncompliance, some strategies for improving compliance include (1) making sure that the homework is explained in detail and that the instructions are written down by the client; (2) ensuring that homework practices are relevant to the individual's goals; (3) simplifying the homework task; (4) encouraging the client to try something easier, if a particular task is too frightening; (5) arranging for telephone contact or additional individual sessions between group meetings; (6) identifying family factors that may be contributing to noncompliance, or factors that may improve compliance (e.g., including family members in the practice); (7) trying the homework practice in the session

before assigning it for homework; (8) encouraging the client to schedule the practice in their calendar, so it is not forgotten; and (9) suggesting that the client find ways to manage other demands, in order to make time for the homework (e.g., taking a day off of work to engage in a prolonged exposure (PE) practice, or hiring a babysitter, so the children do not disrupt the homework session).

Transfer of Responsibility

Occasionally, clients will transfer responsibility to the therapist, which can undermine the effects of exposure. In these cases, it is important to transfer responsibility back to the client. Consider the following dialogue as an example of how this can be accomplished:

> Client: The thought of making mistakes at work over the coming week doesn't bother me. Because you asked me to do it for homework, you will be responsible if anything happens.
>
> Therapist: Because it is so frightening for you to feel responsible for the possibility of doing harm to someone else, it is important that you take responsibility for what happens during your exposure practices. Although I was the one to recommend this practice, ultimately you need to take responsibility for deciding whether to follow my recommendation.
>
> Client: Even so, I don't feel responsible, because you made the suggestion. Because we spoke about doing this, I feel like you will be responsible if something happens, so it doesn't really scare me.
>
> Therapist: In that case, perhaps we should try things differently this week. I would like you to come up with your own homework practice, but not tell me what it is until next week, after you have done it.
>
> Client: Now, that's something that I'm pretty sure will make me anxious. I don't want to do it, but it sounds like it may be helpful.

Issues Surrounding Religion

The literature has generally demonstrated that although religious individuals with OCD may experience more religious obsessions than nonreligious individuals with OCD, religion is not a risk factor for OCD more broadly (Siev, Huppert, & Zuckerman, 2017). However, more recent research has demonstrated that a religious crisis (defined as feeling disconnected from God or one's religious community) is associated with OCD-related beliefs, such as TAF and scrupulosity (a pathological fear of God and sin; Henderson et al., 2020). Interestingly, *spirituality,* which is not necessarily tied to religious observation or practice, is negatively associated with OCD

symptom severity in clinical samples and may buffer against risk factors for OCD (Henderson et al., 2020).

Overall, working with scrupulosity may require adaptations to the delivery of CBT (see Siev et al., 2017). One issue that sometimes arises when treating clients with OCD whose obsessions are primarily of a religious nature is trying to distinguish between religious beliefs that are simply part of the person's religion and those that are best conceptualized as part of the OCD. For example, clients with religious obsessions are usually uncomfortable with the suggestion that they expose themselves to frightening thoughts of a religious nature (e.g., "I am Satan"), but it may be difficult for them to know whether it is their OCD that makes them uncomfortable or their religious convictions. In such cases, it may be useful for clients to consult with family members or their religious leader to see which of their intrusive thoughts and compulsive behaviors are excessive in the context of their religion. Getting "permission" to participate in the treatment assignments can also be helpful in some cases. For example, obtaining reassurance from a minister, priest, rabbi, or other leader that it is okay to complete exposure practices can help a client to move forward with the treatment.

Effects of Functional Impairment

OCD is associated with impairment in a wide range of functional domains, including relationships, work, and quality of life (see Huppert, Simpson, Nissenson, Liebowitz, & Foa, 2009). For most clients, overcoming OCD leads to improvement in functioning across the board. However, for others, functional impairment may need to be targeted as a separate issue. For example, a client who has had OCD for many years, and who has therefore never worked or been in a long-term relationship, may feel overwhelmed as their OCD improves and these other issues move to the forefront. In these cases, it is important to work with clients on overcoming some of the obstacles to improving their quality of life (e.g., obtaining relevant job skills, expanding social networks). Group therapy for OCD may not be the best place to deal with these issues, if they are relevant to only one or two clients in the group. If that is the case, it may be more appropriate to provide some individual sessions to address these broader concerns.

Family Issues

Often family members do things that make it easier for the client to engage in rituals or to avoid feared situations. Such behaviors are often referred to as "accommodation," and they may help to maintain an individual's OCD symptoms over the long term. In a study by Albert and colleagues (2009), family members of individuals with OCD reported a wide range of accommodation behaviors, including participating in rituals, providing

reassurance, and helping the client to avoid feared situations (occurring on a daily basis in 47, 35, and 43% of family members, respectively).

It is often useful to include family members of clients with OCD in the treatment. This can be accomplished in a number of ways. For example, family members of clients can be invited to attend one or more sessions (either with the entire group, or for individual meetings including just the therapist, the client, and one or more family members). Alternatively, if family sessions are not feasible, clients should be encouraged to share treatment guidelines with their families and to have their families complete relevant self-help readings on OCD. Clients will likely do better in treatment if their family members have a good understanding of the nature and treatment of OCD, are provided with instructions not to reinforce OCD behaviors, and are given skills for interacting with the client around issues concerning the OCD (see Turner, Krebs, & Destro, 2017, for a review of family issues in the treatment of OCD).

Conclusions

OCD is a heterogeneous condition associated with a wide range of cognitive and behavioral features. Extensive research supports pharmacological interventions, as well as CBT-based treatments. From a psychological perspective, OCD is believed to stem from a tendency to misinterpret situations, objects, and one's intrusive thoughts as dangerous. CBT aims to shift anxious thinking through a number of behavioral and cognitive means. Although OCD is usually treated individually, several studies have shown that group treatment can be effective for this problem. Treating OCD in groups is associated with unique challenges, but it also has a number of advantages over individual treatment. This chapter provided an overview of strategies for treating OCD in a group format.

CHAPTER 8

Trauma- and Stressor-Related Disorders

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Posttraumatic stress disorder (PTSD) is unique among psychiatric conditions in that its etiology is tied directly to a specific event or set of events. PTSD may occur after an individual is exposed to an extreme traumatic stressor (e.g., life-threatening situation, physical or sexual violence). While lifetime exposure to traumatic events is high in the general population (80–90%), the estimated lifetime prevalence of PTSD is comparatively low (8–9%) in North America (Kilpatrick et al., 2013). Although PTSD develops in a minority of individuals exposed to a traumatic event, many individuals experience symptoms in the immediate aftermath of a trauma. This discrepancy has been partially accounted for by cognitive and behavioral responses to trauma (Friedman, Keane, & Resick, 2014), which is elaborated on later in this chapter. PTSD consists of a constellation of symptoms, including reexperiencing symptoms, avoidance, and changes in mood and cognition, as well as changes in emotional arousal and reactivity (American Psychiatric Association, 2022; Yehuda et al., 2015). Additionally, an estimated 15–30% of individuals with PTSD meet criteria for a dissociative subtype of this disorder, characterized by symptoms of depersonalization (feeling as though you are separate from or outside of your mind or body) and derealization (feeling as though things going on around you are strange or unfamiliar; Hansen, Ross, & Armour, 2017).

PTSD can occur at any age throughout the lifespan following the experience of a traumatic event. However, the presentation of PTSD symptoms

may vary depending on the age of the individual. For example, among children, reexperiencing symptoms may manifest as a reenactment of the event in play (Terr et al., 1999). PTSD can develop in the acute aftermath of the traumatic event or may be delayed in its expression (with symptom onset occurring more than 6 months after the traumatic event). Although PTSD can occur after the onset of any trauma involving death, serious injury, or sexual or physical violence (or threat of these events occurring), there is a well-established dose–response relationship whereby the severity of trauma exposure is associated with the onset of PTSD. For example, 45.9% of rape survivors go on to develop PTSD, whereas 8.8% of motor vehicle accident survivors develop PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Female gender is associated with an increased risk of developing PTSD (Brewin, Andrews, & Valentine, 2000). However, this relationship is likely moderated by factors such as greater risk of exposure to interpersonal violence or sexual assault among females in civilian samples. PTSD is associated with significant functional impairment, including impaired workplace performance (Kessler, 2000), high use of medical care services (Greenberg et al., 1999), reduced psychosocial functioning, and reduced physical and mental health-related quality of life (Olatunji, Cisler, & Tolin, 2007). Finally, PTSD is highly comorbid with other anxiety disorders, substance use disorders (SUDs), and depression (Kessler et al., 1995), as well as BPD (Scheiderer, Wood, & Trull, 2015).

Cognitive and Behavioral Features of PTSD

Cognitive Features

Cognitive-behavioral models of PTSD aim to identify factors that differentiate individuals who experience trauma and do not develop PTSD from those who experience trauma and go on to develop PTSD. Cognitive features are posited to play a role in the development of PTSD, such that PTSD develops and is maintained as a result of appraisals of the traumatic event(s), leading to prolonged and intense emotional responses. Such appraisals include beliefs about the role of the self and others in the traumatic event and generalized beliefs about the self, others, and the world that develop or are reinforced as a result of the traumatic event.

Self-Blame

Cognitive theories of PTSD posit that traumatic events lead to disruptions in previously held belief systems or schemas. Two belief systems that have been associated with self-blame cognitions are (1) beliefs about the self as being either competent or incompetent prior to the traumatic event; and (2) beliefs about the world and others, such as the "just-world belief" that

good things happen to good people, and bad things happen to bad people (Foa, Steketee, & Rothbaum, 1989; Resick & Schnicke, 1992). Foa et al. suggest that individuals with PTSD may associate their behaviors or actions during the trauma with the belief that they were incompetent or at fault for the event, or their behaviors or actions during the trauma may confirm preexisting beliefs that they are incompetent and therefore at fault for the traumatic event. According to Resick and Schnicke, individuals with PTSD may attempt to assimilate their traumatic experience into preexisting belief systems, or may overaccommodate old belief systems by "throwing them away" and adopting new beliefs that incorporate the traumatic event. With respect to self-blame cognitions, an individual may attempt to assimilate the traumatic event into their previously held positive beliefs about the world (e.g., the just-world belief) by assuming that they must have done something bad, or be a bad or incompetent person for the trauma to have occurred. Self-blame cognitions have been found to predict chronicity, severity, and functional impairment in PTSD (Dunmore, Clark, & Ehlers, 2001; Meiser-Stedman, Dalgleish, Glucksman, Yule, & Smith, 2009).

Beliefs about Self, Others, and the World

Ehlers and Clark's (2000) cognitive theory of PTSD posits that appraisals related to impending threat are central to the development of PTSD, whereby appraisals of external threat (e.g., viewing the world as very dangerous) or internal threat (e.g., viewing oneself as incapable of protecting oneself) maintain a state of persistent perceived imminent threat. Similar distorted cognitions have been found among individuals with PTSD for themes related to safety, trust, power, control, esteem, and intimacy (McCann & Pearlman, 1990).

Behavioral Features

Avoidance

Avoidance behaviors have been consistently associated with the onset and maintenance of PTSD following trauma exposure and are posited to do so via prevention of new or corrective learning that may challenge cognitive assumptions about themes such as safety or trust (Foa & Kozak, 1986; Resick & Schnicke, 1992). Avoidance behavior among individuals with PTSD can take the form of avoidance of both internal (e.g., memories, thoughts, or feelings) and external (e.g., people, places, or situations) reminders of the traumatic event, both of which have been associated with greater PTSD symptom severity (Gutner, Rizvi, Monson, & Resick, 2006; Pineles et al., 2011). Avoidance behaviors in PTSD can present in multiple forms, from overt avoidance of places, situations, or people associated with or reminiscent of the trauma, to covert avoidance, such as thought

suppression, mental undoing, or using substances or behaviors (e.g., sex, impulsive spending) to suppress unwanted memories, thoughts, or emotions.

Cognitive-Behavioral Approaches to Understanding PTSD

Several cognitive-behavioral approaches to understanding PTSD have been proposed, each focusing on components that differentiate those who experience trauma and go on to develop PTSD and those who experience trauma and do not develop PTSD (Ehlers & Clark, 2000; Foa et al., 1989; Keane, Zimering, & Caddell, 1985; McCann & Pearlman, 1990).

Emotional Processing Theory

Foa and Kozak's (1986) emotional processing of fear model was applied to the study of PTSD in 1989 by Foa and colleagues. Foa et al.'s conceptualization of PTSD was among the first cognitive-behavioral models proposed to understand this disorder that extended beyond traditional conditioning theories to account for additional symptoms of PTSD. Conditioning theories, such as Mowrer's (1960) two-factor learning theory, were applied to explain the key symptoms of PTSD, whereby fear and avoidance develop and are maintained through classical and instrumental conditioning processes. For example, among combat veterans, it was proposed that exposure to an unconditioned stimulus (e.g., combat) is paired with previously neutral stimuli that become conditioned stimuli (e.g., sounds or odors present during the event), thus later eliciting fear in the absence of the unconditioned stimulus. According to conditioning theory, the aversive nature of the trauma memories and exposure to trauma cues in the environment lead to avoidance as a coping behavior. Further, reductions in anxiety resulting from avoidance reinforce beliefs that memories or trauma-related stimuli are not safe and prevent sufficient habituation and fear reduction from occurring (Keane et al., 1985). Foa et al. suggested that conditioning theories were limited in that they did not account for the high degree of generalization of fear exhibited among individuals with PTSD and proposed that emotional processing theory could account for these limitations.

Emotional processing theory posits that fear is represented as a network in memory that includes three elements: (1) information about the feared stimulus situation; (2) information about verbal, physiological, and behavioral responses to the situation (response elements); and (3) interpretive information about the meaning of the stimulus and response elements of the network (Foa et al., 1989). These elements are paired together at the time of the traumatic event and activation of any one element can activate any of the other elements in the structure. The traumatic event may violate

previously held stimulus–response relationships (e.g., stimuli and responses that previously signaled safety are now associated with danger; Foa et al., 1989). Foa, Hembree, and Rothbaum (2007) describe the emotion structure underlying PTSD as being characterized by a variety of stimulus–response representations that are erroneously associated with themes of danger and self-incompetence (e.g., inability to protect oneself). Natural recovery versus the development of PTSD is accounted for by explaining that high levels of PTSD symptoms are common following a traumatic event, but decrease over time through repeated activation of the memory structure leading to the correction of erroneous associations (e.g., not all men are dangerous). PTSD develops when there is a failure to process the traumatic memory through activation of the memory structure due to avoidance coping (Foa & Cahill, 2001).

Cognitive Theory

Ehlers and Clark (2000) propose a cognitive theory of PTSD, integrating Beck's cognitive theory (Beck et al., 1979) and emotional processing theory, whereby PTSD results from erroneous threat-related appraisals. In this model, although the traumatic event occurred in the past, a continued sense of threat results from the individual's appraisal of the traumatic event and its consequences in combination with the fragmentary nature of traumatic memory, leading to the perception that the trauma is occurring in the present (Ehlers & Clark, 2000). Individuals with PTSD develop negative appraisals of the traumatic event and its consequences, such as overgeneralization of the event (leading to the appraisal of normal activities as dangerous), exaggerated probability of future catastrophic events, or negative appraisals of the role of the self in the event. They also emphasize appraisals of the individual's behavior during the event as contributing to PTSD (e.g., "I was not able to identify the threat, therefore I cannot protect myself"). Ehlers and Clark account for different emotional responses associated with PTSD as being elicited by different appraisals (e.g., threat-related appraisals lead to fear, appraisals about one's role in the event leads to guilt). Trauma memory is also thought of as being associated with unwanted recollections, such that trauma memories are poorly elaborated and incorporated into autobiographical memory, leading to a "here-and-now" quality of reexperiencing symptoms and easy triggering of trauma memories. Finally, this model accounts for the development of PTSD by discussing maladaptive behavioral strategies and cognitive processing styles where individuals with PTSD attempt to control threat and their experience of PTSD symptoms by engaging in strategies such as thought suppression, safety behaviors to reduce anticipated future threat, and avoidance of trauma reminders. These strategies lead to an increase in PTSD symptoms and prevention of opportunities to change negative appraisals or to integrate the trauma into autobiographical memory (Ehlers & Clark, 2000).

Evidence-Based Treatments for PTSD

Pharmacotherapy

There is some evidence for the use of some pharmacotherapies in the treatment of PTSD. The American Psychological Association (2017) clinical practice guidelines suggest the use of three SSRIs—fluoxetine, paroxetine, or sertraline—and one serotonin–norepinephrine reuptake inhibitor (SNRI)—venlafaxine—with moderate strength of evidence and small magnitude of benefit. However, the World Health Organization (2013) suggests that these medications be utilized only when recommended psychotherapies for PTSD have failed or when clients experience comorbid depression of moderate or greater severity. Hoskins et al. (2015) conducted a systematic review and meta-analysis of pharmacotherapy for PTSD and concluded that while there were small, significant effects for fluoxetine, paroxetine, and venlafaxine, these were lower than those reported for psychological treatments with a trauma focus when compared with wait-list or treatment as usual.

Cognitive-Behavioral Therapy

There is a strong evidence base for several cognitive-behavioral treatments for PTSD, including trauma-focused CBT for PTSD, cognitive processing therapy (CPT; Resick et al., 2017), and prolonged exposure (PE) (Foa et al., 2007), all of which are given strong recommendations by the American Psychological Association (2017) and the International Society for Traumatic Stress Studies (2018).

Trauma-focused CBT focuses on challenging maladaptive beliefs or the meaning made of the trauma and resultant changes in behavior, and includes various cognitive and/or behavioral techniques (Ehlers, 2013). Cognitive techniques aim to modify maladaptive appraisals about traumatic experience(s) and include strategies such as Socratic questioning by the therapist to the client, including clarifying questions about the trauma and the context in which it occurred, challenging assumptions and beliefs the client may hold. Cognitive worksheets are used to assist the client in challenging their own assumptions and beliefs. Behavioral techniques aim to adjust the relationships between trauma-related internal and external cues and behavioral and emotional responses. Techniques include imaginal exposure to trauma memories and *in vivo* exposure to trauma-related cues in the environment. Manualized approaches include PE and CPT.

Prolonged Exposure

PE, based on Foa and Kozak's (1986) emotional processing theory, is a manualized individual CBT treatment protocol with an emphasis on behavioral interventions (Foa et al., 2007). PE contains four treatment

components: (1) psychoeducation about common reactions to trauma, with an emphasis on the impact of avoidance in maintaining PTSD symptoms; (2) breathing retraining to reduce general tension; (3) repeated *in vivo* exposure to situations or objects in the environment that the client is avoiding; and (4) repeated prolonged imaginal exposure to the trauma memory utilizing imagery. Clients are provided with the rationale that *in vivo* and imaginal exposures will allow them to process the traumatic events by facing the trauma memories and situations associated with trauma memories and allowing them to learn that the memories and situations are distinct from the trauma itself and they are no longer dangerous (Foa et al., 2007). PE consists of eight to 16 individual sessions. A large body of empirical research has supported the use of PE for PTSD, with meta-analytic findings reporting large effect size improvements in PTSD and related symptoms at posttreatment and follow-up (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010).

Cognitive Processing Therapy

CPT utilizes cognitive strategies to assist clients in identifying and challenging maladaptive beliefs, referred to as "stuck points." Stuck points are identified in collaboration with the client and are conceptualized as beliefs that are keeping the individual "stuck," or inhibiting their recovery from PTSD (Resick et al., 2017). The elements of CPT are described in further detail below. CPT may include a written trauma account, whereby clients write and read a narrative of the most distressing traumatic event—however, research has demonstrated that CPT excluding the trauma narrative was associated with equal efficacy and symptom reduction when compared with CPT with written accounts (Resick et al., 2008). A large body of empirical research has supported CPT for PTSD, with meta-analytic findings reporting large effect size improvements in PTSD and related symptoms at posttreatment and follow-up (Asmundson et al., 2019).

Group Treatments for PTSD

Historically, trauma-focused group interventions for PTSD were thought to be contraindicated due to the sensitive nature of traumatic events and the possibility of increasing symptoms or triggering symptoms in other group members. However, group psychotherapy for PTSD offers a number of potential benefits over individual therapy, including reducing social isolation, providing the opportunity to develop trusting relationships, improving interpersonal skills, validation of traumatic experiences, and normalization of trauma responses through exposure to others who have experienced similar events (Schwartze, Barkowski, Strauss, Knaevelsrud, & Rosendahl, 2019; Sloan, Bovin, & Schnurr, 2012).

Sloan et al. (2012) categorized group psychotherapies for PTSD into three broad categories: psychodynamic and interpersonal groups, supportive groups, and CBT groups. Psychodynamic groups focus on increasing insight about psychodynamic processes, such as internal conflict and defense mechanisms, as well as insight about how the trauma has influenced the individual's sense of self and affective and interpersonal functioning. Interpersonal groups incorporate psychodynamic principles and focus on identifying patterns of relationship difficulties associated with traumatic experiences. Supportive groups focus on the discussion of ongoing stressors emphasizing common experiences within the group, with group members providing feedback, problem solving, and emotional support. Although there is some limited evidence for psychodynamic, interpersonal, and supportive group therapies, they are not currently recommended by clinical practice guidelines for the treatment of PTSD, whereas CBT groups are (American Psychological Association, 2017; International Society for Traumatic Stress Studies, 2018). CBT groups are more structured and may include components such as skills training, exposure practice, and cognitive restructuring (Beck, Coffey, Foy, Keane, & Blanchard, 2009; Ready et al., 2008). For example, Beck and colleagues (2009) adapted individual trauma-focused CBT to a group format incorporating psychoeducation, written exposure and imaginal exposure, mindfulness meditation training, progressive muscle relaxation, cognitive interventions, and behavioral activation to address depression and social isolation. Ready et al. piloted a trial of group-based exposure therapy among combat veterans that incorporated stress management skills, psychoeducation, breathing retraining, grounding, individual presentations about traumatic war-related experiences that continue to "haunt" participants, and exposure to recordings of their trauma presentations between group sessions. Group CPT has emerged as a well-supported treatment approach for individuals with PTSD, retaining the core components of individual CPT (Resick et al., 2015, 2017; Walter, Dickstein, Barnes, & Chard, 2014).

With respect to the effectiveness of group psychotherapies for PTSD, regardless of the type of group therapy (including CBT- and non-CBT-based therapies, such as psychodynamic or interpersonal therapy), these treatments have been found to be more effective in reducing PTSD symptoms in comparison to wait-list or no-treatment control groups (Schwartze et al., 2019; Sloan, Feinstein, Gallagher, Beck, & Keane, 2013). However, comparison of trauma-focused group therapies with supportive or present-centered group therapies has not found an advantage of trauma-focused group therapy (Schwartze et al., 2019). Although group CPT has been found to be somewhat less effective when compared with individual CPT (e.g., large effect sizes for individual CPT as compared to medium effect sizes for group CPT), it represents an efficacious and cost-effective method of treatment delivery (Resick et al., 2015, 2017). Notably, a combination

of group and individual CPT is associated with greater reduction in PTSD symptoms when compared to group alone (Walter et al., 2014).

Assessment and Eligibility for Group CBT for PTSD

Accurate diagnosis of PTSD is essential prior to initiating group CBT for PTSD. Comprehensive assessment should be used to establish a diagnosis and determine eligibility for group CBT. A diagnosis of PTSD should be established by first assessing for the presence of a traumatic event, including exposure to death, serious injury, or sexual or physical violence or significant threat of these events occurring. Posttraumatic stress symptoms should also be differentiated from normal posttrauma symptoms that may resolve through natural recovery within 4–12 weeks following the event (Yehuda, McFarlane, & Shalev, 1998). PTSD should also be differentiated from acute stress disorder, which can be diagnosed within the first month following a traumatic event. Notably, acute stress disorder is predictive of the subsequent development of PTSD (Cahill & Pontoski, 2005) and treatment of acute stress disorder with brief trauma-focused CBT has been shown to significantly reduce symptoms of acute stress disorder, as well as the likelihood of developing chronic PTSD (Bryant, 2016).

Comprehensive clinical interviews, such as the Structured Clinical Interview for DSM-5 (SCID-5; First, Williams, Karg, et al., 2015) and the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers, Blake, et al., 2013), provide a structured format to obtain the information required to establish a diagnosis of PTSD and comorbid conditions. Given the prevalence of comorbid BPD it may also be prudent to assess for its presence using an assessment such as the SCID-5 Personality Disorders (SCID-5-PD; First, Williams, Benjamin, & Spitzer, 2015).

Given the challenging nature of trauma-focused CBT, clinicians should establish that PTSD is the primary concern that the client is seeking treatment for and that they feel ready to address these symptoms. We recommend having a discussion with potential group members about their readiness to reduce avoidance, talk about the traumatic event, and allow themselves to feel their emotions about the traumatic event.

Trauma Type

Trauma-focused CBTs have been found to be efficacious for individuals suffering from PTSD as a result of a broad range of traumatic experiences, including childhood sexual or physical abuse, rape, interpersonal violence, combat or war-related trauma, and motor vehicle accidents (Chard, 2005; Foa et al., 2005; Powers et al., 2010; Rauch et al., 2009; Resick et al., 2008;

Resick & Schnicke, 1992). However, some have suggested that individuals presenting with exposure to prolonged and repeated childhood abuse, and presenting with symptoms consistent with complex PTSD (a diagnosis in the International Classification of Diseases for Mortality and Morbidity Statistics [ICD-11]; World Health Organization, 2018), may require preparatory treatment to increase emotion regulation skills and interpersonal functioning prior to engagement in trauma-focused CBT (e.g., Cloitre et al., 2012). These assertions have been met with significant debate in the literature (e,g., De Jongh et al., 2016). Further, recent work from our group and others has indicated that emotion regulation difficulties can improve with trauma-focused CBT and are not associated with worse treatment outcomes or attrition (Jerud, Pruitt, Zoellner, & Feeny, 2016; Wallach, 2015), including in group settings (Shnaider, Boyd, Cameron, & McCabe, 2021). Thus, it has been our practice not to exclude individuals from participating in trauma-focused group CBT based on trauma type alone. Rather, we assess for markers of more extreme dysregulation that may need to be addressed prior to participating in group-based trauma-focused CBT (see the following sections for examples).

Suicidal Ideation, Suicide Attempts, and Self-Harm

Suicidal ideation and suicide attempts are prevalent among individuals with PTSD (LeBouthillier, McMillan, Thibodeau, & Asmundson, 2015), as is self-harm (i.e., nonsuicidal self-injury; Forbes et al., 2019). Life-threatening behaviors should be addressed prior to engagement in trauma-focused psychotherapy. We recommend that clients not begin trauma-focused CBT until they have not had any suicide attempts or self-harm for a period of at least 2 months. Passive suicidal ideation should be differentiated from active suicidal ideation (e.g., when an individual has a plan and intent to act on a plan). Resick et al. (2017) suggest that passive suicidal ideation can be conceptualized as passive avoidance (e.g., a desire to escape distress) and can be addressed via trauma-focused CBT, such as CPT.

Dissociation

As mentioned above, 15–30% of individuals with PTSD meet criteria for a dissociative subtype (PTSD+DS). Some have reported that dissociative symptoms are associated with reduced treatment response to trauma-focused CBT (Bae, Kim, & Park, 2015), whereas others have not found support for this relationship (Wolf, Lunney, & Schnurr, 2016), have questioned whether any reductions in treatment effectiveness are clinically meaningful (Resick, Suvak, Johnides, Mitchell, & Iverson, 2012), or have found that dissociative symptoms may improve with trauma-focused CBT

(Chard, 2005). Generally, in our practice, we would not exclude individuals from participating in group trauma-focused CBT on the basis of their experience of dissociative symptoms unless these symptoms were so severe that they would interfere in the individual's ability to be present during treatment sessions or when completing homework assignments. Resick et al. (2017) suggest that individuals with high levels of dissociation may benefit from writing a full trauma account prior to engaging in CPT in order to organize a coherent narrative of their traumatic experiences.

Depression

Depressive disorders and PTSD are highly comorbid (Kessler et al., 1995). Depression has been found to improve over the course of participation in trauma-focused CBT, including PE (Aderka, Foa, Applebaum, Shafran, & Gilboa-Schechtman, 2011) and CPT (Liverant, Suvak, Pineles, & Resick, 2012). However, if a client experiences levels of depressive symptomatology that result in difficulty maintaining self-care or engaging in basic daily activities, it may be necessary to address these symptoms prior to beginning group CBT for PTSD (e.g., by beginning a course of antidepressant medication or participating in psychotherapy for depression).

Personality Disorder

Estimates within the literature suggest that as many as 15–25% of individuals with PTSD also meet criteria for a diagnosis of BPD (Scheiderer et al., 2015). A diagnosis of BPD does not necessarily preclude individuals from participating in trauma-focused CBT. As noted above, we assess for markers of extreme dysregulation that may need to be addressed prior to participating in group-based trauma-focused CBT. Among individuals with BPD, dysregulation may include recurrent suicidal threats or gestures, or active self-harm or engagement in other self-damaging behavior (e.g., risky or impulsive sexual behavior, excessive alcohol or drug use, reckless and dangerous driving). Should individuals with comorbid BPD and PTSD present with such concerns, it is recommended that they complete a course of treatment specific to BPD or emotion dysregulation, such as a full course of dialectical behavior therapy (DBT) or a DBT skills group (depending on severity) prior to engaging in trauma-focused CBT (e.g., Harned, Gallop, & Valenstein-Mah, 2018). If a client presents with BPD or BPD traits but is not displaying risky behavior or severe emotion dysregulation, they may benefit from participating in trauma-focused CBT immediately. For example, Walter, Bolte, Owens, and Chard (2012) have found that the presence of comorbid personality disorder symptoms (including BPD) did not negatively impact treatment outcome with CPT. Another consideration for individuals presenting with comorbid BPD or other personality disorders

(e.g., narcissistic traits) is interpersonal sensitivity and interpersonal style. Individuals who present as very interpersonally sensitive or who have frequent conflict with others may be better suited to individual treatment.

Motivation and Preference

Motivation for participation in trauma-focused CBT is a critical consideration. In particular, we recommend asking individuals if they feel that now is a good time for them to participate in this treatment, whether they are willing to reduce avoidance and think about or discuss the traumatic event, feel their emotions about the traumatic event without avoiding, and engage in regular homework exercises throughout treatment. Motivation can be determined by explaining the treatment and treatment requirements, including weekly homework assignments, as well as expectations for group treatment (e.g., participation).

If possible, it is ideal to assess the individual's preference for either group or individual treatment, as providing individuals with their preferred treatment has been demonstrated to predict treatment outcomes across disorders (Swift & Callahan, 2009). If individual treatment is not available or only available in a limited capacity, apprehension about group treatment should be normalized and the potential benefits of group treatment should be explained (e.g., meeting others who are suffering from the same symptoms, reducing social isolation).

If an individual does not currently feel ready to participate in treatment, it is helpful to normalize this and to provide ways in which they may access treatment in the future, should they feel more able.

Other Considerations

Individuals with serious mental illness (e.g., bipolar disorder or psychotic disorders) may still benefit from trauma-focused CBT depending on their symptom acuity and management. Individuals with well-managed bipolar disorder are considered appropriate for group CBT for PTSD. Individuals with well-managed psychotic disorders may also benefit from CBT for PTSD—however, depending on the level of residual symptoms, such as paranoia or thinking disturbances, they may benefit more from an individual course of therapy or therapies that are less cognitive in nature (e.g., PE as compared to CPT).

With respect to substance use, we recommend a harm reduction approach. If individuals are currently reporting excessive substance or alcohol use, and particularly if they are exhibiting symptoms of physical dependence, treatment for a SUD may be necessary prior to engaging in group CBT for PTSD. If individuals are using substances and their use is mild in nature, they may be able to begin group CPT for PTSD. We ask

these individuals to commit to refraining from using substances within 2 hours prior to or after attending group therapy sessions, or between sessions when completing homework assignments. Here, substance use is conceptualized as an avoidance behavior that may interfere in benefiting from treatment.

Monitoring Progress and Treatment Outcomes

Measures of PTSD symptomatology and related outcomes should be assessed throughout treatment to monitor progress and assess individual treatment outcomes. The PTSD Checklist for DSM-5 (PCL-5; Weathers, Litz, et al., 2013) is a self-report measure that assesses symptoms of PTSD across DSM-5-TR symptom domains. A cutoff score of 33 has been suggested to reflect a probable diagnosis of PTSD or clinically significant symptoms (Wortmann et al., 2016). The PCL-5 demonstrates high internal consistency, test–retest reliability, and convergent validity with other measures of PTSD symptoms (Weathers, Litz, et al., 2013; Wortmann et al., 2016).

Posttraumatic Cognitions

Changes in cognitions are posited to be a key mechanism by which CBT leads to improvement in PTSD symptoms (Schumm, Dickstein, Walter, Owens, & Chard, 2015)—thus, measurement of change in cognitions can assist clinicians in measuring treatment progress. The Posttraumatic Cognitions Inventory (PTCI; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) is a 36-item self-report questionnaire that assesses cognitions across three subscales, including Negative Cognitions about Self, Negative Cognitions about the World, and Self-Blame. It has demonstrated good internal consistency, test–retest reliability, convergent validity with other measures of posttraumatic cognitions, and discriminant validity when comparing individuals with PTSD, trauma-exposed individuals without PTSD, and non-trauma-exposed controls (Foa et al., 1999).

Avoidance

Avoidance of trauma reminders is also a significant predictor of PTSD symptoms and of symptom improvement following participation in CBT (Gutner et al., 2006; Pineles et al., 2011). In CBT protocols where exposure is used, this can be evaluated by assessing situations or trauma reminders that the individual is currently avoiding and incorporating these situations into their exposure hierarchies. As the individual rates their anticipated level of anxiety or fear when exposed to these situations, ratings can be used to assess treatment progress (e.g., having the individual rerate their anticipated fear or anxiety as treatment progresses). Avoidance can also be measured using the Avoidance subscale on the PCL-5.

Depressive Symptoms

Given the strong association between PTSD and depressive symptoms (Kessler et al., 1995), and the documented impact of CBT for PTSD on depressive symptoms, it is recommended that these symptoms are also monitored throughout treatment. Resick et al. (2017) suggest the use of the Patient Health Questionnaire–9 (PHQ-9) to monitor symptoms of depression. The PHQ-9 is a short (nine item) screening measure that provides estimates of the severity of depressive symptoms (Kroenke & Spitzer, 2002).

Structuring Group CBT for PTSD

Group Format

Due to evidence supporting the use of group CPT for the treatment of PTSD, we focus on this treatment for the remainder of the chapter. Based on Resick et al.'s (2017) CPT manual, 12 weekly 120-minute sessions are recommended. Additional sessions may be delivered on an individual basis for those individuals who have shown some benefit from treatment but continue to experience residual PTSD symptoms. Galovski, Blain, Mott, Elwood, and Houle (2012) found that modifying the structure of CPT to add up to six additional sessions led to an additional 34% of clients reaching good end-state criteria (scoring below the clinical threshold on a measure of PTSD symptom severity and scoring in the mild range on a measure of depressive symptom severity). Additional sessions should focus on continuing to challenge residual stuck points.

To prevent relapse and maintain treatment gains, we recommend monthly booster group sessions. Booster sessions provide an opportunity for individuals to troubleshoot obstacles, maintain skills learned during treatment, and identify further treatment goals.

Group Composition

A maximum of nine group members for treatment of PTSD in groups and a minimum of two group therapists is suggested. This is particularly important when administering group CPT due to the need for group therapists to review and provide feedback on all group homework between sessions and in the case of any difficulties that may arise during a group session (e.g., individual group members becoming distressed and in need of individual support). If possible, groups can be organized by trauma type, such that participants within the group share the same type of trauma. For example, at our clinic, we run separate CPT groups for individuals who have experienced sexual abuse, individuals who have experienced interpersonal violence, and individuals who have been involved in accidents (e.g., motor vehicle collisions, workplace accidents). Homogeneous groups provide the

benefit of increased comfort of group members in sharing their homework examples, increased identification with other group members, and may facilitate challenging one another's stuck points. However, we also run an "other" group for individuals who do not fit into the aforementioned categories and have not found substantial differences in the effectiveness of the "other" group as compared to the trauma-specific group, nor have Resick and colleagues (2017) reported differences between homogeneous and heterogeneous CPT groups.

Key Treatment Components

Group CPT retains the core components of the original individual protocol. These include psychoeducation about PTSD and factors that maintain PTSD, written impact statements to identify stuck points, examination of the facts and context of the trauma through Socratic dialogue with therapists, and the use of progressive CT worksheets to independently challenge stuck points. Group members are encouraged to assist one another in challenging beliefs as therapy progresses.

CPT relies on the use of cognitive strategies to identify and challenge maladaptive beliefs, referred to as stuck points. Therapists and clients work together to identify stuck points, which are conceptualized as beliefs that are preventing their recovery from PTSD (Resick et al., 2017). Group CPT consists of 12 sessions over which psychoeducation, trauma processing via Socratic dialogue, and independent challenging of stuck points using cognitive worksheets are incorporated. Clients begin treatment by writing an impact statement detailing their beliefs about why their most distressing traumatic event (e.g., the index trauma) occurred and how this event has impacted their beliefs about themselves, others, and the world with respect to five themes discussed later in treatment (safety, trust, power and control, esteem, and intimacy). The impact statement is used by clients and the therapists to identify stuck points. Stuck points are progressively challenged throughout the course of treatment, starting with beliefs about the trauma itself (e.g., self- or other-blame) and followed by beliefs across the five theme areas. There are several key mechanisms hypothesized to drive symptom change in CPT. First, processing of traumatic memories via engaging with and thinking about the events is hypothesized to allow individuals to feel and process natural emotions that arise from these events (e.g., sadness) and to accept that the traumatic events have occurred. Shifting beliefs via Socratic dialogue and the use of cognitive worksheets is thought to allow individuals to reduce or shift emotions resulting from their appraisals of the events and current situations (e.g., guilt, fear, anger). Finally, creating alternative beliefs is also thought to lead to a reduction in avoidance behaviors that may serve to maintain symptoms of PTSD (Resick et al., 2017).

Sample CPT Group Protocol for PTSD

The 12-session group treatment protocol outlined in Table 8.1 provides a session-by-session description of group CPT as described by Resick et al. (2017). A summary of what occurs in each session is described below.

Pretreatment Individual Meeting

This session involves a meeting between the individual group member and one or both of the group therapists. The purpose of this meeting is to provide the client with an introduction to the group, a description of what CPT will involve (including required practice assignments), and how group CPT may be similar or different compared to other previous group treatments the individual has attended. This session also provides the opportunity for the therapist and the group member to work together to identify the index trauma that the client will focus their work on. In the case that the individual has experienced multiple traumatic events, the group member and therapist should identify the traumatic event that is currently causing the group member the most distress (e.g., the event that is associated with the most frequent or intense reexperiencing symptoms or avoidance). If the individual has experienced prolonged traumatic experiences (e.g., prolonged childhood abuse, exposure to combat or war), the therapist should help the client determine an incident within those experiences that causes them the most distress (e.g., a memory that recurs frequently and causes intense emotional or physiological reactions). The therapist should then obtain a brief (no more than 5 minutes) account of the traumatic event that the group member will focus on in treatment. Finally, the pretreatment meeting allows the opportunity for the therapist to assess any potential barriers to treatment or factors that may preclude the individual from starting trauma treatment at the present time (see the section "Assessment and Eligibility for Group CBT and PTSD" for more detail).

Session 1: Presenting the Treatment Rationale

At the beginning of each group session, group members should be asked to complete a symptom measure assessing severity of their PTSD symptoms, such as the PCL-5 described above.

Session 1 serves as an introduction for group members and therapists and to provide psychoeducation about trauma and PTSD, as well as the rationale for treatment. Introductions of group members and therapists can be done in a go-around style where each member states their name and something about themselves that is unrelated to trauma or PTSD (e.g., favorite hobby, if the member has children or animals) as an icebreaker. Group facilitators should then lead a discussion about confidentiality both

TABLE 8.1. Session-by-Session Description of Strategies and Content Covered in Group CPT

Session	Session content and strategies covered

Session 1	• Introduction to check-in process and introduction to group facilitators and patients.
	• Review of group expectations and structure of the group.
	• Psychoeducation about PTSD:
	  ○ Introduction to four symptom clusters of PTSD.
	  ○ Discussion of natural recovery versus development of PTSD.
	  ○ Model of factors that contribute to development of PTSD (avoidance, changes in beliefs).
	• Introduction to cognitive theory.
	• Introduction to role of emotions in PTSD and recovery.
	• Review of goals of treatment.
	• Assignment of first homework assignment (impact statement).
	• Check-in regarding reactions to session.

Session 2	• Group check-in. • Review of impact statements. • Introduction to stuck points. • Introduction to A-B-C worksheet and relation among situations, thoughts, and emotions. • Homework assignment: A-B-C worksheets with at least one focusing on the trauma. • Check-in regarding reaction to session.
Session 3	• Group check-in. • Homework review: A-B-C worksheets. • Socratic questioning of stuck points elicited via A-B-C worksheets. • Introduction to questions to challenge thoughts identified on A-B-C worksheets. • Homework assignment: A-B-C worksheets with at least one focusing on the trauma. • Return of homework collected at previous session (suggested stuck points pulled from impact statement). • Check-in regarding reaction to session.
Session 4	• Group check-in. • Homework review: A-B-C worksheets. • Socratic questioning of stuck points elicited via A-B-C worksheets. • Discussion of concepts of intention, responsibility, and the unforeseeable, and their relation to self- or other-blame. • Introduction to challenging questions worksheets to assist group members in challenging stuck points. • Homework assignment: challenging questions worksheets. • Return of homework collected at previous session with comments from group facilitators (A-B-C worksheets). • Check-in regarding reaction to session.
Session 5	• Group check-in. • Homework review: challenging questions worksheets. • Introduction to cognitive distortions (problematic patterns of thinking worksheets).

(continued)

TABLE 8.1. *(continued)*

Session	Session content and strategies covered
Session 5 *(continued)*	• Homework assignment: problematic patterns of thinking worksheets. • Return of homework collected at previous session with comments from group facilitators (A-B-C worksheets). • Check-in regarding reaction to session.
Session 6	• Group check-in. • Homework review: problematic patterns of thinking worksheets. • Introduction to final worksheet: challenging beliefs worksheets, incorporating components of previous worksheets. • Homework assignment: challenging beliefs worksheets focusing on self-blame stuck points. • Return of homework collected at previous session with comments from group facilitators (challenging questions worksheets focusing on self-blame). • Check-in regarding reaction to session.
Session 7	• Group check-in. • Homework review: challenging beliefs worksheets focusing on self-blame stuck points. • Introduction to first module: safety. • Homework assignment: challenging beliefs worksheets focusing on safety stuck points. • Return homework collected at previous session with comments from group facilitators (problematic patterns of thinking worksheets). • Check-in regarding reaction to session.
Session 8	• Group check-in. • Homework review: challenging beliefs worksheets focusing on safety. • Introduction to trust module. • Homework assignment: challenging beliefs worksheets focusing on trust stuck points and trust star worksheets. • Return homework collected at previous session with comments from group facilitators (challenging beliefs worksheets focusing on self-blame stuck points). • Check-in regarding reaction to session.
Session 9	• Group check-in. • Homework review: challenging beliefs worksheets focusing on trust. • Introduction to power and control module. • Homework assignment: challenging beliefs worksheets focusing on power and control. • Return homework collected at previous session with comments from group facilitators (challenging beliefs worksheets focusing on safety stuck points). • Check-in regarding reaction to session.
Session 10	• Group check-in. • Homework review: challenging beliefs worksheets focusing on power and control. • Introduction to esteem module.

(continued)

TABLE 8.1. *(continued)*

Session	Session content and strategies covered

Session 10 *(continued)*	• Homework assignments:
	  ◦ Challenging beliefs worksheets focusing on esteem stuck points.
	  ◦ New homework assignment: behavioral experiments of doing nice things for oneself and giving and receiving compliments.
	• Return homework collected at previous session with comments from group facilitators (challenging beliefs worksheets focusing on trust stuck points).
	• Check-in regarding reaction to session.

Session 11	• Group check-in.
	• Homework review: challenging beliefs worksheets focusing on esteem.
	• Introduction to intimacy module.
	• Homework assignments:
	  ◦ Challenging beliefs worksheets focusing on intimacy stuck points.
	  ◦ Behavioral experiments of doing nice things for oneself and giving and receiving compliments.
	  ◦ New homework assignment: rewrite impact statement.
	• Return homework collected at previous session with comments from group facilitators (challenging beliefs worksheets focusing on power and control stuck points).
	• Check-in regarding reaction to session.

Session 12	• Group check-in
	• Homework review:
	  ◦ Challenging beliefs worksheets focusing on intimacy.
	  ◦ Comparison of new impact statement to impact statement written after Session 1 and discussion of treatment gains and areas for further work.
	• Return homework collected at previous sessions with comments from group facilitators (challenging beliefs worksheets focused on esteem stuck points).
	• Discussion of relapse prevention and how to maintain gains and any stuck points about group ending.

from a professional and legal obligation standpoint, and what is expected of group members (e.g., not to share details of what is discussed in group that would include any identifying information, such as the name or profession of another group member, with others). Following introductions, expectations and structure of the group should be reviewed, including the number of group sessions (12), session length (2 hours), and session format. Expectations regarding attendance, punctuality, advanced notice for missed sessions, and the importance of between-session assignment completion should be discussed.

The group check-in should be introduced next. The group check-in provides group members with the opportunity to ask for assistance from the group (both group therapists and clients) in problem-solving stressors unrelated to group content that may interfere in their ability to participate. Group members can ask for time at the beginning or end of the

group. Discussions should be limited to 2–3 minutes to allow sufficient time to address group content. Group therapists should meet with clients individually if greater attention is required.

The key features of PTSD, including the four symptom clusters, should be introduced and discussed in a collaborative manner with group members (e.g., with group therapists eliciting examples of symptoms from group members). Therapists should then introduce the concepts of natural recovery as compared to the development of PTSD, focusing on a discussion of factors that keep the individual "stuck" in the process of recovery, including avoidance of trauma reminders and changes in beliefs about the self, others, and the world. Next, group therapists introduce cognitive theory to help clients learn the role that their thinking plays in the development and maintenance of PTSD. In particular, the therapists facilitate a discussion about how individuals develop beliefs and categories to help them understand the world, with a focus on the "just-world belief" (good things happen to good people and bad things happen to bad people). Then a discussion about how trauma may have impacted their beliefs is facilitated. Group participants are introduced to the idea that they may try to fit the trauma into their previously held beliefs, referred to as assimilation (e.g., "If good things happen to good people and bad things happen to bad people, I must be bad or have done something wrong to have caused the traumatic event to occur"), and/or they may get rid of their old beliefs completely as a result of the trauma, referred to as overaccommodation (e.g., "Bad things can happen to anyone at any time; therefore, I am never safe"). The group then discusses that the goal of therapy is to change negative beliefs about the self and the world enough to include new information about the trauma without getting rid of previous beliefs completely, referred to as accommodation (e.g., "Sometimes bad things happen to good people; the trauma was not my fault").

Group therapists then introduce the role of emotions in PTSD and recovery. Clients are introduced to the concept of natural versus manufactured emotions, where natural emotions refer to emotions that anyone would naturally feel as a result of an event (e.g., sadness in response to loss, fear in response to immediate danger) and manufactured emotions refer to emotions that are generated by an individual's interpretations of an event (e.g., guilt as a result of the thought that the trauma was their fault). Participants are educated on the process of processing both natural and manufactured emotions, whereby natural emotions are expected to subside with time if they are not avoided and the individual allows themselves to feel them, and manufactured emotions reduce as a function of challenging and restructuring the thoughts or beliefs that cause them.

Finally, group participants are given a brief overview of the therapy and the following goals for treatment: (1) to help them modify their thoughts about the trauma and the world, (2) to allow them to feel their natural emotions about the trauma, and (3) to help them accept that the trauma occurred (*Note:* It is important to clarify to participants that this

does not mean that they have to forgive individual(s) who have harmed them but rather that they must accept the reality of the event in order to move forward). Participants are informed that the first step in modifying their thoughts is to identify automatic thoughts that may be keeping them stuck in their recovery and that these thoughts are referred to as stuck points.

The first practice assignment, the impact statement, is introduced. Participants are asked to write at least one page about why they believe the index traumatic event occurred and how this event has impacted their beliefs about themselves, others, and the world with respect to the five theme areas: safety, trust, power and control, esteem, and intimacy. Clients should be reminded that the index event is the one that they identified as the most distressing event during their individual pretreatment session. It is important to emphasize to group participants that they are not being asked to write an account of what happened to them but rather are being asked to write about why it happened and how it has affected their beliefs. It is also important at this point to discuss any anticipated challenges in completing the practice assignment with an emphasis on anticipated avoidance and strategies to manage avoidance.

Finally, group therapists should check in with group participants' reactions to the session and the practice assignment. As they are provided with a lot of information in this session, it is important to normalize that they may be feeling overwhelmed or apprehensive and experiencing strong emotions in reaction to the information presented thus far. Group therapists should praise group participants for taking the first step toward recovery by coming to group and overcoming the urge to avoid that they may have experienced prior to the session.

Sessions 2 and 3: Processing the Index Trauma, Identifying Stuck Points, and Introducing A-B-C Worksheets

Sessions 2 and 3 also begin with the group check-in as described above. Group therapists should conduct a more general check-in of group members' reactions to the first group session. Group therapists should then turn to reviewing the impact statement that was the practice assignment for Session 1. Group therapists can ask the group for general feedback on the impact statement and their experience in completing it. If any group members did not complete the impact statement, this should be addressed directly, as this is an essential component of treatment. The role of avoidance in not completing the impact statement can be discussed and the impact statement should be reassigned as a practice assignment between Sessions 2 and 3.

The concept of stuck points should be reviewed. Group participants should be reminded of the two types of stuck points that will be addressed: assimilated stuck points (beliefs about the event itself) and

overaccommodated stuck points (overgeneralized, extreme beliefs about other people, themselves, and the world). Group therapists can then reinforce the concept of stuck points in one of two ways: (1) they can have group members read their own impact statements and pair up with another group member to discuss any potential stuck points they see in their statements and then have a larger group discussion about this, or (2) group therapists can provide a sample impact statement and have the group practice identifying stuck points in the sample statement that fall into the two categories. Therapists should not worry too much about group members understanding assimilation and overaccommodation, and can refer to these instead as beliefs about the event and beliefs about the "here and now," respectively. Examples of assimilated stuck points include hindsight bias, self-blame, or denial, such as "The assault was my fault because I was wearing a skirt" or "The accident was my fault because I didn't leave the house on time." Examples of overaccommodated stuck points include "I can only be safe when I am at home," "I can't trust my own judgment," or "All men are dangerous." Group members should be introduced to the stuck point log where they will record all of their stuck points throughout the course of group treatment.

After reviewing the impact statements, group therapists will begin teaching group members how to identify and label thoughts and emotions, and learn to see the connections among events, thoughts, and emotions using the A-B-C worksheets. Clients should also be provided with information about emotions, including different types of emotions and the fact that emotions can be of varying intensities (e.g., from 0 to 100). The goal of the A-B-C worksheets is to have group members identify events (Column A: "something happens," or antecedent), thoughts that arise in response to the events (Column B: "I tell myself something," or beliefs), and emotions that occur as a result of their thoughts (Column C: "emotions," or consequences). Group members should be oriented to the fact that one event may lead to several thoughts and that different thoughts can lead to different emotions. An example worksheet can be filled out as a group with the activating event (A [of the A-B-C]) being "writing the impact statement."

At the end of Session 2, group therapists should collect group members' impact statements. These should be reviewed by group therapists between sessions and a list of possible stuck points should be identified and provided to clients at Session 3. Group members are then assigned the between-sessions assignment for Session 2, to complete one A-B-C worksheet each day, with at least one worksheet about the index trauma. The impact statement should be reassigned to anyone who did not complete it after Session 1. Group members should be given the opportunity to ask any clarifying questions or address any concerns about the material presented before concluding the group session. At the end of Session 2 (and all subsequent sessions), group therapists should collect each of the group

members' homework sheets and review these between sessions to provide feedback and comments for further consideration.

During Session 3, group therapists and members review the A-B-C worksheets. Group members are asked to pull out their homework and are encouraged to go through some examples. Nontrauma examples can be reviewed first to increase group comfort. The focus of the homework review should be on ensuring that group members accurately identified thoughts and emotions, and that the emotions logically follow from the thought (e.g., the emotion of anger directed toward the self in response to the thought "I'm a failure for making a mistake while preparing dinner"). Group therapists should also listen for potential stuck points in the homework examples and encourage group members to record these on their stuck point logs. Group members are also introduced to gentle Socratic questioning during this session as the therapists begin challenging stuck points. Group members are asked to continue completing A-B-C worksheets for homework this week (one each day) with the addition of two questions asking them to consider whether their thoughts are realistic or helpful and what else they might consider telling themselves on future occasions.

Sessions 4–6: Introduction to Cognitive Restructuring Strategies and Challenging Assimilated Stuck Points

Sessions 4–6 begin with the group check-in. At the beginning of Session 4, A-B-C worksheets are reviewed focusing on assimilated stuck points. Therapists should continue to use Socratic questioning to challenge assimilated stuck points and endeavor to assist clients in seeing the broader context of the traumatic event in order to challenge erroneous assumptions. For example, in response to the stuck point "The assault wouldn't have happened if I had fought back," the therapist might ask questions, such as "Do you know for sure if you had fought back, the assault would have been prevented?"; "Could there have been any negative consequences to fighting back?"; or "Did you know that the perpetrator was going to assault you before it happened?" Group members should also be asked to consider whether they experienced any change in the intensity of their emotions or the type of emotions they were experiencing after writing down a potential alternate thought.

In Session 4, group members are asked to consider the differences between the concepts of intention, responsibility, and unforeseeable events in order to assist in resolving stuck points about self-blame and associated emotions of guilt and anger toward themselves. They are then introduced to the challenging questions worksheet, which introduces questions to assist group members in challenging their own stuck points. An example should be completed with the group, focusing on assimilated stuck points before concluding the group session. For homework, group

members are asked to complete one challenging questions worksheet each day using stuck points from their stuck point log as the belief or thought they are challenging.

In Session 5, group members are introduced to the problematic patterns of thinking worksheet, which lists common types of cognitive distortions or thinking errors. Group therapists should assist group members in identifying which stuck points fit under which type of thinking error. For homework, group members are asked to review their stuck point log and categorize stuck points on the problematic patterns of thinking worksheet.

In Session 6, group members are introduced to the final worksheet, which incorporates components of the A-B-C worksheet, the challenging questions worksheet, and the problematic patterns of thinking worksheet. Session 6 also marks the midpoint of treatment and it is helpful for group therapists to assess group members' scores on the PCL-5 to ensure that scores have decreased. If scores have not decreased, this is an opportunity for group therapists to check in individually with group members about factors that may be getting in the way (e.g., continued avoidance, insufficient processing of assimilated stuck points).

On this new worksheet, group members are asked to start considering how much they believe their initial stuck point when they begin the worksheet and how much they believe their stuck point when they finish the worksheet. They are also asked to develop an alternative thought and rate how much they believe this new thought. Group members are also asked to rate the intensity of their emotions when they begin the worksheet and rerate their intensity when they finish the worksheet, as well as add any new emotions that may have developed after completing the worksheet. Rating the believability of their thoughts assists clients in noticing shifts in their beliefs, whereas rating the intensity of emotions allows clients to notice that changes in thinking are associated with changes in emotions. It is important to discuss with group members that the goal of these worksheets is to develop more balanced and realistic beliefs, rather than to develop overly positive beliefs or to go back to their old way of thinking (e.g., for someone who believed previously that they could trust everyone, it would not be helpful or realistic to return to this previous belief). Clients are asked to complete one challenging beliefs worksheet each day to challenge stuck points related to the trauma, focusing on assimilated or self-blame stuck points.

Sessions 7–11: Challenging Overaccommodated Stuck Points Related to Safety, Trust, Power and Control, Esteem, and Intimacy

The focus of Sessions 7–11 shifts to challenging stuck points across the five theme areas: safety, trust, power and control, esteem, and intimacy. Group therapists should also ensure that group members have adequately

addressed self-blame or assimilated stuck points and encourage those who feel that these stuck points are still relevant to continue to challenge these as well.

At the beginning of Session 7, group members should be asked to review homework examples using the challenging beliefs worksheet and group facilitators should ensure that group members have a good understanding of how to complete this worksheet, as they will continue to use this worksheet until the end of treatment. As clients learn to challenge beliefs, group therapists should aim to balance Socratic dialogue with having clients challenge their beliefs independently and encouraging group members to assist one another in challenging beliefs. Socratic dialogue can continue to be used in situations where group members become stuck, are missing important information, or are including erroneous information in their challenging beliefs worksheet (e.g., a client who states that the fact that they got into a car accident is evidence for the stuck point "driving is always dangerous").

The end of Session 7 focuses on the introduction of the first theme area: safety. In subsequent sessions, the beginning of each session focuses on challenging beliefs relating to the previous week's theme area and the end of the session focuses on introducing the next theme area. When introducing themes, therapists should orient group members to the idea that beliefs about the self, others, and the world can be impacted by the traumatic event in two ways: (1) if an individual reports that prior to the traumatic event, they already had negative beliefs about themselves, others, or the world, the traumatic event serves to reinforce those negative beliefs (e.g., reinforcing the preexisting belief that nobody can be trusted); and (2) if an individual reports that prior to the traumatic event, they had relatively positive beliefs about themselves, others, and the world, the traumatic event may serve to shatter those beliefs (e.g., shattering the belief that most people can be trusted).

During Session 10, the esteem module is introduced and in addition to completing the challenging beliefs worksheets focusing on esteem-related stuck points, group members are asked to make behavioral changes of doing one nice thing for themselves each day and practicing giving and receiving compliments, with the goal of challenging esteem-related beliefs. With respect to the "doing nice things" assignment, group members are given the instructions to do one nice thing for themselves "just because" (i.e., not as a reward for completing a task) each day. The concept underlying this assignment is that the value that we place on something (including ourselves) is reflected in how we treat that thing and treating something with greater care reflects greater value. Making behavioral changes that are reflective of an increased value placed on the self is hypothesized to improve self-esteem and esteem-related stuck points. For giving and receiving compliments, group members are asked to give one compliment to another person each day and also to pay attention to and note any

compliments that they receive. It is important to explain to group members that this exercise also includes accepting compliments, as opposed to rejecting or minimizing them. They may also take note of more subtle compliments if they do not have a lot of social interaction (e.g., someone opening the door for you). Group members are asked to make note of their experiences with this.

At the beginning of Session 11, after reviewing group members' challenging beliefs worksheets related to esteem stuck points, group therapists should review group members' experience with behavioral experiments of doing nice things and giving and receiving compliments. Therapists should pay particular attention to any stuck points that may arise related to these experiments (e.g., if the client notices difficulty accepting compliments, the therapists should probe as to whether any stuck points are underlying this difficulty). Therapists should also note whether group members have noticed any differences in their experiences with these experiments over time and whether they have noticed any shifts in their esteem-related stuck points as a result of these experiments. During Session 11, the intimacy module is introduced. For homework, group members are asked to challenge stuck points related to intimacy. They are also asked to continue with behavioral experiments of doing nice things and giving and receiving compliments. Finally, group members are asked to write a new impact statement about what they believe now about why the index traumatic event occurred and what they believe now about themselves, others, and the world, with respect to the five theme areas of safety, trust, power and control, esteem, and intimacy. It is important to ask that group members not review their original impact statement before writing the new impact statement to ensure that what they write is not influenced by the original statement.

Session 12: Reviewing the Final Impact Statement and Relapse Prevention

The first half of Session 12 should focus on reviewing group members' homework. Group leaders should endeavor to go through at least one group member's challenging beliefs worksheet on intimacy stuck points as a group. Group therapists should review group members' experience with behavioral experiments of doing nice things and giving and receiving compliments, as in Session 11.

The second half of Session 12 should focus on group members reviewing their original and new impact statements. Group members should be asked to first read their original impact statement to themselves and then read their new impact statement to themselves. Group members and therapists should engage in a conversation about which beliefs have shifted and which beliefs may require further challenging. Group members should be reminded that they have now learned a new skill and that

this skill can continue to be applied to stuck points that remain and any new stuck points that arise. There should also be a discussion regarding any concerns that group members have about treatment termination. If any stuck points arise, these can be discussed as a group (e.g., "I will not be able to maintain my progress after the group finishes"). Relapse prevention and maintaining gains should be discussed next. At our clinic, all group members are offered a monthly CPT booster group that they can attend on a drop-in basis to review strategies and concepts.

Posttreatment Individual Meetings

Posttreatment meetings are conducted with each group member meeting individually with the group therapists following the final group session to update current symptom status (e.g., full or partial remission) and determine any further treatment needed for additional difficulties.

Group Process Factors in CPT for PTSD

One of the greatest advantages of offering CPT in a group format is the opportunity for group members to meet other individuals struggling with similar issues and who have experienced similar traumatic events. Given the association between social support and PTSD symptoms (Shallcross, Arbisi, Polusny, Kramer, & Erbes, 2016), the group setting provides a valuable opportunity for group members to reduce social isolation, which may provide opportunities for individuals to challenge stuck points relating to trust (e.g., challenging the stuck point "nobody can be trusted" through opportunities to build trust within the group setting). Nonetheless, a number of obstacles related to group process unique to group CPT may arise and merit particular attention.

As with any group treatment, group cohesiveness can be an issue if there is significant heterogeneity among group members. This can be minimized by attempting to reduce heterogeneity beforehand (e.g., balancing group membership for sex and age, having groups made up of similar trauma types). If groups are going to be mixed gender, group participants should be informed of this beforehand to mitigate potentially triggering circumstances. Group therapists should be cognizant of group members who do not seem to fit into the group or who are quieter or more reserved than other group members. Strategies that would allow them to feel more a part of the group can be discussed individually with that group member. Further, clinicians may take the opportunity to highlight common experiences (e.g., shared symptomatology) that may enhance group cohesion.

Another potential factor that may contribute to process issues are concerns related to hearing about other group members' traumatic experiences.

Clinicians and group members alike may present with beliefs that it would be too distressing or challenging for group members to hear about other group members' traumatic events. In our experience, this has not been the case. There are several ways that this issue is mitigated. First, group members in group CPT are asked not to share details about the specific traumatic events they have experienced. Nonetheless, discussion about the context of the events is often used to challenge stuck points (e.g., the individual's age at the time of the event, factors in the environment that may have influenced the outcome of the event), but we have not observed that this has had a significant negative effect on the group members. Other considerations may include grouping individuals based on the types of traumatic experiences they are seeking help for (e.g., grouping individuals who have experienced childhood sexual or physical abuse with other individuals who have had similar experiences).

Homework compliance can present another challenge and is an important predictor of both symptom improvement and dropout, such that greater homework completion is associated with greater symptom improvement and lower dropout among individuals participating in CPT (Stirman et al., 2018). Given that avoidance is a significant factor in PTSD, it is likely that most, if not all, clients will have an urge to avoid completing homework. In group CPT, it is important to anticipate this avoidance and address it directly. In the first session, time is allotted to discussion about avoidance of homework assignments and any potential barriers to completion. We also find that collection of, and feedback on, homework assignments is an effective way to keep up to date on each group member's progress and any avoidance behaviors. Group members may express certain beliefs regarding completing homework that can be processed as stuck points if there is time in the group setting, or these can be assigned to be processed as homework (e.g., "If I think about the trauma, I won't be able to handle it"; "There is no point in completing homework because I won't get better"). We have also found it helpful to provide clients with additional support in completing homework if they are struggling, including scheduling time for them to come into the clinic and complete homework in a quiet space, or scheduling telephone calls with clients to check in regarding homework completion between sessions. Resick et al. (2017) also recommend implementing a phone list assignment between sessions. Here, all clients who are willing provide their phone numbers to the group. Each week clients are assigned to contact one person on the list before the next session to check in regarding homework completion and to provide peer support. This can be done via text message or a phone call depending on client preference. It is important to remind clients that these check-ins should not be used to talk about the traumatic events they have experienced but rather to talk about the practice assignment and gain support. This additional accountability may assist individuals in reducing avoidance of homework assignments. We also encourage group members not to share details about their personal lives or

current stressors, as this may detract from each individual's focus on their own treatment. Group members are instead encouraged to obtain support from the group or group therapists as needed during the group check-ins.

Finally, group leaders should anticipate that some group members will present with more "rigid" thinking and may be resistant to challenging or Socratic questioning. This can be frustrating at times for other group members. On the other hand, we have found it helpful to employ other group members in helping one another challenge stuck points. It is often the case that a more "stuck" group member is more open to hearing the perspectives of other group members who have shared similar experiences. Clinicians can also employ the "foot-in-the-door" technique, by asking group members who are stuck to start by gently exploring the possibility of an alternative interpretation, rather than asserting that they agree to it right away.

Addressing Multiple Traumas

A question that often arises from individuals who have experienced multiple traumas or repeated, prolonged traumatic events in which there were multiple incidents of trauma (e.g., childhood abuse, war) is whether they can address all of these events in treatment. In order to deliver CPT effectively (as well as other trauma-focused CBTs, such as PE), it is crucial to identify an index traumatic event (or the traumatic event that is currently causing the most distress; see the "Pretreatment Individual Meeting" section for more detail). Some clients will have significant difficulty with identifying an index traumatic event and may express concerns that treatment will not work if they are not able to address all of their traumatic events, or feel that by choosing one event, it means that the other events are not as important. It is important to emphasize to clients that this is not the intent of choosing an index traumatic event but rather, the intent is to provide an anchoring point from which to focus treatment. It should also be explained to participants that stuck points and distress about other traumatic incidents often decreases by challenging stuck points relating to the index trauma. If, after choosing an index traumatic event and challenging stuck points about this event, a client reports that they are continuing to have significant reexperiencing symptoms related to another traumatic event, the client can write a second impact statement about the other traumatic event in order to identify and challenge stuck points related to this event. However, it has been our experience that the majority of clients find that their symptoms reduce without addressing additional traumatic events specifically. If a client does find that stuck points relating to another traumatic event are significantly affecting them, the client may begin to challenge self-blame stuck points related to this around Session 6 (after the client has mastered the core cognitive skills). Some clients may initially avoid the most distressing traumatic event or minimize its impact until later in treatment. For example, we had one gentleman who initially focused on physical abuse by

his parents, but later in treatment shared that he had experienced a sexual assault in his early 20s that was reinforcing many of his stuck points. Once this information was shared, the focus of treatment transitioned to the sexual assault and the client wrote a new impact statement. Clients should also be reminded that they are learning a skill in this treatment that they can apply independently after treatment is complete and that they may choose to process additional traumatic events after treatment termination or while attending booster sessions (which are offered monthly at our clinic).

Training for Therapists Providing Group CPT

Several training opportunities are available for CPT that can be found on the official website for CPT hosted by Patricia Resick, Kathleen Chard, and Candace Monson (*www.cptforptsd.com*). Training opportunities include a web course (available at *www.cpt2.musc.edu*), workshops (usually taking place over 2–3 days), consultation, and opportunities to achieve provider status (following completion of the CPT web course, CPT workshop, group or individual consultation, and initiation of a number of individual CPT cases, group CPT, or a combination of individual and group). The majority of training available focuses on individual CPT, although consultation and provider status training do include opportunities for training in group CPT and a daylong group workshop is offered.

At our clinic, training is offered to clinicians with training and competency in CBT to become competent in delivering CPT in a group format. Typically, our model of training for CPT includes initial observation of a CPT group being facilitated by two clinicians competent in the delivery of CPT followed by co-facilitation in a CPT group with a clinician competent in CPT. Typically, the two clinicians meet before and after each group session to review new material delivered, to discuss therapeutic strategies used (e.g., Socratic dialogue), and to divide client homework for review. The experienced clinician may also review and provide guidance on the learning clinician's homework feedback before returning homework to clients. CPT therapists are also encouraged, but not required, to attend a 2-day CPT workshop. Consultation is available as needed with more experienced CPT clinicians at our clinic.

Conclusions

PTSD is a unique psychological disorder characterized by the experience of a traumatic event and subsequent onset of a range of symptoms, including intrusive symptoms, avoidance symptoms, changes in mood and cognition, and changes in arousal and reactivity. Cognitive features of PTSD include erroneous beliefs relating to the traumatic event, such as self- or inappropriate other-blame, as well as generalized beliefs about the self, others, and

the world, including negative beliefs about safety, trust, power and control, esteem, and intimacy. CBT is considered a first-line treatment for PTSD and there is a strong evidence base for multiple CBT-based treatments for this disorder. Group CPT has emerged more recently as an efficacious and cost-effective method of treatment delivery that promotes social support and normalization of traumatic experiences and symptoms. We reviewed the key components of CBT for PTSD, as well as group CPT for PTSD, in addition to discussion of potential issues and considerations with conducting this treatment in a group format.

CHAPTER 9

Mood Disorders

Mood disorders, particularly depression, were the first application of CBT in the late 1960s, culminating in the landmark book by Beck et al. (1979), *Cognitive Therapy of Depression,* which remains a standard reference. Much of what we know about how to conduct CBT, as well as its efficacy, effectiveness, how to train practitioners, and related matters were pioneered in depression. In this chapter, we focus on this core of CBT groups, first in unipolar depression and then in bipolar disorder, a related but later-developed CBT group intervention with unique nuances. This chapter is structured to first tackle depression because the approach, skills, techniques, and process are building blocks toward modifications for bipolar disorder. Simply put, everything one learns about CBT group for depression needs to be retained and added to conduct groups for bipolar disorder.

Unipolar Depression and Bipolar Disorder

Depression is the most frequently occurring psychiatric disorder with an estimated 350 million people affected globally (World Health Organization, 2017)—17.3 million within the United States alone (Substance Abuse and Mental Health Services Administration, 2018)—and numbers are continuing to rise due to population growth and aging (Kassebaum et al., 2016). With a life prevalence ranging anywhere from 1.5 to 19.0%, depending on the country (Kessler & Bromet, 2013), depression is also a major source of disability, responsible for 40.5% of total disability-adjusted life years (DALYs) caused by mental and substance use disorders (SUDs; Ferrari et

al., 2013). Because of its prevalence, aspects of depression treatment are relevant to nearly all clients with psychiatric issues seen across different kinds of clinical settings.

In contrast, bipolar disorder is a much less frequently occurring illness that affects approximately 1.0–3.0% of the population worldwide (Grande, Berk, Birmaher, & Vieta, 2016; Merikangas et al., 2011) and an estimated 4.4% of people in the United States will experience bipolar disorder at some time in their lives (Harvard Medical School, 2017). Although major depression affects considerably more individuals, 89.2% of individuals with bipolar disorder (vs. 63.8% of those with depression) report serious disability (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Substance Abuse and Mental Health Services Administration, 2018). With its often unpredictable cycles of deep depressions followed by periods of mania, the disorder can wreak havoc on clients' lives. Bipolar disorder is a frequent cause of inpatient hospitalizations and places sufferers at increased risk of suicide. Both ends of the bipolar continuum lead to problems in functioning; the depressive episodes are characterized by the same symptoms as unipolar depression and undermine the individual's functional capacities. In addition, the manias/hypomanias often generate their own unique set of problems and stressors in occupational, interpersonal, and financial domains. Bipolar disorder is also, for most, an illness that impacts individuals over their entire adult lifespan, with symptoms waxing and waning in potentially unpredictable ways.

This chapter first introduces some of the clinical and diagnostic aspects of major depression, followed by a description of a group CBT approach to depression and discussion of relevant group process factors. We then discuss the clinical and diagnostic features of bipolar disorder, with an overview of how group CBT for depression can be adapted or modified for this population.

Cognitive and Behavioral Features of Unipolar Depression

As with other diagnostic categories, DSM-5-TR and ICD-11 provide the official symptom criteria that qualify a client for receiving a diagnosis of major depressive disorder (MDD), and a review of these schemes is important. From a CBT group perspective, some degree of consistency should be applied in diagnosis, and group therapists ought to be familiar with the criteria for "clinical" depression—a much more complex and distinct entity from the way the word "depression" is used in usual speech. Clinical depression contains not just mood-related components but several physical symptoms that can have multiple causes. A CBT group for depression is more likely to be successful when other possible causes of physical symptoms (e.g., disturbed sleep) have been ruled out.

Symptoms of depression may also be present as a part of another diagnosis and an episode must stand alone in its simplest form in order to constitute a diagnosis of MDD. For example, symptoms of depression may also manifest themselves in a less severe but more long-standing form that falls short of meeting criteria for a full major depressive episode. This diagnosis, persistent depressive disorder, is characterized by at least 2 years of chronically depressed mood, accompanied by a minimum of two other symptoms of depression, including changes in appetite, change in sleep, low energy, difficulty concentrating, and feelings of hopelessness, and has historically been known as dysthymia. To meet criteria for persistent depressive disorder, the individual must not have experienced a symptom-free period for more than 2 months at a time, and the symptoms for MDD may also co-occur with those of persistent depressive disorder—termed "double depression"—and is distinct from chronic depression, which involves the uninterrupted existence of major depression symptoms for a 2-year period.

Evidence-Based Treatment for Unipolar Depression

CBT is the most researched form of psychotherapy for adult depression and there is no doubt it is effective for the treatment of depression (e.g., Cuijpers et al., 2013; Li et al., 2018). CBT was initially developed for working with clients with depression, and some authors have suggested that because CBT teaches the clients a set of skills they can implement after therapy ends, CBT is likely to have a more lasting and potentially prophylactic effect than comparator treatments, such as antidepressant medications.

Evidence for Group CBT in Unipolar Depression

Depression was the first kind of disorder to which a CBT group format was formally applied and evaluated. These early validation studies conducted by Hollon and Shaw (1979) were small but important, in that they compared group CBT not only to medication but also to individual CBT. Hollon and Shaw found that a CBT group was superior to several other treatments, but seemingly not as effective as individual CBT (Beck et al., 1979).

Despite a considerable amount of time having passed since the inception of CBT for depression, very little controlled research has assessed the difference in efficacy between individual and group approaches. From the research that does exist, it appears as though individual and group CBT for depression perform at approximately equivalent levels (Cuijpers, van Straten, & Warmerdam, 2008; Huntley, Araya, & Salisbury, 2012; Oei & Dingle, 2008). There is some reason to believe that individual CBT confers a greater benefit immediately following treatment, but this difference is of questionable clinical value and is also seen to disappear at later follow-up

assessments (Cuijpers et al., 2008). All review papers assessing the differences between individual and group CBT note the potential for publication bias and the low quality of evidence present in the small number of studies being discussed, so there is clearly a need to assess whether the observed differences are clinically relevant. Nevertheless, it is apparent that CBT has been shown to be at least as effective in the treatment of depression as pharmacotherapy and, if anything, the effects of CBT may be longer lasting (DeRubeis, Seigle, & Hollon, 2008).

Assessment and Eligibility for Group CBT in Unipolar Depression

A thorough description of diagnostic and assessment issues in depression is beyond the scope of this chapter—however, diagnostic screening is recommended prior to group CBT. Given the heterogeneity of depression, current diagnostic dilemmas, and comorbidity rates, it is important to assess carefully for not only the mood disorder of interest but also other presenting problems. Various clinical settings and clinicians make different decisions about the inclusion of a range of comorbidity—that is, some clinicians elect to treat clients with only certain presentations of depression and not others—for example, where depression is a "result" of some other condition. The reasoning for such exclusions is the idea that CBT might be less helpful where depression has a "root" in some other problem (e.g., as a result of a cancer diagnosis and treatment). In any case, problems are more likely to arise in situations in which diagnostic screening has not been of sufficient depth or breadth, and comorbidity has gone undetected in screening. Once clients are enrolled in a group, the presence of comorbidity often becomes very apparent in both process and application of techniques. Decisions about how to handle this comorbidity are best made before the group starts rather than post hoc. In the instance of previously undetected comorbidity, therapists must all too quickly decide whether and how to alter the group agenda and structure to address this problem. Unfortunately, there is almost no empirical guidance on this question—there is no doubt that CBT for depression is a powerful treatment, but where the limits of its power lie is a source of debate and clinical judgment. Decisions about denying this care for individuals need to be made with humility, and it is likely best to err on the side of inclusion rather than exclusion.

Assessing Treatment Outcome

As in individual CBT, the focus of treatment is certainly not only symptoms but also function and reducing vulnerability to future depressive episodes. The assessment of symptoms can be accomplished by a variety of measures—though, for the sake of efficiency, a self-report scale is likely to

be preferred. Perhaps the most commonly used scale for the assessment of depression severity is the revised Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996). The BDI is simple to administer and relatively short (21 items taking 5–10 minutes), and at the same time accurately assesses a variety of important domains. Typically, clients are provided with a BDI as they arrive at the group session. The scale can usually be completed while other members arrive, before the start of the group itself. Obviously, a self-report scale that takes a short time has many strengths compared to clinician ratings or assessments that could take up important group time. The BDI also has the advantage of having a specific item concerning suicidality (Item 9). Clinicians reviewing the scales (often this would be the cotherapist, while the therapist leads the group) not only can determine overall severity but can also readily recognize any increases in suicidality or hopelessness. Also, the meaning of scores and ranges of scores can be discussed with clients. It is also possible to "plot" scores on a chart, allowing participants to see the pattern of their scores over time. This pattern of scores and changes in symptoms likely also form a component of the formal documentation for group members in progress notes or discharge summaries. Finally, the BDI scores can be meaningful for structure and process of the group. Participants whose scores decrease substantially may well be a focus for discussing successful applications of techniques that have been learned. At the same time, participants whose scores have increased can also be a focus in order to better understand why symptoms have increased and what techniques may be useful to control their symptoms more effectively.

The BDI is of course one example of a symptom measure and there are certainly others with similar virtues that could be used; the main criteria for choosing a measure are evidence of reliability and validity, relatively brief so as not to take inordinate time weekly, and self-report rather than clinician rated. There are numerous other measures that can be informative for a clinician to monitor changes in a client's progression throughout treatment, such as functional impairment, quality of life, or illness intrusiveness. Indeed, the universe of measures of depression is large enough that the therapists will have many choices to suit their needs and clinical settings (Nezu, Ronan, Meadows, & McClure, 2000).

Structuring Group CBT for Unipolar Depression

Number of Participants

Importantly, there are few data on optimal group size in CBT for depression. However, although some group process factors might be expected to change with the size of the group, one meta-analysis describes no effect of group size (ranging from 5 to 13 members) on the overall effect of treatment (Cuijpers et al., 2008). The advantage of a somewhat smaller number, up to perhaps seven participants, is that it is often possible to work on

one example with all individuals in each group session. This removes the need to determine, for clinical, technique, and process reasons, which individual's examples, or which individual, should be the focus during session. However, as the number of individuals in a group decreases, efficiency of the group approach also decreases. Thus, more typical sizes for a depression group may well be 10–12 members. In larger groups, issues may arise, such as insufficient time to work effectively with each member, lack of cohesion stemming from disproportionate time to speak and share, and difficulty drawing out members struggling with techniques or those with social phobia. In smaller groups, there is more time to foster discussion for the sake of cohesion and to ensure that each individual understands and can implement the techniques that have been taught.

Another important principle is to ensure that group members receive the same amount of attention from therapists. It is not unusual for some group members to volunteer examples consistently or even draw the attention of the group to themselves consistently across sessions. This may be because these individuals are experiencing fewer symptoms and are eager to describe their successes. Focusing on members who are pleased to volunteer their examples can often be the path of least resistance for therapists too, especially if these individuals understand and use the techniques, and other group members seem reticent to put forward their own examples. Although focusing on successfully implemented techniques can be important, it is equally important to ensure that all group participants have the opportunity to have the therapists and the group focus on them. Otherwise, the group risks having some members who understand and use the techniques, and others who may not understand the strategies or feel a sense of belonging to the group. Ensuring equal attention to all members may require being more direct with participants, but it is often the only way to involve group members who are more severely depressed and withdrawn.

Structure of Group Sessions

In depression, closed groups have been the norm. The group is typically led by two therapists: either one primary leader and a coleader, or two coleaders. The latter approach is suggested only when therapists have previously worked together and have a strong sense of how to divide the material evenly, and whose central message is highly consistent. A primary leader and coleader format is often preferable for clarity, in that one person is primarily responsible for the delivery of techniques and leading the process, and the other therapist contributes in a planned way. The coleader, having fewer moment-to-moment responsibilities in the group, can also often observe client and process factors, and point these out to the leader as needed. We suggest a 2-hour session length, because it can often take extra time to start the group, and this length allows more opportunities to include as many individuals as possible in the discussion and examples.

Each group session starts with a review of each person's experiences over the past week. This needs to be done efficiently to keep the session on track. Areas to be covered for each person should include symptom severity, use of techniques (or homework), and any other relevant life events. This is useful both for therapists and for other group members to understand what has occurred in the individual's life in the intervening interval. As in individual sessions, both the content and affect of these summaries are important for determining the nature of the agenda and relevant examples. For example, a number of group members may describe problems doing or understanding the homework. This may be an indication that therapists need to review more and confirm group members' understanding before introducing new material.

The next component of the session involves a description of the previous week's content and how this relates to the planned agenda. It is important to offer opportunities for group members to ask questions at this point, and this bridging between sessions should not be rushed or cursory. Next, the agenda should formally be set—it is preferable to record this on a flip chart or whiteboard for the group to follow visually. This can also be the time to decide which group members' examples, and in what order, should be the focus of the session. Again, there should be explicit time set aside to ask whether group members have items to add to the agenda—these need to be triaged carefully by the therapists. A large component of the "art" of group leadership is balancing new material to be learned, while also attending to the needs of group members to facilitate cohesion. Too much emphasis on either side of this balance is undesirable; in the former instance, the group may become too much like a "course" or lecture, because members do not feel an affective or interpersonal connection between themselves and the material. In the latter instance, not moving forward with the learning of techniques and skills can result in a group that is stuck on disclosure and affect processing rather than changing problems by applying techniques.

The group next proceeds through the agenda, ideally in the planned order. During this component of the work, therapists need to be acutely aware of their time management. This involves a strong sense of the direction of the group, how much time can be spent on examples, and what is left to cover. As in individual treatment, frequent summaries should be offered by the therapists to consolidate learning. Finally, near the end of the session, therapists must manage one of the most important transitions, setting the stage for homework that is clear, understandable, and related to group members' affective experiences. The single most important factor in accomplishing this is to leave sufficient time for discussion and dissemination of the homework plan. Often, due to time constraints, work on examples can threaten to make homework assignment an afterthought as the group draws to a close. As a result, therapists may not have sufficient time to explain the nature of the homework and its relationship to the session. Similarly, group members may not have time to ask questions

about the homework, and any uncertainty very often leads to compliance problems. Ironically, this can lead to a more in-depth discussion of the previous week's homework tasks at the start of the next session—a discussion that should have occurred in the previous session but did not because time had run out! As a general guide, the last example of the day should be completed with at least 10 minutes of group time left to transition into the homework discussion. This not only allows time for questions and answers but it also emphasizes the central importance of the homework to therapy and group members' progress toward their goals.

Overview of CBT Strategies in Unipolar Depression

The 17-session protocol described here (see Table 9.1) was derived from a combination of sources, including Beck and colleagues' (1979) seminal reference and Greenberger and Padesky's (2016) *Mind over Mood,* which is recommended to clients as a companion manual for this group. This protocol consists of 14 weekly sessions based on a linear approach to teaching the various behavioral and cognitive strategies. Sessions 15 and 16 follow, with 2-week intervals between each session. These sessions are also more open-ended in terms of agenda and techniques based on group needs. The final session, a month after Sessions 15 and 16, is designed to introduce the concept of relapse and relapse prevention. As an option, booster sessions may continue once every 2 months or at monthly intervals, with a focus on retention of gains and relapse prevention. Although other CBT protocols and forms of cognitive restructuring exist, the Beck model for CBT appears to show the greatest treatment effects (Cuijpers et al., 2013). The National Institute for Health and Care Excellence (2018) clinical guidelines for the treatment of depression generally recommend a CBT group run by two health care professionals, with a group size of eight to 10 people, and 10–12 sessions covered over 12–16 weeks, but no recommendation is made as to the specific protocol to be applied.

Next, we review in greater depth some of the unique features of an effective group protocol in the treatment of depression. We focus not only on technique factors in each session but also on some of the more common process issues that arise in this protocol for depression.

Key Treatment Components of Group CBT for Unipolar Depression

Behavioral Techniques

A prominent feature of clients with depression is the withdrawal from many activities, which can result in future tasks, including treatment, seeming like a chore; impoverished expression of affect is typical. Because

TABLE 9.1. Sample Outline of Treatment Protocol for Group CBT for Depression

Session	Strategies covered
Session 1	• Introduce therapists and group members. • Group "rules." 1. Confidentiality. 2. Check-in and rating scales. 3. Homework. 4. Missing appointments. • Introduce the CBT approach to depression. 1. Behavioral interventions. 2. Cognitive interventions. • Describe the biopsychosocial model of depression and introducing the five components. 1. Behavior. 2. Thoughts. 3. Emotions. 4. Biology. • 5. Environment. • Homework: Complete biopsychosocial model and purchase companion manual.
Session 2	• Goal setting. 1. Eliciting goals from patients. 2. Specifying behavioral changes to meet goals. 3. How to track goals and monitor progress. • Outline relationship between mood state and behavior. • Introduce mood/emotion rating system. • Demonstrate relationship between activities and mood (i.e., what activities improve mood, what activities worsen mood). • Homework: Complete activity schedule with activities and mood ratings.
Session 3	• Behavioral interventions: Modifying activities to improve mood. 1. Introduce the concepts of mastery (sense of accomplishment) and pleasure, using examples from the past to illustrate these types of activities. 2. Focus on adding mastery and pleasure activities to establish balance of reinforcement. • Homework: Complete activity schedule with new activities added in and rate mood.
Session 4	• Examine outcome of behavioral modifications and adjust where needed. • Identify "mood shifts" to target with cognitive interventions. • Label and rate emotion(s) experienced in difficult situations from examples. • Homework: First two columns of dysfunctional thought record (DTR; situation and emotion) to be completed.
Session 5	• Review examples of thought records: Situation description and emotion identification. • Describe interpretation and "self-talk" as the link between situation and emotion, using client examples. • Automatic and "hot thoughts": Focusing on the thought most related to the emotion. • Homework: First three columns of the DTR, and identifying hot thoughts.

(continued)

TABLE 9.1. *(continued)*

Session	Strategies covered
Session 6	• Review examples from thought records: situation, mood, and thoughts description. • Identify hot thoughts in the examples. • Introduce the evidence technique, finding evidence "for" the hot thought. • Evaluate evidence that is "for" the hot thoughts. • Homework: First four columns of the DTR (adding evidence "for" the hot thought).
Session 7	• Review examples from thought records: situation, mood, thoughts, and evidence "for" the hot thought. • Introduce evidence "against" by asking questions to bring out new facts that do not support the hot thought. • Use patient examples to illustrate questioning to elicit evidence for and against automatic thoughts. • Homework: First five columns of the DTR (adding evidence "against" the hot thought).
Session 8	• Introduce the "thought distortion" list to illustrate that biases in thinking may occur systematically. • Illustrate examples of cognitive errors in examples recorded. • Homework: First five columns of the DTR and identifying the distortion.
Session 9	• Introduce "alternative thoughts," including how to write them. • Troubleshoot alternative thoughts, including ignoring evidence, misspecification of the hot thought, activation of core belief. • Homework: Complete DTR (adding alternative thought and mood rerating).
Session 10	• Review thought record examples in which insufficient information exists to draw a conclusion. • Introduce experiments: When there is insufficient evidence to draw a conclusion and more information is needed, devise a way to collect that information. • Create an experiment that is consistent with a client example. • Homework: Execute the experiment and monitor the outcome.
Session 11	• Review thought records that identify a problem that needs to be solved. • Introduce problem-solving strategies when the evidence suggests a problem that needs to be resolved. • Use a group member's examples to create a problem-solving plan. • Homework: Complete the problem-solving task.
Session 12	• Introduce "deep cognition"; concepts of conditional assumptions and core beliefs. • Illustrate deep cognition using the "downward-arrow" technique. • Describe downward arrow as used for conditional assumptions about self, others, and the world. • Homework: Complete a downward arrow exercise.
Session 13	• Explain the connection between conditional assumptions and core beliefs. • Illustrate the "continuum" model of core beliefs and emphasize prospective techniques to change core beliefs.

(continued)

TABLE 9.1. *(continued)*

Session	Strategies covered
Session 13 *(continued)*	• Describe evidence gathering, experiments, and problem-solving plans for changing typical patterns of coping and collecting information to support alternative core beliefs. • Homework: Generate a continuum of core beliefs and keep track of evidence concerning alternative core belief.
Session 14	• Introduce coping strategies associated with core beliefs. • Use client examples to illustrate the potential self-defeating nature of coping strategies. • Propose alternative coping strategies for clients. • Homework: Implement alternative coping strategies and monitor outcome of the alternatives.
Session 15	• Biweekly booster session to integrate and implement skills learned, as directed by clients.
Session 16	• Biweekly booster session to integrate and implement skills learned, as directed by clients.
Session 17	• Introduce the concepts of lapse and relapse. • Introduce strategies for dealing with lapse and relapse. • Plan client-specific strategies for coping in relapse. • Wrap-up.

of this "behavioral profile" in depression, CBT usually begins with strategies related to behavioral activation. In the protocol, Sessions 2, 3, and a portion of Session 4 address these issues. In Session 2, clients are oriented to the notion of goals, typically translated into behavioral terms, and the steps necessary to reach those goals. This counters hopelessness and helplessness, and specifies how to move toward reasonable. More formal activation begins by having clients monitor, or record, their daily activities (hour for hour) and rate their mood for each waking hour of the day; this information is processed in Session 3. This is perhaps the most accurate and comprehensive way to understand the client's level of functioning, and it provides an excellent "snapshot" of the person's life. Also, having clients monitor their usual activities is a quite involving, straightforward assignment that helps to socialize them to the CBT model of homework early in the sessions.

The next phase in behavioral activation, again in Session 3, is to identify the extent of the death of activity and the imbalance of mastery and pleasurable activities across group members. This is followed by an explanation of the notions of mastery and pleasure (or work and play) to the group, and an explanation that a balance in the perception of these must be in place to achieve satisfaction and happiness. The therapists also explain to the group how the onset of depression can lead to withdrawing

from events and activities that actually may improve mood and energy level. The group members are likely to be able to offer many ready examples, and are encouraged to comment on one another's monitoring homework. Along with this, the group therapists can point to times in the course of the week when a group member was active, and their mood was improved. It may be useful to use metaphors, such as the "battery" metaphor, which describes a typical, depressive way of viewing one's energy level. One wakes with a certain level of energy that gets used up by activities and is then depleted. It is always helpful to demonstrate, with group examples, that humans fit much more closely with a "generator" model than a "battery." In other words, engaging in activities draws out more energy that is replenished—for example, by eating and drinking. Only a "generator" metaphor can explain the finding that vigorous exercise results in greater alertness and energy when it is completed.

As a result of this rationale, group members are encouraged to "experiment" with their level of activity, and are asked to introduce new activities in what is termed a "graded task assignment." There are a number of ways to identify activities that might be rewarding, and therapists should have group members contribute to one another's list of potential new behaviors to implement. The most commonly used strategies involve asking about past activities, hobbies, and pastimes that were once enjoyable. Often, even when a group member identifies potentially reinforcing behaviors from the past, it has been a long time since the person engaged in those activities. This is probably a result of the depressed person's pessimism ("This won't make me feel better") and is an excellent opportunity to reinforce the need to always test one's predictions by actually engaging in the behavior. Another strategy is to ask what kinds of things the person has always wanted to try, without ever having had the opportunity to do so. Group members can learn from this experience not only about the commonalities in pleasurable events but also marked differences in what can be rewarding to one person versus another. This typically reinforces more divergent, creative thinking, allowing all group members to think more broadly and with less self-censoring, pessimism, or criticism of themselves.

Indeed, as much as possible, it is desirable to allow group members to work with one another to plan events. This facilitates group cohesion, less self-focus, and efficacy in members who are helping one another. A third alternative for adding behaviors is for the group to examine and discuss the pleasant events list (e.g., MacPhillamy & Lewinsohn, 1982), which contains hundreds of pleasant activities from which to choose. Reviewing this list can also be a component of homework.

Adding such activities not only raises clients' energy levels, but also increases self-confidence from having accomplished more in their daily lives. Group discussion of planned activities—the homework for Session 3—is also useful for fostering motivation between group members.

Feedback about the outcome of these behaviors is elicited in the first portion of Session 4. Here, too, ample time should be provided for group members to discuss their "findings." Important questions to seed group discussion include "How did things turn out?"; "Was the response they got from [themselves, others] what they predicted?"; "What lesson do they learn about depression from this exercise?"; and "What are the implications of this outcome for the immediate and long-term future?" The goal by the end of the behavioral activation section is for group members to mutually reinforce attempts to change depressive behavioral habits and more actively cope with their illness. As in individual treatment, the increase in group members' physical energy and perceptions of self-efficacy become very useful when the group therapists begin working on the depressive cognitions. This part of treatment also sets the stage for group members to offer one another supportive, encouraging, but also probing, feedback. Critically, the behavioral activation aspect of the treatment provides a prototype for positive and collaborative group process prior to working through the more affectively laden, usually very private aspects of the treatment protocol, such as core beliefs.

Cognitive Techniques for Automatic Thoughts

Overview

In clients with depression, thinking reflects the "cognitive triad." Clients have a preponderance of highly salient, negative thoughts and beliefs about themselves, others, and the world (Beck et al., 1979). Since this model of depression was put forward, literally hundreds of carefully controlled studies have been conducted to test its every aspect. Overall, the research evidence points to strong support for these ideas (Clark et al., 1999), which are now also reinforced with neurobiological evidence (Disner, Beevers, Haigh, & Beck, 2011).

Clinically, when clients with depression describe their thoughts, the content of these cognitions is likely to be pervasively pessimistic and negative, especially in response to any problematic or even ambiguous events. When the person with depression encounters a positive event, they are likely to see it as a chance occurrence or a passing event. This cognitive error is usually described clinically as "minimizing" and is also intimately related to the attributional style associated with depression. As a general guide, one theme of cognitive strategies in the protocol is that group leaders, and in time other group members, point out minimizing when it occurs, so that group members pay greater attention to positive events.

The person with depression may also deny responsibility for the good outcome, seeing the positive event as being related to outside factors, such as luck or the result of other people's doing. The aim of the group, then, is to help the client evaluate more accurately where the responsibility for

positive events truly lies. Alternatively, when encountering a negative event, the client sees him- or herself as 100% responsible for the negative outcome, when in fact that outcome may have been due to outside factors. These factors are unlikely to occur to the client with depression who is affected by the event—however, with very basic modeling of Socratic dialogue, group members become much more likely to ask one another these critical questions.

Specific Cognitive Strategies

The group protocol described here involves many of the strategies described in Chapter 3, including the thought record, experiments, problem solving, and the conditional and core beliefs exercise. We focus here on specific applications of these techniques in depression.

An initial point of departure is for clients in the group to begin to monitor their thoughts. The first discussions of "thoughts" occur around specific mood shifts that have been identified by clients following Greenberger and Padesky (2016) in Session 4. By Session 5, group members have completed the first three columns (situation, mood, thought) of a seven-column thought record (Greenberger & Padesky, 2016) for discussion. This represents a critical foray by group members into an examination of their own and others' thought content. Whereas concepts such as collaborative empiricism and Socratic dialogue have components of the behavioral interventions described previously, these now occur at another level for cognitive strategies. Through specific didactic discussion, but just as important, through modeling, group leaders can emphasize the necessary questions that reveal the nature of the thoughts underlying negative emotions.

During initial discussions of thought content, it is important to consider that this is likely the first time that group members have explored the true nature of their negative thoughts. Even more important, they are doing so in the context of a group, and are thus disclosing very private, emotionally laden, and possibly frightening material (e.g., suicidal thoughts or ideas). Thus, the protocol allows considerable time, perhaps an entire session, for the elicitation of thoughts before moving into disputation and evidence gathering. It is important to emphasize to group members their shared experience of negative thoughts, and the universality of this experience in depression. Another important reason to spend time simply eliciting automatic thoughts is to communicate the need to identify the most salient "hot thought" around which evidence gathering or disputation will occur. It may be useful for therapists to emphasize, as they would in individual therapy, that recording and discussing negative thoughts could well lead to more feelings of depression initially. The need to specify the nature of negative thoughts as the first step to reducing their impact may need to be discussed several times in Sessions 4 and 5.

As discussion of cognitive strategies continues, group interaction becomes steadily more important, especially as therapy progresses toward examining the veracity of thoughts. The protocol focuses on four major themes for exploring the basis of thoughts: evidence gathering (Sessions 6 and 7); labeling of distortions (Session 8); experiments (Session 10); and problem solving, when there is some truth to a negative thought (Session 11). Teaching these techniques should ideally be highly interactive, with group members often questioning one another, pointing out alternative viewpoints to a cognitive distortion or potential ways around a real obstacle in problem solving, or offering feedback that forms the backbone of an experiment. During these sessions, the therapist has four main tasks whose goal is keeping the discussion focused on topic.

First, the group leader needs to determine which examples will be chosen for group work. Here, a straightforward example is often the most useful teaching aid, unless illustrating the role of deeper beliefs in negative thoughts is the goal, in which case, a more complex thought record can be chosen. Also, some thought records or experiments are more salient to group members than others because of shared experiences. For example, thought records that involve themes of loss, inadequacy, or unlovability are likely to be relevant to almost all group members. Finally, therapists must determine how well thought records and other tasks are being completed. Struggling participants may benefit from discussing examples with the group, but this can take more time to work through.

The second task during the sessions on negative thoughts is for group leaders to "seed" questions that stimulate a Socratic dialogue. Once therapists have modeled questions or applied different distortions to several examples, it is preferable to ask group members to begin any example with questions that occur to them. Practically, the therapist might record the example on a whiteboard or flip chart, and then ask the group, "What questions do people think we should ask about this [thought, experiment, problem]?" Occasionally, group leaders may need to shape discussions to lead group members to uncover areas the therapist thinks are important. The group dialogue that occurs around thought records is one of the most critical and productive phases of therapy. As group members question one another, they are also learning how to question their own thoughts. Moreover, it is not unusual for group members to ask questions of one another that the therapists might not have thought of—this is the benefit of having many people considering the same problem at once, each with their unique perspective.

The third task during this part of the protocol is to ensure that the group dialogue stays productive in terms of the techniques being taught. For example, one group member may provide evidence or an observation for another, rather than asking a question. This can be effective in a limited way—that is, the person whose example is being discussed might shift their perspective. However, there is an obvious benefit to creating

collaborative empiricism among group members as opposed to having group members simply reassure one another. Therapists need to help group members stay focused on the Socratic questioning approach by continuing to emphasize its benefits.

Finally, as always, group leaders need to manage time and the agenda carefully during these sessions. It can be all too easy to spend a great deal of time on one or two examples rather than working through the four or five examples on the agenda. Therapists need to be attuned to making solid progress on examples rather than working them through to completion in every instance. If a member's example requires more work than the group can provide in any single session, then this can form part of the homework for that group member.

Cognitive Techniques for Beliefs

In depression, the cognitive model suggests that deeply held core beliefs lead to other levels of cognition, including automatic thoughts. Session 12 introduces this concept to the group and marks a return to more didactic work to explain the connection between the readily observable "automatic thought," early life events, and "deep" levels of cognition. The therapist can usually effectively communicate this through an example, possibly focusing on a generic case before moving to group members' examples.

The first of numerous techniques related to deep cognition is the downward arrow. This approach, rather than examining what evidence exists for automatic thoughts, explores the meaning and possible early origins of automatic thoughts (see also Chapter 3). In Session 12, the construct of conditional assumptions, or affectively laden evaluative rules clients have for themselves and others, is also described. Session 13 focuses on core beliefs and early learning, and the therapist works with group members to create a narrative of how they learned their various core beliefs and assumptions. Sessions 13 and 14 also focus on long-term change strategies that can be implemented to help group members move away from rigid, self-defeating rules, and offer an alternative set of rules toward which to work.

Discussion of "deep cognition" can often lead to higher levels of affect than almost any other phase of therapy. Therapists can emphasize that changes in these areas may take some time, usually well beyond the time needed to conclude the therapy sessions and that identification of these beliefs is truly the most important step toward moving past them. For example, in Sessions 13–16, group members can be asked to rate their degree of belief in both the old belief and the new core beliefs or conditional assumptions. Group members are also encouraged to gather both new and historical information that supports the new, alternative belief.

Sessions 15 and 16 similarly have no specific preplanned agenda. However, a group-driven agenda should be made to review techniques

that group members nominate as helpful or for which "refresher" practice may be useful. Time should be provided throughout for implementing exercises (e.g., downward arrow), positive events logs, or core belief worksheets.

The final session is used to discuss relapse and to prepare group members for times when their mood might become worse. It is important to emphasize that some negative affect is a part of living, particularly in response to stressors. Strategies to reduce negative affect that have been learned in the group should be revisited and summarized. At the same time, the notion of relapse needs to be emphasized, so that group members seek proper follow-up should they suffer a relapse. It is therefore important to describe the criteria and signs of a developing clinical depression. It may also be useful to describe possibilities for relapse prevention, such as mindfulness-based cognitive therapy (MBCT; Segal et al., 2013) or self-help relapse approaches (Bieling & Antony, 2003).

Group Process Factors in CBT for Unipolar Depression

Prior to the development of the cognitive model of treatment, conventional clinical wisdom suggested that a group modality was contraindicated in depression (Hollon & Shaw, 1979). This was based on the twin premises that the needs of clients with depression exceeded what could be offered in a group, and that the group process would contribute to a negative spiral of unfavorable self-comparisons and displays of pessimism and hopelessness about the possibility for change. During their initial explorations of a group CBT approach, Hollon and Shaw suggested that these factors would be less of an issue in a homogeneous group of clients with depression than in a heterogeneous group that included only some clients with depression—that is, previous accounts of group process tended to consider the impact of only one or two individuals who were very depressed within a group of higher-functioning, less-impaired individuals. However, the more compelling question was what would happen in a setting in which all of the clients suffered from depression? Would depression in a group setting cause a spiraling depressive process?

The ensuing years and experience with CBT groups for depression suggest that, in the main, group process does not result in clients becoming worse, nor do group members with depression typically "act" in a stereotypically depressed way. Indeed, the efficacy of group CBT approaches is testimony that the dire predictions of increasing pessimism and hopelessness are unfounded. At the same time, when process problems do occur in depression, hopelessness, pessimism, and social comparison are often the culprits.

Ideally, the response to pessimism and hopelessness is a combination of empathy, encouragement, and also persistence. Indeed, this happens almost naturally in most groups. Earlier writers may well have underestimated the capacity for empathy and understanding that most people with depression have for others, especially fellow sufferers. For example, in the case of pessimism about the usefulness of pleasant activities, an ideal and quite typical response is for other group members to empathize with the client who is pessimistic, perhaps by relating times when they have been pessimistic themselves, and possibly with guidance modeled by group leaders. To conclude the example, group leaders would then need to carefully leverage this empathy and support with gentle persistence about at least attempting the pleasant event before drawing conclusions about whether it is worthwhile. This fairly simple approach—empathy, understanding, and support, followed by a change strategy—is a critical tool for dealing with other "depressogenic" group processes, including social comparison, rejection of help, and even suicidal or self-harm ideation. In each instance, the group must acknowledge the validity of the person's feelings and thoughts, yet also communicate that change, even from this difficult position, is not only possible but also has happened for others.

There are few, but not insignificant, instances in which specific members of a group do have needs that exceed the capacity of the group. Clients with serious suicidal ideation and intent, and those whose concentration and ability to understand the material falls well below the group average, may need to be seen individually. Many times, pessimistic behaviors change over the course of sessions, and such progress can provide important examples of overcoming obstacles and typically end up increasing cohesion. Only if group members consistently demonstrate a lack of understanding or interest in the group process should other treatment options be considered. A rigorous screening process, described earlier in this chapter, also contributes to minimizing the number of clients who might need an alternative approach.

Just as the capacity of individuals with depression to support one another is often underestimated, so too is the ability of clients with depression to note "depressive" cognitive distortions and biased thinking in others. In a number of ways, this notable capacity is not surprising. In individual CBT, a common approach in having people question their thoughts is the general strategy of "perspective shift," in which a therapist asks the client to consider how they would respond to a friend who had negative thoughts, or what friends would say if they shared these thoughts. In group treatment, having other people offer fresh perspectives is integral to nearly all cognitive interventions, and it is an important form of sharing and mutual support for members to ask questions about one another's thoughts and even point out alternative perspectives. At the same time, some group members may tend to focus on offering others new perspectives or to note

others' distortions without recognizing their own! Thus, an important part of group process in depression is, ironically, to ensure that participants focus on the ability to question their own thoughts as incisively as they help others to question theirs. Whenever one client uses a questioning strategy to help someone else, it can be useful for therapists to reflect those questions back to determine whether the group member is learning to question their own negative thoughts and assumptions.

Cognitive and Behavioral Features of Bipolar Disorder

In the next section of this chapter, we turn our attention to CBT groups for bipolar disorder. For decades, bipolar disorder has been understood and treated through an exclusively biological lens. Indeed, based on heritability and the necessity of mood-stabilizing medications to achieve even a modicum of recovery, psychosocial interventions have tended to be overlooked, or at the very least understudied, in bipolar disorder. Nonetheless, the past decade has seen a number of developments in psychosocial therapies for this disorder, including a growing body of work advocating CBT as an important and effective adjunct to pharmacotherapy conferring benefits such as improvements in depression and mania, increased psychosocial functioning, and reduced relapse rates (e.g., Chiang et al., 2017; Hofman et al., 2012). So while it is clear that bipolar disorder is a distinct entity from unipolar depression, much of the foregoing discussion about group CBT for depression is highly relevant and frankly something of a "prerequisite" for CBT in bipolar disorder. In this next section, we seek to highlight some of the unique aspects of using CBT for bipolar disorder, though the astute reader will note in the sample protocol, something approaching 70–80% of the content is the same.

Assessment and Diagnosis

The official criteria for a formal diagnosis of bipolar disorder are found in DSM-5-TR. Fundamentally, bipolar disorder involves a combination of major depressive episodes and shorter, marked elevations in mood and energy called manias and hypomanias. The symptoms that an individual experiences for depression in bipolar disorder are identical to those for MDD, described above. Manic or hypomanic episodes can be seen as the opposite pole (hence, the term "bipolar") of mood, energy, and behavior. However, such episodes go beyond feeling "good." There may be elation and positive affect, certainly—however, often there is also irritability and an admixture of depressive symptoms superimposed on a higher level of driven energy that the affected person cannot control.

Evidence-Based Treatment for Bipolar Disorder

The application of CBT to bipolar disorder is actually relatively recent when compared to treatments for depression and anxiety disorders. This is understandable when considering the centrality of biological treatments, mainly mood stabilizers, for the management of bipolar disorder. Thus, management of bipolar disorder was largely left within psychiatric settings using a completely medical model that called for somatic treatments only. However, it is clear now that supplying a prescription and clinical management of mood stabilizers is simply not sufficient to meet criteria for the best possible care. Indeed, other factors, including client and family education about the nature and treatment of the illness, and formation of a strong collaborative alliance between the client and the treatment team, are now viewed as critical ingredients in effective treatment (Basco & Rush, 1996, 2007). These developments helped to kindle further interest in dedicated, specific treatments that could serve as a useful adjunct not only to control symptoms but also to help clients to live more satisfying and productive lives.

A number of specific issues are a priority in the treatment of bipolar disorder. Perhaps the most vexing problem is noncompliance with medication. Most studies report nonadherence rates from 20 to 50%, with some reporting between 6 and 70% (Chakrabarti, 2016). This has a tremendous impact, because taking this medication not only reduces symptoms during episodes but also has a prophylactic effect (Basco & Rush, 1996, 2007). Clients who stay on mood stabilizers are less likely to have repeated mood and mania/hypomania episodes. Thus, management of bipolar disorders and CBT for bipolar disorders explicitly includes interventions designed to educate the client and address, very directly, the notion of medication compliance and obstacles to compliance.

A second area that is distinctive and unique to bipolar disorder is the use of CBT to help orient the client, early in the cycle, to any shifting between depression and manic mood states. Transitions from the depressed phase of the illness to the manic phase can sometimes be rapid, and it is important for clients to bring the shift to the attention of the treatment team so that decisions can be made about how to manage such a shift. For example, the start of a depressive episode might require adjustment of an antidepressant medication or mood stabilizer. Similarly, a shift in the direction of mania could trigger treatment decisions that will help to reduce the possibility of self-defeating behaviors. As an example, many clients with bipolar disorder with a history of impulsive, excessive spending may want to consider, with the aid of their treatment team, means to curtail their spending ability by surrendering credit cards or access to bank accounts when they are vulnerable to mania. Clients are unlikely to be able to follow such plans during a full-blown manic episode—thus, early detection and management of mood cycles is a priority. CBT protocols teach clients the

skills to better manage the early stages of mania and depression, with a view toward modulating the "amplitude" of swings to either extreme.

The cognitive model of bipolar disorder suggests that manic and hypomanic phases of illness are associated with content that is diametrically opposite the cognitive "pole" of major depression along the same content dimension (Schwannauer, 2004). Thus, the same schema, for example, "worth," will be activated in both depressions and manias—however, the valence of that schema will be radically different. During normal moods, such a schema may function at a healthy midpoint; in manias, the schema is positively biased, and in depressions, negatively biased. The cognitive model integrates biologically determined activation of these modes, as well as external triggers (Beck, 1996). But consistent with the general cognitive approach, the model for bipolar disorder also suggests that the kinds of external events that trigger mode activation differ between individuals. For example, a promotion at work may initiate hypomania in one affected individual, whereas in another, such an episode is triggered by a new romantic relationship, an observation consistent with available data (Schwannauer, 2004). Thus, as in unipolar depression, much depends not only on events but also the affected individual's beliefs and idiosyncratic schemas. Once this manic pole of the motivational and affective subsystems is activated, the person sees the triad of self, world, and future in glowing, positive, and very unrealistic terms (Scott, 2001). This extremely positive cognitive processing is believed to be associated with individuals' consequent behavioral choices because of their belief in themselves as omnipotent, and in the future as limitless in the context of a world of infinite opportunities. These unrealistic thoughts and beliefs, especially when identified early in a mood cycle episode, can be subjected to cognitive techniques involving reality testing and consideration of multiple perspectives.

Because external stressors play an important role in episodes of both depression and mania/hypomania (Aldinger & Schulze, 2017; Gershon, Johnson, & Miller, 2013), reducing the frequency and intensity of such difficulties is also an important goal. Here, classical CBT strategies can be used in conjunction with problem solving—where stressors and daily hassles can be reduced, detected early, or defused with problem solving, the client is likely to have a greater overall level of stability. Moreover, there is evidence that during the depressed phase of bipolar disorder, the cognitive "profile" of thoughts is similar to unipolar depression in terms of content and structure (Clark et al., 1999; Rose, Abramson, Hodulik, Halberstadt, & Leff, 1994). Cognitive vulnerability to depression appears to be similar in unipolar and bipolar mood disorders as well (Scott, Stanton, Garland, & Ferrier, 2000). Thus, techniques used in unipolar depression that help individuals to monitor and evaluate their thoughts and beliefs have also been adapted to bipolar disorder. Indeed, the sections on treatment protocols in bipolar disorder for the depressive phase of illness are largely identical to those for unipolar depression, with some additions that are described in the subsequent protocol.

Evidence for CBT and Group CBT in Bipolar Disorder

The first formal description of individual CBT for bipolar disorder was published in 1996, preceded by a number of case reports that cited promising outcomes when CBT was used as an adjunct treatment (cf. Scott, 2001). To date, there persists a paucity of large-scale randomized controlled trials (RCTs) for group CBT in bipolar disorder, but reviews tend to show generally positive results compared to TAU (Chiang et al., 2017; Lam, Burbeck, Wright, & Pilling, 2009; Swartz & Swanson, 2014). The most commonly reported effects across systematic reviews are the prevention or delay of relapse, and a decrease in depressive symptoms, with improvements in mania reported more rarely. Importantly, all studies tend to note that stabilization of and adherence to medication is essential for these outcomes, and while neither pharmacotherapy nor CBT appears to be adequate for treatment-resistant depression, the combination of both may be an effective strategy.

Assessment and Eligibility for Group CBT in Bipolar Disorder

Because of the significant heterogeneity of bipolar illness and the nature of "spectrum" bipolar disorders, a thorough diagnostic assessment should be carried out prior to considering group CBT. Even with very structured assessment approaches, it may be difficult to distinguish between bipolar and more characterological presentations of mood cycling. Perhaps most important is the differentiation between bipolar disorder and borderline personality disorder (BPD), which can also co-occur (Bieling & MacQueen, 2004), yet have different psychological implications. A bipolar group that includes clients with BPD plus comorbid bipolar disorder and clients with bipolar disorder only will have unpredictable and likely unproductive group dynamics and should be avoided. Treatment of clients with bipolar disorder begins with obtaining a thorough history and planning a pharmacotherapy regimen aimed at achieving some stability in mood. This is then followed by considering the client's other psychosocial treatment needs and any need to improve functioning and quality of life. It is at this point, when diagnosis is well-known, that placement in a CBT group should be considered.

Clients with bipolar type I and type II disorder appear, given extant data, to have equally good potential as candidates for CBT. More challenging decisions occur when a given client also meets criteria for another disorder, whether an Axis I or Axis II condition. Reviews suggest that comorbidity rates for bipolar and Axis II disorders are in the range of 30.0–50.0%, with the most frequent diagnoses being obsessive–compulsive, histrionic, and BPD (Bieling & MacQueen, 2004; Post et al., 2018), with a higher percentage of diagnoses being obtained when clients were depressed compared

to those who were euthymic (Post et al., 2018). The World Mental Health Survey Initiative (Merikangas et al., 2011) also reported high levels of Axis I conditions, with anxiety disorders being the most frequent (76.5 and 74.6% for bipolar I and II, respectively), as well as SUDs (54.1 and 51.8% for bipolar I and II, respectively). In day-to-day clinical practice, it is therefore likely that any group of clients with bipolar disorder will contain considerable heterogeneity—however, when another condition may be considered the primary diagnosis, individual treatment might be the preferred choice. For example, for a client with bipolar disorder that has been well controlled with medications, with no recent history of manias but a notable presentation and impairment due to paranoid personality disorder, a bipolar CBT group is not indicated and individual, schema-based CT is likely to be the preferred option. On the other hand, an individual recovering from a manic episode that resulted in a recent hospitalization, who also meets criteria for social anxiety disorder at the assessment, may well benefit from a group, even if at a later stage it also becomes necessary to address the social anxiety disorder with additional treatment. Thus, the presence of comorbidity should not be an automatic exclusion factor for a group, but should be evaluated on an individual basis.

Group suitability assessment is important generally but there are several unique aspects that arise in bipolar disorder. First, a stated aim of CBT for bipolar disorder is education about the nature of the illness, recognizing the potential for misconceptions about and even denial of symptoms, possibly stemming from inaccurate recall of episodes (Schwannauer, 2004). This is not necessarily a predictor of poor outcome because the treatment explicitly targets readiness to address cognitive and behavioral domains. A second factor that must be acknowledged in suitability interviewing is that clients with bipolar disorder are not likely to have a biopsychosocial view of their illness—thus, they may not recognize what role they may play in helping themselves. Instead, clients with bipolar disorder more typically have a strong biological view, which is not surprising given the centrality of medications in their illness and the exclusively biological model of the disorder that is propagated in some psychiatric circles. Openness to accepting external triggers is, therefore, central to suitability for treatment.

A final issue that is of central concern in selecting clients for a bipolar group is state of illness. Clients experiencing a hypomanic or manic episode will likely be disruptive and unable to follow treatment, while those in a depression may also struggle to follow or will be withdrawn. In any case, it is critical to consider a CBT group only when clients have been offered a pharmacotherapy treatment plan with known efficacy and side effects, and have achieved some modicum of stability.

It may be difficult to find the middle ground during which it is appropriate for someone to participate in treatment. It can be valuable to include an inpatient who is severely depressed for the sake of activation, whereas including clients who are relatively stable might reduce the likelihood of

relapse. However, because many clients with bipolar disorder spend a considerable period of time with syndromal or subsyndromal depression symptoms, we suggest that clients with a mild-to-moderate level of depression, as well as clients who are presently euthymic but motivated to prevent relapses, be included in group treatment.

Assessing Treatment Outcome

The focus of CBT treatment in bipolar disorder, and by extension, measures of outcome, go well beyond symptoms. Nonetheless, it is very useful for clinicians to track current depression and mania/hypomania symptoms during the course of treatment. As in unipolar depression, a relatively brief but reliable and valid tool like the BDI is useful; more challenging though is the assessment of mania and hypomania because, at least to some extent, the symptoms themselves do not lend themselves to a simple self-report checklist. Group leaders need to attend to subtle signs and in some cases much more obvious behavioral indicators that a person has "switched" to another phase of bipolar disorder—more on this is described in the group process section. The possibility of a hypomanic or manic episode emerging during a group is among the host of possibilities that can make a CBT group for bipolar disorder somewhat more complicated and requires a considerable degree of therapist experience and confidence.

Structuring Group CBT for Bipolar Disorder

Number of Participants

As in unipolar depression, data-driven conclusions about the optimal number of participants are not readily available. Given the complexity of this disorder, the number of participants should be somewhat smaller than that for unipolar depression, perhaps between seven and 10 individuals. Because of the inherent heterogeneity with regard to stage of illness, comorbidity, and lability of mood states, therapists need to have an opportunity to work with and monitor each participant at each group meeting. This is unlikely to be realistic for two therapists if the group size is in the double digits.

Structure of Group Sessions

The general guidelines for a bipolar group format are similar to those mentioned in the section on depression, with the notable addition of two formal psychoeducation sessions to which family members may be invited. This is not intended to be "family therapy" but rather to provide necessary basic information about a disorder that is complicated and difficult to understand to those close to the affected individual. These two sessions, because they involve larger numbers and a large flow of information, have a very

different process and format from subsequent sessions. Aside from questions and facts, there is little emphasis on disclosure or group process per se.

Therapists

There is general agreement that the level of therapist expertise required for CBT in bipolar disorder is higher than that for unipolar depression (Scott, Garland, & Moorhead, 2001). Therapists should be experienced with the entire protocol for unipolar depression, and need to be comfortable with the additional material needed for mania/hypomania, as well as the management of an inherently more complex population. As described above, a good test for therapists is to consider how they might respond if a client were to "switch" to mania during the course of group treatment, including access to emergency psychiatric care, and the potential need for hospitalization. General knowledge of medications and the ability to answer clients' difficult questions is essential. In addition to this, we recommend that therapists have considerable exposure to the clinical management of bipolar disorder.

Key Treatment Components of Group CBT for Bipolar Disorder

The 20-session group protocol described here (see Table 9.2) was derived from a combination of sources, including Basco and Rush (1996, 2007), Newman, Leahy, Beck, Reilly-Harrington, and Gyulai (2002), and a group protocol developed for an outcome study (Patelis-Siotis et al., 2001). The first 17 sessions occur weekly, followed by three monthly booster sessions for follow-up, although such boosters could be continued at increasing intervals. The weekly sessions are carefully structured to cover the critical content areas, including psychoeducation, behavioral and cognitive strategies for depression and mania/hypomania, problem solving, and core belief work related to bipolar disorder. The booster sessions are relatively less structured and are likely to reflect each group's needs for certain strategies or content areas. In the next section, we describe a sample protocol and the session-by-session flow illustrated in Table 9.2.

Psychoeducation

The first two sessions of this protocol are largely didactic, but it is important to leave time for discussion and questions. Given that clients in the group, and their family members, may have variable understanding of this disorder, many questions are likely to arise. A significant theme in these sessions is related to moving clients from one stage of change to

TABLE 9.2. Sample Outline of Treatment Protocol for Group CBT for Bipolar Disorder

Session	Strategies covered
Session 1	• Psychoeducation I: Family present. • Introduction of therapists. • Overview of the protocol, including psychoeducation plan and brief description of sessions. • Description of bipolar disorder. 1. Signs and symptoms, using examples. 2. Biopsychosocial model, including what is known about genetics, stressors, and psychological factors. 3. Course of illness. 4. Treatments, including medication and therapy. • Impact of bipolar disorder. 1. Impact on affected individual. 2. Impact on family and loved ones.
Session 2	• Psychoeducation II: Family present. • Review of medications used in bipolar disorder. 1. Mood stabilizers: types, therapeutic effects, side effects. 2. Antidepressants: types, therapeutic effects, side effects. • Psychological treatments. 1. Adherence with medications. 2. Early intervention in cycling. 3. Behavioral and cognitive strategies. • Question-and-answer period.
Session 3	• Group CBT "rules." 1. Confidentiality. 2. Check-in and rating scales. 3. Homework. 4. Missing appointments. • Group members' narratives concerning their illness. • Goal setting. 1. Elicit goals around treatment adherence. 2. Elicit goals around early prevention of episodes. 3. Elicit goals for problem solving/stress reduction.
Session 4	• Outline relationship between mood state and behavior in depression. • Introduce mood/emotion rating system. • Demonstrate relationship between activities and mood (i.e., what activities improve mood, what activities worsen mood). • Homework: Complete activity schedule with activities and mood ratings.
Session 5	• Behavioral interventions: Modifying activities to improve mood in depression. • Introduce the concepts of mastery (sense of accomplishment) and pleasure, using examples from the past to illustrate these types of activities. • Focus on adding mastery and pleasure activities to establish balance of reinforcement. • Homework: Complete activity schedule with new activities added in and rate mood.

(continued)

TABLE 9.2. *(continued)*

Session	Strategies covered
Session 6	• Examine outcome of behavioral modifications for depression. • Behavioral signs of mania/hypomania. 1. Activity levels. 2. Productivity increases. 3. Physical signs of mania/hypomania. • Behavioral strategies for reducing mania/hypomania. 1. Simulation control. 2. Strategies for normalizing sleep. 3. Relaxation strategies. 4. Contacting treatment team. • Homework: Client reviews own early behavioral signs of mania/hypomania and lists alternatives.
Session 7	• Identify negative "mood shifts" to target with cognitive interventions. • Label and rate emotion(s) experienced in difficult situations from examples. • Describe interpretation and "self-talk" as the link between situation and emotion, using client examples. • Automatic and "hot thoughts": Focusing on the thought most related to the emotion. • Homework: First three columns of dysfunctional thought record (DTR; situation and emotion) to be completed.
Session 8	• Review examples of thought records. • Describe relationships between positive thoughts and early signs of mania/hypomania. • Historical review of "activating" situations and associated positive automatic thoughts. • First three columns of the DTR using positive automatic thoughts. • Homework: First three columns of the DTR, and identifying hot thoughts.
Session 9	• Review examples from thought records: situation, mood, and thoughts. • Identify hot thoughts in the examples. • Introduce the evidence technique, finding evidence "for" and "against" the hot thought and distortions. • Evaluate evidence and distortions for "depression" thoughts examples. • Homework: DTR, including evidence gathering.
Session 10	• Review examples from thought records: situation, mood, thoughts, evidence, and distortions. • Introduce evidence gathering and distortions for positive automatic thoughts in early signs of mania/hypomania. • Review examples to illustrate elicit evidence for and against positive automatic thoughts. • Homework: Complete sample DTR for positive automatic thoughts.
Session 11	• Introduction of "alternative thoughts" for depression and mania/hypomania. • Troubleshooting alternative thoughts and thought records, including ignoring evidence, misspecification of hot thought, activation of deeper beliefs. • Homework: Complete DTRs as needed.

(continued)

TABLE 9.2. *(continued)*

Session	Strategies covered
Session 12	• Review thought record examples where insufficient information exists to draw a conclusion. • Introduce experiments: When there is insufficient evidence to draw a conclusion and more information is needed, devise a way to collect that information. • Create an experiment that is consistent with a client example. • Homework: Execute an experiment and monitor the outcome.
Session 13	• Review thought records that identified a problem that needed to be solved. • Review problems related to goals around adherence to medication regimen, and stressors from goal setting. • Examine connection between stressors and onset of episodes. • Interpersonal relationships stressors. • Intrapersonal stressors. • Homework: Construct list of stressors to be resolved.
Session 14	• Introduce problem-solving strategies. 1. Problem definition. 2. Brainstorming solutions. 3. Evaluating alternatives. 4. Implementation and feedback loop. • Introduce coping strategies. 1. Emotion focused. 2. Distraction coping. 3. Action coping. • Balancing coping and problem solving. • Homework: Complete a problem-solving exercise.
Session 15	• Introduce “deep cognition”; concepts of conditional assumptions and core beliefs. • Illustrate deep cognition using “downward-arrow” technique. • Describe downward arrow as used for conditional assumptions about self, others, and the world. • Homework: Complete a downward-arrow exercise.
Session 16	• Explain connection between conditional assumptions and core beliefs. • Illustrate “continuum” model of core beliefs and emphasize prospective techniques to change core beliefs. • Describe evidence-gathering, experiment, and problem-solving plans for changing typical patterns of coping, and collect information to support alternative core beliefs. • Homework: Generate a continuum of core beliefs and keep track of evidence concerning alternative core beliefs.
Session 17	• Core beliefs associated with bipolar disorder. • Defectiveness and shame beliefs. • Interventions for coping with illness-based beliefs. • Responsibility and biological “determinism” of illness. • Homework: Implement CBT strategies as needed.
Session 18	• Monthly booster session to integrate and implement skills learned, as directed by clients.

(continued)

TABLE 9.2. *(continued)*

Session	Strategies covered
Session 19	• Monthly booster session to integrate and implement skills learned, as directed by clients.
Session 20	• Monthly booster session to integrate and implement skills learned, as directed by clients.

another, based broadly on the transtheoretical model of change pioneered by Prochaska and DiClemente (1983). Not all clients accept that bipolar disorder is "real" or an "illness," and such individuals often do not fully acknowledge that a problem exists at all. As in the substance abuse literature, it is important to emphasize that the individual's problem has a name, diagnostic features, very important treatment implications, and that the problem is real and needs to be addressed. Including family members is another avenue to communicate fully the nature and seriousness of the problem and its implications. Family members are also included so that they better learn to recognize and, as much as possible, help manage emerging symptoms of depression or mania/hypomania.

At the same time, therapists should be prepared to discuss both the centrality and limitations of medication treatment in this disorder. Many clients will have experienced variable benefits from medications, considerable side effects, difficulties accessing proper treatment, or significant negative experiences during hospitalizations. The implications of these experiences for process are described more fully in a subsequent section.

During these psychoeducational sessions, provision of empathy and understanding is critical, but negative treatment-related experiences can also be reframed to point out the benefits of active management of the illness through proper medical and psychosocial treatment. Moreover, such difficult questions can often be used to set the stage for viewing the disorder in broader psychosocial terms, thus helping the sufferer to wrest back some degree of control over this difficult illness. Around the issue of medication, it is important to combat "all-or-none" thinking in both the affected person and their loved ones. Medications may have side effects and other limitations, but the option of not taking medications at all will undoubtedly leave the affected person much worse off.

Therapists are encouraged to use a resource list, both for themselves and for clients to peruse in the group and for homework. A number of audiovisual materials, mainly illness education videos, are also available from a variety of sources. Prepackaged educational materials are available, though therapists can also construct brochures, pamphlets, or a frequently asked questions (FAQ) list that covers the points described in this protocol. For further detail, Basco and Rush (1996, 2007) list a number

of educational resources, materials, and distribution channels in a useful appendix in their monograph.

Behavioral Techniques

The content of Sessions 4 and 5 are the same as those for unipolar depression. Session 6 is clearly unique, in that therapists review the behavioral indicators of mania and hypomania. As described earlier, a key feature of CBT for bipolar disorder is early detection of cycling, and subtle behavioral changes are likely the first sign for most clients that mania/hypomania episodes are starting (Basco & Rush, 1996, 2007).

Before such episodes are "clinically" problematic, clients may notice themselves feeling more energetic, productive, or rested on a minimum of sleep. As a response, clients are taught the basics of good sleep hygiene and a variety of strategies to reduce stimulation. Depending on the specific triggers, reduction of stimulation is likely to be desirable. Clients are encouraged to eliminate use of any stimulating substances, including caffeine or sugar. Practical limitations are discussed to prevent physical overstimulation (e.g., overexercising), and plans are drawn up to reduce environmental stimulation by having clients avoid overly social situations or too much sensory input. Clients on an upswing are likely to actively seek out situations that reinforce mania in a positive feedback loop. For example, they may seek out exciting and stimulating environments that speak to their particular triggers; persons for whom overspending is a reliable indicator of mania are likely to seek out their favorite store for "bargains." Of course, such behavior simply provides a kind of incubation for mania and, unfortunately, sets the stage for a situation that is likely to cause further damage. This cycle should be illustrated to clients—who can share their own examples—and instruction on how to mitigate or avoid bad outcomes can be reinforced.

Relaxation strategies may also be useful but involve more than progressive muscle relaxation. Indeed, in early mania/hypomania, clients may be unlikely to be able to follow up on an approach that involves sitting for long periods. Stretching exercises, yoga, walking, and other slow physical movement, with an emphasis on limited stimulation, are more likely to be feasible. Also, practical "brakes" on manic behavior should be discussed. For example, clients can be encouraged to surrender their credit cards, methods of identification, or even car keys, so that they cannot spend excessively or travel impulsively. Early in a manic cycle, clients may well still understand the wisdom of giving up some of their freedoms and autonomy. However, once an episode has peaked, they are unlikely to see a need to curtail their behavior. The earlier the client, family, and care providers are aware of a potential episode, the more management strategies can be planned, and the greater the effectiveness of prevention efforts.

For some clients who have had numerous manic episodes, this portion of treatment is particularly useful, while those who have not had a manic episode for some time may have more difficulty recalling their triggers. The different experiences of all group members should be considered and it is important to emphasize that these are strategies that ought to be attempted and refined, but are not a panacea for mood cycling. What should be emphasized in the group process is that clients may struggle at times but these strategies have promise and should be given an opportunity to work.

Cognitive Techniques in Bipolar Disorder

Overview

The procedures for introducing the connection between situations, negative emotions, and automatic thoughts, as well as evidence gathering in Sessions 7 and 9, are largely identical to the approach in the depression section of this chapter. Sessions 8, 10, and 11, however, are distinct in that they describe the centrality of thoughts and their relevance to the "pole" of the disorder that is associated with mania/hypomania. In addition to the techniques applied for unipolar depression at the "deep cognition" level, this protocol also explores beliefs uniquely related to bipolar disorder—these are the focus of the following sections. We refer the reader to the depression section of this chapter, for details on working with the depressive end of the cognitive spectrum.

Specific Cognitive Strategies for "Manic Thinking"

In Session 8, the group is introduced to the connection between positive thoughts and the emergence of a potential mania or hypomania. In addition to working on evidence gathering to help counteract the impact of these thoughts on the behavioral and affective domains, this aspect of the treatment maintains the theme of treatment compliance. Changes in thoughts in a positive direction should cue the individual to seek the advice of their treatment team and inform loved ones, so that more careful monitoring can be put in place.

Clients in the group will have already learned skills to monitor negative and pessimistic thoughts. Indeed, because most clients are likely to have spent far more time with symptoms of depression as opposed to mania, they are likely to have more facility recording and sharing negative automatic thoughts. Monitoring the positive thoughts associated with the relatively rare manic and hypomanic states may well involve a more historical perspective. Such thoughts are also heterogeneous, given the various kinds of phenomenology of mania. Some clients may have

experienced early signs of mania in the form of expansive well-being and positive evaluations of themselves and their abilities. Others may notice a sense of irritation and being "driven" toward some goal, along with thoughts that are in line with those states. By revisiting, with each member, if possible, their thoughts during the most recent manic/hypomanic episode, group members will undoubtedly learn to recognize the many guises in which such episodes appear.

Basco and Rush (1996) list nine types of positive thinking associated with mania, and their examples can be useful to round out the group's experiences and examples. Adapting this list for the group may be especially useful when clients have forgotten, or are unaware of, past manic thoughts. Each type of thought is listed below:

1. Increased sexual thoughts as libido rises. This can often involve misinterpretation of normal positive social cues as indicative of sexual interest.
2. Concern that other people and events are moving too slowly. Because emergent mania may result in increased energy, the affected person may experience others as slowing down, when it is the affected person who is speeding up.
3. A need to go to the highest level to accomplish some goal—for example, having a complaint about a product and asking to speak to the chief executive officer (CEO) of the company. This grandiose thought, which may also be evident in narcissistic personality disorder, does not place the needs of the affected person in the proper context.
4. Thoughts and impulses involving the need to insert humor when it is inappropriate. The affected person may see a serious situation (a meeting at work) as being in need of "lightening up" to reflect their expansive mood.
5. A sense that others believe that the affected person is very smart and has excellent ideas. This usually involves misinterpretation of some signs of general approval and seeing these as strong support for novel ideas or plans the manic person may have.
6. Thoughts about other people being humorless, slow, or dull. These are also based on not recognizing that it is the self that has become different.
7. Thoughts related to the medication as a brake on the current good feeling, or as being unnecessary.
8. A set of beliefs that the affected person knows more than anyone else about him- or herself or situations—thus, they do not accept feedback from others.
9. A focus on the present as the only thing that counts, and possibly losing sight of learning from the past or the consequences of actions for the future.

Each type of thought can be written on a whiteboard in Session 8, and the group can discuss the relationship of the thought to bipolar symptoms, as well as the problems and dysfunction that arise from the thought. Group members can then be taught to use evidence-gathering strategies, as they did with depressive thoughts, so that these thoughts, too, can be subjected to "reality" testing. Clients should be aware of their actions so that thoughts can be slowed when they arise, and family members can be notified. Catching such thoughts early should be a priority before they reach an intensity beyond which these strategies are no longer helpful. This can be difficult due to the nature of these types of thoughts, but as with behavioral control strategies, it is important for participants to understand that cognitive strategies can work, though they may not always be able to stop a manic cycle.

By Session 10, the group is working on and discussing thought records that involve both positive and negative thoughts. To illustrate questioning strategies and evidence gathering for both poles of the bipolar spectrum, therapists may wish to include examples of thoughts that are overly positive and overly negative. Thus, over the course of Sessions 7–11, all participants gain familiarity with examining both kinds of distorted thinking because skills for examining both kinds of thoughts are necessary for their current needs and any future prevention efforts.

Problem-Solving and Coping Strategies

Session 13 introduces action plans in response to thought records, and Session 14 introduces coping and advanced problem-solving strategies. As described earlier, the main reason for including these topics explicitly is the resolution and prevention of stressors and problems that might set the stage for a depressive or manic/hypomanic episode. The topics introduced here are also revisited in subsequent sessions; there are often intimate links between the stresses and problems associated with bipolar disorder and the formation of core beliefs about the self as flawed or damaged. Indeed, it is difficult to conceive of an illness that would be a better catalyst for producing stressors and lasting problems; by the time a client has reached a bipolar group for CBT, the illness is likely to have caused any number of interpersonal problems (e.g., loss of job, hospitalization). Thus, it is necessary to introduce both problem-solving strategies to assist with major difficulties and to resolve smaller problems, and coping strategies to help clients manage already entrenched problems that may be difficult to eliminate entirely.

Now that group members and therapists have a good understanding of each person's current life situation, Session 13 uses the action plan approach to dealing with thought records that point out the existence of a problem—similar to unipolar depression but carried out more extensively. Group members select broader areas, beyond those identified by thought

records, that they would like to work on with concerted problem solving. Clients are then taught a series of steps to work toward a solution to one problem area they wish to work on during the group (D'Zurilla & Goldfried, 1971; Hawton & Kirk, 1989; Mueser, 1998).

The steps described to the group are problem definition and assessment, brainstorming solutions, evaluating the possible plans for their advantages and disadvantages, and implementing and evaluating the solution. In Step 1, "defining the problem," group members are encouraged to contemplate the nature of the problem, their feelings about it, and the specific issues that need to be concretely resolved. In Step 2, "brainstorming," the participant with a problem and the other group members are encouraged to come up with ideas for resolving a problem, with the only instruction being that there are no instructions; open-minded thinking and creativity are encouraged. In Step 3, "evaluating options," the focus changes to the practical advantages and disadvantages of the options generated by brainstorming. Step 4, "action and feedback," involves implementing, in step-by-step fashion, the best of the options and assessing how well that action achieves the goal. Working through a complete example with the group is likely to take considerable time—thus, therapists should take care to select an area that is relevant to as many group members as possible.

The second component of Session 14 is to present coping strategies that are introduced as another set of tools to deal with ongoing stressors. Group members are introduced to three different types of coping: emotion focused, distraction–avoidance, and action oriented. Therapists emphasize the need to choose a balance of strategies depending on the type of stress, and help to identify when coping strategies may fail. For example, distraction–avoidance coping may actually be useful when someone is facing a transient stressor that they can neither prepare for nor put off but might make something like a financial crisis even worse. Various problems and stressors should be discussed in relation to different coping strategies.

Working with Beliefs

This component of therapy, in Sessions 15–17, has considerable technique overlap with belief work in unipolar depression. For example, use of prototypical thought themes to identify underlying cognitive "rules," or of a downward arrow to uncover conditional assumptions and core beliefs, are applicable techniques to both bipolar and unipolar depression groups. Processwise, higher levels of affect are common during these sessions, and therapists should be prepared to use the techniques in a less structured but no less directive manner to help participants confront their long-standing beliefs and schemas. However, the design of the sessions in this portion of the protocol also reflects a number of unique challenges to belief work in bipolar disorder.

It is not unusual for clients with bipolar disorder to struggle with a sense of "who I am" (Patelis-Siotis et al., 2001), particularly those with childhood or adolescent onset where symptoms might have interfered with major life events. Because of this, core belief work in bipolar disorder often focuses on a deeply felt sense of "defectiveness." Participants may describe confusion between "me" and "the illness," and be uncertain of what they control in their lives through their own volition and what is caused by symptoms of the disorder. Even more complex is when hypomania or mania at some point leads to increased functioning—for example, in academic or vocational contexts—and the affected individual is uncertain whether they deserve credit for those achievements.

During these three "beliefs" sessions in the protocol, therapists should focus the discussion on these defectiveness beliefs. For positive adjustment to occur, participants need to first understand that these beliefs do exist and are important in governing their emotions, where such beliefs originate, and what consequences they have. An important exercise during these sessions is working with participants to delineate carefully what they are responsible for in their lives and what is not under their control because of the disorder. Time should be spent on helping participants feel more empowered by making choices about their identities, values, and goals. Once a proper equilibrium is established, and affected individuals have a better sense of self versus symptoms, there is a much higher probability that clients will accept having an illness that needs to be treated medically and at the same time engage in psychological strategies to cope and limit the impact of the illness on their lives.

The shame and defectiveness beliefs so common in this disorder are unlikely to shift completely in these three sessions, and often this topic area is revisited in the booster groups. It is important to emphasize that changing such beliefs requires more time and attention, and that doing so reflects a process of recovery and acceptance that may involve occasional setbacks. The final sessions of the group also typically represent a subtle but important shift from an emphasis on the management of symptoms to broader questions concerning changes to enhance the quality of life and long-term adjustment to what is, for almost all sufferers, likely to be a chronic illness.

Group Process Factors in CBT for Bipolar Disorder

Despite considerable overlap with unipolar depression, therapists can expect bipolar depressive mood states to be more entrenched with less robust response to treatment. Nonetheless, group members currently in a depressed phase of the illness will, in most respects, react to interventions

and other members in a manner that is often indistinguishable from that of individuals with unipolar depression. Thus, a thorough understanding of process factors for unipolar depression, described earlier, is a prerequisite for therapists interested in treating clients with bipolar disorder. However, three other process areas are relatively unique to bipolar disorder: the client's model of the illness, mood cycling over the course of treatment, and difficult past treatment experiences. Each area and its impact on process is described.

Therapists should be prepared for clients to enter the group with various levels of understanding and often wildly varying views of the disorder. Clients with a biological view might be skeptical about "talking" therapy, and might show different levels of commitment to the group experience. Other group members may be at a stage in which they are not yet convinced they have an illness at all. Clearly, people with such varied views will have to come to some shared understanding and acceptance of one another's positions. Therapists are advised to allow time for such discussions to take place, and to be ready to revisit the biopsychosocial model when needed to help group members find common ground, especially in the early psychoeducation sessions.

Clients skeptical of therapy, who may also be reluctant to disclose or participate actively, should be encouraged to allow the experience of treatment to unfold. Therapists may need to be patient, allowing time and opportunity for these group members to participate fully. Relative to other kinds of CBT groups, therapists may wish to place fewer demands on group members who do not participate equally, recognizing that each group member may participate in a variety of ways. Participants who are not yet ready to change actively can still gain valuable information and motivation despite their reluctance to be fully engaged in all components of treatment. Even if group members start the group at different stages, by the time the group ends, it is not unusual for all members to be full participants, because they have been allowed the time and opportunity to resolve their skepticism and denial through the experiences of the group itself.

The second issue that not only affects the process but also has important clinical implications is when a client moves into a manic/hypomanic phase. Often the first knowledge the clinical care team has about a client starting such a cycle is when they arrive at group demonstrating signs of mania. A client may act, talk, and dress differently from the week before, in ways that are likely to be quite obvious to the group and the therapists. This can be a challenging situation, especially when the client attributes the change to a "cure" or improvement in the illness rather than recognizing that they are having a manic upswing. In the group sessions, such a client may be overly talkative, wish to dominate the agenda, or even ignore group rules entirely. At a certain point of severity, therapists may have little choice but to work with the person one-on-one and arrange for a more detailed mood and mental status assessment. In those rare instances, one

of the coleaders can carry on with the rest of the group. In any case, when such signs begin to emerge in group, it is often useful for group members to discuss what they are seeing, if possible, by questioning the affected person directly. This can be a useful demonstration of the early signs of an upswing for all group members, and may give the affected client insight into their emerging mania/hypomania as well.

Finally, particularly when dealing with illnesses such as bipolar disorder, it is important to consider the emerging topic of trauma-informed care and practice. Due to various negative experiences that clients with bipolar disorder might have had with the health care system in the past—such as misdiagnosis, medication side effects, or forced hospitalization—it is important for group leaders to be empathetic to each client's individual experience. Muskett (2014) identified several principles of trauma-informed care, including (1) that clients have a need to feel connected, valued, informed, and hopeful of recovery; (2) the connection between the existence of past trauma and current psychopathology is known and understood by care providers; and (3) care providers work with clients, their families, friends, and other supports in ways that are mindful and empowering, and promote and protect autonomy. Not only does practicing trauma-informed care have the potential to improve the trust between clients and care providers, it can also help to reduce the risk of retraumatization from future experiences with mental health services.

Understanding that such traumatic experiences likely alter a person's view of treatment and acknowledging the limitations of the health care system in treating those with bipolar disorder can go a long way to fostering trust between client and therapist. However, this acknowledgment should be balanced with the provision of hope that good care is possible. It is not uncommon for clients to express anger as the group explores illness experiences—fortunately, the group environment allows for the modeling of positive coping strategies. These issues can arise at any point, and therapists need to provide adequate time to explore them, acting as an advocate for the client's best interests, even if the protocol time line is disrupted. There now exist several thorough resources (e.g., British Columbia Ministry of Health, 2013; Poole & Greaves, 2012) intended to educate mental health practitioners on the incorporation of trauma-informed care into practice, and interested readers should turn to these sources for more information.

Conclusions

The group CBT format was pioneered in the area of depression, and evidence for the effectiveness of the approach has accumulated for over 40 years. The techniques used for depression represent almost all of the basic cognitive strategies, and for this reason, CBT depression groups are a very

effective introduction for therapists who are new to the group format. Mastering these techniques in a depression group is an important building block for treating more complex disorders, such as bipolar disorder and Axis II conditions in a group. Finally, although a reasonable volume of efficacy data have accumulated for CBT groups in depression, much remains to be discovered about process factors and effective ingredients. We anticipate that the next challenge in the field will be to document which factors are associated with individual and group change. This could in turn lead to further specification and optimization of techniques and process to achieve the best possible outcomes.

The addition of CBT-based strategies, alongside standard medication treatments, has been an important step forward in the management of bipolar disorder. In a condition with such dramatic consequences for emotions, functioning, and quality of life, treatments that go beyond mood-stabilizing medications have been much awaited and needed. The group CBT approach offers a number of useful ingredients, treating not only the symptoms of the condition but also clients in the context of their lives and the desire for recovery. For many clients, this biopsychosocial view is a breath of fresh air and welcome news that there is something they can do aside from taking medications. Evidence for the approach is still growing, and it is useful to evaluate more directly group versus individual CBT for this disorder. Bipolar disorder is an illness that often leads to a sense of isolation and hopelessness. A CBT group provides an important antidote to the view "I am alone," and it offers clients a host of strategies to help them take back control over their lives and futures.

CHAPTER 10

Eating Disorders

With the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022), the category of eating disorders was broadened to "feeding and eating disorders" and includes the following diagnoses: pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa (AN), bulimia nervosa (BN), binge-eating disorder (BED), other-specified feeding or eating disorder, and unspecified feeding or eating disorder. This chapter focuses on the three most common eating disorders: AN, BN, and BED. DSM-5-TR contains the official symptom criteria that qualify a client for receiving a diagnosis of AN, BD, or BED.

Although the prevalence rates of eating disorders are low, their associated psychiatric and medical morbidity are high. Lifetime prevalence rates of DSM-5-TR-defined eating disorders in a population-based U.S. sample from the National Epidemiologic Survey on Alcohol and Related Conditions of 36,306 adults were all below 1.0%: 0.80% for AN, 0.28% for BN, and 0.85% for BED, with all three eating disorders significantly more prevalent in women than men, even after controlling for age, race/ethnicity, education, and income (Udo & Grilo, 2018). Some studies have found a higher prevalence of BED. For example, data from the World Health Organization World Mental Health Surveys across 14 countries found a mean lifetime prevalence rate of 1.90% for BED (Kessler et al., 2013).

As noted above, eating disorders are much more prevalent in females than in males. Sociocultural emphasis on thinness as the female beauty ideal exerts pressure on women to try and achieve an unrealistic standard (Striegel-Moore, Silberstein, & Rodin, 1986). Not surprisingly,

this sociocultural factor plays a role in the etiology of eating disorders, because both across and within different ethnic groups there is a correlation between the prevalence of eating disorders and societal pressures to be thin (Hsu, 1990). There has been less attention in the research literature on men—however, men do report eating disorder symptoms (Striegel-Moore et al., 2009). In individuals presenting with AN and BN, it has been estimated that 10–25% of cases are male (Hudson, Hiripi, Pope, & Kessler, 2007; Weltzin, 2005), with a higher rate of BN than AN.

Although there are many similarities between AN and BN, individuals with AN typically require more intensive treatment within a multidisciplinary team environment to facilitate the necessary weight gain required for recovery, as well as to manage medical complications. BN is the most researched eating disorder, likely due to the higher prevalence rate than AN. Individuals with BED are quite similar to individuals with BN with regard to maladaptive concerns regarding shape and weight. However, BED is characterized by considerably reduced dietary restriction compared to BN—thus, it is not surprising that BED is significantly related to obesity (Wilfley, Schwartz, Spurrell, & Fairburn, 2000). Compared to BN, BED is associated with greater age of onset, increased body mass index (BMI), and a less pronounced gender difference (e.g., Ramacciotti et al., 2005; Striegel-Moore & Franko, 2003). BED is also associated with comorbid psychiatric disorders, particularly depression (Wilfley, Friedman, et al., 2000).

Cognitive and Behavioral Features of Eating Disorders

CBT models of eating disorders place central emphasis on the role of cognitive factors in the development and maintenance of the core eating disorder features of dietary restraint, binge eating, and behaviors aimed at weight control (Garner & Bemis, 1982, 1985). These cognitive factors include abnormal attitudes about weight and shape, information-processing biases, and beliefs about the self (Vitousek & Ewald, 1993; Vitousek & Hollon, 1990). CBT for eating disorders targets negative thoughts and schemas, and core eating disorder psychopathology, as well as maladaptive eating disorder behaviors, with an emphasis on both cognitive and behavioral change (see Bowers, 2001; Murphy, Straebler, Cooper, & Fairburn, 2010; Shafran & de Silva, 2003, for reviews).

CBT for BN was developed by Fairburn and colleagues (Fairburn, 1981, 1985; Fairburn, Marcus, & Wilson, 1993) and emphasizes the key role of both cognitive and behavioral processes in the development and maintenance of the disorder. In their model, Fairburn et al. detail a causal sequence of factors involved in the development and maintenance of the disorder as follows: Low self-esteem in the context of extreme personal value placed on an idealized body shape and low body weight leads to

the development of strict dieting. Lapses in dietary restraint lead to episodes of binge eating that are followed by compensatory behaviors, such as vomiting, resulting in a perpetuating cycle of symptoms. Binge eating may serve to reduce negative affect in the short term, and is maintained in part by purging behaviors that reduce anxiety about possible weight gain. In the long term, binge eating and purging cause increased distress and lower self-esteem, thus contributing to further dieting and consequent binge eating. (See Fairburn et al., 1993, for a detailed manual on conducting CBT for BN.) CBT for BN typically lasts 20 sessions. Fairburn et al. structure treatment in three phases. In the first phase, treatment strategies include self-monitoring, weekly weighing, psychoeducation about weight and eating, prescription of regular eating patterns, and self-control strategies. The second phase of treatment focuses on eliminating dieting, teaching problem-solving skills, implementation of cognitive restructuring, and behavioral strategies. The third stage of treatment focuses on relapse prevention strategies.

In CBT for AN (Garner, Vitousek, & Pike, 1997), abnormal concerns about shape and weight are conceptualized as the core feature. Greater emphasis is placed on interpersonal factors in CBT for AN than in CBT for BN. CBT for AN, developed by Garner and Bemis (1982, 1985), emphasizes three treatment phases: (1) development of trust and establishment of treatment parameters (e.g., minimal body weight threshold, target body weight range, meal planning); (2) modification of beliefs related to food and weight, and associated symptoms (e.g., behaviors aimed at weight control), followed by broadening to other relevant issues (e.g., self-esteem, self-control, impulse regulation, interpersonal functioning, emotional expression); and (3) relapse prevention.

Fairburn, Shafran, and Cooper (1999) presented a conceptualization of the maintenance of AN based on the work of Slade (1982), in which an extreme need to control eating is the central maintaining feature of the disorder. A general need for self-control is driven by a general sense of ineffectiveness and perfectionistic tendencies, combined with low self-esteem. According to Fairburn et al., difficulties controlling various life aspects lead to a specific focus on control over eating for a number of powerful reasons. Restriction of eating provides evidence of successful control that is immediate; it has a strong effect on the individual's social environment, and eating is a salient behavior in families. In addition, control over eating allows the interruption or reversal of puberty, and it is reinforced by Western values emphasizing dieting as a means to control shape and weight. Fairburn et al. specify three mechanisms through which control over eating is maintained: enhanced sense of personal control, starvation sequelae (e.g., intense hunger) that drive further caloric restriction, and extreme concerns about shape and weight. CBT for AN typically lasts much longer than CBT for BN, from 1 to 2 years. A longer duration of treatment is necessitated by motivational obstacles, the degree of weight gain needed to achieve a

minimal healthy weight, and the necessity for occasional hospitalization or partial hospitalization (Garner et al., 1997).

CBT for BED was developed as a group-based intervention consisting of 20 weekly 90-minute sessions divided into three phases (Wilfley et al., 2002). The first phase consists of six sessions and uses behavioral strategies to help individuals normalize their eating by identifying episodes of restriction and overeating. The second phase consists of eight sessions and focuses on cognitive restructuring of negative thoughts that trigger binge episodes and that are associated with negative body image. The third phase consists of six sessions and focuses on maintaining gains and preventing relapse using problem-solving skills and strategies to manage high-risk situations.

To improve upon existing CBT interventions and target the shared psychopathology across eating disorders, Fairburn and colleagues (2009; Fairburn, Cooper, & Shafran, 2003; Murphy et al., 2010) developed CBT-E, an enhanced version of CBT for BN, based on a transdiagnostic theory of eating disorders. CBT-E is designed to improve treatment outcome and incorporates modules to address factors in the clinical presentation that may interfere with recovery, including clinical perfectionism, low self-esteem, and interpersonal difficulties. There are two versions of CBT-E: the focused version (CBT-Ef), which is designed to target core eating disorder symptom domains; and the broad version (CBT-Eb), which is for complex presentations where the associated difficulties of clinical perfectionism, low self-esteem, and/or interpersonal difficulties are prominent. CBT-E may be delivered in 20 sessions over 20 weeks for those clients who are not significantly underweight. For those who are substantially underweight, the treatment is delivered in 40 sessions over 40 weeks. CBT-E is delivered in four stages. Stage 1 is an intensive stage consisting of twice-weekly sessions for 4 weeks. In this stage, the clinician develops a therapeutic rapport to engage the client in therapy, collaborates with the client to develop an individualized conceptualization of how the eating disorder developed and is maintained, provides education about the nature of eating disorders and their treatment, introduces self-monitoring, establishes weekly weighing, and also introduces a regular eating plan (i.e., three planned meals plus two to three snacks daily). Stage 2 consists of two weekly sessions during which the therapist reviews progress, identifies any obstacles to change, and plans for Stage 3. Stage 3 occurs over eight weekly sessions during which the therapist and client work together to implement strategies targeting the therapeutic targets that are maintaining the eating disorder, including overvaluation of weight and shape; body checking and avoidance; dietary rules; and developing a problem-solving, active stance to address triggers in the environment that lead to eating disorder behaviors. If CBT-Eb is being delivered, this stage would also include strategies that address clinical perfectionism, low self-esteem, and interpersonal problems. Stage 4 is the final phase of treatment and it is focused on maintaining progress and preventing relapse over three appointments spaced every 2 weeks.

Evidence-Based Treatments for Eating Disorders

In clinical practice, CBT interventions are often used with a mixed group of clients with eating disorders, although there are very few studies examining CBT in such samples. In one study, CBT was found to be well received by a mixed group of clients on an inpatient eating disorder unit, with clients preferring a brief CBT intervention over a psychoeducation group (Wiseman, Sunday, Klapper, Klein, & Halmi, 2002). Another study found that a 13-week group CBT intervention was efficacious in producing symptom reduction in an adolescent sample with mixed eating disorders (Charpentier, Marttunen, Fadjukov, & Huttunen, 2003).

Until the more recent development of transdiagnostic CBT-E, the research literature focused on CBT interventions developed specifically for BN, AN, and BED. Overall, there is greater evidence for the efficacy of CBT in BN and BED, and preliminary evidence that it may also be helpful in the treatment of AN (Galsworthy-Francis & Allan, 2014; Watson & Bulik, 2013).

CBT is considered the first-line treatment for BN (Wilson, 1999; Wilson & Fairburn, 2002). Approximately 50% of individuals receiving manual-based CBT for BN cease binge eating and purging (Wilson & Fairburn, 2002). In addition to improvement in the core clinical features of the eating disorder (binge eating, purging, caloric restriction, and maladaptive thoughts and beliefs about weight and body shape), improvement in concurrent psychological symptoms is also observed (e.g., low self-esteem and depression; Wilson & Fairburn, 2002). CBT for BN has been associated with good treatment efficacy and maintenance of gains (Jacobi, Dahme, & Dittmann, 2002). In one study, 69% of clients had no current eating disorder diagnosis and 85% no longer met criteria for BN at a 3-year follow-up post-CBT (Carter, McIntosh, Joyce, Sullivan, & Bulik, 2003). At 10-year follow-up, CBT was associated with improved social adjustment compared to the control group (Keel, Mitchell, Davis, & Crow, 2002). For CBT nonresponders, the success of secondary sequential treatments, such as interpersonal psychotherapy (IPT) and pharmacotherapy, appears to have little added benefit (Mitchell et al., 2002). In addition, there is some evidence that combining CBT with pharmacotherapy (fluoxetine) does not lead to better outcome than CBT alone (Jacobi et al., 2002). CBT for BED is based on CBT for BN and has been shown to have good efficacy for reducing binge eating and associated symptoms (see Iacovino, Gredysa, Altman, & Wilfley, 2012, for a review).

Application of CBT to AN has been understudied for a number of reasons: The low prevalence of the disorder hinders recruitment to ensure adequate power for detection of statistically significant effects; treatment is lengthy, averaging at least 1 year; study recruitment is hampered by difficulties with motivation; and the presence of serious medical illness due to complications does not allow for participation in an RCT (Wilson &

Fairburn, 2002). However, evidence indicates that CBT for AN shows promise. There is some indication that CBT is preferred over standard behavioral treatment and is associated with significant symptom reduction in AN (Channon, de Silva, Hemsley, & Perkins, 1989; Serfaty, Turkington, Heap, Ledsham, & Jolley, 1999). Based on the utility of CBT in BN, there is good reason to believe that it may be beneficial for treatment of AN (Wilson & Fairburn, 2002), although more research is needed as a review of studies shows mixed findings (Galsworthy-Francis & Allan, 2014).

However, the clinical efficacy of CBT in the treatment of eating disorders is not ideal. Although CBT is clearly a beneficial treatment for BN, the degree of symptom improvement is limited, with about 50.0% of clients achieving symptom remission (Wilson, 1999). The remaining half of clients achieve partial improvement or exhibit no response to treatment (Wilson, 1999). Given this reality, Wilson has proposed that current CBT be improved either through expansion of clinical focus to broader issues (self-esteem, emotion regulation, interpersonal issues, etc.) or through increased emphasis on the core features of BN, especially weight- and shape-related cognition. CBT-E was developed to address a broader range of mechanisms that may maintain the eating disorder. Results from studies on the efficacy of CBT-E for individuals with any form of eating disorder are promising and have been shown to have efficacy across different eating disorder presentations (Fairburn et al., 2009, 2013; Norris, Gleaves, & Hutchinson, 2019). In a comparison of CBT-E and IPT, 65.5% of CBT-E participants achieved remission of their eating disorder compared to 33.3% of IPT after 20 weekly sessions of treatment and maintenance of gains over the 60-week follow-up period (69.4% CBT-E vs. 49.0% IPT; Fairburn et al., 2015). A systematic review of CBT-E in BN and mixed eating disorder samples provided strong support that it is an effective treatment, although there was high variability in posttreatment remission rates across studies that ranged from 22.2 to 67.6% (de Jong, Schoorl, & Hoek, 2018).

In addition to reducing the symptoms of eating disorders, CBT has been associated with improvements in quality of life. In a recent meta-analysis, CBT was associated with significant but modest improvements in quality of life relative to comparison conditions (Linardon & Brennan, 2017).

Despite the promise of CBT and CBT-E, a substantial portion of clients still remain symptomatic following treatment. Thus the eating disorder field is highly focused on optimizing treatment outcomes by addressing barriers to access and uptake of evidence-based treatments, improving delivery of evidence-based treatments across the levels of care in which clients are seen for treatment, and identifying the key treatment mechanism to guide optimization efforts. There is a significant need to improve treatment outcomes in eating disorders (Murray, 2019).

Evidence for Group Treatments for Eating Disorders

This section focuses on CBT. (See Polivy & Federoff, 1997, for a review of other types of group treatments.) Many studies demonstrate the effectiveness of group CBT, with significant reductions in bulimic symptoms (e.g., Leung, Waller, & Thomas, 2000). One study directly comparing individual and group CBT for BN found that both modalities were equivalent on the majority of outcome variables and in attrition rates—however, clients receiving individual CBT had a greater degree of abstinence from bulimic behaviors than did those in group CBT. However, this difference was not evident at follow-up (Chen et al., 2003). Although there is some evidence that group treatment may be associated with a higher dropout rate than individual treatment (Garner, Fairburn, & Davis, 1987), other research, including a meta-analysis (Hartmann, Herzog, & Drinkmann, 1992), suggests that the two modalities are essentially equivalent. In one study, group CBT was associated with higher abstinence rates than pharmacotherapy (fluoxetine) only, or CBT combined with pharmacotherapy (Jacobi et al., 2002). A meta-analysis of 10 studies examining group therapy for BN found that group CBT is effective for BN compared to no treatment but there was limited data to directly compare group versus individual formats (Polnay et al., 2014). Group CBT has also shown good efficacy for treatment of BED. In a large study comparing group CBT to group IPT for BED, both treatments were found to be effective for reducing the symptoms of BED with 79% (CBT) and 73% (IPT) of participants abstinent from binge eating following the 20-session group (Wilfley et al., 2002). These gains were maintained over a long-term follow-up period of 4 years (Hilbert, Bishop, Stein, Tanofsky-Kraff, & Swenson, 2012). In another study comparing individual and group CBT for BED, both formats were associated with a significant reduction in binge eating frequency following treatment and over a 3-year follow-up period (Ricca et al., 2010). A randomized controlled study comparing individual and group CBT for BED found that both delivery formats were associated with a similar treatment response across all outcome measures both immediately posttreatment and over a 3-year follow-up period (Ricca et al., 2010).

A meta-analysis of 27 randomized controlled studies examining the efficacy of group psychotherapy (primarily CBT based) for adults with eating disorders found that group therapy was more effective compared to the wait-list control in reducing eating disorder symptoms with medium to large treatment effect sizes (Grenon et al., 2017). Interestingly, group CBT did not differ from other forms of group psychotherapy (e.g., IPT) on any outcomes examined.

There has been limited research on group CBT for AN, with mixed results. One study provided evidence that group CBT leads to symptom reduction (Aranda et al., 1997). However, in another study, a 10-week CBT

group was not associated with any significant symptom reduction, likely due to the short-term nature of the intervention, as well as process factors important for symptom change, such as motivation, insight, and ambivalence toward treatment (Leung, Waller, & Thomas, 1999). Given the lack of controlled trials examining group CBT in AN, it is premature to come to any conclusions at this time (see Galsworthy-Francis & Allan, 2014, for a review).

Research examining the implementation of a CBT-E in a group setting suggests that it is effective in reducing eating disorder symptoms compared to a wait-list control after the first 8 weeks of treatment in a sample of individuals with mixed eating disorder presentations (all BMI ≥ 18), with over 70.0% of the sample completing the group treatment and good outcome achieved in 66.7% of treatment completers after 20 sessions, including significant improvements in associated symptoms of clinical perfectionism, self-esteem, interpersonal difficulties, and mood intolerance (Wade, Byrne, & Allen, 2017).

More recently, Stice, Yokum, and colleagues (2019) reported on the effectiveness of a brief (eight weekly 1-hour sessions) transdiagnostic group treatment for eating disorders designed to be more accessible and less resource intensive than CBT-E. The body project treatment (BPT) group extended their body project eating disorder prevention group (Stice, Marti, Spoor, Presnell, & Shaw, 2008) and utilizes verbal, written, and behavioral exercises to create dissonance by highlighting the costs of valuing a thin body ideal and eating disorder beliefs and behavior. BPT has been found to be an effective intervention when compared to a wait-list control (Stice, Yokhum, et al., 2019) and compared to a supportive mindfulness group (Stice, Rohde, Shaw, & Gau, 2019) for reducing eating disorder symptoms, body dissatisfaction, and negative affect.

Assessment and Eligibility for Group CBT in Eating Disorders

Before treatment begins, assessment is conducted one-on-one, typically beginning with a diagnostic interview to confirm that an eating disorder is present and is the primary disorder, and to identify any comorbid disorders present. A thorough clinical interview is necessary to assess the important features of the eating disorder and to determine eligibility for group treatment. Issues for determining eligibility for group treatment are discussed in later sections in this chapter.

The clinical interview should cover the following topics: demographic features, current body weight and weight history, weight-controlling behaviors, food and liquid consumed on a typical day, binge-eating and eating behavior (e.g., food intake on a typical day), attitudes toward weight and shape, activity level, family history, medical history, social supports,

history of self-harm, trauma and abuse, comorbid conditions, motivation, and treatment goals. A useful assessment tool for providing a detailed assessment of the intensity and frequency of eating disorder symptoms is the Eating Disorder Examination (EDE; Cooper & Fairburn, 1987; Fairburn & Cooper, 1993), a semistructured interview comprising 62 questions that provide five subscale scores based on symptoms over the past month: dietary restraint, bulimia, eating concern, weight concern, and shape concern. Another option is the Eating Disorder Module of the Diagnostic Assessment Research Tool (DART; McCabe et al., 2017). The DART is a modular, semistructured interview to assess DSM-5-TR mental disorders.

To supplement the clinical interview, self-report measures are recommended to assess initial symptom severity and treatment response in the following areas: eating disorder symptoms and associated features, self-esteem, depression, anxiety, and personality functioning. Some of the most popular measures for eating disorders are described here. For a more comprehensive review of a range of assessment tools for eating disorders, the reader is referred to Grilo and Mitchell (2010), and Walsh, Attia, Glasofer, and Sysko (2015).

To assess eating disorder features, the Eating Disorder Inventory (EDI; Garner, Olmsted, & Polivy, 1983) and the Eating Disorder Inventory–2 (EDI-2; Garner, 1991) are excellent measures to capture symptoms across eating disorder diagnoses. Norms are available for both eating disorder client and nonclient samples. The original EDI is a 64-item measure with three subscales assessing specific eating disorder attitudes and behaviors (Drive for Thinness, Bulimia, and Body Dissatisfaction), and five subscales assessing general features associated with an eating disorder (Maturity Fears, Ineffectiveness, Perfectionism, Interoceptive Awareness, and Interpersonal Distrust). The EDI-2 includes an additional 27 items that form three additional subscales (Asceticism, Impulse Regulation, and Social Insecurity). The EDI-3 (Garner, 2005) incorporates the same question set as the EDI-2 with some modifications to response choices and scoring, and has been shown to have good psychometric properties (Clausen, Rosenvinge, Friborg, & Rokkedal, 2011). There is also a self-report version of the EDE, the Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994), although data are inconsistent on the degree of agreement between the EDE and the EDE-Q (see Peterson & Miller, 2005, for a review). Furthermore, a number of studies suggest that the reliability and validity of the EDE-Q may be enhanced by providing definitions of the concepts (e.g., "binge") asked about prior to administration of the EDE-Q (Peterson & Miller, 2005). In addition, there are measures specific to eating disorder diagnosis, such as the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979) for assessment of AN, and the Binge Eating Scale (BES; Hawkins & Clement, 1980) and Bulimia Test—Revised (BULIT-R; Thelen, Farmer, Wonderlich, & Smith, 1991) for assessment of BN. When selecting a measure, it is important to ensure it has good psychometric properties

in the sample you are assessing. For example, common measures of disinhibited eating and binge eating do not demonstrate good reliability in men (Forbush, Hilderbrand, Bohrer, & Chapa, 2019). The Eating Pathology Symptoms Inventory (EPSI; Forbush et al., 2013) was developed as a broad measure of eating disorder symptoms to improve upon existing measures that had poorer psychometric properties in samples of men and overweight or obese individuals. The EPSI comprises eight scales assessing body dissatisfaction, binge eating, cognitive restraint, excessive exercise, purging, restricting, muscle building, and negative attitudes toward obesity.

Inclusion Guidelines

The suggestions in this section describe ideal conditions under which eating disorders are treated in groups. In clinical practice, it is unlikely that such conditions will be met in assembling an ideal group, although it may be useful to consider these guidelines.

Diagnosis and Clinical Severity

Although research studies examining treatment efficacy using RCTs have focused on a homogeneous composition of group members (e.g., only clients with BN), in clinical practice this may not always be feasible or practical. It is common for groups in clinical settings to comprise members with a range of eating disorder diagnoses. However, there is very little research on which to base this decision. There is some evidence that mixed groups of AN, BN, and groups including males do not have a negative impact on outcome (e.g., Inbody & Ellis, 1985)—however, this work was not specific to CBT group therapy.

If resources allow, we recommend separating groups by diagnosis for a number of reasons, both process and practical. Mixed groups include differences in symptom presentation and treatment goals that may detract from cohesiveness (e.g., weight gain for AN vs. no weight goal for BN). Variation in symptom severity is a factor that may detract from treatment gains when individuals with less severe symptoms develop greater symptom severity when exposed to individuals with more severe disorders (Frommer, Ames, Gibson, & Davis, 1987). In addition, a mixed group may contribute to a group culture of envy (e.g., individuals with BN and BED admiring the low weight of those with AN) and competition (MacKenzie & Harper-Guiffre, 1992), although competition can exist in a homogeneous group as well. Differences in disorders may also contribute to a reduction in safety and comfort of self-disclosure in the group. For example, BN and BED are associated with shame, guilt, and embarrassment that is not present to the same degree with AN. Individuals with BN and BED may be more comfortable revealing their feelings in a group of individuals sharing their concerns (Roy-Byrne, Lee-Benner, & Yager, 1984). There is evidence that individuals

with BN report feeling intimidated by individuals with AN—thus, a mixed group may contribute to an individual with BN feeling self-disgust and shame (Enright, Butterfield, & Berkowitz, 1985). Individuals with BED tend to be older, with a greater proportion of males—thus, they may not relate to younger, predominately female clients with AN and BN in terms of stage of life and life issues. Finally, clients with AN require a longer course of treatment than do individuals with BN or BED.

Given the practical necessity of running a mixed group composed of clients with varying symptom presentations in most clinical settings, it is worth noting that there are also benefits to a heterogeneous group composition. Clients may benefit from being exposed to group members of varying body sizes, all of whom share common concerns and fears. Clients with more severe symptoms may gain hope and possible strategies from interacting with group members who have less severe symptoms and have achieved greater symptom control. In clients with AN, a mixed group may lessen competition among group members and challenge weight stereotypes and prejudice. The potential difficulties that may arise with a heterogeneous group (noted earlier) can be managed within the group by acknowledging individual differences at the outset of the group, and later emphasizing commonalities and shared concerns.

Ideally, when treating individuals with eating disorders in a group, the eating disorder should be the primary diagnosis. Given the significant comorbidity with other psychiatric disorders, the presence of additional disorders should be considered when determining an individual's suitability for group inclusion. For example, the presence of severe social anxiety disorder (SAD) may interfere with an individual's ability to participate fully in a group format. Alternatively, the presence of a SUD may compromise an individual's ability to benefit from a group treatment.

If group members have mixed diagnoses, it is ideal to have a balance of the disorders represented, as well as symptom severity (e.g., including at least two individuals with the same diagnosis). For example, a group consisting primarily of individuals with BN and BED and only one individual with AN may not function well because the individual with AN may view him- or herself as not fitting in or may feel that their needs are not being met. Individuals with very severe symptoms may benefit more from individual treatment tailored to meet treatment needs. Feeling that a group is not addressing one's needs has been shown to be significantly related to dropout in a CBT group for BN (McKisack & Waller, 1996).

Comorbidity

Comorbidity is not a rule out for group membership, although there is little research examining the impact of comorbidity on treatment outcome. Given the high degree of comorbidity in a population with eating disorders, comorbidity is more the norm than the exception. Generally speaking,

when comorbidity is present, the therapists should consider whether the individual's treatment needs would be better met with individualized treatment. In addition, the impact of comorbidity on the treatment experience of other group members should be considered when determining eligibility for group treatment. For example, an individual with comorbid BPD who engages in frequent self-harm and suicidal behaviors may not be best served in a group format. If an individual presents with comorbid symptoms that would interfere with participation in the group, negatively impact other group members, or interfere with the ability to follow through with treatment, then it is best to have that person treated on an individual basis. Examples of comorbid diagnoses that may warrant exclusion from the group include psychotic disorders and SUDs.

Motivation and Commitment

CBT is an active treatment intervention requiring a great deal of effort on the part of the client through extensive between-session homework exercises. If an individual is not ready to engage in a change intervention, then group CBT is not a good match. Such an individual would benefit more from a treatment focused on enhancing motivation for change. An important part of the assessment is determining an individual's motivation for change and commitment to therapy. Dropout rates for a CBT group for BN were as high as 42% in a study by Jacobi et al. (2002). In a study of group CBT-E in AN, the dropout rate was 50%, with 22 of the 44 participants not completing treatment (Frostad et al., 2018). Thus, therapists need to prepare group participants for involvement and try to boost commitment. Establishing a contract with group members regarding attendance, participation, and expectations may be useful (Lacey, 1983). It is important for group members to be able to commit to all the group sessions to minimize disruption to their own treatment, as well as that of the rest of the group. It may also be useful to provide educational sessions that clearly outline what the treatment process involves to address potential concerns and to correct misinformation.

Treatment ambivalence and ego syntonicity of some symptoms may require more direction from therapists to address aspects that clients do not see as being problematic (i.e., low weight in AN). There is some evidence that readiness for change is associated with better treatment outcome in BN (Franko, 1997). In addition, reduced symptom severity has been related to group dropout in a CBT group for BN (McKisack & Waller, 1996), most likely due to the impact on treatment motivation. A useful exercise in the initial stage of treatment is to have group members examine the personal costs and benefits of living with an eating disorder versus recovery, and then share their experiences in the group. This motivational interviewing (MI) intervention helps to increase awareness and boost motivation for treatment.

Structuring Group CBT for Eating Disorders

Table 10.1 provides details of group composition and treatment format from a number of studies on group treatment for BN and BED. In this section, we make specific recommendations based on the research literature and our own clinical experience with regard to group context, composition, group inclusion considerations, the structure of group sessions, and treatment considerations, paying attention to how various aspects may affect group process. In addition, challenges to group process are discussed. Group therapy may be particularly beneficial by providing an interpersonal therapeutic environment that may foster change in relation to proposed eating disorder maintenance factors, including interpersonal problems, low self-esteem, and clinical perfectionism (Grenon et al., 2017).

Sessions should be scheduled to last 2 hours. Each session begins with setting an agenda, in which therapists give a brief overview of the topics to be covered. Clients may be given the opportunity to add items to the agenda (e.g., questions, issues arising from the last session). Material and homework from the previous week are then reviewed. Once self-monitoring begins, group members are asked to refer to their monitoring forms to discuss how their homework went. It can be helpful for therapists to collect the monitoring forms, so that feedback can be provided. This is especially important in the initial weeks of normalized eating, because clients benefit from specific feedback and clarification regarding food servings and classification of food. Collection of homework also underscores for clients the importance of homework completion. Homework review often takes half the session; concepts are highlighted and reviewed, group members' experiences are linked, and obstacles and challenges are identified and problem solved within the group. The remainder of the group session focuses on new material. The last part of the session involves assigning homework for the next week, such as cognitive restructuring, assertiveness, nutrition skills, activity guidelines, and so forth.

Context

Group CBT for eating disorders may be conducted in an outpatient, day hospital, or inpatient setting. Given that each CBT session builds upon previous sessions, with an emphasis on skills development, a closed group is required, with group members remaining together from the outset until completion of the group. This format works well in an outpatient setting but will likely present a challenge to the day hospital or inpatient context, where open groups tend to be utilized as clients enter and leave the program at varying times due to differing lengths of stay and treatment needs. Incorporation of small, brief modules (cognitive strategies, behavioral strategies, etc.) that are closed may provide one format that is suitable for a day hospital or inpatient setting.

TABLE 10.1. Format and Composition for a Sample of Group Eating Disorder Treatments

Study	Number of sessions	Group composition	Session length	Strategies
BN				
Bailer et al. (2004)	18 weekly sessions	8–12 patients, 2 therapists	1.5 hours	Psychoeducation, self-monitoring, CBT model of BN, cognitive and behavioral strategies for symptom control, cognitive restructuring, behavioral experiments, relapse prevention
Chen et al. (2003)	19 weekly sessions	6 patients, 1 therapist	1.5 hours	CBT based on Fairburn et al. (1993)
Jacobi et al. (2002)	20 sessions over 16 weeks (twice weekly for first month and weekly for remaining 3 months)	Number of patients not specified, 2 therapists	2 hours	CBT based on Fairburn (1985), Agras (1987), and Jacobi, Thiel, and Paul (1996)
BED				
Wilfley et al. (2002)	20 weekly sessions	9 patients, 2 therapists	1.5 hours	Behavioral strategies and self-monitoring, with a focus on normalizing eating, cognitive restructuring, and relapse prevention techniques
Gorin et al. (2003)	12 weekly sessions	6–11 patients, 2 therapists	1.5 hours	Cognitive and behavioral strategies to promote symptom reduction and normalization of eating based on Telch and Agras (1992), including self-monitoring, examination of triggers for binges, development of exercise program, and relapse prevention

(continued)

TABLE 10.1. *(continued)*

Study	Number of sessions	Group composition	Session length	Strategies
Transdiagnostic				
Wade et al. (2017)	18 weekly sessions, 1 individual session at Week 8, 1 individual session at 3-month follow-up	Number of patients not specified, 2–3 therapists	2 hours group, 50 minutes individual	5- to 10-minute session with individual therapist at start of group session to complete weighing and discuss self-monitoring; CBT group sessions based on individual CBT-E (i.e., motivation; psychoeducation; self-monitoring; regular eating; mood intolerance; review of progress and barriers to change; overevaluation of weight, shape, and eating; self-esteem; clinical perfectionism; interpersonal difficulties; maintaining gains; and relapse prevention.
Stice, Yokum, et al. (2019)	8 weekly 1-hour sessions	4–9 participants, 2 therapists		Various written, experiential, and verbal exercises focused on costs of pursuing thin beauty ideal and eating disorder behaviors; targeted reduction of eating disorder behaviors using self- monitoring and strategies, including normalizing eating.

Composition and Format

Composition of Groups

It is generally recommended that the group be run by two therapists. Based on efficacy studies of CBT, the average number of group members ranges from six to 12 in studies of BN and BED (see Table 10.1). There is a lack of studies on group CBT for AN, but it has been speculated that clients with AN may do better in a smaller group (from four to five participants), which allows more group time for each member and maximizes client interaction (Hall, 1985). It is advisable to allow a few extra members in the group to balance group attrition rates, which may range from 11% for BED (Wilfley et al., 2002) to over 30% for AN (Chen et al., 2003) and BN (Leung et al.,

1999, 2000). Given the higher prevalence of eating disorders in women compared to men, it is likely that the group would be composed primarily of women. However, men do present with eating disorders and often have unique gender-specific issues (e.g., increased stigma, body image focused more on muscularity) that may be better addressed by having a group tailored solely to men versus including one man in a group of women, which may increase the risk of dropout (Gorrell & Murray, 2019; Strother, Lemberg, Stanford, & Turberville, 2012).

Number and Frequency of Sessions

The few existing studies of group CBT for BN and BED have typically consisted of 18–20 sessions of 1.5–2 hours' duration, with sessions held on a weekly basis (see Table 10.1). In the protocol presented in this chapter, we recommend 20 weekly 2-hour sessions. Further research is needed to determine the optimal number of group CBT sessions for BN, BED, AN, and mixed disorders.

Therapist Training

Attention should be given to the training and background of the cotherapists. Therapists should be trained in application of CBT to a population with eating disorders. It can be beneficial to have a dietician with training in CBT for eating disorders as one of the cotherapists. This is especially important in a group for AN, where emphasis is placed on increasing food intake for weight gain, but it may also be helpful in groups for BN and BED given the major role that normalized eating plays in treatment. A dietitian serves as a credible resource for education regarding issues related to food intake and caloric needs, thus engendering trust in clients to make behavioral changes to their eating.

Key Treatment Components for Eating Disorders

This section provides an overview of the main CBT components for treating eating disorders. (See Wilson, Fairburn, & Agras, 1997, for a more detailed description of treatment for AN; Garner et al., 1997, and McCabe, McFarlane, & Olmsted, 2003, for a more detailed description of treatment for BN. See Murphy et al., 2010, for a more detailed description of treatment for transdiagnostic CBT-E.) Table 10.2 provides a summary of what is covered in each session (and see the "sample protocol" that follows below). This outline is based on a group treatment for mixed eating disorders developed by Laliberté and McKenzie (2003).

TABLE 10.2. Sample Outline of Treatment Protocol for Group CBT for Eating Disorders

Session	Strategies covered
Pretreatment individual meeting	• Explain how the group will work and what to expect. • Introduce norms and rules for group and provide practical information (e.g., location). • Answer any questions and address concerns.
Session 1	• Introduction to group members (group members share personal experiences of what brought them to group). • What to expect from treatment. • Psychoeducation: physical and psychological consequences of eating disorders. • Discussion of reasons for change and the benefits and costs. • Homework: exercise to determine the pros and cons for giving up eating disorder and working on recovery.
Session 2	• Homework review. • Psychoeducation: set-point theory and normalized eating. • Discussion of what this means for group members and what they need to work on. • Homework: readings.
Session 3	• Homework review. • Psychoeducation: CBT model for understanding an eating disorder. • Group members discuss how the model is personalized for them, based on their experiences.
Session 4	• Homework review. • Introduce role of self-monitoring. • Each group member develops a personalized plan for working toward normalized eating and sets an eating goal to work toward for the next session. • Homework: daily monitoring of food intake.
Session 5	• Homework review. • Group members discuss progress made toward working on eating goals. • Obstacles and challenges are identified and problem solved within the group. • Behavioral strategies for normalizing eating are reviewed. • Homework: daily monitoring of food intake and situational context; each group member sets new behavioral goal related to normalizing eating.
Session 6	• Homework review. • Discussion of the connection between situational context and eating. • Exploration of social, interpersonal, and emotional triggers for eating disorder symptoms. • Behavioral strategies for managing symptoms are reviewed. • Homework: daily monitoring of eating, eating disorder symptoms, and triggers; each group member sets new behavioral goal related to normalized eating.
Session 7	• Homework review. • Group members discuss connections between triggers and symptoms, and identify patterns; high-risk situations are identified for each group member.

(continued)

TABLE 10.2. *(continued)*

Session	Strategies covered
Session 7 *(continued)*	• Group problem solving is used to manage triggers and risky situations. • Homework: daily monitoring (eating and symptoms, triggers); behavioral goals are set for normalizing eating and managing risky situations.
Session 8	• Homework review. • Check on progress toward normalized eating. • Discussion of common challenges to normalized eating (e.g., restaurants, buffets, parties, illness, holiday meals). • Strategies for managing these challenges are discussed. • Individualized goals are set. • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals.
Session 9	• Homework review. • Discussion of exercise as an eating disorder symptom. • Group members share their current level of activity and how it may play a role in their eating disorder. • Discussion of reasons to exercise other than weight control (e.g., health, stress relief, fun). • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals; development of a healthy exercise plan. (*Note:* For an individual with AN, this would mean no exercise until a minimum healthy weight is achieved.)
Session 10	• Homework review. • Discussion of emotional triggers and introduction of techniques to manage strong emotions and anxiety (e.g., tolerating discomfort, self-soothing, relaxation, mindfulness). • Identification of obstacles and challenges, problem solving, and goal setting. • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals.
Session 11	• Homework review. • Psychoeducation: role that thoughts play in the eating disorder. • Introduction of cognitive strategies (e.g., identifying thoughts, cognitive distortions). • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals; completion of monitoring form; recording situation, thoughts, and feelings.
Session 12	• Homework review. • Introduction to cognitive strategies for challenging thoughts using group examples from the homework. • Setting of behavioral goals. • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals; completion of a thought record.
Session 13	• Homework review. • Review of group examples from thought records to identify common challenges or difficulties. • Further discussion of application of cognitive strategies. • Setting behavioral goals. • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals; completion of a thought record.

(continued)

TABLE 10.2. *(continued)*

Session	Strategies covered
Session 14	• Homework review. • Review of group examples from thought records to identify common challenges or difficulties. • Introduction to core beliefs, underlying rules and assumptions, and strategies for shifting core beliefs. • Setting behavioral goals. • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals; using a thought record to identify core beliefs.
Session 15	• Homework review. • Review of group examples from thought records to identify common challenges or difficulties. • Group discussion of core beliefs and exploration of their origins. • Introduction to the connection between core beliefs and compensatory strategies (perfectionism, need to please others, etc.). • Introduction to behavioral experiments. • Setting behavioral goals. • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals; using a thought record to identify core beliefs, and explore origins and related compensatory strategies; plan behavioral experiment.
Session 16	• Homework review. • Psychoeducation: review of the basic building blocks of nutrition. • Review of progress toward normalized eating for each group member. • Discussion of challenges and problem solving. • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals; completion of thought record.
Session 17	• Homework review. • Discussion of challenges and problem solving. • Discussion of strategies for managing interpersonal triggers and conflicts (e.g., assertiveness, communication, problem solving). • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals; completion of thought record.
Session 18	• Homework review. • Discussion of challenges and problem solving. • Body image. • Homework: daily monitoring (eating and symptoms, triggers); working toward behavioral goals; completion of thought record.
Session 19	• Homework review. • Discussion of challenges and problem solving. • Discussion of issues and problems that may underlie the eating disorder and strategies for dealing with these issues (e.g., problem solving, further therapy needs). • Homework: completion of exercise to review progress made in group and identify continued goals and areas of vulnerability.
Session 20	• Homework review. • Identification of potential triggers for relapse. • Relapse prevention strategies.

Psychoeducation

Psychoeducation is a critical component in CBT for eating disorders. In one study, a brief psychoeducation group treatment was found to be as effective as individual CBT with the least symptomatic clients with BN (Olmsted et al., 1991). Many of the maladaptive compensatory behaviors are based on misinformation (e.g., that vomiting and laxatives are effective ways of controlling weight)—thus, provision of corrective information assists individuals in giving up purging behaviors and provides a basis to buy into the treatment rationale (e.g., that normalized eating will reduce bingeing urges caused by caloric restriction). Psychoeducation may be provided in a separate group, before the CBT group begins, or it may be fully integrated into the CBT group.

It is important to cover a number of topics in the psychoeducational material:

- A CBT model for understanding how eating disorders develop, and the biological and psychological processes that maintain the disorder (e.g., eating disorder symptoms play a role in maintaining the eating disorder: caloric restriction leads to a binge, which then leads to steps to eliminate the calories consumed in the binge, such as vomiting, overexercising, use of laxatives, and further caloric restriction, thus leading to a vicious cycle of symptoms).

- The connection between eating disorder symptoms (dietary restriction, binge eating, purging, etc.) and self-esteem and related problems, and the many functions that the eating disorder may serve in the individual's life (self-protection, distraction from overwhelming problems, a way of taking control, getting attention, etc.).

- The process of weight regulation and set-point theory of body weight (e.g., the idea that body weight physiologically regulates around a "set point" that the body tries to "defend" to prevent significant changes in weight; Keesey, 1993) and more recent findings on the role that biological factors play in stable body weight.

- The link between strict dieting (eating too little, avoiding pleasurable foods) and binge eating.

- The physical, psychological, and social consequences of an eating disorder and the health risks associated with starvation, low body weight, vomiting, laxative and diuretic abuse, and excessive exercise.

- Guidelines for normalized eating (restoration of regular eating patterns) and activity level, and their role in recovery.

- The idea of a healthy weight range (vs. an "ideal" number) or a

personalized "natural" weight associated with a healthy lifestyle (vs. a prescribed "ideal" weight).

Across treatment sessions, the therapists serve as sources of education. It is also helpful for all clients to be given a list of self-help treatment manuals to read as they go through treatment, such as *The Overcoming Bulimia Workbook* (McCabe et al., 2003; see Garner, 1997, for more detailed information on the psychoeducational topics described above).

Weekly Weighing

Regular weighing is essential for AN, in which work toward establishing a healthy weight is a central goal of treatment. In the case of BN, weighing is optional. Clients may be instructed to weigh themselves on their own once per week, and then discuss their thoughts and feelings about their weight in the group. The rationale for weekly weighing should be presented. Weighing is a behavioral strategy for assessing concerns about weight and shape, as well as a source of feedback on changes related to eliminating symptoms (e.g., binges, overexercising) and efforts toward normalizing eating. Emphasis is placed on accepting a weight range rather than a specific number. In addition, education is given regarding natural fluctuations in weight. For individuals who weigh themselves frequently, reducing this behavior to once per week is a form of response prevention. Excessive weighing is a checking behavior typically used to reduce anxiety about what the number on the scale might be, as well as a source of information that guides behavior and increases symptoms (e.g., if one's weight has increased, more caloric restriction or exercising is indicated). Weighing is also useful once clients have normalized their eating and activity, because it demonstrates the stability of weight even after exposure to "forbidden" foods or eating a large meal. This information helps to reduce anxiety about normalized eating.

Self-Monitoring

Self-monitoring is an integral tool in CBT. When working with eating disorders, self-monitoring is used to detect triggers of symptoms, patterns of symptoms, urges for symptoms, and to identify goals. Self-monitoring also increases awareness of the links among thoughts, feelings, and behaviors, and the environmental context. In addition, self-monitoring forms the basis for homework assignments across treatment. Clients should be provided with the treatment rationale for self-monitoring, including the purpose and why it is important, as well as guidelines for how to self-monitor (e.g., recording data specifically and accurately as soon as possible after an event). To monitor eating symptoms, clients typically record patterns of food and liquid intake on a daily basis. In addition, the context (e.g.,

situation, time, and place) and associated thoughts, feelings, and behaviors are also recorded. Clients are encouraged to record data directly after eating, if possible. Given the labor-intensive nature of self-monitoring, therapists should focus on having the group track only those aspects that will be discussed in the group.

In the group setting, clients review their self-monitoring records in detail. Therapists and other group members may help the client to identify patterns and gaps, situational triggers, and context. The quantity, as well as the quality and timing, of eating is reviewed to establish homework goals. Cognitive and behavioral strategies are then applied in the group to manage triggers and urges for symptoms.

Normalized Eating

One of the main strategies for recovery from an eating disorder is promotion of normalized eating and reduction of dietary restraint. "Normalized eating" refers to a meal plan consisting of three nondieting meals and one to two snacks per day, with meals incorporating variety and including high-energy foods (typically avoided foods) and added fats. Eating typically is planned to start within 1 hour of waking, then every 3–4 hours thereafter. Elimination of diet products is an important part of exposure to more normal foods, in addition to allowing the client to achieve the necessary energy intake. A normalized meal plan is approximately 2,000–2,200 calories for females and 2,300–2,500 for males, although these totals may vary depending on age, height, and activity level. Ideally, a dietitian estimates the exact energy needs for the individual. Individuals work to normalize eating at their own pace, with emphasis on the timing and structure of meals, increased variety, and exposure to feared or "risky" foods. Cognitive-behavioral strategies are used to manage urges, to identify high-risk situations that trigger symptoms, and to develop skills for coping with high-risk situations (e.g., stimulus control, meal planning, introduction of feared foods). It is important to prepare clients to tolerate the physical discomfort that may come from normalized eating and to emphasize that the discomfort will gradually pass. This is especially true for individuals with AN or for clients who frequently purge, both of whom may suffer from delayed gastric emptying. In some cases, when expert medical advice is available, medication may be useful to help manage gastrointestinal symptoms that occur in the early stages of normalized eating.

Behavioral Strategies for Symptom Control

Behavioral strategies are a key component for achieving symptom control. Strategies should be individually tailored, planned, specific, and simple. Clients are encouraged to distinguish between an urge and actually engaging in symptomatic behavior. Once the urge is identified, strategies can be

applied until the urge passes or reduces in intensity. Separation of the urge from the symptom itself helps to increase feelings of personal control. It is helpful to remind clients that the strategies they use are not necessarily permanent but represent a temporary tool used for recovery. Also, clients are encouraged over time and with self-monitoring to anticipate the circumstances commonly associated with urges for symptomatic behavior. In this way, the situation can be managed by problem solving and planning, which is easier than dealing with the symptom once it is activated. It is also helpful to review the benefits and costs for acting on an urge versus not acting on an urge. In terms of not acting on an urge, the cost is short-term distress and the benefit is long-term, permanent change and increased control. We next discuss behavioral strategies to manage symptoms.

Delay and Distraction

Delay involves introducing a waiting period between experiencing an urge and acting on the urge with symptomatic behavior (e.g., vomiting). Delay is typically combined with the use of distraction. For example, in response to an urge to vomit, an individual may decide to delay acting on the urge for 10 minutes, in the hope that the urge will pass. During the 10-minute period, the individual is instructed to engage in activities to distract him- or herself from acting on the urges (e.g., leaving the house, calling a friend).

Mechanical Eating

Mechanical eating involves planning meals in advance (including the time and place, and the food and liquid to be consumed) and then following through with the plan no matter what (e.g., despite not feeling hungry or being busy). The goal of this strategy is to eliminate confusion (e.g., wondering what and when to eat) that may lead to restriction, as well as the anxiety associated with having to make a spontaneous decision regarding what and how much to eat.

Exposure

Exposure-based strategies involve having the individual gradually confront feared and/or avoided situations or foods. Examples include eating an avoided food (e.g., a risky dessert), wearing a bathing suit or a particular item of clothing, or looking in a mirror. Exposure should be combined with response prevention when appropriate—for example, preventing the response of checking weight change on the scale following consumption of an avoided food. Usually, treatment is focused initially on exposure to risky/avoided foods. Exposure to body image situations occurs in the later stages of treatment, once the individual's symptoms have stabilized.

Coping Phrases

Coping phrases are also a helpful strategy for managing an urge to engage in symptomatic behavior. Coping phrases should be individualized and meaningful, and often incorporate goals for recovery (e.g., "Restricting now will only lead to bingeing later," "Vomiting will not help me in my recovery process," "Food is my medicine," "This urge will pass," "Feeling full is not the same as feeling fat"). Coping phrases are useful when it may be too difficult to challenge thoughts associated with the eating disorder and may incorporate education received in earlier sessions.

Environmental Control

Controlling environmental stimuli that are associated with symptoms is another useful strategy. Clients should be encouraged to take an environmental inventory of triggers for symptomatic behavior and then make a plan to eliminate these items (a picture on the fridge as a source of motivation, a measuring cup for food, an item of clothing used to measure size, laxatives in the medicine cabinet, etc.).

Additional behavioral strategies include reduction of checking behaviors (e.g., weighing, looking in the mirror, reassurance seeking related to appearance), planning for high-risk situations (e.g., taking a list when grocery shopping and going with a supportive friend), and activity planning (e.g., activities involving new interests and hobbies).

Cognitive Strategies

Cognitive strategies for eating disorders focus on maladaptive automatic thoughts related to food, weight, and shape. Chapter 3 provides a detailed discussion on the application of cognitive strategies in a group session. In this section, we describe the use of cognitive strategies in the context of treating individuals with eating disorders within the four categories of strategies described in Chapter 3.

Exploring the Relationship among Thoughts, Situational Triggers, and Affect

Early on in treatment, group members are taught to examine the connections among their feelings, the situational context, and their thoughts. Self-monitoring by using thought records facilitates this process. Examples of common eating disorder thoughts include the following:

"I am a weak person, because I ate that piece of pizza."
"I will only eat one meal today, because my weight is too high."
"If I eat a fattening food, the fat will go directly to my thighs."

"I am a loser. I need to lose weight."
"I am not going to the pool party. I cannot wear a bathing suit. People will think I am disgusting."

Exploring Evidence and Challenging Cognitive Distortions

Individuals with eating disorders engage in a variety of cognitive distortions. Common ones include extreme or black-and-white thinking (e.g., seeing oneself as either thin or fat, strong or weak), harsh self-judgment (e.g., "I am a pig," "I am disgusting," "I am a freak"), emotional reasoning ("I felt like I gained 5 pounds from eating that piece of chocolate—therefore, I did"), and using "feeling fat" to mask true feelings about real-life situations and problems. Clients also engage in frequent social comparison, typically in the upward direction (e.g., others are more successful, thinner, attractive).

These distortions may be challenged by examining evidence that supports or does not support the thought, and by considering alternate perspectives (e.g., "What would someone without an eating disorder think about this situation?"). Consider the following example:

Situation	I was at a party with friends and they ordered pizza. I hadn't eaten all day, so I ended up having three pieces.
Feelings	Disgust—90 out of 100 Anxiety—95 out of 100 Out of control—98 out of 100
Thoughts	I shouldn't have had that pizza. I am a weak pig. I feel like I binged. I need to go vomit.
Supporting evidence	I broke all of my rules. I don't eat after 6 P.M., and pizza is a forbidden food.
Disconfirming evidence	Even though I feel like that was a binge, it is normal to eat three pieces of pizza. People without an eating disorder would think nothing of it. Given that I hadn't eaten all day, the pizza was really like my dinner. I know that I need to start incorporating forbidden foods in my recovery. Just because I feel out of control doesn't mean I should vomit. Vomiting won't really solve things, and I will just feel worse about it later. Not eating after 6 P.M. is one of my eating disorder rules, and breaking it is going to be a part of my recovery.

Balanced thought	It is okay to have had the pizza. Everyone else was having it. It was really like my dinner. Not eating all day set me up for feeling out of control. If I tolerate this discomfort, my urge to vomit will pass.
Revised feeling levels	Disgust—40 out of 100 Anxiety—60 out of 100 Out of control—50 out of 100

Exploring Underlying Beliefs and Assumptions

In addition to the examination of core beliefs, rules, and assumptions that underlie thoughts associated with eating disorders, it is also very important to focus on schema-level cognitions (core beliefs) unrelated to eating disorder themes (e.g., self-worth). The central feature across AN and BN is that weight is an important determinant of self-worth. Core beliefs unrelated to food, shape, and weight have been associated with treatment outcome (Leung et al., 2000). Core beliefs often focus on themes in which individuals believe that they are worthless, ineffective, defective, or insufficient. Interpersonal and competency themes are common as well. Individuals who have a history of being teased or abused may have core beliefs associated with rejection and likability. Behaviors aimed at weight control serve as compensatory strategies for these underlying beliefs. Perfectionism may also serve as a compensation strategy for a core belief of incompetency.

It is also important to explore what "thin" and "fat" mean to the individual. Thinness is typically related to positive themes (e.g., success, control, power, beauty), whereas "feeling fat" is typically related to negative themes (e.g., failure, weakness, unattractiveness). Once these connections are identified, individuals are encouraged to examine these connections and their validity, as well as how these beliefs fit with personal values and goals (e.g., "Do you want to be remembered for being 'thin' or for being a good person?"; "Do you judge other people based on their weight? If not, why?"). In the process of shifting core beliefs, it is important to examine how these beliefs may have developed (e.g., family factors, past experiences, traumatic events, episodes of teasing).

Behavioral Experiments

Behavioral experiments are an excellent strategy for targeting both automatic thoughts and underlying assumptions and beliefs. In a behavioral experiment, group members are encouraged to test the validity of their beliefs, the way a scientist might test a hypothesis. Examples of behavioral experiments that may be useful for people with eating disorders include the following:

- Wearing a bathing suit to the pool to see what happens. Focusing attention on what other people are doing, to see whether they are repelled or repulsed.
- Purposely trying not to do something perfectly.
- Going to a party or social event when "feeling fat" to see what the outcome might be.
- Engaging in an activity that has been put on hold until a certain weight has been achieved (getting a massage, buying a new outfit, etc.).
- Letting go of weight control measures.
- Trying normalized eating and activity.

Relapse Prevention Strategies

In the final phase of treatment, it is important to incorporate relapse prevention strategies for maintenance of change and continued recovery. These strategies include identifying and preparing for high-risk situations, development of coping and problem-solving skills to manage stress, and using past relapses as learning opportunities. Resources should be facilitated so that group members can continue work on underlying issues (e.g., self-esteem, body image, abuse, relationships, anger, and stress management) after the group has finished. Exploring what has led to past relapses provides important information that can be used in dealing with similar situations in the future. It is also beneficial to examine group members' expectations about recovery, so that the therapists may ensure that expectations are realistic and conducive to continuing and maintaining the gains clients made during treatment.

Lapses are highly likely, so it is important for the therapists to help group members prepare for such instances and use them as an opportunity to learn, as well as to practice the skills they have developed. Establishing a concrete plan of what to do in case of a slip is a useful exercise for the last group session.

Sample CBT Group Protocol for Eating Disorders

Until the development of CBT-E, research had primarily focused on the development of separate treatment protocols for individuals with AN and BN. In clinical practice, however, it is common and more practical to treat individuals with a variety of eating disorder symptoms, due to often limited resources and the variety of symptoms in individuals presenting for treatment. Thus, the following 20-session protocol is outlined for a mixed group and is based on CBT treatments described by Laliberté and McKenzie (2003), Garner et al. (1997), McCabe et al. (2003), and Wilson et

al. (1997). Treatment begins with an individual pretreatment session, followed by 20 group treatment sessions. A brief description of what occurs in each session (elaborating on the summary provided in Table 10.2) follows.

Pretreatment Individual Meetings with Group Members

Before the group begins, we recommend that each group participant meet with at least one of the therapists. The purpose of this meeting is twofold: to ensure that the individual is ready and that group treatment is appropriate for him or her, and to allow each group member to know at least one person before the group starts (thus increasing their comfort level). During the meeting, the therapist explains how the group will run and what to expect. Group norms and rules are briefly reviewed and practical information (location, time, etc.) is provided. This is also an opportunity to address any concerns or questions that an individual has in relation to the group treatment.

Session 1: Treatment Rationale and Commitment to Change

In the first session, group members are oriented to one another and to the group treatment. They are provided with an understanding of what to expect from treatment, as well as psychoeducation on the nature of an eating disorder and its physical and psychological consequences. The various functions of an eating disorder are explored within the group, with discussion of group members' reasons for wanting to change. The costs and benefits of recovery (giving up the eating disorder) versus keeping the eating disorder are discussed. For homework, group members conduct a cost–benefit analysis for giving up the eating disorder and working on recovery versus keeping the eating disorder. The purpose of this exercise is to build motivation and provide a realistic appraisal of the challenges of recovery (i.e., overcoming the costs of giving up the eating disorder).

Session 2: Introduction to Normalized Eating

Session 2 and all sessions following it begin with setting an agenda, addressing any questions from the previous week, and homework review. During homework review, a whiteboard is often used to illustrate common themes within the group. Therapists make an effort to involve the group as each group member provides a review, using questions such as "Did anyone else have difficulty with _____?" and "Can other people relate to _____?" In addition, group members are encouraged to help one another through problem-solving obstacles and challenges. In Session 2, psychoeducation on set-point theory and weight regulation, the

link between dieting and eating disorders, and the concept of normalized eating is provided. Concerns and issues raised by this information are the focus of group discussion. Group members discuss their reactions to set-point theory and how they may start to work toward normalizing their eating. For homework, group members are given material to read on the topics raised in group.

Session 3: The CBT Model of Eating Disorders

Following a review of the homework and discussion of issues raised, the CBT model for understanding an eating disorder is presented. Group members discuss how the model is personalized for them, based on their own experiences. The role that self-monitoring will play in recovery is introduced. For homework, group members complete daily monitoring of food intake.

Session 4: Working toward Normalized Eating

Following a review of homework and discussion of issues raised, group members develop personalized plans for working toward normalized eating. Each group member sets an eating goal to work toward for the next session. The role of coping statements to aid normalized eating is discussed. Homework is daily monitoring of food intake.

Session 5: Behavioral Strategies and Planning for Normalizing Eating

Following a review of self-monitoring homework and progress on eating goals, CBT strategies for eating/restricting are introduced (e.g., mechanical eating, meal planning, coping strategies). The connection between the situational context and eating symptoms is discussed. For homework, group members continue monitoring of food intake and also note the situational context. Each group member sets a new behavioral goal related to normalizing eating (e.g., increasing quantity, improving quality/variety, working on structure/timing).

Session 6: Behavioral Strategies for Managing Symptoms

During the homework review, the connection between situational context and eating is highlighted. Group discussion focuses on an exploration of the social, interpersonal, and emotional triggers for eating disorder symptoms. Psychoeducation on the difference between an urge and a symptom is presented. CBT strategies for managing the range of eating disorder urges and symptoms (e.g., bingeing, vomiting, laxative/diuretic abuse,

overexercising) are reviewed (e.g., delay, distraction, coping statements). For homework, group members complete daily monitoring of eating, eating disorder symptoms, and triggers. Each group member sets a behavioral goal related to normalized eating.

Session 7: Managing Risky Situations

Following homework review, group members discuss connections between their eating disorder symptoms and triggers, and identify patterns (e.g., risky situations/mood states that typically lead to symptoms). Group problem solving is used to generate strategies and plans for managing triggers and risky situations. For homework, group members continue daily monitoring of eating, symptoms, and triggers. Behavioral goals are set for normalizing eating and controlling symptoms.

Session 8: Managing Challenges to Normalized Eating

Following homework review, each member checks in regarding progress toward normalized eating (e.g., what changes they made, what goals they will continue to work on). Group discussion focuses on the common challenges to normalized eating, such as eating in restaurants, dealing with a buffet situation, coping with eating at parties, how to eat during illness, and managing eating at holiday meals and family gatherings. Strategies for managing these situations are reviewed. For homework, group members continue daily monitoring of eating, symptoms, and triggers, as well as working toward behavioral goals.

Session 9: The Role of Exercise in an Eating Disorder

Following homework review, group discussion focuses on exercise as an eating disorder symptom. Group members share their current level of activity and how it may play a role in their eating disorder. Reasons for exercising, other than weight control, such as health, stress relief, and fun, are brainstormed. Types of exercise that tend to be associated with the eating disorder are identified (e.g., solitary exercise), as well as "safer" types of exercise that are not typically used for weight control (e.g., team sports, yoga). For homework, group members develop a healthy exercise plan, taking into consideration their eating disorder symptoms and recovery. For an individual with AN symptoms, this may mean planning not to exercise until a minimum healthy weight is achieved and then selecting activities that were not part of the eating disorder. For an individual with symptoms of BED or BN, where exercise did not play a role, this may mean planning to incorporate new activities. In addition, group members continue daily monitoring of eating, symptoms, and triggers, as well as working toward behavioral eating goals.

Session 10: Identifying and Managing Emotions

Homework is reviewed and the role of emotional triggers is highlighted. Emotions are discussed, with an emphasis on identifying emotions that may be masked by other states (e.g., feeling fat, feeling numb). Strategies for managing strong emotions and anxiety are introduced (e.g., tolerating discomfort, self-soothing, relaxation, and mindfulness). The remainder of the session is spent on identifying and problem-solving obstacles and challenges thus far, and goal setting related to eating and symptoms. For homework, group members continue daily monitoring of eating, symptoms, and triggers, and working toward behavioral goals.

Session 11: Introduction to Cognitive Strategies

Homework is reviewed, with an emphasis on problem-solving obstacles identified through self-monitoring, as well as detailed discussion of each group member's exercise plan. The remainder of the session focuses on the introduction of cognitive strategies. Topics covered include the role of automatic thoughts in eating disorder symptoms; the connection among thoughts, feelings, and behavior; identification of automatic thoughts; and cognitive distortions. For homework, group members continue monitoring of daily eating, symptoms, and triggers, as well as working toward behavioral eating goals. In addition, group members complete a new monitoring form whenever they experience an urge to engage in symptomatic behavior, and record the situation, their thoughts, and their feelings.

Session 12: Challenging Automatic Thoughts

Homework is reviewed, with an emphasis on the connection among thoughts, situations, feelings, and urges to engage in symptomatic behavior. Cognitive strategies for challenging eating disorder thoughts are introduced (e.g., exploring the evidence, cost–benefit analysis, shifting perspective) and exemplified using group members' examples from the homework. Working with a thought record is illustrated. For homework, group members complete thought records and continue daily monitoring of eating and symptoms, as well as progress toward behavioral eating goals.

Session 13: Applying Cognitive Strategies

Homework is reviewed. The group problem solves challenges or obstacles identified as individual group members practice challenging their eating disorder thoughts. The remainder of the session focuses on mastering the application of cognitive techniques for challenging eating disorder

thoughts using group members' experiences. For homework, group members complete thought records and continue daily monitoring of eating and symptoms, as well as progress toward behavioral eating goals.

Session 14: Examining Underlying Rules, Assumptions, and Core Beliefs

Following homework review, the concepts of underlying rules, assumptions, and core beliefs are introduced. Topics discussed include their origins and how they develop, how they differ from automatic thoughts, and methods for identification (e.g., the downward-arrow technique). Strategies for shifting rules and challenging core beliefs, as well as establishing new core beliefs, are reviewed. For homework, group members complete thought records, with a focus on identifying and working with the rules, assumptions, and core beliefs underlying their initial automatic thoughts. In addition, group members continue daily monitoring of eating and symptoms, as well as working toward behavioral eating goals.

Session 15: Origins of Core Beliefs and Compensatory Strategies (e.g., Perfectionism)

Homework is reviewed with an emphasis on working with group members' examples from their thought records to identify common challenges or difficulties. Group discussion focuses on core beliefs that were identified and their origins. The connection between core beliefs and compensatory strategies, such as perfectionism and efforts to please others all the time, is discussed, with group members identifying possible compensatory strategies that they may use. Homework focuses on using thought records to identify core beliefs, to explore their origins, and to identify related compensatory strategies. In addition, group members continue monitoring of eating and symptoms, and working on goals for normalized eating.

Session 16: Progress toward Normalized Eating

Homework is reviewed, with a focus on the origins of core beliefs and identification of compensatory behaviors. Strategies for changing compensatory strategies are discussed, with an emphasis on behavioral experiments, such as purposely making a mistake (perfectionism) and saying no to a request (pleasing others). The remainder of the session focuses on reviewing individualized progress toward normalized eating. Information on the nutritional building blocks is presented. Common challenges and obstacles are discussed. Group problem solving is used to identify strategies to overcome obstacles. For homework, group members continue to complete thought records, monitor eating and symptoms, and work

toward goals for normalized eating. Group members also set goals for behavioral experiments, if relevant.

Session 17: Managing Interpersonal Triggers

Homework is reviewed and feedback regarding group members' activity plans is given. The role of interpersonal triggers and conflicts in the eating disorder is discussed. The remainder of the session is spent on practicing social skills techniques (e.g., assertiveness, communication styles) and reviewing strategies for managing interpersonal situations (e.g., problem solving). The group practices different forms of communication (passive, assertive, and aggressive) and then group members engage in role plays of various conflict scenarios. For homework, group members continue self-monitoring of eating and symptoms, completion of thought records, and work on behavioral eating goals.

Session 18: Body Image

Homework is reviewed, with a focus on the learning gained from completion of behavioral experiments related to group members' compensatory strategies. The group focus then shifts to body image. Topics dealing with body image include the longer-term work of recovery, individualized meaning of fat versus thin, triggers of negative body image, the role of the scale, CBT strategies for dealing with negative body image, coping with sociocultural influences and weight prejudice, and strategies for developing a healthier body image. For homework, group members continue self-monitoring of eating and symptoms, completion of thought records, and work on behavioral eating goals.

Session 19: Dealing with Underlying Issues

Following the homework review, group discussion focuses on the issues and problems that may underlie the eating disorder for each group member. Strategies for dealing with these issues are discussed, such as problem solving or seeking further treatment for secondary disorders (social phobia, PTSD, etc.). For homework, group members complete an exercise designed to review progress made in group and to identify continued goals and areas of vulnerability.

Session 20: Relapse Prevention

Homework is reviewed with an emphasis on reinforcing progress made in the group and plans for continued recovery work. The remainder of the session is spent on relapse prevention issues, including common triggers for relapse (e.g., stress) and strategies for dealing with slips. Finally,

termination issues are discussed (e.g., feelings about the group coming to an end, saying good-bye to the group).

Follow-Up

It is important to plan scheduled follow-up sessions or booster sessions to check progress. Research suggests that clients with BN who have difficulty following successful treatment are unlikely to seek additional visits of their own accord to help manage relapse (Mitchell et al., 2004). Planned sessions or phone calls are recommended as a relapse prevention strategy. This is especially important in the first 6 months posttreatment, when risk of relapse is high (Olmsted, Kaplan, & Rockert, 1994). It is also useful to have an individual meeting with each group member following the end of the group to identify further treatment needs and to offer direction to appropriate resources. Many day hospital and outpatient eating disorder programs have groups that would be of great benefit following this 20-session CBT group, such as a body image group or a monthly relapse prevention group.

Treatment Considerations for Adolescents

Group CBT in adolescents with eating disorders requires family involvement to enhance motivation, to provide a supportive environment for change, and to buffer stress that could trigger relapse (Lock, 2002). It is recommended that family therapy sessions be held in conjunction with CBT sessions for younger clients (Garner et al., 1997). Adjunctive groups specifically for parents to provide support, as well as to facilitate treatment outcome, are also recommended (Zucker, Loeb, Patel, & Shafer, 2011). A model for involving parents in CBT for adolescents with BN is described by Lock (see also Wolf & Sefferino, 2008). Adult clients may also benefit from family sessions, where family members receive education and have the opportunity to ask questions about the treatment process.

Group Process Factors in CBT for Eating Disorders

Running a group for eating disorders is particularly challenging to group therapists compared to running groups for other disorders (e.g., panic disorder, depression) due to the ego-syntonic nature of eating disorders. Even when individuals are motivated to change, letting go of the eating disorder is a challenging process punctuated by periods of ambivalence. One study comparing an eating disorder group to a mixed psychiatric control group

found that the eating disorder group reported not only greater engagement in treatment but also greater avoidance of treatment content (Tasca, Flynn, & Bissada, 2002).

A major concern for any eating disorder group, but particularly for a homogeneous group, is that members will teach one another techniques and encourage symptoms that contribute to increased pathology (e.g., Hall, 1985). It is important for group leaders to be aware of this possibility and be prepared to manage its occurrence within the group. This issue should also be addressed in the pregroup individual meeting and in Session 1, where group members are encouraged to support one another in trying to achieve recovery and make every effort to avoid teaching one another new behaviors that worsen their eating disorder. At the outset, it is helpful to provide specific guidelines to group members regarding limiting discussion of symptoms, such that they describe a difficult symptom week without mentioning specific strategies used to engage in symptoms (e.g., methods of purging). This guideline also applies to discussions that may occur between group members outside of the group, because it is common for group members to form relationships with one another that take on a life of their own, separate from the group. Despite the therapists' intention to discourage relationships outside the group, this common occurrence is beyond the therapists' control.

Another potential issue that the group therapists should be aware of is group members' formation of a strong eating disorder identity through overidentification with other group members (Polivy & Garfinkel, 1984). This may be addressed to some extent by encouraging group members to expand their awareness beyond others' eating disorders and to develop attachment opportunities that diversify their sense of self. Group leaders need to examine their own beliefs and personal issues related to body image and weight (MacKenzie & Harper-Guiffre, 1992). Group leaders can also benefit from clinical supervision given that clients with eating disorders are well-known for focusing on therapists' weight and shape. Such scrutiny may be difficult for some therapists to manage—thus, an outlet for debriefing and discussing such issues is valuable for facilitating the therapeutic experience. In addition, given the role of modeling in CBT, we would recommend that the therapists be nondieters who are able to model a nondieting, normalized eating approach, and that they be fairly comfortable with their weight and shape, and the scrutiny they may receive from group members. For these reasons, therapists who have recently recovered from an eating disorder or who have active weight and shape issues should reconsider their appropriateness as therapists in an eating disorder group.

Another issue that may affect group process is ambivalence regarding recovery. Given that ambivalence is expected at various points throughout treatment, it is important for group leaders to be prepared for and to manage the impact of a group member's ambivalence on the rest of the group. Treatment ambivalence may manifest itself in a variety of ways,

both passive (e.g., homework incompletion, absenteeism) and explicit (e.g., stating in group that "recovery is impossible"). Failure to manage ambivalence may have a negative impact on other group members' level of motivation. Normalizing ambivalence, processing feelings, and validating the challenges group members face in their recovery are all useful therapeutic strategies for maintaining the group environment.

Conclusions

Following an overview of the diagnostic and descriptive features of eating disorders, this chapter focused on reviewing the cognitive-behavioral approach to eating disorder treatment, with an emphasis on group intervention. CBT has been demonstrated to be an effective intervention for both diagnostic-specific and transdiagnostic groups. This chapter provides an overview of various issues in structuring a group treatment for eating disorders. In addition, particular attention is paid to the issues involved in group process with an eating disorder group. The essential treatment components for a CBT group are presented, along with a 20-session sample protocol geared to a mixed client group. In clinical practice, groups are more likely to be run with mixed groups of clients rather than groups tailored to specific eating disorders, largely due to resources and practical constraints.

CHAPTER 11

Substance Use Disorders

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Drinking alcohol and using substances occurs across a variety of settings, and has been part of religious rites and sociocultural traditions across the world for centuries. In the 2015 National Survey on Drug Use and Health (NSDUH), 86.0% of adults in the United States ages 18 and over reported lifetime alcohol use, with 70.0% reporting alcohol use in the past year and 56.0% in the past month (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). The 2013 NSDUH prevalence rate for past-month illicit drug use was 9.4%, with the most commonly used substances being marijuana, nonprescription psychotherapeutics (e.g., pain relievers, tranquilizers, stimulants, sedatives), cocaine, hallucinogens, inhalants, and heroin (SAMHSA, 2014). However, the misuse of alcohol and other substances has serious and wide-ranging negative effects that impact not only the individuals who misuse substances but society at large. The global disease burden due to alcohol is staggering: In 2016, harmful use of alcohol resulted in 3 million deaths (5.3% of all deaths) worldwide, with alcohol consumption responsible for higher mortality rates than tuberculosis, HIV/AIDS, and diabetes (World Health Organization, 2018). Alcohol misuse remains one of the leading risk factors for premature death and disability worldwide (World Health Organization, 2014). Currently, what has become known as the opioid crisis in the United States has reached epidemic proportions: more than 72,000 individuals in the United States died of a drug overdose in 2017, with 68.0% due to overdose of a prescribed or

illicit opioid (National Institute on Drug Abuse [NIDA], 2019; Spaniol, Smith, Thomas, & Clark, 2019).

Results from the National Epidemiologic Survey on Alcohol and Related Conditions–III (NESARC-III) indicate 12-month and lifetime prevalence rates for substance use disorder (SUD) of 3.9 and 9.9%, respectively (Grant et al., 2016), with sedative/tranquilizer, cannabis, amphetamine, cocaine, nonheroin opioid, heroin, hallucinogen, club drugs, and solvent/inhalant use disorders aggregated into an SUD. NESARC-III 12-month and lifetime prevalence rates for alcohol use disorder (AUD) were 8.5 and 30.3%, respectively (Hasin & Grant, 2015).

Cognitive and Behavioral Features of SUD

DSM-5-TR provides the official symptom criteria that qualify a client for receiving a diagnosis of SUD. CBT group therapists require some familiarity with these diagnostic schemes to aid in selecting clients for groups, and there are numerous ways an individual may meet diagnostic criteria. In most general terms, and to differentiate SUD from normal use of substances, the individual is likely to struggle with using more substance than intended; social and other consequences for the individual that results from this overuse; and changes in physiology, including tolerance and withdrawal. The diagnostic criteria for SUD dictate that a client may have mild, moderate, or severe SUD, depending on how many of these symptoms the individual is experiencing (two or three, four or five, or six or more, respectively). The need to consider an individual's strong urges or desires for a substance is supported by studies showing the neurobiological basis of craving on substance use across both animal and human studies (Berridge & Robinson, 2016). The overarching diagnosis of SUD allows more dimensionality and improved identification of individuals with milder levels of substance use severity compared with previous diagnostic methods (e.g., Takahashi et al., 2017). The increased dimensionality of SUD has important implications for both public health initiatives and clinical intervention/prevention efforts, given that a small percentage of adults with SUD or substance-related problems ever receive intervention or treatment (SAMHSA, 2017).

Effectiveness of CBT for SUD

Numerous studies have demonstrated the effectiveness of CBT for SUD. Meta-analyses indicate small but significant effect sizes for CBT over control conditions (g = 0.15; Magill & Ray, 2009). Large multisite studies of CBT for SUD, such as Project MATCH for alcohol (Project MATCH Research Group, 1997), Project COMBINE for alcohol (Anton et al., 2006), NIDA's Cooperative Cocaine Treatment Study (Crist-Cristoph et

al., 1999), and the Marijuana Treatment Project (Babor & The Marijuana Treatment Project Research Group, 2004), have all demonstrated CBT's effectiveness.

There are few studies examining the efficacy of group versus individual CBT for SUD (Weiss, Jaffee, de Menil, & Cogley, 2004). Sobell, Sobell, and Agrawal (2009) compared a cognitive-behavioral motivational intervention in a group versus individual format among 212 individuals seeking alcohol treatment and 52 individuals seeking substance use treatment. While results showed large decreases in alcohol and substance use at follow-up, with no significant differences between group versus individual formats, therapists spent 41.4% less time conducting the group versus individual format treatment (Sobell et al., 2009). Another study examining group versus individual CBT among a sample of women with AUD found significant reductions in drinking during treatment and at follow-up across the sample, with no significant differences between group versus individual conditions (Epstein et al., 2018). These studies highlight the advantages of cost containment for group (vs. individual) CBT for SUD, given their equivalent outcomes. Evidence in support of cue exposure treatment (CET) has been mixed (Conklin & Tiffany, 2002), in part because there have been fewer controlled trials of CET. In a meta-analysis of seven studies of CET for AUD (Mellentin et al., 2017), a small effect size of CET was found for drinking days, but not heavy drinking days, 6-months posttreatment. In one study, a small effect size was also observed on heavy drinking days after 12 months. Overall, results suggested that CET plus urge-coping skills may be more effective than CET alone (Mellentin et al., 2017), which supports the CET plus urge-coping skills protocol described later in this chapter.

In an earlier study (Monti et al., 1993b), inpatients on a Veterans Administration Medical Center alcohol treatment unit received either individual CET with urge-coping skills or an assessment-only contrast condition. At follow-up, participants in CET demonstrated higher abstinence rates and fewer drinks per day, along with significantly more coping skills used, compared to those in the contrast condition. In a larger RCT not included in the Mellentin et al. (2017) meta-analysis, Monti and colleagues (2001) used a 4 × 4 trial to examine the combined effects of group CET + communication skills training versus education + relaxation contrast group, and naltrexone medication treatment versus placebo. Those in the CET + communication skills training had significantly fewer heavy drinking days, fewer drinks on drinking days, greater use of coping skills, fewer urges, and increased self-efficacy at follow-up than those in the contrast group. Importantly, there was a significant association between reduced drinking at follow-up and greater use of coping skills and self-efficacy, and lower reported urges.

Other research has examined the effects of combining CBT and other evidence-based treatments, including MI. In a systematic review of RCTs of

CBT and MI for co-occurring alcohol misuse and depression/anxiety disorders, Baker, Thornton, Hiles, Hides, and Lubman (2012) found that CBT and MI interventions were effective in reducing psychiatric symptoms and alcohol use, with longer treatments associated with improved outcomes. Cook, Heather, McCambridge, and United Kingdom Alcohol Treatment Trial Research Team (2015) examined predictors of the therapeutic working alliance and whether therapist and/or client ratings of the working alliance predicted posttreatment motivation and treatment outcomes in participants randomized to either motivational enhancement therapy (MET) or social behavior and network therapy (SBNT). Interestingly, only client ratings of the working alliance were significant predictors of posttreatment motivation to change drinking and treatment outcomes, and only for those participants randomized to MET.

In an RCT examining the cocaine CST described in this chapter (Rohsenow et al., 2004), participants in a SUD day treatment program were randomized to either two sessions of individual MET or meditation/relaxation treatment (MRT), followed by either a cocaine CST group or an education control group. At follow-up, participants in MET with lower baseline motivation reported less cocaine and alcohol use, and fewer alcohol problems, compared to MET participants with higher baseline motivation. Additionally, women in CST were less likely to relapse to cocaine or to alcohol at follow-up versus women in the education control group. A previous RCT of group-based cocaine CST versus a group-based MRT found that among participants who reported using cocaine at follow-up, those in CST reported significantly fewer cocaine use days at 6-month follow-up compared to those in MRT (Rohsenow, Monti, Martin, Michalec, & Abrams, 2000). A prior RCT of cocaine CST delivered in an individual format similarly found reduced cocaine use rates at 3-month (Monti, Rohsenow, Michalec, Martin, & Abrams, 1997) and 12-month (Rohsenow et al., 2000) follow-up.

Given the high prevalence of depressive and anxiety disorders among individuals with SUD (Grant et al., 2004), and more impaired functioning among individuals with SUD plus co-occurring disorders (Mills et al., 2009), there has been an increased focus on examining integrated approaches—namely, clinical interventions that address mental health conditions and SUD concurrently, rather than serially or separately. Milosevic, Chudzik, Boyd, and McCabe (2017) piloted a 12-week integrated CBT group treatment for co-occurring SUD and DSM-IV (American Psychiatric Association, 1994) mood and/or anxiety disorder. Treatment elements included MI, cognitive restructuring, relapse prevention, urge-coping skills, exposure therapy to avoided situations/activities, and problem solving, with in-session practice and between-session self-monitoring and homework assignments. Results at posttreatment indicated significant reductions in stress symptoms, excessive drinking, and drinking days per week, with significant increases in drinking-/drug-refusal self-efficacy. Additionally, medium to large effect sizes were observed for several coping

skills at posttreatment—namely, using substances to cope with stressors and seeking social support.

The Unified Protocol (UP; Barlow, Allen, & Choate, 2004; Barlow et al., 2017), a transdiagnostic, emotion-focused, cognitive-behavioral approach to treating emotional disorders, has also been examined for treating co-occurring SUD. The UP consists of five core components that target neuroticism and emotion dysregulation, which are hypothesized to underlie emotional disorders. These five components are (1) mindful emotion awareness, (2) cognitive flexibility, (3) decreasing emotional avoidance, (4) tolerance of emotion-related physical sensations, and (5) interoceptive and situational emotion-based exposure. In one study, Ciraulo and colleagues (2013) examined the combined effects of CBT and venlafaxine, a serotonin–norepinephrine reuptake inhibitor (SNRI) used in the treatment of depression and anxiety. Individuals with co-occurring DSM-IV anxiety and AUD were randomly assigned to one of four conditions: venlafaxine + CBT (the UP version), venlafaxine + progressive muscle relaxation, placebo + CBT, or placebo + progressive muscle relaxation. Results indicated that the placebo + CBT group had greater drinking reductions than the comparison group (Ciraulo et al., 2013). Administration of UP in a group format has comparable effectiveness to individual formats (Bullis et al., 2015).

Overview of Evidence-Based Psychological Approaches to SUD

Group-based intervention has been a hallmark of SUD treatment since the dawn of the self-help movement. In the early 20th century, the Oxford Group, a religious movement in the United States and Europe, promoted self-improvement and healthy living through such activities as self-inventories, making amends, spirituality, and sharing these practices with others. As the Oxford Group gained momentum, several individuals in the 1930s began to apply these principles to their efforts to remain abstinent from alcohol, and Alcoholics Anonymous (AA) and the 12-step self-help/recovery movement were thus born. AA's widespread availability and focus on group-based support have likely contributed to the prevalent view that individuals with alcohol problems need group treatment in order to recover. For example, one national cross-sectional study of clinicians found that the most frequently referred aftercare treatment was AA—94% of clinicians endorsed recommending it to clients posttreatment (Fenster, 2006). It is no surprise that group therapy is one of the most well-established and frequently offered treatment modalities for SUD (Center for Substance Abuse Treatment, 2005; Weiss et al., 2004). An important difference between self-help groups and group therapy is that group therapy leaders require professional training, whereas self-help groups rely on peers who themselves are in the recovery process.

CBT is among the interventions with the most empirical support for the treatment of SUD (U.S. Department of Health and Human Services, 2016). It has been shown to be effective across a range of different substances (Magill & Ray, 2009) and is one of the evidence-based treatments included in large-scale clinical practice guidelines in the United States (e.g., NIDA, 2007; U.S. Department of Veterans Affairs and Department of Defense, 2015). The primary goals of CBT for SUD are to reduce harmful or hazardous substance use and to decrease the likelihood of future use through relapse prevention skills. Across numerous clinical outcome studies, the skills most widely and consistently used include functional analysis (examining the antecedents, behaviors, and consequences of alcohol and substance use), planning ahead, problem-solving skills, urge-specific coping skills, drink-/drug-refusal skills, cognitive restructuring/reframing, engaging in alternate behaviors not associated with alcohol/other substance use, and relationship-building skills (e.g., improving interpersonal communication skills, developing social supports; Carroll & Kiluk, 2017). Also central to CBT approaches to SUD is homework—the repeated practice of skills between treatment sessions—in order to consolidate learning, increase one's skills in managing real-life trigger situations, and integrate newly acquired skills into one's repertoire so that the skills become the default behaviors, rather than alcohol or drug use.

Major reviews of group versus individual SUD therapy have generally found no significant differences in outcomes (Weiss et al., 2004). However, reasons why group therapy has remained the preferred choice of SUD treatment (Wendt & Gone, 2017) include cost containment through treating multiple clients simultaneously and group processes (social reinforcement for reducing harmful use, peer support for change). In our experience, the group dynamics inherent in SUD treatment capitalize on the motivational aspects for wanting to change. Group members realize that they are not alone and have others cheering them on in their recovery efforts. The group setting heightens a sense of accountability and concern for fellow members.

Acknowledging the importance of craving is essential in effective CBT treatment of SUD. Individuals struggling with SUD often share that although there is little that they still like about drinking or using drugs, cravings to drink or use drugs can be extraordinarily difficult to resist. Despite experiencing serious negative consequences of drinking or using substances, individuals with addictions often find themselves drinking or using drugs in spite of knowing that it will not end well. This is uniquely frustrating not only to the person with the addiction but also to family and friends who simply cannot understand this seemingly irrational, self-sabotaging behavior. Clinicians in hospital settings may encounter this phenomenon among individuals who repeatedly present for SUD detoxification (Chang et al., 2016). The term "frequent flyers" refers to high-utilizer clients who present to the emergency department and are admitted for inpatient detoxification treatment for several days, and are then

discharged, only to resume substance use and then present for readmission for detox within days, sometimes even hours, of discharge.

However, there is a growing body of research that is beginning to untangle this paradox. Studies have pointed to mesolimbic dopaminergic systems in the brain that become not only sensitized but also hyperreactive to alcohol and other drug cues and contexts with repeated use. This in turn may result in stronger cue-elicited cravings that can last for years, even for individuals with prolonged periods of abstinence (Berridge & Robinson, 2016). Indeed, in a study of individuals with cocaine dependence in residential treatment, those reporting higher baseline urges to use spent significantly more money on cocaine in relapse situations 3 months after treatment (Rohsenow, Martin, Eaton, & Monti, 2007). The protracted intensity of urges and cravings highlights the importance of relapse prevention as a core feature of CBT for SUD.

There are several CBT-based group approaches to understanding and treating SUD (Carroll & Kulik, 2017; Marlatt & Gordon, 1985; Sobell & Sobell, 2011). In this chapter, we present our CBT approach, referred to as coping skills training (CST: Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002), which relies heavily on social learning theory (SLT; Bandura, 1997; Marlatt & Gordon, 1985). The SLT model views SUD as a habitual, maladaptive means of coping with stress, with the interaction of biological and genetic vulnerability, one's social learning history, and acute situational stressors resulting in SUD. A major tenet of SLT is that individuals who lack skills to cope with stressors may rely on substance use as their main coping strategy. Thus, teaching individuals more effective and adaptive coping skills is expected to result in a decreased likelihood of relying on substances to manage stress, and a consequent decrease in substance use more generally.

Another main tenet of SLT is addressing substance-related expectancies, which are often internalized from parental/peer modeling. Having positive expectancies about the effects of substance use is predictive of future substance use (Montes, Witkiewitz, Pearson, & Leventhal, 2019). This supports the inclusion of modeling techniques in our CST group treatment described below for SUD—when a new coping skill is introduced and reviewed, the therapists demonstrate and model the skill through role play. Thus, the social learning approach emphasizes developing an effective repertoire of behavioral skills to apply in high-risk situations for drinking or drug use. Modeling, practicing, and rehearsing drink-/drug-refusal skills, giving and receiving feedback, and conflict resolution skills with group members are fundamental aspects of this approach. Indeed, increased use of CST has been shown to be a mechanism of change in CBT for SUD (Dolan, Rohsenow, Martin, & Monti, 2013; Morgenstern & Longabaugh, 2000).

Other foci in the SLT model include positive reinforcement (feeling "buzzed" or "high," social rewards for drinking), negative reinforcement

(using substances to cope with negative emotions, treat physical pain, or avoid withdrawal symptoms), and the environment itself. Through classical and operant conditioning, individuals may be exposed to a wide variety of substance-related cues. This includes the familiar "people, places, and things" triad of high-risk trigger situations for relapse, as well as more interoceptive and internal reactions—for example, the sight and smell of one's favorite alcoholic beverage, negative mood states, and physical sensations that become paired over time with substance use and can result in cravings. Negative mood induction is associated with increased craving across a number of substances, including alcohol (Amlung & MacKillop, 2014), tobacco (Heckman et al., 2013, 2015), cocaine (Sinha et al., 2003, 2005), and opiates (Hyman, Fox, Hong, Doebrick, & Sinha, 2007; Stathopoulou, Pollack, & Otto, 2018). The CET plus urge-coping skills for AUD protocol described in this chapter was designed to address urges when exposed to alcohol cues, interoceptive sensations, and emotional states that are often cited as reasons for relapse among individuals with SUD (Hogarth et al., 2019; Ramirez, Monti, & Colwill, 2015; Rohsenow et al., 2007). Through repeated unreinforced exposure to alcohol cues, the goal is habituation of the conditioned reactions to alcohol and an increased sense of mastery and confidence in refraining from use.

Belief in one's ability to cope in situations without using substances and to successfully avoid substance use are important factors in developing confidence and mastery in high-risk situations. Through graduated and repeated practice of coping skills within and outside of treatment, individuals can increase their self-efficacy in handling high-risk situations. The group setting is particularly ideal for promoting self-efficacy. Individuals often report feeling a boost in their confidence from the support and feedback they receive from their fellow group members, as well as through vicariously observing fellow group members successfully using the skills.

Research has shown that the *quality* (vs. quantity) of coping responses is a mediator of treatment outcomes in CBT for SUD (Magill, Kiluk, McGrady, Tonigan, & Longabaugh, 2015). Furthermore, secondary analyses from Project MATCH show mediating effects of self-efficacy, such that greater therapeutic alliance predicts higher self-efficacy, which in turn predicts improved treatment outcomes (Maisto et al., 2015). This underscores how imperative it is that therapists spend sufficient time and effort modeling high-quality, effective coping skills and helping group members apply those skills to manage high-risk trigger situations.

Groundbreaking work on MI (Miller & Rollnick, 1991, 2002, 2013; Rollnick, Miller, & Butler, 2008) has had a seismic effect on the field of SUD treatment approaches, including CBT group treatment (e.g., group-based guided self-change treatment; Sobell & Sobell, 2011). MI is a directive, client-centered, therapeutic style that involves eliciting motivation to change problem behavior, exploring ambivalence about change, and highlighting discrepancies between current problematic behaviors and goals. It

focuses on establishing a collaborative, empathic, nonjudgmental stance throughout treatment and avoiding confrontation and argument. Of note, it incorporates a harm reduction approach, meaning that moderation goals are supported and encouraged for individuals who do not identify abstinence as a treatment goal. In addition, some individuals are mandated to treatment by the legal system, or seek out treatment because of an ultimatum from their spouse or employer. These individuals may report lower levels of motivation to change drinking or substance use. Therapists who are well versed and trained in MI can direct the content of group discussions toward reasons for change and tailor the CBT skills to meet the needs and goals of all group members, regardless of their baseline motivation to change. From a process perspective, group members with higher motivation will often chime in with their own reasons for being in treatment and wanting to change. As a general rule, the therapists in our treatment studies have all been trained to consistently adopt an MI stance when conducting our group CBTs for SUD by engaging in change talk, enhancing self-efficacy for change, avoiding arguments, and affirming personal choice and autonomy.

Structuring Group Treatment

Setting the stage for CBT group treatment for SUD involves a number of important factors. Given our focus on developing and enhancing behavioral coping skills, groups are structured to allow ample time for the therapist to review and model the skills and for group members to practice the skills and be provided feedback in real time. In many respects, CBT group therapists must be exceptionally proficient in interpersonal skills—empathy, warmth, patience, compassion, a nonjudgmental stance—to be effective in delivering skills-based training. Indeed, the therapists in our clinical treatment outcomes trials have also been trained in MI, in light of how crucial the MI style is in helping people change.

The ability to translate behavioral coping skills to real-life situations for group members is one of the most powerful ways to assist people in recovery. Through repeated rehearsal of skills in a supportive group setting, group members gain confidence in their ability to cope with situations without drinking or using drugs. The group setting also helps increase the verisimilitude of trigger situations and immediacy of effective responses. Group members often share feedback with one another about the observed effectiveness of responses and let one another know when a strategy seems phony, unrealistic, or ineffective.

In light of the sizable amount of time devoted to the behavioral rehearsal of coping skills, therapists who conduct CBT group treatment for SUD must also be well versed in behavioral principles (see Creed et al., 2016). Therapists must convey their strong belief that the CBT skills are effective through demonstrating those skills and coaching group members

in the skills. Typically, therapists in our studies are at the master's level of training in a mental health discipline (psychology, social work, counseling) and have had prior experience in treating individuals with addictions. Importantly, the therapists in our programs have excellent interpersonal skills and are able to quickly establish rapport, encourage group participation, and elicit responses from members. They take an active and directive role in conducting groups and must serve as credible role models to group members. Group members often become disengaged if they perceive that the material is not relevant to their experiences, or if the skills are presented in a "manualized" or inflexible manner. When the presentation sounds like a lecture coming from "an expert," it creates distance between the therapist and the group members that is difficult to surmount. Group members wind up discounting both the therapist and the material as unrelatable to their struggles with SUD. Therapists must maintain enthusiasm, positivity, spontaneity, and high energy during group sessions so that group members stay interested in the topic and share their experiences in discussions.

Group sessions are usually 60 minutes in duration, which allows sufficient time to present the coping skill to the group, role-play effective use of the skills, and engage group members in behavioral rehearsal role plays for skill consolidation and feedback. In our groups, therapists work from a session outline with bullet points summarizing the major points to be covered, so that therapists stay on track and review all of the essential elements of the particular topic. Importantly, keeping the outline in bullet points lends itself to therapists paraphrasing the materials and minimizes the risk of reading long, scripted material that can devolve into a dry lecture. Therapists use a dry-erase board to write out and summarize skill guidelines and to tailor the behavioral rehearsal role plays to real-life triggers and situations of group members. Therapists provide a brief, 5-minute review of the ground rules during the first session of our group protocols. This includes information about dates and times of the group sessions, expected attendance, refraining from alcohol and other substance use during treatment, contact information for therapists and for emergency contacts, and limitations to confidentiality, such as state-mandated reporting laws concerning child/elder abuse and suicidal/homicidal ideation. Group members are asked to respect the privacy of their fellow group members by keeping details of group discussions and identities of fellow group members confidential. This point cannot be overemphasized when working with individuals with SUD. In addition to worries regarding perceived social stigma, group members may have justifiable concerns about losing their jobs, losing custody of their children, or legal issues due to SUD. Creating a therapeutic environment where people feel safe in sharing their experiences is vital for treatment to be effective. Indeed, in some of our federally funded clinical outcome treatment trials, we have obtained certificates of confidentiality from the National Institutes of Health (NIH) as an added layer of privacy and confidentiality for study participants.

The therapist then provides a brief review of the rationale and guidelines for each coping skill presented during a group session, which takes about 5–10 minutes. The majority of the session should focus on (1) presenting and modeling the skill (10 minutes), (2) role plays and feedback (25 minutes), and (3) group discussion/debriefing regarding members' experiences in using the coping skills (5 minutes). The remaining 5 minutes are spent assisting group members in identifying situations they anticipate will arise prior to the next group session that can provide opportunities to practice the coping skill. This supportive approach to practicing and developing skills in an accepting and encouraging environment helps to foster group cohesion, increase self-confidence and self-efficacy in applying the skills, and ultimately should increase motivation to use the skills in real-life situations. Therapists should be mindful of the time when conducting the group sessions, prevent drift into unrelated topics, and redirect group discussions if they veer off course. In a similar vein, having a good sense of humor and using it sensitively and judiciously in the service of helping group members is a powerful therapist attribute. It promotes the therapeutic alliance and instills a sense of lightness and hope. We have had group members tell us that being able to smile and laugh in sessions, despite the considerable stressors and problems they were facing, encouraged them to be optimistic about change—that things would get better. They were eager to continue to attend group sessions—and retention in treatment is associated with improved outcomes (Hser, Evans, Huang, & Anglin, 2004; Simpson, Joe, Dansereau, & Flynn, 2010).

In setting up behavioral rehearsals and role plays, therapists should generate scenes to practice in groups. The therapist should first ask group members to recall a past situation in which the use of the skill would have been ideal (e.g., not speaking up at a work meeting that negatively impacted their job schedule, having difficulty turning down drink offers at a party, feeling stressed about bills). Alternatively, therapists can ask group members to think about upcoming situations that will be difficult or challenging (e.g., going on vacation, having an annual performance appraisal at work, interacting with an unpleasant neighbor). We find that using scenes from group members' own experiences are typically most effective and realistic. In those rare occasions when group members are not able to generate anticipated situations, the therapist can use hypothetical situations as a starting point for role plays, including self-disclosure of common situations—for example:

> "I once had a roommate who left dirty dishes in the sink and often 'forgot' to clean them. I'd wind up doing all the dishes. I'd get more and more annoyed each time, but I kept it to myself, thinking it wasn't a big deal. My irritation and anger built up until I became pretty upset over it, and it led to an argument. Maybe I could have avoided that, if I had talked with my roommate earlier. What kinds of situations

have you experienced when you didn't speak up about something that bothered you?"

Then, the therapist will conduct the role play with a group member, with the goal to model the skill and then shape and reinforce skill acquisition. This is followed by having group members role-play the skill as partners, asking the partners to provide their thoughts and reactions to the role play, eliciting feedback from the group, and providing constructive feedback on elements of the role play that were effective and other parts that would benefit from fine-tuning. Finally, group members are encouraged to practice the skills outside of the group sessions by trying them out in real-life situations. It is fairly common for group members to initially feel reticent about role playing in front of others. Therapists can acknowledge this by normalizing this reaction and reminding group members that behavioral rehearsals will get easier with time and practice. Finally, the therapist provides group members with a brief handout summarizing the main points of the coping skill reviewed and a practice exercise to do in-between group sessions.

The CST program described in this chapter was initially designed and conducted as a 12-session protocol in inpatient settings or residential/rehabilitation treatment, after 3–5 days of inpatient detoxification. At that time, SUD treatment programs were often 30 or more days in duration. Clients would continue to participate in our coping skills groups and be exposed to topics more than once during the course of their treatment stay. With the advent of managed care in the early 1990s, the average length of treatment began to decrease, and insurance-approved treatment shifted from costly and intensive inpatient/residential to partial hospital and outpatient settings. Further cuts in partial hospital treatment length (from 15 to 10 to 5 or fewer days) led us to adapt our group protocol to allow for rolling admissions, an open versus closed group model, and outpatient settings. Despite some concerns about truncating treatment, studies have shown significant reductions in drinking with five sessions of CET and interpersonal skills training in the partial hospital setting (Monti et al., 2001).

Regarding CET, several points are important to keep in mind when conducting group treatment. Ideally, CET is conducted earlier in the day, so that there is time for urges to decrease. For alcohol-based CET, the client's beverage of choice, and the way in which they consumed it in the past (on the rocks, with mixers, in a tall or short glass, etc.) should be presented during the exposure. Also important is the smell of alcohol, as the sight and smell of alcohol leads to higher reported urge levels than the sight alone (Staiger & White, 1991). Group size should be limited to four to five members for logistical reasons. The therapist transports all of the exposure materials (preferred beverage containers, glasses, ice, mixers, etc.) to the group in an enclosed cooler, and then at the time of the exposure, takes the materials out and has each group member pour and mix/

prepare their preferred drink. During CET, the therapist should ask group members to (1) hold their preferred beverage, (2) look at it, and (3) smell it. The therapist then asks the clients to imagine themselves in various high-risk situations associated with urges or cravings. When conducting CET in groups, we standardize the duration of the exposures to alcohol and to imaginal triggers, with 3 minutes to experience and observe the urges, followed by 5 minutes of using urge-specific coping skills. Studies have shown that within-session reductions in urge levels occur in less than 20 minutes, and in one study of alcohol cue reactivity, urges peaked within 6 minutes and then declined (Monti et al., 1993a).

Key Treatment Components

In our CST, we focus on interpersonal skills, intrapersonal skills, and cue exposure/urge-specific coping skills. Interpersonal skills (also referred to as communication skills) include (1) nonverbal communication, (2) assertiveness, (3) conversation skills, (4) positive feedback, (5) listening skills, (6) constructive criticism, (7) criticism about drinking/drug use, (8) drink-/drug-refusal skills, (9) resolving relationship problems, and (10) social supports. Over time, we have woven the nonverbal communication and assertiveness topic contents into those of the other eight sessions. Communication and assertiveness skills feature prominently in our treatment, as difficulties with interpersonal situations are often cited as triggers for drinking and high-risk situations for relapse. Moreover, our clients have often used substances to cope with various social and interpersonal situations in their lives. Coping with these situations without resorting to substance use is vital in short- and long-term recovery and relapse prevention. Additionally, helping clients to enhance their communication skills is particularly useful in maintaining social support for recovery and nurturing positive connections with family, friends, and peers.

Intrapersonal skills include coping skills for internal drinking triggers (anger, urges to drink/use drugs, negative affect/cognitions) and general lifestyle modification skills (identifying and avoiding high-risk situations for drinking/drug use, behavioral activation, problem-solving techniques). Topics covered include managing urges, problem solving, pleasant activities, managing anger, coping with negative thoughts, and planning ahead. The therapist should provide a brief rationale for why coping skills training is an important part of treatment and recovery:

> "At some point, we all experience difficult times—not getting along with someone, dealing with upsetting thoughts and feelings, or navigating uncomfortable social situations. When people use substances to cope, those situations and feelings can become triggers for future drinking/drug use and relapse. We'll review skills that you can use

to successfully cope with your own high-risk situations. You'll have the opportunity to practice these skills in group, using role plays of your high-risk situations, and you can tailor the skills to best suit your needs."

Our CST protocol for cocaine problems has a similar format and structure to the session outlines above, with the exception that it covers topics endorsed by study participants in our cocaine treatment outcome trials as most strongly associated with cravings to use cocaine (Michalec et al., 1992): (1) urges to use and triggers, (2) cocaine-refusal skills, (3) anger, (4) testing control and alcohol as a trigger, (5) depression, and (6) enhancing good times. A functional analysis (trigger–thoughts–feelings–behaviors–consequences) is conducted to analyze high-risk situations for relapse among group members and to explore alternative cognitions and behaviors to cope with these high-risk situations. For both interpersonal and intrapersonal CST, the session format includes (1) rationale for the skill, (2) skill guidelines, (3) modeling, (4) behavioral rehearsal role plays, and (5) handout and practice exercise.

CET with urge-specific CST is another element of our treatment program that targets urges to drink or use drugs. Clients often struggle with intense cravings early on in treatment, and cravings can persist for years. These observations have borne out with an increased understanding of the nature of craving in addiction and its biological determinants (Berridge & Robinson, 2016). Developed from classical learning theory and SLT, CET has the primary goals of eliciting conditioned reactions in the presence of alcohol or other drugs and applying skills in the moment to cope with those reactions without drinking or using drugs. The sight and smell of one's preferred alcoholic beverage or drug of choice, people and places associated with drinking and substance use, negative mood states, and times during the week (weekends, holidays, etc.) are just a few examples of typical alcohol- and drug-related cues. Seeing drug-related paraphernalia is also a powerful cue. For example, clients have told us that being in the room where they typically used cocaine (certain countertops or tables, if they used intranasally) can cue cravings. Cash is another powerful trigger for urges to use cocaine, as cocaine is typically purchased with cash, with payday or weekends being another major trigger for cocaine use.

In treatment, clients are usually instructed to avoid triggers—the people, places, and things associated with their alcohol or drug use—as a coping strategy. However, after treatment has ended, individuals may find that some of these cues are not avoidable and sometimes take them by surprise. For instance, given alcohol's ubiquitous presence in society, individuals regularly encounter alcohol-related cues—in the media, advertisements, family functions, work events, holidays, and the like. Learning how to effectively cope with urges and cravings to drink or use drugs, and how to prepare for these situations, is a key part of recovery and relapse

prevention. CET targets these internal reactions by fostering awareness of the internal physical reactions, thoughts, and feelings in the presence of one's preferred alcoholic beverage or preferred drug of choice. Importantly, it provides a compelling lesson that despite intense cravings or urges to drink or use drugs, one can choose not to drink or use. Group members learn that their urges will not last forever, and that tolerating them is easier when using coping skills. Below is the rationale for CET specific to alcohol that the therapist provides to the group:

> "After treatment, many people find it hard to cope with triggers that were related to drinking in the past. They may find themselves experiencing urges and cravings to drink, in spite of doing their best to avoid high-risk situations for drinking. When we say 'urge,' we mean how much you want, wish, crave, desire, or thirst for alcohol. Not all drinking triggers can be completely avoided. You might be watching TV and see a commercial featuring your favorite beer, or you might run into an old drinking buddy who invites you over to watch the game, or you might feel down or irritable, which perhaps is a trigger for you. The goal of CET is to help you manage these urges and cravings through practice and in the safety and structure of treatment. We'll first ask you to experience your urges, without drinking, until they decrease. You'll then learn urge-specific coping skills and strategies to handle urges and have the opportunity to practice those skills while you're experiencing urges and cravings to drink. We don't recommend that you try to expose yourself to alcohol triggers outside of treatment. Rather, the goal is to help you be prepared for situations that you aren't able to avoid."

The session structure for CET plus urge-specific CST for alcohol is as follows: (1) prepare the session materials and transport beverages and glasses/cues to the group setting in an enclosed container, (2) provide rationale for CET and review the definition of urge, (3) review urge monitoring, (4) conduct alcohol cue exposure, (5) prompt to focus on beverage and internal/interoceptive sensations, (6) prompt to allow oneself to experience the urges, (7) inquire about urge levels, (8) discuss the exposure experience, (9) review urge-coping skill for session, (10) conduct imaginal exposure to trigger situation, (11) monitor urge levels, (12) discuss reactions to session, and (13) prepare for urges outside of session and encourage use of skill.

Sample CBT Group Protocol for SUD

Below is a sample protocol of selected sessions from our CST. In our groups, we focus on the primary SUD, and below are the protocols for alcohol treatment. For illustrative purposes, we describe one of the

protocol's group modules in detail for each category of coping skills: drink-refusal skills module for interpersonal coping skills, the receiving-criticism-about-drinking module of the intrapersonal coping skills, and CET plus urge-specific coping skills. The interested reader is referred to Monti and colleagues (2002).

Drink-Refusal Skills

The therapist should begin this session by reviewing how common it is to be offered a drink, and how this is a high-risk situation for people who are trying to avoid drinking. It helps to remind the group that even when someone actively avoids bars, clubs, and other alcohol-related venues, there will be times and situations when one is offered a drink: family functions, holidays, sporting events, restaurants, weddings, office parties, and dining out, to name a few examples. Those offering drinks may or may not know of one's drinking problems or status in recovery. Drink offers may be subtle or may involve repeated requests, even demands, to drink. Moreover, group members often report that being able to refuse drink offers is more difficult when they are feeling stressed, down, irritable, tired, or upset. Thus, having a repertoire of effective drink-refusal skills is important throughout recovery. The therapist should emphasize that it takes practice to develop this repertoire of skills. In our experience, clients often overestimate their drink-refusal skills at first and find it surprisingly challenging to refuse a drink offer. Thus, this topic relies heavily on assertiveness skills in terms of setting limits/boundaries and in communicating one's rights.

After providing the above rationale, the therapist would then write on the dry-erase board the following five points:

1. Refuse drink in clear, firm voice and make eye contact.
2. After saying no, change subject.
3. Suggest alternative activity.
4. Request behavior change—ask person to stop offering if they persist.
5. Avoid excuses/vague answers.

Again, the therapist sticks to brief bullet points so that each point can be discussed and paraphrased by eliciting comments and feedback from the group. For example, the therapist can ask the group members for reasons why changing the subject is an important facet of the skill—which is to avoid getting into a back-and-forth debate about drinking. Suggesting alternative activities can translate into going for a walk, or out to the movies. Request behavior change refers to feeling pressured to drink and requires more review and examples. For instance, being able to say, "No, and I would appreciate it if you would stop asking me," is

often more difficult and thus requires practice in the role plays. Avoiding excuses/vague answers is also important to review with the group. Those early in recovery may be reluctant to state that they are no longer drinking. Sometimes the default response to a drink offer becomes "Not right now, thanks," which has the potential to be misinterpreted as "Maybe later."

Finally, the therapist should review the benefits of the "broken record" technique in assertiveness, which refers to being repeatedly consistent in one's response and staying on message, for as long as it takes until the other person stops pressuring or making drink offers. The therapist also reviews how in some situations it might be helpful to let people know about one's past drinking problems as a way to engender support for not drinking, but at other times, others may not have a need to know. The bottom line is that people have the right to refuse a drink offer, regardless of their reasons for declining, and without having to justify their decision. The therapist reminds the group that exercising this right skillfully takes practice.

After review of drink-refusal skill guidelines, the therapist models the skill by asking for a volunteer from the group to role-play a situation involving drink-refusal skills. It is most helpful to have the volunteer group member make the drink offer, and the therapist model effective drink-refusal skills. The therapist should set up the scenario as follows:

> "Let's review a common situation involving offers to drink. Tammy, imagine that you're at a friend's house for a birthday party. Your friend offers you a drink and says, 'Here you go! Your favorite wine—I opened up the bottle just for you!' I want you to role-play your friend, and I'll be you. I want you to keep offering me a drink for the next 1–2 minutes. Really try to convince me to drink."

The therapist will then model effective refusal skills, as follows:

TAMMY: Here you go—your favorite wine. I got this bottle just for you!

THERAPIST: No thanks (*firmly, clearly, and looking at Tammy in the eye*).

TAMMY: Oh, come on, have one! This stuff's expensive. I don't want it to go to waste.

THERAPIST: No thanks, I'm all set. Hey, I got you a little something for your birthday. I hope you like it!

TAMMY: What I'd really like is if you take this glass of wine and enjoy yourself.

THERAPIST: No thanks. I'm going to get a water and something to

eat from the buffet table in the dining room. Do you want me to grab you a plate?

TAMMY: I really want you to have a drink with me. You know I hate to drink alone. I bought this bottle of wine for you, you know. Come on.

THERAPIST: Please stop asking me to drink. I already said no. I'm not drinking, and I'd appreciate it if you didn't keep asking. Hey, let's head over to the buffet table while I get some food. I've been meaning to ask you about your son—how is he doing at his new high school? (*Changes the subject.*)

At this point, the therapist would pause to discuss and review each skill used during the modeling exercise. Then, the therapist asks the group to anticipate a high-risk situation coming up that involves being offered drinks, and asks group members to alternate the role play as those making the drink offers and those refusing. It assists in setting a realistic tone if the person making the drink offer does so several times in a row, so that the person declining the offer has an opportunity to try out different drink-refusal skills. Importantly, after the behavioral role plays, the therapist debriefs with group members by eliciting feedback on what worked well and what areas need fine-tuning. The therapist should guide the discussion of the role-play exercise with constructive feedback and encouragement:

THERAPIST: Okay, let's pause at this point. What went well during that role play?

RON: I thought Sue did great at saying no and not getting upset when Tom kept asking her to have a beer.

THERAPIST: What skills did Sue use that were effective?

TOM: She kept saying, "No thanks," and looked me in the eye. I felt like she really meant it, that I probably wasn't going to change her mind.

THERAPIST: So, her nonverbal body language communicated a lot of assertiveness. What else worked well?

RON: She kept her cool and didn't raise her voice. She changed the subject when Tom kept bringing up drinking.

PAT: I liked how Sue asked Tom for a soda instead at the end. He kind of ignored her, but I think in a real-life situation, asking for a soda or water is a good idea. Or just getting a soda herself—even better! When she said she was going to the kitchen to get a soda and asked him if he wanted a soda, too, before she left the room—that worked because she was able to leave the situation without alienating Tom or getting pissed off herself.

THERAPIST: That's interesting that you say that—alienating Tom. Sounds like there's some concern about things leading to an argument in these situations.

SUE: I could feel myself getting annoyed when Tom kept pressuring me to take the beer. That's the kind of situation where I'd either just keep my mouth shut and take the beer to avoid an argument, or lose it and start yelling at him to leave me alone.

THERAPIST: These drink-refusal skills led to you to staying in the situation, keeping your cool, and getting your message across. How do you feel about how you did?

SUE: Good, really good.

THERAPIST: What about when Sue said that she wasn't going to drink because she was taking medication—what did others think of that strategy?

RON: Not sure about that one, because after she said it, Tom started asking her what kind of medication she was on and that she could still drink on medications.

TOM: I've been in that situation, too. I'll tell people that my doctor won't let me drink or that I can't because I'm on meds. Some people try to convince you it's okay to drink anyway.

THERAPIST: Meaning that it can lead into a long conversation about drinking that you don't want to get into?

SUE: Yeah, I can see that.

To wrap up the session, the therapist distributes a handout outlining the skill to group members and encourages them to mentally rehearse how they ideally plan to handle high-risk situations involving drink offers, and what skills they would use in those situations.

Receiving Criticism about Drinking

This session begins with the therapist providing the rationale for the benefits of being able to receive criticism about drinking. The message is that being on the receiving end of criticism is tough for most of us and is something that comes up for all of us at one point or another. The ability to hear and be open to criticism gives us an opportunity to learn about ourselves and to change our behavior for the better. Unfortunately, the criticism might be delivered to us in a harsh offensive manner. It can be difficult to respond to such criticism, which is why it is a frequent high-risk situation for relapse. Many group members with alcohol problems indicate that this is often the most difficult coping skill to learn and master: to receive criticism gracefully, without getting angry or defensive, particularly when it has to do with drinking.

The therapist reviews the differences between constructive criticism and destructive criticism, with constructive criticism directed at the behavior, with the intent to help, and destructive criticism with the intent to hurt the person. In terms of drinking, sometimes loved ones may be concerned about a slip or a relapse back to drinking and make false accusations (e.g., "You're saying you've been doing a lot of overtime lately, but I think you're drinking again"). The therapist should talk about how trust sometimes has to be reestablished, which takes time and patience. In other instances, criticism about drinking has to do with past events that were a cause of negative consequences (e.g., "You were a mean drunk and said terrible things to me and the kids. I can't get past the pain you caused our family"). After presenting the rationale, the therapist covers these bullet points:

- Don't get defensive, don't debate, and don't counterattack with criticism.
- Ask questions to clarify and understand the person's position.
- Find something to agree with in the criticism.
- Suggest a compromise.

After providing clarifying remarks about each of the skill guidelines, the therapist will then model a role-play situation. The example below involves a spouse getting upset with their partner when they do not attend a family party because of being physically ill. Because the partner often was hung over in the past after drinking excessively, the partner was frequently absent from family get-togethers, and the spouse usually wound up attending these events solo. It caused numerous arguments between them. The therapist plays the role of the partner in recovery who is physically ill and asks a group member to volunteer to play the spouse in the role play. To increase the authenticity of the role play, the therapist instructs the group member playing the spouse to draw from what their own loved ones have said to them in the past about their substance use:

SPOUSE: Aren't you coming to Dad's birthday party with me? We're going to be late.

THERAPIST: I'd like to, but I can't. I feel sick to my stomach and feverish. I'd better stay home and rest.

SPOUSE: I can't believe it! You're drinking again! This always happens—my family has a get-together, you get drunk and stay home, and I wind up going alone. This is so unfair. You know how important my family is to me. You're such a jerk.

THERAPIST: So, you think I'm sick because I'm hung over and don't want to go to your Dad's party with you?

SPOUSE: Yes, that's exactly what I think. We've been planning on

going for weeks now. He's going to be so disappointed. As usual, you only care about you. You're so selfish when you're drinking.

THERAPIST: I can see how you might think that, because that would happen in the past. I missed out on a lot of things because of drinking. I wasn't there for you as much as I should have been. I'm sorry that I hurt you. This time, I'm not able to be there because I really am sick. I took my temperature earlier, and I have a fever and I'm nauseous. My throat's hurting now, too. I don't want anyone to catch what I have. That's why I need to stay home.

SPOUSE: But you're suddenly sick on the same day as my Dad's big party? Quite a coincidence, don't you think?

THERAPIST: I can see why you'd doubt me. I was looking forward to going to the party, especially now that I'm not drinking. I wanted to be there with you and see everyone. Last night I noticed a tickle in my throat but didn't say anything because I figured I'd feel better in the morning. I should have told you last night I wasn't feeling well. I'm sorry.

SPOUSE: What am I supposed to tell my family? They're all going to think you're drinking. I'm tired of making excuses for you.

THERAPIST: You're right—it's not fair for you to tell them I won't be there. How about this—I'll call your Dad now, let him know that I'm sick and can't make it, and ask him if we can take him out for dinner sometime next weekend. Hopefully by then I'll be feeling better. How does that sound?

SPOUSE: That sounds okay.

The therapist then generates behavioral role plays with group members by asking them to recount situations in which they received criticism for drinking and/or high-risk situations that they anticipate in the future. At the conclusion of the behavioral role plays, the therapist distributes a handout to the group and encourages group members to practice the skills in-between sessions.

CET and Urge-Coping Skills

The protocol for CET + urge-coping skills follows a different format than our communication-based groups. Because CET is an exposure-based treatment paradigm, the focus is on eliciting and maximizing urges in the presence of the target substance (in the case described below, alcohol) and introducing urge-coping skills to manage cravings in the session. Based on CET treatment studies, we recommend six to eight sessions of CET + urge-coping skills, each lasting 45–60 minutes in duration, for optimal results

(Drummond & Glautier, 1994; Monti et al., 1993a, 1993b; Rohsenow et al., 2000; Sitharthan, Sitharthan, Hough, & Kavanaugh, 1997). Our protocol does not include priming or other consumptive behaviors, and as such, the therapist is a constant presence in the room when alcohol is being exposed. Similarly, we advise group members to avoid exposing themselves to alcohol outside of treatment sessions as much as feasibly possible. They are encouraged, however, to practice the urge-coping skills outside of group sessions when urges and cravings arise. Therapists working in treatment settings that do not permit exposure to alcohol or other substances may consider virtual reality (VR) approaches to CET (Ghita & Gutierrez-Maldonado, 2018). With technological advances, the quality of VR continues to improve and may allow for increasingly greater similarity to real-life, personalized drinking and other substance use contexts and environments.

The cue exposures ideally will include all aspects of each group member's preferred alcoholic beverage, prepared in the manner in which they normally consumed it. This increases the likelihood of a stronger physical and emotional reaction to the sight and smell of alcohol and thus maximizes the intensity of the exposures. We start each CET group session with exposure to alcoholic beverage cues, and then follow with imaginal exposures to participants' high-risk situations for urges to drink. The beverage cues and alcohol are left in sight for the duration of the session, including during imaginal exposures. This is particularly important, as on occasion, a group member will report very low (or absent) urge levels in the presence of their preferred alcoholic beverage. We have found that imaginal exposure to trigger situations associated with urges/cravings to drink is effective in eliciting urges during exposure. To do this successfully in a group setting, the therapist meets with each group member individually for assessment of trigger situations specific to that individual, and then writes out the trigger situations on index cards that the therapist hands out to each group member. The group is then asked to silently read their trigger situation on their card during the exposure and allow themselves to fully experience whatever physical sensations, thoughts, feelings, and memories come to mind during the exposure period. We have found that this personalized approach to imaginal exposure elicits urges more reliably than reading generic trigger situations out loud to the group. In addition, the therapist conducts the cue exposure for 8 minutes, as this is the amount of time that it generally takes for urge levels to decrease to a 2 or less (on a 0–10 scale) in our groups.

The therapist should spend some time reviewing the importance of attentional focus during the exposures, prior to bringing out the beverage cues. Sometimes clients may try to avoid experiencing urges by distracting themselves during the exposures. However, in an earlier lab-based study, participants who reported paying more attention to the alcohol and their internal sensations/reactions also reported less drinking during

a follow-up period (Rohsenow et al., 1994). Interestingly, cue-elicited salivation is more predictive of posttreatment drinking than cue-elicited, self-reported urge to drink (Monti, Rohsenow, & Hutchison, 2000). Debriefing with the group after the exposures helps to ensure that group members are fully attentive to the beverage and to their own physical reactions to the beverage. It is eye-opening for group members to not only experience cravings and urges without drinking or using but also to see that their urges go down eventually, even when those urges are initially strong.

The therapist starts with the beverage exposure, and then the imaginal exposure to high-risk trigger situations (a specific, individualized situation written on an index card and given to each group member, with instructions to read the card and vividly imagine him- or herself in the trigger situation). After the imaginal exposure, the therapist introduces and reviews the urge-coping skill for that session. This is followed by another imaginal exposure session and instruction to use the coping skill to manage urges and cravings. Once the exposure is done, the therapist puts the beverage containers back into the enclosed cooler and discusses group members' reactions during the exposures and use of skills. Finally, the therapist provides a handout describing the skills to the group members.

The therapist's instructions for alcohol cue exposure follow:

> "I'm going to bring out the drinks and glassware. Please allow yourself to experience the urge as much as you can. Observe the urge inside you, along with the thoughts, feelings, sensations, and memories it brings up for you. Just let it happen and observe it. Now, I'd like you to open, pour, and prepare your alcohol beverage the way you normally would. Fill the glass halfway [to avoid spills]. Hold the glass or bottle [if they drink it out of the bottle directly] the entire time. Look at the glass/bottle and notice everything about it. Notice how the glass/bottle feels in your hand as you hold it. Notice the smell of the beverage. Focus all of your attention on the beverage and all of the sensations you're experiencing. [Uses a stopwatch and prompts group members to continue to focus during the exposure.] Continue to focus all of your attention on the beverage in your hand, and whatever makes you want to have it—the way it makes you feel, the look of it, the smell, the taste, the feel of the bottle or glass in your hand. Think about nothing else except for the urge and allow yourself to experience the urge. Stay with your urge and watch it, observe it, see what happens to it."

The therapist periodically prompts group members to focus on the beverage and their urges every 1–2 minutes during the exposure. After 8 minutes has elapsed, the therapist instructs the group to stop thinking about the beverage and assesses for urge levels. Group members are asked

for their thoughts, feelings, internal sensations, and reactions experienced during the exposure.

This is followed by the therapist introducing the first urge-coping skill for CET, which is delay/waiting the urge out. The therapist discusses with the group how the urges declined across the exposure period and that even by not engaging in anything else except focusing on the alcohol and cues, the urges eventually go down on their own. It is helpful to generate some examples of things that group members can say to themselves to wait out urges, such as "This urge will pass"; "Urges don't last forever"; "I'm stronger than this urge"; "I can surf the urge, watch it go up and down"; and "I can wait this out without drinking."

Then the therapist begins the imaginal exposure by instructing the group to imagine the trigger situation that they read on the index cards and allow themselves to experience any urges to drink. The focus should not be imagining drinking, but rather imagining themselves in a situation involving intense urges to drink. The therapist distributes the index cards with each group member's personalized high-risk trigger situation for drinking/urges and asks the group members to silently read their index card. Below is an imaginal exposure scenario written on an index card for Nick, one of our group members:

> "You've had a bad day at work. You got in an argument with one of your customers and then had to stay late to finish up a job. You get in your truck to head home and check your phone. There's a bunch of texts and voicemails from your girlfriend, asking where you are because you were supposed to pick her up an hour earlier to bring her to a doctor's appointment. She's upset and says in her last text to forget it, that she got a ride from someone else, and not to bother calling her back. You got so tied up at work that you completely forgot about giving her a ride. You're feeling angry, depressed, and exhausted. You just want to get home and relax. You start up your truck, and as you're driving toward home, you see the liquor store up ahead that you used to stop at after work, where you'd pick up a six-pack of beer for the night. You think about how tired and stressed you are, and you have an urge to stop at the liquor store and get some beer. You think about how good a cold beer would taste right now."

Then the therapist conducts the imaginal exposure for 8 minutes, debriefs/discusses reactions with group members, and then repeats the imaginal exposure session, but this time after a few minutes the therapist instructs the group members to utilize the delay/wait-it-out urge-coping skill as an active coping strategy. After the time has elapsed for the exposure, the therapist again debriefs/discusses reactions with the group and encourages group members to practice the urge-coping skill prior to the next session. Urges are monitored and assessed, and once everyone in the

group reports urge levels of 2 or less on the 0–10 urge scale, the session is ended.

The structure for subsequent CET sessions is the same, with a different urge-coping skill covered during each session. This includes negative consequences of drinking for me (e.g., "lose my job," "arguments with wife," "financial problems"), positive consequences of not drinking for me (e.g., "physically and mentally healthy," "more money at the end of the month," "family is proud of me," "get more done around the house"), and an alternative activity I can do ("go for a walk," "go for a bike ride," "call a friend," "go to the movies," "play with my kids in the yard"). In the past, we also included alternative food/drink as an urge-coping skill, but more recent findings suggest that this coping skill is not significantly related to reduced drinking outcomes (Dolan et al., 2013). For each coping skill covered, the therapist introduces the skill, provides one or two examples, and then asks the group to generate their own examples that they think will work for them that they can write down. For the alternative activity coping skill, we recommend that therapists encourage group members to think of alternatives that are not associated with alcohol use. Some clients have found it helpful to think about activities that are incompatible with drinking for them personally (e.g., having an ice cream cone, going to the gym, bike riding, taking their kids to the movies).

Group Process Factors for CBT for SUD

It is not uncommon for group members to ask therapists about their own drinking and drug use history. Therapists in recovery themselves may wish to disclose this information as clinically appropriate, but only in the therapeutic spirit of helping group members better connect with the discussion and treatment. We generally encourage therapists to focus more on addressing group members' concerns, regardless of whether the therapist opts to self-disclose. It is useful if the therapist emphasizes that their expertise is not how to use substances but rather how to avoid using and maintain sobriety/recovery. The vignette below highlights an effective therapist response to Tom, who has been in detox several times, had a recent driving under the influence (DUI) charge, and struggles with both cocaine- and alcohol-related problems:

Tom: You talk like you know a lot about drinking and cocaine. Do you drink? Have you used coke before?

Therapist: You're concerned that I might not know what it's like to be in your shoes.

Tom: Yeah. Don't take this the wrong way, but you don't learn this

from reading a few textbooks in school. You have to live it to understand.

THERAPIST: I can see why you'd ask about that. Sometimes, people have concerns that if the therapist hasn't been through it, they won't be able to help someone who's struggling with those issues.

TOM: People who aren't in recovery aren't in a position to tell us what to do or how to do it. They never had to go through detox, or jail, or losing a job or a wife. I've been through a lot, and I've lost a lot. It's not easy.

THERAPIST: That's a valid question—whether I can understand your experiences and what you're going through. My role is to help the group learn coping skills to deal with triggers and high-risk situations, and to review skills to successfully avoid drinking or using, now and in the future. These are the skills that our group members have told us through the years are most effective and work for them. My responsibility is to work alongside you and the rest of the group, to tailor these skills to your own personal situations. I want to make sure that the skills we cover are helpful in your recovery. You are the expert on you.

TOM: Okay, that sounds all right. No offense, just want to make sure you understand where I'm coming from.

THERAPIST: I hear you and really appreciate you sharing your perspective—thank you.

When group members voice negative and pessimistic views about change during group discussions, it can cause a contagion effect—other group members may voice doubts, and the group rapidly takes on a negative, nihilistic tone and attitude. A group member may minimize the potential usefulness of the coping skills presented by stating that it has not worked for them, it has made it worse for them, and the like. It is essential that therapists be attuned to group members who express negativity and to use change talk to get the topic back to the goals of the group. Change talk, a concept frequently associated with MI techniques, refers to verbalizations that demonstrate movement toward change (Moyers & Martin, 2006). Therapists facilitate change talk when they make statements that are consistent with the spirit of MI (e.g., affirming strengths, emphasizing personal autonomy). This is in contrast to sustain talk, or verbalizations from clients regarding not wanting or not feeling able to change substance use (Apodaca et al., 2014; Apodaca et al., 2016; Baer et al., 2008; Gaume et al., 2016; Magill et al., 2016). Sustain talk is more likely to occur when therapists engage in confrontational behaviors and verbalizations with clients. It has been associated with worse outcomes among individuals with substance use problems across a number of studies (Apodaca et al., 2014;

Magill et al., 2014). Thus, it is important that therapists proactively guide group discussions to topics focused on reasons for change and to avoid discussions that promote sustain talk—in essence, to avoid confrontation. The following is a vignette that underscores the importance of using change talk when Jim, one of the members in the interpersonal skills group, starts engaging in sustain talk, and Chris, another group member, chimes in:

JIM: This "giving criticism" topic is unrealistic. Where I work, no way could I give my boss constructive feedback on anything. It's survival of the fittest at my job. I'd probably get fired if I said any of this crap to my boss. He is the biggest jerk. My coworkers would laugh me right out of the building, too. Not worth it.

CHRIS: I agree. This won't work in real-life situations. You don't want him to lose his job, do you?

THERAPIST: Jim, it sounds like you work in a very challenging and difficult environment. Is that a trigger for drinking for you?

JIM: Sometimes. I get home and I'm spent, so exhausted by the end of the day, so beaten down, that all I want to do is get a drink, lie down on the couch, and zone out—everyone just leave me alone!

THERAPIST: Wow, that sounds stressful. It also sounds like this is one of your high-risk situations—getting home after a difficult day at work and feeling like you have no option other than to drink to cope with what you're going through.

JIM: Right.

THERAPIST: And you saying that you want to be left alone—sounds like you want to avoid an argument or a confrontation.

CHRIS: Well, of course! Who wouldn't? Better to keep it to yourself than to blow up over it and get fired.

In working with group members like Jim and Chris, who are pessimistic or dismissive about the utility of the skills, the therapist should shift gears temporarily to first understand Jim's stance, remind the group members of their personal choice and autonomy, and then to actively steer the group discussion toward change talk. The therapist needs to listen to Jim's perspective and refrain from confronting or arguing with group members. A more collaborative tone is called for in this situation, as continued below:

THERAPIST: So, this is a common high-risk situation that some members of the group are clearly concerned about. No one wants to jeopardize their job. On the other hand, it sounds like work can be a significant trigger for drinking. It can be tough to figure out what to do.

JIM: That's right. My boss is a piece of work. You can't reason with

him. It keeps me up at night sometimes—thinking about how he treats me, the things he says that piss me off so much. I can't lose my job. I have a mortgage to pay. Half the time I'd like to lay into him, but it's not worth the aggravation.

CHRIS: Yeah—my boss is the same way. Can't talk to her. Better to avoid her altogether.

THERAPIST: It sounds like you've thought about this for a while, trying to figure out how to handle these work situations. I hear your concern about losing your job if you bring up issues with your boss. I also hear the anger and frustration in your voice. This seems like a significant high-risk situation for drinking and for relapse for several of you. I'm not here to tell you what to do. Rather, I'd like to hear what it's been like for you, trying to cope with these difficult job situations, and see if there are ways we can tailor the coping skills to your unique situations and stressors.

JIM: Well, that would be good, because I'm all out of ideas at this point.

At this point, the therapist would review a recent trigger situation involving Jim's boss, introduce the behavioral role play, and ask Jim or Chris to role-play the part of the boss. The therapist should instruct Jim and Chris to verbalize and react in the role play in the way they anticipate their boss would, while the therapist utilizes and models the coping skills to the group and then has the client switch roles. In our clinical experience, clients often report either avoiding expressing anger as much as possible, or aggressively expressing it by verbally lashing out and "losing it," with no middle ground. Reviewing and modeling assertiveness skills can be eye-opening for the group, particularly if they see how using the skills can effectively diffuse and de-escalate interpersonal conflicts in the role plays.

Yet another process issue that therapists should be attuned to when conducting group CBT for SUD is when group members reminisce and express nostalgia about drinking and substance use. A group member may recall times when their drinking was associated with happy memories, or state that their drug use resulted in improved performance. For example, one group member who was a writer initially described how using cocaine increased her creativity. However, when she later shared some of her writing samples done when high on cocaine versus when she was not using, her writing was qualitatively far better—more engaging, clearer, and more cohesive—when she was not using cocaine. Regarding alcohol, we sometimes hear group members expressing their belief that alcohol improves their conversational skills and that they are more fun to be around if they are drinking. The reality, of course, is that alcohol's disinhibitory effects temporarily dampen social anxiety but also increase the likelihood of

impulsively saying or doing things that result in longer-term negative consequences, such as regret, embarrassment, and fractured relationships. Below is an example of a therapist's response to Eric, a group member who expressed strong positive expectancies of alcohol use:

THERAPIST: So, Eric, let's review a trigger situation for you that we can use for our topic today of drink-refusal skills. You mentioned earlier that attending work-related social events is a major high-risk situation for drinking.

ERIC: Yeah, if I've had a few drinks at work functions, I'm much more relaxed when I'm there.

THERAPIST: So, this is particularly relevant for you. Describe for us a work-related social function coming up.

ERIC: Well, the holiday work party is scheduled for later this month. Everyone goes, including the district and regional managers. These are important get-togethers, because they happen right before our end-of-year performance evaluations at work. I need to make a good impression. I don't want to look nervous or be uncomfortable, so I have a few cocktails to take the edge off and loosen up. Plus, some of the higher-ups are usually offering to buy rounds. It's rude to say no.

THERAPIST: This would be a good scenario to role-play.

ERIC: Yeah, but I'd prefer to have a drink, rather than say no. I don't want anyone to think I'm weird for not drinking.

At this point, the therapist would consider shifting the direction of the conversation by asking other group members to recount other high-risk situations where the intention to have one or two drinks led to drinking excessively instead.

THERAPIST: Have others encountered these situations, where it's been challenging to refuse a drink, or where you drank much more than you intended?

MISSY: Oh, yes—very similar for me—I used to go to an industry convention every year for my job. There was a reception on opening night, and at the last one, a few coworkers started getting rounds. I didn't say no when they gave me a drink, because I was like, okay, I'm a team player, I want to be polite, I'll have a drink or two and that's it—I can handle it. The next thing I know, it's 11:30 A.M. the next day, I'm waking up in the hotel room with a wicked hangover, and I have no idea how I got there or what happened the night before. I missed a really important early-morning meeting

with a vendor. My boss smoothed things over with the vendor, but it was never the same after that. Evidently, I also said some inappropriate things at the reception that I didn't even remember. It was awful. Just talking about it makes me cringe!

THERAPIST: That must have been very upsetting for you. It sounds like you thought you could have one or two drinks and stop, but you had much more than that.

MISSY: Right. It's never just one or two for me. I should have known that, but kinda like Eric, I felt a little nervous and self-conscious. I thought it would be easier to mingle if I had a few drinks. It never really worked out that way.

THERAPIST: You're saying that drinking made things harder for you.

MISSY: It did. I wish I could go back in time and just have said no thanks!

At this point, the therapist has successfully elicited a common scenario (drink offers in a work setting), elicited strong reasons and reactions from a group member regarding the importance of drink-refusal skills, deftly changed the tenor and direction of the discussion without disagreeing with or confronting group members, and set the stage for a behavioral rehearsal role play.

Another challenge when conducting group CBT for SUD is working with individuals with cognitive impairment. Current estimates suggest that over half of individuals presenting for SUD treatment have some level of cognitive impairment (Aharonovich et al., 2018; Dominguez-Salas, Diaz-Batanero, Lozano-Rojas, & Verdejo-Garcia, 2016). This raises concern about the effectiveness of CBT for these individuals, given CBT's focus on cognitive coping skills and overall worse retention rates and treatment outcomes for those with cognitive deficits (Arahonovich, Nunes, & Hasin, 2003), particularly those with impaired decision making (Dominguez-Salas et al., 2016). There is a clear need in the field for more synergy between neuroscience research and psychological treatments (Holmes, Craske, & Graybiel, 2014). In response, researchers are examining the impact of modifying CBT for SUD with cognitive remediation methods targeting executive function skills (such as attention, memory, working memory, emotion regulation, decision making, and problem solving; Berry et al., 2019), compensatory strategies for enhanced retention of material (Aharonovich et al., 2018), and computer-enhanced interventions (Carroll et al., 2008; Kiluk et al., 2018; Shulman et al., 2018). Carroll and Kiluk (2017) propose a framework linking CBT to neuroscience findings by mapping various CBT elements to assessment/treatment targets and to corresponding interventions. In this framework, for example, the topic of urge coping is linked to distress tolerance and regulation of craving, which in turn is linked to urge surfing, mindfulness, and affect tolerance (Carroll & Kiluk, 2017).

Conclusions

In sum, our group-based CST for SUD has shown to be effective in reducing substance use and cravings, and increasing utilization of coping skills, with effects persisting up to 12-months posttreatment. Integrated approaches that address co-occurring conditions, and approaches that incorporate MI, have had promising results and may reach and appeal to a wider and more representative segment of individuals with SUD. Recent advances in technology (e.g. ecological momentary interventions; Wray, Merrill, & Monti, 2014) and recent developments in understanding cognitive functioning, computer-enhanced treatment, cognitive remediation strategies, and medication-assisted treatment for SUD have all contributed to an increased understanding of the biological and psychological underpinnings of CBT for SUD. Additionally, stepped care and population-based approaches (e.g., identification of individuals with SUD in primary care settings and other larger-scale health delivery systems) allow for increased accessibility and availability of CBT for those individuals who are most in need of services.

CHAPTER 12

Borderline Personality Disorder

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Borderline personality disorder (BPD) is a highly comorbid disorder characterized by interpersonal, behavioral, cognitive, self-, and emotion dysregulation. People with BPD present in outpatient, inpatient, hospital, and primary care settings at a disproportional rate compared to the low base rate of prevalence of this disorder in the general population. While there are several evidence-based treatments for BPD, the present chapter focuses on dialectical behavior therapy (DBT). DBT is derived from cognitive-behavioral principles. In addition, DBT is the only evidence-based practice for BPD that includes an essential group component (DBT skills group).

Cognitive and Behavioral Features of BPD

BPD is a mental illness characterized by severe emotion and interpersonal dysregulation, functional impairment, and high rates of suicide (American Psychiatric Association, 2022). According to the current diagnostic system, a diagnosis of BPD may consist of a range of symptoms encompassing cognitive, interpersonal, behavioral, and emotion dysregulation (see American Psychiatric Association, 2022, for specific symptom criteria). Despite a rather straightforward approach to diagnosis, several nosological complications can make the identification, differential diagnosis, and treatment of BPD difficult. First, there is no single symptom or symptoms that serve as a

hallmark of the disorder. In other words, two individuals with a diagnosis of BPD may only overlap in terms of a single symptom (i.e., if Person A was experiencing symptoms one through five and Person B was experiencing symptoms five through nine). Second, given the heterogeneity in the clinical phenotype of BPD, there are a total 256 possible symptom profiles. Third, phenotypic heterogeneity does not include the large population of clients that may be experiencing subsyndromal levels of BPD. This might include a diagnostic rule out because they have not been experiencing the symptoms for a sufficient length of time (2 years) or because they are experiencing less than the required five symptoms. These diagnostic factors should be taken into consideration when deciding on a specific treatment protocol for those with BPD.

BPD is estimated to affect 1–2% of the general population (Lenzenweger, 2008), with prevalence rates as high as 10% found in psychiatric outpatients and inpatients (e.g., Skodol et al., 2002). As a result, people with BPD use more psychiatric and nonpsychiatric services (e.g., psychotherapy, inpatient psychiatric hospitalizations, outpatient medical visits) than clients with other personality disorders (PDs) or mood or anxiety disorders (Ansell, Sanislow, McGlashan, & Grilo, 2007). Consequently, the increased use of treatment resources has led to extensive wait-list times within sites that specialize in treating BPD. A study examining the supply and demand of psychotherapy for BPD has cited average wait-list times ranging from 14.3 weeks to 2 years (Richter, Steinacher, zum Eschenhoff, & Bermpohl, 2016). This is particularly concerning because a high percentage of those with BPD (70–80%) are at a high risk of suicide or self-injury (Black, Blum, Pfohl, & Hale, 2004; Paris, 2004). Additionally, a major complicating factor in the diagnosis and treatment of BPD is the high comorbidity with other mental disorders (Zanarini et al., 1998; Zimmerman & Mattia, 1999). BPD is most frequently associated with anxiety disorders, mood disorders, and disorders associated with substance misuse (Grant et al., 2008; Lenzenweger, Lane, Loranger, & Kessler, 2007; Skodol et al., 2005). Studies report that about 84% of individuals with BPD also had a lifetime anxiety disorder, 83% had a lifetime mood disorder, and 78% had a lifetime SUD (Tomko, Trull, Wood, & Sher, 2014).

Individuals with BPD experience high levels of functional impairment. Studies of clinical populations have found substantial impairment in occupational, health, and social functioning relative to other psychiatric disorders (Skodol et al., 2002). A literature review examining employment functioning over time revealed that approximately 45% of individuals with BPD remained unemployed at follow-up and 20–45% remained on disability (Sansone & Sansone, 2012). These statistics are above the average unemployment rates seen in other PDs (Skodol et al., 2002). Studies have also noted a significant association between BPD symptoms and impaired physical functioning (i.e., pain and fatigue) in older adults (Powers & Oltmanns, 2012; Tugade, Fredrickson, & Barrett, 2004). This physical

impairment is independent of other chronic physical health problems (e.g., diabetes, arthritis) that are usually seen in individuals with BPD (El-Gabalawy, Katz, & Sareen, 2010; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005). Last, studies have examined the influence of environmental stress and the association of the emergence of BPD features. Consistent empirical evidence links maladaptive family functioning, low maternal support, and weak family cohesion with the later development of BPD symptoms (Fruzzetti, Shenk, & Hoffman, 2005; Stepp, Olinio, Klein, Seeley, & Lewinsohn, 2013).

CBT/DBT Treatment of BPD

Biosocial Theory

Linehan's (1993) biosocial theory is one of the most pervasive models of BPD pathology. It serves as a framework for understanding the etiological mechanisms of BPD and for formulating DBT treatment strategies. According to the biosocial theory, emotion dysregulation, a result of an interaction between individual and environmental factors, can influence the emergence of BPD symptoms. The two primary factors at work are the biological factor of emotion vulnerability and the social factor of an invalidating environment in childhood. When these factors are both present in an individual, they are likely to experience amplified and long-lasting emotion experiences. As these experiences intensify over time, they are typically not met with modeling or instruction on more adaptive emotion regulation strategies. Instead, maladaptive strategies (i.e., threats, angry outbursts, frantic efforts to engage others) are reinforced as they garner attention, aid, and caregiving behaviors. Below we describe each aspect of the biosocial theory in general and then provide a specific example of how it may be expressed.

Biological Vulnerability

Biological vulnerability to BPD is typically represented as emotion vulnerability, the tendency for an individual to experience a high resting state of emotional arousal, a sharp increase in emotional intensity when confronted with a stimulus, and a slow return to baseline levels of emotionality once a stimulus is removed (Kuo & Linehan, 2009; Linehan, 1993). Recent research has even demonstrated that these emotion vulnerability tenets occur for negative emotions in the presence of *positive* stimuli (Williams & Uliaszek, 2019). Furthermore, this type of vulnerability is identifiable as early as infancy in the form of negative affectivity and effortful self-control (Linehan, 2015). The actual amount of vulnerability varies between individuals, as does the severity of the disorder. An individual's vulnerability is thought to be determined from genetic factors (i.e., 5-HTT

s/s polymorphism, TPH-1 gene, 5-HT receptor genes, DAT-1), abnormalities of brain systems (i.e., 5-HT, dopamine, frontolimbic dysfunction), and early biological factors (e.g., intrauterine factors; Crowell, Beauchaine, & Linehan, 2009).

Social Vulnerability

In the DBT context of the biosocial theory, social vulnerability is best represented as an invalidating childhood environment. Validation refers to the nonjudgmental acknowledgment of one's emotions, thoughts, and feelings, and almost always results in a decrease of emotional intensity (Pederson, 2015). In contrast, negating or devaluing one's emotional experience results in an escalation of emotional intensity. Over time, this pattern of escalation and continuous invalidation contributes to emotion dysregulation by failing to teach an individual how to trust their own emotional experiences. Consequently, this mistrust of emotional responses can lead to difficulty tolerating distress and learning how to self-validate. In addition, it necessitates maladaptive expressions of emotionality to elicit help and warmth. Thus, a child may learn that they will gain emotional support only if they are experiencing an extremely intense emotion with significant behavioral correlates (e.g., suicidality, self-harm).

Emotion Dysregulation

While not evident according to the DSM-5-TR conceptualization, biosocial theory and the DBT treatment protocol proposes emotion dysregulation as a core, hallmark feature of BPD. It represents a primary etiological component and an explanation for other associated symptoms. At its core, emotion dysregulation is the inability to change emotional cues, experiences, or actions (Linehan, 2015). Conversely, emotion regulation refers to how one influences, implicitly or explicitly, their emotional experience, whether it be by change in valence, type, intensity, or expression (see Gross, 1998). Those experiencing pervasive emotion dysregulation appear to have a deficit in the ability to effectively engage in adaptive emotion regulation strategies, resulting in maladaptive patterns of emotional responding (see Gratz & Roemer, 2004). Adaptive emotion regulation strategies are those we often teach and encourage in the context of CBT and DBT—these include cognitive reappraisal, acceptance, and situation modification (Gross, 1998). Those with pervasive emotion dysregulation and BPD are often unable to enact less "adaptive" emotion regulation strategies in time-limited, effective ways. These strategies include distraction and suppression. Instead, emotional stimuli are responded to with an inability to turn attention away from cues, confusion regarding the emotion experience, self-damaging impulsive behaviors, difficulty with goal setting, and cognitive distortions.

Other Etiological Models

While the biosocial model has been lauded as a primary etiological model that drives both research and treatment approaches alike, several other research programs have pointed to differential pathways for the development of BPD apart from an invalidating childhood environment and a biological sensitivity to emotional stimuli. Taken together, the bulk of research suggests evidence for both equifinality (the fact that many diverse developmental sources can lead to an adult diagnosis of BPD) and multifinality (the fact that the developmental sources named as being important in BPD can also result in many other disorders or no disorder at all).

For example, trait-specific etiological models of BPD focus on neuroticism, impulsivity, emotional instability, and low constraint (Paris, 2005). Of course, these traits are found across both normal and abnormal populations and have been associated with a range of disorders, displaying evidence of multifinality. Interestingly, BPD appears to be a combination of both internalizing and externalizing symptomatology (e.g., Paris, 2005; Uliaszek & Zinbarg, 2016). From a developmental perspective, it is likely that the developmental factors putting those at risk for impulsivity (the externalizing dimension) and mood and anxiety symptoms (the internalizing dimension) are both present in those with BPD (Paris, 2005). Models focusing on traits and underlying psychopathology dimensions provide additional treatment implications because modes of CBT treatment for other, overlapping disorders and symptoms may point to new and innovative ways to treat BPD symptoms with proven methods. For example, clinicians may combine cognitive reappraisal techniques common in CBT for depression with contingency management techniques common in CBT for substance abuse to properly target emotion regulation difficulties, high neuroticism, and impulsivity in a particular person with BPD.

Evidence-Based Treatment of BPD

DBT was first developed through the work of Marsha Linehan in the early 1990s as a treatment for chronically suicidal individuals with BPD. DBT aims to change behavior and manage emotions through "a balance and synthesis of both acceptance and change" (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006, p. 461). It uses principles of CBT with strong foundations in behavioral principles, Zen Buddhism, and dialectical theory. There is consistent evidence supporting DBT as a gold-standard psychological intervention for a range of disorders and symptoms (see Panos, Jackson, Hasan, & Panos, 2014; Ritschel, Lim, & Stewart, 2015; Robins & Chapman, 2004, for reviews). While it began as a treatment for BPD, suicidality, and nonsuicidal self-injury (e.g., Linehan et al., 2006, 2015;

Linehan, Tutek, Heard, & Armstrong, 1994), it has expanded to be an efficacious treatment for severe and comorbid depression (e.g., Lynch et al., 2007) and eating disorders (e.g., Telch, Agras, & Linehan, 2001). In fact, DBT is now best conceptualized as a transdiagnostic treatment for emotion dysregulation (Ritschel et al., 2015).

In its entirety, DBT typically includes individual therapy sessions, a weekly skills group, telephone coaching, and team consultation. This standard protocol is unique in that, unlike most evidence-based therapies, it mandates a group therapy component. This modular, hierarchical approach has been beneficial in transforming DBT into a transdiagnostic treatment, as it can be altered and selectively employed dependent on the targeted symptomatology (Linehan & Wilks, 2015; Ritschel et al., 2015). Several studies conducted by Linehan and colleagues (Linehan, Heard, & Armstrong, 1993; Linehan et al., 1994; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) examined the efficacy of standard DBT as a psychosocial treatment for BPD as compared to "treatment as usual" (TAU). A number of significant findings were reported highlighting the benefit of DBT over TAU. Individuals randomized to DBT experienced a significant decrease in risk associated with suicidal behavior, depression, and feelings of hopelessness compared to TAU. Furthermore, attrition rates were significantly lower in DBT (17%) than in TAU (58%; Linehan et al., 1991). The maintenance of these effects has been demonstrated at 6- and 12-month follow-up assessments with DBT associated with significantly less anger, greater social adjustment, and better work performance than TAU (Linehan et al., 1993). Since the initial studies described above, several replication studies have been conducted examining the efficacy of DBT versus TAU. Similar to the findings of Linehan et al. (1991), individuals receiving DBT had a significant decrease in suicide attempts (Linehan et al., 1999), nonsuicidal self-injury (Koons et al., 2001; van den Bosch, Verheul, Schippers, & van den Brink, 2002; Verheul et al., 2003), hospitalizations, depression symptoms, anger, and feelings of hopelessness (Koons et al., 2001) when compared to individuals receiving TAU.

DBT can also be adapted to offer DBT skills group only as a primary intervention or as an adjunct to TAU. There is mounting evidence that DBT skills group is a necessary and sufficient component to treatment outcome in DBT. Several studies have examined DBT skills group as a stand-alone treatment targeting symptom reduction for a range of disorders (see Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015, for a review). Several additional studies have examined DBT skills group as an add-on to TAU with positive results (Fleming, McMahon, Moran, Peterson, & Dreessen, 2015; Klein, Skinner, & Hawley, 2013; Muhomba, Chugani, Uliaszek, & Kannan, 2017; Uliaszek, Rashid, Williams, & Gulamani, 2016; Uliaszek, Wilson, Mayberry, Cox, & Maslar, 2014). In addition, mechanism studies have found that skills use is a mediator of therapeutic

outcome in various emotion dysregulated populations (e.g., Neacsiu, Rizvi, Vitaliano, Lynch, & Linehan, 2010; Rudge, Feigenbaum, & Fonagy, 2017; Uliaszek, Hamdullahpur, Chugani, & Rashid, 2018). Taking a broad lens to this quickly growing literature, we can determine that DBT skills group as a stand-alone or add-on treatment is being offered in large numbers as an alternative to standard DBT, likely due to its ease of administration and its ability to treat several people simultaneously (Valentine et al., 2015).

Assessment

BPD is associated with multiple reliable and valid questionnaire and interview measures that can be completed by both clients and clinicians. A well-validated and frequently utilized self-report questionnaire is the Borderline Symptom List (BSL), which can include a 95-item measure (Bohus et al., 2007), a 23-item short measure, and a supplemental form (BSL-23; Bohus et al., 2009). The Zanarini Rating Scale for BPD (ZAN-BPD; Zanarini, 2003) is a clinician-administered rating scale specifically designed to assess change in BPD symptoms. Finally, diagnostic interviews, including the Structured Clinical Interview for DSM-5-Personality Disorders (SCID-5-PD; First, Williams, Benjamin, et al., 2015), can be administered by clinicians to give a diagnostic picture of DSM-5-TR BPD symptomatology. Any of these measures can be used as outcome measures to assess change during the course of group therapy. Because of the time necessary to complete a diagnostic interview, those might be better served as pre- and post-treatment measures, while self-report questionnaires can be used for more frequent, midtreatment assessments.

PD Assessment Issues

Despite the range of well-validated measures, there are specific difficulties that contribute to problems with the assessment of PDs, and BPD in particular. It is well established that people with PDs may have a difficult time accurately self-reporting their own symptoms and have difficulty understanding how their behavior affects others (see Oltmanns & Turkheimer, 2006). This is often attributed to a lack of insight, which then affects self-reporting. Perhaps specific to BPD is the tendency to overreport negative life events and stressful circumstances (Lewinsohn, Rohde, & Gau, 2003). In other words, a person with BPD may minimize the negative impact they have on others, while overstating their experience of environmental stress. Finally, there is considerable evidence that the current experience of negative mood causes a negative response bias in the retrospective reporting of affective states and symptomatology (e.g., Sato & Kawahara, 2011). This finding has been found to be exaggerated in BPD compared to healthy controls (Ebner-Priemer et al., 2006).

Differential Diagnosis

As mentioned above, BPD frequently co-occurs with other disorders, including both PDs and non-PDs, making differential diagnosis difficult. The most commonly co-occurring disorder is major depressive disorder (MDD). The high negative affect, suicidality, problematic interpersonal relationships, and trouble with decision making and concentrating (which could potentially mimic identity disturbance) evident in MDD might seem to be characteristic of BPD. In addition, similarities in the emotional experiences of individuals with BPD and MDD have been observed in the literature, including the frequent experience of emotions, such as shame, emptiness, and hopelessness (Farabaugh, Mischoulon, Fava, Guyker, & Alpert, 2004). Difficulties distinguishing between transient low mood in BPD and clinical depression has been highlighted (Beatson & Rao, 2013; Silk, 2010), and previous research shows strong correlations between self-report measures of BPD and depressive symptoms, as well as elevations on measures of BPD among individuals with MDD only (Bohus et al., 2007, 2009). A study by Fava et al. (2002) has also underscored the difficulties in effectively measuring co-occurring BPD and depression, demonstrating that PD diagnoses are frequent among adults seeking treatment for MDD, and that these diagnoses are not stable following improvement in depressive symptoms (Fava et al., 2002). Because both BPD and MDD can be diagnosed simultaneously, clinicians should avoid a diagnosis of BPD based only on a cross-sectional presentation without having documented that the pattern of behavior is long-standing and occurs outside of major depressive episodes (American Psychiatric Association, 2022).

BPD has several symptoms in common with other PDs. This includes, but is not limited to, paranoia in paranoid and schizotypal PDs, inappropriate anger in narcissistic and paranoid PDs, and rapidly shifting emotions in histrionic PD (American Psychiatric Association, 2022). The characterization of these symptoms is different for BPD than these other PDs—however, it is important to note that all can be diagnosed simultaneously. First, paranoia in BPD is characterized as transient and stress induced. Second, inappropriate anger in BPD is typically associated with an unstable self-image, abandonment concerns, and self-destructive impulsivity. These associated symptoms are not typically evident in either narcissistic or paranoid PD. Finally, the shifting of emotions in histrionic PD is more consistent with a shallow experience of emotionality, not the emptiness and shifting relationships found in those with BPD.

Finally, BPD should be distinguished from identity concerns associated with normative developmental patterns (i.e., adolescence), as well as symptomatology that develops as the result of chronic substance use (American Psychiatric Association, 2022). In the latter case, this might look like the irritability and angry outbursts, problematic interpersonal relationships, or self-damaging impulsivity of a chronic substance

abuser—typically seen as being provoked by withdrawal symptoms and efforts to obtain substances.

Dimensional Assessment

We thought it important to point out that there is significant interest and empirical evidence in conceptualizing BPD as a dimensional construct. In light of the shortcomings underlying the traditional diagnostic classification of PDs, modern PD conceptualizations are shifting away from categorical diagnoses in a movement emphasizing dimensional individual differences (Al-Dajani, Gralnick, & Bagby, 2016; Widiger & Trull, 2007). Among the various failings associated with categorical PD classification are the employment of arbitrary cutoffs (Skodol, 2012), notably high comorbidity rates across PDs (Oldham, Skodol, Kellman, Hyler, & Rosnick, 1992), marked heterogeneity of presentations in individuals with the same PD diagnosis (e.g., Johansen, Karterud, Pedersen, Gude, & Falkum, 2004), and frequent use of the personality disorder not otherwise specified category (Verheul, Bartak, & Widiger, 2007). The alternative model for PDs (AMPD) is a hybrid approach in conceptualizing PDs (included in Section III of DSM-5-TR) that was designed to introduce a dimensional method of PD assessment while maintaining continuity with preexisting DSM diagnostic categories (American Psychiatric Association, 2022; Krueger, Skodol, Livesley, Shrout, & Huang, 2007; Waugh et al., 2017). In order to assess BPD using the AMPD, seven criteria must be met. Criterion A, general PD impairment, is determined by significant difficulties in the individual's self- (identity or self-direction) or interpersonal (empathy or intimacy) functioning, as typically operationalized using the Level of Personality Functioning Scale (LPFS; Bender, Morey, & Skodol, 2011; Morey, 2017). Criterion B assesses specific PD presentations, often operationalized using the Personality Inventory for DSM-5 (PID-5; American Psychiatric Association, 2022; Krueger, Derringer, Markon, Watson, & Skodol, 2012). This measure evaluates 25 empirically derived lower-order facets subsuming the following five higher-order maladaptive personality domains (Krueger et al., 2012): negative affectivity, detachment, antagonism, disinhibition, and psychoticism. In order to meet criteria for BPD, an individual must endorse four of the following seven facets spanning the negative affectivity, disinhibition, and antagonism domains: emotional lability, anxiousness, separation insecurity, depressivity, impulsivity, risk taking, and hostility. They must also endorse one of impulsivity, risk taking, or hostility (American Psychiatric Association, 2013). Criteria C–G of the AMPD ensures the pervasiveness, stability, and adolescent/early adulthood onset of PD symptoms while also discriminating personality dysfunction from medical conditions, other psychological disorders, physiological influences of substances, and normative developmental and sociocultural factors (American Psychiatric Association, 2013).

Structuring DBT Skills Group for BPD

While we have decided to focus on DBT in this chapter because of its empirically validated group treatment component, it is important to emphasize that DBT was derived from CBT. When Linehan was seeking to treat suicidality in a client population largely characterized by BPD symptoms, she noted many reasons why CBT was not the best fit. She based the treatment in her CBT background—in fact, the preeminent text on DBT is titled *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (Linehan, 1993)—but integrates aspects of other evidence-based treatments, Zen Buddhism, and a dialectical philosophy specifically designed to target symptoms of BPD and suicidality.

Linehan (2015) notes 10 primary differences between DBT and CBT. Many of these are now common in CBT interventions, but are typically more characteristic of third-wave interventions, such as DBT, acceptance and commitment therapy, and other mindfulness-based approaches.

1. *Synthesis of acceptance with change*. This refers to the dialectical integration of acceptance techniques (i.e., validation) with traditional CBT change-focused strategies (i.e., cognitive restructuring). This addresses the problem of an overreliance on change-focused strategies being viewed as overly critical by those with BPD.
2. *Inclusion of mindfulness*. This serves to increase focus, attention, and emotion regulation skills, and serves as the basis for all skill building.
3. *Emphasis on treating therapy-interfering behaviors of both clients and clinicians*. This target is put above that of other quality-of-life issues (but still addressed after safety concerns are satisfied), putting the somewhat typical therapeutic alliance issues front and center as a treatment target. Therapeutic alliance in the group context has been shown to account for positive treatment outcomes in BPD—thus it is of primary importance in the structuring of treatment goals within session.
4. *Emphasis on clinician self-disclosure*. This is encouraged whenever it is done in the service of the client. In can assist in modeling and validation.
5. *Emphasis on dialectical processes*. This specifically addresses the splitting/black-and-white thinking of those with BPD.
6. *Emphasis on stages of treatment and treatment targets*. This helps to organize a treatment situation that can be plagued by seemingly unrelenting crises. It also emphasizes that nothing of direct concern to the client will be addressed until it is demonstrated that they are safe and that neither the client nor clinician are engaging in behaviors that impede the progress of therapy.

7. *Inclusion of a suicide risk assessment and management protocol* (e.g., Suicide Behaviors Questionnaire–R [SBQ-R]; Osman et al., 2001). This is necessary due to the high-risk nature of this client population.
8. *Inclusion of behavioral skills drawn primarily from other evidence-based interventions*. DBT skills are an expertly curated compilation of tools from CBT, acceptance and commitment therapy, mindfulness-based stress reduction, and many other treatment protocols.
9. *The treatment team as an integral component*. The treatment team provides necessary support among DBT clinicians.
10. *Focus on continual assessment via diary cards*. While frequent monitoring is not novel in the context of CBT, DBT clinicians employ a unique, detailed daily monitoring form to be turned in during DBT skills group. This card typically includes the daily monitoring of emotions, suicide, nonsuicidal self-injury, drug/alcohol use, maladaptive behaviors (e.g., lying, stealing), urges, and skills use.

Group Format

The standard DBT skills group format consists of a 2-hour, weekly format, usually 6 months to 1 year in length. The full gamut of skills can generally be reviewed within 6 months and it is recommended that group members go through skills training twice. However, significant research evidence has demonstrated the efficacy of shorter group formats (McMain, Guimond, Barnart, Habinski, & Streiner, 2017; Soler et al. 2009). The specific length of time that a client spends in DBT skills group is dependent on both client factors (availability of time and monetary resources) and site factors (availability of open spots, commitment length, and number of groups).

During a standard DBT skills group, the first 5 minutes is dedicated to a mindfulness exercise, and the remainder of the first hour is dedicated to homework review. This includes participation from each client, regardless of whether they completed the assigned homework. This provides the opportunity to troubleshoot why homework was not completed and to circumvent avoidance at participating in group by not completing the homework. After a short break, the second half of the group is dedicated to new skill acquisition. This is a combination of didactics, modeling, discussion, and experiential activities allowing clients to learn the details of new skills, possibly test them out, and troubleshoot and plan to practice in the week ahead. Skills acquisition is accompanied by associated handouts and worksheets (Linehan, 2015). The end of group includes a wind down and homework assignment for the next group. Below, we detail

several aspects and questions typically relevant to structuring DBT skills group.

Closed Group versus Open Group

A closed group means that the group starts with a set client group and no one new can enter until the group is complete. This may be typical when groups are running on an abbreviated time frame without plans to continue the group past a single review of the skills. An open group refers to a group structure where new clients can be added at any point in time that there is space available. Most DBT skills groups operate on a hybrid system between open and closed. Typically, new members are able to enter the group only at the beginning of a new module, which occurs approximately every 6–8 weeks within the standard format. This allows each group to be a combination of experienced and new group members.

Graduate Groups

Many sites encourage graduate DBT skills group. These groups are targeted toward clients who have completed 1 year of DBT skills group but still wish to practice skills in a group therapy format. Typically, these groups have a mental health professional as a facilitator but are led by the clients. It is generally assumed that these clients have already achieved significant gains in treatment and are less of a safety concern.

Benefit of a Coleader

DBT skills group can be led by a single, well-trained mental health professional. However, there are several benefits to having two group leaders. First, it is likely that at some point during the group, a client will become emotionally dysregulated (i.e., becoming tearful, angry, or panicked). If this happened with a single group leader, the group would need to be derailed in order to appropriately address any emotional issues that arise. This may have the unintended effect of reinforcing disruptive displays of emotion, either by providing attention only to clients who are the most overtly emotional and/or by pausing homework review and skill instruction. Second, it is a common occurrence that a client may become so emotional that they abruptly leave the group. Because nonsuicidal self-injury and suicide are common symptoms of BPD, there is a significant risk that a client could walk out of the group and attempt to harm him- or herself. Having a coleader allows the group to continue while the group member is checked for safety. Third, DBT skills group requires heavy involvement by the group leader; this includes planning and instruction in new skills each week, conducting commitment and orientation sessions with new

members, and managing safety concerns. Having a coleader helps with reducing group leader burnout.

Group Rules

There are several rules standard to DBT, with some applicable to both individual and group DBT and some that are group specific. The majority of these rules can be found in seminal DBT books and manuals (Linehan, 1993, 2015). Here we review some of the most common rules and those most applicable to treating those with BPD in a group setting.

1. *All clients must have an individual therapist*. DBT skills group is structured to be a skills-learning platform, with less time for processing issues or talking about skills other than the ones focused on that day. This, combined with the high-risk population, necessitates a designated clinician responsible for both skills generalization and safety monitoring.

2. *Four-miss rule*. When a client misses four sessions in a row (either individual or group therapy), they are effectively ending therapy and cannot return until the end of their predetermined commitment. This serves as an environmental contingency to increase attendance and decrease avoidance behaviors.

3. *Suicide, nonsuicidal self-injury, and other self-damaging, safety-compromising behaviors are not discussed during DBT skills group*. This might seem counterintuitive considering that these are primary symptoms experienced by those with BPD, but there are several reasons that this is a rule. First, because of the limited time available in group to process experiences unrelated to skills, there is not enough time to fully address safety concerns in a satisfactory way. Instead, these items should be relegated to the individual therapist. Of course, if there is an imminent safety concern, this should be addressed. Second, because disclosures of suicide and self-harm necessitate the attention of the group leaders, these behaviors may be unintentionally reinforced. Clients may learn that only high-risk behaviors garner increased attention. Third, it is sometimes a core belief in those with BPD that they must be the "sickest person in the room" or be at high-risk as a stamp of validation that they are in extreme pain. This is reflected in the biosocial model where those with BPD learn that only extreme displays of emotion warrant help and reassurance. For these reasons, there may be a competitive need among clients to demonstrate the most severe symptoms. Fourth, it is well documented that suicidality and self-harm can have a contagion effect and that talk about these behaviors can be triggering for certain people (e.g., Cheng, Li, Silenzio, & Caine, 2014).

4. *Do not attend group under the influence of drugs or alcohol*. This rule is likely common to most group treatments. Primarily, it is hard to

absorb information if one is under the influence of a substance. In addition, an impaired client may be more disruptive and interfere with the learning of other clients. Finally, seeing someone high or drunk can be triggering for many clients who may be dealing with their own substance abuse issues.

5. Several rules pertain to the interpersonal relationships between clients. We do not discourage clients from connecting outside of group through phone, social media, or in person. It is not uncommon for clients to initiate social media groups, social gatherings, or texting. This is often a way for clients to garner support, feel "not alone" in their symptoms, and practice skills outside of group with a knowledgeable other. However, some restrictions do apply.

a. *Clients should not have sexual/romantic relationships with another client*. We ask that clients refrain from these relationships until one or both have completed group. Engaging in a sexual/romantic relationship can make it hard to focus during group, cause clients to avoid personal disclosure, and can become a crisis situation if the sexual/romantic relationship does not work out in a satisfactory way for clients.

b. *Extragroup socializing should not exclude any clients*. While clients are not discouraged from having relationships outside of group, we stress that socializing should not exclude anyone. For example, if a social media group is being created or if clients are planning to meet for coffee before group, everyone should be invited. This avoids hurt feelings and awkward interactions within the group.

c. *Clients must accept help from other clients*. Because many clients may be talking to one another outside of group, these conversations often turn to help-seeking behaviors. In other words, a client may ask another for advice, disclose a problem or an urge to harm oneself, or discuss suicidal ideation. This rule states that, if you ask another client for help outside of group, you must accept the help. Thus, it is not appropriate for a client to complain, "vent," discuss problems, and then refuse to use skills suggested by the other client. This helps to prevent any client from being burned out by supporting another client. It also gives everyone an opportunity to help practice skills.

Assessing Eligibility and Group Fit

There may be certain symptoms or characteristics that would make group untenable for certain people, as it is important that the significant time and effort associated with group is worthwhile. For these reasons, it may be counterproductive for those with significant social anxiety or interpersonal difficulties related to autism spectrum or schizotypy to attend group. This could cause an abundance of anxiety for those clients and prevent group-related treatment gains. In addition, those with significant cognitive

impairment may find the fast-paced nature and class-like format too difficult to follow. Important to note is that certain symptoms or characteristics may be disruptive within a group setting. This may include active psychosis or substance abuse as the principal diagnosis. In the case of the latter diagnosis, if someone is unable to commit to showing up to group sober, they would not be appropriate, as this is a rule.

Pretreatment and Commitment

As in individual DBT, "pretreatment and commitment" sessions are conducted prior to the start of DBT skills training. In individual DBT, pretreatment/commitment sessions occur during the first four individual sessions between the client and individual therapist. When the client has already been oriented during the pretreatment phase with their individual DBT therapist, it is common practice for the group leader to meet with the client for a brief pretreatment/commitment session (e.g., 15–30 minutes) prior to the start of the first DBT skills group. During this session, the group leader and the potential group member collectively determine whether DBT skills group is indeed the appropriate treatment for the client's goals and whether all parties agree to work together. It is preferred that both group leaders meet jointly with the client, as it will ease the transition to group, although this is not always possible due to scheduling challenges.

The following tasks are to be completed during the pretreatment/commitment session: (1) a pretreatment assessment is conducted, during which the group leader ascertains the appropriateness of fit between the client and DBT skills group; (2) the group leader determines the intensity of the treatment (e.g., length of time to commit); (3) the client is oriented to the details and rules of DBT skills group; (4) a collaborative, verbal commitment is obtained; and (5) a therapeutic alliance is fostered. In addition, Tasks 3–5 are reviewed at the start of each new treatment module in DBT skills group.

Determining Treatment Intensity

A key function of the pretreatment/commitment assessment is to determine the appropriate intensity of the treatment, as well as the type of skills the client needs. A number of options can be considered. For instance, is DBT skills group alone sufficient for the client's goals and needs or should other treatment models and intensities be considered? The DBT skills training manual (Linehan, 2015) provides a description of client characteristics and needs, paired with suggested interventions of various models and intensities. As well, the length of the treatment is also to be determined during the pretreatment phase. For instance, although standard DBT consists of 1 year of skills group, several studies have also evaluated the efficacy of shorter treatment lengths (e.g., 13 weeks, Soler et al., 2009; 20 weeks, McMain et al., 2017) for individuals with BPD. Although research evaluating the

various intensities and length of treatment are in its infancy, when possible, these decisions should be guided by the empirical literature.

Orientation to DBT Skills Training

During this orientation phase, the group leader presents the biosocial model, describes the group format, group rules, and the roles of the group leader and client. Importantly, the group leader also describes how DBT skills group might differ from other types of group therapy (i.e., that it has an educational function, uses a classroom-type "format," and is not like the typical "process group"). The group leader emphasizes that the primary goal of the group is for the client to gain, strengthen, and practice skills, and that other topics, such as struggles or crises that they have experienced during the week, are reserved for individual therapy.

Commitment to Skills Training

One factor predicting treatment dropout among DBT clients is lack of commitment to change (Barnicot, Katsakou, Marougka, & Preibe, 2011). Obtaining a client's agreement to participate in DBT skills group is critical to enhancing their motivation to engage in treatment and facilitate the uptake of the skills. Indeed, many, if not most clinicians have experienced the trials and challenges of trying to "drag" a client through a treatment when they are unmotivated to engage. For example, trying to treat an adolescent who feels they have been "forced" into therapy by their parents or a client who feels significant antagonism toward the treatment is difficult. It is common for individuals with BPD to come to treatment with high doubts, reservations, and/or cynicism about the efficacy of the treatment. Thus, a core function of obtaining a commitment is to strengthen the client's voluntary desire to engage in the treatment. It is important to note that, although the DBT treatment model designates a specific pretreatment and commitment phase prior to the start of treatment, continuous monitoring and generating the client's (re)commitment to therapy is natural to the course of DBT. Indeed, clients do not necessarily maintain a steady state of commitment and therefore it is common practice to obtain recommitment throughout treatment. Below we describe key guidelines and strategies for the group leader to use when obtaining commitment from the client to engage in DBT skills group, along with several case examples to illustrate the different strategies.

Selling Commitment: Evaluating the Pros and Cons

Collaboratively evaluating and discussing the pros and cons for the client to engage in skills training is one of the core commitment strategies used in DBT. The group leader inquires and generates both the positives and

negatives of choosing to participate in DBT skills group, learn the skills, and adhere to the agreements and guidelines of skills training. General Worksheet 1 in the DBT skills training manual (Linehan, 2015) provides a place for the client to list the pros and cons of both practicing and not practicing skills. It is a useful tool for the practitioner to use to help the client to ultimately generate reasons to participate in group. Importantly, this discussion needs to be firmly nested within the client's stated goals such that the pros and cons generated will detail the advantages and disadvantages of the client choosing to use skills in order to reach those goals. The practitioner should approach this discussion using a curious, inquisitive style that expresses a nonjudgmental desire to understand the tensions that the client might be experiencing with regard to choosing to practice DBT skills. At the same time, through the process of shaping and reinforcement, the therapist should strategically, yet benevolently, strengthen the client's desire toward choosing to practice skills and be committed to skills group. Although a verbal discussion of the pros and cons may be adequate, constructing a 2 × 2 matrix detailing the pros and cons of practicing skills and not practicing skills can also be helpful. Figure 12.1 illustrates a sample pros/cons matrix collaboratively generated by one of the author's clients: "Katie."

Devil's Advocate

This strategy involves the group leader presenting a propositional statement that reflects an extreme or extended version of the client's dysfunctional belief, followed by playing the role of devil's advocate to counter the client's

	Practicing skills	**Not practicing skills**
Pros	It will help me get closer to being able to find a job. It will help me feel better and be less miserable. I would feel proud of myself.	It's the easier thing to do. I wouldn't have to learn anything challenging. I could stay attached to my pain, which I also find soothing.
Cons	It will be hard. I might judge myself for not doing them right. It might not always work when I want it to.	I probably won't ever be able to find a job. I could lose a lot of friendships and relationships that are important to me. I would stay miserable.

FIGURE 12.1. Example of a pros and cons matrix to aid in obtaining commitment to DBT skills group.

attempts to challenge that statement. Take, for example, client Katie who had expressed that she did not want to participate in DBT skills group because, in the past, she had been in a DBT skills group and the group leader taught skills that were "common sense" and she "already knew" them. The therapist then argued in favor of the client's belief that the skills were common sense and therefore, not necessary, by saying, "Well, right—and since they're so common sense, this means that everyone in the world uses them and, in fact, this probably means that therapy isn't even necessary at all." By extending beyond what the client communicated, the dysfunction in Katie's belief became more apparent such that, eventually, she acknowledged that knowing that something is common sense does not always translate into doing the "commonsense thing." Another example of devil's advocate might be when a group leader simply argues against the reasons for the client to engage in skills training or practice skills, which can have the effect of steering the client toward the opposite direction (i.e., choosing to engage in skills group or practice skills). For example, a group leader might say, "Right. I totally agree that learning skills is hard work and frankly, I think hard work is overrated and never gets you anywhere." By providing such an extreme statement, this naturally steers the client toward considering the alternative argument (i.e., hard work might actually get people somewhere).

Foot-in-the Door and Door-in-the-Face

The foot-in-the-door and door-in-the-face techniques are derived from social psychology (Cialdini et al., 1975; Freedman & Fraser, 1966) and function to enhance the client's compliance with the group leader's requests and/or with previous commitments. Foot-in-the-door is when the group leader first makes a smaller or presumably easier request, and then, when the client agrees to the request, the group leader then asks for something larger. For example, a group leader might first ask the client to agree to bring their skills manual to every group. Then, when the client agrees, the therapist might "up the ante" and follow with a more difficult request for the client to not only bring the skills manual but to arrive on time.

In contrast, door-in-the-face is when the group leader first makes a larger unrealistic request, and then, when the client declines the request, the therapist then reduces the request. For instance, a therapist might ask the client to attend every single group for the entire 12-month period. A client's response might be "I can't agree to that—I have kids at home, they get sick, and sometimes I'll have to stay at home with them." Then, the therapist can follow with an easier request: "Okay, then, how about you agree to not miss more than one group per month?"

"Dancing" between the foot-in-the-door and door-in-the-face techniques is often the most effective combination. Going back to client Katie, she mentioned that she did not like going to skills group because she

"couldn't stand" some of the "frivolous" issues that other clients raised. After reviewing the pros/cons, Katie then agreed that she would attend skills group for at least one skills module. The therapist then aimed to strengthen the commitment by using a variation of foot-in-the-door and door-in-the-face strategies: "Great that you're agreeing to attend skills group for one module. You do realize though, that you will need to spend up to 2.5 hours/week with all the people you can't stand" (door-in-the-face). Katie then responded with some hesitation about her commitment, stating she was not sure she could "do this" and would just "try it out" for a couple of weeks. The therapist then applied foot-in-the-door by saying,

> "Look, I completely realize it's hard to be in a room full of people that you're not crazy about on a weekly basis. I'm just asking you to tolerate that for a couple hours a week. It'll be hard, but it won't kill you. In fact, tolerating frustrating situations is a really important skill for you to learn. How about, rather than just trying it out for a couple weeks, you agree to give the entire module a chance?"

Katie then agreed to attend one skills module, to which the therapist then applied foot-in-the-door once again by saying, "Well, actually, if you're going to agree to one module, you might as well do all of them because I don't think just one module will give you the best shot at getting that job you want." This exchange is a variation of foot-in-the-door and door-in-the-face because Katie's commitment was strengthened by her agreeing to not only attend all skills modules but to still attend even when she is unhappy with other members of the group.

Connecting Present Commitment to Prior Commitments

This strategy is a variation of the foot-in-the door technique and is typically used when the client's previous commitment seems to be wavering, or if the client's current behavior is inconsistent with a previous agreement. By reminding the client of previous commitments, the group leader explores two possibilities: (1) the client is still committed to a previous agreement, but is having difficulties maintaining the commitment; or (2) the client is no longer committed to a previous agreement. Thus, this is a strategy that is typically used for "recommitment." For example, although client Katie attended the first 4 weeks of group, by the fifth week, she told her group leader that she could no longer tolerate spending time with the other group members. The group leader then highlighted the disconnect between what the client was saying and her previous commitment: "But I thought you agreed to attend skills group, even when others in the group might drive you nuts."

Highlighting Freedom to Choose and Absence of Alternatives

This commitment strategy represents the dialectic of giving the client the absolute freedom to make a choice and simultaneously fostering a belief that there are no alternative paths to reach set goals. In the context of generating a commitment to join a skills group and/or practice skills, the group leader clearly communicates to the client that they have a choice of whether or not to attend skills group—"It is entirely up to you if you want to join the skills group"—while simultaneously emphasizing that there are little to no other options that will help the client achieve set goals: "Of course, I can't think of any other good ways to help you get your job back." One of the fundamental principles underpinning this strategy is to highlight the realistic consequences of the client's choice. For example, in the pretreatment/commitment session with Katie, she expressed to the group leader that she did not want to participate in DBT skills group, only individual therapy. The group leader then used freedom to choose/absence of alternatives by stating,

> "Choosing whether or not to do skills group is completely up to you. Of course, evidence suggests that DBT skills training might actually be the active ingredient of DBT and that individual DBT alone doesn't seem to add much . . . but if you're okay with receiving a potentially diluted treatment, then that is your choice."

In this example, the group leader presented the client with a choice about whether to attend skills group and simultaneously highlighted the negative consequence of the client electing not to do the skills group. To be effective, the group leader needs to radically accept that the client may not choose the "right" choice. Indeed, by rigidly attaching to a desired outcome (i.e., that the client chooses to do group), the delivery of this strategy can come off as judgmental and sarcastic. Thus, it is important for the group leader to maintain a curious, nonjudgmental, and nonattached stance while trying to understand the client's dilemma.

Key Treatment Components

The overall purpose of teaching skills is to mitigate emotion dysregulation by disrupting and replacing harmful compensatory behaviors with more effective coping strategies (Ritschel et al., 2015). DBT skills group is a targeted approach to maximize the teaching of adaptive coping strategies in emotionally dysregulated populations, while leaving individual therapy for problem-solving and motivational issues (Linehan & Wilks, 2015).

Teaching and reinforcing new behaviors are methods of promoting change and the skills themselves provide shared concepts and language that benefit clients. Below, we briefly review DBT skills, but interested readers should consult *DBT Skills Training Manual* (Linehan, 2015) for a fulsome list of skills, handouts, worksheets, and instruction.

The specific skills taught can be grouped into four modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Each module comprises skills that reflect the overarching goals of the module. Beyond psychoeducation, experiential practice is needed to develop behavioral competencies with the skills, and diary cards are used to track daily individual behavior. Altogether, DBT skills group instructs participants in dozens of skills, while at the same time encouraging the cessation and replacement of dysfunctional coping skills.

Mindfulness

Mindfulness skills are central to the philosophy of DBT and serve as an essential foundation for subsequent modules. They incorporate Eastern meditation practices and psychological and behavioral versions of meditation while teaching nonjudgmental, present-focused awareness. The core mindfulness skills focus on three primary states of mind: *reasonable mind, emotion mind,* and *wise mind*. Individuals in reasonable mind are operating primarily on fact and logic. Although reasonable mind helps us to function in the world, many aspects of life have an emotional component that must be considered. When in emotion mind, an individual's state of being (i.e., one's thoughts and behaviors) is driven by their current emotions. Often, these emotions can cause extreme and intense reactions and impulsive decisions—thus, making logical thinking and reasoning difficult. Individuals in emotion mind tend to act the way they feel without a clear perception of the consequences. DBT theory considers wise mind as the active integration between reasonable mind and emotion mind. Clients are taught to assimilate logical, fact-based thinking with heightened emotional experience to create a centered, calm state of mind.

Specific Mindfulness Skills

Much of the mindfulness module is dedicated to teaching clients how to participate in life with awareness. The "what" skills involve the practice of observing, describing, or participating in the present moment, including both internal and external experience. The "how" skills involve how one would attempt to observe, describe, and participate. This includes the taking of a nonjudgmental stance, as well as focusing on a single attentional aspect (i.e., one-mindfulness) while effectively working toward goals.

Interpersonal Effectiveness

Individuals with BPD often experience difficulties in interpersonal functioning. Not surprisingly, they report highly conflictual relationships with frequent breakups and reconciliations (Bouchard, Sabourin, Lussier, & Villeneuve, 2009), and are more likely to characterize their relationships as hostile (Nicol, Pope, Romaniuk, & Hall, 2015) and untrustworthy (Miano, Fertuck, Arntz, & Stanley, 2013). The goal of the interpersonal effectiveness module is to focus on improving relationships and general interpersonal interactions; this includes skills that can apply to intimate, professional, familial, and unfamiliar relationships. Initial groups focus on the importance of attending to relationships and balancing priorities and life/relationship demands. Subsequent sessions focus on achieving relationship goals, whether to get an objective met, improve the relationship, or maintain self-respect. In addition, groups focus on understanding factors that interfere with being interpersonally effective.

Example Interpersonal Effectiveness Skills

Once clients learn to prioritize objective, relationship, or self-respect relationship goals, specific skills are taught related to each goal. Objectives effectiveness provides individuals with the skills required to stand up for themselves, make reasonable requests, and be taken seriously. These skills can be remembered using the acronym DEAR MAN: Describe, Express, Assert, Reinforce, Mindfully, Appear confident, and Negotiate. The goal of relationship effectiveness is to improve how the other person feels about you after the interaction. These skills can be remembered using the acronym GIVE: Gentle, Interested, Validate, and Easy manner. Finally, respecting personal values and beliefs and walking away from interactions feeling good about oneself are important aspects of maintaining self-respect. These skills can be remembered using the acronym FAST: be Fair, no Apologies, Stick to values, and Truthful.

Emotion Regulation

As described above, emotion dysregulation is a core feature of BPD and perhaps the basis for all other types of dysregulation. The emotion regulation module incorporates a variety of evidence-based tools from several different interventions and spans an impressive gamut of skills related to cognitions, behaviors, and emotions. The module has three main goals: to understand one's emotions, to reduce emotional vulnerability, and to increase positive emotions. These skills are grouped into the following four segments: understanding and naming emotions, changing unwanted emotions, reducing vulnerability to emotion mind, and managing extreme emotions.

Example Emotion Regulation Skills

An example of a skill to understand and name emotions would be to review a comprehensive model of emotions that describes the prompting events, vulnerability factors, interpretation, awareness, biological changes, experience, expression, action, naming, and the aftereffects of an emotional experience. Examples of skills to change an unwanted emotion would be check the facts (similar to cognitive restructuring) and opposite action (similar to exposure). To reduce vulnerability to emotion mind, one might practice building mastery. Finally, an example of managing extreme emotions is utilizing mindfulness of a specific emotional experience.

Distress Tolerance

The distress tolerance module focuses on recognizing, accepting, and skillfully enduring distress, especially when the situation cannot be changed right away. The goal of the module is to employ crisis survival strategies without resorting to behaviors that will make the situation worse. Distress tolerance skills include distraction, self-soothing, improving the moment, and radical acceptance. Since many individuals with BPD struggle with understanding how they can allow their painful emotions without implying approval, these skills are taught within the framework of acceptance (e.g., radical acceptance and willingness). It is important to note that these skills are typically short-term solutions to the temporary survival of painful emotions.

Example Distress Tolerance Skills

Similar to the emotion regulation module, the distress tolerance module includes physiological, behavioral, and cognitive strategies. For physiological strategies, skills are taught to abruptly change body temperature and chemistry to activate the parasympathetic nervous system, effectively shutting down the body's stress response. One such skill is the TIPP skill, which stands for Temperature, Intense exercise, Paced breathing, and Paired muscle relaxation. Behavioral strategies include distraction skills, using the acronym ACCEPTS: Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, and Sensations. A primary cognitive strategy is radical acceptance, which focuses on allowing negative emotions through willingness and turning the mind.

Diary Cards

The diary card is the primary method of self-monitoring in DBT. During the initial sessions, individuals are given instructions for how to fill out the

diary card and are oriented to its purpose and importance. Diary cards are filled out daily, encouraging clients to maintain accountability for tracking important therapy-related information. Research shows that clients value the increased self-knowledge and the identification of patterns associated with filling out the diary cards (Johansson & Werbart, 2009). While diary cards can be modified depending on clinical population or clinical issues, standard DBT diary cards include suicidal urges, self-injurious behavior, and treatment-interfering behavior.

Sample DBT Group Protocol for BPD

A primary issue for the implementation of DBT skills group is the setting of the skills curriculum. Unfortunately, given the number of skills covered in the manual (Linehan, 2015), it is simply not possible to teach all skills within the typical cycle used in standard DBT. Although a majority of research studies evaluating the efficacy of DBT skills training, both in the context of the full comprehensive model and skills training alone, cover all four skills modules, the specific skills covered in each skills session are not typically reported and, likely vary considerably. The DBT skills training manual (Linehan, 2015), however, provides several resources to help determine the skills to be covered. First, throughout the manual, several of the handouts are marked with a star, indicating that it is a "core" handout. These handouts represent the primary skills that are taught in the module and core teaching points related to each skill. At minimum, it is recommended that these core handouts be covered throughout skills training. Appendices in the DBT skills training manual suggest schedules of DBT skills, many of which are based on DBT treatment studies with positive outcomes. These schedules detail the specific skills that are covered in each session and different recommended schedules to accommodate various treatment lengths (e.g., 20-week skills cycle vs. 24-week skills cycle), populations (e.g., adults, adolescents, families), and treatment settings (inpatient, outpatient).

Table 12.1 details a sample 6-month schedule. This schedule is based on "Schedule 2: 24 Weeks, Linehan Standard Adult DBT Skills Training Schedule (Research Studies before 2006)" listed in the Part I Appendix in the DBT skills manual (Linehan, 2015), with modifications to incorporate the new skills that were added after 2006. This schedule is based on a skills cycle of 2 weeks of mindfulness (repeated three times, between each module), 6 weeks of distress tolerance, 7 weeks of emotion regulation, and 5 weeks of interpersonal effectiveness.

TABLE 12.1. Sample 6-Month DBT Skills Group Protocol

Focus of group and suggested homework

Week 1: Orientation, goals and guidelines, mindfulness
- Review goals of skills training.
- Review guidelines for skills training group.
- Discuss assumptions of skills training.
- Engage participants regarding the pros and cons of using skills.
- Homework should include reviewing pros and cons of skills use.
- Review goals of mindfulness practice.
- Discuss states of mind.
- Discuss and practice wise mind.
- Discuss and practice the "what" skills: observe, describe, and participate.
- Homework should include practicing "what" skills.

Week 2: Mindfulness
- Discuss and practice mindfulness "how" skills: nonjudgmentalness, one-mindfulness, effectiveness.
- Homework should include practicing "how" skills.

Week 3: Distress tolerance
- Discuss goals of distress tolerance module.
- Provide overview of crisis survival skills, including when to use them.
- Discuss and practice STOP skill.[a]
- Discuss and practice pros and cons skill.
- Homework should include practicing the STOP and pros and cons skills.

Week 4: Distress tolerance
- Discuss and practice TIPP skills: changing your body chemistry.
- Discuss and practice distraction skills.
- Homework should include practicing the TIPP and distracting skills.

Week 5: Distress tolerance
- Discuss and practice self-soothing skills.
- Discuss and practice how to improve the moment.
- Homework should include practicing self-soothing and improving the moment skills.

Week 6: Distress tolerance
- Provide overview of reality acceptance skills.
- Discuss reality acceptance.
- Discuss turning the mind.
- Homework should include practicing reality acceptance skills.

Week 7: Distress tolerance
- Discuss willingness.
- Discuss and practice half-smiling and willing hands.
- Discuss and practice turning the mind, willingness, and willfulness.
- Homework should include practicing half-smiling and willing hands.

Week 8: Distress tolerance
- Discuss and practice mindfulness of current thoughts.
- Homework should include practicing mindfulness of current thoughts.

Week 9: Orienting and mindfulness skills repeat (refer to Weeks 1 and 2)

Week 10: Orientating and mindfulness skills repeat (refer to Weeks 1 and 2)

(continued)

TABLE 12.1. *(continued)*

Week 11: Emotion regulation
- Review goals of emotion regulation.
- Review the function of emotions and the model for describing emotions.
- Engage with participants regarding what makes it hard to regulate emotions.
- Homework should include monitoring emotions using observing and describing.

Week 12: Emotion regulation
- Review goal of changing emotional responses
- Discuss and practice check the facts skill: using cognitive restructuring to change interpretations.
- Review emotions that fit the facts.
- Homework should include practicing check the facts skill.

Week 13: Emotion regulation
- Discuss and practice opposite action: exposure skills.
- Homework should include practicing opposite action.

Week 14: Emotion regulation
- Discuss and practice problem-solving skills.
- Homework should include practicing problem solving to change emotions.

Week 15: Emotion regulation
- Review how to reduce vulnerability to emotion mind by building a life worth living.
- Discuss how to accumulate positive emotions in the short term.
- Discuss how to accumulate positive emotions in the long term
- Homework should include keeping a pleasant events diary

Week 16: Emotion regulation
- Review different values and priorities.
- Discuss and practice the specific action steps to go from values to goals.
- Review how to build mastery.
- Discuss and practice the cope ahead skill: imaginally coping with future difficulties.
- Homework should be to practice getting from values to specific action steps.
- Homework should be to practice building mastery.
- Homework should be to practice the cope ahead skill.

Week 17: Emotion regulation
- Review skills regarding taking care of your mind and taking care of your body (PLEASE skills).[b]
- Discuss and practice being mindful of emotions.
- Homework should be to practice PLEASE skills.
- Homework should be to practice mindfulness of current emotions.

Week 18: Orienting and mindfulness skills repeat (refer to Weeks 1 and 2)

Week 19: Orienting and mindfulness skills repeat (refer to Weeks 1 and 2)

Week 20: Interpersonal effectiveness
- Review goals of interpersonal effectiveness skills.
- Review factors that get in the way of interpersonal effectiveness.
- Review ways to clarify goals and priorities in interpersonal situations.
- Homework should include practicing clarifying priorities in interpersonal situations.

(continued)

TABLE 12.1. *(continued)*

Week 21: Interpersonal effectiveness
- Discuss and practice obtaining an objective in an interpersonal situation (DEAR MAN skills).
- Homework should include practicing DEAR MAN skills.

Week 22: Interpersonal effectiveness
- Discuss and practice keeping the relationship as a priority in an interpersonal situation (GIVE skills).
- Homework should include practicing GIVE skills.

Week 23: Interpersonal effectiveness
- Discuss and practice guideline for prioritizing self-respect in an interpersonal situation (FAST skills).
- Homework should include practicing FAST skills.

Week 24: Interpersonal effectiveness
- Review how to evaluate options in an interpersonal situation.
- Engage with clients regarding troubleshooting interpersonal problems.
- Discuss and practice the DIME game:[c] figuring out how strongly to ask or say no.
- Homework should include practicing troubleshooting.

[a]The goal of the STOP skill is to refrain from acting impulsively on emotions and making a difficult situation worse by taking a step back and making a mindful decision.
[b]The mnemonic PLEASE includes *P*hysica*L* illness, balanced *E*ating, avoiding mood-*A*ltering substances, balanced *S*leep, and *E*xercise to help clients understand how an out-of-balance body increases vulnerability to negative emotions.
[c]The DIME game is an exercise with a series of "yes" or "no" questions designed to promote interpersonal effectiveness by deciding if it's appropriate to ask for something or to say not to a request.

Process Issues

Process issues in group therapy for BPD may be specific to the presentation of the disorder or the nature of DBT skills group, as well as an interaction between the two. Below we review three potential process issues specific to BPD, along with example dialogue and strategy.

Safety Concerns and High Distress during Group

A primary concern when treating those with BPD is safety. It is estimated that 70% of those with BPD report a past suicide attempt and the rate of death by suicide in BPD is roughly 50 times greater than that observed in the general population (Black et al., 2004; Paris, 2004). Research also suggests more than one-third of outpatients with BPD report suicidal ideation, the experience of thoughts, or urges related to suicide (Zisook, Goff, Sledge, & Shuchter, 1994). For these reasons, during group therapy there is a considerable likelihood that one or more than one client will be experiencing suicidal urges. It should be explicitly stated in the pretreatment/commitment sessions what the process should be when someone feels their

safety is at risk. First, it is common in DBT skills group to have a box or basket filled with items that can be used for distress tolerance. Typically, this would include ice packs, coloring books, modeling clay, and fidget spinners. If a person is feeling highly emotional or unsafe, they are encouraged to select an item and use it to increase mindfulness or to self-soothe until they are ready to reengage with the group. The goal is for the client to practice strategies to allow him or her to remain in a stressful situation (in this case, group), rather than fleeing or having an outburst. This allows the client to practice the new skills they are being taught in terms of a real-world situation and in a supportive climate. For example, if a client tells the group leader, "I can't stand to be in group anymore. I can't stop thinking about leaving here and killing myself. I'm leaving right now," the group leader might respond,

> "I understand that you are feeling incredibly stressed. It is so hard for anyone to concentrate on group if emotions are running high. This is a great opportunity to use skills. What if we try an ice pack or some coloring to get you through the next 30 minutes? That way, you can practice tolerating this distress. At the end of group, we'll spend a bit of time safety planning if you still need it."

A second strategy is for the client to signal to the group coleader when they feel strong suicidal urges. At that point, the coleader can help the client utilize skills to increase emotion regulation in order to return and function in the group. This might include practicing a distress tolerance exercise together (like holding an ice pack or doing self-soothing), problem solving, or using cope ahead (i.e., imaginally rehearsing oneself coping in the future). A final strategy should be to collect safety planning information for all clients. This would include information about the individual therapist, phone numbers of supportive others, and a list of safety strategies that have been found to be helpful.

Life Stress

In addition to safety concerns, highly stressful situations may be currently experienced by clients in the group. A significant amount of research has linked BPD to increased life stress (e.g., Jovev & Jackson, 2006; Pagano et al., 2004; Shevlin, Dorahy, Adamson, & Murphy, 2007). In addition to the likelihood that a stressful circumstance will be ongoing or recent, there is also a common dialectic examined in DBT of unrelenting crises versus apparent competence. This is the tendency for a person with BPD to view their life as a series of crises that need immediate attention or to keep everything inside and avoid help-seeking behavior. For those clients experiencing only one side of this dialectic and having unrelenting crises, they may find it hard to focus in group or to remain nondisruptive in group because of their

urgency to share about current stressors. DBT skills group follows a standard agenda and a within-session time line. Clients are welcome to relate personal experiences as they are related to homework review or the specific skill being reviewed, but this is not the same as being given open format time to discuss weekly events. Because of this format, a client experiencing an unrelenting crisis may find it difficult to be present in group because the group does not provide for a time to process weekly events that are unrelated to group content. The client may find themself feeling an urgency to share with the group, receive support from the group leaders, or do other behaviors related to solving or investigating the crisis. If someone is being continually disruptive in group by talking too much about unrelated issues, standard behavioral tactics include ignoring disruptive behavior, withholding attentional reinforcement of disruptive behavior, and positively reinforcing through praise and attention when discourse is on topic and facilitative of the group process.

For example, a client, "Nancy," might have a hard time focusing in group because of the feeling that her life is falling apart. When the group leader asks Nancy about her mindfulness homework, Nancy begins telling a story about her friend not showing up for a planned dinner and how Nancy became very emotional and ended up drinking heavily that night. The group leader might interrupt after a minute or so and say, "I'm so sorry, Nancy, I'm trying to follow along on our mindfulness homework sheet, but I think I've lost where you are." Nancy responds, "Oh, I didn't do the homework. I was too upset about my friend. So anyway, as I was saying . . . " The group leader interrupts, "Okay, so let's talk about what got in the way and how mindfulness might have been used in this very difficult situation with your friend." Nancy responds, "Well I guess I could have taken a moment to become aware of my feelings and thoughts. Maybe tried to find my wise mind." This tactic, through interruption and ignoring, has redirected Nancy back to the topic, while still validating her difficult experience. The group leader might then respond, "Great! That is an excellent suggestion." At this juncture, the group leader is reinforcing the on-topic focus.

A client might also utilize the group coleader to step out of the room momentarily to get consultation on how to use skills to regulate in the moment in order to participate in group. It should also be explicitly stated in the pretreatment/commitment sessions that the general application of skills to daily life, as well as dealing with suicidality and general crises, are beyond the purview of the group leaders and should be handled with the individual therapist. In cases where the DBT skills group is being employed as a stand-alone intervention, measures should be taken for group members with safety concerns to take action toward obtaining individual therapy.

Boundary Issues

Occasionally, safety concerns and unrelenting crises manifest themselves with clients wanting to stay after group to talk to the group leaders. Of

course, if the concern is safety, measures must be taken to ensure the safety of the client. All group leaders should be fully trained in suicide risk assessment and have significant experience handling those situations. When operating within a DBT framework, hospitalization is considered a last resort in terms of suicidality (see Linehan, 1993, for further explanation)—thus, safety planning becomes of utmost importance.

However, a client who continually stays after group for an extended period of time to discuss suicidality and/or crises is not utilizing group and the group leaders appropriately. First, this client would not be getting optimal treatment as the group leaders may not be familiar with their relevant history and current symptomatology. Second, the abbreviated amount of time focused on "putting out fires" that can be offered postgroup does not allow enough time to give the proper care. Third, this type of behavior runs the risk of burning out the group leaders. Leading or coleading a DBT skills group, potentially in the middle or after a full day of seeing clients, is a demanding task. Urgent issues that present themselves continually as a way to extend therapeutic time may cause resentment and fatigue in the group leaders, thus reducing the effectiveness of therapy for all involved. To address this concern, a group leader may say to a client,

> "It's very clear that you are going through an extremely difficult time. I'm concerned that us chatting for only a few minutes after each group is not enough to adequately solve your problems. That's evident because the problems don't seem to be going away. I think we need to make a plan to get you more care outside of group so that you have a dedicated person helping you with this."

BPD is typically characterized by interpersonal dysregulation (American Psychiatric Association, 2022). This is both evident in the symptom criteria (e.g., frantic efforts to avoid abandonment, extreme ups and downs in relationships, inappropriate displays of anger), as well as the multitude of research studies that demonstrate the difficulties in interpersonal relationships found in those with BPD (e.g., Hepp, Lane, Wycoff, Carpenter, & Trull, 2018; Paris, 2018). This interpersonal stress and dysfunction can often be evident and even exacerbated in the group context. For example, a person with BPD may react with angry, even abusive words when feeling stressed or hopeless. It is important that group leaders are well versed in all aspects of *self*-regulation. In other words, in these instances, group leaders should be aware of the urge to react defensively or angrily. In this case, the group leader may need to regulate their own emotional experience, while encouraging more prosocial behavior on the part of the group member. For example, "Mark" may state to the group, "I can't believe these group leaders are charging us so much money when they are just giving us worksheets like we're in kindergarten. This is a waste of money and it doesn't help." While the group leader may feel a need to defend the treatment, a brief, yet kind response might be "That's understandable, Mark. I can see how that

would be frustrating if that was your impression of this group. Anyway, did you have any difficulty with practicing the skills this week?" This intervention both validates the frustrating experience, without engaging in the content, as well as redirecting to focus on skills.

In addition, a group member may have such difficulty regulating emotions during group, that they enact aggressive behavior. This may include throwing things, yelling loudly, or menacing physical behavior. If there is any risk, whether emotional or physical to a fellow group member, group leaders must quickly take action to stop the aggressive behavior. There are several steps to use to diffuse the situation. First, the group leader should validate the anger and frustration. Second, clearly communicate that the behavior is unacceptable. Third, keep a calm and measured voice. Fourth, suggest an alternative strategy for dealing with the anger (hold an ice pack, paced breathing). Fifth, the coleader can step outside the group room with the group member. In this case, it may be helpful to suggest the group member make a repair when returning to the group.

Overall, these experiences may translate into high emotional and cognitive demand on the part of the group leaders, potentially resulting in group leader burnout. As briefly mentioned above, traditional DBT includes a consultation team. This weekly meeting of DBT clinicians is sometimes referred to as "therapy for the therapists," as it serves to debrief with other clinicians, troubleshoot safety concerns, and jointly practice mindfulness and discuss the underlying theory and tenets of DBT. The primary focus of this weekly consultation team is to reduce clinician burnout. We suggest that anyone leading a DBT skills group join or start a consultation team. In addition, as mentioned above, having a coleader will help decrease burnout. Coleaders can prepare and share workload, take turns managing interpersonally challenging clients, and debrief and offer support after group.

Conclusions

Significant research supports DBT, and DBT skills group in particular, as an efficacious treatment for several symptoms of BPD. This includes depression, emotion dysregulation, suicidality, hospitalization, and many more. In addition, mechanism studies have found that the improvement of adaptive coping and the reduction of maladaptive coping at least partially accounts for positive treatment outcome in DBT skills group. In addition, therapeutic alliance in the group context has also been shown to account for positive treatment outcome in BPD. These promising results indicate that some form of DBT skills group within the context of a cohesive, supportive group format could be beneficial for those with BPD.

CHAPTER 13

Psychosis and Psychotic Disorders

Tania Lecomte

Group CBT for psychosis (CBTp) does not target a single disorder but rather a group of symptoms that form what is commonly called "psychosis." Psychosis refers to the loss of contact with reality and the presence of psychotic symptoms, particularly positive symptoms, such as delusions and hallucinations. Delusions are beliefs that are irrational, not based on facts, and carry great salience, making it almost impossible for the person to focus on something else. The most frequently reported delusions are (1) persecutory delusions (i.e., that someone or something is planning to harm the person) and (2) grandiose delusions (i.e., that the person was chosen for a special mission or has unusual and incredible abilities or powers). At times, people might have both (e.g., "People are out to get me because they are jealous of my superpowers"). Hallucinations can affect any one of the senses but are most frequently auditory. Although voice hearing is found in about 13% of the population, those who seek treatment tend to have voices with strong negative content, criticizing and insulting them, and typically believe the voice is a specific entity with great knowledge (omniscient) and power (omnipotent) over them (Beavan, Read, & Cartwright, 2011).

Psychosis is often associated with schizophrenia but can also be found in other diagnoses, such as schizoaffective disorder, brief psychotic disorder, schizophreniform disorder, bipolar disorder, and depression with psychotic features. The official symptom criteria for psychotic disorders can

be found in DSM-5-TR. But briefly, individuals with schizophrenia may experience a range of what are called positive symptoms, such as delusions, hallucinations, or disorganized speech. These individuals may also exhibit grossly disorganized behavior (e.g., talking to themselves, jumping on cars) or catatonic behavior (e.g., holding rigid, statue-like postures). They may also experience what are called negative symptoms, such as a flat emotional expression, an inability to experience pleasure, and a lack of drive. We use the term "schizophreniform disorder" when an individual experiences these same symptoms but for a shorter period. And when an individual with the symptoms of schizophrenia also experiences the symptoms of mood disorders, such as major depressive episodes or manic episodes, we use the diagnosis of schizoaffective disorder.

Psychotic symptoms affect one's judgment regarding oneself and the world, and are therefore often linked with a lack of insight in some individuals, which does not abate even with many years of treatment. This lack of insight partly explains poor adherence and lack of interest for treatments proposed, whether they be pharmacological or psychotherapy, including group CBT. Negative symptoms also explain the absence of waiting lists for most treatments when it comes to people with psychotic disorders. The lack of motivation and pleasure along with limited emotional expression experienced by some make engagement in therapy more difficult. Cognitive deficits, such as deficits in attention, memory, and executive function, and also in social cognition (deficits in emotion recognition, theory of mind, social rules, and attribution biases), are often part of the clinical picture and need to be considered when offering a treatment.

Individuals with psychosis scarcely have just that: psychotic symptoms. In fact, more often than not they will present with comorbid symptoms and disorders as well. The most prevalent comorbid disorder is substance misuse. Close to 50% of individuals with a severe mental illness, such as schizophrenia, will abuse drugs or alcohol and will qualify for a diagnosis of SUD. Substance misuse is linked with poorer treatment adherence and also with more severe symptoms. The reasons for using are typically similar to those found in the population at large (i.e., to relieve stress, socialize, or disconnect from difficulties; Gregg, Barrowclough, & Haddock, 2007). This brings us to other comorbid symptoms: anxiety and depression. Individuals with severe mental illness, such as schizophrenia, present with important difficulties in emotion regulation, resulting in anxiety (such as social phobia), as well as depressive episodes and obsessive–compulsive disorder (OCD; Khoury & Lecomte, 2012). Childhood adversity and trauma experiences in general are more frequent in people with schizophrenia and psychotic symptoms (Varese et al., 2012), and are even considered risk factors for schizophrenia, which also explains the comorbid presence of PTSD in several individuals with schizophrenia. Finally, it is important to consider the fact that close to 30% of individuals with schizophrenia concurrently

have a personality disorder (Wickett et al., 2006) and that this comorbid presentation is linked with worse clinical outcomes.

Cognitive and Behavioral Features of Psychosis

Psychotic symptoms in CBTp are understood as perceptual and reasoning biases. In fact, a number of reasoning biases have been demonstrated in individuals with psychotic disorders—namely, the jumping-to-conclusions (JTC) bias, and the attributional bias, to name two. The most documented bias is the JTC bias (Garety, Hemsley, & Wessely, 1991). This bias, sometimes called the arbitrary inference bias, implies that the person will collect an insufficient amount of information prior to making a decision. The JTC bias is often measured by the beads task (or an equivalent: the fishing task; Woodward, Muntz, Leclerc, & Lecomte, 2009), whereby a person is to determine which of two jars the person is retrieving the beads from, based on two pieces of information: the percentage of beads of that same color (only two colors are possible) and the color of the bead retrieved. The instructor asks to be stopped when the person is sure regarding which of the two jars the beads are being removed from. The JTC bias is specifically linked with delusional beliefs, as people with active delusions will need only one or two beads before making a decision. The JTC bias diminishes as people get better and their delusions decrease, such as after following a group CBTp (Woodward et al., 2009).

Another common bias found in psychosis concerns attributions. The attribution bias refers to the explanations a person has regarding experiences in their life, in terms of who might be responsible (self/internal or others/external), but also whether the experience is perceived as specific or global, and stable or temporary. Attributions, or locus of control, refer to the idea that people develop patterns of explanations for events, either overattributing the reason for positive events to self and negative to others or circumstances (as is found in mania and paranoia), or in the opposite, overattributing the reason for negative events to self and to others or chance for positive events (as is found in depression). For instance, a depressed young woman trips on ice on her way to work: "It is my fault, I'm always such a klutz, can't even walk to work without looking like a fool, I am such an idiot." She perceives her incident as internal (her fault), stable (always), and global (such an idiot). People with paranoia often tend to hold the opposite belief: everything is always other people's faults ("They are after me; I slipped on the ice because someone intentionally put it there, it is part of the conspiracy against me"; Kinderman & Bentall, 2000). Researchers have tried to better understand this cognitive bias and some have argued that, as Seligman (1990) suggested, we are naturally prone to a self-protection bias but that this might be even more pronounced in individuals who have

a very fragile sense of self (Udachina, Varese, Oorschot, Myin-Germeys, & Bentall, 2013). As such, by solely giving credit to oneself for positive events and blaming others for negative events, the person could be attempting to protect their self-esteem. Delusions of grandiosity in psychosis have been related to a core belief about the self as unlovable or worthless. However, grandiosity is not always apparent and some individuals might present some paranoid fears of being kidnapped or having their organs removed that might also serve as a self-esteem protector for the core belief of being worthless (i.e., if people want you, you are probably valuable). Another core belief is that the world is a dangerous place and must be feared. This constant threat can be partly explained by the high rate of childhood trauma documented in people with psychosis. In fact, a recent plethora of studies have suggested that close to 35% of people with psychosis have experienced trauma (Bonoldi et al., 2013), and that childhood trauma increases the odds of developing psychosis by 2.8 times (Varese et al., 2012).

As mentioned earlier, other cognitive biases have also been studied in individuals with psychosis but they tend to coexist (i.e., individuals who are delusional will score high on most of the cognitive biases reported in psychosis; Peters et al., 2014).

In CBTp, auditory hallucinations (voices) are considered problematic only when they come with strongly held irrational beliefs regarding their origin, power, and knowledge, and affect the person's functioning. It is well-known that voices come from inner speech, imply the activation of speech muscles, and that individuals with psychosis can misinterpret their origin as being external (Stephane, Barton, & Boutros, 2001). People who experience hallucinations have difficulties distinguishing between self-generated experiences and experiences stemming from the outside world (also called "source-monitoring deficit"; Anselmetti et al., 2007). Those who suffer from experiencing negative voices tend to describe them as powerful (omnipotent) and so knowledgeable regarding personal information that the voices must come from a higher power or entity (omniscient; Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000).

Two different cognitive models have been used to explain negative symptoms linked to psychotic disorders. Negative symptoms include "losses," such as loss of energy, pleasure, and emotional reactions—we therefore find symptoms such as alogia, amotivation, flat affect, anhedonia, and motor retardation. The first model perceives these symptoms as linked to core defeatists beliefs, suggesting that there is no point in trying, things will not improve, and failure awaits, and therefore withdrawal is preferred (Beck & Rector, 2005). As such, negative symptoms are considered somewhat like depressive symptoms. The second model, on the other hand, perceives negative symptoms as an intentional recuperation period, a way of taking a break from the sensory overload of positive symptoms. This model proposes that negative symptoms are often temporary and necessary

following the overly scary and chaotic emotional world experienced during a psychotic episode (Hemsley, 1996).

Evidence-Based Treatments of Psychosis and Psychotic Disorders

The front-line treatment of psychosis and psychotic disorders is antipsychotic medication. Depending on the authors, some recommend initial brief treatment (during the acute episode) with quick but gradual removal of the drug if the symptoms are stabilized and do not reoccur with the tapering efforts. Others, on the contrary, recommend lifetime use of medication, with the idea that medication could prevent relapses. Unfortunately, even when individuals follow their prescription, close to 40% continue experiencing frequent, and at times even constant, psychotic symptoms. Also, medication does not help overcome various problems a person might encounter when attempting to lead a satisfying life in the community and is therefore only one of the recommended treatments for the recovery of people with psychotic disorders.

Psychosocial interventions are an essential part of the treatment and recovery of people with psychotic symptoms, such as schizophrenia. Some interventions and treatments have gathered sufficient empirical data to be strongly recommended by national guidelines, such as the Patient Outcomes Research Team (PORT; Dixon et al., 2010), the National Institute for Health and Care Excellence (NICE) guidelines in the United Kingdom (National Collaborating Centre for Mental Health, 2014), or the Canadian Psychiatric Association guidelines (Lecomte, Mian, Abidi, & Norman, 2017; Norman, Lecomte, Addington, & Anderson, 2017), whereas others are considered promising until more studies support their effect. In order for a psychosocial intervention to be considered evidence based, it must not only have accumulated sufficient empirical proof of its efficacy (often in the context of at least two RCTs) but it must answer a need (such as improve functioning, overcome a deficit, or help to cope with symptoms) and be standardized in order to be easily replicable (Mueser, Deavers, Penn, & Cassisi, 2013). The PORT USA report on psychosocial practices for schizophrenia highlighted eight interventions or programs that are considered evidence based (Dixon et al., 2010). These were, in terms of interventions: *family psychoeducation, CBT, social skills training, weight management,* and *token economy.* In terms of programs, they described *assertive community treatment, supported employment,* and *integrated dual-disorder programs* (with *first-episode programs* almost meeting criteria). Since, Mueser et al. have added *cognitive remediation,* which has demonstrated in various meta-analyses its efficacy in helping individuals overcome cognitive deficits, particularly when offered in conjunction with other psychiatric rehabilitation services (e.g., supported employment).

These interventions are briefly described here. Family psychoeducation can be offered individually (per family) or in multifamily groups, with or without the person receiving psychiatric care. Most family interventions offer psychoeducation regarding psychosis, recovery, and medication, but also focus on communication skills in order to decrease the negative stressful impact of family criticism and overinvolvement on those presenting with psychotic symptoms. According to a comprehensive Cochrane review by Pharoah, Mari, Rathbone, and Wong (2006), family interventions are effective in reducing relapse (medium effect supported by fairly good-quality evidence). Some family interventions are CBT based, such as one developed by our team (Leclerc & Lecomte, 2012), and therefore help family members master CBT techniques for themselves (to alleviate distress), as well as for supporting their family member receiving psychiatric care.

CBTp, described in this chapter in its group format and in more detail in a book (see Lecomte, Leclerc, & Wykes, 2016), has gathered evidence from more than 40 meta-analyses as an effective treatment for reducing psychotic symptoms and their related distress. Both the individual and group formats are considered evidence based. The NICE and Canadian Psychiatric Association guidelines both stress the importance of CBTp being offered by well-trained therapists for a minimum of 16 sessions, while following the essential elements of CBTp—namely, monitoring the relationship among beliefs, feelings, behaviors, and symptoms; finding alternative explanations for perceptions, beliefs, and thought processes that contribute to symptoms; promoting new adaptive ways of coping with symptoms; reducing stress; improving self-esteem; and improving functioning.

Weight management is most often offered via nutrition and sport therapy—the goal is to reduce or diminish the weight gain (and metabolic syndrome) all too often associated with antipsychotic medication.

Token economy, a behavioral intervention developed by Paul and Lencz (see Lecomte, Liberman, & Wallace, 2000, for a review) involves positively reinforcing social behaviors with tokens (exchangeable for desired goods or permissions) in order to eliminate undesired behaviors. This approach works only in well-staffed closed and captive environments, such as forensic units.

Although social skills training is not recommended in all guidelines, recent meta-analyses have found that it significantly improves negative symptoms and can lead to sustained behavioral changes, especially when *in vivo* support is present (Tauber, Wallace, & Lecomte, 2000; Turner, van der Gaag, Karyotaki, & Cuijpers, 2014). Social skills training uses basic learning principles (i.e., repetition, positive verbal reinforcement, modeling) to improve interpersonal skills related to social interaction, such as conversational skills, friendship and leisure skills, social problem solving, and assertiveness. In recent years, social cognitive training programs have also been developed, with the aim of improving deficits linked to social interactions, such as in recognizing facial emotions, in theory of mind (guessing what

others might be thinking or feeling), or in understanding social rules (e.g., irony, jokes). These interventions are promising and are gathering data but are not yet considered based on strong empirical evidence.

Cognitive remediation refers to a variety of training strategies, either paper and pencil or via computer, used to improve neurocognitive deficits often found in psychotic disorders—namely, attention, memory, and executive function/planning deficits. There is a plethora of cognitive remediation programs that have been developed, offering different results on different cognitive measures. Overall, there appears to be an advantage in offering cognitive remediation in conjunction with other rehabilitation programs (such as supportive employment/education), when cognitive deficits are important (Wykes, Huddy, Cellard, McGurk, & Czobor, 2011).

Evidence-based programs typically include various interventions, some of which have already been described, and have gathered sufficient empirical support to merit a description. The first is assertive community programs—these programs offer ongoing community services, reaching out to individuals in their homes, and offering them services according to their needs. These programs are meant for individuals who would otherwise constantly be hospitalized because they present with multiple problems (psychosis, substance misuse, homelessness) and often lack the needed autonomy to live in the community without assistance. Assertive community programs have demonstrated their efficacy in diminishing hospitalization rates, and are considered more cost-effective than traditional treatments for this population.

Supported employment programs are also evidence based, with meta-analyses supporting their effectiveness in ensuring rapid real-world employment. These programs offer continuous support, guidance, and counseling, while quickly helping individuals with severe mental illness obtain work related to their preferences and abilities (either part-time or full-time). Their effectiveness is typically improved with complementary interventions, such as cognitive remediation, or CBT (Suijkerbuijk et al., 2017).

Dual-disorder programs have also received empirical support, with better outcomes for participants in these programs compared to participants receiving treatments for substance misuse and psychotic symptoms separately (Mueser & Gingerich, 2013). These programs take into consideration the psychiatric disorder while tackling the substance misuse, often integrating motivational interviewing (MI), social skills training, and CBT components.

Finally, the first episode of psychosis programs are gathering increasing evidence in that they show improved recovery and outcomes when compared to traditional treatments. These programs offer intensive care for the first 2–5 years, with initial weekly treatment tapering off according to need. They also tend to offer most of the evidence-based treatments and programs, including family interventions, CBTp, supported employment, and cognitive remediation.

Assessment Issues

Group CBTp not only aims at diminishing symptoms causing distress, such as positive symptoms of psychosis, but also symptoms of anxiety, depression, and even suicidality. Given that people with psychosis often present with comorbidities, as mentioned earlier, we also discuss substance misuse and dealing with difficult emotions. In order to make the group more efficacious and appealing, there is a strong focus on improving self-esteem and developing new coping strategies when faced with stressors or symptoms. The assessments (pre- and posttherapy) need to consider outcomes that are targeted by the group, such as symptoms, self-esteem, and coping, as well as process measures (assessed during the group, ideally monthly) that have been demonstrated as ensuring positive outcomes in group CBTp—namely, group cohesion (Lecomte, Leclerc, Wykes, Nicole, & Abdel Baki, 2015).

First, the most common question asked when delivering group CBTp workshops is what criteria and assessments are used to determine group eligibility. Most often, no systematic eligibility assessment is used—a simple interview is often sufficient in order to determine whether the person is currently struggling with psychotic symptoms, and whether the person seems at least slightly interested in giving the group a try. As mentioned earlier, motivation is often a problem with this population and given that we seldom have wait lists for our groups, we try to not be overly exclusive. We try to bring together people of similar ages, especially when teens or young adults are involved. Otherwise, should there be enough interested participants to conduct more than one group, then it would be relevant to assess basic cognitive functioning, as well as comorbid personality disorders. We do not exclude people with poor cognitive functioning—it is, however, easier for the therapists when the cognitive functioning level of the group is somewhat similar. Verbal IQ scores, if available, or level of education attained can be good proxies of cognitive functioning, if a more thorough assessment is not possible.

As for comorbid personality disorders, too many participants in a group with personality disorders can be overly challenging for novice therapists and it is therefore easier to limit the inclusion to one or two individuals with such comorbidities in the group, particularly Cluster B personalities (borderline, narcissistic, histrionic, or antisocial). For instance, the Iowa Personality Disorder Screen (IPDS) is a mini structured screening interview that can be completed in less than 5 minutes (Langbehn et al., 1999), rapidly informing the therapists of the personality profiles of their potential participants.

For outcomes, a measure of psychotic symptoms is needed. Most CBTp studies use semistructured assessments, such as the Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein, & Opler, 1987) or the Brief Psychiatric Rating Scale (BPRS; Lukoff, Nuechterlein, & Ventura, 1986), but

a lengthy training is needed to conduct these. The Psychotic Symptom Rating Scales (PSYRATS; Haddock, McCarron, Tarrier, & Faragher, 1999), on the other hand, is a fairly brief semistructured interview that focuses specifically on hallucinations and delusions. It is quite straightforward, and can easily be administered by clinicians. The PYSRATS includes 11 questions on voices, covering their intensity, distress, location, frequency/duration, and impact, as well as six questions on delusions, pertaining to level of conviction, distress, functioning, and frequency/duration.

It is also possible to add a self-report measure like the Brief Symptom Inventory (BSI), which covers multiple symptom categories and has been extensively validated with various populations, including individuals with psychotic disorders (Derogatis, 1993). The BSI includes 53 items offering a global score, as well as symptom scores for the following dimensions: somatization, obsessive–compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

In terms of assessing self-esteem, although multiple assessments exist, it is preferable to select a measure that is known to be sensitive to clinical change, such as the Self-Esteem Rating Scale—Short Form (SERS-SF; Lecomte, Corbiere, & Laisne, 2006), instead of the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965; a more global and stable measure). The SERS-SF consists of 20 items, half worded negatively and half positively, and has been validated with people with psychotic disorders.

Various coping measures also exist and have been used with people with schizophrenia or psychosis. Our team has mostly used Edwards and Baglioni's (1993) Cybernetic Coping Scale (CCS), a 20-item measure that assesses both active coping strategies (e.g., problem solving) and passive strategies (e.g., distraction).

In terms of indirect outcomes, we also found improvements in social functioning, with the First Episode Social Functioning Scale (FESFS; Lecomte et al., 2014), a self-report tool designed specifically for individuals with early psychosis, as well as in social support using the Social Provisions Scale (SPS; Cutrona & Russel, 1987). It could also be relevant to measure recovery with the Recovery Assessment Scale (RAS; Corrigan, Salzer, Ralph, Sangster, & Keck, 2004), or even cognitive insight with the Beck Cognitive Insight Scale (BCIS; Beck, Baruch, Balter, Steer, & Warman, 2004).

Finally, in terms of processes, two of our studies have determined that group cohesion clearly predicts improvements in symptoms and self-esteem following group CBTp. As such, we recommend to measure cohesion, at different times during the treatment (ideally monthly), using the Cohesion Scale (Piper, Marrache, Lacroix, Richardsen, & Jones, 1983), which allows gathering information from three angles: the participant regarding the therapist, the participant regarding the other participants, and the therapist regarding each participant. Each version consists of nine items.

Structuring Group CBTp

Group CBTp offered in an acute inpatient setting can include up to five participants, who will meet three or four times a week. During their inpatient stay, the groups need to be brief, no more than 30 minutes, given the confusion and attention difficulties many might experience. The idea is to repeat as much as possible what has been done so far and what is currently being done, in order to help participants integrate the content. The inpatient version of our group CBT manual includes only 16 sessions (instead of 24), offered over the course of 4 weeks.

Most groups are, however, offered in outpatient settings, and therefore include eight to 10 participants at first, with typically two or three dropouts in the first weeks. Outpatient groups of six regular participants once or twice a week is the norm, with each group lasting an average of 60–90 minutes.

Group CBTp needs to consider the fact that many, if not most, participants will not have previous group experience and that groups may be scary. For someone who is paranoid, a group might be perceived as people who might be threatening or part of a plot against him or her. It is therefore extremely important to take the necessary time for the group cohesion to develop, for people to learn to trust one another, before tackling difficult topics. In fact, discussing nonthreatening topics for the first four to five sessions is often necessary. In our group, we chose the topic of stress, given that it is perceived as a universal problem and is also linked to symptom exacerbation. By learning about stress, and their own symptoms of stress, participants are also learning to gain more control over their mental health.

The group needs to be offered in gradual steps, with each session being complete in itself. This means that a concept should be understood well enough in a single session that the next session can go a step further. For instance, we explore perceptions for proposed situations (rather than personal ones) when explaining the link between thoughts, emotions, and behaviors. The next session would go further and explore alternative explanations for scenarios with paranoid themes that are typical in psychosis. We would then look at strategies to investigate facts. And only then, at another session, would we start exploring participants' own delusional beliefs, facts supporting them, and alternative beliefs for them. It is important to do this process step-by-step, allowing participants to master the model and techniques before trying to apply them to their own beliefs because changing delusional beliefs can otherwise be extremely difficult.

Key Treatment Components

An important aspect of group CBTp is the use of a manual. By proposing a manual (see *Group CBT for Psychosis*; Lecomte et al., 2016), participants are reassured that they will not be surprised or tricked into discussing

themes that make them uneasy. The manual is also a form of contract and guides each session by proposing themes. It also introduces concepts incrementally, breaking them down in easy-to-understand-and-apply activities. Group CBTp involves some typical techniques. Among these, the most commonly used are the following.

Normalization

The therapist helps participants realize that their strange experiences have happened to others in the group and that voices and distressful thoughts can be normal responses to extreme circumstances. Examples of sensory deprivation, mourning, or lack of sleep can be helpful.

Psychoeducation

The therapists educate the participants about psychosis and psychotic symptoms in the context of the stress–vulnerability–protective factors model. The therapists provide a forum to answer questions and collaboratively explore answers.

Explaining the ABCs of CBT

The therapists help participants realize the difference between a situation, a belief, and the associated emotions and behaviors, bringing back these elements as needed (such as when determining emotions linked to beliefs).

Explaining the Stress–Vulnerability–Protective Factors Model

The model, explained earlier, truly helps participants realize they can have a certain control over their mental health. Once personalized, it helps participants co-develop their formulation of their own difficulties and work on developing better cognitive and behavioral coping strategies.

Socratic Questioning

The therapists help participants realize that there are missing elements of proof supporting their beliefs by softly questioning the reasoning that brought them to assume their belief was the only possibility.

Checking the Facts

The therapists suggest ways of verifying the facts supporting the person's belief, by choosing strategies that will likely bring the person to realize that few facts or little proof exist. Participants can also suggest ways of checking the facts for others' beliefs in the group, with either cognitive or

behavioral strategies. Checking the facts may include addressing negative automatic thoughts, unhelpful assumptions, and core beliefs.

Seeking Alternatives

The therapists explore with participants whether alternative explanations can be generated to explain the distressful experience mentioned. The therapists will seek the help of the other participants to generate alternatives. The idea is to bring doubt, even if there is no proof for the alternative explanation proposed—to consider an alternative in itself can help diminish distress.

Downward Spiral

With participants who appear resistant to changing their beliefs, the therapists aim at diminishing the distress experienced by looking at the consequences of the belief, in a stepwise manner, and verifying with the participants whether the situation is really all that bad or dangerous.

Enhancing Self-Esteem

Participants who are resistant to changing their beliefs might feel they are nothing if their belief is gone (especially for beliefs that give them some importance). The therapists should not insist when resistance is sensed and will focus on helping the person develop their strengths, use their positive qualities, and meet their goals.

Changing Attributions

Participants learn to recognize when they have patterns of beliefs that can be linked to blaming others or themselves for all wrongdoings. By recognizing their personal attribution style, they can learn to doubt their belief and contextualize it.

Problem Solving

The therapists help the participants break down problems, evaluate the pros and cons of solutions, and carefully analyze the impact of the solution chosen prior to applying it.

Exploring Coping Strategies

The therapists explore the participants' existing coping strategies (for managing stress, mood, voices, or distressful thoughts) and encourage them to

expand their repertoire by trying new and different coping strategies. The therapists know many different cognitive and behavioral strategies that the participants can choose from, and even propose to try some together. Participants can also share their strategies and can choose new coping strategies from the list in the manual or from other participants. Strategies can also be tried in the group (such as relaxation).

Sample Protocol for Group CBTp

The following protocol for group CBTp has been studied in a large RCT with individuals having been diagnosed recently (less than 5 years) with a psychotic disorder. The study demonstrated statistically and clinically significant outcomes in terms of improvements in overall symptoms, psychotic symptoms (positive symptoms), self-esteem, social support, and active coping strategies (Lecomte et al., 2008). The group has since been offered in various settings around the globe (in more than 15 countries so far), in early psychosis, as well as with people with longer illness trajectories.

Treatment Divided in Four Components

The group CBTp module includes 24 sessions that are divided in four larger components. The themes are not independent, given that the components need to be presented in order. Other CBTp groups have also developed their module in components but accept that people enter the group at the beginning of any component (e.g., Granholm et al., 2005). Our treatment module was not designed this way—in fact, one needs to have completed a previous component in order to continue to the next. The learning is gradual from one component to the next. Furthermore, this method ensures that a solid group cohesion develops before difficult exercises are tackled, such as attempting to introduce doubt into delusional thoughts.

The components are divided in a logical manner and allow participants to gradually grasp concepts before integrating them together and using them to improve their coping strategies and prevent relapses.

1. Stress: How It Affects Me

This first component consists of six sessions that essentially discuss stress, but also opens the discussion to participants' own initial psychiatric experiences. The content is a bit more didactic at first, to let people feel comfortable and not fear too much self-disclosure too soon. Stress is a universal concept that is not stigmatized and is therefore easy to discuss. The sessions' themes are the following:

- *S-1: Introducing Ourselves*—Defining the group rules, sharing interests and strengths, and discussing the goals and objectives of the group. It is important to define the group's rules together, to ensure the group is done in a climate of respect, confidentiality, nonjudgment, and is enjoyable.

- *S-2: What Is Stress?*—Stress is a universal concept; many, however, have trouble recognizing symptoms of stress. The session focuses on recognizing our own symptoms of stress in our body, thoughts, and emotions.

- *S-3: What Do I Consider Stressful?*—Gaining insight into the people, places, events, or situations that can provoke a stressful reaction, and self-rating one's own stress level.

- *S-4: How I Experience My Symptoms*—A look back at the first psychotic break or symptoms is shared with the others. Normalization takes place during this session, with many having experienced some similar thoughts, voices, or hospitalizations.

- *S-5: Vulnerability–Stress–Competence Model*—Learning about the stress–diathesis model and applying it to oneself. Having learned about stress, we see the link with symptoms and are better able to understand the concept of "vulnerability." Participants discover their current protective factors and are made aware of the need to develop more, and often better, protective factors to be stronger in the face of adversity or stress. Participants learn to personalize their own model and discover how they can have a certain control over their symptoms, above and beyond medication.

- *S-6: A Personal Goal*—This is a self-esteem activity aiming at helping participants project themselves into the future, by breaking down large goals into smaller attainable goals. Given the important link between psychotic symptoms and self-esteem, this is the first of many self-esteem activities proposed throughout the group module.

2. Testing Hypotheses and Looking for Alternatives

This second component teaches the core CBTp techniques. Given the various cognitive deficits often present in the participants, the techniques and concepts are explained one at a time, and are at first presented with neutral or nonpersonal examples, before eventually tackling the person's beliefs.

- *T-1: The ABCs of CBT*—The model is explained, whereby we are most affected by the perception we have of a situation rather than by the

situation itself. Short movie clips are presented to illustrate how different perceptions of the same situation can lead to very different emotions and behaviors. Participants are also asked to imagine themselves in various scenarios and to describe their thoughts, emotions, and behaviors (with the quick realization that members of the group have different thoughts, emotions, and behaviors for the same situation).

- *T-2: Common Experiences*—This activity explains normalization—one of the first important CBTp strategies. In a group context, it is much easier to benefit from realizing that others in the group might have experienced similar unusual experiences (such as odd beliefs or hallucinations) than in an individual context. In this session, we also discuss psychotic experiences in people without a psychotic disorder, to further improve their understanding of the fact that psychotic experiences are normal brain reactions in extreme circumstances.

- *T-3: The Traffic Jam*—The goal of this activity is to help participants realize that for any given situation, without the appropriate information, it is possible to find at least two explanations. Many scenarios are proposed, some demanding creativity to generate more than one explanation. Participants are also asked to determine what information they would need to know to be sure of what is happening in the situation.

- *T-4: How Not to Jump to Conclusions*—In this activity, participants learn to take time to investigate the facts that support or not support a story. They are asked to imagine themselves as detectives seeking facts and having to ask the right questions in order to determine whether the story is supported by facts. One of the therapists role-plays someone with the story (or belief) described in the manual, and the participants must check it for facts. When the story is not corroborated by facts, participants must question themselves: What else could explain this story?

- *T-5: Considering Alternatives for My Own Beliefs*—Participants must use what has been learned so far, and explain a personal situation; the related belief, emotion, and behavior; and verify whether the belief is supported by facts. As a group, they offer alternative explanations for each person's belief. This activity is somewhat demanding for participants given that they are usually quite good at suggesting alternatives to others but struggle in finding alternatives for their own beliefs.

- *T-6: Looking at Things from a Positive Perspective*—This is a self-esteem activity. It aims at discussing the notion of "patterns of thinking," or attributions. We discuss the idea of pessimism or optimism and bring back the ABCs of CBT model, suggesting that some people tend to see things in a similar way, which leads them to often feel depressed or suspicious, for instance.

3. Drugs, Alcohol, and How I Feel

The third component of the module aims at helping participants gain insight into potential obstacles to their recovery, such as substance abuse. To balance the positive and more negative themes, self-esteem activities are proposed first. This section also opens the door to exploring difficult emotions and discussing how to cope with them.

- *D-1: Words That Describe Me*—This activity is a classic self-esteem activity that focuses on recognizing one's positive qualities. The activity asks the participant to select personal qualities, but also to find qualities for other participants in the group. Given that the group members know one another quite well by this time, this allows participants to explore not only one's own qualities but how one is perceived by others.

- *D-2: What I Value*—This is also a self-esteem activity but it focuses on values. Values are used here as a positive way of realizing we might be similar to others. So far, participants have shared their difficulties and symptoms, and have normalized negative experiences—here they realize they can also be similar to others in the group regarding what they consider important in life.

- *D-3: Drugs and Alcohol: When, Where, and with Whom*—The goal of this activity is to help participants recognize any substance abuse patterns they might have. Although not everyone will present with this issue, more than 50% of individuals with psychosis have substance misuse problems and therefore it is an important topic to discuss. The activity has no "moral" intention, since the goal is only to enhance insight into the places, moments, and people associated with substance misuse.

- *D-4: Their Effect on My Life*—In continuation with the goal of increasing insight, this activity aims at helping participants realize how they feel when they use, the moment they use, the next day, and in the long run to wonder whether there are any negative consequences associated with their abuse. Should participants consider diminishing or quitting their substance use and wish more assistance than what is proposed in this session, they are directed toward specialized dual-disorder services. The CBTp group aims at developing better coping skills for stress, mood, and psychotic symptoms, and is very useful even for those who are struggling with substance misuse.

- *D-5: Feeling Down or Hopeless*—This activity aims at discussing coping strategies for feelings of hopelessness and suicidal thoughts. Given the high rate of suicide attempts in individuals with psychosis (50%) and the high rate of completed suicides (10%), this theme is considered essential as a means of prevention. Participants are first asked to use CBT techniques learned so far in order to question and try to bring the therapist

(doing a role play of a suicidal person with schizophrenia) to come to the conclusion that suicide is not the answer. As the participants become more involved in the topic, some start discussing their own past or current suicidal thoughts—in turn, a discussion regarding coping strategies unfolds. The activity ends on a hopeful note, with multiple strategies proposed by participants and noted in their workbook for future reference, if needed.

- *D-6: Changing My Mood*—Still focusing on coping strategies, this session aims at helping participants explore coping strategies for other difficult emotions—namely, anger and sadness. Participants share their current strategies and discuss how they can help and choose someone else's strategy that they will try as homework. Of course, we encourage strategies that are "healthy" (not linked with some kind of excess) and possible for everyone to try.

4. Coping and Competence

This last component of the CBTp group aims at further exploring coping strategies and developing competence in managing one's mental health. This section brings together many previously seen concepts and ends with a staying-well plan.

- *C-1: Relief from Stress*—The goal of this session is to offer participants a relaxation strategy that can help them bring down their stress level immediately. We discuss the idea that stress is not necessarily a negative thing, but that too much stress can make it difficult to use coping strategies or to think while in a situation. The relaxation strategy proposed is called Shavasana and is influenced by yoga practice, whereby a focused and unusual type of breathing is proposed. It is important to keep in mind that relaxation or meditation strategies are possible with people with psychosis but need to be offered in a very concrete manner, with guided instructions, ideally brief and without esoteric terms. By focusing on breathing, participants learn to calm down, initially in a calm environment, and eventually, in various contexts.

- *C-2: Dealing with Symptoms*—This session focuses on coping strategies, with participants discovering the coping strategies they currently use for their symptoms and according to the intensity of the symptoms, the ones they know do not work, and are encouraged to try new coping strategies. The participants discuss the importance of having several coping strategies, in order to be able to cope no matter the circumstance.

- *C-3: Available Resources*—Among the protective factors presented in the stress–vulnerability–protective factors model, social and familial support are essential. The current activity aims for participants to reflect

upon their support network, and to name people who are useful to them in terms of informational, emotional, or material support. The idea is for participants to have names and numbers they can call according to their specific needs. Often, participants tend to overuse the same support people, or to only consider people paid to offer them support (e.g., their caseworker or clinician). This activity, along with a list of community resources available in the area, can assist people when they need specific types of support.

- *C-4: My Strengths, Protective Factors, and Challenges*—This session brings back the stress–vulnerability–protective factors model but with new protective factors that have been explored and developed during the group. We wish for participants to reflect on their strengths and protective factors but also on their continuous challenges. We wish for them to continue working on developing their protective factors, even after the group has terminated.

- *C-5: Coping My Own Way*—CBTp typically ends with relapse prevention strategies. This session is essentially that—a relapse prevention strategy that helps participants describe their best coping strategies to use on a daily basis, in order to meet their long-term goals, as well as those needed in case of symptom exacerbation. The coping plan implies reflecting back on past hospitalizations and writing down the precursors to their flaring symptoms, as well as coping strategies to use when such signs occur. The relapse prevention plan is to be shared with a trusted person who is close to the participant and part of their support network.

- *C-6: Review of the Module*—During this last session of the group, participants are congratulated and asked to reflect upon their group experience. We go over what they particularly enjoyed, learned, and wish to remember, as well as things they did not like and personal challenges they will continue to work on.

There is homework proposed every two sessions. This was intentionally planned to not overburden the participants with homework but still ensure that they get to practice what was done in the group by themselves. Homework is reviewed at the beginning of each session.

The end of the group is celebrated with a graduation party, with a diploma given (mentioning that the person completed the CBT group), and the venue and activity decided by the group according to the available budget and participants' interests. It is important to remember that for many, this might be the first time they complete a program or intervention, or receive a diploma. We wish for the group to end with a positive boost, giving participants the motivation to continue and invest in their life projects. We plan for the end of the group in advance, in order to help people prepare for it and not feel overwhelmed by the loss and sadness

linked with its termination. Unlike other groups (with other clienteles), we encourage people with psychosis to keep in touch, and to share their contact information should they wish to stay friends.

Group Process Issues

Several challenges to optimal group functioning can occur with people with psychosis in group CBT. The first challenge is to develop a strong cohesion among people who might be suspicious of others' intentions and who might have different backgrounds and functioning levels, even though they have similar symptoms. We recommend, whenever possible, to make links between participants' experiences, encouraging them to share their ideas and strategies, and to help others in the group. As Yalom mentions in his classic work (Yalom & Leszcz, 2005), altruism has great therapeutic power. This is even more true for people with severe mental illness, given that they often believe they have little to offer and are a burden to others. Once they realize they might be helpful to others, it not only helps create stronger bonds within the group but also diminishes self-stigma and improves their self-esteem.

Some participants might be cognitively sharper and quickly grasp concepts, whereas others might have more clinically significant cognitive and metacognitive deficits. This might also challenge the group dynamic—the therapists need to ensure that everyone gets something out of the group, even if they do not all get everything. It is important to use more than one medium: flip charts, objects, and video clips can all be used to help comprehend concepts. Given that the group established rules of respect, nonjudgment, and "fun," participants tend to be very accepting of others who might have more difficulties and will not make them feel excluded. Cognitive difficulties can also lead to forgetting—forgetting to come to the group if the person was distracted, or forgetting to do the homework between group sessions. Group therapists often need to plan reminders, call the night before, and plan strategies to remember to do the homework with participants who struggle with memory problems.

As mentioned earlier, psychotic disorders, such as schizophrenia, often come with negative symptoms, such as poor motivation. This can also be a challenge for participants, for whom any small obstacle becomes a mountain refraining them from coming to the group. For instance, bad weather, low financial means (end of month—cannot pay for public transportation), or even poor sleep the night before can be excuses for not coming. The participants are not trying to avoid coming to the group, in fact, they typically enjoy the group, but these obstacles appear too great for them to overcome. The group therapists need to plan ahead strategies that can involve buying bus tickets, carpooling, and even offering lifts. The group also needs

to occur at a convenient time, in order to ensure that most people will be able to attend (e.g., groups in the morning are rarely successful because of drowsiness caused by medication). Negative symptoms can also imply low energy in the group. The therapists might feel they are spending a lot of their energy simply trying to get people to participate or react. Again, the therapists might need to be creative, asking participants to work in pairs, getting them to write on the flip chart, making them get up and move around or stand on a chair (to get a different perspective), and verbally reinforcing their participation—such strategies can help energize the group and alleviate negative symptoms. Negative symptoms will diminish as the group becomes more engaged and active.

When training therapists in delivering CBTp, either in group or individually, we focus on similar elements as in most CBT therapies and as measured by competency and fidelity scales (such as the Cognitive Therapy Scale Revised for Psychosis [CTS-RP]; Hardy, Lecomte, & Munro-Clark, 2017). These elements include the following:

- *Agenda setting.* In a group, this involves announcing the day's theme and ensuring everyone understands why we are discussing this theme.

- *Feedback*. The therapists must ensure that feedback is given and asked at different moments during the session. The therapists check for understanding (i.e., the participant understands what they are saying), agreement (i.e., the participant agrees with the idea), or checks for the therapists' understanding (i.e., to make sure that they truly grasp what the participant is trying to say) with empathy and tact. The therapists need to create a context where feedback happens naturally, where participants "understand one another" by asking questions and using various creative tools to help (metaphors, graphs, drawings, cultural references, etc.).

- *Collaboration*. The goal is to have all parties working together—the entire group. Due to their symptoms, people with psychosis can at times appear to withdraw or become less active in the collaboration—the therapists need to encourage collaboration but not force it. Creativity can be very useful in getting clients to participate and collaborate. When problems arise (e.g., a participant is clearly overwhelmed by voices, is feeling less trusting, or brings content that appears delusional and distressing), the therapists are able to respond with skill, finding a way to collaborate on a common theme nonetheless.

- *Effective use of time*. Time management is by far the most difficult skill for novice group therapists to master. Indeed, making sure the agenda is covered, that everyone gets to speak, and that the session ends at the expected time can be challenging. The content should be covered at a good pace, and there should be good flow, as well with therapists having a good sense of the time and how to use it effectively.

- *Positive focus*. Individuals with psychosis experience a lot of stigma and are often treated as walking illnesses with deficits and handicaps. It is important that CBT with this population be oriented in a positive way, focusing on goals, qualities, and strengths rather than problems, deficits, and symptoms. Use of activities that promote self-esteem, self-compassion, and acceptance are encouraged, as well as normalization used appropriately to educate and decrease self-stigma.

- *Interpersonal effectiveness*. It is important for therapists to display the necessary warmth, trustworthiness, authenticity, honesty, positive attitude, and respect toward participants in order to create a strong group cohesion. Do the therapists help create a sense of belonging? Are they able to make everyone feel welcome, and no one singled out? Therapists should be able to de-escalate an agitated participant without becoming defensive, and to use themselves appropriately and when needed (e.g., display true empathy and genuine caring).

- *Accessing key emotions*. Emotion regulation and even emotion recognition can be very difficult for some people with psychosis. Many will not know exactly what they feel, or will attribute their emotions to others (e.g., "The Mafia is angry and wants to kill me" or "My mean voice is angry but my nice voice is happy"). An important part of the therapy is to help people acknowledge what their emotions are, and that they belong to them. People also have difficulties in recognizing emotions in others, creating more confusion in interpersonal situations, such as therapy. It therefore becomes important to name emotions, in the here and now, even from the therapists' experience, to help make them clearer. Emotion regulation strategies are also often needed, given that becoming emotionally overwhelmed can lead to increased psychotic symptoms, as well as increased anxiety, depression, and suicidal ideas in people with psychosis.

- *Eliciting key cognitions*. An important goal of group CBTp is to help clients recognize the link between their thoughts and behaviors or emotions, in order to modify their dysfunctional thoughts by creating doubt. Given that the beliefs and thoughts that might be expressed can at times be delusional, it is important for the therapists to really understand the key cognitions at play and not assume which thoughts are distressing. For instance, a belief that might appear distressing (e.g., someone trying to kidnap her) might in fact hide grandiosity and serve a function, such as protecting the person's self-esteem (if they want her, she must have some value). The therapists should not try to work on every thought that is brought to therapy by the participants, but rather try to determine whether the belief or thought is central to the problem (identification of the "hot thought"). It is also expected that as therapy evolves, more attention is given to the core beliefs. Therapists should address current beliefs and thoughts using more than one strategy to elicit thoughts (e.g., thought records, Socratic

questioning, role plays). The therapists effectively use themselves, or the other participants in a group, to help identify thoughts or beliefs.

- *Eliciting key behaviors.* A person's behaviors can illustrate their reaction to a thought and emotion, but can also maintain or worsen the situation. Therapists need to help the participants see the link between their thoughts and behaviors or emotions, but also to recognize how their behaviors can maintain dysfunctional beliefs and distress. Central behaviors that might interfere with the person's improvements should be worked on more than peripheral ones. Negative behaviors or behaviors that might jeopardize the group therapy are adequately dealt with during the session.

- *Guided discovery.* The therapists should help participants to develop a new understanding of their situation and make their own hypotheses. The therapists should appear open, inquisitive, and flexible. Sometimes people with psychosis might become defensive if they fear being confronted or not believed—it is important that the therapists' position be inquisitive and curious but not pushy. Hence we can adopt the position of sitting on a "collaborative fence" of respecting the participants' current beliefs and merely looking at how the current belief is both beneficial and detrimental. This will minimize any concern of collusion (i.e., that the participant's current belief is the sole explanation of events or of their behaviors and that the therapists are also convinced that it is so). The use of the collaborative fence allows the client to feel that the therapists believe that "This is how I see or experience things," but they do not need the therapists to believe it as well.

- *Conceptual integration.* The therapists should help participants make sense of their experiences or symptoms. Often, in a group setting, it is difficult to propose individual formulations that are specific to each, but a model, such as the stress–vulnerability–protective factors model, can be personalized and used to help participants develop a better understanding of what they need to work on and how they can understand their difficulties. It can be challenging for therapists to explain the model in order for participants to truly grasp it and personalize it. Ideally, the therapists should use the participant's own words.

- *Application of change methods (use of CBT techniques).* It does not suffice to know the appropriate CBTp techniques; therapists should know when to apply them or not, according to the context, the participants' reactions, and also the specificity of the symptoms. Most techniques are scheduled in the manual and presented at a specific session. Nonetheless, once presented, they can be used at any time. The therapists may therefore choose from a wide breadth of interventions focusing on either cognitions or behaviors or both simultaneously. The appropriateness of the intervention chosen should include cognitive methods (evaluating evidence, evaluating helpfulness of thoughts, imagery restructuring, examining pros and cons, cognitive distancing, continua, etc.) and behavioral methods

(behavioral experiments, role plays, graded hierarchical exposure, applied relaxation, evidence gathering, etc.). In group therapy, the techniques are often proposed in a certain order and broken down, for simplicity. Should therapists introduce new techniques, they need to consider whether they are meeting the needs of the participants; whether they are at the right level; whether the participants understand the utility of the intervention; and will they be able to use these techniques without the therapists, outside of the group therapy room?

- *Cultural sensitivity*. Therapists need to be aware of cultural considerations and incorporate them appropriately. In some cultures, for instance, voices are positively viewed. Cultural considerations may include language, religious affiliation, age, or country of origin. These may be incorporated into the participants' understanding of their situation or used in the change methods. Therapists need to seek feedback and discuss cultural issues when needed.

- *Homework*. Given that homework is an integral aspect of group CBTp, and that it maximizes the opportunity for the participants to practice the skills and techniques learned during the sessions, it is important to encourage participants to do their homework. The term "homework" is often not very popular, with most participants making some negative school association with the term. Failed attempts to complete homework should be explored, including barriers to completion and problem solving to increase the likelihood of homework being completed in the future.

Conclusions

Group CBTp has demonstrated its efficacy in helping people struggling with psychotic symptoms in developing better strategies to help them cope with their daily stressors and move along in their recovery. The manualized approach promoted in this chapter enables clinicians to quickly master the necessary skills to conduct such groups, by following a 2-day workshop and by referring to the book (Lecomte et al., 2016) and manual. This does not mean that just about anyone can become an effective CBTp group therapist. In fact, group experience and a good understanding of group processes is essential for the group to develop a strong cohesion and for the participants to optimally benefit from the group. At times, in studies, we have witnessed sessions whereby the therapists would have rated high on a CBT fidelity scale but would be considered mediocre in terms of flexibility and adjusting to the needs of the group. Supervision and appropriate training are thus necessary.

Although people with psychotic symptoms might present with several challenges in a group context, they also greatly benefit from such groups and can see improvements that their caseworkers or psychiatrists would

not have predicted possible. Over the years, we have seen many participants thrive following their participation in the CBTp group, developing a new motivation and sense of competence, allowing them to complete their schooling or integrate the job market. This group CBTp module has inspired the development in our lab of other CBT-oriented group interventions for people with severe mental disorders, such as CBT for supported employment, a group focusing on changing beliefs regarding work while overcoming stressors and negotiating accommodations; WITH-CBT, a multiple-family group intervention offering psychoeducation and CBT skills to parents of people with a psychotic disorder in order to help themselves and their child; and the Power of Two, a group intervention for young men with psychosis wishing to develop healthy romantic relationships. Essentially, group CBT can be very useful, with various targets, in helping people with psychosis or severe mental illness.

PART III

Conclusion

CHAPTER 14

Challenges in Group Therapy

In this book, we integrated concepts from the group process literature into the CBT model of group intervention in a comprehensive manner. We also provided specific approaches for a number of common problems alongside practical advice about running groups in a variety of settings. But throughout, we have been aware of the many open questions, controversies, and new frontiers that remain—many of which are important and require more definitive answers.

In some cases, these caveats have remained consistent from the first edition in 2006, despite the elapse of more than 15 years. For example, then as now, we have reached the same generic conclusion that CBT group treatments tend to be nearly as efficacious and effective as individual therapy. It is possible to find studies with a statistically significant difference in favor of individual CBT (e.g., Huntley et al., 2012). However, that difference may not be clinically significant or meaningful in a broader effectiveness context, and needs to take into account the question of efficiency. Indeed, other studies have shown group CBT to be equally effective. And we cannot overlook or minimize the cost-related benefits of the group format (e.g., Brown et al., 2011). Where the conditions exist for choosing group interventions, choosing a group CBT approach is a sound clinical decision, and preferable to many other less evidence-based treatments.

In at least one domain that thematically affects every aspect of this book—diagnosis—we have even more uncertainty than we did in 2006. At the time of the first edition, the use of DSM was widespread and seemed a near immutable fact. DSM-5 (American Psychiatric Association, 2013) and DSM-5-TR (American Psychiatric Association, 2022) have not had the

same reception as previous editions; indeed, the field is embroiled more than it was then in practical questions related to comorbidity and diagnostic criteria, but also in more philosophical debate about how these diagnostic schemes are created and promulgated (e.g., Cuthbert & Insel, 2013; Khoury, Langer, & Pagnini, 2014).

Notwithstanding the debate about diagnosis, which may feel like a backward step, there are reasons for optimism around the breadth and depth of what group CBT can do. Our overall forecast for the future of CBT groups is positive for two reasons. First, in some domains, much more information now exists—the addition of mindfulness-based CBT and interest in it is but one example. This means the intervention, tried and true as it is, is at the same time evolving and has room for fresh thinking. Second, interest is growing in applying CBT groups to new populations, in nontraditional settings, including peer-to-peer and other brief formats (Bechdolf et al., 2004; Marchand, Roberge, Primiano, & Germain, 2009; Newman, Przeworski, Consoli, & Taylor, 2014). These are important "vital signs"; the intervention itself and the settings in which it is applied are ever expanding and evolving, which suggests the field will be important for years to come.

In this book, we have made specific suggestions for "best practice" when conducting CBT groups. Of course, there remain considerable gaps in our knowledge. For technical questions for which we are still awaiting clear evidentiary support, we relied on standard clinical wisdom, our own experiences, and the recommendations of other experts. Indeed, there are some decisions that group leaders have to make that rely on clinical judgment—for example, it is hard to imagine a definitive study that would tell us with high specificity and certainty when an individual's behavior indicates they ought to be diverted from a group to individual therapy. These circumstances are simply too unique to fully quantify. Nonetheless, it is still striking at times how little we know, and how basic some of the unanswered questions are. Here, we highlight some of these issues—ones where we particularly believe that an answer could be found using scientific methods.

Group Size and Composition

What is an ideal CBT group size? This is a rudimentary question that we need to answer daily in clinical settings. Although the answer might vary for specific disorders, there is almost no research base for making this recommendation. Certainly one can cite the number of participants per group from efficacy trials, and in the absence of other information, this would offer the best possibility for replicating effects in the real world. However, it is not clear that these kinds of studies tell us much about the "ceiling" or "floor" in terms of numbers of individuals in groups. Clinically, when a group grows larger than 12 members, in a 2-hour group session, some

members may not ever have a chance to speak; in a group of six members, there will almost inevitably be time and space for every member to have the floor. Also, the larger the theoretical target size of a group, the more difficult it is to find a shared appointment time. Even in a group of 10–12 participants, people will have to make difficult choices about prioritizing treatment over family or work. Virtual options might be part of the solution because they involve less travel time and at least some opportunity to balance—for example, child care with participating in treatment. The group size question also changes when considering adaptations like mindfulness-based cognitive therapy (MBCT) and inpatient settings. A more skills-based approach, as in MBCT, implies that a larger group size would not be a particular impediment; in an inpatient setting where problems are presumably more acute, we expect a stricter limit on group size would be called for.

Another issue for which few explicit data exist concerns the composition of a CBT group. We have generally argued that some amount of heterogeneity is best for most groups, but this is based on clinical experience. Individuals with different backgrounds and experiences, and different status and socioeconomic standings who recognize through group that they all have the same kinds of problems, connect with one another in ways that appear to us to be meaningful and lead to enhanced motivation and more symptom change. We tend to be open about issues of gender and gender identity rather than restricting groups to one gender, especially as gender concepts are increasingly fluid. Including members with various gender identities aids the discussion of difficulties that are related to "gendered" issues that invariably arise when clients are discussing relationships and navigating everyday situations. However, some differences between group members, too much heterogeneity, can be counterproductive. In one recent example, one of us ran a group in which, by a series of events, a woman whose difficulties were sparked by domestic violence was in the same depression group as a man with a history of arrest for assault, although of a different kind. When these issues emerged in group, the results were dire. The group as a whole banded together around the woman who had been assaulted and asked, as a group, for the male member of the group to be removed. While the group therapists tried to maintain the group for several more sessions, eventually it was necessary to divert the man to individual treatment.

Another example, unlikely but one that can and does happen, is what to do when in the middle of a group a participant dies by suicide. There is no way to be completely prescriptive about this worst-case scenario, nor can we conceive of a quantitative study that could shed light on what course of action to take, but such an event might raise the question of whether the group should continue. Our suggestion is that this exact question be taken to the group; perhaps over two or more sessions in which the protocol is "suspended" while members and the leaders discuss how and whether to

continue. In our experience, as infrequent as this might be, groups will wish to continue having taken time to discuss their sadness and shock. To some extent, the loss of someone by suicide can clarify that concept of "what is it we are up against"—that is to say that the treatment target is serious and needs to be addressed. The group dissolving would mean stopping treatment, when the lesson might be that treatment is important and possibly lifesaving. We would also say that after such a loss, individual group members should be reviewed in case they might need additional supports beyond the group.

Aside from this unusual and tragic circumstance, none of us could ever remember a group that "failed" in the sense that it had to be discontinued. Groups always have some attrition—sometimes a member (and extremely rarely, members) may be asked of their own accord to leave a group as in the example above, or the group cohesion and dynamic is imperfect. It is important to remember that cohesion is probably distributed in a bell curve, which means some groups are not as cohesive as others even if group leaders have done good work. Nonetheless, we think that, precisely because CBT groups are effective and robust, most groups and group leaders have positive results and very few groups will ever meet a threshold where the right decision is to dissolve the group.

Studying these kinds of issues would, of course, be difficult, but not impossible. Individual differences on any number of dimensions could be assessed prior to treatment, and variability in these dimensions could be used to predict process or outcome variables. Unfortunately, we are not aware of any studies on this issue in CBT.

Suitability and Treatment Matching

Another issue that remains understudied is suitability for CBT group and treatment matching. In several chapters in Part II we described some criteria that can be used for screening group members and helping to determine the fit between the person and the CBT group approach. However, most of this depends on clinical wisdom and experience rather than data. A research agenda in this area would seem simple; individual differences on any number of dimensions could be assessed prior to treatment, and variability in these dimensions could be used to predict process or outcome variables, including attendance, compliance with treatment and homework, and dropout. Unfortunately, there are very few high-quality studies of these questions even if it seems within reach to do them.

The advent of approaches like MBCT makes this question even more profound because they introduce significant, and intended, variations in what a CBT group represents. Moreover, those variations are intended at least in theory to create interventions that are more meaningful for

individuals at different "stages" of their disorder or presenting problems. The many variations of group CBT and the number of populations for which these methods are applied is, as mentioned above, a boon to the field and a sign of its health. On the other hand, it also multiplies the number of possible dependent and independent variables: Would a finding about individual difference in group CBT for acute depression also apply to MBCT for those who have recovered from depression? The answer is likely, no.

Process Factors in CBT Groups

But perhaps the most important question to which we have no answer is "Does paying attention to group process matter in CBT?" Throughout this book we have made the point that process does occur in such groups, that it has been undervalued in the CBT group literature, and that supporting and enhancing good group process leads to better outcomes. Still, there is far too little empirical evidence on these questions, and we would love to see more rigorous research on them.

Training Group Leaders

A primer on training issues in CBT is beyond the scope of this book. But it is important to note that determining "competence" in conducting individual CBT, and what training it takes to reach this point, is difficult in and of itself. There is broad agreement that to become a skilled, accredited therapist in CBT, one needs a combination of didactic training and direct supervision on some number of cases. The same holds true for group CBT. It is important for those running CBT groups to learn the basics of individual CBT well first. Only then, when they have mastered the principles and key interventions of individual CBT, should a therapist move on to group intervention. There is simply more inherent complexity in tracking process issues in a group compared to one individual, and the techniques of CBT have to be delivered in a more dynamic way to be effective in a group setting. Ideally, CBT therapists learning to conduct groups would be expending less mental energy on the mechanics of the CBT techniques, and devote more attention to the group modality, including how to present material didactically (but in a lively way) to a group, how to track process issues, and how to devise interventions that enhance positive process.

In an ideal setting, a trainee would first be a cotherapist, with their supervisor acting as primary therapist. This would allow for not only live supervision but also observational learning from a more seasoned therapist. Over time, the trainee would be required to do more and more of the clinical work, based on their competence and confidence. Time for planning

each session and debriefing after a group has occurred are also valuable to consolidate learning. Once a trainee is at the point of leading a group without their supervisor present, videotaping of group sessions, where possible, would be the ideal mode of supervision. Finally, and perhaps this is a point of debate, it might be said that some therapists are simply better suited to individual therapy than to a group. It does take a certain degree of extraversion, confidence, and projection of voice (among other things) that not all therapists possess in equal measure.

Comorbidity

Comorbidity remains the norm in many clinical settings and is important because it affects a host of variables related to treatment, including techniques used and process factors in groups (Craske et al., 2007; Hauksson, Ingibergsdóttir, Gunnarsdóttir, & Jónsdóttir, 2017). Treatment outcomes may also be affected. In individual CBT, comorbidity has been shown to impact treatment response negatively. Studies in this area typically compare clients with and without comorbidity in the context of treatment studies examining the efficacy of CBT for a primary condition; this allows for a direct comparison of treatment response and/or symptomatic changes in those with and without comorbidity. Overall, clients with comorbid conditions respond less robustly to CBT, though the degree of impact differs between studies (Brown, Antony, & Barlow, 1995; Erwin, Heimberg, Juster, & Mindlin, 2002; Newman, Moffitt, Caspi, & Silva, 1998). Comorbidity of social phobia and mood disorders appears to be associated with ongoing impairment after group CBT for social phobia (Erwin et al., 2002). In a treatment study of panic disorder, participants with comorbidity were more likely to seek further treatment when the study treatment ended. Moreover, although the treatment did reduce the level of comorbidity acutely, over 24 months of follow-up, comorbidity rates returned to pretreatment levels, suggesting a lack of long-term improvement in clients with comorbidity (Brown et al., 1995). Comorbidity of depression and OCD appears to result in fewer treatment gains in CBT involving exposure and response prevention (ERP); those with comorbid depression had higher posttreatment OCD symptom scores (Abramowitz & Foa, 2000; Abramowitz, Franklin, Street, Kozak, & Foa, 2000). In a broad review of treatment outcome studies, personality disorder comorbidity has been shown to have a detrimental impact on the outcome of CBT for panic disorder compared to clients without personality comorbidity (Mennin & Heimberg, 2000). Equally striking in these studies of comorbidity and CBT is that despite the presence of multiple conditions, CBT nonetheless makes a significant clinical impact that improves symptoms and functioning (Barlow et al., 2004). This finding, along with studies of the latent structure underlying common Axis I conditions, has prompted some writers to describe a broad "negative

affect syndrome" (Barlow et al., 2004), which is thought to benefit from the common treatment strategies present in most CBT protocols.

Clearly, the presence of multiple disorders is related to not only different kinds of symptoms and symptom severity but also to other kinds of psychopathology indicators. For example, clients with social phobia with comorbid generalized anxiety disorder (GAD) have been found to have more severe levels of social anxiety, greater depressed mood, and more functional impairment than those without GAD (Mennin, Heimberg, & MacAndrew, 2000). Moreover, the impact of comorbidity is not simply additive. In a study of the cognitive profiles of clients with panic alone, depression alone, and comorbid panic and depression, clients with single disorders endorsed thoughts and beliefs consistent with their disorder. The clients with comorbidity endorsed additional, distinct cognitions related to evaluative fears that the pure disorder groups did not (Woody, Taylor, McLean, & Koch, 1998). Comorbidity is also associated with a high level of maladaptive perfectionism, which may not only indicate vulnerability to further distress and symptoms but may also be a focus of treatment (Bieling, Summerfeldt, Israeli, & Antony, 2004). These studies of comorbidity suggest that multiple conditions may not only result in fewer treatment gains but are also associated with other individual differences that impact on the treatment process.

In real-world clinical practice, clinicians are faced with clients who, having much more confounding diagnostic profiles, would almost certainly be excluded from efficacy trials. Thus, difficult decisions need to be made about what type of CBT strategies should be used and whether single-disorder protocols are even appropriate in such cases. Comorbidity issues therefore raise a number of interesting questions and dilemmas: When clients have multiple problems, how are these best understood and what problems are treated first? Should clients with comorbidity be treated in a group context? What is the impact of these comorbidities on the techniques that will be used in the group? How is group process altered when clients have multiple disorders? These questions await empirical answers in careful studies and at the same time underscore the current nonconsensus about diagnostic schemes. Meanwhile, group therapists still need to answer the questions just posed in daily practice. We would suggest that people with comorbidities ought to be included in group modalities as a default and that the primary or "most-responsible-for-impairment" disorder be treated first. We might also be more guarded about the prognosis for individuals with multiple co-occurring problems but generally find that because CBT groups tend to have a fairly set and robust protocol, the group itself is not altered too much by having attendees with comorbidities. It might also be useful to sequence treatments; a CBT group for anxiety can be followed by a CBT group for depression (or vice versa) depending on need. In some settings where problems are very diverse—for example, inpatient hospital settings—transdiagnostic CBT protocol is also a good choice.

Virtual Groups

Similar to other themes identified here where the realities outstrip our ability to gather data to make better decisions, conducting groups virtually is likely to be a fact of life brought on by the COVID-19 pandemic. The benefits of virtual treatment groups are obvious and are described in Chapter 2. They solve many logistical problems like clients having to travel long distances, and in the context of a world buffeted by a pandemic, are a choice that mitigates risk massively. What is sacrificed for a group to be virtual is obvious too: there can be compromises of confidentiality (and simple privacy) when clients are connecting from home, some nonverbal and paraverbal nuances are lost, and it might be clinically difficult to follow up (e.g., a client "disconnects" from the group during a suicidal crisis). There is also a debate to be had about whether virtual groups add or do not add to equitable access: Do these approaches disadvantage populations without technology and Internet access? And yet this can cut both ways: How do materially disadvantaged people make their way to a treatment facility where a car and paid parking are the only practical options? Clearly, we must check our assumptions on all sides.

Ideally, we would be moving toward virtual group therapy as a choice only after having conducted some comparative efficacy and effectiveness studies, and gaining a better understanding of who does and does not wish to make this choice. But for many providers the decision to move to virtual as quickly as possible, not to mince words, was life or death. This will be an important area for researchers to focus on retrospectively and we suspect that many of the same factors we noted here would be relevant to virtual groups. It will still be important for group leaders to develop skills, albeit perhaps with different performative aspects, to be compelling group leaders. It will still be important and possible in a different way to note, foster, reinforce, and discourage various group dynamics. We hope this choice will be a boon to both clients and therapists as it grows, and a new area to explore and optimize, including technology platforms that make the most of multimedia opportunities that Internet group therapy offers. This may become a golden age of creativity—and that would be a fitting epilogue to a forced choice in human history.

Final Thoughts

We hope this book offers the beginning of an integration of CBT group protocols and group process factors. Even in the second edition it remains a beginning and cannot be a definitive statement. The issues we described are subject to further academic inquiry by theorists and researchers alike. In addition, as the field of CBT groups develops, so too will these ideas about process. A really important through line in CBT group work is the

sense of excitement and fulfillment that it provides to group leaders. It can be difficult to name what exactly is so different about doing group work, but it is quite different from individual work. The stakes seem higher, the challenge a little greater, and there is a more complete sense of satisfaction when there has been a "great" session. When you get the process right, and witness participants helping one another, it seems very much like there has been a therapy force multiplier. Similarly, when it becomes clear that group participants have formed supportive relationships that may outlive the span of the group, a leader will know that they have provided more than techniques and symptom relief. This experience is so professionally fulfilling that we encourage readers to pursue this work with vigor and passion; your clients will be better, and so will you.

References

Abramowitz, J. S. (1996). Variants of exposure and response prevention in the treatment of obsessive–compulsive disorder: A meta-analysis. *Behavior Therapy, 27,* 583–600.

Abramowitz, J. S. (1997). Effectiveness of psychological and pharmacological treatments for obsessive–compulsive disorder: A quantitative review. *Journal of Consulting and Clinical Psychology, 65,* 44–52.

Abramowitz, J. S. (2018). *Getting over OCD: A 10-step workbook for taking back your life* (2nd ed.). New York: Guilford Press.

Abramowitz, J. S., & Blakey, S. M. (2020). Overestimation of threat. In J. S. Abramowitz & S. M. Blakey (Eds.), *Clinical handbook of fear and anxiety: Maintenance processes and treatment mechanisms* (pp. 7–25). Washington, DC: American Psychological Association.

Abramowitz, J. S., & Buchholz, J. L. (2020). Psychological treatment for OCD. In N. M. Simon, E. Hollander, B. O. Rothbaum, & D. J. Stein (Eds.), *Textbook of anxiety, trauma, and OCD-related disorders* (3rd ed., pp. 315–340). Washington, DC: American Psychiatric Association.

Abramowitz, J. S., Deacon, B. J., & Whiteside, S. P. H. (2019). *Exposure therapy for anxiety: Principles and practice* (2nd ed.). New York: Guilford Press.

Abramowitz, J. S., & Foa, E. B. (2000). Does major depressive disorder influence outcome of exposure and response prevention for OCD? *Behavior Therapy, 31,* 795–800.

Abramowitz, J. S., Franklin, M. E., & Foa, E. B. (2002). Empirical status of cognitive-behavioral therapy for obsessive–compulsive disorder: A meta-analytic review. *Romanian Journal of Cognitive and Behavioral Psychotherapies, 2*(2), 89–104

Abramowitz, J. S., Franklin, M. E., Street, G. P., Kozak, M. J., & Foa, E. B. (2000). Effects of comorbid depression on response to treatment for obsessive–compulsive disorder. *Behavior Therapy, 31,* 517–528.

Abramowitz, J. S., & Jacoby, R. J. (2015). Obsessive–compulsive and related

disorders: A critical review of the new diagnostic class. *Annual Review of Clinical Psychology, 11,* 165–186.

Aderka, I. M., Foa, E. B., Applebaum, E., Shafran, N., & Gilboa-Schechtman, E. (2011). Direction of influence between posttraumatic and depressive symptoms during prolonged exposure therapy among children and adolescents. *Journal of Consulting and Clinical Psychology, 79*(3), 421–425.

Agras, W. S. (1987). *Eating disorders: Management of obesity, bulimia, and anorexia nervosa*. Oxford, UK: Pergamon Press.

Aharonovich, E., Hasin, D. S., Nunes, E. V., Stoh, M., Cannizzaro, D., Sarvet, A., et al. (2018). Modified cognitive behavioral therapy (M-CBT) for cocaine dependence: Development of treatment for cognitively impaired users and results from a Stage 1 trial. *Psychology of Addictive Behaviors, 32,* 800–811.

Aharonovich, E., Nunes, E. V., & Hasin, D. S. (2003). Cognitive impairment, retention and abstinence among cocaine abusers in cognitive-behavioral treatment. *Drug and Alcohol Dependence, 71,* 207–211.

Albert, U., Bogetto, F., Maina, G., Saracco, P., Brunatto, C., & Mataix-Cols, D. (2009). Family accommodation in obsessive–compulsive disorder: Relation to symptom dimensions, clinical and family characteristics. *Psychiatry Research, 179*(2), 204–211.

Al-Dajani, N., Gralnick, T. M., & Bagby, R. M. (2016). A psychometric review of the Personality Inventory for DSM-5 (PID-5): Current status and future directions. *Journal of Personality Assessment, 98*(1), 62–81.

Aldinger, F., & Schulze, T. G. (2017). Environmental factors, life events, and trauma in the course of bipolar disorder. *Psychiatry and Clinical Neurosciences, 71*(1), 6–17.

Alonso, J., Liu, Z., Evans-Lacko, S., Sadikova, E., Sampson, N., Chatterji, S., et al. (2018). Treatment gap for anxiety disorders is global: Results of the World Mental Health surveys in 21 countries. *Depression and Anxiety, 35*(3), 195–208.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychological Association. (2017). Clinical practice guidelines for the treatment of PTSD. Washington, DC: American Psychological Association, Guideline Development Panel for the Treatment of Posttraumatic Stress Disorder in Adults. Available at *www.apa.org/ptsd-guideline/ptsd.pdf*.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text revision). Washington, DC: Author.

Amlung, M., & MacKillop, J. (2014). Understanding the effects of stress and alcohol cues on motivation for alcohol via behavioral economics. *Alcoholism: Clinical and Experimental Research, 38,* 1780–1790.

Anderson, R. A., & Rees, C. S. (2007). Group versus individual cognitive-behavioural treatment for obsessive–compulsive disorder: A controlled trial. *Behaviour Research and Therapy, 45*(1), 123–137.

Ansell, E. B., Sanislow, C. A., McGlashan, T. H., & Grilo, C. M. (2007). Psychosocial impairment and treatment utilization by patients with borderline personality disorder, other personality disorders, mood and anxiety disorders, and a healthy comparison group. *Comprehensive Psychiatry, 48*(4), 329–336.

Anselmetti, S., Cavallaro, R., Bechi, M., Angelone, S. M., Ermoli, E., Cocchi, F., et al. (2007). Psychopathological and neuropsychological correlates of source monitoring impairment in schizophrenia. *Psychiatry Research, 150,* 51–59.

Anton, R. F., O'Malley, S. S., Ciraulo, D. A., Cisler, R. A., Couper, D., Donovan, D. M., et al. (2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: The COMBINE study: A randomized controlled trial. *JAMA, 295*(17), 2003–2017.

Antony, M. M., & Barlow, D. H. (Eds.). (2020). *Handbook of assessment and treatment planning for psychological disorders* (2nd ed.). New York: Guilford Press.

Antony, M. M., Downie, F., & Swinson, R. P. (1998). Diagnostic issues and epidemiology in obsessive–compulsive disorder. In R. P. Swinson, M. M. Antony, S. Rachman, & M. A. Richter (Eds.), *Obsessive–compulsive disorder: Theory, research, and treatment* (pp. 3–32). New York: Guilford Press.

Antony, M. M., & Roemer, L. (2011). *Behavior therapy.* Washington, DC: American Psychological Association.

Antony, M. M., & Rowa, K. (2005). Evidence-based assessment of anxiety disorders in adults. *Psychological Assessment, 17*(3), 256–266.

Antony, M. M., & Swinson, R. P. (2000). *Phobic disorders and panic in adults: A guide to assessment and treatment.* Washington, DC: American Psychological Association.

Antony, M. M., & Swinson, R. P. (2017). *The shyness and social anxiety workbook: Proven, step-by-step techniques for overcoming your fear* (3rd ed.). Oakland, CA: New Harbinger.

Antony, M., & Watling, M. (2006). *Overcoming medical phobias: How to conquer fear of blood, needles, doctors, and dentists.* Oakland, CA: New Harbinger.

Apodaca, T. R., Borsari, N., Jackson, K. M., Magill, M., Longabaugh, R., Mastroleo, N. R., et al. (2014). Sustain talk predicts poorer outcomes among mandated college student drinkers receiving a brief motivational intervention. *Psychology of Addictive Behaviors, 28,* 631–638.

Apodaca, T. R., Jackson, K. M., Borsari, B., Magill, M., Longabaugh, R., Mastroleo, N. R., et al. (2016). Which individual therapist behaviors elicit client change talk and sustain talk in motivational interviewing? *Journal of Substance Abuse Treatment, 61,* 60–65.

Aranda, F. F., Villar, M. B., Murcia, S. J., Gil, V. T., Ruiloba, J. V., & Vilches, I. G. (1997). Outpatient group psychotherapy for anorexia nervosa. *Anales de Psiquiatria, 13,* 236–242.

Armstrong, T., Sarawgi, S., & Olatunji, B. O. (2012). Attentional bias toward threat in contamination fear: Overt components and behavioral correlates. *Journal of Abnormal Psychology, 121*(1), 232–237.

Asmundson, G. J. G., Thorisdottir, A. S., Roden-Foreman, J. W., Baird, S. O., Witcraft, S. M., Stein, A. T., et al. (2019). A meta-analytic review of cognitive processing therapy for adults with posttraumatic stress disorder. *Cognitive Behaviour Therapy, 48*(1), 1–14.

Aue, T., & Okon-Singer, H. (2015). Expectancy biases in fear and anxiety and their link to biases in attention. *Clinical Psychology Review, 42,* 83–95.

Babor, T. F., & The Marijuana Treatment Project Research Group. (2004). Brief treatments for cannabis dependence: Findings from a randomized multisite trial. *Journal of Consulting and Clinical Psychology, 72*(3), 455–466.

Bae, H., Kim, D., & Park, Y. C. (2015). Dissociation predicts treatment response in eye-movement desensitization and reprocessing for posttraumatic stress disorder. *Journal of Trauma and Dissociation, 17*(1), 112–130.

Baer, J. S., Beadnell, B., Garrett, S. B., Hartzler, B., Wells, E. A., & Peterson, P. L. (2008). Adolescent change language within a brief motivational intervention and substance use outcomes. *Psychology of addictive behaviors: Journal of the Society of Psychologists in Addictive Behaviors, 22*(4), 570–575.

Bailer, U., de Zwaan, M., Leisch, F., Strnad, A., Lennkh-Wolfsberg, C., El-Giamal, N., et al. (2004). Guided self-help versus cognitive behavioral group therapy in the treatment of bulimia nervosa. *International Journal of Eating Disorders, 35,* 522–537.

Bailey, B. E., Wu, K. D., Valentiner, D. P., & McGrath, P. B. (2013). Thought–action fusion: Structure and specificity to OCD. *Journal of Obsessive–Compulsive and Related Disorders, 3,* 39–45.

Baillie, A. J., & Rapee, R. M. (2005). Panic attacks as risk markers for mental disorders. *Social Psychiatry and Psychiatric Epidemiology, 40*(3), 240–244.

Baker, A. L., Thornton, L. K., Hiles, S., Hides, L., & Lubman, D. I. (2012). Psychological interventions for alcohol misuse among people with co-occurring depression or anxiety disorders: A systematic review. *Journal of Affective Disorders, 139,* 217–229.

Baker, J. A. (2000). Developing psychosocial care for acute psychiatric wards. *Journal of Psychiatric and Mental Health Nursing, 7*(2), 95–100.

Bandelow, B., & Michaelis, S. (2015). Epidemiology of anxiety disorders in the 21st century. *Dialogues in Clinical Neuroscience, 17*(3), 327–335.

Bandelow, B., Reitt, M., Röver, C., Michaelis, S., Görlich, Y., & Wedekind, D. (2015). Efficacy of treatments for anxiety disorders: A meta-analysis. *International Clinical Psychopharmacology, 30*(4), 183–192.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

Banks, C., & Moyne, J. (1997). *The essential Rumi*. San Francisco: Harper.

Bar-Haim, Y., Lamy, D., Pergamin, L., Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H. (2007). Threat-related attentional bias in anxious and nonanxious individuals: A meta-analytic study. *Psychological Bulletin, 133*(1), 1–24.

Barkowski, S., Schwartze, D., Strauss, B., Burlingame, G. M., Barth, J., & Rosendahl, J. (2016). Efficacy of group psychotherapy for social anxiety disorder: A meta-analysis of randomized-controlled trials. *Journal of Anxiety Disorders, 39,* 44–64.

Barlow, D. H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.). New York: Guilford Press.

Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy, 35,* 205–230.

Barlow, D. H., & Craske, M. G. (2022). *Mastery of your anxiety and panic: Workbook* (5th ed.). New York: Oxford University Press.

Barlow, D. H., Farchione, T. J., Bullis, J. R., Gallagher, M. W., Murray-Latin, H., Sauer-Zavala, S., et al. (2017). The unified protocol for transdiagnostic treatment of emotional disorders compared with diagnosis-specific protocols for anxiety disorders: A randomized clinical trial. *JAMA Psychiatry, 74*(9), 875–884.

Barlow, D. H., Farchione, T. J., Sauer-Zavala, S., Latin, H. M., Ellard, K. K., Bullis, J. R., et al. (2017a). *Unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide* (2nd ed.). New York: Oxford University Press.

Barlow, D. H., Farchione, T. J., Sauer-Zavala, S., Latin, H. M., Ellard, K. K., Bullis, J. R., et al. (2017b). *Unified protocol for transdiagnostic treatment of emotional disorders: Workbook* (2nd ed.). New York: Oxford University Press.

Barnicot, K., Katsakou, C., Marougka, S., & Priebe, S. (2011). Treatment completion in psychotherapy for borderline personality disorder—A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica, 123*(5), 327–338.

Basco, M. R., & Rush, A. J. (1996). *Cognitive-behavioral therapy for bipolar disorder.* New York: Guilford Press.

Basco, M. R., & Rush, A. J. (2007). *Cognitive-behavioral therapy for bipolar disorder* (2nd ed.). New York: Guilford Press.

Beard, C. (2011). Cognitive bias modification for anxiety: Current evidence and future directions. *Expert Review of Neurotherapeutics, 11*(2), 299–311.

Beatson, J. A., & Rao, S. (2013). Depression and borderline personality disorder. *Medical Journal of Australia, 199*(Suppl. 6), S24–S27.

Beavan, V., Read, J., & Cartwright, C. (2011). The prevalence of voice-hearers in the general population: A literature review. *Journal of Mental Health, 20*(3), 281–292.

Bechdolf, A., Knost, B., Kuntermann, C., Schiller, S., Klosterkötter, J., Hambrecht, M., et al. (2004). A randomized comparison of group cognitive-behavioural therapy and group psychoeducation in patients with schizophrenia. *Acta Psychiatrica Scandinavica, 110*(1), 21–28.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* New York: New American Library.

Beck, A. T. (1996). Beyond belief: A theory of modes, personality, and psychopathology. In P. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 1–25). New York: Guilford Press.

Beck, A. T., Baruch, E., Balter, J. M., Steer, R. A., & Warman, D. M. (2004). A new instrument for measuring insight: The Beck Cognitive Insight Scale. *Schizophrenia Research, 68*(2–3), 319–329.

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56*(6), 893–897.

Beck, A. T., & Rector, N. A. (2005). Cognitive approaches to schizophrenia: Theory and therapy. *Annual Review of Clinical Psychology, 1,* 577–606.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory: Manual* (2nd ed.). San Antonio, TX: Psychological Corporation.

Beck, A. T., & Weishaar, M. E. (2000). Cognitive therapy. In D. Wedding & R. J. Corsini (Eds.), *Current psychotherapies* (6th ed., pp. 241–272). Ithaca, IL: Peacock.

Beck, A. T., & Young, J. E. (1985). Cognitive therapy of depression. In D. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual.* New York: Guilford Press.

Beck, J. G., Coffey, S. F., Foy, D. W., Keane, T. M., & Blanchard, E. B. (2009). Group cognitive behavior therapy for chronic posttraumatic stress disorder: An initial randomized pilot study. *Behavior Therapy, 40*(1), 82–92.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York: Guilford Press.

Belotto-Silva, C., Diniz, J. B., Malavazzi, D. M., Valério, C., Fossaluza, V., Borcato, S., et al. (2012). Group cognitive-behavioral therapy versus selective serotonin reuptake inhibitors for obsessive–compulsive disorder: A practical clinical trial. *Journal of Anxiety Disorders, 26*(1), 25–31.

Belzer, K. D., D'Zurilla, T. J., & Maydeu-Olivares, A. (2002). Social problem solving and trait anxiety as predictors of worry in a college student population. *Personality and Individual Differences, 33*(4), 573–585.

Bender, D. S., Morey, L. C., & Skodol, A. E. (2011). Toward a model for assessing level of personality functioning in DSM-5, part I: A review of theory and methods. *Journal of Personality Assessment, 93*(4), 332–346.

Berman, N. C., Schwartz, R., & Park, J. (2017). Psychological models and treatments of OCD for adults. In J. S. Abramowitz, D. McKay, & E. A. Storch (Eds.), *The Wiley handbook of obsessive compulsive disorders* (Vol. 1, pp. 361–376). Hoboken, NJ: Wiley.

Bernabei, L., Murtinu, C., & Chiaie, R. D. (2016). CBT-oriented group therapy for acute psychiatric inpatients: Effects on aggression and emotional regulation. *Funzione Gamma, 37*.

Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New directions in progressive relaxation training: A guidebook for helping professionals*. Westport, CT: Praeger.

Berridge, K. C., & Robinson, T. E. (2016). Liking, wanting, and the incentive-sensitization theory of addiction. *American Psychologist, 71*(8), 670–679.

Berry, J., Jacomb, I., Lunn, J., Sedwell, A., Shakeshaft, A., Kelly, P. J., et al. (2019). A stepped wedge cluster randomized trial of a cognitive remediation intervention in alcohol and other drug (AOD) residential treatment services. *BMC Psychiatry, 19,* 70.

Bieling, P. J., & Antony, M. M. (2003). *Ending the depression cycle: A step-by-step guide for preventing relapse*. Oakland, CA: New Harbinger.

Bieling, P. J., & MacQueen, G. M. (2004). Bipolar disorder and personality: Constructs, findings, and challenges. In M. Rosenbluth, S. H. Kennedy, & R. M. Bagby (Eds.), *Depression and personality: Conceptual and clinical challenges* (pp. 187–227). Washington, DC: American Psychiatric Press.

Bieling, P. J., Summerfeldt, L. J., Israeli, A. L., & Antony, M. M. (2004). Perfectionism as an explanatory construct in comorbidity of Axis I disorders. *Journal of Psychopathology and Behavioral Assessment, 26,* 193–201.

Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000). The power and omnipotence of voices: Subordination and entrapment by voices and significant others. *Psychological Medicine, 30,* 337–344.

Black, D. W., Blum, N., Pfohl, B., & Hale, N. (2004). Suicidal behavior in borderline personality disorder: Prevalence, risk factors, prediction, and prevention [Special Issue]. *Journal of Personality Disorders, 18*(3), 226–239.

Black, D. W., & Blum, N. S. (1992). Obsessive–compulsive disorder support groups: The Iowa model. *Comprehensive Psychiatry, 33,* 65–71.

Blakey, S. M., Reuman, L., Jacoby, R. J., & Abramowitz, J. S. (2017). Exposure therapy. In J. S. Abramowitz, D. McKay, & E. A. Storch (Eds.), *The Wiley handbook of obsessive compulsive disorders* (Vol. 1, pp. 565–580). Hoboken, NJ: Wiley.

Bloch, S., & Crouch, E. (1985). *Therapeutic factors in group psychotherapy.* New York: Oxford University Press.

Blom, R. M., Koeter, M., van den Brink, W., de Graaf, R., Ten Have, M., & Denys, D. (2011). Co-occurrence of obsessive–compulsive disorder and substance use disorder in the general population. *Addiction, 106*(12), 2178–2185.

Bohus, M., Kleindienst, N., Limberger, M. F., Stieglitz, R. D., Domsalla, M., Chapman, A. L., et al. (2009). The short version of the Borderline Symptom List (BSL-23): Development and initial data on psychometric properties. *Psychopathology, 42*(1), 32–39.

Bohus, M., Limberger, M. F., Frank, U., Chapman, A. L., Kühler, T., & Stieglitz, R. D. (2007). Psychometric properties of the borderline symptom list (BSL). *Psychopathology, 40*(2), 126–132.

Bonoldi, I., Simeone, E., Rocchetti, M., Codjoe, L., Rossi, G., Gambi, F., et al. (2013). Prevalence of self-reported childhood abuse in psychosis: A meta-analysis of retrospective studies. *Psychiatry Research, 30,* 8–15.

Borkovec, T. (1994). The nature, functions and origins of worry. In G. Davey & F. Tallis (Eds.), *Worrying: Perspectives on theory, assessment and treatment* (pp. 5–34). Chichester, UK: Wiley.

Borkovec, T. D., Alcaine, O., & Behar, E. (2004). Avoidance theory of worry and generalized anxiety disorder. In R. G. Heimberg, C. L. Turk, & D. S. Mennin (Eds.), *Generalized anxiety disorder: Advances in research and practice* (pp. 77–108). New York: Guilford Press.

Bouchard, S., Sabourin, S., Lussier, Y., & Villeneuve, E. (2009). Relationship quality and stability in couples when one partner suffers from borderline personality disorder. *Journal of Marital and Family Therapy, 35*(4), 446–455.

Bourque, P., & Ladouceur, R. (1980). An investigation of various performance-based treatments with agoraphobics. *Behaviour Research and Therapy, 18*(3), 161–170.

Bowers, L. (2005). Reasons for admission and their implications for the nature of acute inpatient psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing, 12*(2), 231–236.

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A., et al. (2005). The nature and purpose of acute psychiatric wards: The Tompkins Acute Ward Study. *Journal of Mental Health, 14*(6), 625–635.

Bowers, W. A. (1989). Cognitive therapy with inpatients. In A. Freeman, K. M. Simon, H. A. Arkowitz, & L. E. Beutler (Eds.), *Comprehensive handbook of cognitive therapy* (pp. 583–596). New York: Plenum Press.

Bowles, A. (2000). Therapeutic nursing care in acute psychiatric wards: Engagement over control. *Journal of Psychiatric and Mental Health Nursing (Commentary), 7*(2), 179–184.

Brach, T. (2013). *True refuge.* New York: Random House.

Bream, V., Challacombe, F., Palmer, A., & Salkovskis, P. (2017). *Cognitive behaviour therapy for OCD.* Oxford, UK: Oxford University Press.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68*(5), 748–766.

British Columbia Ministry of Health. (2013). *Trauma-Informed Practice Guide.* Available at *https://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf.*

Brown, J. S., Sellwood, K., Beecham, J. K., Slade, M., Andiappan, M., Landau, S., et al. (2011). Outcome, costs and patient engagement for group and individual CBT for depression: A naturalistic clinical study. *Behavioural and Cognitive Psychotherapy, 39*(3), 355.

Brown, T. A., Antony, M. M., & Barlow, D. H. (1995). Diagnostic comorbidity in panic disorder: Effect on treatment outcome and course of comorbid diagnoses following treatment. *Journal of Consulting and Clinical Psychology, 63,* 408–418.

Brown, T. A., & Barlow, D. H. (2009). A proposal for a dimensional classification system based on the shared features of the DSM-IV anxiety and mood disorders: Implications for assessment and treatment. *Psychological Assessment, 21*(3), 256–271.

Brown, T. A., & Barlow, D. H. (2014). *Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5): Adult version.* New York: Oxford University Press.

Bryant, R. A. (2016). *Acute stress disorder: What it is and how to treat it.* New York: Guilford Press.

Bullis, J. R., Sauer-Zavala, S., Bentley, K. H., Thompson-Hollands, J., Carl, J. R., & Barlow, D. H. (2015). The unified protocol for transdiagnostic treatment of emotional disorders: Preliminary exploration of effectiveness for group delivery. *Behavior Modification, 39,* 295–321.

Bulut, S., & Subasi, M. (2020). Group therapy in adults with obsessive–compulsive disorder: A review. *Open Journal of Medical Psychology, 9*(4), 150–159.

Burlingame, G. M., Fuhriman, A., & Johnson, J. E. (2002). Cohesion in group psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 71–87). New York: Oxford University Press.

Burlingame, G. M., MacKenzie, K. R., & Strauss, B. (2004). Small-group treatment: Evidence for effectiveness and mechanisms of change. In M. J. Lambert, A. E. Bergin, & S. L. Garfield (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 647–696). New York: Wiley.

Burlingame, G. M., McClendon, D. T., & Alonso, J. (2011). Cohesion in group therapy. *Psychotherapy, 48*(1), 34.

Burlingame, G. M., Strauss, B., & Joyce, A. S. (2013). Change mechanisms and effectiveness of small group treatments. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 640–689). Hoboken, NJ: Wiley.

Cahill, S. P., & Pontoski, K. (2005). Post-traumatic stress disorder and acute stress disorder I: Their nature and assessment considerations. *Psychiatry (Edgmont), 2*(4), 14–25.

Cammin-Nowak, S., Helbig-Lang, S., Lang, T., Gloster, A. T., Fehm, L., Gerlach, A. L., et al. (2013). Specificity of homework compliance effects on treatment

outcome in CBT: Evidence from a controlled trial on panic disorder and agoraphobia. *Journal of Clinical Psychology, 69*(6), 616–629.

Carleton, R. N. (2016). Into the unknown: A review and synthesis of contemporary models involving uncertainty. *Journal of Anxiety Disorders, 39,* 30–43.

Carleton, R. N., Norton, M. P. J., & Asmundson, G. J. (2007). Fearing the unknown: A short version of the Intolerance of Uncertainty Scale. *Journal of Anxiety Disorders, 21*(1), 105–117.

Carpenter, J. K., Andrews, L. A., Witcraft, S. M., Powers, M. B., Smits, J. A., & Hofmann, S. G. (2018). Cognitive behavioral therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials. *Depression and Anxiety, 35*(6), 502–514.

Carroll, K. M., Ball, S. A., Martino, S., Nich, C., Babuscio, T. A., Nuro, K. F., et al. (2008). Computer-assisted delivery of cognitive-behavioral therapy for addiction: A randomized trial of CBT4CBT. *American Journal of Psychiatry, 165,* 881–888.

Carroll, K. M., & Kiluk, B. D. (2017). Cognitive behavioral interventions for alcohol and drug use disorders: Through the stage model and back again. *Psychology of Addictive Behaviors, 31,* 847–861.

Carter, F. A., McIntosh, V. V. W., Joyce, P. R., Sullivan, P. F., & Bulik, C. M. (2003). Role of exposure with response prevention in cognitive-behavioral therapy for bulimia nervosa: Three year follow up results. *International Journal of Eating Disorders, 33,* 127–135.

Cartwright-Hatton, S., & Wells, A. (1997). Beliefs about worry and intrusions: The Meta-Cognitions Questionnaire and its correlates. *Journal of Anxiety Disorders, 11*(3), 279–296.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment: Group therapy. Treatment improvement protocol (TIP) Series 41* (DHHS Publication No. SMA 05-3991). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Chakrabarti, S. (2016). Treatment-adherence in bipolar disorder: A patient-centred approach. *World Journal of Psychiatry, 6*(4), 399–409.

Chambless, D. L., Caputo, G. C., Bright, P., & Gallagher, R. (1984). Assessment of fear of fear in agoraphobics: The Body Sensations Questionnaire and the Agoraphobic Cognitions Questionnaire. *Journal of Consulting and Clinical Psychology, 52,* 1090–1097.

Chambless, D. L., Caputo, G. C., Jasin, S. E., Gracely, E. J., & Williams, C. (1985). The Mobility Inventory for Agoraphobia. *Behaviour Research and Therapy, 23*(1), 35–44.

Chang, G., Raffi, E., Tang, M., Fernando, G. I., Zucker, J., & Schein, A. Z. (2016). High utilization of inpatient detoxification: Predictors among US veterans. *American Journal of Drug and Alcohol Abuse, 42,* 279–286.

Channon, S., de Silva, P., Hemsley, D., & Perkins, R. E. (1989). A controlled trial of cognitive-behavioural and behavioural treatment of anorexia nervosa. *Behaviour Research and Therapy, 27,* 529–535.

Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73*(5), 965–971.

Charpentier, P., Marttunen, M., Fadjukov, S., & Huttunen, A. (2003). CBT for

adolescent eating disorder patients: Literature review and a report of an open trial of group CBT for adolescent outpatients with eating disorder. In J. Lönnqvist, M. Heikkinen, M. Marttunen, & T. Partonen (Eds.), *Psychiatria Fennica, 2003* (Vol. 34, pp. 80–98). Helsinki, Finland: Psychiatria Fennica Oy.

Chen, E., Touyz, S. W., Beumont, P. J. V., Fairburn, C. G., Griffiths, R., Butow, P., et al. (2003). Comparison of group and individual cognitive-behavioral therapy for patients with bulimia nervosa. *International Journal of Eating Disorders, 33,* 241–254.

Cheng, Q., Li, H., Silenzio, V., & Caine, E. D. (2014). Suicide contagion: A systematic review of definitions and research utility. *PloS One, 9*(9), e108724.

Chevalier, A., Ntala, E., Fung, C., Priebe, S., & Bird, V. J. (2018). Exploring the initial experience of hospitalisation to an acute psychiatric ward. *PLoS One, 13*(9), e0203457.

Chiang, K. J., Tsai, J. C., Liu, D., Lin, C. H., Chiu, H. L., & Chou, K. R. (2017). Efficacy of cognitive-behavioral therapy in patients with bipolar disorder: A meta-analysis of randomized controlled trials. *PloS one, 12*(5), e0176849.

Chirită, V., Ilinca, M., Chiriță, R., Bîşcă, M., & Chele, G. (2006). Virtual therapy in patients with depression: Preliminary observation. *Annual Review of Cyber Therapy and Telemedicine, 4,* 181–185.

Cialdini, R. B., Vincent, J. E., Lewis, S. K., Catalan, J., Wheeler, D., & Darby, B. L. (1975). Reciprocal concessions procedure for inducing compliance: The door-in-the-face technique. *Journal of Personality and Social Psychology, 31*(2), 206–215.

Ciraulo, D. A., Barlow, D. H., Gulliver, S. B., Farchione, T., Morissette, S. B., Kamholz, B. W., et al. (2013). The effects of venlafaxine and cognitive behavioral therapy alone and combined in the treatment of co-morbid alcohol use-anxiety disorders. *Behaviour Research and Therapy, 51,* 729–735.

Clark, D. A. (2020). *Cognitive-behavioral therapy for OCD and its subtypes* (2nd ed.). New York: Guilford Press.

Clark, D. A., Beck, A. T., & Alford, B. A. (1999). *Scientific foundations of cognitive theory and therapy of depression*. New York: Wiley.

Clark, D. M. (1986). A cognitive approach to panic. *Behaviour Research and Therapy, 24*(4), 461–470.

Clark, D. M. (2001). A cognitive perspective on social phobia. In W. R. Crozier & L. E. Alden (Eds.), *International handbook of social anxiety: Concepts, research and interventions relating to the self and shyness* (pp. 405–430). Hoboken, NJ: Wiley.

Clark, D. M., & Salkovskis, P. M. (2009). *Panic disorder: Manual for improving access to psychological therapy (IAPT) high-intensity CBT therapists*. Oxford, UK: Author.

Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In R. G. Heimberg, M. R. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: Diagnosis, assessment, and treatment* (pp. 69–93). New York: Guilford Press.

Clarke, I., & Wilson, H. (2009). *Cognitive behavior therapy for acute inpatient mental health units: Working with clients, staff and the milieu*. New York: Routledge.

Clausen, L., Rosenvinge, J. H., Friborg, O., & Rokkedal, K. (2011). Validating the

Eating Disorder Inventory–3 (EDI-3): A comparison between 561 female eating disorders patients and 878 females from the general population. *Journal of Psychopathology and Behavioral Assessment, 33,* 101–110.

Cloitre, M., Cancienne, J., Heimberg, R. G., Holt, C. S., & Liebowitz, M. (1995). Memory bias does not generalize across anxiety disorders. *Behaviour Research and Therapy, 33,* 305–307.

Cloitre, M., Courtois, C., Ford, J., Green, B., Alexander, P., Briere, J., et al. (2012). The ISTSS expert consensus treatment guidelines for complex PTSD. Available at *www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf*

Colón, Y., & Friedman, B. (2003). Conducting group therapy online. In S. Goss & K. Anthony (Eds.), *Technology in counselling and psychotherapy: A practitioner's guide* (pp. 59–74). London: Palgrave.

Conklin, C. A., & Tiffany, S. T. (2002). Applying extinction research and theory to cue-exposure addiction treatments. *Addiction, 97,* 155–167.

Conklin, L. R., & Boettcher, H. (2017). Transdiagnostic treatment for anxiety disorders. In S. G. Hofmann & G. J. G. Asmundson (Eds.), *The science of cognitive behavioral therapy* (pp. 359–380). New York: Academic Press.

Connor, K. M., Davidson, J. R. T., Churchill, L. E., Sherwood, A., Foa, E., & Wesler, R. H. (2000). Psychometric properties of the Social Phobia Inventory (SPIN). *British Journal of Psychiatry, 176*(4), 379–386.

Cook, S., Heather, N., McCambridge, J., & United Kingdom Alcohol Treatment Trial Research Team. (2015). The role of the working alliance in treatment of alcohol problems. *Psychology of Addictive Behaviors, 29,* 371–381.

Cooper, Z., & Fairburn, C. (1987). The Eating Disorder Examination: A semi-structured interview for the assessment of the specific psychopathology of eating disorders. *International Journal of Eating Disorders, 6,* 1–8.

Cordioli, A. V., Heldt, E., Bochi, D. B., Margis, R., de Sousa, M. B., Tonello, J. F., et al. (2002). Cognitive-behavioral group therapy in obsessive–compulsive disorder: A clinical trial. *Revista Brasileira de Psiquiatria, 24,* 113–120.

Cordioli, A. V., Heldt, E., Bochi, D. B., Margis, R., de Sousa, M. B., Tonello, J. F., et al. (2003). Cognitive-behavioral group therapy in obsessive–compulsive disorder: A randomized clinical trial. *Psychotherapy and Psychosomatics, 72,* 211–216.

Corrigan, P. W., Salzer, M., Ralph, R. O., Sangster, Y., & Keck, L. (2004). Examining the factor structure of the Recovery Assessment Scale. *Schizophrenia Bulletin, 30*(4), 1035–1041.

Cougle, J. R., & Lee, H. J. (2014). Pathological and non-pathological features of obsessive–compulsive disorder: Revisiting basic assumptions of cognitive models. *Journal of Obsessive–Compulsive and Related Disorders, 3*(1), 12–20.

Covin, R., Ouimet, A. J., Seeds, P. M., & Dozois, D. J. (2008). A meta-analysis of CBT for pathological worry among clients with GAD. *Journal of Anxiety Disorders, 22*(1), 108–116.

Cox, D., & D'Oyley, H. (2011). Cognitive-behavioral therapy with older adults. *British Columbia Medical Journal, 53*(7), 348–352.

Craske, M. G., & Barlow, D. H. (2022). *Mastery of your anxiety and panic: Therapist guide* (5th ed.). New York: Oxford University Press.

Craske, M. G., Farchione, T. J., Allen, L. B., Barrios, V., Stoyanova, M., & Rose, R. (2007). Cognitive behavioral therapy for panic disorder and comorbidity: More of the same or less of more? *Behaviour Research and Therapy, 45*(6), 1095–1109.

Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy, 46*(1), 5–27.

Craske, M. G., Street, L., & Barlow, D. H. (1989). Instructions to focus upon or distract from internal cues during exposure treatment of agoraphobic avoidance. *Behaviour Research and Therapy, 27*(6), 663–672.

Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T., & Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. *Behaviour Research and Therapy, 58*, 10–23.

Creed, A., Frankel, S. A., German, R. E., Green, K. L., Jager-Hyman, S., Taylor, K. P., et al. (2016). Implementation of transdiagnostic cognitive therapy in community behavioral health: The Beck Community Initiative. *Journal of Consulting and Clinical Psychology, 84*, 1116–1126.

Crits-Christoph, P., Siqueland, L., Blaine, J., Frank, A., Luborsky, L., Onken, L. S., et al. (1999). Psychosocial treatments for cocaine dependence: National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Archives of General Psychiatry, 56*(6), 493–502.

Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). A biosocial developmental model of borderline personality: Elaborating and extending Linehan's theory. *Psychological Bulletin, 135*(3), 495–510.

Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *The Canadian Journal of Psychiatry, 58*(7), 376–385.

Cuijpers, P., Cristea, I. A., Karyotaki, E., Reijnders, M., & Huibers, M. J. (2016). How effective are cognitive behavior therapies for major depression and anxiety disorders? A meta-analytic update of the evidence. *World Psychiatry, 15*(3), 245–258.

Cuijpers, P., van Straten, A., & Warmerdam, L. (2008). Are individual and group treatments equally effective in the treatment of depression in adults?: A meta-analysis. *The European Journal of Psychiatry, 22*(1), 38–51.

Cuthbert, B. N., & Insel, T. R. (2013). Toward the future of psychiatric diagnosis: The seven pillars of RDoC. *BMC Medicine, 11*(1), 126.

Cutrona, C. E., & Russel, D. W. (1987). The provisions of social support and adaptation to stress. *Advance in Personal Relationships, 1*, 37–67.

Davey, G. C. (1994). Worrying, social problem-solving abilities, and social problem-solving confidence. *Behaviour Research and Therapy, 32*(3), 327–330.

Davila, J., Hammen, C., Burge, D., Paley, B., & Daley, S. E. (1995). Poor interpersonal problem solving as a mechanism of stress generation in depression among adolescent women. *Journal of Abnormal Psychology, 104*(4), 592–600.

Deacon, B., Lickel, J., & Abramowitz, J. S. (2008). Medical utilization across the anxiety disorders. *Journal of Anxiety Disorders, 22*(2), 344–350.

de Jong, M., Schoorl, M., & Hoek, H. W. (2018). Enhanced cognitive behavioural therapy for patients with eating disorders: A systematic review. *Current Opinion in Psychiatry, 31*, 436–444.

de Jong, P. J. (2014). Information processing. In P. Emmelkamp & T. Ehring (Eds.), *The Wiley handbook of anxiety disorders* (pp. 125–147). Malden, MA: Wiley Blackwell.

de Jongh, A., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., et al. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety, 33*(5), 359–369.

Derogatis, L. R. (1993). *BSI Brief Symptom Inventory: Administration, scoring, and procedures manual* (4th ed.). Minneapolis, MN: National Computer Systems.

DeRubeis, R. J., Siegle, G. J., & Hollon, S. D. (2008). Cognitive therapy versus medication for depression: Treatment outcomes and neural mechanisms. *Nature Reviews Neuroscience, 9*(10), 788–796.

Disner, S. G., Beevers, C. G., Haigh, E. A., & Beck, A. T. (2011). Neural mechanisms of the cognitive model of depression. *Nature Reviews Neuroscience, 12*(8), 467–477.

Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., et al. (2010). The 2009 Schizophrenia PORT Psychosocial Treatment Recommendations and Summary Statements. *Schizophrenia Bulletin, 36*(1), 48–70.

Dolan, S. L., Rohsenow, D. J., Martin, R. A., & Monti, P. M. (2013). Urge-specific and lifestyle coping strategies of alcoholics: Relationships of specific strategies to treatment outcome. *Drug and Alcohol Dependence, 128,* 8–14.

Dominguez-Salas, S., Diaz-Batanero, C., Martin Lozano-Rojas, O. M., & Verdejo-Garcia, A. (2016). Impact of general cognition and executive function deficits on addiction treatment outcomes: Systematic review and discussion of neurocognitive pathways. *Neuroscience and Biobehavioral Reviews, 71,* 772–801.

Dougherty, D. D., Rauch, S. L., & Jenike, M. A. (2012). Pharmacological treatments for obsessive–compulsive disorder. In G. Steketee (Ed.), *The Oxford handbook of obsessive compulsive and spectrum disorders* (pp. 291–306). Oxford, UK: Oxford University Press.

Drummond, D. C., & Glautier, S. (1994). A controlled trial of cue exposure treatment in alcohol dependence. *Journal of Consulting and Clinical Psychology, 62,* 809–817.

Dugas, M. J., Gagnon, F., Ladouceur, R., & Freeston, M. H. (1998). Generalized anxiety disorder: A preliminary test of a conceptual model. *Behaviour Research and Therapy, 36*(2), 215–226.

Dugas, M. J., Ladouceur, R., Léger, E., Freeston, M. H., Langolis, F., Provencher, M. D., et al. (2003). Group cognitive-behavioral therapy for generalized anxiety disorder: Treatment outcome and long-term follow-up. *Journal of Consulting and Clinical Psychology, 71*(4), 821–825.

Dunmore, E., Clark, D. M., & Ehlers, A. (2001). A prospective investigation of the role of cognitive factors in persistent posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy, 39*(9), 1063–1084.

Durrant, C., Clarke, I., Tolland, A., & Wilson, H. (2007). Designing a CBT service for an acute inpatient setting: A pilot evaluation study. *Clinical Psychology and Psychotherapy, 14*(2), 117–125.

D'Zurilla, T. J,., & Goldfried, M. R. (1971). Problem-solving and behavior modification. *Journal of Abnormal Psychology, 78,* 107–126.

D'Zurilla, T. J., & Nezu, A. M. (2006). *Problem-solving therapy: A positive approach to clinical intervention* (3rd ed.). New York: Springer.

Ebner-Priemer, U. W., Kuo, J., Welch, S. S., Thielgen, T., Witte, S., Bohus, M., et al. (2006). A valence-dependent group-specific recall bias of retrospective self-reports: A study of borderline personality disorder in everyday life. *Journal of Nervous and Mental Disease, 194*(10), 774–779.

Eddy, K. T., Dutra, L., Bradley, R., & Westen, D. (2004). A multidimensional meta-analysis of psychotherapy and pharmacotherapy for obsessive–compulsive disorder. *Clinical Psychology Review, 24,* 1011–1030.

Edwards, J. R., & Baglioni, A. J. (1993). The measurement of coping with stress: Construct validity of the Ways of Coping Checklist and the Cybernetic Coping Scale. *Work and Stress, 7,* 17–31.

Ehlers, A. (2013). Trauma-focused cognitive behavior therapy for posttraumatic stress disorder and acute stress disorder. In G. Simos & S. G. Hofmann (Eds.), *CBT for anxiety disorders: A practitioner book* (pp. 161–189). Oxford, UK: Wiley Blackwell.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder: Theory and therapy. *Behaviour Research and Therapy, 38,* 319–345.

Ehring, T. (2014). Cognitive theory. In P. Emmelkamp & T. Ehring (Eds.), *The Wiley handbook of anxiety disorders* (pp. 104–124). Malden, MA: Wiley Blackwell.

Ehring, T., & Watkins, E. R. (2008). Repetitive negative thinking as a transdiagnostic process. *International Journal of Cognitive Therapy, 1*(3), 192–205.

Einstein, D. A., & Menzies, R. G. (2004). The presence of magical thinking in obsessive compulsive disorder. *Behaviour Research and Therapy, 42, 539–549.*

El-Gabalawy, R., Katz, L. Y., & Sareen, J. (2010). Comorbidity and associated severity of borderline personality disorder and physical health conditions in a nationally representative sample. *Psychosomatic Medicine, 72*(7), 641–647.

Ellard, K. K., Fairholme, C. P., Boisseau, C. L., Farchione, T. J., & Barlow, D. H. (2010). Unified protocol for the transdiagnostic treatment of emotional disorders: Protocol development and initial outcome data. *Cognitive and Behavioral Practice, 17*(1), 88–101.

Emmelkamp, P. M., & Wessels, H. (1975). Flooding in imagination vs flooding in vivo: A comparison with agoraphobics. *Behaviour Research and Therapy, 13*(1), 7–15.

Enright, A. B., Butterfield, P., & Berkowitz, B. (1985). Self-help and support groups in the management of eating disorders. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 491–512). New York: Guilford Press.

Epstein, E. E., McCrady, B. S., Hallgren, K. A., Gaba, A., Cook, S., Jensen, N., et al. (2018). Individual versus group female-specific cognitive behavior therapy for alcohol use disorder. *Journal of Substance Abuse Treatment, 88,* 27–43.

Erwin, B. A., Heimberg, R. G., Juster, H., & Mindlin, M. (2002). Comorbid anxiety and mood disorders among persons with social anxiety disorder. *Behaviour Research and Therapy, 40,* 19–35.

Everaerd, W. T., Rijken, H. M., & Emmelkamp, P. M. (1973). A comparison of "flooding" and "successive approximation" in the treatment of agoraphobia. *Behaviour Research and Therapy, 11*(1), 105–117.

Fairburn, C. G. (1981). A cognitive behavioural approach to the management of bulimia. *Psychological Medicine, 11,* 707–711.

Fairburn, C. G. (1985). Cognitive-behavioral treatment for bulimia. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 160–192). New York: Guilford Press.

Fairburn, C. G., Baily-Straebler, S., Basden, S., Doll, H. A., Jones, R., Murphy, R., et al. (2015). A transdiagnostic comparison of enhanced cognitive behavior therapy (CBT-E) and interpersonal psychotherapy in the treatment of eating disorders. *Behaviour Research and Therapy, 70,* 64–71.

Fairburn, C. G., & Beglin, S. J. (1994). Assessment of eating disorders: Interview or self-report questionnaire? *International Journal of Eating Disorders, 16,* 363–370.

Fairburn, C. G., & Cooper, P. J. (1993). The Eating Disorder Examination. In C. G. Fairburn & G. T. Wilson (Eds.), *Binge eating: Nature, assessment, and treatment* (pp. 317–360). New York: Guilford Press.

Fairburn, C. G., Cooper, Z., Doll, H. A., O'Connor, M. E., Bohn, K., Hawker, D. M., et al. (2009). Transdiagnostic cognitive-behavioural therapy for patients with eating disorders: A two-site trial with 60-week follow up. *American Journal of Psychiatry, 166,* 311–319.

Fairburn, C. G., Cooper, Z., Doll, H. A., O'Connor, M. E., Palmer, R. L., & Dale Grave, R. (2013). Enhanced cognitive behaviour therapy for adults with anorexia nervosa: A UK–Italy study. *Behaviour Research and Therapy, 51,* R2–R8.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic theory" and treatment. *Behaviour Research and Therapy, 41,* 509–528.

Fairburn, C. G., Marcus, M. D., & Wilson, G. T. (1993). Cognitive-behavioral therapy for binge eating and bulimia nervosa: A comprehensive treatment manual. In C. G. Fairburn & G. T. Wilson (Eds.), *Binge eating: Nature, assessment, and treatment* (pp. 361–405). New York: Guilford Press.

Fairburn, C. G., Shafran, R., & Cooper, Z. (1999). A cognitive behavioural theory of anorexia nervosa. *Behaviour Research and Therapy, 37,* 1–13.

Fals-Stewart, W., Marks, A. P., & Schafer, J. (1993). A comparison of behavioral group therapy and individual behavior therapy in treating obsessive–compulsive disorder. *Journal of Nervous and Mental Disease, 181,* 189–193.

Farabaugh, A., Mischoulon, D., Fava, M., Guyker, W., & Alpert, J. (2004). The overlap between personality disorders and major depressive disorder (MDD). *Annals of Clinical Psychiatry, 16*(4), 217–224.

Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Thompson-Hollands, J., Carl, J. R., et al. (2012). Unified protocol for transdiagnostic treatment of emotional disorders: A randomized controlled trial. *Behavior Therapy, 43*(3), 666–678.

Fava, M., Farabaugh, A. H., Sickinger, A. H., Wright, E., Alpert, J. E., Sonawalla, S., et al. (2002). Personality disorders and depression. *Psychological Medicine, 32*(6), 1049–1057.

Fenster, J. (2006). Characteristics of clinicians likely to refer clients to 12-step programs versus a diversity of post-treatment options. *Drug and Alcohol Dependence, 83*(3), 238–246.

Ferrari, A. J., Charlson, F. J., Norman, R. E., Patten, S. B., Freedman, G., Murray,

C. J., et al. (2013). Burden of depressive disorders by country, sex, age, and year: Findings from the global burden of disease study 2010. *PLoS medicine, 10*(11), e1001547.

Fiegenbaum, W. (1988). Long-term efficacy of ungraded versus graded massed exposure in agoraphobics. In I. Hand & H.-U. Wittchen (Eds.), *Panic and phobias 2: Treatments and variables affecting course and outcome* (2nd ed., pp. 83–88). Berlin, Germany: Springer-Verlag.

Fineberg, N. A., Reghunandanan, S., Brown, A., & Pampaloni, I. (2013). Pharmacotherapy of obsessive–compulsive disorder: Evidence-based treatment and beyond. *Australian and New Zealand Journal of Psychiatry, 47*(2), 121–141.

First, M. B., Williams, J. B. W., Benjamin, L. S., & Spitzer, R. L. (2015). *Structured Clinical Interview for DSM-5 Personality Disorder (SCID-PD).* Washington, DC: American Psychiatric Association.

First, M. B., Williams, J. B. W., Karg, R. S., & Spitzer, R. L. (2015). *Structured Clinical Interview for the DSM-5 (SCID-5).* Washington, DC: American Psychiatric Association.

Fleming, A. P., McMahon, R. J., Moran, L. R., Peterson, A. P., & Dreessen, A. (2015). Pilot randomized controlled trial of dialectical behavior therapy group skills training for ADHD among college students. *Journal of Attention Disorders, 19*(3), 260–271.

Foa, E. B., Blau, J. S., Prout, M., & Latimer, P. (1977). Is horror a necessary component of flooding (implosion)? *Behaviour Research and Therapy, 15,* 397–402.

Foa, E. B., & Cahill, S. P. (2001). Psychological therapies: Emotional processing. In N. J. Smelser & P. B. Bates (Eds.), *International encyclopedia of social and behavioral sciences* (pp. 12363–12369). Oxford, UK: Elsevier.

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and validation. *Psychological Assessment, 11*(3), 303–314.

Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A. M., Riggs, D. S., Feeny, N. C., et al. (2005). Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology, 73*(5), 953–964.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences: Therapist guide.* New York: Oxford University Press.

Foa, E. B., Hembree, E. A., Rothbaum, B. O., & Rauch, S. A. M. (2019). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences (therapist guide).* New York: Oxford University Press.

Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., et al. (2002). The Obsessive–Compulsive Inventory: Development and validation of a short version. *Psychological Assessment, 14*(4), 485–495.

Foa, E. B., Jameson, J. S., Turner, R. M., & Payne, L. L. (1980). Massed versus spaced exposure sessions in the treatment of agoraphobia. *Behaviour Research and Therapy, 18,* 333–338.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*(1), 20–35.

Foa, E. B., & Kozak, M. J. (1996). Psychological treatment for obsessive–compulsive

disorder. In M. R. Mavissakalian & R. F. Prien (Eds.), *Long-term treatment of anxiety disorders* (pp. 285–309). Washington, DC: American Psychiatric Press.

Foa, E. B., Mathews, A., Abramowitz, J. S., Amir, N., Przeworski, A., Riggs, D. S., et al. (2003). Do patients with obsessive–compulsive disorder have deficits in decision-making? *Cognitive Therapy and Research, 27*(4), 431–445.

Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualizations of post-traumatic stress disorder. *Behavior Therapy, 20*(2), 155–176.

Foa, E. B., & Wilson, R. (2001). *Stop obsessing! How to overcome your obsessions and compulsions* (Rev. ed.). New York: Bantam Books.

Foa, E. B., Yadin, E., & Lichner, T. K. (2012). *Exposure and response (ritual) prevention for obsessive–compulsive disorder: Therapist guide* (2nd ed.). Oxford, UK: Oxford University Press.

Forbes, C. N., Tull, M. T., Richmond, J. R., Chapman, A. L., Dixon-Gordon, K. L., & Gratz, K. L. (2019). Motives for nonsuicidal self-injury in individuals with lifetime depressive disorders and posttraumatic stress disorder. *Journal of Psychopathology and Behavioral Assessment, 41*(4), 652–661.

Forbush, K. T., Hilderbrand, L. A., Bohrer, B. K., & Chapa, D. A. N. (2019). Test–retest reliability for common measures of eating disorder symptoms in men versus women. *Assessment, 26,* 419–431.

Forbush, K. T., Wildes, J. E., Pollack, L. O., Dunbar, D., Luo, J., Patterson, K., et al. (2013). Development and validation of the Eating Pathology Symptoms Inventory (EPSI). *Psychological Assessment, 25,* 859–878.

Freedman, J. L., & Fraser, S. C. (1966). Compliance without pressure: The foot-in-the-door technique. *Journal of Personality and Social Psychology, 4*(2), 195–202.

Freeston, M. H., Rhéaume, J., Letarte, H., Dugas, M. J., & Ladouceur, R. (1994). Why do people worry? *Personality and Individual Differences, 17*(6), 791–802.

Friedman, M. J., Keane, T. M., & Resick, P. A. (2014). *Handbook of PTSD: Science and practice* (2nd ed.). New York: Guilford Press.

Frommer, M. S., Ames, J. R., Gibson, J. W., & Davis, W. N. (1987). Patterns of symptom change in the short-term group treatment of bulimia. *International Journal of Eating Disorders, 6,* 469–476.

Frostad, S., Danielsen, Y. S., Rekkedal, G. A., Jevne, C., Grave, R. S., Rø, Ø., et al. (2018). Implementation of enhanced cognitive behavior therapy (CBT-E) for adults with anorexia nervosa in an outpatient eating-disorder unit at a public hospital. *Journal of Eating Disorders, 6,* 12.

Fruzzetti, A. E., Shenk, C., & Hoffman, P. D. (2005). Family interaction and the development of borderline personality disorder: A transactional model. *Developmental Psychopathology, 17*(4), 1007–1030.

Galovski, T. E., Blain, L. M., Mott, J. M., Elwood, L., & Houle, T. (2012). Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. *Journal of Consulting and Clinical Psychology, 80*(6), 968–981.

Galsworthy-Francis, L., & Allan, S. (2014). Cognitive behavioural therapy for anorexia nervosa: A systematic review. *Clinical Psychology Review, 34,* 54–72.

Garety, P. A., Hemsley, D. R., & Wessely, S. (1991). Reasoning in deluded

schizophrenic and paranoid patients. *Journal of Nervous and Mental Disease, 179,* 194–201.

Garner, D. M. (1991). *Eating Disorder Inventory–2 manual.* Odessa, FL: Psychological Assessment Resources.

Garner, D. M. (1997). Psychoeducational principles in treatment. In P. E. Garfinkel & D. M. Garner (Eds.), *Handbook of treatment for eating disorders* (2nd ed., pp. 145–177). New York: Guilford Press.

Garner, D. M. (2005). *Eating Disorder Inventory–3 manual.* Odessa, FL: Psychological Assessment Resources.

Garner, D. M., & Bemis, K. M. (1982). A cognitive-behavioral approach to anorexia nervosa. *Cognitive Therapy and Research, 6,* 123–150.

Garner, D. M., & Bemis, K. M. (1985). Cognitive therapy for anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (pp. 107–146). New York: Guilford Press.

Garner, D. M., Fairburn, C. G., & Davis, R. (1987). Cognitive-behavioral treatment of bulimia nervosa. *Behavior Modification, 11,* 398–431.

Garner, D. M., & Garfinkel, P. E. (1979). The Eating Attitudes Test: An index of the symptoms of anorexia nervosa. *Psychological Medicine, 9,* 273–279.

Garner, D. M., Olmsted, M. P., & Polivy, J. (1983). Development and validation of a multidimensional Eating Disorder Inventory for anorexia nervosa and bulimia. *International Journal of Eating Disorders, 2,* 15–34.

Garner, D. M., Vitousek, K. M., & Pike, K. M. (1997). Cognitive-behavioral therapy for anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (2nd ed., pp. 94–144). New York: Guilford Press.

Gaume, J., Longabaugh, R., Magill, M., Bertholet, N., Gmel, G., & Daeppen, J. B. (2016). Under what conditions? Therapist and client characteristics moderate the role of change talk in brief motivational intervention. *Journal of Consulting and Clinical Psychology, 84,* 211–220.

Gehrman, P., Shah, M., Miles, A., Kuna, S., & Godleski, L. (2016). Feasibility of group cognitive-behavioral treatment of insomnia delivered by clinical video telehealth. *Telemedicine and e-Health, 22,* 1041–1046.

Gentes, E. L., & Ruscio, A. M. (2011). A meta-analysis of the relation of intolerance of uncertainty to symptoms of generalized anxiety disorder, major depressive disorder, and obsessive–compulsive disorder. *Clinical Psychology Review, 31*(6), 923–933.

Germer, C., Siegel, R. D., & Fulton, P. R. (2016). *Mindfulness and psychotherapy* (2nd ed.). New York: Guilford Press.

Gershon, A., Johnson, S. L., & Miller, I. (2013). Chronic stressors and trauma: prospective influences on the course of bipolar disorder. *Psychological Medicine, 43*(12), 2583–2592.

Ghahramanlou-Holloway, M., Cox, D. W., & Greene, F. N. (2012). Post-admission cognitive therapy: A brief intervention for psychiatric inpatients admitted after a suicide attempt. *Cognitive and Behavioral Practice, 19*(2), 233–244.

Ghiță, A., & Gutiérrez-Maldonado, J. (2018). Applications of virtual reality in individuals with alcohol misuse: A systematic review. *Addictive Behaviors, 81,* 1–11.

Gilbert, P. (2010). An introduction to compassion focused therapy in cognitive behavior therapy. *International Journal of Cognitive Therapy, 3*(2), 97–112.

Goldberg, S. B., Tucker, R. P., Greene, P. A., Davidson, R. J., Wampold, B. E., Kearney, D. J., et al. (2018). Mindfulness-based interventions for psychiatric disorders: A systematic review and meta-analysis. *Clinical Psychology Review, 59,* 52–60.

Goodman, W. K., Rasmussen, S. A., Price, L. H., & Storch, E. A. (2006). *Yale–Brown Obsessive–Compulsive Scale—second edition.* Unpublished manuscript.

Gorin, A. A., Le Grange, D., & Stone, A. A. (2003). Effectiveness of spouse involvement in cognitive behavioral treatment for binge eating disorder. *International Journal of Eating Disorders, 33,* 421–433.

Gorrell, S., & Murray, S. B. (2019). Eating disorders in males. *Child and Adolescent Psychiatric Clinics of North America, 28,* 641–651.

Gosselin, P., Ladouceur, R., Langlois, F., Freeston, M. H., Dugas, M. J., & Bertrand, J. (2003). Développement et validation d'un nouvel instrument évaluant les croyances erronées à l'égard des inquiétudes [Development and validation of a new measure evaluating false beliefs about worry]. *European Review of Applied Psychology, 53,* 199–211.

Gosselin, P., Langlois, F., Freeston, M. H., Ladouceur, R., Dugas, M. J., & Pelletier, O. (2002). Le Questionnaire d'évitement cognitive (QEC): Développement et validation auprès d'adultes et d'adolescents [The Cognitive Avoidance Questionnaire (CAQ): Development and validation among adult and adolescent samples]. *Journal de Thérapie Comportementale et Cognitive, 12,* 24–37.

Grancini, B., Craig, K. J., Cinosi, E., Shodunke, A., Reid, J., Marinova, Z., et al. (2020). Pharmacotherapy for OCD. In N. M. Simon, E. Hollander, B. O. Rothbaum, & D. J. Stein (Eds.), *Textbook of anxiety, trauma, and OCD-related disorders* (3rd ed., pp. 285–314). Washington, DC: American Psychiatric Association.

Grande, I., Berk, M., Birmaher, B., & Vieta, E. (2016). Bipolar disorder. *Lancet, 387*(10027), 1561–1572.

Granholm, E., McQuaid, J. R., McClure, F. S., Auslander, L. A., Perivoliotis, D., Pedrelli, P., et al. (2005). A randomized, controlled trial of cognitive behavioral social skills training for middle-aged and older outpatients with chronic schizophrenia. *American Journal of Psychiatry, 162,* 520–529.

Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., et al. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 69*(4), 533–545.

Grant, B. F., Saha, T. D., Ruan, W. J., Goldstein, R. R., Chou, S. P., Jung, J., et al. (2016). Epidemiology of DSM-5 drug use disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions–III. *JAMA Psychiatry, 73*(1), 39–47.

Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, P., Dufour, M. C., Compton, W., et al. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. *Archives of General Psychiatry, 61,* 807–816.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation

of the difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26*(1), 41–54.

Greenberg, P. E., Sisitsky, T., Kessler, R. C., Finkelstein, S. N., Berndt, E. R., Davidson, J. R. T., et al. (1999). The economic burden of anxiety disorders in the 1990s. *Journal of Clinical Psychiatry, 60*(7), 427–435.

Greenberger, D., & Padesky, C. A. (2016). *Mind over mood: Change how you feel by changing the way you think* (2nd ed.). New York: Guilford Press.

Greeson, J., Garland, E. L., & Black, D. (2014). Mindfulness: A transtherapeutic approach for transdiagnostic mental processes. In A. Ie, C. T. Ngnoumen, & E. Langer (Eds.), *The Wiley Blackwell handbook of mindfulness* (Vol. 1, pp. 533–562). West Sussex, UK: Wiley.

Gregg, L., Barrowclough, C., & Haddock, G. (2007). Reasons for increased substance use in psychosis. *Clinical Psychology Review, 27,* 494–510.

Grenon, R., Schwartze, D., Hammond, N., Ivanova, I., Mcquaid, N., Proulx, G., et al. (2017). Group psychotherapy for eating disorders: A meta-analysis. *International Journal of Eating Disorders, 50,* 997–1013.

Grilo, S., & Mitchell, J. E. (2010). *The treatment of eating disorders: Clinical handbook*. New York: Guilford Press.

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*(3), 271–299.

Gunther, L. M., Denniston, J. C., & Miller, R. R. (1998). Conducting exposure treatment in multiple contexts can prevent relapse. *Behaviour Research and Therapy, 36*(1), 75–91.

Gutner, C. A., Rizvi, S. L., Monson, C. M., & Resick, P. A. (2006). Changes in coping strategies, relationship to the perpetrator, and posttraumatic distress in female crime victims. *Journal of Traumatic Stress, 19*(6), 813–823.

Haddock, G., McCarron, J., Tarrier, N., & Faragher, E. B. (1999). Scales to measure dimensions of hallucinations and delusions: The Psychotic Symptom Rating Scales (PSYRATS). *Psychological Medicine, 29*(4), 879–889.

Haddock, G., Tarrier, N., Morrison, A. P., Hopkins, R., Drake, R., & Lewis, S. A. (1999). A pilot study evaluating the effectiveness of individual inpatient cognitive-behavioral therapy in early psychosis. *Social Psychiatry and Psychiatric Epidemiology, 34,* 254–258.

Hall, A. (1985). Group psychotherapy for anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 213–239). New York: Guilford Press.

Hans, E., & Hiller, W. (2013). A meta-analysis of nonrandomized effectiveness studies on outpatient cognitive behavioral therapy for adult anxiety disorders. *Clinical Psychology Review, 33*(8), 954–964.

Hansen, B., Hagen, K., Öst, L. G., Solem, S., & Kvale, G. (2018). The Bergen 4-day OCD treatment delivered in a group setting: 12-month follow-up. *Frontiers in Psychology, 9,* 639.

Hansen, M., Ross, J., & Armour, C. (2017). Evidence of the dissociative PTSD subtype: A systematic literature review of latent class and profile analytic studies of PTSD. *Journal of Affective Disorders, 213,* 59–69.

Hardy, K., Lecomte, T., & Munro-Clark, T. (2017). *Cognitive Therapy Scale Revised for Psychosis—CTS R-P.* San Francisco: unpublished manuscript.

Harned, M. S., Gallop, R. J., & Valenstein-Mah, H. R. (2018). What changes when? The course of improvement during a stage-based treatment for suicidal

and self-injuring women with borderline personality disorder and PTSD. *Psychotherapy Research, 28*(5), 761–775.

Hartmann, A., Herzog, T., & Drinkmann, A. (1992). Psychotherapy of bulimia nervosa: What is effective? A meta-analysis. *Journal of Psychosomatic Research, 36,* 159–167.

Harvard Medical School. (2017, August 21st). National Comorbidity Survey (NSC). Data Table 1: Lifetime prevalence DSM-IV/WMH-CIDI disorders by sex and cohort. Available at *www.hcp.med.harvard.edu/ncs/index.php.*

Harvey, A. G., Watkins, E., & Mansell, W. (2004). *Cognitive behavioural processes across psychological disorders: A transdiagnostic approach to research and treatment*. Oxford, UK: Oxford University Press.

Hasin, D. S., & Grant, B. F. (2015). The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) waves 1 and 2: Review and summary of findings. *Social Psychiatry and Psychiatric Epidemiology, 50,* 1609–1640.

Hauksson, P., Ingibergsdóttir, S., Gunnarsdóttir, T., & Jónsdóttir, I. H. (2017). Effectiveness of cognitive behaviour therapy for treatment-resistant depression with psychiatric comorbidity: Comparison of individual versus group CBT in an interdisciplinary rehabilitation setting. *Nordic Journal of Psychiatry, 71*(6), 465–472.

Hawkins, R. C., II, & Clement, P. F. (1980). Development and construct validation of a self-report measure of binge eating tendencies. *Addictive Behaviors, 5,* 219–226.

Hawton, K., & Kirk, J. (1989). Problem solving. In K. S. Hawton, P. M. Salkovskis, J. Kirk, & D. M. Clark (Eds.), *Cognitive behaviour therapy for psychiatric problems: A practical guide* (pp. 406–426). Oxford, UK: Oxford University Press.

Hayes, S. C., Follette, V. M., & Linehan, M. M. (2004). *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition*. New York: Guilford Press.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behavior Research and Therapy, 44*(1), 1–25.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2016). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). New York: Guilford Press.

Heckman, B. W., Carpenter, M. J., Correa, J. B., Wray, J. M., Saladin, M. E., Froeliger, B., et al. (2015). Effects of experimental negative affect manipulations on ad libitum smoking: A meta-analysis. *Addiction, 110,* 751–760.

Heckman, B. W., Kovacs, M. A., Marquinez, N. S., Meltzer, L. R., Tsambarlis, M. E., Drobes, D. J., et al. (2013). Influence of affective manipulations on cigarette craving: A meta-analysis. *Addiction, 108,* 2068–2078.

Hedman, E., Mörtberg, E., Hesser, H., Clark, D. M., Lekander, M., Andersson, E., et al. (2013). Mediators in psychological treatment of social anxiety disorder: Individual cognitive therapy compared to cognitive behavioral group therapy. *Behaviour Research and Therapy, 51*(10), 696–705.

Heimberg, R. C., Brozovich, F. A., & Rapee, R. M. (2014). A cognitive-behavioral model of social anxiety disorder. In S. G. Hofmann & P. M. DiBartolo (Eds.), *Social anxiety: Clinical, developmental, and social perspectives* (3rd ed., pp. 705–728). Cambridge, MA: Academic Press.

Heimberg, R. G., & Becker, R. E. (2002). *Cognitive-behavioural group therapy for*

social phobia: Basic mechanisms and clinical strategies. New York: Guilford Press.

Hemsley, D. R. (1996). Schizophrenia: A cognitive model and its implication for psychological intervention. *Behavior Modification, 20*(2), 139–169.

Henderson, L. C., Stewart, K. E., Koerner, N., Rowa, K., McCabe, R. E., & Antony, M. M. (2020). Religiosity, spirituality, and obsessive–compulsive disorder-related symptoms in clinical and nonclinical samples. *Psychology of Religion and Spirituality*.

Hepp, J., Lane, S. P., Wycoff, A. M., Carpenter, R. W., & Trull, T. J. (2018). Interpersonal stressors and negative affect in individuals with borderline personality disorder and community adults in daily life: A replication and extension. *Journal of Abnormal Psychology, 127*(2), 183–189.

Hilbert, A., Bishop, M. E., Stein, R. I., Tanofsky-Kraff, M., & Swenson, A. K. (2012). Long-term efficacy of psychological treatments for binge eating disorders. *British Journal of Psychiatry, 200*, 232–237.

Himle, J. A., Rassi, S., Haghighatgou, H., Krone, K. P., Nesse, R. M., & Abelson, J. (2001). Group behavioral therapy of obsessive–compulsive disorder: Seven vs. twelve-week outcomes. *Depression and Anxiety, 13*, 161–165.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research, 36*(5), 427–440.

Hogarth, L., Hardy, L., Bakou, A., Mahlberg, J., Weidemann, G., Cashel, S., et al. (2019). Negative mood induction increases choice of heroin versus food pictures in opiate-dependent individuals: Correlation with self-medication coping motives and subjective reactivity. *Frontiers in Psychiatry, 10*, Article 274.

Hohagen, F., Winkelmann, G., Rasche-Räuchle, H., Hand, I., König, A., Münchau, N., et al. (1998). Combination of behaviour therapy with fluvoxamine in comparison with behaviour therapy and placebo: Results of a multicentre study. *British Journal of Psychiatry, 173*(Suppl. 35), 71–78.

Hollon, S. D., & Shaw, B. F. (1979). Group cognitive therapy for depressed patients. In A. T. Beck, A. J. Rush, B. F. Shaw, & G. Emery (Eds.), *Cognitive therapy of depression* (pp. 328–353). New York: Guilford Press.

Holmes, E. A., Craske, M. G., & Graybiel, A. M. (2014). Psychological treatments: A call for mental-health science. *Nature, 511*, 287–289.

Hood, H. K., & Antony, M. M. (2016). Perfectionism-related OCD in an adult. In E. A. Storch & A. B. Lewin (Eds.), *Clinical handbook of obsessive–compulsive and related disorders: A case-based approach to treating pediatric and adult populations* (pp. 85–97). New York: Springer.

Hope, D. A., Heimberg, R. G., & Turk, C. L. (2019a). *Managing social anxiety: A cognitive-behavioral therapy approach client workbook* (3rd ed.). New York: Oxford University Press.

Hope, D. A., Heimberg, R. G., & Turk, C. L. (2019b). *Managing social anxiety: A cognitive behavioral therapy approach therapist guide* (3rd ed.). New York: Oxford University Press.

Hoskins, M., Pearce, J., Bethell, A., Dankova, L., Barbui, C., Tol, W. A., et al. (2015). Pharmacotherapy for post-traumatic stress disorder: Systematic review and meta-analysis. *British Journal of Psychiatry, 206*(2), 93–100.

Houck, P. R., Spiegel, D. A., Shear, M. K., & Rucci, P. (2002). Reliability of the

self-report version of the Panic Disorder Severity Scale. *Depression and Anxiety, 15,* 183–185.

Hser, Y. I., Evans, E., Huang, D., & Anglin, D. M. (2004). Relationship between drug treatment services, retention, and outcomes. *Psychiatric Services, 55,* 767–774.

Hsu, L. K. G. (1990). *Eating disorders.* New York: Guilford Press.

Hudson, J., Hiripi, E., Pope, H., & Kessler, R. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 61,* 348–358.

Huntley, A. L., Araya, R., & Salisbury, C. (2012). Group psychological therapies for depression in the community: Systematic review and meta-analysis. *British Journal of Psychiatry, 200*(3), 184–190.

Huppert, J. D., Simpson, H. B., Nissenson, K. J., Liebowitz, M. R., & Foa, E. B. (2009). Quality of life and functional impairment in obsessive–compulsive disorder: A comparison of patients with and without comorbidity, patients in remission, and healthy controls. *Depression and Anxiety, 26*(1), 39–45.

Hyman, S. M., Fox, H., Hong, K. A., Doebrick, C., & Sinha, R. (2007). Stress and drug-cue-induced craving in opioid-dependent individuals in naltrexone treatment. *Experimental and Clinical Psychopharmacology, 15*(2), 134–143.

Iacovino, J. M., Gredysa, D. M., Altman, M., & Wilfley, D. E. (2012). Psychological treatments for binge eating disorder. *Current Psychiatry Reports, 14*(4), 432–446.

Inbody, D. R., & Ellis, J. J. (1985). Group therapy with anorexic and bulimic patients: Implications for therapeutic intervention. *American Journal of Psychotherapy, 39,* 411–420.

International Society for Traumatic Stress Studies. (2018). Posttraumatic stress disorder prevention and treatment guidelines: Methodology and recommendations. Available at *www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_PreventionTreatmentGuidelines_FNL.pdf.aspx*

Inwood, E., & Ferrari, M. (2018). Mechanisms of change in the relationship between self-compassion, emotion regulation, and mental health: A systematic review. *Applied Psychology, Health, and Well Being, 10*(2), 215–235.

Jacobi, C., Dahme, B., & Dittmann, R. (2002). Cognitive-behavioural, fluoxetine and combined treatment for bulimia nervosa: Short- and long-term results. *European Eating Disorders Review, 10,* 179–198.

Jacobi, C., Thiel., A., & Paul, T. (1996). *Kognitive verhaltenstherapie bei anorexia und bulimia nervosa.* Weinheim, Germany: Beltz PVU.

Jerud, A. B., Pruitt, L. D., Zoellner, L. A., & Feeny, N. C. (2016). The effects of prolonged exposure and sertraline on emotion regulation in individuals with posttraumatic stress disorder. *Behaviour Research and Therapy, 77,* 62–67.

Johansen, M., Karterud, S., Pedersen, G., Gude, T., & Falkum, E. (2004). An investigation of the prototype validity of the borderline DSM-IV construct. *Acta Psychiatrica Scandinavica, 109*(4), 289–298.

Johansson, L., & Werbart, A. (2009). Patients' views of therapeutic action in psychoanalytic group psychotherapy. *Group Analysis, 42*(2), 120–142.

Jones, M. K., & Menzies, R. G. (1998). The relevance of associative learning pathways in the development of obsessive–compulsive washing. *Behaviour Research and Therapy, 36,* 273–283.

Jónsson, H., Hougaard, E., & Bennedsen, B. E. (2011). Randomized comparative study of group versus individual cognitive behavioural therapy for obsessive compulsive disorder. *Acta Psychiatrica Scandinavica, 123*(5), 387–397.

Jovev, M., & Jackson, H. J. (2006). The relationship of borderline personality disorder, life events and functioning in an Australian psychiatric sample. *Journal of Personality Disorders, 20*(3), 205–217.

Kabat-Zinn, J. (1990). *Full catastrophe living using the wisdom of your body and mind to face stress, pain, and illness*. New York: Random House.

Kampman, M., Keijsers, G. P. J., Hoogduin, C. A. L., & Verbraak, M. J. P. M. (2002). Addition of cognitive-behaviour therapy for obsessive–compulsive disorder patients non-responding to fluoxetine. *Acta Psychiatrica Scandinavica, 106,* 314–319.

Kassebaum, N. J., Arora, M., Barber, R. M., Bhutta, Z. A., Brown, J., Carter, A., et al. (2016). Global, regional, and national disability-adjusted life-years (DALYs) for 315 diseases and injuries and healthy life expectancy (HALE), 1990–2015: A systematic analysis for the Global Burden of Disease Study 2015. *The Lancet, 388*(10053), 1603–1658.

Katerelos, M., Hawley, L., Antony, M. M., & McCabe, R. E. (2008). The exposure hierarchy as a measure of progress and efficacy in the treatment of social anxiety disorder. *Behavior Modification, 32,* 504–518.

Kay, S. R., Fiszbein, A., & Opler, L. A. (1987). The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. *Schizophrenia Bulletin, 13,* 261–276.

Kazantzis, N., Whittington, C., Zelencich, L., Kyrios, M., Norton, P. J., & Hofmann, S. G. (2016). Quantity and quality of homework compliance: A meta-analysis of relations with outcome in cognitive behavior therapy. *Behavior Therapy, 47*(5), 755–772.

Keane, T. M., Zimering, R. T., & Caddell, J. M. (1985). Behavioral formulation of PTSD in Vietnam veterans. *The Behavior Therapist, 8,* 9–12.

Keel, P. K., Mitchell, J. E., Davis, T. L., & Crow, S. L. (2002). Long-term impact of treatment in women diagnosed with bulimia nervosa. *International Journal of Eating Disorders, 31,* 151–158.

Keesey, R. E. (1993). Physiological regulation of body energy: Implications for obesity. In A. J. Stunkard & T. A. Wadden (Eds.), *Obesity: Theory and therapy* (2nd ed., pp. 77–96). New York: Raven Press.

Keles, S., & Idsoe, T. (2018). A meta-analysis of group cognitive behavioral therapy (CBT) interventions for adolescents with depression. *Journal of Adolescence, 67,* 129–139.

Keng, S.-L., Smoski, M. J., & Robins, C. J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychology Review, 31*(6), 1041–1056.

Keng, S.-L., Smoski, M. J., Robins, C. J., Ekblad, A. G., & Brantley, J. G. (2012). Mechanisms of change in mindfulness-based stress reduction: Self-compassion and mindfulness as mediators of intervention outcomes. *Journal of Cognitive Psychotherapy, 26*(3), 270–280.

Kessler, R. C. (2000). Posttraumatic stress disorder: The burden to the individual and to society. *Journal of Clinical Psychiatry, 61*(Suppl. 5), 4–12.

Kessler, R. C., Berglund, P. A., Chiu, W. T., Deitz, A. C., Hudson, J. L., Shahly, V., et al. (2013). The prevalence and correlates of binge eating disorder in the

World Health Organization World Mental Health Surveys. *Biological Psychiatry, 73*(9), 904–914.
Kessler, R. C., & Bromet, E. J. (2013). The epidemiology of depression across cultures. *Annual Review of Public Health, 34*(1), 119–138.
Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627.
Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048–1060.
Key, B. L., Rowa, K., Bieling, P., McCabe, R., & Pawluk, E. J. (2017). Mindfulness-based cognitive therapy as an augmentation treatment for obsessive–compulsive disorder. *Clinical Psychology and Psychotherapy, 24*(5), 1109–1120.
Khoury, B., Langer, E. J., & Pagnini, F. (2014). The DSM: Mindful science or mindless power? A critical review. *Frontiers in Psychology, 5*, 602.
Khoury, B., & Lecomte, T. (2012). Emotion regulation and schizophrenia. *International Journal of Cognitive Therapy, 5*, 67–76.
Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Traumatic Stress, 26*, 537–547.
Kiluk, B. D., Nich, C., Buck, M. B., Devore, K. A., Frankforter, T. L., LaPaglia, D. M., et al. (2018). Randomized clinical trial of computerized and clinician-delivered CBT in comparison with standard outpatient treatment for substance use disorders: Primary within-treatment and follow-up outcomes. *The American Journal of Psychiatry, 175*(9), 853–863.
Kim, C.-H., Chang, J. W., Koo, M.-S., Kim, J. W., Suh, H. S., Park, I. H., et al. (2003). Anterior cingulotomy for refractory obsessive–compulsive disorder. *Acta Psychiatrica Scandinavica, 107*, 283–290.
Kim, H. S., & Kim, E. J. (2018). Effects of relaxation therapy on anxiety disorders: A systematic review and meta-analysis. *Archives of Psychiatric Nursing, 32*(2), 278–284.
Kinderman, P., & Bentall, R. P. (2000). Self-discrepancies and causal attributions: Studies of hypothesized relationships. *British Journal of Clinical Psychology, 39*, 255–273.
Kisely, S., Hall, K., Siskind, D., Frater, J., Olson, S., & Crompton, D. (2014). Deep brain stimulation for obsessive–compulsive disorder: A systematic review and meta-analysis. *Psychological Medicine, 44*(16), 3533–3542.
Klein, A. S., Skinner, J. B., & Hawley, K. M. (2013). Targeting binge eating through components of dialectical behavior therapy: Preliminary outcomes for individually supported diary card self-monitoring versus group-based DBT. *Psychotherapy, 50*(4), 543–552.
Köhler, S., Hoffmann, S., Unger, T., Steinacher, B., Dierstein, N., & Fydrich, T. (2013). Effectiveness of cognitive-behavioral therapy plus pharmacotherapy in inpatient treatment of depressive disorders. *Clinical Psychology and Psychotherapy, 20*(2), 97–106.
Koons, C. R., Robins, C. J., Tweed, J. L., Lynch, T. R., Gonzalez, A. M., Morse,

J. Q., et al. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy, 32*(2), 371–390.

Koster, E., & Bogaerde, A. (2019). Attentional bias and the anxiety disorders. In B. Olatunji (Ed.), *The Cambridge handbook of anxiety and related disorders* (pp. 41–58). Cambridge, UK: Cambridge University Press.

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals, 32*(9), 509–515.

Krueger, R. F., Derringer, J., Markon, K. E., Watson, D., & Skodol, A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine, 42*(9), 1879–1890.

Krueger, R. F., Skodol, A. E., Livesley, W. J., Shrout, P. E., & Huang, Y. (2007). Synthesizing dimensional and categorical approaches to personality disorders: Refining the research agenda for DSM-V Axis II. *International Journal of Methods in Psychiatric Research, 16*(Suppl. 1), S65–S73.

Külz, A. K., Landmann, S., Cludius, B., Rose, N., Heidenreich, T., Jelinek, L., et al. (2019). Mindfulness-based cognitive therapy (MBCT) in patients with obsessive–compulsive disorder (OCD) and residual symptoms after cognitive behavioral therapy (CBT): A randomized controlled trial. *European Archives of Psychiatry and Clinical Neuroscience, 269*(2), 223–233.

Kuo, J. R., & Linehan, M. M. (2009). Disentangling emotion process in borderline personality disorder: Physiological and self-reported assessment of biological vulnerability, baseline intensity, and reactivity to emotionally evocative stimuli. *Journal of Abnormal Psychology, 118*(3), 531–544.

Lacey, H. (1983). Bulimia nervosa, binge eating, and psychogenic vomiting: A controlled treatment study and long term outcome. *British Medical Journal, 286*, 1609–1613.

Ladouceur, R., Blais, F., Freeston, M. H., & Dugas, M. J. (1998). Problem solving and problem orientation in generalized anxiety disorder. *Journal of Anxiety Disorders, 12*(2), 139–152.

Laliberté, M., & McKenzie, J. (2003). *Making changes: A manual for group-based cognitive behavior therapy for eating disorders*. Hamilton, Ontario, Canada: Crieff Hollow Press.

Lam, D. H., Burbeck, R., Wright, K., & Pilling, S. (2009). Psychological therapies in bipolar disorder: the effect of illness history on relapse prevention–A systematic review. *Bipolar Disorders, 11*(5), 474–482.

Lang, A. J., & Craske, M. G. (2000). Manipulations of exposure-based therapy to reduce return of fear: A replication. *Behaviour Research and Therapy, 38*(1), 1–12.

Langbehn, D. R., Pfohl, B. M., Reynolds, S., Clark, L. A., Battaglia, M., Bellodi, L., et al. (1999). The Iowa Personality Disorder Screen: Development and preliminary validation of a brief screening interview. *Journal of Personality Disorders, 13*(1), 75–89.

Leahy, R. L. (2017). *Cognitive therapy techniques: A practitioner's guide* (2nd ed.). New York: Guilford Press.

Leary, M. R. (1983). A brief version of the Fear of Negative Evaluation Scale. *Personality and Social Psychology Bulletin, 9*(3), 371–375.

LeBouthillier, D. M., McMillan, K. A., Thibodeau, M. A., & Asmundson, G. J. G. (2015). Types and number of traumas associated with suicidal ideation

and suicide attempts in PTSD: Findings from a U.S. nationally representative sample. *Journal of Traumatic Stress, 28,* 183–190.

Leclerc, C., & Lecomte, T. (2012). TCC pour premiers épisodes de psychose: Pourquoi la thérapie de groupe obtient les meilleurs résultats [CBT for first episode of psychosis: Why does group therapy offer better results]? *Journal de Thérapie Comportementale et Cognitive, 22*(3), 104–110.

Lecomte, T., Corbiere, M., Ehmann, T., Addington, J., Abdel-Baki, A., & Macewan, B. (2014). Development and preliminary validation of the First Episode Social Functioning Scale for early psychosis. *Psychiatry Research, 216*(3), 412–417.

Lecomte, T., Corbiere, M., & Laisne, F. (2006). Investigating self-esteem in individuals with schizophrenia: Relevance of the Self-Esteem Rating Scale—Short Form. *Psychiatry Research, 143*(1), 99–108.

Lecomte, T., Leclerc, C., Corbiere, M., Wykes, T., Wallace, C. J., & Spidel, A. (2008). Group cognitive behavior therapy or social skills training for individuals with a recent onset of psychosis? Results of a randomized controlled trial. *Journal of Nervous and Mental Disease, 196*(12), 866–875.

Lecomte, T., Leclerc, C., & Wykes, T. (2016). *Group CBT for psychosis: A guidebook for clinicians*. New York: Oxford University Press.

Lecomte, T., Leclerc, C., Wykes, T., Nicole, L., & Abdel Baki, A. (2015). Understanding process in group cognitive behaviour therapy for psychosis. *Psychology and Psychotherapy: Theory, Research and Practice, 88*(2), 163–177.

Lecomte, T., Liberman, R. P., & Wallace, C. J. (2000). Identifying and using reinforcers to enhance the treatment of persons with serious mental illness. *Psychiatric Services, 51,* 1312–1314.

Lecomte, T., Mian, I., Abidi, S., & Norman, R. (2017). CPA treatment guidelines on psychosocial treatment of schizophrenia in children and youth. *Canadian Journal of Psychiatry, 62*(9), 648–655.

Lenton-Brym, A. P., Rogojanski, J., Hood, H. K., Vorstenbosch, V., McCabe, R. E., & Antony, M. M. (2020). Development and validation of the Ryerson Social Anxiety Scales (RSAS). *Anxiety, Stress, and Coping, 33*(6), 642–660.

Lenzenweger, M. F. (2008). Epidemiology of personality disorders. *Psychiatric Clinics of North America, 31*(3), 395–403.

Lenzenweger, M. F., Lane, M. C., Loranger, A. W., & Kessler, R. C. (2007). DSM-IV personality disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 62*(6), 553–564.

Leung, N., Waller, G., & Thomas, G. (1999). Group cognitive-behavioural therapy for anorexia nervosa: A case for treatment? *European Eating Disorders Review, 7,* 351–361.

Leung, N., Waller, G., & Thomas, G. (2000). Outcome of group cognitive-behavior therapy for bulimia nervosa: The role of core beliefs. *Behaviour Research and Therapy, 38*(2), 145–156.

Lewinsohn, P. M., Rohde, P., & Gau, J. M. (2003). Comparability of self-report checklist and interview data in the assessment of stressful life events in young adults. *Psychological Reports, 93*(2), 459–471.

Li, J. M., Zhang, Y., Su, W. J., Liu, L. L., Gong, H., Peng, W., et al. (2018). Cognitive behavioral therapy for treatment-resistant depression: A systematic review and meta-analysis. *Psychiatry Research, 268,* 243–250.

Linardon, J., & Brennan, L. (2017). The effects of cognitive-behavioral therapy for eating disorders on quality of life: A meta-analysis. *International Journal of Eating Disorders, 50,* 713–730.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Linehan, M. M. (2015). *DBT skills training manual* (2nd ed.). New York: Guilford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*(12), 1060–1064.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*(7), 757–766.

Linehan, M. M., Heard, H. L., & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry, 50*(12), 971–974.

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., et al. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. *JAMA Psychiatry, 72*(5), 475–482.

Linehan, M. M., Schmidt, H., 3rd, Dimeff, L. A., Craft, J. C., Kanter, J., & Comtois, K. A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addictions, 8*(4), 279–292.

Linehan, M. M., Tutek, D. A., Heard, H. L., & Armstrong, H. E. (1994). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry, 151,* 1771–1776.

Linehan, M. M., & Wilks, C. R. (2015). The course and evolution of dialectical behavior therapy. *American Journal of Psychotherapy, 69*(2), 97–110.

Liverant, G. I., Suvak, M. K., Pineles, S. L., & Resick, P. A. (2012). Changes in posttraumatic stress disorder and depressive symptoms during cognitive processing therapy: Evidence for concurrent change. *Journal of Consulting and Clinical Psychology, 80*(6), 957–967.

Lock, J. (2002). Treating adolescents with eating disorders in the family context: Empirical and theoretical considerations. *Child and Adolescent Psychiatric Clinics of North America, 11,* 331–342.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*(3), 335–343.

Lukoff, D., Nuechterlein, K., & Ventura, J. (1986). Manual for the Expanded Brief Psychiatric Rating Scale. *Schizophrenia Bulletin, 12,* 578–602.

Lynch, T. R., Chapman, A. L., Rosenthal, M. Z., Kuo, J. R., & Linehan, M. M. (2006). Mechanisms of change in dialectical behavior therapy: Theoretical and empirical observations. *Journal of Clinical Psychology, 62*(4), 459–480.

Lynch, T. R., Cheavens, J. S., Cukrowicz, K. C., Thorp, S. R., Bronner, L., & Beyer, J. (2007). Treatment of older adults with co-morbid personality disorder and

depression: A dialectical behavior therapy approach. *International Journal of Geriatric Psychiatry, 22*(2), 131–143.

MacKenzie, K. R., & Harper-Guiffre, H. (1992). Developing a health relationship with your body. In H. Harper-Guiffre & K. R. MacKenzie (Eds.), *Group psychotherapy for eating disorders* (pp. 329–333). Washington, DC: American Psychiatric Press.

MacPhillamy, D. J., & Lewinsohn, P. M. (1982). The Pleasant Events Schedule: Studies on reliability, validity, and scale intercorrelation. *Journal of Consulting and Clinical Psychology, 50,* 363–380.

Magill, M., Gaume, J., Apodaca, T. R., Walthers, J., Mastroleo, N. R., Borsari, B., et al. (2014). The technical hypothesis of motivational interviewing: A meta-analysis of MI's key causal model. *Journal of Consulting and Clinical Psychology, 82,* 973–983.

Magill, M., Kiluk, B. D., McCrady, B. S., Tonigan, J. S., & Longabaugh, R. (2015). Active ingredients of treatment and client mechanisms of change in behavioral treatments for alcohol use disorders: Progress 10 years later. *Alcoholism, Clinical and Experimental Research, 39*(10), 1852–1862.

Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs, 70,* 516–527.

Magill, M., Walthers, J., Mastroleo, N. R., Gaume, J., Longabaugh, R., & Apodaca, T. R. (2016). Therapist and client discussions of drinking and coping: A sequential analysis of therapy dialogues in three evidence-based alcohol use disorder treatments. *Addiction, 111*(6), 1011–1020.

Maisto, A. A., Roos, C. R., O'Sickey, A. J., Kirouac, M., Connors, G. J., Tonigan, J. S., et al. (2015). The indirect effect of the therapeutic alliance and alcohol abstinence self-efficacy on alcohol use and alcohol-related problems in Project MATCH. *Alcoholism: Clinical and Experimental Research, 39,* 504–513.

Mancebo, M. C., Grant, J. E., Pinto, A., Eisen, J. L., & Rasmussen, S. A. (2009). Substance use disorders in an obsessive compulsive disorder clinical sample. *Journal of Anxiety Disorders, 23*(4), 429–435.

Marchand, A., Roberge, P., Primiano, S., & Germain, V. (2009). A randomized, controlled clinical trial of standard, group and brief cognitive-behavioral therapy for panic disorder with agoraphobia: A two-year follow-up. *Journal of Anxiety Disorders, 23*(8), 1139–1147.

Margraf, J., Barlow, D. H., Clark, D. M., & Telch, M. J. (1993). Psychological treatment of panic: Work in progress on outcome, active ingredients, and follow-up. *Behaviour Research and Therapy, 31,* 1–8.

Margraf, J., & Ehlers, A. (1988). Etiological models of panic—Psychophysiological and cognitive aspects. In R. Baker (Ed.), *Panic disorder: Theory, research and therapy* (pp. 205–231). Chichester, UK: Wiley.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.

Marsden, Z., Lovell, K., Blore, D., Ali, S., & Delgadillo, J. (2018). A randomized controlled trial comparing EMDR and CBT for obsessive–compulsive disorder. *Clinical Psychology and Psychotherapy, 25*(1), e10–e18.

Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2022). *Behavioral activation for depression, second edition: A clinician's guide*. New York: Guilford Press.

Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of

social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy, 36*(4), 455–470.

Mausbach, B. T., Moore, R., Roesch, S., Cardenas, V., & Patterson, T. L. (2010). The relationship between homework compliance and therapy outcomes: An updated meta-analysis. *Cognitive Therapy and Research, 34*(5), 429–438.

Mayo-Wilson, E., Dias, S., Mavranezouli, I., Kew, K., Clark, D. M., Ades, A. E., et al. (2014). Psychological and pharmacological interventions for social anxiety disorder in adults: A systematic review and network meta-analysis. *Lancet Psychiatry, 1*(5), 368–376.

McCabe, R. E., McFarlane, T. L., & Olmsted, M. P. (2003). *The overcoming bulimia workbook*. Oakland, CA: New Harbinger.

McCabe, R. E., Milosevic, I., Rowa, K., Shnaider, P., Pawluk, E. J., Antony, M. M., et al. (2017). *Diagnostic Assessment Research Tool (DART)*. Hamilton, Ontario, Canada: St. Joseph's Healthcare/McMaster University.

McCabe, R. E., Rowa, K., Farrell, N. R., Young, L., Swinson, R. P., & Antony, M. M. (2019). Improving treatment outcome in obsessive–compulsive disorder: Does motivational interviewing boost efficacy? *Journal of Obsessive–Compulsive and Related Disorders, 22*, 100446.

McCann, E., & Bowers, L. (2005). Training in cognitive behavioral interventions on acute psychiatric inpatient wards. *Journal of Psychiatric and Mental Health Nursing, 12*(2), 215–222.

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. New York: Brunner/Mazel.

McEvoy, P. M., Watson, H., Watkins, E. R., & Nathan, P. (2013). The relationship between worry, rumination, and comorbidity: Evidence for repetitive negative thinking as a transdiagnostic construct. *Journal of Affective Disorders, 151*(1), 313–320.

McKay, M., Davis, M., & Fanning, P. (2018). *Messages: The communications skills book* (4th ed.). Oakland, CA: New Harbinger.

McKisack, C., & Waller, G. (1996). Why is attendance variable at groups for women with bulimia nervosa? The role of eating psychopathology and other characteristics. *International Journal of Eating Disorders, 20*, 205–209.

McLaughlin, K. A., & Nolen-Hoeksema, S. (2011). Rumination as a transdiagnostic factor in depression and anxiety. *Behaviour Research and Therapy, 49*(3), 186–193.

McLean, P. D., Whittal, M. L., Sochting, I., Koch, W. J., Paterson, R., Thordarson, D. S., et al. (2001). Cognitive versus behavior therapy in the group treatment of obsessive–compulsive disorder. *Journal of Consulting and Clinical Psychology, 69*, 205–214.

McMain, S. F., Guimond, T., Barnhart, R., Habinski, L., & Streiner, D. L. (2017). A randomized trial of brief dialectical behaviour therapy skills training in suicidal patients suffering from borderline disorder. *Acta Psychiatrica Scandinavica, 135*(2), 138–148.

Meiser-Stedman, R., Dalgleish, T., Glucksman, E., Yule, W., & Smith, P. (2009). Maladaptive cognitive appraisals mediate the evolution of posttraumatic stress reactions: A 6-month follow-up of child and adolescent assault and motor vehicle accident survivors. *Journal of Abnormal Psychology, 118*(4), 778–787.

Mellentin, A. I., Skot, L., Nielsen, B., Schippers, G. M., Nielsen, A. S., Stenager, E.,

et al. (2017). Cue exposure therapy for the treatment of alcohol use disorders: A meta-analytic review. *Clinical Psychology Review, 57,* 195–207.

Mennin, D. S., & Heimberg, R. G. (2000). The impact of comorbid mood and personality disorders in the cognitive-behavioral treatment of panic disorder. *Clinical Psychology Review, 20,* 339–357.

Mennin, D. S., Heimberg, R. G., & MacAndrew, J. S. (2000). Comorbid generalized anxiety disorder in primary social phobia: Symptom severity, functional impairment, and treatment response. *Journal of Anxiety Disorders, 14,* 325–343.

Menzies, R. G., & Clarke, J. C. (1993). A comparison of in vivo and vicarious exposure in the treatment of childhood water phobia. *Behaviour Research and Therapy, 31,* 9–15.

Merikangas, K. R., Jin, R., He, J. P, Kessler, R. C., Lee, S., Sampson, N. A., et al. (2011). Prevalence and correlates of bipolar spectrum disorder in the world mental health survey initiative. *Archives of General Psychiatry, 68*(3), 241–251.

Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy, 28*(6), 487–495.

Meyer, V. (1966). Modifications of expectations in cases with obsessional rituals. *Behaviour Research and Therapy, 4,* 273–280.

Miano, A., Fertuck, E. A., Arntz, A., & Stanley, B. (2013). Rejection sensitivity is a mediator between borderline personality disorder features and facial trust appraisal. *Journal of Personality Disorders, 27*(4), 442–456.

Michalec, E., Zwick, W. R., Monti, P. M., Rohsenow, D. J., Varney, S., Niaura, R. S., et al. (1992). A Cocaine high-risk situations questionnaire: Development and psychometric properties. *Journal of Substance Abuse, 4*(4), 377–391.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change* (2nd ed.). New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.

Mills, K. L., Deady, M., Proudfoot, H., Sannibale, C., Teesson, M., Mattick, R., et al. (2009). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings.* Sydney: National Drug and Alcohol Research Centre, University of Sydney, Australia.

Milosevic, I., Chudzik, S. M., Boyd, S., & McCabe, R. E. (2017). Evaluation of an integrated group cognitive-behavioral treatment for comorbid mood, anxiety, and substance use disorders: A pilot study. *Journal of Anxiety Disorders, 46,* 85–100.

Mineka, S., Davidson, M., Cook, M., & Keir, R. (1984). Observational conditioning of snake fear in rhesus monkeys. *Journal of Abnormal Psychology, 93*(4), 355–372.

Mitchell, J. E., Agras, W. S., Wilson, G. T., Halmi, K., Kraemer, H., & Crow, S. (2004). A trial of a relapse prevention strategy in women with bulimia nervosa who respond to cognitive-behavior therapy. *International Journal of Eating Disorders, 35,* 549–555.

Mitchell, J. E., Halmi, K., Wilson, G. T., Agras, W. S., Kraemer, H., & Crow, S. (2002). A randomized secondary treatment study of women with bulimia nervosa who fail to respond to CBT. *International Journal of Eating Disorders, 32,* 271–281.

Montero-Marin, J., Garcia-Campayo, J., López-Montoyo, A., Zabaleta-del-Olmo, E., & Cuijpers, P. (2018). Is cognitive-behavioural therapy more effective than relaxation therapy in the treatment of anxiety disorders? A meta-analysis. *Psychological Medicine, 48*(9), 1427–1436.

Montes, K. S., Witkiewitz, K., Pearson, M. R., & Leventhal, A. M. (2019). Alcohol, tobacco, and marijuana expectancies as predictors of substance use initiation in adolescence: A longitudinal examination. *Psychology of Addictive Behaviors, 33*(1), 26–34.

Monti, P. M., Kadden, R. M., Rohsenow, D. J., Cooney, N. L., & Abrams, D. B. (2002). *Treating alcohol dependence: A coping skills training guide* (2nd ed.). New York: Guilford Press.

Monti, P. M., Rohsenow, D. J., & Hutchison, K. E. (2000). Toward bridging the gap between biological, psychobiological, and psychosocial models of alcohol craving. *Addiction, 95*(Suppl. 2), S229–S236.

Monti, P. M., Rohsenow, D. J., Michalec, E., Martin, R. A., & Abrams, D. B. (1997). Brief coping skills treatment for cocaine abuse: Substance use outcomes at three months. *Addiction, 92*(12), 1717–1728.

Monti, P. M., Rohsenow, D. J., Rubonis, A., Niaura, R. S., Sirota, A. D., Colby, S. M., et al. (1993a). Alcohol cue reactivity: Effects of detoxification and extended exposure. *Journal of Studies on Alcohol, 54,* 235–249.

Monti, P. M., Rohsenow, D. J., Rubonis, A., Niaura, R. S., Sirota, A. D., Colby, S. M., et al. (1993b). Cue exposure with coping skills treatment for male alcoholics: A preliminary investigation. *Journal of Consulting and Clinical Psychology, 61,* 1011–1019.

Monti, P. M., Rohsenow, D. J., Swift, R. M., Gulliver, S. B., Colby, S. M., Mueller, T. I., et al. (2001). Naltrexone and cue exposure with coping and communication skills training for alcoholics: Treatment processes and one-year outcomes. *Alcoholism: Clinical and Experimental Research, 25,* 1634–1647.

Morey, L. C. (2017). Development and initial evaluation of a self-report form of the DSM-5 level of Personality Functioning Scale. *Psychological Assessment, 29*(10), 1302–1308.

Morgan, H., & Raffle, C. (1999). Does reducing safety behaviours improve treatment response in patients with social phobia? *Australia and New Zealand Journal of Psychiatry, 33,* 503–510.

Morgenstern, J., & Longabaugh, R. (2000). Cognitive-behavioral treatment for alcohol dependence: A review of evidence for its hypothesized mechanisms of action. *Addiction, 95,* 1475–1490.

Moritz, S., Wendt, M., & Kluwe, R. (2004). Task switching and backward inhibition in obsessive–compulsive disorder. *Journal of Clinical and Experimental Neuropsychology, 26*(5), 677–683.

Mowrer, O. H. (1960). *Learning theory and behavior.* New York: Wiley.

Moyers, T. B., & Martin, T. (2006). Therapist influence on client language during motivational interviewing sessions. *Journal of Substance Abuse Treatment, 30*(3), 245–251.

Mueser, K. T. (1998). Social skills training and problem solving. In A. S. Bellack &

M. Hersen (Eds.), *Comprehensive clinical psychology* (Vol. 6, pp. 183–201). New York: Elsevier.

Mueser, K. T., Deavers, F., Penn, D. L., & Cassisi, J. (2013). Psychosocial treatments for schizophrenia. *Annual Review of Clinical Psychology, 9,* 465–497.

Mueser, K. T., & Gingerich, S. (2013). Treatment of co-occurring psychotic and substance use disorders [Review]. *Social Work in Public Health, 28*(3), 424–439.

Muhomba, M., Chugani, C. D., Uliaszek, A. A., & Kannan, D. (2017). Distress tolerance skills for college students: A pilot investigation of a brief DBT group skills training program. *Journal of College Student Psychotherapy, 31*(3), 247–256.

Mullen, A. (2009). Mental health nurses establishing psychosocial interventions within acute inpatient settings. *International Journal of Mental Health Nursing, 18*(2), 83–90.

Munro, S. L., Baker, J. A., & Playle, J. (2005). Cognitive behavior therapy within acute mental health care: A critical appraisal. *International Journal of Mental Health Nursing, 14*(2), 96–102.

Murphy, R., Straebler, S., Cooper, Z., & Fairburn, C. (2010). Cognitive behavioral therapy for eating disorders. *Psychiatric Clinicals of North America, 33,* 611–627.

Murray, S. B. (2019). Updates in the treatment of eating disorders in 2018: A year in review in eating disorders: The *Journal of Treatment and Prevention. Eating Disorders, 27,* 6–17.

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing, 23*(1), 51–59.

Naragon-Gainey, K. (2010). Meta-analysis of the relations of anxiety sensitivity to the depressive and anxiety disorders. *Psychological Bulletin, 136*(1), 128–150.

National Collaborating Centre for Mental Health. (2014). *Psychosis and schizophrenia in adults: Treatment and management*. London: National Institute for Health and Care Excellence.

National Institute on Drug Abuse. (2007). *Principles of drug addiction treatment: A research based guide*. Bethesda, MD: Author.

National Institute on Drug Abuse. (2019). Overdose death rates. Retrieved April 11, 2019, from *www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates*

Neacsiu, A. D., Rizvi, S. L., Vitaliano, P. P., Lynch, T. R., & Linehan, M. M. (2010). The Dialectical Behavior Therapy Ways of Coping Checklist: Development and psychometric properties. *Journal of Clinical Psychology, 66*(6), 563.

Neal, R. L., Alcolado, G. M., & Radomsky, A. S. (2017). Responsibility, checking, and reassurance-seeking in OCD. In J. S. Abramowitz, D. McKay, & E. A. Storch (Eds.), *The Wiley handbook of obsessive compulsive disorders* (Vol. 1, pp. 361–376). Hoboken, NJ: Wiley.

Neenan, M., & Dryden, W. (2015). *Cognitive behaviour therapy: 100 key points and techniques*. New York: Routledge.

Neff, K. D. (2015). *Self-compassion: The proven power of being kind to yourself.* New York: HarperCollins

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled

trial of the mindful self-compassion program. *Journal of Clinical Psychology, 69*(1), 28–44.

Newby, J. M., McKinnon, A., Kuyken, W., Gilbody, S., & Dalgleish, T. (2015). Systematic review and meta-analysis of transdiagnostic psychological treatments for anxiety and depressive disorders in adulthood. *Clinical Psychology Review, 40,* 91–110.

Newman, C. F., Leahy, R. L., Beck, A. T., Reilly-Harrington, N. A., & Gyulai, L. (2002). *Bipolar disorder: A cognitive therapy approach.* Washington, DC: American Psychological Association.

Newman, D. L., Moffitt, T. E., Caspi, A., & Silva, P. A. (1998). Comorbid mental disorders: Implications for treatment and sample selection. *Journal of Abnormal Psychology, 107,* 305–311.

Newman, M. G., Przeworski, A., Consoli, A. J., & Taylor, C. B. (2014). A randomized controlled trial of ecological momentary intervention plus brief group therapy for generalized anxiety disorder. *Psychotherapy, 51*(2), 198.

Nezu, A. M., Ronan, G. F., Meadows, E. A., & McClure, K. (2000). *Practitioner's guide to empirically based measures of depression.* New York: Kluwer Academic/Plenum Press.

Nicol, K., Pope, M., Romaniuk, L., & Hall, J. (2015). Childhood trauma, midbrain activation and psychotic symptoms in borderline personality disorder. *Translational Psychiatry, 5*(5), e559.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology, 100*(4), 569–582.

Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. *Perspectives on Psychological Science, 3*(5), 400–424.

Norman, R., Lecomte, T., Addington, D., & Anderson, E. (2017). Canadian treatment guidelines on psychosocial treatment of schizophrenia in adults. *Canadian Journal of Psychiatry, 62*(9), 617–623.

Norman, S. B., Cissell, S. H., Means-Christensen, A. J., & Stein, M. B. (2006). Development and validation of an Overall Anxiety Severity and Impairment Scale (OASIS). *Depression and Anxiety, 23*(4), 245–249.

Norris, S. C., Gleaves, D. H., & Hutchinson, A. D. (2019). Treatment oucome research of enhanced cognitive behavior therapy for eating disorders: A systematic review with narrative and meta-analytic synthesis. *Eating Disorders, 27,* 482–502.

Norton, P. J. (2008). An open trial of a transdiagnostic cognitive-behavioral group therapy for anxiety disorders. *Behavior Therapy, 39*(3), 242–250.

Norton, P. J. (2012). *Group cognitive-behavioral therapy of anxiety: A transdiagnostic treatment manual.* New York: Guilford Press.

Norton, P. J., & Barrera, T. L. (2012). Transdiagnostic versus diagnosis-specific CBT for anxiety disorders: A preliminary randomized controlled noninferiority trial. *Depression and Anxiety, 29*(10), 874–882.

Norton, P. J., Barrera, T. L., Mathew, A. R., Chamberlain, L. D., Szafranski, D. D., Reddy, R., et al. (2013). Effect of transdiagnostic CBT for anxiety disorders on comorbid diagnoses. *Depression and Anxiety, 30*(2), 168–173.

Norton, P. J., & Hope, D. A. (2005). Preliminary evaluation of a broad-spectrum cognitive-behavioral group therapy for anxiety. *Journal of Behavior Therapy and Experimental Psychiatry, 36*(2), 79–97.

Norton, P. J., & Paulus, D. J. (2016). Toward a unified treatment for emotional disorders: Update on the science and practice. *Behavior Therapy, 47*(6), 854–868.

Norton, P. J., & Philipp, L. M. (2008). Transdiagnostic approaches to the treatment of anxiety disorders: A quantitative review. *Psychotherapy: Theory, Research, Practice, Training, 45*(2), 214–226.

Norton, P. J., & Price, E. C. (2007). A meta-analytic review of adult cognitive-behavioral treatment outcome across the anxiety disorders. *Journal of Nervous and Mental Disease, 195*(6), 521–531.

Norton, P. J., & Robinson, C. M. (2010). Development and evaluation of the Anxiety Disorder Diagnostic Questionnaire. *Cognitive Behaviour Therapy, 39*(2), 137–149.

Obsessive Compulsive Cognitions Working Group. (2001). Development and initial validation of the Obsessive Beliefs Questionnaire and the Interpretation of Intrusions Inventory. *Behavior Research Therapy 39*(8), 987–1005.

Obsessive Compulsive Cognitions Working Group. (2003). Psychometric validation of the Obsessive Beliefs Questionnaire and the Interpretation of Intrusions Inventory: Part 1. *Behavior Research Therapy 41*(8), 863–878.

O'Connor, K., Freeston, M. H., Gareau, D., Careau, Y., Dufour, M. J., Aardema, F., et al. (2005). Group versus individual treatment in obsessions without compulsions. *Clinical Psychology and Psychotherapy, 12*, 87–96.

O'Connor, K., Todorov, C., Robillard, S., Borgeat, F., & Brault, M. (1999). Cognitive-behaviour therapy and medication in the treatment of obsessive–compulsive disorder: A controlled study. *Canadian Journal of Psychiatry, 44*, 64–71.

Oei, T. P., & Browne, A. (2006). Components of group processes: Have they contributed to the outcome of mood and anxiety disorder patients in a group cognitive-behaviour therapy program? *American Journal of Psychotherapy, 60*(1), 53–70.

Oei, T. P., & Dingle, G. (2008). The effectiveness of group cognitive behaviour therapy for unipolar depressive disorders. *Journal of Affective Disorders, 107*(1–3), 5–21.

Olatunji, B. O., Cisler, J. M., & Tolin, D. F. (2007). Quality of life in the anxiety disorders: A meta-analytic review. *Clinical Psychology Review, 27*(5), 572–581.

Olatunji, B. O., Davis, M. L., Powers, M. B., & Smits, J. A. J. (2013). Cognitive-behavioral therapy for obsessive-compulsive disorder: A meta-analysis of treatment outcome and moderators. *Journal of Psychiatric Research, 47*(1), 33–41.

Olatunji, B. O., Rosenfield, D., Tart, C. D., Cottraux, J., Powers, M. B., & Smits, J. A. J. (2013). Behavioral versus cognitive treatment of obsessive–compulsive disorder: An examination of outcome and mediators of change. *Journal of Consulting and Clinical Psychology, 81*(3), 415–428.

Oldham, J. M., Skodol, A. E., Kellman, H. D., Hyler, S. E., & Rosnick, L. (1992). Diagnosis of DSM-III-R personality disorders by two structured interviews: Patterns of comorbidity. *American Journal of Psychiatry, 149*(2), 213–220.

Olmsted, M. P., Davis, R., Garner, D. M., Rockert, W., Irvine, M. J., & Eagle, M. (1991). Efficacy of a brief group psychoeducational intervention for bulimia nervosa. *Behaviour Research and Therapy, 28*, 71–83.

Olmsted, M. P., Kaplan, A. S., & Rockert, W. (1994). Rate and prediction of relapse in bulimia nervosa. *American Journal of Psychiatry, 151,* 738–743.

Oltmanns, T. F., & Turkheimer, E. (2006). Perceptions of self and others regarding pathological personality traits. In R. F. Krueger & J. L. Tackett (Eds.), *Personality and psychopathology* (pp. 71–111). New York: Guilford Press.

Osman, A., Bagge, C. L., Gutierrez, P. M., Konick, L. C., Kopper, B. A., & Barrios, F. X. (2001). The Suicidal Behaviors Questionnaire—Revised (SBQ-R): Validation with clinical and nonclinical samples. *Assessment, 8*(4), 443–454.

Öst, L., Havnen, A., Hansen, B., & Kvale, G. (2015). Cognitive behavioral treatments of obsessive–compulsive disorder. A systematic review and meta-analysis of studies published 1993–2014. *Clinical Psychology Review, 40,* 156–169.

Ouellet-Courtois, C., Wilson, S., & O'Connor, K. (2018). Cognitive confidence in obsessive–compulsive disorder: A systematic review and meta-analysis. *Journal of Obsessive–Compulsive and Related Disorders, 19,* 77–86.

Ougrin, D. (2011). Efficacy of exposure versus cognitive therapy in anxiety disorders: Systematic review and meta-analysis. *BMC Psychiatry, 11*(1), 200.

Owen, M., Speight, T., Sarsam, M., & Sellwood, W. (2015). Group CBT for psychosis in acute care: A review of outcome studies. *The Cognitive Behavior Therapist, 8,* e2.

Pagano, M. E., Skodol, A. E., Stout, R. L., Shea, M. T., Yen, S., Grilo, C. M., et al. (2004). Stressful life events as predictors of functioning: Findings from the Collaborative Longitudinal Personality Disorders Study. *Acta Psychiatrica, 110*(6), 421–429.

Page, A. C., & Hooke, G. R. (2012). Effectiveness of cognitive-behavioral therapy modified for inpatients with depression. *International Scholarly Research Network Psychiatry, 2012*(4), 461265.

Panos, P. T., Jackson, J. W., Hasan, O., & Panos, A. (2014). Meta-analysis and systematic review assessing the efficacy of dialectical behavior therapy (DBT). *Research on Social Work Practice, 24*(2), 213–223.

Papageorgiou, C., Carlile, K., Thorgaard, S., Waring, H., Haslam, J., Horne, L., et al. (2018). Group cognitive-behavior therapy or group metacognitive therapy for obsessive–compulsive disorder? Benchmarking and comparative effectiveness in a routine clinical service. *Frontiers in Psychology, 9,* 2551.

Paris, J. (2004). Borderline or bipolar? Distinguishing borderline personality disorder from bipolar spectrum disorders. *Harvard Review of Psychiatry, 12*(3), 140–145.

Paris, J. (2005). The development of impulsivity and suicidality in borderline personality disorder. *Development and Psychopathology, 17*(4), 1091–1104.

Paris, J. (2018). Clinical features of borderline personality disorder. In W. J. Livesley & R. Larstone (Eds.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 419–425). New York: Guilford Press.

Patelis-Siotis, I., Young, L. T., Robb, J. C., Marriott, M., Bieling, P. J., Cox, L. C., et al. (2001). Group cognitive behavioral therapy for bipolar disorder: A feasibility and effectiveness study. *Journal of Affective Disorders, 65,* 145–153.

Paterson, C., Karatzias, T., Harper, S., Dougall, N., Dickson, A., & Hutton, P. (2019). A feasibility study of a cross-diagnostic, CBT-based psychological intervention for acute mental health inpatients: Results, challenges, and methodological implications. *British Journal of Clinical Psychology, 58*(2), 211–230.

Pawluk, E. J., Musielak, N., Milosevic, I., Rowa, K., Shnaider, P., Schneider, L. H.,

et al. (2022). Psychometric properties of the Diagnostic Assessment Research Tool (DART) Self-Report Screener for DSM-5 mental disorders. *Journal of Psychopathology and Behavioral Assessment*.

Pearl, S. B., & Norton, P. J. (2017). Transdiagnostic versus diagnosis specific cognitive behavioural therapies for anxiety: A meta-analysis. *Journal of Anxiety Disorders, 46,* 11–24.

Pederson, L. D. (2015). *Dialectical behavior therapy: A contemporary guide for practitioners*. Hoboken, NJ: Wiley.

Peters, E. R., Moritz, S., Schwannauer, M., Wiseman, Z., Greenwood, K. E., Scott, J., et al. (2014). Cognitive Biases Questionnaire for psychosis. *Schizophrenia Bulletin, 40*(2), 300–313.

Peters, L., Sunderland, M., Andrews, G., Rapee, R. M., & Mattick, R. P. (2012). Development of a short form Social Interaction Anxiety (SIAS) and Social Phobia Scale (SPS) using nonparametric item response theory: The SIAS-6 and the SPS-6. *Psychological Assessment, 24*(1), 66–76.

Peterson, C. B., & Miller, K. B. (2005). Assessment of eating disorders. In S. Wonderlich, J. Mitchell, M. de Zwann, & H. Steiger (Eds.), *Eating disorders review, Part I* (pp. 105–126). Oxon, UK: Radcliffe.

Peterson, R. A., & Reiss, S. (1993). *Anxiety Sensitivity Index—Revised test manual*. Worthington, OH: IDS.

Pharoah, F., Mari, J., Rathbone, J., & Wong, W. (2006). Family intervention for schizophrenia [Review]. *The Cochrane Library, 1*(4), Cd000088.

Pineles, S. L., Mostoufi, S. M., Ready, C. B., Street, A. E., Griffin, M. G., & Resick, P. A. (2011). Trauma reactivity, avoidant coping, and PTSD symptoms: A moderating relationship? *Journal of Abnormal Psychology, 21*(8), 1039–1049.

Pinto, A., Dargani, N., Wheaton, M. G., Cervoni, C., Rees, C. S., & Egan, S. J. (2017). Perfectionism in obsessive–compulsive disorder and related disorders: What should treating clinicians know? *Journal of Obsessive–Compulsive and Related Disorders, 12,* 102–108.

Piper, W. E., Marrache, M., Lacroix, R., Richardsen, A. M., & Jones, B. D. (1983). Cohesion as a basic bond in groups. *Human Relations, 36,* 93–108.

Polivy, J., & Federoff, I. (1997). Group psychotherapy. In P. E. Garfinkel & D. M. Garner (Eds.), *Handbook of treatment for eating disorders* (2nd ed., pp. 462–475). New York: Guilford Press.

Polivy, J., & Garfinkel, P. E. (1984). Group treatments for specific medical disorders: Anorexia nervosa. In H. B. Roback (Ed.), *Helping patients and their families cope with medical problems* (pp. 60–78). San Francisco: Jossey-Bass.

Polnay, A., James, V. A., Hodges, L., Murray, G. D., Munro, C., & Lawrie, S. M. (2014). Group therapy for people with bulimia nervosa: Systematic review and meta-analysis. *Psychological Medicine, 44,* 2241–2245.

Poole, N., & Greaves, L. (Eds.). (2012). *Becoming trauma informed*. Toronto: Centre for Addiction and Mental Health.

Post, R. M., Leverich, G. S., McElroy, S., Kupka, R., Suppes, T., Altshuler, L., et al. (2018). Prevalence of axis II comorbidities in bipolar disorder: Relationship to mood state. *Bipolar Disorders, 20*(4), 303–312.

Powers, A. D., & Oltmanns, T. F. (2012). Personality disorders and physical health: A longitudinal examination of physical functioning, healthcare utilization, and health-related behaviors in middle-aged adults. *Journal of Personality Disorders, 26*(4), 524–538.

Powers, M. B., Halpern, J. M., Ferenschak, M. P., Gillihan, S. J., & Foa, E. B. (2010). A meta-analytic review of prolonged exposure for posttraumatic stress disorder. *Clinical Psychology Review, 30*(6), 635–641.

Powers, M. B., Sigmarsson, S. R., & Emmelkamp, P. M. (2008). A meta-analytic review of psychological treatments for social anxiety disorder. *International Journal of Cognitive Therapy, 1*(2), 94–113.

Pozza, A., & Dèttore, D. (2017). Drop-out and efficacy of group versus individual cognitive behavioural therapy: What works best for obsessive–compulsive disorder? A systematic review and meta-analysis of direct comparisons. *Psychiatry Research, 258,* 24–36.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *The American Psychologist, 47*(9), 1102–1114.

Project Match Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH Posttreatment drinking outcomes. *Journal of Studies on Alcohol, 58*(1), 7–29.

Purdon, C. (1999). Thought suppression and psychopathology. *Behaviour Research and Therapy, 37,* 1029–1054.

Purdon, C., Rowa, K., & Antony, M. M. (2007). Diary records of thought suppression by individuals with obsessive–compulsive disorder. *Behavioural and Cognitive Psychotherapy, 35*(1), 47–59.

Rachman, S. (1997). The evolution of cognitive behaviour therapy. In D. M. Clark & C. G. Fairburn (Eds.), *Oxford medical publications. Science and practice of cognitive behaviour therapy* (pp. 3–26). Oxford, UK: Oxford University Press.

Rachman, S. (1998). A cognitive theory of obsessions. *Behaviour Research and Therapy, 36*(4), 385–401.

Rachman, S. (2002). A cognitive theory of compulsive checking. *Behaviour Research and Therapy, 40*(6), 625–639.

Rachman, S., & de Silva, P. (1978). Abnormal and normal obsessions. *Behaviour Research and Therapy, 16*(4), 233–248.

Rachman, S., Radomsky, A. S., & Shafran, R. (2008). Safety behaviour: A reconsideration. *Behaviour Research and Therapy, 46*(2), 163–173.

Rachman, S., & Shafran, R. (1999). Cognitive distortions: Thought–action fusion. *Clinical Psychology and Psychotherapy: An International Journal of Theory and Practice, 6*(2), 80–85.

Radomsky, A. S., & Alcolado, G. M. (2010). Don't even think about checking: Mental checking causes memory distrust. *Journal of Behavior Therapy and Experimental Psychiatry, 41*(4), 345.

Radomsky, A. S., & Alcolado, G. M. (2012). Information processing in obsessive compulsive disorder and related problems. In G. Steketee (Ed.), *The Oxford handbook of obsessive compulsive and spectrum disorders* (pp. 145–167). Oxford, UK: Oxford University Press.

Radomsky, A. S., & Rachman, S. (1999). Memory bias in obsessive–compulsive disorder (OCD). *Behaviour Research and Therapy, 37,* 605–618.

Ramacciotti, C. E., Coli, E., Paoli, R., Gabriellini, G., Schulte, F., Castrogiovanni, S., et al. (2005). The relationship between binge eating disorder and nonpurging bulimia nervosa. *Eating and Weight Disorders, 10,* 8–12.

Ramirez, J. J., Monti, P. M., & Colwill, R. M. (2015). Brief and extended

alcohol-cue-exposure effects on craving and attentional bias. *Experimental and Clinical Psychopharmacology, 23,* 159–167.

Rapee, R. M., & Heimberg, R. G. (1997). A cognitive-behavioral model of social anxiety in social phobia. *Behaviour Research and Therapy, 35*(4), 741–756.

Rapp, A. M., Bergman, R. L., Piacentini, J., & McGuire, J. F. (2016). Evidence-based assessment of obsessive–compulsive disorder. *Journal of Central Nervous System Disease, 8,* 13–29.

Rauch, S. A. M., Defever, E., Favorite, T., Duroe, A., Garrity, C., Martis, B., et al. (2009). Prolonged exposure for PTSD in a Veterans Health Administration PTSD clinic. *Journal of Traumatic Stress, 22*(1), 60–64.

Raune, D., & Daddi, I. (2011). Pilot study of group cognitive behavior therapy for heterogeneous acute psychiatric inpatients: Treatment in a sole-standalone session allowing patients to choose the therapeutic target. *Behavioral and Cognitive Psychotherapy, 39*(3), 359–365.

Ready, D. J., Thomas, K. R., Worley, V., Backsheider, A. G., Harvey, L. A. C., Baltzell, D., et al. (2008). A field test of group based exposure therapy with 102 veterans with war-related posttraumatic stress disorder. *Journal of Traumatic Stress, 21*(2), 150–157.

Rector, N. A., Richter, M. A., Katz, D., & Leybman, M. (2019). Does the addition of cognitive therapy to exposure and response prevention for obsessive compulsive disorder enhance clinical efficacy? A randomized controlled trial in a community setting. *British Journal of Clinical Psychology, 58*(1), 1–18.

Ree, M. J., French, D., MacLeod, C., & Locke, V. (2008). Distinguishing cognitive and somatic dimensions of state and trait anxiety: Development and validation of the State–Trait Inventory for Cognitive and Somatic Anxiety (STICSA). *Behavioural and Cognitive Psychotherapy, 36*(3), 313–332.

Rego, S. A. (2016). *Treatment plans and interventions for obsessive–compulsive disorder.* New York: Guilford Press.

Reinholt, N., & Krogh, J. (2014). Efficacy of transdiagnostic cognitive behaviour therapy for anxiety disorders: A systematic review and meta-analysis of published outcome studies. *Cognitive Behaviour Therapy, 43*(3), 171–184.

Reiss, S., & McNally, R. J. (1985). The expectancy model of fear. In S. Reiss & R. R. Bootzin (Eds.), *Theoretical issues in behavior therapy* (pp. 107–121). New York: Academic Press.

Resick, P. A., Galovski, T. E., Uhlmansiek, M. O. B., Scher, C. D., Clum, G. A., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology, 76*(2), 243–258.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748–756.

Resick, P. A., Suvak, M. K., Johnides, B. D., Mitchell, K. S., & Iverson, K. M. (2012). The impact of dissociation on PTSD treatment with cognitive processing therapy. *Depression and Anxiety, 29*(8), 718–730.

Resick, P. A., Wachen, J. S., Dondanville, K. A., Pruiksma, K. E., Yarvis, J. S., Peterson, A. L., et al. (2017). Effect of group vs individual cognitive processing therapy in active-duty military seeking treatment for posttraumatic stress disorder: A randomized clinical trial. *JAMA Psychiatry, 74*(1), 28–36.

Resick, P. A., Wachen, J. S., Mintz, J., Young-McCaughan, S., Roache, J. D., Borah, A. M., et al. (2015). A randomized clinical trial of group cognitive processing therapy compared with group present-centered therapy for PTSD among active duty military personnel. *Journal of Consulting and Clinical Psychology, 83*(6), 1058–1068.

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology, 61*(6), 984–991.

Ricca, V., Castellini, G., Mannucci, E., Lo Sauro, C., Ravaldi, C. M., & Faravelli, C. (2010). Comparison of individual and group cognitive behavioral therapy for binge eating disorder: A randomized, three-year follow-up study. *Appetite, 55,* 656–665.

Rice, D. P., & Miller, L. S. (1998). Health economics and cost implications of anxiety and other mental disorders in the United States. *British Journal of Psychiatry, 173*(34), 4–9.

Richter, C., Steinacher, B., zum Eschenhoff, A., & Bermpohl, F. (2016). Psychotherapy of borderline personality disorder: Can the supply meet the demand? A German nationwide survey in DBT inpatient and day clinic treatment facilities. *Community Mental Health Journal, 52*(2), 212–215.

Ritschel, L. A., Lim, N. E., & Stewart, L. M. (2015). Transdiagnostic applications of DBT for adolescents and adults. *American Journal of Psychotherapy, 69*(2), 111–128.

Roberge, P., Marchand, A., Reinharz, D., & Savard, P. (2008). Cognitive-behavioral treatment for panic disorder with agoraphobia: A randomized, controlled trial and cost-effectiveness analysis. *Behavior Modification, 32*(3), 333–351.

Robichaud, M., & Dugas, M. J. (2005). Negative problem orientation (Part II): Construct validity and specificity to worry. *Behaviour Research and Therapy, 43*(3), 403–412.

Robichaud, M., & Dugas, M. J. (2015). *The generalized anxiety disorder workbook: A comprehensive CBT guide for coping with uncertainty, worry, and fear.* Oakland, CA: New Harbinger.

Robichaud, M., Koerner, N., & Dugas, M. J. (2019). *Cognitive-behavioral treatment for generalized anxiety disorder: From science to practice* (2nd ed.). New York: Routledge.

Robins, C. J., & Chapman, A. L. (2004). Dialectical behavior therapy: Current status, recent developments, and future directions. *Journal of Personality Disorders, 18*(1), 73–89.

Roemer, L., Borkovec, M., Posa, S., & Borkovec, T. D. (1995). A self-report diagnostic measure of generalized anxiety disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 26,* 345–350.

Rohsenow, D. J., Martin, R. A., Eaton, C. A., & Monti, P. M. (2007). Cocaine craving as a predictor of treatment attrition and outcomes after residential treatment for cocaine dependence. *Journal of Studies on Alcohol and Drugs, 68,* 641–648.

Rohsenow, D. J., Monti, P. M., Martin, R. A., Colby, S. M., Myers, M. G., Gulliver, S. B., et al. (2004). Motivational enhancement and coping skills training for cocaine abusers: Effects on substance use outcomes. *Addiction, 99,* 862–874.

Rohsenow, D. J., Monti, P. M., Martin, R. A., Michalec, E., & Abrams, D. B.

(2000). Brief coping skills treatment for cocaine abuse: 12-month substance use outcomes. *Journal of Consulting and Clinical Psychology, 68,* 515–520.

Rohsenow, D. J., Monti, P. M., Rubonis, A. V., Sirota, A. D., Niaura, R. S., Colby, S. M., et al. (1994). Cue reactivity as a predictor of drinking among male alcoholics. *Journal of Consulting and Clinical Psychology, 62,* 620–626.

Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational interviewing in health care: Helping patients change behavior.* New York: Guilford Press.

Romanelli, R. J., Wu, F. M., Gamba, R., Mojtabai, R., & Segal, J. B. (2014). Behavioral therapy and serotonin reuptake inhibitor pharmacotherapy in the treatment of obsessive–compulsive disorder: A systematic review and meta-analysis of head-to-head randomized controlled trials. *Depression and Anxiety, 31*(8), 641–652.

Rosa-Alcázar, A. I., Sánchez-Meca, J., Gómez-Conesa, A., & Marín-Martínez, F. (2008). Psychological treatment of obsessive–compulsive disorder: A meta-analysis. *Clinical Psychology Review, 28*(8), 1310–1325.

Rose, D. T., Abramson, L. Y., Hodulik, C. J., Halberstadt, L., & Leff, G. (1994). Heterogeneity of cognitive style among depressed inpatients. *Journal of Abnormal Psychology, 103,* 419–429.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Rowa, K., Antony, M. M., & Swinson, R. P. (2007). Exposure and response prevention. In M. M. Antony, C. Purdon, & L. J. Summerfeldt (Eds.), *Psychological treatment of obsessive–compulsive disorder: Fundamentals and beyond* (pp. 79–109). Washington, DC: American Psychological Association.

Rowe, M. K., & Craske, M. G. (1998). Effects of varied-stimulus exposure training on fear reduction and return of fear. *Behaviour Research and Therapy, 36,* 719–734.

Roy-Byrne, P., Lee-Benner, K., & Yager, J. (1984). Group therapy for bulimia. *International Journal of Eating Disorders, 3,* 97–116.

Rudge, S., Feigenbaum, J., & Fonagy, P. (2017). Mechanisms of change in dialectical behaviour therapy and cognitive behaviour therapy for borderline personality disorder: A critical review of the literature. *Journal of Mental Health,* 1–11.

Salkovskis, P. M. (1985). Obsessional–compulsive problems: A cognitive-behavioural analysis. *Behaviour Research and Therapy, 23,* 571–583.

Salkovskis, P. M. (1991). The importance of behaviour in the maintenance of anxiety and panic: A cognitive account. *Behavioural and Cognitive Psychotherapy, 19*(1), 6–19.

Salkovskis, P. M. (1998). Psychological approaches to the understanding of obsessional problems. In R. P. Swinson, M. M. Antony, S. Rachman, & M. A. Richter (Eds.), *Obsessive–compulsive disorder: Theory, research, and treatment* (pp. 33–50). New York: Guilford Press.

Sansone, R. A., & Sansone, L. A. (2012). Employment in borderline personality disorder. *Innovations in Clinical Neuroscience, 9*(9), 25–29.

Sarawgi, S., Oglesby, M. E., & Cougle, J. R. (2013). Intolerance of uncertainty and obsessive–compulsive symptom expression. *Journal of Behavior Therapy and Experimental Psychiatry, 44*(4), 456–462.

Sato, H., & Kawahara, J. I. (2011). Selective bias in retrospective self-reports of negative mood states. *Anxiety, Stress and Coping, 24*(4), 359–367.

Scheiderer, E. M., Wood, P. K., & Trull, T. J. (2015). The comorbidity of borderline personality disorder and posttraumatic stress disorder: Revisiting the prevalence and associations in a general population sample. *Borderline Personality Disorder and Emotion Dysregulation, 2,* 11.

Schneider, L. H., Pawluk, E., Milosevic, I., Shnaider, P., Rowa, K., Antony, M. M., et al. (2022). The Diagnostic Assessment Research Tool (DART) in action: A preliminary evaluation of a semistructured interview for DSM-5 disorders. *Psychological Assessment, 34*(1), 21–29.

Schumm, J. A., Dickstein, B. D., Walter, K. H., Owens, G. P., & Chard, K. M. (2015). Changes in posttraumatic cognitions predict changes in posttraumatic stress disorder symptoms during cognitive processing therapy. *Journal of Consulting and Clinical Psychology, 83*(6), 1161–1166.

Schwannauer, M. (2004). Cognitive behavioural therapy for bipolar affective disorder. In M. Power (Ed.), *Mood disorders: A handbook of science and practice* (pp. 259–273). Chichester, UK: Wiley.

Schwartze, D., Barkowski, S., Burlingame, G. M., Strauss, B., & Rosendahl, J. (2016). Efficacy of group psychotherapy for obsessive–compulsive disorder: A meta-analysis of randomized controlled trials. *Journal of Obsessive–Compulsive and Related Disorders, 10,* 49–61.

Schwartze, D., Barkowski, S., Strauss, B., Knaevelsrud, C., & Rosendahl, J. (2019). Efficacy of group psychotherapy for posttraumatic stress disorder: Systematic review and meta-analysis of randomized controlled trials. *Psychotherapy Research, 29*(4), 415–431.

Scott, J. (2001). Cognitive therapy as an adjunct to medication in bipolar disorder. *British Journal of Psychiatry, 178*(Suppl. 41), S164–S168.

Scott, J., Garland, A., & Moorhead, S. (2001). A pilot study of cognitive therapy in bipolar disorders. *Psychological Medicine, 31,* 459–467.

Scott, J., Stanton, B., Garland, A., & Ferrier, I. N. (2000). Cognitive vulnerability in patients with bipolar disorder. *Psychological Medicine, 30,* 467–472.

Segal, Z. V., & Teasdale, J. (2018). *Mindfulness-based cognitive therapy for depression*. New York: Guilford Press.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2013). *Mindfulness-based cognitive therapy for depression* (2nd ed.). New York: Guilford Press.

Seligman, M. (1990). *Learned optimism*. New York: Vintage Books.

Serfaty, M. A., Turkington, D., Heap, M., Ledsham, L., & Jolley, E. (1999). Cognitive therapy versus dietary counseling in the outpatient treatment of anorexia nervosa: Effects of the treatment phase. *European Eating Disorders Review, 7,* 334–350.

Shafran, R., & de Silva, P. (2003). Cognitive-behavioral models. In J. T. Treasure, U. Schmidt, & E. van Furth (Eds.), *Handbook of eating disorders* (2nd ed., pp. 121–138). West Sussex, UK: Wiley.

Shafran, R., Thordarson, D. S., & Rachman, S. (1996). Thought–action fusion in obsessive–compulsive disorder. *Journal of Anxiety Disorders, 10,* 379–391.

Shallcross, S. L., Arbisi, P. A., Polusny, M. A., Kramer, M. D., & Erbes, C. R. (2016). Social causation versus social erosion: Comparisons of causal models for relations between support and PTSD symptoms. *Journal of Traumatic Stress, 29*(2), 167–175.

Shapiro, D. H. (1992). Adverse effects of meditation: A preliminary investigation of long-term meditators. *International Journal of Psychosomatics, 39*(1–4), 62–67.

Sharp, D. M., Power, K. G., & Swanson, V. (2004). A comparison of the efficacy and acceptability of group versus individual cognitive behaviour therapy in the treatment of panic disorder and agoraphobia in primary care. *Clinical Psychology and Psychotherapy, 11,* 73–82.

Sheaves, B., Isham, L., Bradley, J., Espie, C., Barrera, A., Waite, F., et al. (2018). Adapted CBT to stabilize sleep on psychiatric wards: A transdiagnostic treatment approach. *Behavioral and Cognitive Psychotherapy, 46*(6), 661–675.

Shevlin, M., Dorahy, M., Adamson, G., & Murphy, J. (2007). Subtypes of borderline personality disorder, associated clinical disorders and stressful life-events: A latent class analysis based on the British Psychiatric Morbidity Survey. *British Journal of Clinical Psychology, 46*(Part 3), 273–281.

Shin, N. Y., Lee, T. Y., Kim, E., & Kwon, J. S. (2014). Cognitive functioning in obsessive–compulsive disorder: A meta-analysis. *Psychological Medicine, 44*(6), 1121–1130.

Shnaider, P., Boyd, J. E., Cameron, D. H., & McCabe, R. E. (2021). The relationship between emotion regulation difficulties and PTSD outcomes during group cognitive processing therapy for PTSD. *Psychological Services*.

Shulman, M., Campbell, A., Pavlicova, M., Hu, M. C., Aharonovich, E., & Nunes, E. V. (2018). Cognitive functioning and treatment outcomes in a randomized controlled trial of internet-delivered drug and alcohol treatment. *American Journal on Addictions, 27*(6), 509–515.

Siev, J., Huppert, J. D., & Zuckerman, S. E. (2017). Understanding and treating scrupulosity. In J. S. Abramowitz, D. McKay, & E. A. Storch (Eds.), *The Wiley handbook of obsessive compulsive disorders* (Vol. 1, pp. 527–546). Hoboken, NJ: Wiley.

Silk, K. R. (2010). The quality of depression in borderline personality disorder and the diagnostic process. *Journal of Personality Disorders, 24*(1), 25–37.

Simpson, D. D., Joe, G. W., Dansereau, D. F., & Flynn, P. M. (2010). Addiction treatment outcomes, process and change: Texas Institute of Behavioral Research at Texas Christian University. *Addiction, 106*(10), 1733–1740.

Sinha, R., Lacadie, C., Skudlarski, P., Fulbright, R. K., Rounsaville, B. J., Kosten, T. R., et al. (2005). Neural activity associated with stress-induced cocaine craving: Functional magnetic resonance imaging study. *Psychopharmacology, 183,* 171–180.

Sinha, R., Talih, M., Malison, R., Cooney, N., Anderson, G., & Kreek, M. (2003). Hypothalamic–pituitary–adrenal axis and sympatho–adreno–medullary responses during stress-induced and drug cue-induced cocaine craving states. *Psychopharmacology, 170,* 62–72.

Sitharthan, T., Sitharthan, G., Hough, M. J., & Kavanaugh, D. J. (1997). Cue exposure in moderation drinking: A comparison with cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology, 65,* 878–882.

Sizino da Victoria, M., Nascimento, A. L., & Fontenelle, L. F. (2012). Symptom-specific attentional bias to threatening stimuli in obsessive–compulsive disorder. *Comprehensive Psychiatry, 53*(6), 783–788.

Skapinakis, P., Caldwell, D., Hollingworth, W., Bryden, P., Fineberg, N., Salkovskis, P., et al. (2016). Pharmacological and psychotherapeutic interventions for management of obsessive–compulsive disorder in adults: A systematic review and network meta-analysis. *Lancet Psychiatry, 3*(8), 730–739.

Skodol, A. E. (2012). Personality disorders in DSM-5. *Annual Review of Clinical Psychology, 8*(1), 317–344.

Skodol, A. E., Gunderson, J. G., Pfohl, B., Widiger, T. A., Livesley, W. J., & Siever, L. J. (2002). The borderline diagnosis I: Psychopathology, comorbidity, and personality structure. *Biological Psychiatry, 51*(12), 936–950.

Skodol, A. E., Gunderson, J. G., Shea, M. T., McGlashan, T. H., Morey, L. C., Sanislow, C. A., et al. (2005). The Collaborative Longitudinal Personality Disorders Study (CLPS): Overview and implications. *Journal of Personality Disorders, 19*(5), 487–504.

Slade, P. D. (1982). Towards a functional analysis of anorexia nervosa and bulimia nervosa. *British Journal of Clinical Psychology, 21,* 167–179.

Sloan, D. M., Bovin, M. J., & Schnurr, P. P. (2012). Review of group treatment for PTSD. *Journal of Rehabilitation Research and Development, 49*(5), 689.

Sloan, D. M., Feinstein, B. A., Gallagher, M. W., Beck, J. G., & Keane, T. M. (2013). Efficacy of group treatment for posttraumatic stress disorder symptoms: A meta-analysis. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(2), 176–183.

Small, C., Pistrang, N., Huddy, V., & Williams, C. (2018). Individual psychological therapy in an acute inpatient setting: Service user and psychologist perspectives. *Psychology and Psychotherapy: Theory, Research and Practice, 91*(4), 417–433.

Smith, B. M., Bluett, E. J., Lee, E. B., & Twohig, M. P. (2017). Acceptance and commitment therapy for OCD. In J. S. Abramowitz, D. McKay, & E. A. Storch (Eds.), *The Wiley handbook of obsessive compulsive disorders* (Vol. 1, pp. 261–281). Hoboken, NJ: Wiley.

Snyder, H. R., Kaiser, R. H., Warren, S. L., & Heller, W. (2015). Obsessive–compulsive disorder is associated with broad impairments in executive function: A meta-analysis. *Clinical Psychological Science, 3*(2), 301–330.

Sobell, L. C., & Sobell, M. B. (2011). *Group therapy for substance use disorders: A motivational cognitive-behavioral approach.* New York: Guilford Press.

Sobell, L C., Sobell, M. B., & Agrawal, S. (2009). Randomized controlled trial of a cognitive-behavioral motivational intervention in a group versus individual format for substance use disorders. *Psychology of Addictive Behaviors, 23,* 672–683.

Soler, J., Pascual, J., Tiana, T., Cebria, A., Barrachina, J., Campins, M., et al. (2009). Dialectical behavior therapy skills training compared to standard group therapy in borderline personality disorder: A 3-month randomized controlled clinical trial. *Behaviour Research and Therapy, 47*(5), 353–358.

Spaniol, E. D., Smith, W. B., Thomas, D. A., & Clark, D. B. (2019). Addressing the opioid crisis: Social and behavioral research contributions at the National Institutes of Health. Translational Behavioral Medicine, *10*(2), 482–485.

Staiger, P. K., & White, J. M. (1991). Cue reactivity in alcohol abusers: Stimulus specificity and extinction of the responses. *Addictive Behaviors, 16,* 211–221.

Starcevic, V., Berle, D., Brakoulias, V., Sammut, P., Moses, K., Milicevic, D., et al. (2011). The nature and correlates of avoidance in obsessive–compulsive disorder. *Australian and New Zealand Journal of Psychiatry, 45*(10), 871–879.

Stathopoulou, G., Pollack, M. H., & Otto, M. W. (2018). Anxiety sensitivity moderates drug cravings in response to induced negative affect in opioid dependent outpatients. *Addictive Behaviors, 84,* 75–78.

Steele, S. J., Farchione, T. J., Cassiello-Robbins, C., Ametaj, A., Sbi, S., Sauer-Zavala,

S., et al. (2018). Efficacy of the unified protocol for transdiagnostic treatment of comorbid psychopathology accompanying emotional disorders compared to treatments targeting single disorders. *Journal of Psychiatric Research, 104,* 211–216.

Steketee, G., & Frost, R. (2001). Development and initial validation of the Obsessive Beliefs Questionnaire and the Interpretation of Intrusions Inventory. *Behaviour Research and Therapy, 39,* 987–1006.

Stephane, M., Barton, S., & Boutros, N. N. (2001). Auditory verbal hallucinations and dysfunction of the neural substrates of speech. *Schizophrenia Research, 50,* 61–78.

Stepp, S. D., Olino, T. M., Klein, D. N., Seeley, J. R., & Lewinsohn, P. M. (2013). Unique influences of adolescent antecedents on adult borderline personality disorder features. *Journal of Personality Disorders, 4*(3), 223.

Stern, R., & Marks, I. (1973). Brief and prolonged flooding: A comparison in agoraphobic patients. *Archives of General Psychiatry, 28,* 270–276.

Stewart, K. E., Sumantry, D., & Malivoire, B. (2020). Family and couple integrated cognitive-behavioural therapy for adults with obsessive–compulsive disorder: A meta-analysis. *Journal of Affective Disorders, 277,* 159–168.

Stewart, R. E., & Chambless, D. L. (2009). Cognitive-behavioral therapy for adult anxiety disorders in clinical practice: A meta-analysis of effectiveness studies. *Journal of Consulting and Clinical Psychology, 77*(4), 595–606.

Stewart, S. E., & Loh, A. S. (2017). Biological models and treatments for OCD in adults. In J. S. Abramowitz, D. McKay, & E. A. Storch (Eds.), *The Wiley handbook of obsessive compulsive disorders* (Vol. 1, pp. 261–281). Hoboken, NJ: Wiley.

Stice, E., Marti, C. N., Spoor, S., Presnell, K., & Shaw, H. (2008). Dissonance and healthy weight eating disorder prevention programs: Long-term effects from a randomized efficacy trial. *Journal of Consulting and Clinical Psychology, 76*(2), 329–340.

Stice, E., Rohde, P., Shaw, H., & Gau, J. M. (2019). Randomized trial of a dissonance-based group treatment for eating disorders versus a supportive mindfulness group. *Journal of Consulting and Clinical Psychology, 87,* 79–90.

Stice, E., Yokum, S., Rohde, P., Shaw, H., Gau, J. M., Johnson, S., et al. (2019). Randomized trial of a dissonance-based transdiagnostic group treatment for eating disorders: An evaluation of target engagement. *Journal of Consulting and Clinical Psychology, 87*(9), 772–786.

Stirman, S. W., Gutner, C. A., Suvak, M. K., Adler, A., Calloway, A., & Resick, P. (2018). Homework completion, patient characteristics, and symptom change in cognitive processing therapy for PTSD. *Behavior Therapy, 49*(5), 741–755.

Storch, E. A., Rasmussen, S. A., Price, L. H., Larson, M. J., Murphy, T. K., & Goodman, W. K. (2010). Development and psychometric evaluation of the Yale–Brown Obsessive–Compulsive Scale—second edition. *Psychological Assessment, 22*(2), 223–443.

Striegel-Moore, R. H., & Franko, D. L. (2003). The epidemiology of binge eating disorder. *International Journal of Eating Disorders, 34*(Suppl.), S19–S29.

Striegel-Moore, R. H., Rosselli, F., Perrin, N., DeBar, L., Wilson, G. T., May, A., et al. (2009). Gender difference in the prevalence of eating disorder symptoms. *International Journal of Eating Disorders, 42,* 471–474.

Striegel-Moore, R. H., Silberstein, L. R., & Rodin, J. (1986). Toward an

understanding of risk factors for bulimia. *American Psychologist, 41,* 146–163.

Strother, E., Lemberg, R., Stanford, S. C., & Turberville, D. (2012). Eating disorders in men: Underdiagnosed, undertreated, and misunderstood. *Eating Disorders, 20*(*5*), 346–355.

Substance Abuse and Mental Health Services Administration Substance. (2014). *Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health* (HHS Publication No. SMA 14-4863, NSDUH Series H-48R). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52). RockvilleV, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

Suijkerbuijk, Y. B., Schaafsma, F. G., van Mechelen, J. C., Ojajärvi, A., Corbière, M., & Anema, J. R. (2017). Helping adults with severe mental illness get a job and to keep it, a network meta-analysis. *Cochrane Systematic Review, 9,* CD011867.

Summerfeldt, L. J. (2001). Obsessive–compulsive disorder: A brief overview and guide to assessment. In M. M. Antony, S. M. Orsillo, & L. Roemer (Eds.), *Practitioner's guide to empirically-based measures of anxiety* (pp. 211–218). New York: Kluwer Academic/Plenum Press.

Swartz, H. A., & Swanson, J. (2014). Psychotherapy for bipolar disorder in adults: A review of the evidence. *Focus, 12*(3), 251–266.

Swift, J. K., & Callahan, J. L. (2009). The impact of client treatment preferences on outcome: A meta-analysis. *Journal of Clinical Psychology, 65*(4), 368–381.

Takahashi, T., Lapham, G., Chavez, L. J., Lee, A. K., Williams, E. C., Richards, J. E., et al. (2017). Comparison of DSM-IV and DSM-5 criteria for alcohol use disorders in VA primary care patients with frequent heavy drinking enrolled in a trial. *Addiction Science and Clinical Practice, 12,* 17.

Tasca, G., Flynn, C., & Bissada, H. (2002). Comparison of group climate in an eating disorders partial hospital group and a psychiatric partial hospital group. *International Journal of Group Psychotherapy, 52,* 409–417.

Tauber, R., Wallace, C. J., & Lecomte, T. (2000). Enlisting indigenous community supporters in skills training programs for persons with severe mental illness. *Psychiatric Services, 51,* 1428–1432.

Taylor, S., Abramowitz, J. S., McKay. D., & Cuttler, C. (2012). Cognitive approaches to understanding obsessive compulsive and related disorders. In G. Steketee (Ed.), *The Oxford handbook of obsessive compulsive and spectrum disorders* (pp. 233–250). Oxford, UK: Oxford University Press.

Taylor, S., Abramowitz, J. S., McKay, D., & Garner, L. E. (2020).

Obsessive-compulsive and related disorders. In M. M. Antony & D. H. Barlow (Eds.), *Handbook of assessment and treatment planning for psychological disorders* (3rd ed., pp. 253–294). New York: Guilford Press.

Teasdale, J. D., & Segal, Z. V. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: Guilford Press.

Teasdale, J. D., Williams, J. M. G., & Segal, Z. V. (2014). *The mindful way workbook: An 8-week program to free yourself from depression and emotional distress*. New York: Guilford Press.

Telch, C. F., & Agras, W. S. (1992). *Cognitive behavioral therapy for binge eating disorder therapist manual*. Stanford, CA: Stanford University Press.

Telch, C. F., Agras, W. S., & Linehan, M. M. (2001). Dialectical behavior therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology, 69*(6), 1061–1065.

Terr, L. C., Bloch, D. A., Michel, B. A., Shi, H., Reinhardt, J. A., & Metayer, S. (1999). Children's symptoms in the wake of *Challenger*: A field study of distant-traumatic effects and an outline of related conditions. *American Journal of Psychiatry, 156,* 1536–1544.

Thelen, M. H., Farmer, J., Wonderlich, S., & Smith, M. (1991). A revision of the Bulimia Test: The BULIT-R. *Psychological Assessment, 3,* 119–124.

Tolin, D. F., Abramowitz, J. S., Brigidi, B. D., & Foa, E. B. (2003). Intolerance of uncertainty in obsessive–compulsive disorder. *Journal of Anxiety Disorders, 17,* 233–242.

Tolin, D. F., Gilliam, C., Wootton, B. M., Bowe, W., Bragdon, L. B., Davis, E., et al. (2018). Psychometric properties of a structured diagnostic interview for DSM-5 anxiety, mood, and obsessive–compulsive and related disorders. *Assessment, 25*(1), 3–13.

Tolin, D. F., Woods, C. M., & Abramowitz, J. S. (2003). Relationship between obsessive beliefs and obsessive–compulsive symptoms. *Cognitive Therapy and Research, 27,* 657–669.

Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2014). Characteristics of borderline personality disorder in a community sample: Comorbidity, treatment utilization, and general functioning. *Journal of Personality Disorders, 28*(5), 734–750.

Tsao, J. C. I., & Craske, M. G. (2000). Timing of treatment and return of fear: Effects of massed, uniform-, and expanding-spaced exposure schedules. *Behavior Therapy, 31*(3), 479–497.

Tucker, M., & Oei, T. P. (2007). Is group more cost effective than individual cognitive behaviour therapy? The evidence is not solid yet. *Behavioural and Cognitive Psychotherapy, 35*(1), 77–91.

Tugade, M. M., Fredrickson, B. L., & Barrett, L. F. (2004). Psychological resilience and positive emotional granularity: Examining the benefits of positive emotions on coping and health. *Journal of Personality, 72*(6), 1161–1190.

Turner, C., Krebs, G., & Destro, J. (2017). Family-based conceptualization and treatment of obsessive–compulsive disorder. In J. S. Abramowitz, D. McKay, & E. S. Storch (Eds.), *The Wiley handbook of obsessive compulsive disorders* (Vol. 1, pp. 614–631). Hoboken, NJ: Wiley.

Turner, D. T., van der Gaag, M., Karyotaki, E., & Cuijpers, P. (2014). Psychological interventions for psychosis: A meta-analysis of comparative outcome studies. *American Journal of Psychiatry, 171*(5), 523–538.

Turner, S. M., Johnson, M. R., Beidel, D. C., Heiser, N. A., & Lydiard, R. B. (2003). The Social Thoughts and Beliefs Scale: A new inventory for assessing cognitions in social phobia. *Psychological Assessment, 15,* 384–391.

Udachina, A., Varese, F., Oorschot, M., Myin-Germeys, I., & Bentall, R. P. (2013). Dynamics of self-esteem in "poor-me" and "bad-me" paranoia. *Journal of Nervous and Mental Disease, 200*(9), 777–783.

Udo, T., & Grilo, C. M. (2018). Prevalence and correlates of DSM-5-defined eating disorders in a nationally representative sample of U.S. adults. *Biological Psychiatry, 84*(5), 345–354.

Uliaszek, A. A., Hamdullahpur, K., Chugani, C. D., & Rashid, T. (2018). Mechanisms of change in group therapy for treatment-seeking university students. *Behaviour Research and Therapy, 109,* 10–17.

Uliaszek, A. A., Rashid, T., Williams, G. E., & Gulamani, T. (2016). Group therapy for university students: A randomized control trial of dialectical behavior therapy and positive psychotherapy. *Behaviour Research and Therapy, 77,* 78–85.

Uliaszek, A. A., Wilson, S., Mayberry, M., Cox, K., & Maslar, M. (2014). A pilot intervention of multifamily dialectical behavior group therapy in a treatment-seeking adolescent population: Effects on teens and their family members. *Family Journal, 22*(2), 206–215.

Uliaszek, A. A., & Zinbarg, R. E. (2016). An examination of the higher-order structure of psychopathology and its relationship to personality. *Journal of Personality Disorders, 30*(2), 157–176.

U.S. Department of Health and Human Services, Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.* Washington, DC: U.S. Department of Health and Human Services.

Valentine, S. E., Bankoff, S. M., Poulin, R. M., Reidler, E. B., & Pantalone, D. W. (2015). The use of dialectical behavior therapy skills training as stand-alone treatment: A systematic review of the treatment outcome literature. *Journal of Clinical Psychology, 71*(1), 1–20.

Van Ameringen, M., Patterson, B., & Simpson, W. (2014). DSM-5 obsessive–compulsive and related disorders: Clinical implications of new criteria. *Depression and Anxiety, 31*(6), 487–493.

Van Ameringen, M., Simpson, W., Patterson, B., Dell'Osso, B., Fineberg, N., Hollander, E., et al. (2014). Pharmacological treatment strategies in obsessive compulsive disorder: A cross-sectional view in nine international OCD centers. *Journal of Psychopharmacology, 28*(6), 596–602.

van Balkom, A. J., van Oppen, P., Vermeulen, A. W., & van Dyck, R. (1994). A meta-analysis on the treatment of obsessive–compulsive disorder: A comparison of antidepressants, behavior, and cognitive therapy. *Clinical Psychology Review, 14,* 359–381.

van Balkom, A. J. L. M., & van Dyck, R. (1998). Combination treatments for OCD. In R. P. Swinson, M. M. Antony, S. Rachman, & M. A. Richter (Eds.), *Obsessive–compulsive disorder: Theory, research, and treatment* (pp. 349–366). New York: Guilford Press.

Van den Bosch, L. M. C., Verheul, R., Schippers, G. M., & van den Brink, W. (2002). Dialectical behavior therapy of borderline patients with and without

substance use problems: Implementation and long-term effects. *Addictive Behaviors, 27*(6), 911–923.

van Dis, E. A. M., van Veen, S. C., Hagenaars, M. A., Batelaan, N. M., Bockting, C. L., van den Heuvel, R. M., et al. (2020). Long-term outcomes of cognitive behavioral therapy for anxiety-related disorders: A systematic review and meta-analysis. *JAMA Psychiatry, 77*(3), 265–273.

Van Noppen, B., Steketee, G., McCorkle, B. H., & Pato, M. (1997). Group and multifamily behavioral treatment for obsessive compulsive disorder: A pilot study. *Journal of Anxiety Disorders, 11,* 431–446.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., et al. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin, 38*(4), 661–671.

Veltro, F., Falloon, I., Vendittelli, N., Oricchio, I., Scinto, A., Gigantesco, A., et al. (2006). Effectiveness of cognitive-behavioral group therapy for inpatients. *Clinical Practice and Epidemiology in Mental Health, 2*(1), 16.

Veltro, F., Vendittelli, N., Orichhio, I., Addona, F., Avino, C., Figliolia, G., et al. (2008). Effectiveness and efficiency of cognitive-behavioral therapy for inpatients: 4-year follow-up study. *Journal of Psychiatric Practice, 14,* 281–288.

Verheul, R., Bartak, A., & Widiger, T. (2007). Prevalence and construct validity of personality disorder not otherwise specified (PDNOS). *Journal of Personality Disorders, 21*(4), 359–370.

Verheul, R., Van Den Bosch, L. M., Koeter, M. W., De Ridder, M. A., Stijnen, T., & Van Den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomised clinical trial in the Netherlands. *British Journal of Psychiatry, 182*(2), 135–140.

Veterans Administration, U.S. Department of Veterans Affairs and Department of Defense (2015). *VA/DoD clinical practice guideline for the management of substance use disorders*. Washington, DC: Author.

Vitousek, K. B., & Ewald, L. S. (1993). Self-representation in eating disorders: A cognitive perspective. In Z. V. Segal & S. J. Blatt (Eds.), *The self in emotional distress: Cognitive and psychodynamic perspectives* (pp. 221–266). New York: Guilford Press.

Vitousek, K. B., & Hollon, S. D. (1990). The investigation of schematic content and processing eating disorders. *Cognitive Therapy and Research, 14,* 191–214.

Wade, S., Byrne, S., & Allen, K. (2017). Enhanced cognitive behavioral therapy for eating disorders adapted for a group setting. *International Journal of Eating Disorders, 50,* 863–872.

Wagner, C. C., & Intersoll, K. S. (2013). *Motivational interviewing in groups*. New York: Guilford Press.

Wallach, J. R. (2015). *Emotion dysregulation: A predictor for CBT treatment outcomes in a comorbid PTSD and SUD population*. New York: CUNY Academic Works.

Walsh, B. T., Attia, E., Glasofer, D. R., & Sysko, R. (2015). *Handbook of assessment and treatment of eating disorders*. Arlington, VA: American Psychiatric Association.

Walter, K. H., Bolte, T. A., Owens, G. P., & Chard, K. M. (2012). The impact of personality disorders on treatment outcome for veterans in a posttraumatic

stress disorder residential treatment program. *Cognitive Therapy and Research, 36*(5), 576–584.

Walter, K. H., Dickstein, B. D., Barnes, S. M., & Chard, K. M. (2014). Comparing the effectiveness of CPT to CPT-C among U.S. veterans in an interdisciplinary residential PTSD/TBI treatment program. *Journal of Traumatic Stress, 27,* 438–445.

Watson, H. J., & Bulik, C. (2013). Update on the treatment of anorexia nervosa: Review of clinical trials, practice guidelines and emerging interventions. *Psychological Medicine, 43,* 2477–2500.

Watts, S. E., Turnell, A., Kladnitski, N., Newby, J. M., & Andrews, G. (2015). Treatment-as usual (TAU) is anything but usual: A meta-analysis of CBT versus TAU for anxiety and depression. *Journal of Affective Disorders, 175,* 152–167.

Waugh, M. H., Hopwood, C. J., Krueger, R. F., Morey, L. C., Pincus, A. L., & Wright, A. G. (2017). Psychological assessment with the DSM-5 alternative model for personality disorders: Tradition and innovation. *Professional Psychology: Research and Practice, 48*(2), 79–101.

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). Available at *www.ptsd.va.gov*

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Available at *www.ptsd.va.gov*

Wegner, D. M. (1989). *White bears and other unwanted thoughts: Suppression, obsession, and the psychology of mental control.* New York: Viking/Penguin.

Wegner, D. M., & Schneider, D. J. (2003). The white bear story. *Psychological Inquiry, 14*(3/4), 326–329.

Weiss, R. D., Jaffee, W. B., de Menil, V. P., & Cogley, C. B. (2004). Group therapy for substance use disorders: What do we know? *Harvard Review of Psychiatry, 12,* 339–350.

Wells, A., & Cartwright-Hatton, S. (2004). A short form of the Metacognitions Questionnaire: Properties of the MCQ-30. *Behaviour Research and Therapy, 42*(4), 385–396.

Wells, A., Clark, D. M., Salkovskis, P., Ludgate, J., Hackman, A., & Gelder, M. (1995). Social phobia: The role of in-situation safety behaviors in maintaining anxiety and negative beliefs. *Behavior Therapy, 26,* 153–161.

Wells, A., Myers, S., Simons, M., & Fisher, P. (2017). Metacognitive model and treatment of OCD. In J. S. Abramowitz, D. McKay, & E. S. Storch (Eds.), *The Wiley handbook of obsessive compulsive disorders* (Vol. 1, pp. 644–662). Hoboken, NJ: Wiley.

Weltzin, T. (2005). Eating disorders in men: Update. *Journal of Men's Health and Gender, 2,* 186–193.

Wendt, D. C., & Gone, J. P. (2017). Group therapy for substance use disorders: A survey of clinician practices. *Journal of Groups in Addiction and Recovery, 12,* 243–259.

Wenzel, A., Dobson, K. S., & Hays, P. A. (Eds.). (2016). Problem solving. In *Cognitive behavioural therapy techniques and strategies* (pp. 67–86). Washington, DC: American Psychological Association.

Westra, H. A. (2012). *Motivational interviewing in the treatment of anxiety*. New York: Guilford Press.

White, J. R. (2000). Depression. In J. R. White & A. S. Freeman (Eds.), *Cognitive-behavioral group therapy: For specific problems and populations* (pp. 29–61). Washington, DC: American Psychological Association.

Whitfield, G. (2010). Group cognitive-behavioural therapy for anxiety and depression. *Advances in Psychiatric Treatment, 16*(3), 219–227.

Whittal, M. L., & McLean, P. D. (2002). Group cognitive behavioral therapy for obsessive compulsive disorder. In R. O. Frost & G. Steketee (Eds.), *Cognitive approaches to obsessions and compulsions: Theory, assessment, and treatment* (pp. 417–433). Oxford, UK: Elsevier.

Whittal, M. L., Thordarson, D. S., & McLean, P. D. (2005). Treatment of obsessive–compulsive disorder: Cognitive behavior therapy vs. exposure and response prevention. *Behaviour Research and Therapy, 43,* 1559–1576.

Whittingham, M., & Martin, J. (2020). How to do group therapy using telehealth. American Psychological Association Services. Available at *www.apaservices.org/practice/legal/technology/group-therapy-telehealth-covid-19*

Wickett, A., Essman, W., Beck-Jennings, J., Davis, L., McIlvried, J., & Lysaker, P. H. (2006). Cluster B and C personality traits, symptom correlates, and treatment utilization in postacute schizophrenia. *Journal of Nervous and Mental Disease, 194*(9), 650–653.

Widiger, T. A., & Trull, T. J. (2007). Plate tectonics in the classification of personality disorder: Shifting to a dimensional model. *American Psychologist, 62*(2), 71–83.

Wilamowska, Z. A., Thompson-Hollands, J., Fairholme, C. P., Ellard, K. K., Farchione, T. J., & Barlow, D. H. (2010). Conceptual background, development, and preliminary data from the unified protocol for transdiagnostic treatment of emotional disorders. *Depression and Anxiety, 27*(10), 882–890.

Wilfley, D. E., Friedman, M. A., Dounchis, J. Z., Stein, R. I., Welch, R., & Ball, S. A. (2000). Comorbid psychopathology in binge eating disorder: Relation to eating disorder severity at baseline and following treatment. *Journal of Consulting and Clinical Psychology, 68,* 296–305.

Wilfley, D. E., Schwartz, M., Spurrell, E. B., & Fairburn, C. G. (2000). Using the Eating Disorder Examination to identify the specific psychopathology of binge eating disorder. *International Journal of Eating Disorders, 27,* 259–269.

Wilfley, D. E., Welch, R. R., Stein, R. I., Spurrell, E. B., Cohen, L. R., Saelens, B. E., et al. (2002). A randomized comparison of group cognitive-behavioral therapy and group interpersonal psychotherapy for the treatment of overweight individuals with binge-eating disorder. *Archives of General Psychiatry, 59,* 713–721.

Wilhelm, S., McNally, R. J., Baer, L., & Florin, I. (1996). Directed forgetting in obsessive–compulsive disorder. *Behaviour Research and Therapy, 34,* 633–641.

Wilhelm, S., & Steketee, G. S. (2006). *Cognitive therapy for obsessive–compulsive disorder: A guide for professionals*. Oakland, CA: New Harbinger.

Williams, G., & Uliaszek, A. A. (2019). Emotion vulnerability in the context of positively valenced stimuli: Associations with borderline personality disorder symptom severity. *Psychopathology and Behavioral Assessment, 41*(3), 4360446.

Williams, J. M. G., Mathews, A., & MacLeod, C. (1996). The emotional Stroop Task and psychopathology. *Psychological Bulletin, 120*(1), 3–24.

Williams, J. M. G., Watts, F. N., MacLeod, C., & Mathews, A. (1997). *Cognitive psychology and emotional disorders* (2nd ed.). Chichester, UK: Wiley.

Wilson, G. T. (1999). Cognitive behavior therapy for eating disorders: Progress and problems. *Behaviour Research and Therapy, 37*(Suppl. 1), S79–S97.

Wilson, G. T., & Fairburn, C. G. (2002). Treatments for eating disorders. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (2nd ed., pp. 559–592). New York: Oxford University Press.

Wilson, G. T., Fairburn, C. G., & Agras, W. S. (1997). Cognitive-behavioral therapy for bulimia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (2nd ed., pp. 67–93). New York: Guilford Press.

Wiseman, C. V., Sunday, S. R., Klapper, F., Klein, M., & Halmi, K. A. (2002). Short-term group CBT versus psycho-education on an inpatient eating disorder unit. *Eating Disorders: Journal of Treatment and Prevention, 10,* 313–320.

Wolf, E. J., Lunney, C. A., & Schnurr, P. P. (2016). The influence of the dissociative subtype of posttraumatic stress disorder on treatment efficacy in female veterans and active duty service members. *Journal of Consulting and Clinical Psychology, 84*(1), 95–100.

Wolf, E. M., & Sefferino, M. R. (2008). Group treatments of eating disorders with children and adolescents. In L. VandeCreek & J. B. Allen (Eds.), *Innovations in clinical practice: Focus on group, couples, and family therapy* (pp. 29–45). Sarasota, FL; Professional Resource Press/Professional Resource Exchange.

Woodward, T. S., Muntz, M., Leclerc, C., & Lecomte, T. (2009). Change in delusions is associated with change in "jumping to conclusions." *Psychiatry Research, 170,* 124–127.

Woody, S. R., Detweiler-Bedell, J., Teachman, B. A., & O'Hearn, T. (2003). *Treatment planning in psychotherapy: Taking the guesswork out of clinical care.* New York: Guilford Press.

World Health Organization. (2013). *Guidelines for the management of conditions specifically related to stress.* Geneva, Switzerland: Author.

World Health Organization. (2014). Global Status Report on Alcohol and Health (2014 ed., p. xiv). Retrieved January 18, 2019, from *www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_1.pdf?ua=1*

World Health Organization (2017). *Depression and other common mental disorders: Global health estimates.* Geneva: World Health Organization.

World Health Organization. (2018). Global Status Report on Alcohol and Health, 2018. Available at *https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1*

Wortmann, J. H., Jordan, A. H., Weathers, F. W., Resick, P. A., Dondanville, K. A., Hall-Clark, B., et al. (2016). Psychometric analysis of the PTSD Checklist-5 (PCL-5) among treatment-seeking military service members. *Psychological Assessment, 28*(11), 1392–1403.

Wray, T. B., Merrill, J. E., & Monti, P. M. (2014). Using ecological momentary assessment (EMA) to assess situation-level predictors of alcohol use and alcohol-related consequences. *Alcohol Research: Current Reviews, 36*(1), 19–27.

Xia, J., & Li, C. (2007). Problem solving skills for schizophrenia. *Cochrane Database of Systematic Reviews, 2,* CD006365.

Yadin, E., Foa, E. B., & Lichner, T. K. (2012a). *Treating your OCD with exposure and response (ritual) prevention for obsessive–compulsive disorder, therapist guide* (2nd ed.). Oxford, UK: Oxford University Press.

Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York: Basic Books.

Yalom, I., & Leszcz, M. (2005). *Theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Yehuda, R., Hoge, C. W., McFarlane, A. C., Vermetten, E., Lanius, R. A., Nievergelt, C. M., et al. (2015). Post-traumatic stress disorder. *Nature Review:s Disease Primers,* 1, 1.

Yehuda, R., McFarlane, A. C., & Shalev, A. Y. (1998). Predicting the development of posttraumatic stress disorder from the acute response to a traumatic event. *Biological Psychiatry, 44*(12), 1305–1313.

Yuen, E. K., Goetter, E. M., Stasio, M. J., Ash, P., Mansour, B., McNally, E., et al. (2019). A pilot of acceptance and commitment therapy for public speaking anxiety delivered with group videoconferencing and virtual reality exposure. *Journal of Contextual Behavioral Science, 12,* 47–54.

Zanarini, M. C. (2003). Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD): A continuous measure of DSM-IV borderline psychopathology. *Journal of Personality Disorders, 17*(3), 233–242.

Zanarini, M. C., Frankenburg, F. R., Dubo, E. D., Sickel, A. E., Trikha, A., Levin, A., et al. (1998). Axis I comorbidity of borderline personality disorder. *American Journal of Psychiatry, 155*(12), 1733–1739.

Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2005). The McLean Study of Adult Development (MSAD): Overview and implications of the first six years of prospective follow-up. *Journal of Personality Disorders, 19*(5), 505–523.

Zimmerman, M., & Mattia, J. I. (1999). Axis I diagnostic comorbidity and borderline personality disorder. *Comprehensive Psychiatry, 40*(4), 245–252.

Zinbarg, R. E., Craske, M. G., & Barlow, D. H. (2006). *Mastery of your anxiety and worry (MAW): Therapist guide* (2nd ed.). New York: Oxford University Press.

Zisook, S., Goff, A., Sledge, P., & Shuchter, S. R. (1994). Reported suicidal behavior and current suicidal ideation in a psychiatric outpatient clinic. *Annals of Clinical Psychiatry, 6*(1), 27–31.

Zucker, B. G., Craske, M. G., Barrios, V., & Holguin, M. (2002). Thought–action fusion: Can it be corrected? *Behaviour Research and Therapy, 40,* 653–664.

Zucker, N. L., Loeb, K. L., Patel, S., & Shafer, A. (2011). Parent groups in the treatment of eating disorders. In D. Le Grange & J. Lock (Eds.), *Eating disorders in children and adolescents: A clinical handbook* (pp. 362–380). New York: Guilford Press.

Zylowska, L., Ackerman, D. L., Yang, M. H., Futrell, J. L., Horton, N. L., Hale, T. S., et al. (2008). Mindfulness meditation training in adults and adolescents with ADHD: A feasibility study. *Journal of Attention Disorders, 11*(6), 737–746.

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