HANDBOOK OF COGNITIVE-BEHAVIOR GROUP THERAPY WITH CHILDREN AND ADOLESCENTS

Edited by Ray W. Christner, Jessica L. Stewart, and Christy A. Mulligan

SECOND EDITION

Handbook of Cognitive-Behavior Group Therapy with Children and Adolescents

Now in its second edition, the *Handbook of Cognitive-Behavior Group Therapy with Children and Adolescents* offers a review of cognitive-behavior therapy fundamentals, evidence-based group interventions, and practical guidelines for group psychotherapy.

This extensive guide presents innovative and evidence-based treatments for the challenges faced by today's youth. Each chapter covers areas such as assessment, case conceptualization, group selection, cultural considerations, protective factors, and detailed strategies and treatment protocols for use in clinical practice. This handbook combines theoretical foundations with practical application, highlighting the authors' personal experiences through case studies and therapeutic vignettes.

This book is an invaluable reference for professionals providing therapeutic intervention to children and adolescents.

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Second edition

Edited by Ray W. Christner,
Jessica L. Stewart, and Christy A. Mulligan

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Thanks to my family for continuing to support me taking on another project, even when I say, “This is the last one!” I dedicate this book to my dear friend and colleague, Dr. Rosemary Mennuti, whose relationship provides me with energy, knowledge, and the desire for more connection.

Ray W. Christner

I dedicate this book to the three Bien Men. Dan, thank you for your never-ending support, picking up the slack so I could commit my time to this project, and being my best friend in this chaos we call life. Josh and Colby, thank you for your patience, your grace, and for being more independent when I had to spend way more time in my office than any of us wanted.

Jessica L. Stewart

I dedicate this book to my parents, who have supported me through all my educational aspirations. Thank you for all you do and for all you are.

Christy A. Mulligan

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Part I

Essentials of Cognitive-Behavior Group Therapy

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Chapter 1

Finding Strength in Numbers

An Introduction to Cognitive-Behavior Group Therapy (CBGT) with Youth

Jessica L. Stewart and Ray W. Christner

The application of cognitive-behavior therapy (CBT) with children and adolescents has proven to be a valuable and effective approach to providing therapeutic intervention for multiple disorders, ethnicities, formats of delivery, and treatment settings. CBT is a well-established and efficacious therapeutic modality for anxiety, depression, obsessive-compulsive disorders, autism spectrum disorders, externalizing disorders, and posttraumatic stress (Friedberg & Thordarson, 2018). Not only has CBT been applied to numerous presenting problems experienced by youth, but there is also growing implementation of CBT interventions in a variety of settings outside of traditional mental health offices, such as primary care settings, schools, juvenile detention centers, and other community settings (e.g., churches, non-profit organizations).

Most CBT resources for youth clients primarily center on delivering individual treatment services. Yet, many professionals in the field face greater time constraints and increasing numbers of referrals. This is especially true over the last few years with significant increases in mental health concerns for youth, which the COVID-19 global pandemic has exacerbated. Clinicians must adapt their practice and think beyond providing traditional individual therapy to meet these increased needs. One such option is group therapy – an alternative or enhancement for providing effective evidence-based services to youth. Since the first edition of this Handbook, there continues to be a growing evidence base for delivering CBT within a group format to children and adolescents. Cognitive-behavior group therapy, or CBGT, has shown positive outcomes with youth for a variety of issues, including anger and aggression (Lochman, Boxmeyer, Gilpin, & Powell, 2021; Tavakoli & Mirghaemi, 2023), depression (Nardi, Massei, Arimatea, & Moltedo-Perfetti, 2016), anxiety (Flannery-Schroeder & Kendall, 2000; Wolgensinger, 2015; Villabø et al., 2018), and autism spectrum disorders (Scarpa, Williams, White, & Attwood, 2013).

Our goal when deciding to develop this Handbook in the early 2000s was to fill the void for a comprehensive resource that not only presents the theoretical foundations of CBT and group psychotherapy but also captures the innovative practices of CBGT with various presenting problems while considering essential aspects of service delivery. This revision expands on the original volume by including updated research and practice on the original topic areas while also considering emerging applications where CBGT is showing promise. We are excited to present this updated volume to help guide professionals in expanding their roles and practices to include CBGT. Now, more than ever, this essential means of delivery is critically needed.

Readers would benefit from having a basic understanding of CBT before reading this book. However, each chapter will provide a fundamental review of the components of CBT relevant to the treatment being discussed and direction on how to apply them effectively in group therapy with youth. For those needing a more thorough understanding of the underlying tenets of CBT, consider Dr. Judy Beck's *Cognitive Therapy: Basics and Beyond, Third Edition* (2020) and Dr. Robert Friedberg and Dr. Jessica McClure's *Clinical Practice of Cognitive Therapy with Children and*

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Adolescents: The Nuts and Bolts, Second Edition (2015). In this chapter, we will outline key considerations, benefits, and challenges when providing therapy to youth within a group format, outline a framework for conceptualizing issues through a cognitive-behavioral lens, and present a general understanding of the "what to do when" and how to structure goals and interventions for the effective practice of CBGT.

Considerations for the Provisions of Group Therapy

Service Accessibility

A primary benefit to the group modality is simply the capability to reach a large number of children and adolescents at one time. For some professionals, this has become a primary modality as a matter of necessity, based on healthcare limitations and resource restrictions, rather than a desire to work with groups of clients. Yet for other clinicians, group interventions allow them to deliver therapy to multiple clients within a limited timeframe, thus maximizing efficiency while not compromising effectiveness. This is convenient from time, space, staffing, and financial standpoints, and groups also (and more importantly) allow clinicians to begin seeing clients sooner to prevent further decline in their well-being that may occur during extended wait periods for service. This issue of convenience can also have some disadvantages as well. For instance, although clinicians may be able to see individuals in groups sooner, it also means that there will be less direct time devoted to each client.

Social Comparison and Support

According to Festinger's (1954) social comparison theory, change is internally motivated and occurs more readily when relevant others are available for social comparison, particularly in the presence of an ambiguous situation. The situations that typically produce emotional and behavioral disturbances for young people are often new and ambiguous to them, as they are largely unaware of their mental processes (Reinecke et al., 2003). Observing and hearing others experiencing similar problems, symptoms, or circumstances affords group members reference points that can offer information and increase motivation to adapt to their challenges and difficulties while normalizing what makes members feel "different" or alone. Yalom and Leszcz (2020) note that "normalizing behavior" promotes a sense of universality, one of group therapy's most helpful features. Given the common tendency for patients, especially when working with adolescents, to challenge a therapist's ability to understand what they are "going through," the group setting limits the ability of members to dismiss the observations of others who currently share similar problems.

Generally, this is an excellent benefit of group interventions, though we must also be aware that there can be a negative impact on some youth. We can recall group members who, in comparing themselves with their group mates, dismiss their growth and progress or become discouraged if they perceive that others are making more obvious or notable gains. For them, this can reinforce negative self-talk, including "I am a failure" or "I am not capable of changing." To minimize and overcome this risk, we recommend both naming at the outset that change will be different (in both rate and degree) for each member and also setting specific goals for each child so they have a target to meet for themselves. This necessitates celebrating the moments when each member achieves steps leading to their goal, which clinicians must intentionally monitor and highlight for the group.

Opportunities for Observations

Many child and adolescent clients presenting for therapy are experiencing, to some degree, difficulties interacting with others. This may manifest for some through social anxiety. In contrast, it may relate to being disruptive or disturbing to others, as is the case with children with anger problems or difficulty with behavioral inhibition. In individual therapy, we often face the problem of skills not generalizing outside of the therapeutic setting. Goldstein and Goldstein (1998) suggested that interventions must occur in an environment near where the problem occurs. In this way, a group format offers an ideal opportunity for clinicians to directly observe participants' emotional and behavioral reactions and interactions with peers. This affords valuable information regarding group members' repertoire of interpersonal responses and skills (e.g., decision-making, coping, problem-solving, communication, and so on) and their abilities to implement those skills successfully. Clinicians can use this information to refine their ongoing conceptualization of the client and monitor their progress. For children or adolescents with social problems, monitoring can occur with specific skills (e.g., listening to others when they are talking, making eye contact, turn-taking) by establishing a baseline during the initial first group sessions and then collecting data on the skills via observations across sessions over time. This information can be tracked and compared to baseline data to measure growth.

Natural Laboratory

As noted earlier, group therapy settings offer a unique opportunity for clients to interact and practice skills in a safe environment. The group therapy setting is a natural laboratory where members can "test out" their beliefs and newly acquired strategies and skills learned during the *skill acquisition* phase. This "testing out" phase, or *skill implementation*, provides members the opportunity and setting to experiment with new behaviors in general, especially those that specifically relate to navigating the social world. This can occur naturally during group interactions or through role-play and practice activities the therapist facilitates, which offers an excellent opportunity before trying new skills in the "real world." It provides a way to observe, give feedback, and help refine these skills.

Group members may practice any number of skills within the group. However, it is especially beneficial for experimenting with effective coping strategies (e.g., emotional regulation, relaxation, feeling identification and tracking, behavioral regulation, goal setting, problem-solving) and interpersonal skills (e.g., social awareness, appropriate self-disclosure, effective communication and listening skills, developing empathy, conflict management). As participants often model the behaviors of other group members or therapists, group facilitators must be mindful of the potential for ineffective or dysfunctional thoughts and behaviors to be repeated and strengthened or adopted by other members. Group therapy requires clinicians to have strong management skills to avoid being sidetracked and be mindful of – and able to interrupt – negative patterns occurring within the group.

Cohesiveness and Shared Responsibility

Effective CBGT with children and adolescents promotes collaboration between members through goal setting, establishing group rules, agenda setting, feedback and sharing of ideas, role-playing, and practice exercises. These ongoing opportunities for members to work together for the betterment of each other promote cohesiveness, which facilitates each member taking an active role and a personal investment in their success and that of the group and other participants. Ideally, this investment leads each member to share responsibility for the group's maintenance, progression, and successful completion. Facilitators should monitor the degree to which members are actively

collaborating and portraying an interest in working together, offering positive (and constructive) feedback to others, and working to meet group goals so that challenges to group cohesion may be detected and addressed early and directly. Some members may be less willing (or able) than others to assume responsibility for their progress, let alone the group's growth. However, others may be quick to show self-awareness and positive leadership attributes. Facilitators must be conscious of the motivation or resistance of these members to participate in the change process actively. This will be evident if the conceptualization of each group member's presentation and the group dynamics are adjusted for accuracy throughout the process of group therapy.

Assessment and Group Inclusion

A thorough assessment of group members is crucial to developing and starting any group therapy process. This assessment may vary based on the setting or presenting problem, and thus, readers are encouraged to review guidance within specific chapters in this Handbook. Clinicians must consider multiple factors that may influence group composition and make-up (e.g., developmental level, individual experiences, aspects of identity, and so on), in addition to the presenting symptoms and severity, desired goals for treatment, and readiness to engage in the therapeutic process. Assessment should include standardized objective measures (both comprehensive, broadband measures, and more narrow, problem-specific questionnaires), observations (when possible), and an extensive interview with potential group members, their families, teachers, etc. Samples of broadband measures that might be useful during the initial assessment include the *Behavior Assessment System for Children, Third Edition* (BASC-3™; Reynolds & Kamphaus, 2015), *Child Behavior Checklist* (CBCL; Achenbach & Rescorla, 2001), and the forthcoming *Christner Behavior and Adaptability Assessment System* (C-BAAS™; Christner, in progress). The information gathered from these rating scales helps the clinician formulate a thorough and accurate conceptualization of each member's needs, skill deficits, competencies, and strengths through the CBGT framework. Once an individual is determined appropriate for inclusion in the group, additional baseline data not included in the initial assessment that relates to the presenting problem must be considered for progress monitoring, such as problem-specific measures given at periodic intervals (e.g., depression, anxiety, anger). Readers are referred to individual chapters in this book for problem-specific rating scales and measures that can be used in assessment and progress monitoring.

CBT Group Formats

One factor that can majorly impact cohesion and sharing is the type of CBT group. Traditionally, groups are designated as "closed" or "open" groups. Closed groups often have a set number of sessions or timeframe (e.g., eight weeks), and once they begin, no new members are added to the group. There is a greater chance for group unity in this case, and the therapist can sequentially progress through topics. With open groups, conversely, new members may be continuously added. While this may impact group cohesion, it has its benefits of offering group members an opportunity to move from new to experienced members and practice new skills, such as teaching new members what they have learned. Open groups are more likely to be seen in short-term settings, such as inpatient or hospital units.

Another option for a group format is a *rotating group*. In rotating groups, therapists design the group based on an 8- to 12-week cycle, and each session serves as a treatment module. No matter when a new member enters, they remain in the group until they complete the entire course of sessions. This format is ideal in specific settings. For instance, we have used this approach in schools as an alternative to suspension. Students would be assigned to the group for certain disruptive behaviors (e.g., anger outbursts). They would be required to attend the entire eight-week program,

which consisted of eight distinct lessons, including (1) relaxation training, (2) understanding and modifying negative thoughts, (3) social problem-solving, (4) self-monitoring, (5) self-instruction, (6) stress management, (7) communication skills, and (8) setting goals for your future. No matter where the student began the group, they continued until they completed all modules. It should be noted that with rotating groups, therapists must be skilled at introducing and making new members part of the group. Having time set aside each session to introduce new group members is encouraged.

Virtual Group Therapy

Especially since the COVID-19 global pandemic, therapeutic intervention is now more commonly provided within a virtual/remote setting than ever. Whether members and facilitators are meeting from different classrooms within the same school building or the comfort of their own homes, virtual group therapy has become more commonplace, making this treatment modality more accessible. Group format may still be open, closed, or rotating. However, facilitators of virtual services will need to establish clear rules and expectations for confidentiality (e.g., recording images, audio, or video of meetings, not having others in the room) and member participation (e.g., camera on or off, phones away and hands visible, sharing openly or in the chat). Clinicians will need to be more creative in delivering lessons, assessing members' acquisition of knowledge and skills, and facilitating the practice and implementation of strategies. For example, getting any required physical materials to group members before the start of each lesson will be necessary.

Even the flow of the lesson and member interactions will be different when virtual, requiring more support and proactive direction from the facilitator. For example, whereas when in-person members can go around a circle to share out, we have experienced the long and awkward pause when members are invited to share their progress on homework, but they do not know in what order they may be required to "go next" (e.g., because there is no circle, they are not sure in what order their "square" may be on the facilitator's screen). Facilitators will need to be more direct about how they call on or solicit member involvement and how they intentionally foster cohesion when members are not physically in each other's presence. Promoting group member interaction or collaboration may also be more challenging (e.g., members cannot pair off for "turn and talks"). If there are multiple facilitators, options like break-out rooms or side chats may be possible but should be closely monitored for member safety and appropriate engagement. Even technological aspects of virtual group therapy may prove challenging, such as a lag in a member's feed requiring more patience and tolerance from the facilitator and other members, links not working, and so on.

Social Loafing

Whether related to compliance with homework or in-session exercises, the social psychology concept of *social loafing* is critical to consider within the group modality. Essentially, facilitators must be aware of the possibility that when involved in a group, each member may experience the perception that they do not need to engage in an activity because other members will, which will be enough to guide the exercise. This concept of social loafing exists given that, by the nature of a group, each member's identity is lessened to the extent that they contribute to the group's identity as a whole. Therefore, the sense of individual responsibility or contribution is also decreased, as the emphasis typically shifts to the group's production as a whole. It is important for facilitators to actively address members' perceptions of their accountability to individual growth and goal attainment and the simultaneous contribution to the success of other members. By being cognizant of drawing attention to individual contributions and gains and helping members stay accountable to

the goals they set at the start of the group, facilitators help minimize the likelihood that members will engage in social loafing.

One way we have found to encourage participation from all members is to use the members' real-life experiences for group problem-solving but to do so in a manner that gives all members a chance – even those who may not be that outgoing. We use a technique called *This is My Life* (Christner, 2006), in which all group members are given a 3 × 5 card as they come into the group session and have to briefly write down one recent personal situation related to the topic being discussed (e.g., "Write down a situation that made you angry this week."). All the cards are then placed into a paper bag (or any object), randomly selected, and read aloud to the group without identifying the group member. As a group, they begin talking about thoughts, feelings, and behaviors (both positive and negative) related to the chosen situation and work collaboratively to produce a positive thought–feeling–behavior connection. This is a form of group problem-solving. Then, we invite the individual who wrote the situation to identify themself and describe what they did in the situation and then evaluate how they think the group's suggestions would help next time they are in a similar situation.

Readiness to Change

The idea of readiness to change is not a new concept to psychotherapy, as it has been supported in the literature for many years (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992) and has been applied to many psychological, psychosocial, and medical issues (see Prochaska et al., 1994). Freeman and Dolan (2001) provided a revision to the original model, including the following ten stages: (1) Noncontemplation, (2) Anticontemplation, (3) Precontemplation, (4) Contemplation, (5) Action Planning, (6) Action, (7) Prelapse, (8) Lapse, (9) Relapse, and (10) Maintenance. See Freeman and Dolan (2001) for a thorough review of these stages.

The group context presents an additional dynamic, as each member's change stage potentially influences the stages of others (both in positive and negative directions). In a positive way, for example, a member who is just thinking about the need to change but has yet to take action may move more quickly toward the action planning and action phases by observing the successes of other group members. However, we have seen instances where the opposite has occurred, and members' reluctance to attempt change strategies results from a negative report of another member. The therapist must be aware of this possible dynamic and use session time to problem-solve less than positive experiences and to encourage further attempts for all members to move forward.

Challenging Group Members

When we think of challenging group members, "resistant" often comes to mind. Malekoff (2015) noted that *resistance* could manifest in many ways, including denial of the problem, superficial compliance, testing the limits, silence, blaming others, etc. However, while these resistant behaviors appear planned and deliberate on the surface, in many cases, these behaviors stem from sources outside of awareness (Yalom & Leszcz, 2020). Although resistance is a commonly used word, we feel it is pejorative and implies intentionality to the client's behavior, which instead may be protective or defensive reactivity to pressures involved in change. Thus, we prefer to use the term *challenging*. In our experiences, disruptive and difficult group behaviors may result from several cognitive errors or distortions at work.

For instance, the group member who needs to be "the center of attention." This child responds to every question, but they do so in a manner that is disruptive and often superficial (e.g., from the perspective "If I look like I know this stuff, I won't get put on the spot."). Sometimes, however,

another need is being met for this child, such as “I need to be noticed, or people will forget about me.” Another common presentation within child and adolescent groups is the **silent challenger**. This child attends every group but rarely responds; if they do, it is usually, “I don’t know.” These children often have concerns regarding social perception in the group (e.g., “I don’t want to embarrass myself or look stupid”). However, in our work, we have seen other children and adolescents whose silence was because they did not believe the intervention would work for them. We remember one teenage girl in a school-based resilience group who, while talking with the facilitator about her lack of active engagement, shared aloud her thoughts that she has “tried these things before, and this is just the way it is, I can’t change anything about my life,” and that “I’m just never going to be happy anyway.” By addressing the underlying, distorted cognitions, we were able to collaborate with her to alter her perceptions that were serving as barriers to her participation and treatment.

Finally, there is the **active challenger**. This is the client who is more actively noncompliant and often disruptive. Again, it is essential to consider what thought pattern may be contributing to the observable behavior. We have had some clients who expressed thoughts like “If I change, I will be weak (or vulnerable)” or “If I try in the group, I’m admitting I have a problem.” These are just a few examples, and we encourage therapists to explore the cognitive factors that may be at the root of challenging behavior individually with the group members.

In addition, while individual factors are often looked at when a client’s behavior is challenging, we encourage therapists to consider other potential factors that impede change. These can include family factors, systems or setting factors, peer factors, and provider factors (e.g., teachers, nurses, physicians, and so on), to name a few – including aspects related to the facilitators themselves. Each of these, and others, should be considered when a client presents as challenging in a group. Keeping an open mind and exploring a range of factors, we can often identify the root of the challenge and work with the child or adolescent to overcome the difficulty, facilitating greater success for each member within the group experience.

Cultural Considerations

The impact of cultural factors will always be present to some degree within the group context, given the diversity of elements present in group dynamics, and specifically impact how individual members engage in the therapeutic process. Clinicians must remain aware of the certainty that underlying beliefs and norms unique to the identities and experiences of each group member will impact their nonverbal communication (e.g., eye contact), willingness to share, ways they may interact with facilitators and other group members, ability to follow-through with tasks outside of the group, and their openness to discussing emotions and psychological experiences within the group. Clinicians need to possess knowledge of specific cultural differences, experiences, and considerations to keep in mind within a therapeutic process throughout assessment, goal setting, intervention, communication, and evaluation. However, a general sense or knowledge of specific cultural tendencies or characteristics is insufficient. Facilitators must especially understand that culturally informed and sensitive assessment and treatment consider these individual factors and the therapist–client (and client-group) interactive cultural context (Tanaka-Matsumi, 2022).

This is especially critical when assessing and treating youth (and interacting with family members) of historically isolated, marginalized, and harmed populations since their experiences (including generational trauma) impact members’ thinking, emotions, and behaviors that will influence not only symptom presentation but also members’ ability to engage comfortably in, and thus benefit from, the therapeutic process. For example, how racism-related stress may be an added factor in the emotional challenges of youth of color should be understood to the best of the clinician’s ability. We refer readers to the work of DeLapp and Gallo (2022) for more information and

examples to help inform the clinician's conceptualization of the member's presentations within the group.

Because belief systems are shaped by experiences that are unique to the individual, it is important during the assessment process to understand both the illness narrative and desired therapy goals through the lenses of each specific client and their family, not simply their identified or perceived cultural backgrounds. Pedersen and Pope (2016) emphasized the importance of inclusive cultural empathy, which "involves increased awareness to prevent false assumptions, increased knowledge to protect against incomplete comprehension, and increased skill to promote right actions" (p.28).

So, at a minimum, facilitators need to appreciate that there **will be** belief systems interacting within the group therapy context that are influenced by cultural experiences and perspectives and appreciate that these dynamics cannot be understood from simply a fact-based perspective alone. Some examples include beliefs about emotional matters and mental health (e.g., stigmas about help-seeking, what should be kept private or shared, vulnerability versus "weakness"); power, authority, and the trustworthiness of the medical profession (especially if a facilitator appears to be of the White majority and a group member does not identify as such); responsibility to the collective group benefit versus individual growth (particularly of emphasis in some cultures); issues of privacy and loyalty regarding disclosing family experiences; spiritual belief systems; etc.

Maintaining this appreciation, without judgment or assumption, and including these considerations within the overall conceptualization of each member's presentation, strengths, and needs – as they relate to achieving individual goals and the larger group process – is critical to supporting the effectiveness of group therapy for each member. Facilitators need to make the process emotionally safe for all youth – those who are comfortable actively participating and those who may not be – so that all members can benefit from each component of treatment (e.g., psychoeducation, skills practice, social support, the modeling or context others may provide, and so on). Clinicians should be mindful to include storytelling and careful dialogue that can transcend cultural issues or experiences when they look to teach the social–emotional skills and competencies we know youth need to develop so that all children can benefit and the group process will be effective.

Each problem-specific chapter that follows will include cultural considerations specific to assessing and treating that presenting problem. Readers are also encouraged to familiarize themselves with research-based information and guidance for providing culturally informed and sensitive (and therefore more effective) counseling, such as the classic and multiple works of Sue, Sue, Neville, and Smith (2019) and Pedersen, Lonner, Draguns, et al. (2015), among others. In addition, the International Association for Cross-Cultural Psychology (IACCP) sponsors the *Online Readings in Psychology (ORPC)*, which consists of free resources for anyone interested in the interrelationships between psychology and culture. Articles grouped in Unit 10 (Health/Clinical Psychology and Culture) "demonstrate the importance of developing the interface between psychology and culture, particularly about counseling and psychotherapeutic activities in a cultural context" (Tanaka-Matsumi, 2022).

Therapist Cognitions

When conceptualizing the presenting problems, strengths, needs, participation, and progress of each group member, facilitators must be familiar with the influence of their cognitions and biases. Just as the schemas, automatic thoughts, and resulting emotional and behavioral responses of members influence each other and the group as a whole, so do the same factors of the group facilitator impact dynamics within the group therapy process. As clinicians, we often take for granted that we are just as likely to possess less-than-entirely-accurate or helpful perceptions that may negatively impact our responses to those with whom we interact. In addition to our cultural context (as noted above), it is crucial to be mindful of our beliefs related to our competencies and

abilities, and to the intentions, motivations, behaviors, and skills of others (e.g., group members, family members). The group setting presents a unique situation with additional challenges, which may activate underlying schema that would otherwise be less of an issue in a one-to-one situation. For example, clinician beliefs related to incompetence are more salient in the group setting, as the idea of making a mistake or not being skilled enough is far more threatening given an audience of six to eight children instead of one. We must be aware of our reactions to particular kinds of group dynamics that may stem from our upbringing (e.g., position within a multi-child household, experiences with complicated peer relationships) and play out in the group. For example, reactions to unkindness, dominance, and learned helplessness within group dynamics may urge us to intervene in ways that undermine members' ability to develop skills for navigating these situations in the real world (e.g., regulating their emotional arousal, finding their voice to practice assertiveness). We must remain focused on managing these group dynamics to ensure members' safety and skill building, not necessarily to assuage our comfort.

Facilitators may also possess beliefs related to their ability to work with a cofacilitator, which is often a benefit or even, at times, a necessity in specific group programs. But this may introduce concerns for professional judgment from one's colleague, "power" dynamics around seniority or experience discrepancies, and differences in style that can impact the sense of cohesiveness. Clinicians must monitor their thought–feeling–behavior responses and regulate them in real time to limit their impact on members' group experience and progress. We must especially monitor our beliefs about the intentions or motivations of youth in our group to avoid biases that impact our ability to deliver the most effective treatment for the betterment of all members. This includes biases regarding member backgrounds and identities (e.g., ethnicities, race, religion, culture, sexuality, gender, abilities, socioeconomic status, family make-up, or experiences) and reactions to member personality traits or behaviors. For example, we may assume that adolescents of certain backgrounds would resist engaging in role-play exercises and, therefore, be less likely to assign these practice situations – which would deny members access to a highly effective, well-established intervention tool. Maintaining an awareness of the impact that our own beliefs, assumptions, emotions, and behavioral reactivity may have on the dynamics of the group or the participation and progress of individual members is crucial to ensure the effectiveness of therapy.

Cognitive-Behavior Group Therapy: The "What"

There has been much written over the years discussing the fundamental aspects of the CBT model. It is beyond the scope of this chapter to take a deep dive into CBT theory. Therefore, we refer readers to several seminal texts to obtain a solid footing in CBT, including *Cognitive Therapy and The Emotional Disorders* (Beck, 1976) and *Cognitive Behavior Therapy: Basics and Beyond, Third Edition* (Beck, 2020). For an outstanding reference of the use of CBT with children and adolescents, we direct readers to *Clinical Practice of Cognitive Therapy with Children and Adolescents: The Nuts and Bolt* (Friedberg & McClure, 2018). However, before using the resources provided within this Handbook, we feel it is important to offer a brief review of the basic goals, structure, and components of CBT, specifically as they relate to group therapy with children and adolescents.

Brief Overview of CBT

The aim of CBT, in general, is to identify and restructure irrational or distorted beliefs and schema related to the self, others, and the world that produce emotional distress and maladaptive behavior (Beck, Rush, Shaw, & Emery, 1979; Beck, 2020). This same fundamental goal is maintained for

each participant when CBT is provided in a group format. However, the group modality offers the additional benefits of support, peer modeling, a sense of commonality, and an environment in which to practice the variety of skills acquired (as discussed above). Through CBT and CBGT, everyone in the group is encouraged to be active in the collaborative process of therapy, even younger children. However, it remains necessary, especially in a group setting, for the clinician to guide sessions and group processes.

Traditionally, CBT is viewed in a linear manner, in which situations, thoughts, feelings, and behaviors are connected in that sequence. For instance, a child who is afraid to be in their bedroom (situation) begins to think that someone will break into the house (thought), and subsequently, they become nervous and afraid (feelings) and refuse to be in their bedroom alone (behavior). While this functional view can be helpful as a starting point, we have not always found this connection to be as simplistic, clear, or direct. Instead, rather than simply a linear approach, these factors tend to influence each other in a multidirectional manner. We encourage clinicians to think and view the interactions of situations, thoughts, feelings, and behaviors less as a linear process and instead more as one whereby each aspect affects the others. Mennuti and Christner (2012) offered a visual illustration of this process in Figure 1.1.

In general, the CBT model postulates that the way a child responds to situations depends on the ways in which they interpret those experiences (Friedberg & McClure, 2015) and that these interpretations and responses can affect each other. Distorted thinking will, naturally, result in irrational and unnecessary emotional reactions and exaggerated behavioral responses. These are usually the symptoms that result in referral for psychological intervention and, in this case, inclusion in group psychotherapy. CBT aims to use the therapeutic situation to identify distorted thinking and

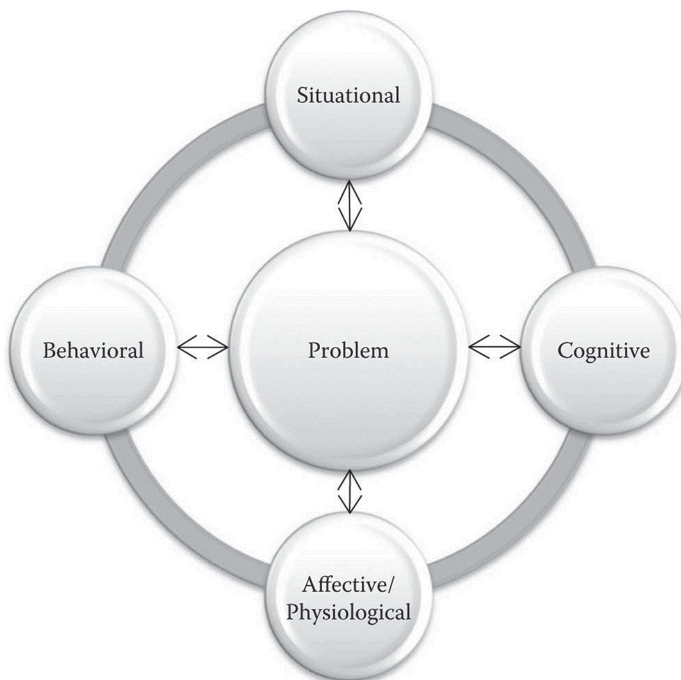

Figure 1.1 Multidirectional Model of CBT.

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responding and to modify both. The identification of distorted perceptions and beliefs may be direct or indirect, depending on the age and cognitive flexibility of group members (discussed in more detail below). Modification of beliefs can be through various cognitive techniques and means or through behavioral experiments that result in "evidence" that counters or corrects distorted thinking. Similarly, ineffective emotional and behavioral responses can be modified through behavioral techniques and interventions that aim to build more effective coping skills. The inherent benefits of the group setting highlighted above support the objectives of identifying and restructuring distorted perceptions and beliefs and facilitating the development of more effective skills, making the group modality a natural extension of individual CBT.

As the name implies, there are two primary elements in CBT – (1) cognition and (2) behavior. The CBT literature uses numerous terms to describe the various levels of cognition: core beliefs, schema, intermediate beliefs, irrational beliefs, cognitive distortions, automatic thoughts, etc. To simplify these terms for use in working with young people, we suggest using three terms – schema, automatic thoughts, and cognitive distortions. *Schemas* are an individual's basic beliefs or assumptions through which individuals perceive and interpret various events (Freeman et al., 2004; Friedberg & McClure, 2015; Young, Klosko, & Weishaar, 2006). They are shaped by our life experiences and are often reinforced throughout our development. They are, essentially, the lenses through which people view themselves, others, the world, events, and interactions. Schema are not easy to identify in younger children, and in many cases, their schema are just developing. However, it is much easier to identify *automatic thoughts*, which are the immediate, superficial level of cognition (Beck, 2020; Freeman et al., 2004).

Automatic thoughts are situation-specific and occur spontaneously without cognitive effort. Essentially, automatic thoughts "pop" into our minds in response to what just happened or what may be happening in the future. We can have many automatic thoughts in a short amount of time. These thoughts typically produce immediate emotional or behavioral responses, are usually easy to identify, and provide a basis for understanding the patterns in thinking that are generated by our schemas to target for change.

When a youth's thinking affects their behavior, there are two possible cognitive explanations – *cognitive deficiencies* and *cognitive distortions* (Kendall & MacDonald, 1993). *Cognitive deficiencies* refer to a deficit in a child's or adolescent's cognitive processing ability. For instance, consider the child who responds impulsively *without* thinking in social situations, and this results in social conflict. *Cognitive distortions* generally refer to errors or inaccuracies in thinking (Freeman et al., 2004). These errors lead to the individual misperceiving or misinterpreting a situation that subsequently alters their emotions and actions. For example, a teenager is in class and the teacher, with a stern look on their face, glances in their direction. The adolescent thinks, "Ms. Jones must be upset with me; maybe I failed the quiz," without considering other more reasonable options, such as "Ms. Jones is thinking and making a face." It should be noted that not all cognitive distortions are negative, though we will alter incoming information to fit our underlying schema.

Several experts in the field have identified a number of cognitive distortions or errors in thinking common to a number of disorders (Beck, 2020; Burns, 1999; Freeman et al., 2004). These distortions invalidate or modify information that poses a threat to a person's existing schematic framework (even if that framework is irrational or maladaptive) so that the incoming information is, instead, compatible with what the person already believes. In Table 1.1, we offer a sample of common cognitive distortions we have seen in our work with children and adolescents in both individual and group settings. Not only may the cognitive distortions of youth clients influence their feelings and behaviors in general, but they may also affect the youth's group participation (e.g., "If I say the wrong thing, the group will make fun of me," "The other students are going to think my problems are silly," and so on).

Table 1.1 Common Cognitive Distortions of Children and Adolescents

1. **Catastrophizing** – The individual predicts that future situations will be negative and treats them as intolerable catastrophes. For example, "I'm going to fail my test and never graduate."
2. **Comparing** – The individual compares their performance to others. Oftentimes, the comparison is made to higher performing or older individuals. For example, "I can't run as fast as my older brother. He is a better athlete than me."
3. **Dichotomous thinking** – The individual views situation in only two categories rather than on a continuum. The world is either black or white with no shades of gray. For example, "People either love me or hate me."
4. **Disqualifying the positive** – The individual discounts positive experiences that conflict with their negative views. For example, "Doing well on my homework was just because my mom helped me." Or "I suck for missing that shot" (ignoring the 18 shots they blocked). (This is also called *maximizing the negative and minimizing the positive*.)
5. **Emotional reasoning** – The individual assumes that their feelings or emotional reactions reflect the true situation. For example, "I feel lonely, so no one wants to be with me."
6. **Labeling** – The individual attaches a global label to describe themself rather than looking at behaviors and actions. For example, "I'm a failure" rather than "Boy, I had a bad game last night."
7. **Mind reading** – The individual believes they know what others are thinking about them without any evidence. For example, "I just know that my friends are mad at me."
8. **Overgeneralization** – The individual sees a current event as being characteristic of life in general, instead of one situation among many. For example, "Because she didn't invite me to the party, I'll never be invited to anyone else's either."
9. **Personalization** – The individual assumes that they are the cause of negative circumstances. For example, "Juan wouldn't talk to me in the hall today. I must have done something that made him angry."
10. **Selective abstraction** – The individual focuses attention on one detail (usually negative) and ignores other relevant aspects. For example, "My teacher gave me an unsatisfactory on the last assignment, so this means I must be one of his worst students!"
11. **Should statements** – The individual uses *should* or *must* to describe how they or others are to behave or act. For example, "I must always get good grades." Or "she shouldn't have said that to me."

The other element of CBGT is the focus on behaviors. This also can be broken down into two areas: *skills deficits* and *skills deficiencies*. Children with *skills deficits* are viewed as not yet having particular skills that would support more adaptive functioning, and through *skills acquisition* exercises in groups, they will learn new ways to approach situations. The simplest example is what we see in typical social skills groups. However, we often use acquisition interventions that also focus on building executive function skills, such as task monitoring, self-regulation, organization, and emotional regulation. *Skills deficiencies*, on the other hand, are seen in children who have acquired a given skill and can use it effectively in certain situations (e.g., the child who can use diaphragmatic breathing well in the session), yet they do not apply it consistently to general situations. For children at this level, *skills implementation* exercises are essential for them to make progress. While these are also conducted in group sessions, the use of "homework" or between-session work is essential in improving implementation and generalizing from the therapy room to real-life situations.

Process Considerations of CBGT: The "How"

We are often asked, "What makes a successful group?" Of course, specific, research-based interventions to treat a given problem are critical components of CBGT that result in positive and sustainable change for group members. But clinicians also need to understand several key aspects of

the structure and process of CBGT that work together to facilitate change and, further, to appreciate the context within which change and growth occur in CBT groups.

Therapeutic Relationship

Perhaps the most important tool a therapist can utilize is the working relationship. Those not familiar with cognitive-behavioral approaches often assume CBT or CBGT ignore the "therapeutic relationship," yet this is not accurate. In fact, Beck and his associates (1979) stressed the importance of active interaction between patient and therapist and stressed that not attending to the relationship is a common error in therapy. When referring to relationships, this goes beyond getting along with those with whom we work. The relationship between clinician and client is empowering and empathetic. The therapeutic connection creates a safe space in which youth can be seen, heard, and understood, which is often a new experience for them. The ways in which we interact will open the opportunity for children to explore and voice their true thoughts, feelings, and needs in a manner that helps move them into action.

On a basic level, Bordin (1979), in his influential work, identified the "working alliance" to include three important components to its effectiveness – (1) an agreement on goals, (2) an agreement on assigned tasks, and (3) the development of a personal bond. While the first two are important, the idea of bond or connection is essential, and our role as therapists is to ensure that the connection we have with youth is empathetic, validating, and empowering. This is accomplished through collaboration, and in group settings this relationship extends beyond patient and clinician to include the relational dynamic between group members as well. We must be aware of connection and disconnection that occur, and in groups, ensure that the disconnection is not passed over but addressed as part of the process. As we attend to and address the ruptures in real time, we can create increased energy and trust in the group process while further increasing understanding and providing a sense of self-worth for all members.

Session Structure

Setting and following an agenda. No matter which group type or format you use, consistent with individual CBT, CBGT relies on the use of session agendas, though some alterations will be necessary. The agenda helps structure the group format and flow, but clinicians must be flexible to allow content and processes to emerge. It is important to have a basic idea of the agenda for each session, and some specific group formats may be more structured than others (e.g., modules to provide education and skills instruction/practice in a particular way). However, sessions should include aspects that are established and implemented collaboratively so members feel a sense of shared responsibility for the session's success. Some common elements of CBGT include "checking in" since the last session, reviewing between-session work, discussing specific topics or skills of the session, obtaining feedback from the members, setting new between-session work, and adjourning. While some clinicians may want to allow members to have much more influence in determining the group agenda, we caution this could be counterproductive with youth clients and result in a loss of critical time that could be spent on the work at hand. Instead, we suggest that therapists using CBGT with children and adolescents have a relatively standard agenda but allow for the opportunity for the group to discuss and negotiate tasks to accomplish the goals of the session. In Table 1.2, we offer a suggested agenda format for various stages of group therapy. This is a guideline that therapists can use in planning their sessions.

In-session skills practice. As noted above, a major goal of CBGT is to develop greater awareness in members of the interaction between their thoughts, feelings, behaviors, and physiological perceptions and to facilitate the development of more effective and adaptive ways of operating

Table 1.2 Example of CBGT Agendas

First session	*Middle sessions*	*Last session*
Introductions	Greeting and check-in	Greeting and check-in
Setting the agenda	Setting agenda	Setting agenda
Clarifying group rules	Eliciting feedback from last session	Eliciting feedback from last session
Getting to know your activity	Reviewing between-session work	Reviewing between-session work
Socializing to CBT	Conducting skills building	Developing a maintenance plan
Providing a summary	Obtaining examples from group	Identifying group members "plans for success"
Developing between-session work	Providing summary	Providing summary
Eliciting feedback	Developing between-session work	Eliciting feedback
Adjourning	Eliciting feedback	Adjourning
	Adjourning	

through education, modeling, and skills implementation exercises. A critical component of sessions, therefore, is the opportunity for group members to not only ask questions and engage in discussion that makes concepts more meaningful, relatable, and attainable but also to see skills implemented – both poorly and successfully, for juxtaposition – and practice skills themselves while supportive, affirming, and corrective feedback can be provided. Again, CBGT aims to use the therapeutic situation to identify distorted thinking that contributes to exaggerated emotional experiences and maladaptive or ineffective behaviors and modify each of these interconnected elements of members' experiences to help them improve their overall functioning and well-being. Therefore, it is critical that sessions are not merely didactic but rather provide members with the chance to experience concepts directly, uncover underlying thought patterns, see ineffective or even maladaptive behaviors as no longer helpful, and feel the cognitive dissonance that results from evolving beliefs that do not align with existing behavior patterns. It is this dissonance that helps to facilitate change – so long as group members are shown and given the opportunity to practice healthier and more effective skills. Through shared, lived experiences that include emotion and often humor, the material will be more easily remembered, as experiential learning is typically more impactful – even if it is contrived within group activities.

Homework. The inclusion of between-session practice (typically referred to as "homework" in CBT) is a primary component of the CBGT model, given that the emphasis is on skill building, with the goals of making newly learned skills automatic, generalizing skills across settings, and altering the ways in which group members perceive events. Essentially, homework attempts to "put in action" the skills discussed and learned in group therapy, but in real-life situations. Homework is often first practiced within a group session, then planned for additional practice between sessions, and finally reviewed in the following session. Members work together to learn and practice skills and then support and provide feedback to one another on the success or failure of homework completion. Homework in CBGT has particular value, as it offers members the chance to learn from one another's experiences when between-session work is reviewed as a group.

An important consideration for facilitators beyond the assignment of meaningful homework is how to handle when group members fail to follow-through with between-session work. This consideration cannot be underscored enough, as it contributes to the perceptions and beliefs that members have about themselves, others, and the process of therapy. Suppose a particular member is having compliance difficulty. In that case, the facilitator must seek to accurately understand their difficulty rather than automatically attributing noncompliance to behavioral difficulties or

resistance (as discussed as a caution above). Some group members may have difficulty with follow-through because of a lack of support or resources outside of the group (e.g., a reliable adult to help facilitate the assigned activities, a lack of opportunities to generalize the skills, and so on). Others may be experiencing self-doubt, feelings of incompetence, or confusion about the assignment that must be understood as part of the conceptualization of the automatic thoughts and schemas of the individual members at work within the group.

Reasons for missed homework must be accurately and directly ascertained and addressed by facilitators within the group to prevent the members from perceiving that homework is not important (i.e., if they observe that Beth continually does not do her between-session work and the facilitator does not address this with her or do anything to "make her," they may begin to discredit the importance of the work). Also, understanding the reason for noncompliance can be an assessment tool to help determine factors that may hinder or impede an individual client's change process. In addition, the group could work to help one member by sharing ideas to overcome particular obstacles. When a therapist does not address issues related to non-completion of between-session work, it may lead to members feeling that the therapist "doesn't care." For example, consider a socially rejected child who is not completing assignments, but the clinician does not directly address the issue. The child may perceive, "She really doesn't care that I am a member of the group" or "She doesn't even notice me." These perceptions result from and, worse, reinforce his beliefs that he is worthless, dispensable, and lacks value in the eyes of others.

Time limitations. The amount of time available for conducting each group meeting will likely depend on the setting and the purpose of the group. For example, groups conducted in the school setting may be limited by class period scheduling (e.g., 45 minutes), while inpatient groups may be 60–90 minutes. Likewise, groups that include lengthy aspects of exposure treatment may require more time. Regardless, we feel it is important to include the key components of CBGT still, even if that means some aspects are shorter to allow for more time spent, for example, on skill acquisition and implementation practice. Facilitators will need to use clinical judgment as to how best to budget time given their unique circumstances and be mindful that this may not be the same budget from week to week. Early on in the process, for example, more time may need to be spent on rapport building (for group cohesion and trust to develop), and practical activities to promote member interest and motivation as they experience change more directly.

Case Conceptualization

The use of case conceptualization or case formulation is common in CBT (Beck, 2020), and it has been discussed widely when working with children and adolescents (Murphy & Christner, 2012; Manassis, 2014; Friedberg & McClure, 2015). When using case conceptualization in group CBT it refers to the structured and systematic understanding of not only the individual's presenting concerns but also how each member's concerns relate within the context of the group environment. This process involves gathering comprehensive information about the individual's cognitive, behavioral, and emotional patterns and integrating this knowledge into a comprehensive understanding of the individual and the broader group dynamics. A well-formed conceptualization assists clinicians in tailoring interventions not only to the individual's needs but also in a manner that optimizes the therapeutic benefits of the group setting. Christner (2022) provides a list of different components for clinicians to consider when formulating an understanding of a child or adolescent, which is shown in Table 1.3.

Within the group context, it is imperative to consider how individual patterns of cognition and behavior influence and are influenced by the different dynamics seen within group therapy. For instance, an individual with social anxiety might interpret benign comments from other members as critical or hostile, which in turn might affect group cohesion. By thoroughly understanding these nuances through case conceptualization, clinicians have a greater potential to preempt challenges

Table 1.3 Components of Case Conceptualization

Identifying Data/Personal Information
Reported Concerns
Antecedents/Triggers
Developmental Considerations
Ethnoracial Considerations
Wellness and Resiliency Factors
Barriers to Progress
Readiness to Change Factors
Relevant Assessment Data
Working Hypothesis(es)
Diagnostic Impression/Educational Classifications
Goals/Treatment Considerations

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and use group dynamics to foster change. By weaving these insights into the group process, clinicians can foster richer, more diverse discussions and learning experiences to broaden outcomes. Each of the problem-specific chapters in this volume will provide valuable insight and important considerations to guide case conceptualization unique to that issue.

Goals and Objectives

The CBGT approach is both goal-driven and time-limited. It emphasizes the creation of distinct objectives to steer the application of its techniques. Such a method is vital in every therapeutic setting, but it becomes even more crucial in group therapy. While some group sessions might have predefined goals before the attendees begin the group (e.g., CBGT for alleviating social anxiety), it is essential to also set individual objectives for each participant. By doing so, each member feels more invested in the group therapy process, having a clear personal target rather than measuring success against others. When determining goals, we will have the overarching therapeutic goals (e.g., "Reduce John's anxiety so he can approach others in conversation 8 out of 10 times"), and also support youth to come up with personal and highly motivating goals (e.g., "I will improve my anxiety level so I can go with my friends to SkyZone.").

We use many metaphors, analogies, and references to pop culture in our work with children and adolescents, especially when discussing goals and the process to reach them. For example, highlighting the process by which Taylor Swift became a global sensation, we consider that her first goal was likely not to sell out stadiums but instead to first write a song, then another, record them, then get people to listen, then get a record label, etc. A common metaphor we use involves thinking of goals as a map or a GPS – to find your way, you must first know where you want to go. For younger children, we use a strategy, "The Captain's Map to the Chest of Success" (Christner, 2023). We liken the process of goal setting to a pirate going on a journey to find the treasure of a lifetime – *Feeling Success*. If you are a pirate not knowing where you want to go, you might wander aimlessly, unsure of your direction. But with a map that has an "X" that marks the spot (the goal), you can chart a course toward your desired destination, adjusting as necessary when obstacles or new paths emerge.

Intervention Selection: The What to Do When

When selecting interventions to use in CBGT, there are several options to consider. CBT has been refined over the years to address the multifaceted nature of psychological disorders, resulting in

various programs, approaches, and interventions. While there are some distinctions between different approaches, it is important to remember that all approaches are grounded in the foundational principles of CBT and are developed with the aim of providing efficient and effective treatments. Throughout the forthcoming chapters, you will see these different methods and approaches brought to life based on the specific problem areas discussed. These chapters will include specific, "apply tomorrow" interventions we know readers look forward to. However, we want to take a moment here to discuss the frameworks clinicians have when choosing different ways to identify interventions for use within a group.

One approach that clinicians may be familiar with is the use of *manualized therapy*. Multiple published manuals and programs exist for delivering CBGT to youth for a variety of concerns, several of which are discussed in chapters within this book and other publications on CBGT (see Christner & Bernstein, 2017). While some may view manualized programs as rigid, they offer clearly defined, step-by-step procedures to follow and specific activities to use in session. This is ideal for new clinicians but can also be of benefit to seasoned practitioners working in larger organizations or schools, where different providers might run the same group. The concern of manualized approaches being rigid has been challenged more recently, and we recommend clinicians using treatment manuals review Phillip Kendall's book, *Flexibility within Fidelity: Breathing Life into a Psychological Treatment Manual* (2021), for inspiring ideas in using manuals in group therapy.

The two other main options for formatting intervention seek to increase adaptability and move away from the idea of a "one-size-fits-all" method. The second approach is the use of *unified protocols*. The goal of unified protocols is to address commonalities across anxiety and mood disorders, focusing on the core underlying factors rather than the specific diagnostic labels. This is referred to as transdiagnostic treatment, which highlights the shared emotional and cognitive processes across many clinical presentations, and how they contribute to an array of disorders. The adaptability of unified protocols is through this transdiagnostic lens. Clinicians aim to target underlying contributing factors, such as emotional dysregulation and cognitive distortions, and less attention is focused on the specific disorder, per se. Thus, group members might have differing diagnoses, but the goal of therapy is to address and build skills in those common areas. Those interested in unified protocols with children and adolescents are referred to the work of Ehrenreich-May and colleagues (2018) for specific guidance and strategies in using this approach.

Finally, there is the use of *modular-based therapy*, which promotes adaptability by allowing clinicians to select from a set of modules or components tailored to the patient and their unique problems and needs. The use of modular-based therapy relies on the clinician using good case conceptualization skills to understand the child and the group (Mennuti & Christner, 2012). Chorpita and Weisz (2009) offer an excellent application of the modular approach using MATCH-ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems). MATCH-ADTC consists of core and supplemental modules to meet each patient's unique presenting concerns. Beyond using a program such as MATCH-ADTC, clinicians well versed in CBT and integrative psychotherapy could use effective case conceptualization to identify a youth's critical knowledge and skill gaps and then develop an appropriate treatment plan, consisting of intervention components that guide the group work. While the modules or components of practice differ based on the core presenting problem(s), Table 1.4 offers a list of common modules that are seen in transdiagnostic literature.

It is necessary to note that with each of these approaches, there remains an emphasis on the importance of empirical evidence. Their foundations lie in evidence-based practices, with each program, module, or element in these treatments having strong research backing. Selecting interventions using one of these methodologies ensures that patients and groups receive CBT treatments

Table 1.4 Sample of CBT Modules for Children and Adolescents

Activity Scheduling (Activation)	Maintenance Strategies (relapse prevention)
Assertiveness Training	Modeling
Cognitive Interventions (e.g., refocusing, reframing, restructuring, and so on)	Parental Education (e.g., response cost, differential reinforcement)
Communication Skills	Problem-Solving
Confronting Physical Sensations	Psychoeducation
Emotional Self-Monitoring	Relaxation
Emotional Regulation	Self-Reward/Praise
Goal Setting	Social Skills Training
Interoceptive/Emotion Exposure	Understanding Emotions
Maintaining Motivation	

that are not only tailored to their needs but are also rooted in scientifically proven methods. The key to all good group therapy approaches is that they involve adaptability, personalization, and evidence-based practice.

Summary

CBGT provides a systematic, theoretically driven model that aids in understanding each patient's unique information within the context of the group's dynamics. This model helps clinicians anticipate challenges and select structured intervention methods. Throughout this chapter, we have underscored the significance of having a flexible understanding of each group member, taking into account their cultural contexts individually and when interacting within the group – including interactions with facilitators – to meet clearly defined goals and objectives.

It is crucial to see each member's needs and objectives through the lens of the CBGT model. This way, facilitators can grasp the thoughts, emotions, perceptions, and behaviors exhibited by each child and the group as a whole. This aids in shaping the group's program, choosing relevant and effective interventions, and monitoring each member's progress in the change process. Facilitators must also be conscious of their thoughts and actions and how they influence the group's dynamic. With the interplay of thoughts, emotions, perceptions, and behaviors in CBGT, numerous simultaneous reactions influencing each other are ever present in a group setting.

We hope readers will understand from this Handbook that while facilitating CBGT with children and adolescents comes with its unique set of considerations (and even challenges at times) in comparison to individual therapy, it also offers numerous benefits and rewards. These challenges are manageable within the group context, provided facilitators stay attentive to potential hurdles, remain true to core principles of CBT, consistently evaluate factors impacting group dynamics, and guide the group toward achieving well-defined goals and objectives for both individual patients and the group collectively. We are excited to present readers with subsequent chapters, written by a diverse team of thoughtfully chosen experts in the field, that provide a more in-depth exploration of the use of CBGT with specific problems facing youth.

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