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Cognitive-Behavioral Group Therapy

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11

COGNITIVE-BEHAVIORAL GROUP THERAPY

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Overview

Cognitive-behavioral therapy (CBT) is an increasingly applied framework for group interventions for a variety of presenting problems in children and adolescents. CBT is a structured collaborative approach that focuses on skill building; it is time-limited and goal oriented, and thus has multiple benefits for use in a group setting (Olatunji, Cisler, & Deacon, 2010). In groups, CBT can be used proactively and preventively to remediate subclinical symptoms, decreasing incidence rates for certain disorders (Christner, Stewart, & Freeman, 2007; Mennuti, Christner, & Freeman, 2012). This method has been used successfully with children and adolescents with depression, anxiety, anger and aggression, and eating disorders (Ollendick & King, 2004). CBT promotes changes in behaviors and patterns of thinking within the young person's social context. As such, it emphasizes problem solving, cognitive information processing, coping skills, and interpersonal relationships within a performance-based framework in which practice is a critical component (Kaufman, 2015). CBT fits contextually in multiple service delivery settings, including clinical and private practice settings, as well as schools (see Christner et al., 2007).

In recent years, the number of programs and resources for implementing CBT with youth populations has increased considerably. Programs are aimed at both clinical and school settings; however, the research on successful school-based applications of CBT lags behind that of clinical applications (Mennuti et al., 2012). Clinicians, both in clinical settings and schools, have access to multiple published CBT programs, including manualized, modularized (see Chorpita, 2007), and even computer-assisted (Khanna & Kendall, 2008; Rooksby, Elouafkaoui, Humphris, Clarkson, & Freeman, 2015) models to use with children and adolescents with a range of presenting concerns, and applied in a group format.

The current chapter will present the evidence base for using CBT with child and adolescent populations and describe applications of CBT in groups, including specific techniques to employ, unique features of cognitive-behavioral group therapy (CBGT), and means for addressing challenges in conducting CBT in groups.

Evidence for Using CBT With Children and Adolescents

A growing body of evidence over 20 years supports the use of CBT with children and adolescents with a variety of referral concerns (Crawley, Podell, Beidas, Braswell, & Kendall, 2010). Both efficacy

and effectiveness trials exist, and to date, current studies on the use of CBT with children and adolescents are generally impressive. In fact, CBT is the most commonly endorsed evidence-based treatment, across disorders and age groups, on the list published by the Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1998; Epp & Dobson, 2010).

Outcome Studies on Cognitive-Behavioral Group Therapy (CBGT)

Recent studies reported positive outcomes when CBT was applied in a group setting for a range of presenting problems, specifically examining CBGT in family-oriented groups for adolescents with anxiety (Stewart & Villavicencio, 2012), intensive-needs groups for children with social phobia (Donovan, Cobham, Waters, & Occhipinti, 2015), game-based group CBT for victims of child sexual abuse (Springer, Misurell, & Hiller, 2012), brief groups for older female adolescents with eating disorders (Jones & Clausen, 2013), and school-based applications (Christner, Mennuti, Heim, Gipe, & Rubinstein, 2011). These studies demonstrate the effectiveness of CBGT in addressing symptom targets both following the intervention and, in some cases, at post-treatment follow-up.

Multiple published manuals and programs exist for delivering CBT in a group setting for a variety of referral concerns. Structured manualized approaches are often chosen because they offer clearly defined, step-by-step procedures to follow and specific activities to implement. Researchers have recently examined a modularized approach to treatment (Chiu et al., 2013), wherein evidence-based techniques are provided in a flexible protocol that allows for individualization, the lack of which is typically a criticism of manualized interventions (see Friedberg et al., Chapter 27, this volume). The modularized approach is focused on specific strategies that promote behavior change for a given problem and that are applied to a particular case in a manner that addresses the specific needs of the young person. In order for this approach to be valuable, the clinician must have good case conceptualization skills (Mennuti & Christner, 2012), use progress monitoring efficiently to measure outcomes, and have a good understanding of the literature across various disorders and problems.

A recent application of the modular approach for multiple presenting problems is referred to as MATCH-ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems; Chorpita & Weisz, 2009). MATCH is grounded in CBT principles and is made up of a set of core modules for each presenting concern as well as supplementary modules to be implemented according to a child's or adolescent's unique needs. It has been studied extensively in community mental health settings, and its application in schools shows great promise (Chiu et al., 2013). Table 11.1 summarizes available CBGT programs for a range of presenting concerns.

Basic Tenets of CBT

The CBT model with children and adolescents, as with adults, suggests that an individual's thoughts mediate his or her emotions and behavioral responses to certain situations and events, which in turn results in cognitive (attributions), behavioral (avoidance), and emotional (anxiety) consequences. It is important to view the connection between thoughts, feelings, and behaviors as multidirectional rather than linear. There is not a cause-and-effect relationship but, instead, a dynamic interactional process that occurs between situational, cognitive, affective/physiological, and behavioral components for the individual. This is particularly true for children and adolescents, whereby these factors influence and, at times, exacerbate each other (for example, feelings of anxiety make the child's stomach upset, which in turn, reinforces the thoughts that s/he will vomit). Thus, clinicians must be aware of the multiple, interacting factors affecting children and adolescents.

CBT focuses on the way in which a young person interprets his or her experiences, and how these thoughts ultimately influence his or her emotional or behavioral functioning; thus it can include varying degrees of cognitive strategies as well as traditional behavioral techniques depending on the

Table 11.1 Cognitive-Behavioral Group Therapy Programs

Program/Author	*Setting(s)*	*Age Group*	*Session Structure & Content*	*Selective Outcome Studies*	*Cost/Publisher Information*
Anxiety					
Cool Kids Rapee et al. (2006)	Clinical/ School	7- to 17-year-olds **Additional Versions*: Cool Little Kids (3–6) Cool Kids Chilled (12–17) Cool Kids ASD (7–12) Cool Kids Anxiety & Depression (12–17)	12 (~2-hour) sessions; some sessions include parents. Sessions include: psychoeducation, cognitive restructuring, systematic desensitization, problem solving, assertiveness training, and homework.	Hudson, J. L., Rapee, R. M., Deveney, C., Schniering, C. A., Lyneham, H. J., & Bovopoulous, N. (2009)	Therapist Manuals: $40; Workbooks: $35–50 https://shop.centreforemotionalhealth.com.au/product-category/forprofessionals/
Taming Sneaky Fears Monga, Young, & Owens (2009)	Clinical	5- to 7-year-olds	12 (1-hour) sessions. Techniques delivered with stories, games, puppets, and crafts, and include: feelings identification, relaxation training, and cognitive strategies (labeling feeling states, ignoring scary thoughts, and thinking "brave thoughts"). Parent component focuses on teaching behavioral strategies to support generalization of skills outside of treatment.	Monga, S., Young, A., & Owens, M. (2009)	Not available
Anxiety & Depression					
The FRIENDS Program Barrett (2010)	Clinical/ School	Fun friends (4–7) FRIENDS for life (8–11) My friends youth: Skills for life (12–15) Adult resilience: Strong not Tough (16–18+)	5 (2- to 2.5-hour) sessions, including: psychoeducation, relaxation, cognitive restructuring, practice, problem solving, role modeling, and (self) reinforcement. Effective parenting sessions through the Adult Resilience Program.	Pahl, K. M. & Barrett, P. M. (2010)	Child Activity Books: $19.10 Facilitator Manual: $28.67 http://friendsprograms.com/
Anger					
Coping Power Program Lochman, Wells, & Lenhart (2008)	Clinical/ School	Late elementary—early middle school	34 structured sessions focused on goal setting, organization and study skills, anger management, social skills, problem solving, and resisting peer pressure. Parent component promotes parents use of praise and positive attention, clear rules and expectations, appropriate discipline, and effective communication.	Lochman, J. E. & Wells, K. C. (2002) Lochman et al. (2009)	Facilitator's Guide: $59.95 Parent Group Facilitator's Guide: $47.95 Child Workbooks: $67.50/8 Parent Workbooks: $98.50/8 http://www.copingpower.com/

Depression					
ACTION Program Stark et al. (2007)	Clinical/ School	9- to 14-year-olds	20 (1-hour) sessions and 2 individual sessions completed over 11 weeks including: psychoeducation, problem- solving, cognitive restructuring, in-session practice and homework.	Stark, K. D. (2008) Stark, K. D., Arora, P., & Funk, C. L. (2011)	Therapist Manual $24 Client Workbook (versions for girls and boys): $26.95 Parent Manual: $19 http://www.cebc4cw.org/program/action/detailed
Coping with Depression (CWD-A) Clarke, Lewinsohn, & Hops (1990, 2003)	Clinical/ School	14- to 18-year-olds	16 (2-hour) sessions (with groups of 10 adolescents) focused on self-observation, reducing tension, changing your thinking, positive thinking, disputing irrational thinking, relaxation, communication, problem solving, and goal setting and planning; 3 sessions include parents.	Lewinsohn, P. M., Clarke, G. N., Hops, H., & Andrews, J. (1990); Rohde, P., Clarke, G. N., Mace, D. E., Jorgensen, J. S., & Seeley, J. R. (2004)	Materials are free and available for download from: http://www.kpchr.org/research/public/acwd/acwd.html
Social Phobia/Social Anxiety					
Cognitive-Behavior Group Therapy—Adolescent (CBGT-A) Albano & DiBartolo (2007)	Clinical	Adolescents	16 (1.5-hour) sessions (with groups of 4–6 adolescents) delivered by 2 therapists, involves psychoeducation, social skills, social problem solving, assertiveness, cognitive restructuring, in vivo and simulated within-session exposure.	Hayward, C., Varady, S., Albano, A. M., Thienemann, M., Henderson, L., & Schatzberg, A. F. (2000)	Therapist Guide available from Oxford University Press, Programs that Work Series
Skills for Academic and Social Success (SASS) Masia, Beidel, Albano, Rapee, Turner, & Morris (1999)	School	Adolescents Adapted from Social Effectiveness Therapy for Children (SET-C; Beidel & Turner, 1998)	12 (40-min) group sessions (3–6 children/group), 2 individual meetings, 2 parent meetings, 2 teacher meetings, 4 social events with outgoing peers, and 2 booster sessions. Primary components: psychoeducation, realistic thinking, social skills, exposure, & relapse prevention.	Fisher, P. H., Masia-Warner, C., & Klein, R. G. (2004); Masia-Warner, Fisher, Shrout, Rathor, & Klein (2007); Ryan & Masia-Warner (2012)	Available from Carrie Masia Warner, PhD, New York University School of Medicine, Child Study Center
Trauma					
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) Jaycox (2004)	School	6- to 12-year-olds	10 (1-hour) sessions with 5–8 children; 1–3 individual sessions; 2 parent education sessions; 1 teacher education meeting. Treatment components include psychoeducation, relaxation, adaptive coping skills, cognitive restructuring, graduated imaginal exposure to traumatic memories, processing of traumatic memories, and social problem solving.	Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., et al. (2003); Nadeem, E., Jaycox, L. H., Kataoka, S. H., Langley, A. K., & Stein, B. D. (2011)	Manual: $40 DVD: $10 Training available: $4,000 for 12–15 participants http://cbitsprogram.org/

youth's age and presenting problem(s). An important goal of CBT is to help the child or adolescent develop an adaptive, problem-solving orientation, often termed a *coping template*—the lens through which he or she views future events and situations and integrates them into their patterns of thinking and behaving (Crawley et al., 2010). We encourage readers to refer to additional resources for a detailed review of CBT that is beyond the scope of this chapter (see Friedberg & McClure, 2015; Reinecke, Dattilio, & Freeman, 2003).

CBGT Techniques

The particular CBT techniques employed in group applications vary according to the age of the group members and the problems being addressed; however, several specific strategies are common across applications (Crawley et al., 2010). Treatment must be tailored to the group's developmental level in order to be most effective. An understanding of the developmental issues of the group can assist with case conceptualization and treatment planning. This is particularly important for CBT, as many of the specific strategies involve challenging faulty patterns of thinking, thus requiring important cognitive (language, memory, attention) and metacognitive skills, which are highly dependent on a developmental level.

When implementing CBT in a group setting, there is a core set of techniques and strategies to employ for most presenting problems, each of which will be described in detail in this section.

Psychoeducation

Psychoeducation lays an important framework for youth to participate in CBT. It is typically the first component of any CBT program, including group applications. Psychoeducation orients the group to the CBT model, by which they are taught to recognize the relationship that exists between situations, beliefs, emotions, and behaviors. We suggest that when assisting children and adolescents in understanding the cognitive-behavioral connections, it is best to begin by using generic understandable situations that differ from their own. For instance, with younger children you may use stick figure drawings of common situations, such as a child holding a present, playing with a dog or cat, or swinging on a swing, with an empty thought bubble to demonstrate how altering thoughts may change feelings and behaviors.

An important first step in teaching the *feelings-thoughts-behaviors* connection that is central in CBGT is teaching group members to label and report feelings and mood states, the detail of which will vary according to developmental level (as in using simple words such as 'mad,' 'sad,' or 'glad' versus more nuanced words like 'irritated,' 'glum,' or 'delighted'). Younger children may not have adequate language to describe their feelings; thus, teaching feelings identification is important before any additional cognitive work can occur. This can be done creatively using various expressive techniques (such as games, art, and bibliotherapy); for example, clinicians may use 'feelings bingo,' charades, or faces charts that the child or clinician creates to assist young children in identifying and labeling different emotions.

Ultimately, psychoeducation serves to normalize the range of emotions and thoughts that youth have. In particular, when applied in a group format, psychoeducation sessions can help group members to learn that others may feel similar feelings or think similar thoughts; having others available for social comparison, particularly in the presence of ambiguous situations, can be a powerful tool to encourage change. Yalom and Leszcz (2005) noted that 'normalizing behavior' promotes a sense of universality that may be the most helpful feature of group therapy. It is common, especially in working with adolescents, for clients to discount the therapist's ability to understand what they are 'going through.' However, the group setting makes it less feasible for members to dismiss the observations of others who share similar problems.

Cognitive Restructuring

Once group members have the necessary emotional language (*feelings vocabulary*) and an understanding of the reciprocal relationship between one's feelings, thoughts, and behaviors, the next step is identifying maladaptive thought patterns. To begin, the therapist helps the group members gain an awareness of their self-statements, expectations, or beliefs that may represent faulty interpretations about themselves, future events, or the world. Developing a personal insight into these patterns of thinking is a key element in cognitive restructuring. The next step is to begin to challenge faulty patterns of thinking and help the group to develop alternative ways of thinking about a given situation or event.

A number of experts in the field have identified cognitive distortions or errors in thinking common to several disorders (Beck, 1995; Burns, 1999; Freeman, Pretzer, Fleming, & Simon, 2004). These distortions serve to invalidate or modify information that poses a threat to a person's existing schematic framework so that the incoming information is, instead, compatible with what the person already believes (even if that framework is irrational or maladaptive). In Table 11.2, 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 young clients influence their feelings and behaviors in general, but they may also affect the individual's participation in the group (for example, "*If I say the wrong thing, the group will make fun of me*" or "*The other kids are going to think my problems are silly*").

Table 11.2 Common Cognitive Distortions of Children and Adolescents

1. *Dichotomous thinking*—The child 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, "If I don't get all A's then it is like failing."
2. *Overgeneralization*—The child sees a current event as being characteristic of life in general, instead of one situation among many. For example, "Because I failed that test, I'll never pass the class."
3. *Mind reading*—The child believes he or she knows what others are thinking about him or her without any evidence. For example, "I can tell that Sally doesn't like me."
4. *Emotional reasoning*—The child assumes that his or her feelings or emotional reactions reflect the true situation. For example, "I don't feel smart, so I must be stupid."
5. *Disqualifying the positive*—The child discounts positive experiences that conflict with his or her negative views. For example, "I made the basketball team because the coach knows my dad and I made some lucky shots at tryouts."
6. *Catastrophizing*—The child predicts that future situations will be negative and treats them as intolerable catastrophes. For example, "I'm going to bomb the SATs and I will never get into a college."
7. *Personalization*—The child assumes that he or she is the cause of negative circumstances. For example, "My mother had a mean look on her face. I must have messed up."
8. *Should statements*—The child uses 'should' or 'must' to describe how he or she or others are to behave or act. For example, "I must do what others say or they won't like me."
9. *Comparing*—The child compares his or her performance to others. Often, the comparison is made to higher-performing or older children. For example, "My older brother can get homework done in 20 minutes. It takes me an hour. I must be slow."
10. *Selective abstraction*—The child focuses attention to one detail (usually negative), and ignores other relevant aspects. For example, "My teacher told me I was too loud today, so she must not like me!"
11. *Labeling*—The child attaches a global label to describe him or herself rather than looking at behaviors and actions. For example, "I'm stupid" rather than "This class is hard for me."

Source: Adapted from Christner, R. W., Stewart, J., and Freeman, A. (2007). *Handbook of cognitive-behavior group therapy with children and adolescents: Specific settings and presenting problems.* New York, NY: Routledge.

Once group members understand that thoughts are associated with feelings and subsequent behaviors/actions, they can begin to track their own thoughts, perhaps as homework in between sessions. Thought records (see Table 11.3) are another helpful tool for tracking the connection between thoughts, feelings, and behaviors, typically requiring group members to write down information about a situation in a columned chart—what they were thinking, how they felt (physically/affectively), what happened, and if they made any thinking errors. The number of columns in the thought record should reflect the group's developmental level (for example, younger children may have a thought record with only three columns: thought, feeling, action). Finally, the therapist works with the members to examine evidence that supports or refutes their negative thinking patterns (as in, "*How else could we look at this?*" and "*What evidence do we have to say this is true?*") and, if appropriate, poses the "What if?" question ("*Even if your thought is true, is it really so awful?*" or "*What is the worst that could happen?*"). Sources of evidence for examining thinking errors may include past experiences ("*Has anyone laughed at you in class before?*"), alternative possibilities ("*Could they have been laughing at someone else?*"), general knowledge ("*How often do you get answers wrong; what about other classmates?*"), and different perspectives ("*How might others feel about answering the teacher's question?*").

It is important to note that much of the success of cognitive restructuring relies on the young person's willingness to test alternative thinking strategies via practice exercises completed during treatment sessions or as homework in between sessions. The therapist, therefore, serves as a guide, encouraging the child or adolescent to examine the evidence for a particular thought, test the alternative thought, and talk through the experience in group. In groups, members can work together on cognitive restructuring exercises, using non-threatening examples to start, and then completing homework tasks in which they monitor their own thinking patterns and report back to the group the following session. The group setting offers the benefit of normalizing faulty patterns of thinking and gives youth the opportunity to problem solve situations and challenge other group members' thinking in a safe and supportive environment.

Relaxation Training

Particularly useful in the treatment of internalizing disorders in children, relaxation training is a key element in most CBT treatments for a variety of concerns of childhood and adolescence. CBT therapists present relaxation as a coping skill, which is taught directly, and encouraged when the members' symptoms arise (Crawley et al., 2010). The primary goal of relaxation training is to assist young people in developing an awareness of (and eventually the ability to regulate) their own physiological sensations associated with symptoms; thus, relaxation training is particular helpful for youth who express somatic complaints (headaches, stomachaches, and so on). Relaxation training, specifically when used with children and adolescents with anxiety, is most effective when paired with imaginal and/or in vivo exposure (Kendall, 2012).

Several well-researched strategies exist, including progressive muscle relaxation (the Jacobson technique; Jacobson, 1929), the Benson (cue-controlled) technique (Benson, 1983), guided imagery, and mindfulness meditation. Scripts and/or audio recordings are often helpful when teaching relaxation methods, and will vary in length and depth according to the group's ages and developmental

Table 11.3 Example of a Thought Record for Youth

What Happened? (Situation)	*How Did You Feel? (Emotion)*	*What Went Through Your Mind? (Thought)*	*What Did You Do? (Behavior)*

levels. For example, when using the progressive muscle relaxation technique, which requires youth to tense and relax different muscle groups throughout their body, older adolescents may be able to work through all parts of the body, tensing and relaxing muscle groups, while younger children may require metaphors and incorporation of play to understand the technique (such as pretending to be stiff like a robot and then relaxing like a ragdoll, or squeezing the juice out of a lemon and then letting the juice go into a cup). The group setting can assist children in feeling comfortable attempting relaxation strategies among same-age peers as they may be more willing to engage in it if they see their peers are as well.

Role Play and Practice

Bandura's (1969, 1986) notion of observational learning or modeling, grounded in social learning theory, has an important role in a CBT treatment package. In group CBT, there is the added benefit of having group members serve as models for each other. Models, in CBT, aim to demonstrate for youth the use of effective coping strategies, such as through spotting and challenging thought errors and maladaptive behaviors. The most effective model is one who verbalizes his or her thoughts and actions while engaging in the behavior (Meichenbaum, 1971). Therapists providing group-based CBT may consider first demonstrating a new skill as a *verbalizing coping model* (one who demonstrates a task, struggles, or makes a mistake along the way, and talks through their problem-solving strategies) and then offering opportunities for group members to serve as the model. The benefit of using a verbalizing coping model is that the leader can demonstrate to the group member that, with effort, the model completed the task in the face of discomfort or distress (Crawley et al., 2010). A *mastery model*, on the other hand, is one that demonstrates successful completion of a task with minimal struggle or anxiety. When the group member models a skill, the therapist, or other members, can provide encouragement and praise as well as corrective feedback. Modeling is most effective when used in combination with performance-based learning experiences (in other words, practice; Chorpita, 2007), thus group sessions should incorporate a combination of the strategies described.

Role play provides opportunities for these performance-based learning experiences, a mechanism for youth to practice newly learned cognitive, behavioral, and problem-solving skills (and for the therapist to assess progress) during the course of the treatment. In a group setting, role plays can occur between therapist and group members or between and among members. They should be based initially on non-threatening situations that are not specific to any of the group members. They may then expand and relate directly to an experience described in a group member's thought record. Role plays are also excellent practice for exposure work (either imaginal or in vivo), a critical component of CBT for anxiety (Chorpita, 2007; Friedberg et al., Chapter 27, this volume), in which the child or adolescent practices newly learned coping skills in situations perceived or experienced as anxiety provoking.

Teaching Problem-Solving Skills

An important skill that is taught directly in CBT is the ability to problem solve. Teaching children and adolescents how to problem solve encourages them to view new (and potentially threatening) situations with confidence and allows them to draw from and apply the skills (for example, challenging thinking errors, taking deep breaths, and so on) they acquired in treatment to future experiences. Teaching problem-solving skills helps to maintain treatment outcomes and prevent relapse. Kendall (2012) noted that children acquire cognitive problem-solving strategies through experience, observation, and interactions with others; however, these strategies can be improved through intentional intervention.

Problem-solving strategies should be taught in conjunction with modeling and role play. It is helpful to teach children and adolescents how to problem solve using a step-by-step framework in which they identify the problem, brainstorm possible solutions, evaluate the proposed solutions and consider alternative ones, and evaluate the chosen solution. Kendall (2012) suggested encouraging young people to ask: (1) What is the problem? (2) What are all the things I could do about it? (3) What will probably happen if I do those things? (4) Which solutions do I think will work best? (5) After I have tried it, how did I do?

Homework

To reinforce newly learned skills in a CBT model, therapists assign homework tasks to encourage youth to practice strategies outside of treatment. In-between practice sessions, as they are often called, assist youth with applying newly learned skills in group. It is suggested that homework first be practiced together during a group session before tasks are assigned, and then reviewed again when the group reconvenes the following session. This structure allows group members to support one another and provide each other with feedback before and after homework tasks are completed. Homework in CBGT has particular value, as it offers members the chance to learn from one another's experiences.

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. If a particular member is struggling to comply with between-session tasks, the facilitator must seek to accurately understand his or her difficulty, rather than automatically attributing noncompliance to behavioral difficulties or resistance. Some group members may have difficulty with follow-through because of a lack of support or resources outside of group (such as a reliable adult to help facilitate the assigned activities or a lack of opportunities to generalize the skills).

Reasons for missed homework should be accurately and directly ascertained and addressed by facilitators within the group to prevent members from perceiving homework as unimportant. Further, understanding the reason for noncompliance can help the facilitator to assess factors that may impede an individual group member's change. It can be helpful to ask group members to share ideas for overcoming potential obstacles, such as those that impede completion of homework. When a therapist does not address issues of 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 therapist 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.

Planning for Generalization and Maintenance

A final component of CBT and CBGT is to take time to plan for the generalization and maintenance of the newly acquired skills that the group members have mastered as a result of treatment. Generalization of skills outside of treatment does not occur automatically, but requires specific planning and homework tasks—finding and structuring opportunities to use the skills in daily experiences at school, at home, and in the community. As an example, the facilitator cannot assume that a member will practice newly learned relaxation strategies at home without specifically planning for this occurrence. Generalization planning in treatment with young people, therefore, should include parents. This may involve inviting parents to a select number of group sessions or holding separate sessions for parents. Parents can be critical allies in supporting children's application of newly acquired skills outside of group.

Beyond generalization of skills is the child or adolescent's continued use of skills once treatment has ended (*maintenance*). Group closure should be planned in advance and discussed openly with group members. In CBT, youth are often encouraged to create a final product to document their success

with the treatment and the skills they have learned and mastered. The permanent product can serve as a future reminder of treatment gains and the relationships established in the group as well as a form of self-reward for their hard work during treatment. An example of a product might be a short story with illustrations in which a child describes how he or she learned to manage anxiety, the strategies used, and recommendations for others who may be experiencing similar emotions. Children should be encouraged to share the product with their parents to further promote generalization of skills.

A Typical CBGT Session

As previously noted, CBT is a structured, goal-oriented treatment modality that often involves some type of manual or individual modules to ensure that essential components are covered during the course of treatment. As such, CBGT typically involves the use of session agendas. An agenda helps structure the group format, though clinicians must be flexible to allow content and process to emerge as sessions unfold. Session length should also take into consideration the age of the members and the constraints of the setting. Clinicians should plan agendas in advance of treatment sessions to ensure logical connections to previous sessions are made and that new treatment goals and skills are introduced. Common elements of a CBT agenda include (1) checking in since the last session, (2) reviewing homework, (3) discussing specific issues or teaching skills planned for the session, (4) obtaining feedback from group members, (5) assigning new practice tasks for between sessions, (6) checking in on the relationship (for example, completing a fun task to continue building rapport and to end on a light note), and (7) adjourning. It is suggested that therapists using CBGT with children and adolescents maintain a relatively standard agenda, but allow for opportunities for the group to discuss and engage in additional tasks, particularly those that encourage rapport among group members and with the group facilitator.

Important Considerations for Group Applications of CBT

Group Dynamics and Cohesion

Effective CBGT with children and adolescents promotes collaboration between members through goal setting, the establishment of rules for group, 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 promotes a cohesiveness (Yalom & Leszcz, 2005), which facilitates each member taking an active role and a personal investment in his or her own success and that of the group and other participants. This investment ideally 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 feedback to others, and working to meet group goals, so that challenges to group cohesiveness may be detected and addressed early and directly. Some members may be less willing than others to assume responsibility for their own progress, let alone the growth of the group as a whole. Facilitators must be cognizant of the motivation of these members to actively participate in the change process, which should be evident if the conceptualization of each group member's presentation and the group dynamics as a whole is adjusted for accuracy throughout the group process.

Role of the Group Leader

Perhaps the most important tool a child and adolescent therapist can rely on is his or her working relationship with the youth. Those not familiar with cognitive-behavioral approaches often assume CBT ignores the 'therapeutic relationship,' yet this is not accurate. In fact, Beck and his associates

(1979) stressed the importance of active interaction between client and therapist, and the therapeutic alliance or working relationship as a key element to effective CBT. A number of experts have asserted that a positive, authentic connection between client and therapist can produce an opportunity for the client to make notable change and to enhance overall outcome (Corey, Corey, Callanan, & Russell, 1992; Mennuti & Christner, 2005).

The group leader in CBGT, thus, is tasked first with developing a therapeutic relationship with the members. In CBGT, the group leader is seen as a 'coach' of sorts (Kendall, 2012). To this end, he or she does not purport to have all of the answers, but instead facilitates group problem solving. The group leader takes an educative role, working with the members to develop coping strategies and encouraging them to try out the strategies via active behavioral practice. The CBGT therapist does not force the use of a specific strategy; she or he provides opportunities for the client(s) to practice newly learned skills in session and encourages the use of the strategies outside of therapy. To this end, the group leader may use collaborative problem-solving phrases such as "*How can we look at this [situation] differently?*" or "*Why don't you try that new strategy out [when you are feeling anxious] and report back on how it worked?*"

Addressing Challenges in CBGT

Stage of Change

The idea of stage of change is not a new concept to psychotherapy, as it has been supported in the literature for a number of years (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992), and has been applied to a number of psychological, psychosocial, and medical issues (see Prochaska, Redding, Harlow, Rossi, & Velicer, 1994). Despite literature focusing on these stages, there remains minimal data on the use of this very important model with children and adolescents. The group context presents an additional dynamic, as the stage of change of each member 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 not yet taken action may move more quickly toward the action-planning and action phases by observing the successes of other group members. However, we have had cases in which the opposite has occurred, and members' reluctance to attempt change strategies occurs because of a negative report of another member. It is necessary for the group therapist to be aware of this possible dynamic and use session time to problem solve less-than-positive experiences and to encourage further attempts.

Types of Challenging Group Members

In considering challenging group members, the term 'resistant' often comes to mind. Malekoff (2014) noted that resistance can be manifested in a number of ways, including denial of the problem, superficial compliance, testing the limits, silence, and blaming others. However, while on the surface these resistant behaviors appear planned and deliberate, in many cases they stem from sources outside of awareness (Yalom & Leszcz, 2005). Disruptive and challenging behaviors in group may actually be the result of a number of cognitive errors or distortions.

Take, for instance, the group member who needs to be the center of attention. This is the child who responds to every question, but they do so in a manner that is disruptive and often superficial. Sometimes, however, there is another need being met for this member, 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 is the child who attends every group but rarely responds, and if he or she does, it is usually, "I don't know." Many of these children have concern regarding social perception in the group ("*I don't want to embarrass myself*").

However, in our work, we have seen a number of children and adolescents whose silence was because they did not believe the intervention would work for them. We recall one adolescent in a depression group who, while discussing his silence individually, reported having thoughts of *"I've screwed up so bad, nothing will make it better."* By addressing the underlying cognition, we were able to work with him to alter his perception serving as a barrier to participation and treatment. Finally, there is the *active challenger.* This is the member who is more actively noncompliant and often disruptive. Again, there are many thoughts that may be contributing to the behavior. We have had some clients, who have expressed thoughts like *"If I change, I will be vulnerable,"* or *"If I try in group, I'm admitting I have a problem."* These are just a few basic examples, and we encourage therapists to explore the cognitive factors that may be at the root of challenging behaviors.

In addition, while the individual child or adolescent may be viewed as "resistant" when displaying challenging behavior, we suggest that therapists also look at other potential factors that underlie the challenges and may impede change. These can include family factors, systems or setting factors, peer factors, and provider factors, to name a few. Each of these, as well as other potential influences, should be considered when a client presents as challenging in group. We have found that through keeping an open mind and exploring various factors, we can often identify the reason for the challenge and work with the child or adolescent individually to overcome the difficulty.

Summary

The use of CBGT with children and adolescents is promising in a variety of settings. Not only does CBGT offer a systematic, theoretically driven model, but it has notable evidence to support its use with children and adolescents. The direct, skill-based approach provides youth with a familiar format, as it mimics a format similar to school. We offered a number of techniques and example programs in this chapter, though there are many other programs available. For information on using CBGT with specific problems and settings, readers are referred to *Handbook of Cognitive-Behavior Group Therapy With Children and Adolescents: Specific Settings and Presenting Problems* (Christner et al., 2007).

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