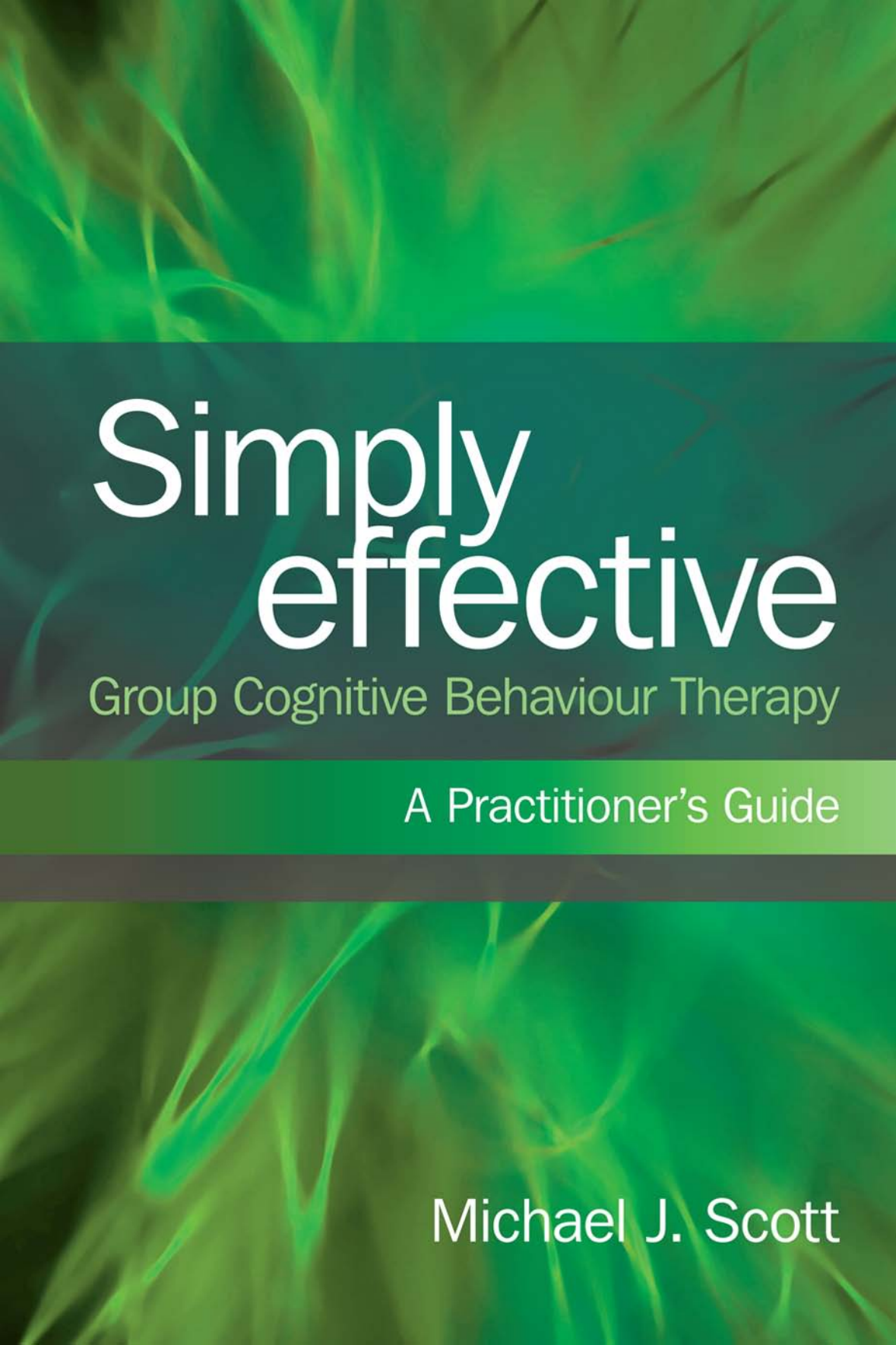
Simply effective
Group Cognitive Behaviour Therapy
A Practitioner's Guide
Michael J. Scott

Simply Effective Group Cognitive Behaviour Therapy

Group Cognitive Behaviour Therapy (GCBT) and guided self-help widen the availability of evidence-based treatment for common mental health disorders. This volume provides GCBT protocols for common disorders as well as session-by-session teaching materials and self-help survival manuals covering:

- Depression
- Panic disorder and agoraphobia
- Post-traumatic stress disorder
- Social phobia
- Obsessive compulsive disorder
- Generalised anxiety disorder

The specifics of selecting and engaging clients in GCBT are first addressed and general group therapeutic skills are detailed. Transcripts of sessions show how group processes can be utilised to enhance outcome. *Simply Effective Group Cognitive Behaviour Therapy* adds to the armamentarium of tools for low intensity intervention and complements the high intensity individual approach of the companion volume *Simply Effective Cognitive Behaviour Therapy*. It will prove essential reading for all professionals using CBT with groups.

Michael J. Scott is a practising Consultant Psychologist working in Liverpool and author of seven books on CBT. He taught CBT for 15 years at the University of Manchester and was External Examiner for the MSc in Cognitive and Behavioural Psychotherapies at the University of Chester and currently holds this post at Sheffield Hallam University.

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Chapter 1

Group cognitive behaviour therapy

Cognitive behaviour therapy (CBT) is distinguishable from its psychotherapy forebears by its educational emphasis. However, for the most part CBT clients have undergone an individual rather a group intervention. The reasons for this are probably multifarious: a lack of training opportunities in group CBT (GCBT) interventions, the logistics of running a group, the unpopularity of group interventions amongst clients and a feeling of many therapists of being particularly exposed in a group.

Unfortunately therapists using individual CBT (ICBT) treat the tip of the iceberg of clients with psychological problems; in England only 10% of sufferers from depression or anxiety disorders receive a talking therapy (*Adult Psychiatric Morbidity in England, 2007* 2009). This has led to a demand to widen access by utilising innovative modes of service delivery such as GCBT, bibliotherapy and computer-assisted therapy (IAPT 2008). The educational nature of CBT makes it particularly suitable for dissemination in group format. There are four key features of CBT that lend themselves to an educational group format:

1 *Therapy begins with an elaborated well-planned rationale*. This feature encourages the client to believe that by changing their thoughts and behaviour they can affect how they feel. There is a cognitive model of each disorder; for example, in panic disorder catastrophic cognitions about unusual but not abnormal bodily sensations (e.g. 'my heart racing means I am having a heart attack') are held to play a pivotal role in the maintenance of the disorder. The model of a disorder can be presented just as well to a group as to an individual, with examples of the model (case formulation) used that are pertinent to all group members. Thus various examples of catastrophic cognitions would be offered, 'I am going to faint and there will be nobody there for me', 'I am going to choke to death', etc. Therapy is then described as challenging these beliefs both cognitively and by actions.
2 *Therapy provides training in skills that the client can utilise to feel more effective in handling daily life*. A group session is probably more easily

construed as a training session than is an individual session and lessens the possibility of dependence. The focus is on giving clients strategies to try out before the next session that may make a difference. In individual sessions a client can easily feel a failure if they do not do the homework task perfectly. However, in a group it soon becomes apparent that mastery is an inappropriate standard and the group norm is one of gradually learning to cope better: 'two steps forward and one back'; further difficulties are reframed as learning opportunities.

3 *Therapy emphasises the independent use of skills by the client outside the therapy context*. The knowledge that other group members are also being asked to engage in similar activities outside of a therapy session is likely to enhance compliance. It is not simply that group pressure is enhancing compliance but because the activity has been sold to other group members it has credibility. For example, if in a depression group members are asked to plan an activity to offset their anticipated low spot in the week, the endorsement of the rationale by others enhances motivation.

4 *Therapy should encourage clients to attribute improvement in mood to their own skilfulness rather than to the therapist's endeavours*. In GCBT the therapist is more likely to be construed as a teacher rather than a therapist, more like a 'driving instructor', important initially, but with a knowledge that it is essentially independent practice that makes a difference.

In the understandable rush to give psychological help to all in need, there is an ever present danger of a sacrifice of quality on the altar of quantity. Fortunately, with regard to GCBT the evidence is that GCBT is as efficacious as individual CBT for depression and probably most anxiety disorders. Further, the goal of this volume is to assure the reader that there is a simplicity (and fun) in GCBT and that it can be conducted effectively in routine practice. This chapter begins with a review of the evidence supporting the efficacy of GCBT for depression and anxiety disorders and then looks at whether there is evidence that GCBT is effective in routine practice. It is suggested that ICBT and GCBT are not mutually exclusive and can be judiciously combined to address the needs of real world clients with more than one disorder. Finally, the strengths and limitations of heterogeneous groups are discussed.

Individual versus group CBT

One of the key axioms of Beck's cognitive theory of psychological disorders (Alford and Beck 1997) is cognitive content specificity, i.e. that the different disorders have a different cognitive content necessitating a different approach with each. For example, the sufferer from depression might regard

themselves as worthless, the future hopeless, whilst the sufferer from anxiety by contrast might see themselves as vulnerable and the future uncertain. As a consequence of cognitive content specificity, different protocols were developed and evaluated for different disorders. This development was made possible by Beck's earlier work on improving the reliability of psychiatric diagnosis (Beck *et al.* 1962), so that in discussing, say, a person with depression there was clear agreement as to what this label meant. Beck *et al.* (1962) noted the poor reliability of routine unstructured psychiatric assessments (32–54%) in terms of diagnosis, making research impossible, and paved the way for structured interviews with much higher levels of reliability. For the most part it is disorder-specific CBT treatments that have been evaluated and the focus below is on studies of depression and the anxiety disorders.

Depression

A review of ten studies of the relative efficacy of ICBT and GCBT for depression by Tucker and Oei (2007) concluded that GCBT for depression is more cost-effective than ICBT. However, five of the studies showed the superiority of ICBT over GCBT and five showed the equivalence of the two modalities.

Social phobia

In a comparison of GCBT for social phobia with a waiting list control condition, Hope *et al.* (1995) found that the former was superior, with treatment gains being largely maintained in the year afterwards (Salaberria and Echeburua 1998). More recently Stangier *et al.* (2003) compared GCBT and ICBT delivered over 15 weekly sessions and found the latter superior, with 50% of clients in individual CBT no longer meeting criteria for social phobia at the end of treatment compared with 13.6% in the group condition. However, only the first seven sessions of the Stangier *et al.* (2003) programme included training in shifting attentional focus to external cues, stopping safety behaviours, video feedback to correct distorted self-imagery, behavioural experiments and cognitive restructuring. The majority of the second half of treatment was devoted to cognitive work on schemas rather than behavioural experiments. It may be that had the latter half of the Stangier *et al.* (2003) programme been more behavioural, capitalising in the group modality on group norms about 'daring' to engage in social situations, the differences between ICBT and GCBT would have been less and both interventions more powerful. However, at present it is difficult to come to any firm conclusions about the relative effectiveness of GCBT and ICBT for social phobia. Marom *et al.* (2009) found that whilst the presence of coexisting depression did not affect the immediate outcome of GCBT for

social phobia, those who had depression suffered an exacerbation of symptoms post-treatment, suggesting that people with depression and social phobia may need additional interventions to maintain gains.

Panic disorder and agoraphobia

Roberge and colleagues (2008) in a comparison of GCBT and standard CBT in the treatment of panic disorder and agoraphobia found that GCBT incurred lower treatment costs and had a superior cost-effectiveness ratio. (Whilst, as in most outcome studies for any disorder, clients with a severe comorbid disorder were excluded from the study, in the Roberge *et al.* (2008) study 30% of those treated met criteria for another anxiety disorder and 8% criteria for depression). If clients are given a free choice between ICBT and GCBT following initial assessment, the overwhelming majority (95% in Sharp *et al.*'s [2004] study of panic disorder clients) will opt for individual therapy.

Post-traumatic stress disorder (PTSD)

GCBT can produce results comparable to ICBT. Beck *et al.* (2009) assigned individuals with PTSD following a serious motor vehicle accident to either GCBT or a minimum contact comparison group. Of treatment completers, 88.3% did not meet criteria for PTSD at the end of treatment compared to 31.3% of the minimal contact condition; further treatment gains were maintained at 3-month follow-up. However, earlier efforts by Taylor *et al.* (2001) to transport individual treatment into a group setting without modification were much less successful with only 38% of clients no longer meeting criteria for PTSD after treatment. In their translation of an individual programme into a group format Beck and Coffey (2005) addressed issues such as group cohesion and the possibility of a re-traumatisation of clients by hearing the stories of other group members about their accidents.

Engaging clients in GCBT is a particular challenge and Thompson *et al.* (2009) found that just over half of the people invited to consider attending a PTSD group chose not to do so. Further, there is evidence that the severity of PTSD symptoms varies by type of trauma – sexual assault, road traffic accidents, sudden death of a loved one – and the pattern of PTSD symptoms also varies (Kelley *et al.* 2009) suggesting that PTSD treatment groups should not be totally heterogeneous.

Generalised anxiety disorder (GAD)

In a comparison of GCBT for generalised anxiety disorder with a waiting list control condition, Dugas *et al.* (2003) found that the active condition was superior and the results similar to those in ICBT treatments reported in

the literature. However, Dugas *et al.* (2003) add a cautionary note in that 5 of the 48 participants in GCBT dropped out compared to none out of 26 in an earlier study of ICBT for GAD. But Dugas *et al.* (2003) also pointed out that many participants reported that the group therapy format was particularly useful because it helped them to feel less isolated and better understood and it gave them the opportunity to learn from others in the group.

Obsessive compulsive disorder (OCD)

GCBT is an effective treatment for OCD but often, it seems, less so than ICBT. In a comparison of ICBT and GCBT for OCD conducted by Cabedo *et al.* (2010), though GCBT was effective in decreasing OCD severity, with 41% classified as recovered post-treatment, this was less than the 69% recovered in ICBT. At 12-month follow-up the figure for GCBT was 32% compared with 63% in ICBT. The results of Whittal *et al.* (2008) were slightly more promising for GCBT, in that recovery status or relapse rates were equivalent for ICBT and GCBT, but the psychometric test results for OCD and depression favoured ICBT. (Further, within the Whittal *et al.* [2008] study a comparison with exposure and response prevention was made and the cognitive therapy was better tolerated and resulted in less dropout. Interestingly in the GCBT programme, one session was held in the presence of a family member or friend. Overall about 50% of OCD sufferers recovered with cognitive therapy.) However, in a study by Jaurrieta *et al.* (2008), GCBT and ICBT appeared equally effective at 6- and 12-month follow-up and there was no difference in the dropout rate.

In a study of GCBT for obsessive compulsive disorder (O'Connor *et al.* 2005) 38% of clients refused treatment in a group format. Reasons for the refusal included anxiety about sharing problems with others, social anxiety, lack of personal attention and fears of acquiring new obsessions from others in the group.

Delivering effective GCBT

Whilst the above review of GCBT interventions for depression and the anxiety disorders makes clear the potency of this intervention modality, it also indicates that it is not a simple matter to translate proven individual protocols into an appropriate group format or to engage clients in GCBT. It is suggested in this volume that group intervention needs supplementing with individual sessions, some of which would be concurrent with the group sessions but some sessions may precede the group if motivation for the group is an issue. Further, if the group programme is ineffective clients should be offered an individual programme. The motivational sessions can be used to address fears about attending a group. For example, a client with

obsessive compulsive disorder who is besieged by repugnant thoughts/images of a sexual or harmful nature may be very fearful about any possibility of disclosing such material in a group. Such concerns would be a focus in individual sessions and if the client's fears were allayed, they may then opt into a GCBT programme. The particulars of how to address such concerns are detailed in Chapter 2. In routine practice clients should not be 'assigned' to GCBT but invited to engage when fears are assuaged; if they are not ready, individual treatment should continue. Attention to clients' motivations with regard to GCBT could increase the uptake of the latter and reduce defaulting from a group programme.

The individual sessions can also be used to address other comorbid anxiety disorders/depression or associated marital problems. Individual sessions do not necessarily have to take place face to face and when conducted over the telephone typically take about 20 minutes (Clark *et al.* 2009); in the Clark *et al.* study (2009), about a quarter of sessions were face to face. Telephone consultations take place at a prearranged time and the therapist follows up the call if the client is not available. The comorbid disorders are addressed using a combination of at least one face-to-face individual session and CBT guided self-help (CBTgsh) – brief telephone/e-mail contact based on the disorder-specific manuals (Appendices H–M), self-help books and blank self-help forms.

Group members can affect each other for both good and ill and good group therapeutic skills are required of the therapist to maximise the former and reduce the latter. Thus the therapist not only has to have competence in treating the specific disorder at an individual level but also has to develop group work skills; this latter is addressed in Chapter 3. The succeeding chapters describe ten-session group programmes for depression and each of the anxiety disorders.

Transdiagnostic groups

There is an added convenience in running a transdiagnostic group that covers depression and the anxiety disorders (Free 2007) but they appear suboptimal. Hagen *et al.* (2005) examined the efficacy of GCBT in a mixed group of patients with depression and anxiety disorders. Whilst the authors concluded that the programme seemed to have a favourable effect both in the short and long term they added that specific treatments for specific disorders seemed to be more effective than their GCBT programme for depression and the anxiety disorders. These results are echoed by Oei and Boschen (2009), who examined the effectiveness of GCBT in a in a client population, 17.3% of whom were suffering from depression, 30.2% panic disorder, 14% generalised anxiety disorder and 8.4% post-traumatic stress disorder. Only 43% of individuals showed reliable change and 17% were 'recovered' from their anxiety symptoms. Oei and Boschen (2009) concluded that their mixed

group treatment was less effective than a disorder-specific treatment but was comparable to the individual CBT treatments (Westbrook and Kirk 2005) that are common in routine practice without fidelity to a disorder-specific protocol. However, GCBT appears effective in groups of limited heterogeneity. For example, Norton *et al.* (2008) examined the effects of GCBT in a sample for which the primary diagnosis was an anxiety disorder; for 50% of the sample the primary diagnosis was social anxiety disorder and for 35% the primary diagnosis was panic disorder but no client had PTSD and only one OCD, thus although the intervention was effective caution has to be exercised in terming it 'transdiagnostic'. It may be that in a group largely composed of clients with panic disorder and social phobia, there is such a commonality in the need to confront feared situations that neither population feels significantly different to the other.

The viability of evidence-based treatment in routine practice

There is a concern that the results of studies conducted in research centres, i.e. of efficacy studies, may not generalise to routine clinical practice. Necessarily in efficacy studies the focus is on clients with relatively 'pure' conditions. Further, the therapists in research centres have higher levels of training and supervision than those found amongst therapists in routine practice. It is therefore important to determine how well CBT for depression and the anxiety disorders holds up in actual clinical practice. Fortunately there are now effectiveness studies that indicate that the protocols from research centres can be applied to routine practice with little if any loss of power with regard to depression and the anxiety disorders.

In a study conducted in inner city Liverpool, an area of high deprivation, Scott and Stradling (1990) compared the effectiveness of ICBT and GCBT for depression with a waiting list control condition. The active conditions were equally effective and the results comparable to those in efficacy studies of ICBT. In line with Shaw and Hollon's (1979) recommendation, Scott and Stradling (1990) provided supplementary individual sessions; however, the former recommended up to six whereas the latter provided only three such sessions. Scott and Stradling (1990) concluded that the GCBT modality resulted in a 25–50% cost saving. Bright *et al.* (1999) also examined the effectiveness of GCBT for depression and found that therapist adherence to the manual-based treatment was associated with greater improvement in clinician-rated depressive symptoms. Observers rated four general objectives associated with cognitive therapy: set and/or followed an agenda, presented information as an educator, discussed automatic thoughts and/or cognitive distortions and reviewed and/or assigned homework. A high score indicated greater compliance with the protocol, which was predictive of a better outcome. Further, acquired skills in cognitive restructuring were

associated with greater improvement. The dropout rate for GCBT was 35% and the number of dropouts was significantly correlated with group size. Interestingly this study included a mutual support group comparison condition which did as well as the GCBT. The mutual support group had a number of specific goals, including interpersonal insight, the acquisition of disclosure skills and the sharing of feedback and advice. This suggests that there can be mechanisms of therapeutic change in a group that are not necessarily specific to CBT and consideration of group process may also be of importance. The subjects in the Bright *et al.* (1999) study were media recruited and had mean initial Beck Depression Scores of 23 compared to 28 in the Scott and Stradling (1990) study, suggesting a less troubled population. Further, in the Bright *et al.* (1999) study clients were not offered any individual sessions, it is possible that this may have increased attrition.

In the 56 anxiety disorder effectiveness studies reviewed by Stewart and Chambless (2009), large effect sizes were found for panic disorder, post-traumatic stress disorder, generalised anxiety disorder and obsessive compulsive disorder and a medium effect for social anxiety disorder. Overall, CBT in routine settings had an improvement of 78% versus 22% for control groups, with large pre-test–post-test effect. Stewart and Chambless (2009) also found that effect sizes decreased significantly when therapists were not asked to follow a manual and when there was little or no monitoring to make sure the treatment was followed. Stewart and Chambless (2009) assessed the clinical representativeness of the studies they reviewed on a nine-point scale, where points were awarded for clinically representative setting (e.g. outpatient mental health clinic), clinically representative referral (e.g. from GP), clinically representative therapists (e.g. clinicians for whom service is a substantial part of job), clinically representative structure (e.g. treatment with a structure used in clinical practice), clinically representative monitoring (e.g. no formal adherence checks), no pretherapy training (e.g. therapists did not receive special training immediately before study in specific techniques to be used), no randomisation (e.g. clients were not part of a trial), clinically representative patients (e.g. no exclusionary criteria aside from psychosis, suicidality, organic brain disease or substance dependence) and medications allowed. Whilst the study showed that the more representative a study was the smaller the impact of CBT, the magnitude of the relationship was quite small.

Most of the effectiveness studies considered by Stewart and Chambless (2009) related to individual CBT and though they included GCBT effectiveness studies they did not perform a separate analysis for this modality, most probably because there are too few GCBT effectiveness studies at present. In the same year, Oei and Boschen (2009) published a study of the effectiveness of a GCBT programme for clients with a variety of anxiety disorders. Oei and Boschen (2009) concluded that whilst their study

demonstrated that treatment was effective in reducing anxiety symptoms to an extent comparable with other effectiveness studies, only 43% of individuals showed reliable change and 17% 'recovered'. Further, Oei and Boschen (2009) claimed that their results were comparable to those found in an effectiveness study of individual CBT conducted by Westbrook and Kirk (2005). The effect sizes in both the Oei and Boschen (2009) and Westbrook and Kirk (2005) studies were less than in efficacy studies conducted in research centres. There are a number of possibilities for this; in the Oei and Boschen (2009) study it could be that having a variety of anxiety disorder clients in the same group resulted in a less than optimal dose of treatment for each disorder. The suboptimal performance in both studies could have arisen because neither used a treatment manual and there was no monitoring to check adherence to a protocol. Alternatively the poorer performance could have arisen because of differences between the population/therapists in the research centres and routine practice; the different explanations are not mutually exclusive. Though the precise reason for the lower effect sizes in these two studies remains unclear, it seems sensible to use a manualised approach with adherence checks and where possible not to have a mixed group of anxiety disorders.

Comorbidity

The presence of additional disorders (comorbidity) can affect outcome. To some extent this can be prevented by excluding those who are psychotic, substance dependent or suicidal, but comorbidity is the rule rather than the exception. Zimmerman *et al.* (2008) found that 50–75% of clients receiving a diagnosis of PTSD, GAD, OCD, depression, social phobia and panic disorder (with or without agoraphobia) met criteria for at least one additional diagnosis. In a study of clients with either panic disorder or generalised anxiety disorder receiving different forms of CBT, van Balkom *et al.* (2008) found the additional presence of depression led to less improvement. Further, there was a lower remission rate for those comorbid with depression than for those comorbid with another anxiety disorder or those with no comorbidity, i.e. it is not just comorbidity per se that makes a difference but the type of comorbidity. However, some caution is necessary in generalising from these results about the significance of a comorbid anxiety disorder in that in the van Balkom *et al.* (2008) study, of those comorbid with another anxiety disorder only two clients (4%) had PTSD and three clients (5%) had obsessive compulsive disorder.

Evidence-based treatment protocols can be blended together (Scott 2009) for the effective treatment of principal and comorbid disorders. However, in combining evidence-based protocols for disorders the therapist runs the risk of providing a sub-therapeutic dose of any one protocol. A combination of a therapeutic dose for one disorder and a sub-therapeutic dose for

another will yield an unsatisfactory outcome and may lead to a result that is worse than if just one disorder were targeted. When it is necessary to utilise more than one protocol, say A and B, it is inappropriate to decide in advance on the appropriate number of sessions for each, as there are likely to be some common elements in treatment foci, e.g. low mood and treatment method such as thought record (i.e. transdiagnostic features); rather, doses of each should be slowly titrated until there is a significant change in the combination of disorders, see Figure 1.1, as assessed by a structured interview. (Thus any one client may need more or fewer sessions than the standard ten session programmes outlined in Scott [2009].) During the titration the therapist must remain aware of the different properties of A and B. Just as the end point of mixing two colours together is a particular colour, so too the end point treating principal and comorbid disorders is a change in the diagnostic status of each of the conditions with which the client presents.

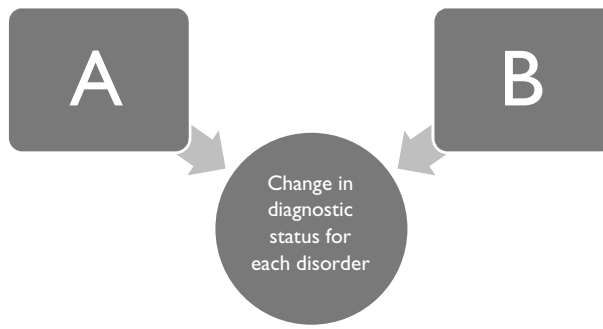

Figure 1.1 Blending protocols.

Each protocol is guided by a Sat Nav (see Appendix A) which summarises treatment targets and treatment strategies. At any point in time during treatment the therapist must be aware of which Sat Nav they are using for what. Each Sat Nav draws upon the variety of available evidence-based CBT protocols for that disorder. In this volume the protocols are presented in such a way as to minimise confusion between the different theoretical inputs into a Sat Nav.

Candidates for GCBT can be allocated to a group either on the basis of their principal diagnosis (the main disorder the person wants treating) or in terms of the disorder which produces the greatest functional impairment. The author knows of no empirical reason to prefer one method of selection over the other and in practice there are often two disorders worthy of focus. The author offers the rules of thumb in Table 1.1.

In support of the allocation rules in Table 1.1, a study by Teng *et al.* (2008) of clients with both PTSD and panic disorder found that whilst a

Table 1.1 Allocation to group on basis of diagnoses

Depression	Depression trumps social phobia and generalised anxiety disorder except if the depression is mild. However, PTSD, panic disorder and OCD trump depression unless the latter is severe.
Social phobia	Social phobia can be the prime focus if depression is mild or not present. However, if other anxiety disorders are present they should be the prime focus with the possible exception of GAD.
PTSD	PTSD should be the prime focus unless depression is severe and trumps the other disorders except if panic disorder or OCD are severe.
Panic disorder and agoraphobia	Panic disorder trumps social phobia and GAD but not PTSD or OCD or depression when the latter is severe.
Generalised anxiety disorder	GAD trumps only mild depression.
OCD	OCD trumps the other disorders except for severe depression, severe PTSD and severe panic disorder.

CBT programme focused on the latter disorder resulted in substantial reduction of panic frequency, severity and distress, there was no reduction in PTSD symptoms. The intent of Table 1.1 is to construct a group whose needs can be comprehensively met by a group focus on the principal disorder, graded exposure to feared situations, and typically up to three individual sessions for 'personal' issues/extra focus on comorbid disorders, but the number of individual sessions should be determined by those that are necessary to resolve the comorbid disorder/s.

Though a client may be assigned to a group on the basis of their principal disorder using Table 1.1, group sessions need not necessarily have an exclusive focus on just one disorder. For example, social anxiety disorder can lead to depression and if depression is an issue for the majority of the social phobia group (bearing in mind that given Table 1.1 it would have to be mild) then it would be legitimate to integrate the materials from the depression protocol. (The pathway from social anxiety disorder to depression is discussed in the Chapter 7 [Jack 1999].) The key principle is that the groups be as homogeneous as possible so that disorder-specific interventions can be dovetailed. But there should be a clear mechanism of how one disorder relates to another, otherwise if a multiplicity of disorders is addressed in the group each is likely to receive an inadequate dose. For example, many clients with PTSD have substance abuse/alcohol problems. There is evidence that the addictive behaviours can be construed as an attempt at self-medication, indeed that improvement in PTSD symptoms leads to improvements in addictive behaviours rather than vice versa (calling into question the conventional wisdom that clients need to be alcohol/drug free before commencing PTSD treatment). Thus it is perfectly possible to run a group for clients dually diagnosed as suffering from PTSD

and substance abuse (Najavits 2002) and produce significant results for both conditions (Hien *et al.* 2010), though interestingly homogeneity has been engineered by confining such groups to women.

Craske *et al.* (2007) have looked at two different ways of addressing comorbidity in GCBT in clients with panic disorder. All clients were given in addition six individual sessions; for one half of the sample these sessions were used to reinforce teaching in the group session and for the other half these sessions were utilised to address the most severe comorbid condition. Addressing the most severe comorbid condition resulted in a poorer outcome both for that condition and for the panic disorder. But it could be argued that six sessions of treatment for whatever was the most severe comorbid disorder is not an evidence-based treatment for any disorder and it is therefore unsurprising that it conferred no additional benefit; arguably an evidence-based protocol is needed for the comorbid disorder. It may also be that addressing the full range of comorbid conditions, (clients in the Craske *et al.* [2007] had on average 2.4 comorbid conditions), rather than just the most severe, would have produced a better outcome as clients do wish for treatment of the full range of conditions from which they suffer (Zimmerman and Mattia 2000). A further possible explanation of the results of the Craske *et al.* (2007) study is that those who received individual sessions to reinforce teaching in the group session were in effect receiving a form of motivational interviewing with regard to the group material, increasing homework compliance and expectancy for anxiety control, as there is some evidence that motivational interviewing improves outcome in GCBT (Westra and Dozois 2006). At present the jury is out on the best way of addressing comorbidity in GCBT. The approach adopted in this volume is to include both motivational interviewing and evidence-based treatment protocols for each comorbid disorder in the supplementary individual sessions. Whilst the best way of handling comorbidity is a matter of debate, there is agreement that reliable diagnosis is an important issue (van Balkom *et al.* 2008).

Reliable diagnosis

Historically, diagnosis has been very important in CBT, determining which evidence-based protocol is to be used with which client. This approach is an outgrowth of Beck's cognitive-content specificity theory (Alford and Beck 1997) that the disorders are distinguished by their differing cognitive content. Beck *et al.* (1962) paved the way for reliable diagnosis by noting the poor levels of agreement (32–54%) that arise from traditional open-ended interviews and suggesting that if clinicians were to have a common language about what constitutes a particular disorder, e.g. depression, then there had to be a consensus on what range of symptoms were considered pertinent (information variance) and on the threshold needed to determine

whether a symptom was present at a clinically significant level (criterion variance). As a consequence of these considerations structured interviews were developed that minimised information and criterion variance, resulting in reliabilities of 80–90% (e.g. the SCID, First *et al.* [1997a, 1997b]). Further, without a structured interview assessors are likely to stop at the first disorder/problem identified (Zimmerman *et al.* 2008).

DSM-IV-TR (American Psychiatric Association 2000, p. xxxii) has echoed Beck's strictures by stating that proper use of its diagnostic criteria means directly accessing the information in the criteria set and requiring that a question/s be asked about each symptom that comprises a disorder; for a symptom to be regarded as present it must significantly impair functioning. As an aid to diagnosis, in Appendix A, the author has provided a CBT Pocketbook with interview questions about each of the DSM symptoms that cover depression and the anxiety disorders.

Assessment and treatment pathways for GCBT

Potential clients for GCBT can be assessed and treated using the decision tree in Figure 1.2.

Screening clients

The first step in assessing referred clients is to screen them for the whole range of disorders from which they might be suffering and not just depression and the anxiety disorders. This can be accomplished using the 7 Minute Mental Health Screen/Audit – Revised (Appendix B) or the self-report counterpart the First Step Questionnaire – Revised (Appendix C). Using the Interview or Questionnaire, key questions are asked about each disorder followed by a question that asks clients whether this is something with which they would like help (the screening questions for panic disorder, for example, are shown in Table 1.2).

The screening questions for depression have been found to correctly identify 79% of those who are depressed (i.e. the sensitivity is 0.79) and correctly identify 94% of those who are not depressed (i.e. the specificity is 0.94). Importantly, including the question 'Is this something with which you would like help' greatly reduced the number of false positives (Arroll *et al.* 2005). This question has therefore been added to the screening for the other disorders. The screening symptom questions for post-traumatic stress disorder (Prins *et al.* 2004), obsessive compulsive disorder (Fineberg *et al.* 2003) and substance abuse (Ewing 1984) have also been subjected to empirical investigation and found to be reliable. Further, the screening questions for generalised anxiety disorder (GAD) symptoms cover the same content area as the two-item GAD scale that has been demonstrated to have high sensitivity and specificity for detecting GAD (Kroenke *et al.*

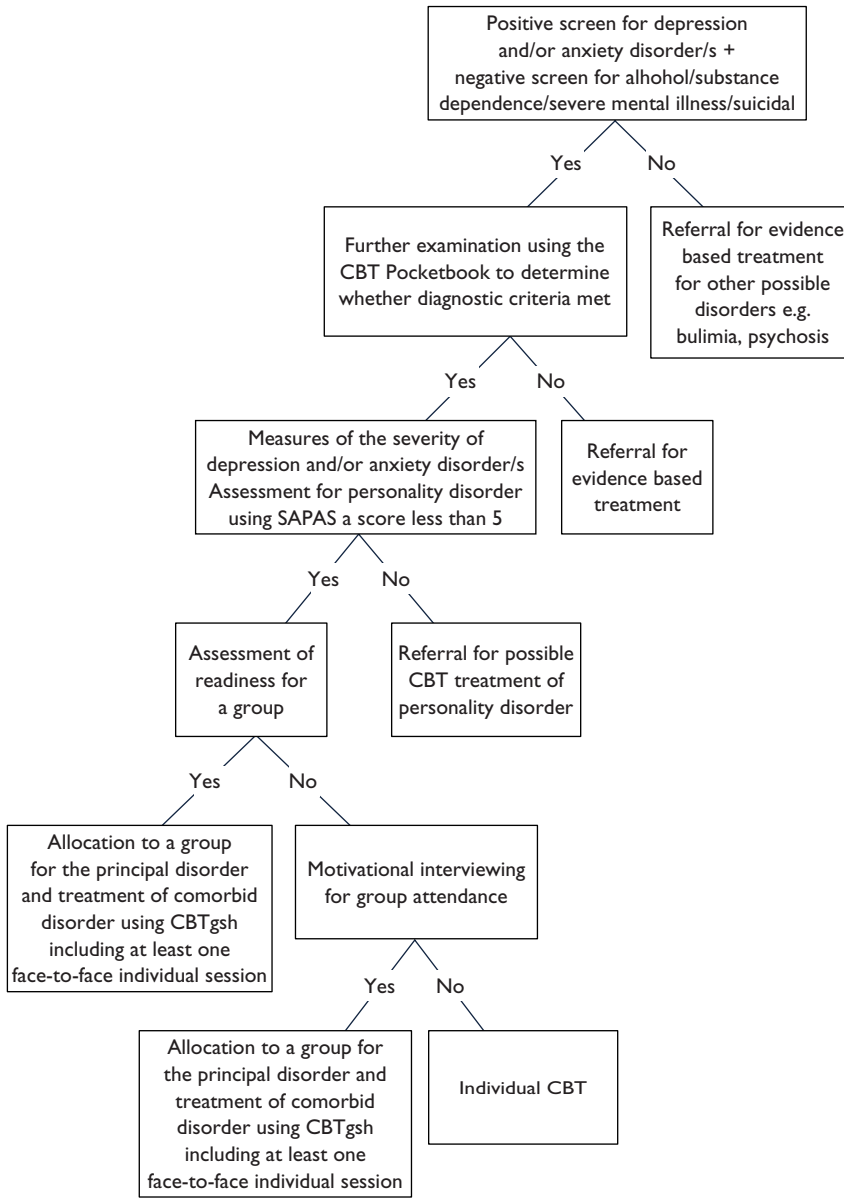

Figure 1.2 Assessment and treatment pathways for GCBT. The Standardised Assessment of Personality – Abbreviated Scale (SAPAS), Appendix G; 7 Minute Mental Health Screen/Audit – Revised, Appendix B; First Step Questionnaire – Revised, Appendix C; CBT Pocketbook, Appendix A; readiness for a group, Chapter 2; group programmes, Chapters 4–9; CBT guided self-help (CBTgsh), Appendices H–M; motivational interviewing, Chapter 2; individual treatment protocols, Scott (2009).

Table 1.2 Excerpt from the 7 Minute Mental Health Screen/Audit – Revised/ First Step Questionnaire – Revised: panic disorder

2. Panic Disorder and Agoraphobia	*Yes*	*No*	*Don't know*
Do you have unexpected panic attacks . a sudden rush of intense fear or anxiety?			
Do you avoid situations in which the panic attacks might occur?			
Is this something with which you would like help?			

2007). However, at this time the screening questions for other disorders have only a face validity. The self-report version of the screen 'The First Step Questionnaire – Revised' similarly awaits validation; its strength is that it takes the client 2–3 minutes to complete and it takes the therapist only a minute to interpret using the guidance given for the correspondingly numbered items in the 7 Minute Mental Health Screen. If a screen/ questionnaire response for a disorder is positive then more detailed enquiry can be made for that disorder using the questions in Appendix A, the Pocketbook.

The First Step Questionnaire – Revised/7 Minute Mental Health Screen – Revised has an advantage in screening for multiple common psychiatric disorders rather than for just depression or anxiety alone. Gaynes *et al.* (2010) in their study of another multiple psychiatric disorder screening measure, the M-3, pointed out that in a typical sample of 100 patients in primary care, if the clinician administered only the nine-item PHQ-9 (Kroenke *et al.* 2001) it would identify 14 of the 16 depressed patients. The PHQ-9 would not identify the 9 patients experiencing anxiety alone, however, and would misidentify 5 bipolar depressed patients as having a unipolar major depressive disorder. Similarly, using only the seven-item GAD-7, whilst 7 of the 9 patients with an anxiety disorder alone would be captured, it would miss approximately 20 patients with major depressive disorder or bipolar disorder.

The First Step Questionnaire – Revised/7 Minute Mental Health Screen – Revised has an advantage over the M-3, in that it casts a wider net, screening in addition for alcohol/drug abuse, bulimia and psychosis. In Table 1.3 the diagnostic accuracy of the depression and PTSD questions (the * indicates that these questions were asked minus the 'Is this something with which you would like help?' question) from the First Step Questionnaire – Revised/7 Minute Mental Health Screen – Revised are compared with the accuracy of disorder-specific measures, the PHQ-9 (Kroenke *et al.* 2001) and the Self Rating Inventory for Post-Traumatic Stress Disorder (SRIP) (Gaynes *et al.* 2010), and also compared with the accuracy of the depression and PTSD items from the M-3 (Gaynes *et al.* 2010). The First

Table 1.3 Comparison of sensitivity and specificity of First Step Questionnaire – Revised/7 Minute Mental Health Screen – Revised with other standard instruments

	Depression	*PTSD*
	First step Depression	*First step PTSD*
Sensitivity	0.79	0.78*
Specificity	0.94	0.87*
	PHQ-9	*SRIP*
Sensitivity	0.88	0.74
Specificity	0.88	0.84
	M-3	*M-3*
Sensitivity	0.84	0.88
Specificity	0.80	0.76

Step Questionnaire – Revised/7 Minute Mental Health Screen – Revised is at least as accurate as the disorder-specific measures and the multiple psychiatric disorder screening measure, the M-3, whilst being broader in scope than both.

The importance of a provisional diagnosis has been stressed by IAPT (2010a): 'Provisional diagnoses are needed as specific treatments have been developed to assist people with particular symptom patterns and NICE guidelines are diagnosis based. We can therefore only ensure that patients receive the best treatments in line with NICE recommendations if provisional diagnoses have been obtained. Provisional diagnosis should not be viewed as a pejorative label. Many patients feel diagnosis is useful to reassure them that there are others with similar patterns and difficulties.'

There are two alternative diagnostic classification systems, DSM-IV-TR (American Psychiatric Association 2000) and ICD-10 (World Health Organization 1992) and IAPT have drawn on the latter to produce a set of Screening Prompts (freely available from the IAPT website www.iapt.nhs.uk), IAPT (2010b) to give a slightly different way of screening clients, but it is not as broad based a screening as the 7 Minute Mental Health Screen – Revised.

Structured interview

Clients who screen positive for a disorder are then assessed using a structured interview to determine whether in fact they meet diagnostic criteria for a disorder/s. Diagnosis provides a common language and structured interviews such as the SCID (First *et al.* 1997a, 1997b) are the most reliable way of determining diagnoses. The interview questions in the CBT Pocketbook, Appendix A, directly access each of the symptoms of the depression and anxiety disorders considered in this volume. Whether or not a particular symptom is endorsed as present or not depends on the therapist's

judgement not only of the client's response but also on the basis of all other information available, e.g. records, information from relatives. The therapist has also to determine whether a symptom is present at a clinically significant level, i.e. whether it produces functional impairment. For example, mere dreams of a trauma would probably be below the threshold but dreams related to the trauma that woke the person for more than a few minutes would be regarded as being above the threshold. The questions in the CBT Pocketbook should not be regarded as a symptom checklist and should not be presented as an interrogation. The questions are simply an aid to eliciting details regarding particular symptoms and supplementary clarifying questions may be needed depending on a client's responses.

Personality disorder?

The third step in assessing referred clients is to screen them for personality disorder. GCBT programmes for depression and the anxiety disorders have excluded those with cluster A and B personality disorders (DSM-IV-TR; American Psychiatric Association 2000). Cluster A personality disorders, termed the 'odd' personality disorders, refer to those with paranoid personality disorders, schizoid personality disorders and schizotypal personality disorders. Such is the pervasive level of mistrust among clients with 'odd' personality disorders that they are very unlikely to agree to participate in a group. If clients with an 'odd' personality disorder were included in a group they would present the therapist with an extreme challenge to make them feel included and this would be at the expense of focus on other group members. Cluster B personality disorders refer to those with antisocial, borderline, histrionic and narcissistic personality disorders, termed the 'dramatic' personality disorders, and again they are likely to make disproportionate demands on the therapist's time and other group members are likely to be alienated from the group. However, clients with cluster C personality disorders, dependent, avoidant, obsessive-compulsive personality disorders, are usually manageable in groups focused on depression and the anxiety disorders.

The Standardised Assessment of Personality – Abbreviated Scale (SAPAS), Appendix G, is a screen for personality disorders (Moran *et al.* 2003), consisting of just eight items, each item answered with a 'yes' or a 'no'; example items are 'Would you normally describe yourself as a loner?' and 'In general do you trust other people?' A score of 3 or more identifies 90% of those with personality disorders. However, for the purpose of screening clients for a group, probably the most appropriate cut-off is a score of 5 or more. Use of this cut-off in the Moran *et al.* (2003) study meant that no one who did not have a personality disorder was identified as having one, i.e. there were no false positives. Using a cut-off of 5 or more, Moran *et al.* (2003) identified three out of five of those who did have a personality

disorder, thus letting some of those with a personality disorder through the gate but probably those with a more manageable personality disorder from the point of view of group treatment. It is of course possible to use the cut-off of 3 or more on the SAPAS and for those who screened positive to be followed up with a 'gold standard' assessment of personality disorder using the SCID II (First *et al.* 1997), but this takes over an hour to do and whilst it would be appropriate in a research context, a busy practitioner might well content themselves with using a SAPAS score of 5 or more.

Clients who are actively suicidal have also been excluded from GCBT as they require special individual attention (see Brown *et al.* 2005). A framework for risk assessment is detailed in Scott (2009). Alcohol/drug abuse is a common concomitant of depression and the anxiety disorders and can usually be dealt with in the context of the programmes outlined in this volume but the programmes are probably inappropriate for those who are dependent. Clients with more than very slight learning difficulties are likely to feel frustrated and demoralised in a group composed of those without learning difficulties and probably best served by ICBT with a stress inoculation focus (Meichenbaum 1985).

Highly autonomous individuals, i.e. those who base their sense of worth on their achievements, with cognitions of the type 'if I am not the top I am a flop', have been found to do less well in GCBT than in ICBT (Zettle and Herring 1995), but may benefit sufficiently if offered a number of individual sessions as well.

Psychometric tests

A full range of established psychometric tests for depression and the anxiety disorders is available free of charge for personal use in the IAPT *Data Handbook Appendices v 1.0* (IAPT 2010b), www.iapt.nhs.uk. They include the PHQ-9 (Kroenke *et al.* 2001) for depression, GAD-7 (Spitzer *et al.* 2006) for generalised anxiety disorder, Panic Disorder Severity Scale (Shear *et al.* 1997) for panic disorder, Fear Questionnaire (Marks and Mathews 1979) for agoraphobia, Impact of Event Scale – Revised (Weiss and Marmar 1997) for post-traumatic stress disorder, Social Phobia Inventory (Connor *et al.* 2000) for social phobia and the Obsessive Compulsive Inventory (Foa *et al.* 2002) for obsessive compulsive disorder. These tests are very useful as measures of changes in the severity of a disorder during treatment. Tests which identify the cognitions or behaviours that maintain a disorder also have a clear clinical utility and in Table 1.4 there are example tests of severity and cognitive measures for each disorder.

Clients should be asked to complete a measure of the severity of their disorder/s at each session so that progress can be charted (Appendix F) and also complete a cognitive measure. Psychometric tests are, however, not a substitute for diagnosis, as generally speaking psychometric tests yield false

Table 1.4 Commonly used tests

1	Depression – PHQ-9 (Kroenke *et al.* 2001), Dysfunctional Attitude Scale (Weissman and Beck 1978)
2	Panic disorder and agoraphobia – Beck Anxiety Inventory BAI (Beck and Steer 1993), Agoraphobic Cognitions Questionnaire (ACQ; Chambless *et al.* 1984)
3	The PTSD Checklist (PCL; Weathers *et al.* 1993), Posttraumatic Cognitions Inventory (PCTI; Foa *et al.* 1999)
4	Generalised Anxiety Disorder – GAD-7 Scale (Spitzer *et al.* 2006), Anxious Thoughts Inventory (AnTI; Wells 1994)
5	Social phobia – Social Phobia Inventory (SPIN; Connor *et al.* 2000), Social Cognitions Questionnaire (SCQ; Wells *et al.* 1993)
6	Obsessive compulsive disorder – Yale-Brown Obsessive-Compulsive Disorder Inventory (Y-BOCS; Goodman *et al.* 1989), Obsessive Belief Questionnaire (OBQ; Obsessive Compulsive Cognitions Working Group 2005), Personal Significance Scale (Rachman 2003)

positives, which means that sole reliance on them can result in targeting the wrong disorder.

The client's view

As well as diagnostic interviews and psychometric tests it is important to get the client's perspective on treatment; this can be garnered using the Satisfaction With Therapy and Therapist Scale – Revised (STTS-R; Oei and Green 2008). One additional item on the STTS-R relates to outcome and is probably particularly salient; it asks 'How much did this treatment help with the specific problem that led you to therapy?' and the responses are on a 5-point scale, Made things a lot better (1), Made things somewhat better (2), Made no difference (3), Made things somewhat worse (4) and Made things a lot worse (5).

Chapter 2

Engagement

It is likely that most clients, given the choice, would initially opt for individual rather than a group intervention. Thus even in those prepared to engage in group therapy there is likely to be a certain reluctance, a few are likely to be positively antagonistic and for others their motivation to participate in a group is somewhere in between. GCBT has therefore to be positively marketed, and client reservations anticipated and appropriately dealt with. Whilst the focus of this volume is on GCBT for depression and anxiety disorders, the same issue of preparedness to join a group appears to raise its head for other disorders and difficulties. For example, in a study of CBT for back pain (Lamb *et al.* 2010) only 63% of participants attended three or more of the six group sessions but the GCBT was still superior to standard advice. During an assessment session a client can be asked to complete the readiness for a group form (Table 2.1).

For clients with a determination to attend a group, i.e. a score of 8–10 on the 'ruler' (Table 2.1), their motivation to attend a group may be buttressed using a simple 10-minute pre-treatment procedure shown by Buckner *et al.* (2009) to increase treatment sessions attended and to lower treatment severity at termination. Clients are asked to picture themselves acting out their first four group therapy appointments and to spend a couple of

Table 2.1 Readiness for a group

Please circle a number, on the ruler below, to indicate how ready you feel to join a group of others with your difficulties, to learn new ways of handling your problems.

No			Maybe				Yes		
1	2	3	4	5	6	7	8	9	10

If you indicated a 'No' or 'Maybe' number above, what is it that puts you off joining a group?

. . . . . .

. . . . . .

. . . . . .

minutes going through the specifics, going into the building, meeting the leader or co-leader, leaving, returning the following week. Next, clients are asked to explain why they personally would continue with therapy for at least four sessions. These reasons are solicited in two ways. Clients are asked to select reasons from a list (e.g. I like to finish what I begin) as well as write a paragraph listing traits and qualities about themselves that would explain why they would 'stick' with therapy.

For clients with reservations about joining a group, individual sessions can be scheduled immediately prior to the start of the scheduled group to address their fears. Tolin and Maltby (2008) have described a four-session 'Readiness Intervention (RI)' for clients about to undergo treatment for obsessive compulsive disorder. Their intervention consisted of providing psychoeducation, motivational interviewing, video of a simulated session using actors, introduction to the type of materials they would encounter for use with the type of problems they had, and telephone contact with a client who had already completed a programme. They found their RI facilitated engagement in treatment and it is used in this volume as a model here for engaging clients in GCBT. An alternative way of motivating clients to attend a group is to construct a five-minute video of a client who has responded to the envisaged group programme. In this interview the ex-client can be depicted answering the following questions: (a) How did you first feel when invited to attend a group for your difficulties? (b) What was it like as you went through the group programme? (c) Looking back what did you find most useful? (d) What would you say to others doubtful about attending a group like the one you were in? Clients can be asked: 'To help people make a decision about whether or not to give a group a try, we have made a five-minute video; could you let me know what you think after we have watched it? The testimony of an ex-group member is likely to be a more credible source of persuasion than the therapist. Motivational issues are also important in the early group sessions and where possible an ex-group member should be invited along to provide their testimony live, using the structure of the above questions. It is recommended that the individual sessions that are conducted as a prelude to the group take place as close as possible to the beginning of the scheduled group as the newly found motivation to attend the group may be short-lived, 'striking whilst the iron is hot' as Tolin and Maltby (2008) suggest.

Readiness for change, be it joining a group, overcoming substance abuse, tackling a specific problem such as anger, can be conceptualised in terms of Prochaska, DiClemente and Norcross's (1992) stages of change model. First there are those in Precontemplation, not ready to think about change seriously. Somewhat more motivated are those in the Contemplation stage, ready to think about change, weighing up the pros and cons. More motivated still are those in the Determination phase who are preparing to make plans for change. The ruler in Table 2.1 can be regarded as a measure of

where an individual is with regard to these first three stages. The same measuring instrument can be applied to whether a client wants to work on, say, a comorbid alcohol abuse problem or applied to say whether a PTSD client sees their post-trauma anger as a problem they wish to address or not. Thus the same person might score differently on the ruler depending on the 'object being measured' (group/substance abuse/anger). Those scoring 1–3 on the ruler may be regarded as in Precontemplation, whilst those scoring 4–7 are in Contemplation, with those scoring 8–10 in Determination. The fourth stage of Prochaska *et al*.'s (1992) model is Action, in which the client is implementing change. The fifth and final stage of the model is Maintenance, ensuring that the change in behaviour becomes habitual. Thus a client who has attended say the first two group sessions might be regarded as in the Maintenance phase but then misses the third session; it might be discovered via a phone call to the client or at a concurrent individual session that the client has reverted to say the Contemplation phase with regard to attending the group. There is thus a fluidity between stages and Miller and Rollnick (2002) suggest that different interventions are necessary at different stages and these comprise motivational interviewing. However, Tolin and Maltby (2008) have reflected that their Readiness Intervention delivered as a prelude to intervention may have affected fear of treatment to a greater extent than it did stages of change or expectancies for improvement.

Using a framework developed by Murphy *et al*. (2002) and applying it to readiness for a group, it is suggested those in a precontemplative stage are best served by (a) discussing what is involved in group attendance, e.g. times, extent of need for self-disclosure, confidentiality, (b) familiarising clients with the Survival Manuals for each of the disorders from which they suffer (Appendices H–M), explaining that they are the focus in both individual and GCBT and discussing issues arising from the client's reading of them and (c) asking open questions about their reasons for not wishing to join a group. Those in a contemplative stage would be asked in addition to (a) consider the pros and cons both short and long term for attending a group, (b) contact a former group member to chat about the possibility of attending and (c) watch a simulated video of a group session. Clients in the determination phase would be encouraged to attend a group session on an experimental basis, recording their expectations and contrasting them with their experience. In the action phase clients begin learning skills in the group and are committed to trying them out at home.

Individual sessions

The marketing of the group is made much easier by the offer of complementary individual sessions; this latter tends to be particularly important the more severe the disorder, for those with greater additional disorders

(comorbidity) or highly personal concerns. The focus in the individual session/s is twofold: Motivational interviewing (MI) with regard to group attendance and the tackling of any comorbid disorder/s. To address motivational problems individual sessions can begin before the group programme. If clients default from a group programme it is usually in the early sessions, so the provision of prior or simultaneous individual sessions can act as a buttress against clients dropping out.

The following exchange illustrates the marketing of GCBT:

THERAPIST: We usually provide a combination of group and individual sessions for your type of difficulties.

NATALIE: Group?

THERAPIST: Yes, if I see people just by themselves they usually think there's something odd about them to be seeing someone like me. Even if I say lots of people have this problem, they still think of themselves as odd. In a group it's just like a night school class for your nerves, you can say as little or as much as you want.

NATALIE: I was never much good at school.

THERAPIST: If anything is not clear in the group there is a time to have a chat about it afterwards, or in an individual session or just before the start of the next group session.

NATALIE: When is the group?

THERAPIST: We were thinking of Tuesdays at 6. p.m., how would that be?

NATALIE: I would have to get someone to mind the kids. Usually I would get mother-in-law but she would think I should just pull myself together. I suppose I could get my friend Angie.

THERAPIST: Would Angie think you should just pull yourself together?

NATALIE: No, Angie is great, she has had her own troubles.

THERAPIST: Hopefully there will be others like Angie in the group.

NATALIE: What if they are like my mother-in-law?

THERAPIST: Maybe we can stop 'mother-in-law types' being too 'toxic' and focus on 'Angies'.

NATALIE: OK I'll give it a go.

THERAPIST: By the end of the group people are usually really happy they have had the benefit of it, as well as individual attention.

NATALIE: It might help me think I am less of a 'weirdo'.

In the above transcript the therapist has recognised the client's ambivalence about attending a group, and then addressed her self-efficacy, i.e. her beliefs about her capacity and her beliefs about whether joining a group would make a worthwhile difference, increasing her motivation to attend. Supporting self-efficacy is one of the four pillars of motivational interviewing, which are summarised in Table 2.2.

Table 2.2 Pillars of motivational interviewing

1	Express empathy using reflective listening
2	Juxtapose the client's important values with their current behaviour (e.g. 'You say you really want to be able to be connecting with others but couldn't face attending a group?)
3	Sidestep resistance by responding with empathy and understanding rather than confrontation
4	Enhancing self-efficacy

A client's ambivalence about change can also be picked up from the initial screening instrument, The 7 Minute Mental Health Screen – Revised (Appendix B)/First Step Questionnaire – Revised (Appendix C). For example, when the therapist asked the questions in Table 2.3 from the Interview screen of Natalie whom we met earlier in this chapter, though she felt she should cut down on her drinking, acknowledged that her mother-in-law got annoyed about her drinking and sometimes felt guilty about her drinking, she indicated that she did not know whether she wanted help with it. The therapist was able to clarify that she drank excessively most Friday nights when her friend Angie visited, though very occasionally she had drunk too much on a Sunday night when she was by herself and missed work the next day. In terms of the DSM-IV-TR criteria (American Psychiatric Association 2000) Natalie was abusing alcohol rather than being dependent on it. The therapist addressed the issue using a motivational interviewing framework in the initial individual sessions:

Table 2.3 Extract from the 7 Minute Mental Health Screen – Revised

8. Substance abuse/dependence	*Yes*	*No*	*Don't know*
Have you felt you should cut down on your alcohol/drug?			
Have people got annoyed with you about your drinking/ drug taking?			
Have you felt guilty about your drinking/drug use?			
Do you drink/use drugs before midday?			
Is this something with which you would like help?			

THERAPIST: Do you look forward to drinking on Friday night as your well-deserved break from the working week?

NATALIE: I suppose I do.

THERAPIST: But it causes problems with your mother-in-law?

NATALIE: It's not just her, sometimes it leaves me too disorganised on the Saturday morning to get the kids to dance class on time and they get annoyed.

THERAPIST: So you want a break for yourself but not to 'break' things up for the kids and mother-in-law.

In the above exchange the therapist is highlighting the discrepancy between Natalie's behaviour and her values. As the exchange continues, the therapist continues to express empathy, avoids confrontation and heightens the discrepancy between Natalie's behaviour and values further:

THERAPIST: So Angie enjoys a break at the weekend with you as well?
NATALIE: Yes, we have a good time on a Friday.
THERAPIST: What about on a Sunday, doesn't Angie drink then?
NATALIE: No, she has to get up for work the next day.
THERAPIST: Doesn't she drink in her own home on a Sunday?
NATALIE: No, because she is not an idiot like me.
THERAPIST: Is having a break stupid?
NATALIE: It's *when* you have a break, I hate ringing in work on Monday morning lying that I am not well.
THERAPIST: It seems that you want a break but without it affecting the kids or work; we could discuss this further at the next individual session if you like.
NATALIE: Yes, I need to do something about it.

In the above Natalie has moved from a Contemplation stage to the Determination stage. Given that there is strong evidence for MI as a brief pre-treatment in the area of substance abuse (Burke *et al.* 2003) and this is often a complication of depression and the anxiety disorders, it seems reasonable that initial individual sessions should be framed around MI. Some of the individual sessions may take place before the group programme. The exact number would depend on the motivational level of the client for the group, the client's willingness to address comorbid conditions and the number of comorbid conditions.

Motivational interviewing was originally developed with the addictions in mind but its scope has been extended so that it can be a useful adjunct to the treatment of depression and the anxiety disorders. Westra and Dozois (2006) found that MI pre-treatment (three sessions) enhanced the efficacy of GCBT for a mixed anxiety disorders group (45% panic disorder, 31% social phobia and 24% generalised anxiety disorder) compared to those who received only the group CBT. The MI pre-treatment group had greater homework compliance in GCBT and a significantly higher number of responders. (In a subsequent study Westra *et al.* [2009] found that MI pre-treatment significantly improved the efficacy of an individual CBT programme for generalised anxiety disorder.) Adding two individual sessions of motivational interviewing and thought mapping before GCBT for obsessive compulsive disorder has also been found to be more effective than

GCBT alone (Meyer *et al.* 2010). However, in this study it is not possible to determine whether the added benefit of the two pre-treatment individual sessions arises from the motivational interviewing or the thought mapping. More generally it is not known whether any type of pre-treatment enhances outcome or whether the increased potency is specific to MI.

There appears to be no reason why MI sessions in relation to the disorder that is the group focus could not be run concurrently with the group. In practice the distinction between MI for a comorbid disorder and MI for group attendance is often blurred. For example, in relation to the client Natalie, discussed earlier, the therapist felt that depression was Natalie's primary problem and it was agreed that she would attend a depression group. At her third individual session, which occurred just before attending the group, the following dialogue ensued:

THERAPIST: How do you see alcohol fitting into your life when you are attending the group?

NATALIE: I'll just drink on Fridays, I only drink on Sundays because I get low by myself.

THERAPIST: Alcohol is a depressant, possibly not the best way of managing a low mood.

NATALIE: Don't I know it, maybe I'll find better ways of handling my low mood in the group.

THERAPIST: Yes they are like having driving lessons for low mood, some people get the hang of it quicker than others but it is more to do with practice of what you learn outside the lesson that really makes the difference.

In this exchange the therapist has shifted from motivational interviewing focused on alcohol abuse to MI for attending the group, underlining that the latter can be a credible vehicle for change.

Sharing of provisional case formulations of each identified disorder

At the individual sessions the therapist should distil and refine the case formulation for each client for each of the disorders that they are suffering from, drawing not only on what the client has said in the individual session but also on what they have verbalised in the group. The case formulation is the therapist's working hypotheses of how the client came to be suffering from their current problems and to present at this particular point in time.

The development of a case formulation is illustrated with regard to Natalie, whose difficulties were described earlier in this chapter. Using the 7 Minute Mental Health Screen – Revised, Appendix B, Natalie screened positive for depression, social phobia, panic disorder and alcohol abuse;