

Group Cognitive Behavioral Therapy for Obsessive-Compulsive Disorder: A Review

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Behavioral therapy utilizing exposure and response prevention (ERP) is considered the psychosocial treatment of choice for obsessive-compulsive disorder (OCD). Individual ERP treatment is the most common therapy format, and much of the empirical support for ERP is based upon studies of OCD subjects treated individually. However, there are numerous advantages of delivering this effective intervention in a group format, including cost savings to patients and time-efficiency for ERP therapists. This review summarizes the 12 adult trials and 4 adolescent trials of group behavioral therapy for OCD conducted to date. The paper also describes a typical group therapy protocol in detail and describes the costs and benefits of delivering ERP for OCD in a group format. [*Brief Treatment and Crisis Intervention* 3:217–229 (2003)]

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Individual behavioral exposure and response prevention (ERP) for obsessive-compulsive disorder (OCD) is well established as an effective treatment method (Rachman & Hodgson, 1980; Foa, Franklin, & Kozak, 1998). However, the delivery of such cognitive-behavioral treatment (CBT) in a group format is relatively new and is less well studied. The group format holds promise in terms of cost-effectiveness, efficient use of the scarce resource of skilled CBT therapists for OCD, and the potential clinical advantages of the group milieu. Shortcomings to the group ap-

proach may include the practical challenge of assembling groups, difficulties with group heterogeneity, and the possible reluctance of some group candidates to share symptom details. This article reviews the literature to date on group behavioral interventions for OCD, provides a description of typical group treatment protocols, and further highlights some of the advantages and disadvantages of this treatment delivery format.

Adult Studies

Twelve studies of group CBT for adults with OCD have been completed to date, with all supporting the feasibility and effectiveness of this treatment approach (see Table 1; Hand &

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Table 1. Studies of Group Behavioral Therapy for OCD

Study	Population	Methods	Session Length and Duration	Patients per Group	Session Content	Outcomes
Hand & Tichatzki, 1979	17 Adults	Uncontrolled naturalistic study: 3-phase program with both individual and group therapy components	30-week program with both individual and group sessions	5-7	Therapist-directed ERP, family sessions, and consumer-led sessions	"Improved OCD"
Epsie, 1986	5 Adults	Uncontrolled naturalistic study: group BT for patients relapsing after individual BT	10 weekly 1.5-hour group sessions	5	Psychoeducation + ERP + cognitive techniques	"Significant improvement in OCD"
Enright, 1991	24 Adults	Uncontrolled naturalistic study: group CBT	9 weekly 1.5-hour group sessions	6-7	ERP + stress-management and assertiveness training	"Mild improvement in OCD, but other benefits to mood"
Krone et al., 1991	36 Adults	Uncontrolled open trial: group BT	7 weekly 2-hour group sessions	5-8	Psychoeducation + ERP	Y-BOCS: 5-point decrease at post-treatment, 10-point decrease by 3-month follow-up
Fals-Stewart et al., 1993	93 Adults	Controlled trial: individual BT vs. group BT vs. relaxation control	24 two-hour group sessions over 12 weeks	10	Individual or group ERP; progressive muscle relaxation control	Y-BOCS: 10-point (group condition) and 8-point (individual condition) decrease
Van Noppen et al., 1997	36 Adults	Uncontrolled comparative trial: multifamily BT vs. group BT	10 to 12 two-hour weekly group sessions + 6 monthly review sessions	6-8	Psychoeducation + ERP	Y-BOCS: 7-point (multifamily BT groups) and 8-point (regular groups) decrease
Fischer et al., 1998	15 Adolescents (12-17 years)	Uncontrolled naturalistic study: group CBT	7 weekly 1.5-hour group sessions	5-8	Psychoeducation + ERP	CY-BOCS: 6.6-point decrease at post-treatment, 10.3-point decrease by 6-month follow-up

Study	Population	Methods	Session Length and Duration	Patients per Group	Session Content	Outcomes
Van Noppen et al., 1998	90 Adults	Uncontrolled naturalistic study: group CBT	10 weekly group sessions	6–10	ERP + cognitive techniques	Y-BOCS: 5.2-point decrease
Yoon et al., 2000 (conference presentation)	14 Adults	Uncontrolled naturalistic study: group CBT	12 weekly group sessions + booster sessions	Not reported	"CBT"	"Improvement in OCD, anxiety, depression, and functioning"
Mendlowitz & Saltzman, 2000 (conference presentation)	20 Adolescents (12–16 years)	Uncontrolled naturalistic study: group CBT	12 weekly group sessions	Not reported	"CBT"	"70% in mild to subclinical range CY-BOCS at posttreatment"
Mancini et al., 2000 (conference presentation)	6 Adolescents	Uncontrolled naturalistic study: group CBT	13 weekly group sessions	Not reported	Psychoeducation + ERP + cognitive techniques	"3 of 6 were treatment responders and 2 were partial responders"
Steketee et al., 2000	6 Adults	Uncontrolled open trial: combined individual and group CBT for compulsive hoarding	20 weekly individual and group sessions	6	Psychoeducation + ERP + cognitive techniques	"Noticeable improvement"
Himle et al., 2001	113 Adults	Uncontrolled comparative trial: 7-week vs. 12-week group BT	7 or 12 weekly 2-hour group sessions	5–8	Psychoeducation + ERP	7-point decrease in Y-BOCS in both conditions
McLean et al., 2001	63 Adults (completers)	Uncontrolled comparative trial: BT groups vs. CBT groups	12 weekly 2.5-hour group sessions	8	ERP alone or ERP + cognitive therapy	Y-BOCS: 8.6-point decrease (BT groups) and 5.8-point decrease (CBT groups)
Thienemann et al., 2001	18 Adolescents (13–17 years)	Uncontrolled naturalistic study: group CBT	14 weekly 2-hour group sessions	5–9	Psychoeducation + ERP + cognitive techniques	CY-BOCS: 6.2-point decrease
Cordioli et al., 2002	32 Adults	Uncontrolled open trial: group CBT	12 two-hour weekly sessions + 3 monthly follow-ups	5–8	ERP + cognitive techniques	Y-BOCS: 12.6-point decrease

BT = behavioral therapy; ERP = exposure and response prevention; OCD = obsessive-compulsive disorder; CBT = cognitive-behavioral therapy; Y-BOCS = Yale-Brown Obsessive Compulsive Scale; CY-BOCS = Children's Yale-Brown Obsessive Compulsive Scale

Tichatzki, 1979; Epsie, 1986; Enright, 1991; Krone, Himle, & Nesse, 1991; Fals-Stewart, Marks, & Schafer, 1993; Van Noppen, Steketee, McCorkle, & Pato, 1997; Van Noppen, Pato, Marsland, & Rasmussen, 1998; Steketee, Frost, Wincze, Greene, & Douglass, 2000; Himle et al., 2001; McLean et al., 2001; Cordioli et al., 2002).

In the only controlled trial, 93 medication-free adult subjects diagnosed with OCD via structured interview were randomly assigned to group behavior therapy, individual behavior therapy, or a relaxation control condition (Fals-Stewart et al., 1993). All treatments were delivered in 24 sessions over the course of 12 weeks, with individual sessions lasting 1 hour and group sessions lasting 2 hours. The group condition included 10 participants per therapy group. Behavioral treatments focused on ERP and involved both *in vivo* exposures as well as between-session ERP homework assignments. The relaxation control condition focused exclusively on in-session progressive muscle relaxation. Individual and group behavior therapy were found to be comparably effective, and both were superior to the relaxation control, with scores on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) showing an average improvement of 10 points in the group condition and 8 points in the individual condition. Gains in both treatment conditions were maintained at 6-month follow-up. While subjects given individual treatment demonstrated somewhat faster reductions in OCD symptoms, this advantage was fully eliminated by the 8th of this 12-week savings program. Also, a substantial saving in the therapist time was reported for the group intervention. This remains the most rigorous study of group CBT to date, with its inclusion of structured diagnostic interviews, medication-free subjects, random assignment to treatment condition, and the use of a control group. However, the study did not report whether blind independent evaluators or treatment fidelity checks were utilized. Also, patients with severe major depres-

sion (major depressive disorder and Beck depression score of >22) and a concurrent Axis II diagnosis were excluded. However, only 11 of the 114 potentially eligible subjects who met criteria for OCD were excluded by these criteria, suggesting that the study's external validity was not severely affected by these exclusions.

Three additional uncontrolled studies have compared two forms of group CBT for adult OCD (Van Noppen et al., 1997; Himle et al., 2001; McLean et al., 2001). In the largest of these, Himle and colleagues compared group CBT delivered in 7-week and 12-week formats in 113 patients (Himle et al., 2001). Subjects with various comorbid conditions were included, and 60% of the sample was on medication during the study. Y-BOCS scores showed a clinically significant improvement of approximately 7 points in both the 7-week and 12-week conditions, with no significant difference between the two manualized treatments. Given the absence of random assignment to groups and the lack of several other gold standard research methods in this naturalistic study, caution is advised in interpreting the results. Nonetheless, the comparability of outcomes in the 7-week and 12-week models is consistent with improvements observed in the Fals-Stewart et al. (1993) groups, in which nearly all the gains (90%) were obtained by week 8 of that 12-week protocol.

In the comparative uncontrolled trial by Van Noppen and colleagues (1997), two forms of group therapy were compared for 36 patients: multifamily behavior therapy (MFBT) groups attended by patients and their family members together, and group behavior therapy (GBT) without family involvement. The groups engaged in 10 to 12 weekly 2-hour sessions of acute treatment followed by 6 monthly review sessions to consolidate gains, with 6 to 8 participants per therapy group. Average Y-BOCS improvements of 7 and 8 points, respectively, were observed in the GBT and MFBT groups; and across measures, the groups were generally equivalent. However,

an examination of study criteria for clinically significant improvement favored the MFBT group. Strengths of this study included manualized treatment delivered by highly experienced therapists, while weaknesses included lack of randomized assignment to groups, of structured clinical interviewers, of blind and independent raters of progress, and of formalized assessments of treatment fidelity.

Finally, McLean and colleagues (2001) compared CBT groups with "traditional" behavioral therapy groups focused exclusively on ERP, without the cognitive component. Each group comprised 8 participants, and sessions lasted 2.5 hours for 12 weeks. Both treatments were manualized and led by experienced therapists. Subjects were required to have had OCD for at least one year, common comorbid conditions were included, and almost 50% of the sample were taking medication, which was held stable during the trial. Y-BOCS scores for the 63 completers (15% dropout) indicated that those treated with ERP showed slightly greater improvement (8.6 points) than those treated in CBT groups (5.8 points), at posttreatment and also at the 3-month follow-up. Surprisingly, treatment improvements brought little change in obsessive-compulsive beliefs regardless of treatment condition, despite the specific attempt to target faulty beliefs in the cognitive intervention. It may be that the time allotted to cognitive strategies in the CBT groups was insufficient for achieving cognitive change. The authors suggest that the measures used to assess OC beliefs may not be sensitive to change, and in fact they highlight that more sensitive measures of OC beliefs are currently being developed by the Obsessive Compulsive Cognitions Working Group (see Steketee & Neziroglu, this issue, for a review).

Significant improvement in OCD symptoms was also observed in the eight other uncontrolled, open-trial reports. The most recent and most methodologically sound of these uncontrolled trials was a 12-week study of group CBT

conducted in Brazil with 32 patients diagnosed with OCD via structured interview (Cordioli et al., 2002). Groups of 5 to 8 participants were treated in 2-hour weekly sessions and in 3 monthly follow-up meetings. Sessions included ERP as well as cognitive therapy that included Socratic questioning and other methods for correcting dysfunctional beliefs. Treatment fidelity ratings indicated good adherence to this manualized intervention. Over half the patients (52%) were taking medications, with doses stabilized for 3 months prior to the CBT trial. Excellent retention was achieved (94%), and independent ratings on the Y-BOCS showed an average improvement of 12.6 points, which was maintained at 3-month follow-up. Over three quarters of the sample (78%) were considered treatment responders. The substantial change in Y-BOCS scores observed in this study may be due to the additive effects of cognitive- and exposure-based treatments, although this is uncertain. Although this study lacks a control group, the presence of several other methodological gold standards makes it perhaps the most convincing of the uncontrolled studies to date.

In an uncontrolled case series, Hand and Tichatzki (1979) reported improved OCD symptoms among patients who participated in a 30-week, 3-phase, outpatient treatment program that included both individual and group exposure sessions. The group treatment program included therapist- and consumer-led groups in addition to a specialized group for family members only. Epsie (1986), in another uncontrolled study, reported significant improvement in a 10-week group treatment for patients who had relapsed after previously benefiting from individual behavioral therapy. Improvement was maintained at up to one-year follow-up. Enright (1991) found only modest reduction in OCD symptoms among patients given a multicomponent group CBT program. This group included additional behavioral treatments beyond ERP,

including stress management techniques and assertiveness training. It may be that the additional behavioral components in this particular group treatment protocol diluted the effectiveness of ERP, thus resulting in a smaller effect size.

In a naturalistic study of 36 patients completing a brief 7-week group CBT program, Krone and colleagues reported an average improvement of 5 points on the Y-BOCS and a further improvement of an additional 5 points by the 3-month follow-up period (Krone et al., 1991). Subjects taking medication (55%) showed comparable improvements to those not on medication. While this study also lacked the methodological strengths of a controlled trial, it did utilize a manualized treatment protocol, and the therapy was delivered by experienced CBT clinicians.

Van Noppen and colleagues describe an uncontrolled naturalistic study of 90 patients completing a 10-week group CBT program (Van Noppen et al., 1998). Subjects were excluded only if comorbid conditions posed a threat to the group process. Most patients (81%) were on stabilized medications during the CBT trial. An average improvement of 5.2 points on self-reported Y-BOCS scores was reported, and gains were maintained over a naturalistic follow-up period that averaged 2 years. Interestingly, patients receiving medication showed greater improvement than those who were medication free, although the absence of a medication-only control makes this comparison preliminary.

One study to date has examined the impact of combined group and individual behavioral therapy in the treatment of OCD (Steketee et al., 2000). This study included only patients with compulsive hoarding as their primary complaint. Steketee and colleagues report that 5 of the 6 subjects who received the combined treatment experienced improvement in their hoarding symptoms after 20 weeks of treatment. In a small unpublished South Korean pilot study,

Yoon and colleagues report improvement in OCD, general anxiety and depression, and functioning in 14 patients treated with 12 weeks of group CBT plus booster sessions (Yoon, Sup, Ghun, & Kim, 2000).

Adolescent Studies

The first published study on group CBT for adolescents with OCD was a naturalistic open trial of 15 patients aged 12–17 years, completed by Fischer and colleagues (Fischer, Himle, & Hanna, 1998). Their relatively brief 7-week group intervention employed a structured protocol that involved psychoeducation about OCD and cognitive techniques for viewing OCD as an enemy to be battled, as well as a major focus on ERP conducted both in session and as homework assignments. Weekly group sessions lasted one and a half hours each, with an additional eighth group session involving parents. Few exclusion criteria (mental retardation, autism, psychosis) were applied, in an attempt to heighten external validity. Two thirds of the sample was on medication, which was stabilized prior to group CBT participation, and one third had been nonresponders to prior individual CBT for their OCD.

According to total scores on the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS), 58% of the sample improved by at least 30% by posttreatment, and 80% met this improvement criteria by the 6-month follow-up. Total CY-BOCS scores decreased by an average of 6.6 points by posttreatment, and by 10.3 points by follow-up. A follow-up report showed that outcomes were comparable for patients with and without a comorbid tic disorder (Himle et al., 2003). While the study by Fischer and colleagues (1998) lacked the obvious methodological strengths of a randomized controlled trial, it offered the first preliminary evidence that CBT delivered in a brief group format can be effective

for adolescent OCD. The significant improvement from posttreatment to follow-up was particularly hopeful, although follow-up ratings were not completed by blind raters, and further treatment was not restricted during the follow-up period.

More recently, Thienemann and colleagues completed a naturalistic open trial for adolescent OCD that was very similar to the Fischer et al. (1998) study in terms of methods, sample size, group treatment protocol, age range, and findings, but varied in terms of treatment length (Thienemann, Martin, Cregger, Thompson, & Dyer-Friedman, 2001). In this study, 18 adolescents aged 13–17 were treated in a group CBT program modeled after March, Mulle, and Herbel's 1994 protocol, which again involved psychoeducation, ERP, and cognitive techniques. Relative to the Fischer et al. (1998) study, however, treatment in this study was considerably longer (14 weeks), and group sessions were 2 hours rather than 1.5 hours in duration. No parent involvement was noted. The sample was similarly inclusive and included notable comorbidity as well as patients who had been previous nonresponders to individual CBT. Fifteen of the 18 subjects were on medication during the group CBT intervention, and 4 experienced medication changes during the group CBT.

CY-BOCS total scores decreased by an average of 6.2 points by posttreatment, and 50% of the sample were noted to have met an improvement criteria of 25% or more on the CY-BOCS. Of note in this study, medication changes during the group CBT trial may have confounded results somewhat, and maintenance of gains is unknown, as follow-up scores were not reported. Like the Fischer et al. (1998) study, this study also lacked the rigor provided by a control group and structured diagnostic interviews, but afforded further preliminary support for the effectiveness of group CBT for adolescent OCD.

There exist two other unpublished preliminary studies on group CBT for adolescent OCD.

Mendlowitz and Saltzman (2000) found significant improvement among 20 adolescents completing 12 weeks of group CBT. Subjects were aged 12–16, diagnosed via semistructured interviews, no exclusion criteria were applied, and 2 subjects were on stable medication during the study. Over 70% of the sample scored in the mild to subclinical range on the CY-BOCS by posttreatment. General anxiety levels also improved according to scores on the Multidimensional Anxiety Scale for Children, although effect sizes were smaller than for the OCD-specific measures. Although results are promising, one methodological weakness of the study was the use of the self-rated, rather than interviewer-administered, CY-BOCS, although posttreatment scores were confirmed with a parent interview.

Mancini, Van Ameringen, Farvolden, and Davies (2000) also reported improvement in a small sample of 6 adolescents treated in a 13-week group CBT program modeled after the 1994 March, Mulle, and Herbel protocol. According to Clinical Global Improvement and Global Assessment of Functioning ratings, 3 of the 6 subjects were considered treatment responders, and 2 were partial responders.

As noted, none of these four studies was controlled, and several other methodological shortcomings were present. Additional and methodologically improved studies of the efficacy of group treatments for pediatric OCD would not only begin to address the substantial gap in empirically demonstrated treatments for this pediatric condition, but would simultaneously investigate the feasibility of this cost-effective and therapist-efficient treatment modality.

Group Program Description

Group CBT programs typically involve 10–12 two-hour group sessions, or possibly 90-minute sessions for adolescent groups. Groups include 5–10 participants and one to two therapists per

group. A parent/guardian or spouse/partner is often invited to attend selected sessions in adolescent and adult groups, respectively. Most protocols involve psychoeducational topics about OCD and the principles of CBT, *in vivo* ERP, and ERP homework assignments. Some protocols also include various cognitive strategies. For example, adolescent groups, often modeled after the March, Mulle, and Herbel protocol (1994), usually involve adjunctive cognitive strategies to help participants view their OCD as an externalized enemy they must battle. Both adolescent and adult groups may include training in the use of coping self-statements (“I can win, it’s just my OCD”). Participants are encouraged to collaborate with each other in their collective battle against OCD, to support each other in their pursuit of ERP goals, and to help destigmatize the experience.

Early psychoeducational topics may focus on the nature of obsessions and compulsions, the prevalence and causes of OCD, information designed to reduce guilt and blame, and an introduction to the principles of ERP in the treatment of OCD. Clinicians introduce ERP as a strategy that involves confronting uncomfortable stimuli with the expectation that discomfort will first increase, then decrease over time if the ritual is prevented. Subjects are taught to complete a behavioral analysis of their OCD symptoms for future use in designing ERP assignments. Group rapport is continually fostered through discussion and group reinforcement of homework compliance.

In sessions attended by family members, parents and/or significant others are taught to not reassure patients or join in the group member’s rituals. They are also taught strategies to reduce “nagging” while increasing reinforcement of efforts to fight the OCD using ERP. Attitudes that facilitate ERP (e.g., being aggressive in confronting OCD) are reviewed and encouraged. Family members are given instructions on how

to respond to observed rituals and requests for reassurance, and how to differentiate OCD from non-OCD behavior. Family members also learn to disengage from the participant’s OCD problems and to take the position that the battle against OCD is ultimately one that must be fought by the person with the condition. Specific verbal responses are to be modeled for family members in some group protocols.

Throughout the sessions, the importance of daily compliance with ERP is emphasized, along with the value of tolerating anxiety, avoiding tuning-out during ERP exercises, tolerating boredom, and accepting progress as it comes. Additionally, groups often include relapse prevention strategies. These strategies usually involve discussion on how improvement can reduce motivation to participate in ERP and how giving up OCD can lead to negative outcomes such as greater responsibility in other areas of life. In some group treatment protocols (e.g., Fischer et al., 1998), mock OCD scenarios are used to help give group members practice at generating ERP assignments from case vignettes. Such exercises help subjects become proficient in the design and implementation of ERP exercises for current problems not addressed in the group and for future OCD problems that may develop.

Sample Group Protocol

The following protocol was used in our recent, controlled, group trial for adolescents (aged 13–17 years) with OCD. This 12-session CBT program included 5 adolescent members per group with parents attending 3 group sessions.

Both the adolescents and their parent(s) attend session 1. This session begins with general introductions, review of group ground rules, and a review of what the adolescent participants and parents already know about OCD. As noted above, psychoeducational materials provided to participants and parents focus on the nature and

prevalence of the condition, are designed to reduce feelings of guilt and blame, and introduce the principles of ERP as a strategy that may involve an initial increase in discomfort as painful stimuli are confronted, until prevention of ritual is stabilized. Session 1 concludes with emphasis on viewing OCD as an externalized bully or a bitter foe in a battle.

Sessions 2 through 5 are attended by the adolescent participants without parents present. These sessions begin with a review of each participant's week with OCD, including a brief review of symptoms and their impact on home life, school functioning, and participants' social life. Session 2 includes further psychoeducation about the nature of OCD, the principles of ERP, and discussion of OCD as an externalized enemy. Also in session 2, participants are initially taught how to keep a record of OCD problems, and a behavioral analysis of OCD symptoms is completed for each group member. The development of group rapport through discussion and group reinforcement of homework compliance is also emphasized in this session. Session 3 introduces the use of the discomfort scale to rate severity of OCD symptoms. Behaviors recorded in the behavioral analysis worksheet are then rated using this scale and arranged in a hierarchy. Finally, in collaboration with each subject, the therapist designs an initial ERP exercise for each group member. Each member is given guidance as to the proper recording of compliance with the assignment and corresponding discomfort. The importance of homework compliance is stressed. Session 4 begins with group reinforcement of homework compliance and group support for those who did not comply. This group support is coupled with problem-solving efforts to enhance compliance for those who did not follow through. This session also includes further discussion of the causes of OCD and again reinforces the idea that OCD is not the subject's fault. Cognitive self-statements, es-

pecially those designed to facilitate ERP compliance (e.g., "Don't give in, it's just my OCD talking, I can beat it"), are introduced in this session.

Finally, a detailed collaborative review of each subject's ERP homework assignment is conducted and adjustments are made in the assignment. If appropriate, new assignments are given. Session 5 includes psychoeducational material related to family life and OCD. Topics include family response to OCD, avoiding reassurance seeking and family participation in rituals, and strategies to reduce parental nagging while increasing parental reinforcement (this material is introduced in preparation for session 6, where parents are again present). Session 5 also includes a group discussion of attitudes that facilitate ERP (e.g., being aggressive in confronting OCD). Homework review and generation of ERP assignments are conducted as in other sessions. Finally, in-session ERP is introduced and conducted as appropriate.

Session 6 includes parents and adolescents. The session begins with a brief review of homework and generation of ERP assignments for the next week. The session continues with a group discussion of family issues and OCD. Parents are given further instruction in how to respond to rituals when they are observed, how to respond to requests for reassurance, techniques for avoiding nagging and increasing reinforcement for treatment compliance, and how to differentiate OCD from non-OCD behavior. An important component to this session involves helping the parents to disengage from their child's OCD problems and to take the position that the battle against OCD is ultimately one that must be fought by the child. This session is highly collaborative, and specific verbal responses are modeled for parents.

Sessions 7 through 11 continue with only the adolescent participants in attendance. Each of these sessions includes individualized home-

work review and collaborative generation of new ERP assignments as appropriate. Each session also involves in-session ERP. In session 7, the family session is reviewed, including discussion of whether parents/guardians are using strategies discussed. CBT topics for the remaining sessions include: further cognitive methods (session 7), including discussion of self-statements helpful in facilitating ERP; strategies for making CBT more effective (session 8), including discussion of the importance of daily compliance with ERP, tolerating anxiety and boredom, avoiding tuning out during exercises, and accepting progress as it comes; and dangers of improvement and secondary gain (session 9), including discussion of how improvement can reduce motivation to participate in ERP and how giving up OCD can lead to negative outcomes such as greater responsibility in other areas. Finally, specialized CBT exercises involving mock OCD scenarios are included in sessions 10 and 11. These exercises involve group-generated ERP assignments created from case vignettes provided by the therapist. The purpose of these exercises is to help participants become proficient in the design and implementation of ERP exercises for current problems not addressed in the group and for future OCD problems that may develop.

Finally, session 12 includes both the adolescent participants and parent(s). After a final review of ERP homework assignments, issues related to maintenance of gains are discussed, and family strategies for managing OCD are reviewed. After discussion of other issues raised by parents and/or participants, a pizza party concludes the treatment program.

Advantages and Disadvantages of Group Treatment for OCD

A number of studies have highlighted potential advantages of providing CBT for OCD in a group

format. Direct therapeutic benefits may stem from peer modeling of CBT exercises, peer support and reinforcement of compliance with ERP homework assignments, normalization and destigmatization of OCD symptoms, and the generalization of treatment gains as a result of exposure to a broader spectrum of OCD symptoms and ERP applications (Fals-Stewart et al., 1993; Van Noppen et al., 1997; Fischer et al., 1998; Himle et al., 2001; McLean et al., 2001). In the randomized, controlled trial of group CBT currently under way in our clinic, these advantages of the group milieu were supported by high ratings of group cohesiveness and likability. Our own clinical experience in providing group CBT to both adult and pediatric OCD patients indicates other additional advantages to the group format. One such advantage we observed was the satisfaction that group members experienced by assisting other members in their struggles with OCD and in helping others develop ERP assignments. This experience of helping others appeared to aid improvement in patients' self-esteem, sense of social competency, and overcoming of feelings of loneliness. Another observed benefit of group CBT was the development of informal support networks formed during the group. Many patients reported ongoing use of these support networks even after the formal treatment was concluded. Interestingly, parents and significant others used our waiting area to develop their own informal support group, as they shared information, strategies, and resources with one another.

Group therapy also offers significant cost-savings and therapist-efficiency advantages in comparison with individual treatment. Based upon \$120 per individual therapy session and \$70 per group session, cost savings for a 12-week course of CBT are estimated at \$600 per patient. Additionally, the number of CBT clinicians trained in treating OCD are relatively few (Marks, 1997), especially those proficient in working with children and adolescents (March,

Frances, Carpenter, & Kahn, 1997). Group CBT more efficiently utilizes the scarce resource of CBT clinicians trained in delivering ERP for OCD. Therapist time savings are substantial, amounting to a 67–75% reduction in therapist time per patient. Based upon a 12-week course of treatment with 6 participants per therapy group, 90- to 120-minute group sessions, and individual sessions lasting 60 minutes, 18–24 therapist hours are required to treat 6 patients in a group, versus 72 hours of therapist time required to treat 6 patients individually. Groups led by co-therapy teams obviously reduce the therapist-efficiency benefits of group treatment, yet co-therapists still offer therapist-efficiency benefits over individual treatment. Of course, the cost savings and therapist efficiency afforded by the group format would be tempered if the effect size of group treatment were found to be less than that of individual treatments. However, the one randomized controlled trial comparing individual and group CBT has suggested comparable outcomes for these two treatment formats (Fals-Stewart et al., 1993).

Despite these advantages, potential disadvantages for delivering CBT in groups also exist. One significant feasibility challenge involves the expedient recruitment of sufficient patients to form therapy groups, since recruitment is dependent upon a steady flow of OCD patients. Lengthy delays to treatment may occur if clinic flow is slow, causing otherwise interested patients to defer group participation. On the other hand, clinics servicing high volumes of OCD patients may cut wait times into treatment by using this more therapist-efficient format. In support of this latter point, epidemiologic studies indicate that OCD is a relatively common, chronic condition (Karno, Golding, Sorenson, & Burnam, 1988; Leonard et al., 1993), and a number of clinics both nationally and internationally have successfully implemented group CBT interventions for patients with OCD (e.g., the United States, South Korea, Canada, Brazil, Norway).

A potential clinical disadvantage of the group approach is the limited time available for the group therapist to develop personalized ERP assignments. In a 120-minute group with 5 members that includes some psychoeducation, a therapist may be able to spend only 20 minutes directly focused on the OCD symptoms of each individual group participant. A problematic or dominating patient could make it very difficult to proportionately divide therapist time during the group. Although an experienced therapist may be able to temper this shortcoming to some extent, the amount of individual attention provided in a group cannot equal that provided in an individual therapy session.

Another clinical concern associated with the group approach is the possible reluctance on the part of some patients to fully discuss their most problematic and/or embarrassing OCD symptoms in front of others. Given that many OCD patients hide their OCD from others and may find it difficult to discuss their symptoms with a single therapist, their reluctance may be heightened in a group. On the other hand, once sharing commences in the group, these reluctant patients may feel more comfortable disclosing their own symptoms, perhaps for the first time, thereby enhancing normalization and reducing shame.

The group approach also exposes patients to the possibility of acquiring new symptoms through observing and interacting with other participants, although clinical experience suggests that this exchange of symptoms is rare. More commonly, group members report benefits from hearing about others' symptoms, since such sharing facilitates recognition of symptoms that a given participant may not have previously identified as OCD. Another potential problem related to group interaction is the possibility that participants may trivialize each other's symptoms. This problematic interaction can be minimized by establishing clear rules of group conduct at the initial session and by

timely redirection by the group therapist. Periodic absences from weekly group sessions are also a likely possibility over the course of treatment. Such absences can affect group structure and cohesiveness, thus limiting the potential benefits of the group milieu. To counter this potential problem, the importance of regular and timely attendance is stressed throughout the course of treatment.

Finally, the limited amount of solid research into the relative effectiveness of group versus individual treatments makes it difficult to know whether the group format is advantageous or disadvantageous in terms of likely improvement in OCD symptom severity. While the only direct comparative study of group versus individual treatment for OCD showed comparable outcomes (Fals-Stewart et al., 1993), some studies of individual CBT (e.g., Franklin et al., 1998; Lindsay, Crino, & Andrews, 1997) have shown larger effect sizes than in any group reports to date. Clearly, further research is needed to determine the relative effectiveness of group versus individualized treatments for OCD, and to compare effect sizes in light of the cost-savings and therapist-efficiency benefits associated with the group approach.

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