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INTENSIVE GROUP TREATMENT OF OBSESSIVE-COMPULSIVE DISORDER: A PILOT STUDY

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Abstract

Objective: Obsessive-compulsive disorder (OCD) is a disabling anxiety disorder. The established treatment of choice is exposure and response prevention (ERP) and it has been demonstrated that ERP is effective across a range of different treatment formats. The aim of the present pilot study was to evaluate the effectiveness and patients' acceptability of individually delivered ERP in a group setting. In the current paper we describe the main features of this novel approach as compared to standard individual ERP and other group approaches.

Method: Six consecutively referred OCD patients (aged 23-59) were included, five with OCD since childhood or early teens. The treatment was run four successive days, with prolonged exposure training on Day two and Day three, designed as one long session. This procedure was partly modeled over the one-session approach to treatment of specific phobias.

Results: All patients expressed high acceptance of the treatment procedures, content and format. Mean Y-BOCS score at pre-treatment was 23.5 points, at post-treatment 5.7 points and at six months follow-up 6.3 points.

Conclusions: Intensive group ERP appears to be a promising treatment format and future larger scale studies are warranted.

Key words: obsessive-compulsive disorder, cognitive behavior therapy, brief group therapy, intensive format

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Introduction

Obsessive-compulsive disorder (OCD) is a disabling anxiety disorder with a chronic course in absence of treatment (Nelson & Rice 1997). Exposure and response prevention (ERP) has been demonstrated to be a highly efficient and cost-effective approach and is widely recognized as the treatment of choice for patients suffering from this disorder (National Collaborating Centre for Mental Health 2006, Task Force on Promotion and Dissemination of Psychological Procedures 1995). Since Victor Meyer (1966) first demonstrated that OCD could be treated with ERP, numerous studies have showed that this treatment can be successfully delivered in different settings, formats and with different intensity (Abramowitz 1996, 1998).

The core feature of ERP is to assist the patient, in a systematic and planned way, to approach their most feared situations or thoughts and at the same time refrain from any activity that purposively reduces anxiety (Kozak & Foa 1997). Although ERP is effective, many patients consider it to be challenging, and a considerable number decline the approach when offered. Drop-out is also relatively high (Fisher & Wells 2005).

ERP delivered in a *group format* has been seen as an effective method for enhancing patient compliance by using the peer influences of the group (Håland et al. 2010), but the results so far seem to be somewhat poorer than what is usually obtained in individual trials (Fisher & Wells 2005). Several factors might contribute to this (see **table 1**).

In the Kozak and Foa (1997) treatment manual, revised by Foa, Yadin, and Lichner (2012), it is recommended that the main content of the sessions should be extensive and individually tailored therapist-supervised ERP along with planning and reviewing homework to practice the tasks covered in the 90 minute sessions. Exposure typically starts in session three. The therapist and patient work closely to actively create and establish situations that expose the patient to relevant triggers. In a group format these features are typically attenuated since the therapist/patient ratio neither allows for the same flexibility when it comes to identifying and creating relevant triggers, nor the same amount of

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Table 1. *Comparisons of standard individual ERP, typical group ERP and the current approach*

	Individually delivered ERP	ERP in group format	Current group approach
Individually tailored exposures	Yes	Lesser extent	Yes
Therapist assisted exposures	Yes	Lesser extent	Yes
Exposures early in treatment	Yes	No	Yes
Most challenging exposures the first third of the treatment course	Yes	No	Yes
Refrain from all rituals once a task is included in the exposure training	Yes	Unclear	Yes
Flexibility to actively seek potent triggers outside office	Yes	No	Yes

therapist assisted exposure (Håland et al. 2010, Jonsson and Hougaard 2009). Foa, Yadin, and Lichner (2012) recommend that exposure starts immediately after the initiation of treatment, and that the most challenging exposure occurs during the first third of the treatment. However, in a group format, exposure training is often postponed to the second half of the treatment, and the most demanding tasks saved for last sessions (Håland et al. 2010). Another fundamental feature of ERP is to refrain from all rituals after a specific exposure task has been completed, and to record any deviations from this rule. If the patient performs a ritual, he or she is asked to immediately re-expose. This principle of complete ritual prevention seems to be more loosely practiced in the group format (Krone, Himle, & Nesse 1991).

It might be argued that these adaptations of the core ERP-principles might contribute to the somewhat weaker results typically seen when ERP is delivered in group format. In the current pilot study, ERP is delivered in a group format, without violations of the basic principles for individually tailored, therapist assisted exposure combined with full response prevention. In addition it is delivered within a limited and very short time frame, similar to one-session treatment for specific phobia (Öst 1989). To our knowledge, such short and intensive ERP has not been reported. When it comes to specific phobia nearly 30 controlled trials have demonstrated clinically significant and sustainable change is obtained in a single treatment session of three hours duration (see e.g. Haukebø et al. 2008; Öst, Alm, Brandberg, & Breitholtz 2001; Vika, Skaret, Raadal, Öst, & Kvale 2009). Before starting single session exposure for specific phobias the patient is informed that the goal is to approach the most feared situations and learn to deal with them within only three hours. They accept that this will be accomplished by exposure to all relevant triggers. This exposure is assisted by the therapist and individually tailored. The patients are also familiar with the fact that in contrast to self-guided pretreatment exposure in real-life situations, exposure therapy is planned, systematic, repeated, as well as voluntary. Patients have been given detailed information about the 'anxiety curve' that illustrates how repeated presentations of anxiety-eliciting stimuli gradually result in a reduced response; given no escape or avoidance (Foa, Yadin, and Lichner 2012). In addition patients have explicitly agreed to do tasks suggested by the therapist. The therapist on the other hand promises that surprise or unpredictability will not be part of the treatment and that the patient will be asked to give consent to each exposure before it is initiated. Although OCD is usually by far more complicated and complex than specific phobia, treatment principles are thus basically similar.

Substantial clinical experience with one-session phobia treatment (Haukebø et al. 2008, Vika et al. 2009) as well as OCD-treatment à la the Foa and Kozak (1997) approach (Vogel, Hansen, Stiles, & Gotestam 2006) and brief and intensive group treatment for other disorders (Hansen, Kvale, Stubhaug, & Thayer 2013) comprise the background for the current pilot study. Patients were offered individually tailored ERP treatment based on Foa, Yadin, and Lichner principles (2012), delivered in a group setting over the course of four consecutive days, where the two middle days constituting one long ERP-session. The aims of this pilot study was thus to both explore the acceptability of the format, as well as the clinical effects.

Methods

Patients

Diagnostics and comorbidity. Seven patients consecutively referred for treatment to the outpatient OCD-team at Haukeland University Hospital in Bergen, Norway, were assessed for inclusion in the intensive group treatment. The patients were first referred by their general physicians to the local district psychiatric outpatient facility, and thereafter to OCD treatment. As a component in ongoing quality-improvement

procedures patients were offered the opportunity to participate in the current group format. If they declined, they were offered standard individual ERP. All the patients preferred the intensive format, but one was excluded due to insufficient skills in Norwegian.

All patients fulfilled the DSM-IV-TR (APA 2000) criteria for OCD and had a Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al. 1989) score of minimum 17 (see **table 2**). Comorbidity included: major depressive disorder, current episode moderate (one patient), panic disorder with or without agoraphobia (two patients) and generalized anxiety disorder (one patient). Comorbid disorders in remission: alcohol abuse (one patient) and major depressive disorder (two patients). None of the patients were suicidal. Personality disorders were not evaluated.

Onset and duration. The OCD had for all but one patient started in childhood or early teens (mean 17.5 years old), with a duration from 3-41 (mean 21.3) years.

Previous treatment. Three patients had previously undergone psychological treatment for their OCD, three participants had not. Two patients had received treatment for several years, and one patient had seen a number of therapists. Two of the patients with previous treatment experience had received ERP treatment. One patient had been hospitalized for OCD.

Medication. Two patients had been on stable doses of SSRI for more than three months before treatment start, no change in medication was made prior to, or during, treatment. One patient had previously used SSRI, but this was discontinued three weeks before group treatment started.

Demographics. The patients (two male) were aged between 23-59 (mean 38.8) years. One patient was married, two divorced and three unmarried. Only one patient was in fulltime work (due to a flexible employer). Three were on sick leave due to OCD, and two had dropped out of university studies.

OCD-symptoms

Patient A had symptoms primarily related to symmetry and orderliness, and a fear that negative events could happen if objects were not arranged correctly, and that world order could be disturbed unless certain actions were repeated. The patient performed rituals that included overly tidiness, ordering or rearranging objects, and repeating actions until "it felt just right".

Patient B had obsessions mainly related to committing unwanted sexual acts and about being infected with HIV. Main rituals were thought control by blocking unwanted sexual thoughts from entering consciousness and substitution of inappropriate sexual thoughts with thoughts with acceptable sexual content. The patient also engaged in excessive washing and cleaning rituals. Situations that triggered obsessions (e.g. social encounters, parties and public areas like parks and restaurants) were avoided. After being in a public setting the patient performed repeated memory searches to check for possible unwanted sexual acts.

Table 2. *Sample Scores on the Yale-Brown Obsessive Compulsive Scale*

	Y-BOCS				
	Pre	Post	1 month	3 months	6 months
Patient A	20	4	3	9	14
Patient B	22	9	14	8	8
Patient C	32	0	4	4	4
Patient D	27	0	4	3	0
Patient E	19	10	4	4	6
Patient F	21	11	10	7	6
Mean:	23.5	5.7	6.5	5.8	6.3

Patient C's obsessions consisted mainly of thoughts that something bad could happen to significant others unless excessive counting rituals, repetition of actions and body movements to the right were performed. Counting rituals were performed virtually constantly. The thoughts were triggered in situations associated with death, for example black-colored objects, hospitals/medical care, graveyards, churches etc. The patient was unable to listen to the news, read newspapers or books in fear of being confronted with triggers. At the time of referral the patient also was diagnosed with panic disorder with agoraphobia.

Patient D suffered from obsessive thoughts about committing suicide. The patient tried to control the extremely distressing thoughts by 'positive thinking', reassurance seeking from others as well as mental distraction. Situations that evoked fear of acting on the intrusions were avoided (e.g. crossing bridges, train platforms and standing close to windows in tall buildings). Other obsessive thoughts were focused on being unfaithful. These were controlled and neutralized by mental rituals and distraction. The patient avoided situations with the possibility of meeting potentially attractive persons.

Patient E had obsessions mainly related to contamination, with the worst fear being in contact with one's own or other people's urine. The patient engaged in excessive toilet, shower and washing rituals, and had established clean zones at home. Clothes were changed repeatedly throughout the day, and public toilets/restrooms were avoided.

Patient F's main obsession was thoughts about harming others by spreading contamination. The patient had excessive washing and cleaning as well as checking rituals, often combined with counting and praying. The patient also had intrusions about bumping into objects in stores and tearing them down, along with recurrent thoughts related to performing below standard, which led to checking compulsions and repetition of actions.

Measures

Treatment credibility and expectancy was measured by the Credibility and Expectancy Questionnaire (Borkovec & Nau 1972) before the group started, in accordance with the Foa et al. (2012) manual.

OCD-symptoms were evaluated by the Y-BOCS interview, which was administered at pre-treatment, 1 week post-treatment and at 1, 3 and 6 months follow-up. Y-BOCS is comprised of 10 questions assessing severity of both obsessive and compulsive symptoms on a 0-4 rating scale, higher scores indicating more severe symptoms. All follow-up Y-BOCS interviews were administered by an independent therapist highly experienced in the administration of Y-BOCS.

Comorbidity was assessed by the Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al. 1998) conducted by an experienced clinical psychologist before the OCD assessment started. M.I.N.I. is a short structured diagnostic interview which screens axis 1 DSM-IV-disorders and the Norwegian version has

sound psychometric properties (Leiknes, Malt, Malt, & Leganger 2005; Mordal, Gundersen, & Bramness 2010).

Depressive symptoms were measured by the Beck Depression Inventory (BDI; Beck, Steer, & Brown 1996). BDI is a 21-item self-report questionnaire; each question is assessed on a 0-3 scale with higher scoring indicating more severe symptoms. BDI was administered at pre-treatment, 1 week post treatment and at 3 months follow-up. Follow-up measures were administered by mailing the questionnaire to the participants with a pre-paid return envelope enclosed.

Overall satisfaction with the group sessions. At the end of each day the patients were asked to use a 1-6 scale ('dice score'), with 1 indicating that they were "not satisfied" and 6 indicating "very satisfied" to give an overall evaluation of the day's treatment. At the end of the final treatment day the patients were interviewed by one of the therapists regarding satisfaction with different aspects of the treatment.

Procedure

Prior to treatment patients met for two OCD-screening sessions equivalent to the first and second information gathering sessions in the Foa, Yadin and Lichner (2012) manual. These sessions are basically the same for all patients referred to our clinic. Towards the end the patients decided whether they would like to have standard individual or intensive group treatment. In these pre-treatment sessions patients received psycho-education about maintaining factors in OCD and the basic ingredients of exposure and response prevention. They were given information that a main feature of all anxiety disorders is that the brain wrongfully mistakes discomfort and anxiety for danger. It was explained that in order to gain knew knowledge, it was essential to trigger discomfort and anxiety without performing rituals or actions aimed at anxiety reduction. They were told that in order for the treatment to work, it was essential that they actively took responsibility for the identification of useful triggers and that exposure tasks would be planned and agreed upon. It was also discussed that if they were reluctant and could not commit to ERP-treatment, it would be better to postpone it until they were ready. If the patient was interested in treatment, he or she was given information about content and form of the four day intensive group. Treatment was presented as a course or workshop with the goal of learning and practicing principles and techniques they themselves could use to get rid of the OCD. Even though the other patients in the group might have different OCD symptoms, treatment has basically the same features, but with content tailored to each individual in the group. Observing treatment for other patients could be of help in understanding one's own OCD. It was explained that all exposure tasks would be therapist assisted, and that most of the treatment would take place in real-life situations and settings. Also, they were informed that exposure to triggers and situations that elicit the most anxiety and discomfort usually produce the largest therapeutic gains, and are therefore extremely valuable. In order to utilize the brief and intensive treatment, patients were given the task before the first group meeting of compiling a list of triggers and situations they avoided the most and that were associated with the strongest urge to ritualize. It was also explained that it was essential to refrain from all rituals once treatment had started. Also, they were informed that they should not expect to be able to do any work or engage in social activities during the four day group treatment.

Treatment

Day 1 the group met for four hours (3 p.m. - 7 p.m.), during which basic understanding of OCD was repeated. "How to do exposure and response prevention" was reviewed and discussed, and the therapists' role as coaches underlined. A metaphor from sports was used to illustrate the rational for the therapist role: "When you are learning a new skill, you need to focus on technique. If not, you risk learning a set of unhelpful habits that may thwart your development and prevent obtaining the level of excellence". In accordance with this, treatment principles for "exposure without holding back" and response prevention were explained in detail by the use of a wide range of metaphors. Anxiety and discomfort were to be viewed as "the raw material for change" and compared to tokens to be collected in the old Packman computer game ("Don't leave any behind. It's important to take every opportunity to seek for triggers and confront them without holding back"). The importance of "not holding back" during the exposure tasks was explained in detail ("If you hold back, you signal "danger" to your brain"). "Holding back" as well as "fully engaged" exposure were modeled and demonstrated, using metaphors like "not speeding and braking simultaneously". Partial response prevention was compared to encouraging an alcoholic to only stop drinking whiskey but continue drinking red wine in the evening. A rule of zero tolerance for rituals was established. It was also emphasized that they had made a choice of getting rid of OCD, and that the following days they would have a wonderful opportunity to literally make hundreds of choices designed to mock the OCD. Every metaphor was scored by the patients for its usefulness by using a scale from 1-6 ("dice score"), which generally contributed to a positive, humoristic and energetic atmosphere.

The participants gave a brief presentation of themselves: First name, number of years they had suffered from OCD and what kind of changes they were looking forward to making in their lives when they had learned skills to eliminate their symptoms. The last part of Day 1 was used to decide in plenum the individual exposure tasks for each patient. All of the patients were invited to list all OCD-relevant tasks, and they were encouraged to be creative and to be on the look-out for the most potent tasks ("If you leave any anxiety or discomfort unexplored, the OCD will hide, and you will most likely just get the discomfort without getting the gains"). Furthermore they were told that that they would have the chance to combine as many relevant triggers as possible and that the two next days would be filled to the brim with different exposure tasks in as many areas and domains as possible. Also, they were prepared for being exposed to the most relevant physical settings (e.g. public toilets, hospital, their own home, graveyards, bridges etc.) They were told that after we had worked with the triggers expected to be the most potent and useful, we would check what was left of the "oil-wells of anxiety" and start emptying these by means of renewed exposure. The patients were asked to not start any exposure until the treatment session on day 2.

Day 2 the group met for 10 hours (9 am to 7 pm). The first hour was used to review the selected triggers and repeat principles for exposure and response prevention. The patients split up in pairs, each with one experienced

therapist and one assistant. Principles for ERP were demonstrated and technique worked on in detail using one of the expectedly most potent triggers. Focus was on how to be fully engaged, and not to down-regulate anxiety or discomfort by subtle strategies (repeating the metaphor "not speeding and braking at the same time"). In order to obtain sustained exposure (e.g. for the patients with contamination OCD) traces of the triggers were diluted in water and filled in spray-containers, and thereafter sprayed all relevant places (e.g. all parts of their homes, personal belongings etc.). For the patients with issues of symmetry, a non-symmetric picture could be the screen saver on the cell phone etc. When relevant, loop-tapes with anxiety provoking sentences were recorded and listened to, often in combination with other triggers. During this 10 hour long session, the group met for lunch (prepared by the participants as part of their exposure) and during the lunch their experiences were summarized. If regarded useful, the pairs and therapist were rearranged. During the first day each patient had basically worked through their list of triggers anticipated to be the most potent and beneficial. The group met again at 6 p.m. for summarizing the day's experiences and learning, and to plan the evening at home as well as the next morning with a focus on response prevention and continued exposure. Day 3 the group met for 8 hours (9 a.m. to 5 p.m.). The first hour was used to summarize the previous day and evening, and to plan new exposure tasks. Again the group split, and worked on using and repeating basic ERP-principles in the most relevant places. During lunch (again made by participants) the experiences were summarized and the afternoon planned. The afternoon was spent the same way as the previous day, and the lessons learnt were summarized between 4 and 5 p.m., and the evening and next morning planned.

Day 4 the group met for 5 hours (9 a.m. to 2 p.m.) Again, the first hour was used to summarize lessons learnt during the course. Focus was then shifted to how to maintain the change and apply the principles on their own. Each participant made a day-to-day plan for exposure for the next two weeks.

A booster session was arranged 3 months after the treatment. This session lasted two hours, and the focus was repetition of the basic principles for initiating and maintaining change. The session was conducted with the entire group present.

Therapists

Three therapists, each with more than ten years of experience with OCD-patients were in charge of the group sessions (BH, PP, and GK). All therapists were highly skilled and experienced in cognitive and behavioral therapy, two at doctoral level (BH, GK); the third was a certified supervisor in cognitive therapy (PP). One of the therapists had more than 10 years of experience with one session treatment for specific phobias, as well as several years of experience with brief and intensive group treatment for patients with chronic fatigue (GK). Two of the therapists (GK and PP) were officially certified as clinical specialists, and had more than twenty years of clinical outpatient experience. In addition two assistants, one psychologist (AH) and one physician currently specializing as a psychiatrist (ETH) both with substantial ERP experience participated in the treatment.

Results

The results show that the treatment was highly effective for all the participants. Y-BOCS score pre-treatment was 23.5 points (range 19-32) (see **table 2**). Mean score one week post-treatment was 5.7 (range 0-11), 1 month post-treatment mean score was 6.5 (range 3-14). At three months follow-up mean score was 5.8 (Range 3-9), and at six months follow-up mean score was 6.3 (range 0-14). When patients clearly stated that "OCD is simply not a problem anymore" they were given a Y-BOCS score of 0. This was the case for two patients one week post, and for one of these the Y-BOCS score was 0 also at 6 months follow up. **Table 3** shows the patients' scores on Beck Depression Inventory. At pre-treatment mean BDI score was 15.6 (range 3-29), at 1 week post-treatment mean score was 12.8 (range 6-22) and at 3 months follow-up mean BDI score was 11.8 (range 1-22).

Overall, the results indicate that the patients were highly satisfied with the treatment (see **table 4** and **table 5**). At evaluation three months post-treatment five of the patients had either started working or resumed their studies.

Discussion

The results from this pilot study suggest that ERP can be effectively delivered in a focused, intensive group format over four consecutive days. Admittedly, the study lacks a proper control group. It does however fulfill basic requirements single case designs (Kazdin 2011). All participating patients had a long history of OCD (mean 17.5 years, with a duration from 3-41 years), suffering from their compulsive behavior. They had tried different forms of treatment both pharmacological and psychological without any success. In addition, no

Table 3. *Sample Scores on Beck Depression Inventory*

	BDI		
	Pre	Post	3 months
Patient A	16	15	10
Patient B	29	22	22
Patient C	24	15	14
Patient D	13	10	12
Patient E	9	6	1
Patient F	3	9	12
Mean:	15.6	12.8	11.8

Table 4. *Satisfaction with group treatment (dice measure)*

	Day 1	**Day 2**	**Day 3**	**Overall**
Patient A	5	5	6	6
Patient B	6	5	6	5
Patient C	6	5	5	5
Patient D	6	6	6	6
Patient E	6	5	5	5
Patient F	6	6	5	5

Table 5. *Patient evaluations of treatment acceptability*

	Question	Patient A	Patient B	Patient C	Patient D	Patient E	Patient F
1	If you could choose, would you rather prefer that the treatment had been delivered in 16 weekly sessions instead of this intensive format (yes/no)	No	No	No	No	No	No
2	How confident would you be in recommending the treatment to a friend? (0-100)	100	100	100	100	100	100
3	Choose **one word** to describe the treatment **process**	Satisfying	Exhausting	Tough	Intensive	Developing	Chal-lenging
4	Choose **one word** to describe the treatment **result**	Cool	Promising	Fantastic	Satisfying	Freedom	Surpris-ing
5	To what extent do you think the results will last? (0-100)	95	80	90	80	97	100
6	To what extent have you learnt something that you can use in other settings? (0-100)	100	100	100	100	90	80
7	How effective do you think the treatment had been if it was given individually as compared to in the group format? (0-100)	Poorer	Better	Poorer	Poorer	Poorer	Poorer
8	How effective do you think the treatment had been if it was spread over a longer period instead of this intensive format? (0-100)	Poorer	Poorer	Poorer	Poorer	Poorer	Poorer
9	Would you preferred if the rules for response prevention had been looser (allowing for an occasional ritual)? (0-100)	No	No	No	No	No	No
10	How will you rate the relationships to the therapists (confidence, trust)? (0-100)	99	95	100	100	95	95
11	To which extent did your own treatment goals correspond to those presented by the therapists? (0-100)	100	100	100	100	100	100
12	To what extent did you experience the treatment methods as appropriate? (0-100)	100	85	100	100	100	85
13	Based on your new skills, how well would you be able to help a person with OCD? (0-100)	90	90	95	70	90	90

specific inclusive criteria were used and the patients had different degrees of comorbidity. When offered treatment, no one declined, however, one patient was excluded because of language problems. The drop-out rate was zero. Mean Y-BOCS score at pre-treatment was 23.5, which indicates moderate symptom severity, and after the 4 days of which only two were dedicated to exposure, all patients could be classified as recovered (Fisher & Wells 2005). Even if some of the patients showed fluctuation in obsessive-compulsive symptoms during the post treatment period, at six months follow-up all patients could still be classified as recovered. Four of the patients had resumed working or studying after treatment.

The results indicate that a specific individually tailored exposure tasks, a significant amount of assisted exposure training across all OCD-relevant situations and strict adherence to response prevention is viable in an intensive group setting. Even more important, the patients regarded the strict adherence to full response prevention as an absolutely essential element of the ERP protocol and a critical prerequisite for improvement. When asked if they would have preferred a gradual hierarchal exposure, all patients stated that they preferred the intense immediate exposure to high anxiety stimuli, especially since they in every exposure had to make a choice and commitment and to focus on not holding back. We know from previous studies that confronting the most anxiety provoking situations from the beginning of treatment is as efficient as a gradual approach (Abramowitz 1996), and it seems like our approach to introducing ERP and obtaining commitment to treatment is effective. All patients expressed high acceptance of the group treatment, both content and format. They were highly satisfied with the two core days that was seen as one long exposure session with a myriad of exposures. Also, they stated that they had learnt something of importance for other areas of life.

The results obtained in this pilot study are somewhat stronger than what is usually obtained in individual trials (Abramowitz 1996), and significantly larger than most group therapy trials (Fisher & Wells 2005). The depression scores were in the moderate range at treatment start, and declined somewhat during the treatment and follow-up.

In order to ensure high quality, the therapist to patient ratio in the current pilot study was high, as was the competence and clinical experience of the therapists. We regard this as important factors for the success, and based on the current experience we might be able to rely on less experienced assistants. The pilot study is regarded as promising, and further studies are required to test the efficacy of the intensive group treatment format with a larger sample.

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