

Chapter Seven

Group Cognitive-Behavior Therapy in Outpatient Settings

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Clinical practice in outpatient settings represents the most common professional setting for cognitive-behavior group therapy (CBGT). Office visits are the most familiar entry points for young patients and their families. In fact, most outpatient mental health environments resemble the professional settings of other referral sources, such as pediatric clinics and schools, which help to facilitate a familiar transition. Given the diminishing financial resources and market pressures resulting in shortened residential and inpatient stays, outpatient settings are pivotal points on the mental health care continuum. Accordingly, conducting CBGT in outpatient settings is a very viable option.

This chapter presents a framework for considering and implementing CBGT in outpatient settings. The chapter's first section begins with a rationale for a group approach, lists several typical outpatient group programs, and briefly reviews the outcome literature supporting the approach. Measures for group member evaluation and selection such as the *Beck Depression Inventory, Second Edition* (BDI-II), *Children's Depression Inventory* (CDI), *Multidimensional Anxiety Scale for Children* (MASC), *Screen for Child Anxiety Related Emotional Disturbances* (SCARED), and *Conners Parent Rating Scales* (CPRS) are recommended. Further, a modular approach to group CBT, including introduction to treatment, self-monitoring, behavioral interventions, priming/problem-solving, self-instruction, rational analysis, and performance attainment is described. Helpful examples of specific interventions within each module are also given. Finally, cautions and considerations in group CBT are explicated.

RATIONALE AND ADVANTAGES OF GROUP CBT

Group therapy offers several advantages to the outpatient cognitive-behavior therapist. First, group therapy accommodates greater numbers of patients in fewer peak after school hours, which has been reported to improve access to care (Tynan, Schuman, & Lampert., 1999). Second, a cognitive-behavioral group offers a learning model characterized by psychoeducation, which makes it similar to school, and consequently, the group may be less stigmatizing for young people (Clarke, DeBar, & Lewinsohn, 2003). Further, group CBT represents a social learning laboratory, where therapists can work with patients

to elicit and change thoughts and feelings (Friedberg & Crosby, 2001). Finally, CBGT includes powerful elements such as peer modeling, feedback, group problem-solving, and social comparison processes (Ginsburg, Silverman, & Kurtines, 1995; Lochman, Barry, & Pardini, 2003).

TYPES OF CBT GROUPS IN OUTPATIENT SETTINGS

CBGT is applicable to a plethora of problems typically encountered in outpatient settings. Externalizing disorders, such as oppositional defiant disorders, are suited to group treatment. Similarly, internalizing disorders, such as depression, anxiety, and eating disorders, can be effectively treated with group CBT. There is also promise for using CBGT skills training groups for children with Asperger's Disorder (see chapter 21 in this text).

Depending on the goals of treatment and the children's diagnoses, CBGT may elect a variety of group formats, including psychoeducational, skills training, and process-oriented groups. In purely psychoeducational groups, patients are typically given information about their disorder and possible coping strategies with limited opportunities to practice their acquired skills. Skills training groups directly coach patients in particular techniques such as relaxation, social skills, and problem-solving. Process groups emphasize the interpersonal dynamics occurring within the group. Most group programs combine psychoeducational, skill training, and process elements. There are a number of group protocols that have been developed and researched, several of which I describe below.

Social Effectiveness Therapy for Children (SET-C; Beidel & Turner, 1998) is a 12-week group program where children attend two sessions per week. Each child completes one group skills training session and one individual exposure session. The social skills components include greetings and interactions, initiating conversations, listening skills, joining, establishing and maintaining friendships, giving and receiving compliments, assertiveness with peers and adults, and telephone skills. SET-C also includes the use of non-anxious peers who act as models and helpers. The patients and peers are involved in 90-minute outings together, where patients practice skills, observe and learn from their models, and receive feedback.

Hinshaw (1996) described a group intervention for boys with Attention Deficit-Hyperactivity Disorder (ADHD). In this intervention, groups of four to five boys learn about ADHD, discuss medication, and rehearse social skills. Moreover, an anger management component is also a pivotal ingredient to the program. The anger management curriculum involves the child sharing the exact names, taunts, teases, and phrases that provoke him. Training continues with developing recognition of anger triggers and coping strategies. Next, children practice these coping strategies under gradually increasing provocative conditions.

The Chill Out Program for Adolescents (Feindler & Ecton, 1986; Feindler & Guttman, 1994) emphasizes anger management, which decreases impulsive responding and increases productive expression of anger. The program develops ways for tolerating emotional arousal, self-control strategies, problem-solving skills, reattribution, and communication skills. Five treatment foci for the 10-session program include (1) recognizing the interaction between cognitive, physiological, and behavioral components of angry arousal; (2) constructing a cost-benefit analysis examining the maladaptive and adaptive aspects of anger; (3) identifying the antecedents to their anger; (4) intro-

ducing the concept of choice and responsibility; and (5) learning methods to express anger appropriately.

The Cognitive-Behavior Group Therapy-Adolescent (CBGT-A; Albano, 2000) is a 16-session group protocol delivered by two therapists. Each session lasts 90 minutes and includes 4 to 6 adolescent group members. The initial four sessions occur in the first 2 weeks of treatment. Children meet weekly in sessions 5 through 11. The last sessions occur biweekly. The first eight sessions focus on psychoeducation and coping skills training, whereas sessions 9 through 16 emphasize exposure training. Homework assignments are part of each session, and parent involvement is encouraged through their attendance at sessions 1, 2, 8, and 15.

Positive Adolescent Choices Training (PACT; Hammond, 1991) is a behavioral-social skills training program that targets 12- to 15-year-old African American youngsters. The program is culturally responsive to racial, ethnic, and gender issues. Training includes communication training, negotiation, and problem-solving. More specifically, the adolescents learn to give positive and negative feedback, accept negative feedback, resist peer pressure, and negotiate conflicts. The program integrates direct instruction, videotape modeling, and role-plays. The role-plays and "mini" psychodramas are presented via videotaped vignettes featuring African American teen role models.

The Coping with Depression-Adolescents (CWDA; Clarke et al., 2003) is a 16-session skills training group for young people ages 13- to 18-years old. The group usually runs 8 weeks, including two sessions per week. This group program addresses depressive symptoms, such as anhedonia, guilt, hopelessness, social withdrawal, poor problem-solving, and impaired social skills. CWDA includes both behavioral activation and cognitive therapy. The specific skill modules, include cognitive restructuring, behavior therapy, problem-solving, communication, negotiation, relaxation training, and goal-setting.

Berman, Silverman, and Kurtines (2000) described their group intervention for youth traumatized by crime and violence. The program emphasizes three goals, including the reduction of PTSD symptoms, enhancement of adaptive coping resources, and increasing social support availability and utilization. Berman and colleagues integrated exposure-based activities, coping skills training, and mobilizing social support systems into this program. The exposure exercises are accomplished through youngsters writing about their experiences and reading them aloud in group, followed by group discussion about features of the trauma. The coping skills component teaches problem-solving and reattribution by employing the STOP acronym. Improving social support is done through modeling, role-playing, contingency contracting, and group feedback.

The Child Anxiety Management Program (CAMP) (Friedberg & Elamir, in preparation) at the Penn State Milton Hershey Medical Center is an eight week CBT group emphasizing psychoeducation and coping skills training for anxious children ages 8- to 12-years old. CAMP is a modular based program focusing on problem identification, self-monitoring, self-instruction, rational analysis, and performance attainment. The program includes tokens and prizes for participation, psychoeducational material, and homework assignments. A unique feature of the program is a weekly session feedback form completed by each child. Youngsters are referred to the group by parents, pediatricians, psychiatrists, and social workers. For many children, CAMP augments their individual treatment and/or medication management. For still others, CAMP is their only therapy experience. The approach is modified for younger children (5- to 7-years old, CAMP Jr.) and adolescents (Teen CAMP).

OUTCOME LITERATURE OF GROUP CBT

There is considerable promise for cognitive-behavior group therapy with children and adolescents. Specific literature has demonstrated support of group CBT for anxiety, depressive spectrum disorders, and disruptive behavioral disorders (Baer & Garland, 2005; Beidel, Turner, & Morris, 2000; Berman, Silverman, & Kurtines, 2000; Feindler, Marriott, & Iwata, 1984; Friedberg et al., 2003; Gillham, Reivich, Jaycox, & Seligman, 1995; Lochman et al., 2003; Muris, Meesters, & van Melick, 2003; Thienemann, Martin, Cregger, Thompson, & Dyer-Friedman, 2001; Silverman, Kurtines, Ginsburg, Weems, Lumpkin, & Carmichael, 1999; Tynan et al., 1999).

Anxiety Disorders

Muris and colleagues (2003) found that CBT treatment was superior to emotional disclosure groups in reducing anxiety and depressive symptoms in 9- to 12-year-old children. *Social Effectiveness Therapy for Children (SET-C)*, a cognitive behavioral approach for treatment of socially anxious youth, has demonstrated effectiveness in children ages 7 to 13 years of age. Specifically, Beidel and colleagues (2000) found that 67% of participants did not meet diagnostic criteria for social anxiety following treatment using SET-C. Most impressively, however, was that 85% of the children no longer met diagnostic criteria at a 6 month follow-up, which shows increased improvement over time. Silverman et al. (1999) conducted a randomized clinical trial evaluating group CBT with anxiety disordered children, which demonstrated improvement on all main outcome measures at the end of treatment, as well as at 3, 6, and 12 month follow ups. Similarly, Friedberg and others (2003) showed reductions in self-reported depressive and anxious symptoms in children who completed a cognitive-behavioral coping skills group.

Baer and Garland (2005) conducted a pilot study of community based group CBT for adolescents with social phobia. After receiving a course of group CBT, adolescents with social phobia showed symptom reductions on objective and subjective reports. Thienemann and colleagues (2001) evaluated manual driven group CBT for adolescents with Obsessive-Compulsive Disorder. Patients completed a 14-week course of CBT, based on March and Mulle's (1998) seminal manual. They found symptoms improved and adolescents reported high levels of satisfaction with treatment.

Depressive Disorders

Jaycox and colleagues (1994) found that children completing a brief, group cognitive-behavioral program that focused on preventing depressive symptoms experienced fewer depressive symptoms at both the end of treatment and at the 6 month follow-up. Evaluating the same program, Gillham and colleagues (1995) reported that only 7% of children in the program had moderate to severe depression one year after the program, as compared to 29% of the matched control counterparts. Further, only 12% of the treatment group were significantly depressed at an 18-months follow-up point, whereas 33% of the control group were depressed at this evaluation. The *Coping with Depression-Adolescent Version (CWDA; Clarke et al., 2003)* has been shown to be quite efficacious, as results

have shown an improvement of depressive symptoms at post-intervention points. Specifically, 67% of the treatment groups showed decreased symptoms, while only 48% of their wait-listed counterparts showed a decrease in symptoms.

Disruptive Behavioral Disorders

Tynan and associates (1999) evaluated a group cognitive-behavioral training for children with ADHD. The group focused on following directions, taking turns, initiating conversation, recognizing emotions in others, and problem-solving. They found improvement in children's behaviors following 6.7 group therapy hours. Furthermore, there was high compliance and cooperation with a low attrition rate.

Feindler and colleagues' *Chillout* anger management program has been evaluated on groups of adolescents in inpatient and outpatient settings (Feindler, 1995; Feindler & Ecton, 1986; Feindler & Guttman, 1994; Feindler et al, 1984). Feindler and colleagues (1984) examined the effects of teaching self-control skills and anger management to disruptive junior high school students in an in-school program. They found that their intervention lead to decreases in fines and expulsions for disruptive and aggressive behavior. Additionally, students' problem-solving abilities improved.

Lochman and colleagues' group intervention entitled the *Anger Coping Program* has also enjoyed considerable support (Larson & Lochman, 2002; Lochman, Barry, & Pardini, 2003). Lochman, Nelson, and Sims (1981) found that 12 sessions of cognitive-behaviorally focused group interventions contributed to decreased aggressive behavior and teacher reported increases in on-task behavior for second and third grade African American children. Further investigation found that the *Anger Coping Program* led to decreased parent reported aggression, lower rates of time-sampled observations of disruptive classroom behavior, and higher self-esteem in elementary school boys (Lochman, Burch, Curry, & Lampron, 1985).

ASSESSMENT AND GROUP MEMBER IDENTIFICATION FOR OUTPATIENT SETTINGS

Specific Measures

A comprehensive clinical interview is recommended for assessment. More specifically, developmental, social, school, family, and physical history should be obtained. Substance abuse issues and cultural considerations need to be addressed, as well. Ideally, the best candidates are patients who do not present extreme behavior problems that will disrupt the group or claim excessive amounts of time to manage. Additionally, patients should have some minimal level of motivation to change, modest frustration tolerance, and an ability to appreciate, as well as profit, from peer feedback (Lochman et al., 2003)

Screening measures should be selected based on the treatment focus. For anxiety, narrow band measures such as the *Screen for Child Anxiety Related Emotional Disorders* (SCARED; Birmaher et al., 1997), the *Multidimensional Anxiety Scale for Children* (MASC; March, 1997), and the *Revised Child Manifest Anxiety Scale* (RCMAS; Reynolds & Richmond, 1986) are suggested. The SCARED is a 41-item measure of anxiety that

yields a total anxiety score as well as separate factor scores for panic/somatic, generalized anxiety, separation anxiety, social anxiety, and school refusal. The MASC also produces a total score, as well as factor and subfactor scores. The MASC contains an inconsistency scale and an anxiety disorder index. MASC factor scores include physical symptoms, harm avoidance, social anxiety, and separation anxiety. Subfactor scores include tense/restlessness, somatic, autonomic, anxious coping, perfectionism, performance fears, and humiliation/rejection. Finally, the RCMAS produces a total score, three factors (Physiological, Worry, and Social), and a Lie Scale. These measures provide a molar assessment of distress and a more molecular evaluation of specific aspects of anxiety.

Narrow band measures such as the *Children's Depression Inventory* (CDI; Kovacs, 1992) and the *Beck Depression Inventory-Second Edition* (BDI-II; Beck, 1996) are recommended for groups focusing on depressive symptoms. The CDI is a 27-item inventory tapping pivotal depressive symptoms. It yields 5 factors (Anhedonia, Low Self-Esteem, Interpersonal Problems, Ineffectiveness, and Negative Mood). The CDI also has a short form that is useful for monitoring effects of treatment (CDI-S). The BDI-II is a 21-item inventory that taps physiological, cognitive, affective, and behavioral symptoms of depression. Both the CDI and BDI-II provide clinicians with clinically relevant psychometrically sound measures.

The *Conners Parent Rating Scales* (CPRS; Conners, 1990) is a 48-item scale measuring symptoms associated with AD/HD. The CPRS is highly focused on AD/HD symptoms and like other narrow band measures sacrifices breadth of coverage for in-depth assessment of specific symptoms (Kronenberger & Meyer, 1993). The 10-item *Hyperactivity Index* (HI) is recommended to assess treatment effects (Kronenberger & Meyer, 1993). The *Conners Teacher Report Scale* is similar to the CPRS and contains 39 items.

Member Characteristics

Lochman and colleagues (2003) suggested several general characteristics of good candidates for group intervention. Poor problem-solvers with low perceived hostility and an understanding that aggressive behavior is a problem are well-suited to group therapy. Moreover, Lochman and colleagues stated that children with internal attributions who are rejected by peers and are motivated to change are expected to profit from a group therapy experience. Friedberg and Crosby (2001) noted that children must possess sufficient self-control to benefit from group therapy. For instance, children who are so disruptive and dysregulated that they cannot stay seated or keep their hands and feet to themselves are not likely to gain from group experience. Additionally, symptom acuity is a determining issue, and a moderate level of acuity is ideal. A depressed child who suffers from paralyzing hopelessness and vegetative symptoms is initially better served with individual therapy, and then, when symptoms are relieved somewhat, therapists could consider group treatment.

COGNITIVE-BEHAVIORAL GROUP INTERVENTIONS

A modular or component approach to cognitive-behavior group therapy is recommended. Rudimentary modules of CBT, including introduction to treatment, behavioral interven-

tions, problem-solving, self-instruction, rational analysis, and performance attainment, provide the basic intervention skeleton. Therapists then determine the number of sessions to allocate to each module depending on the patient and the goals of the group. Thus, interventions are organized under modular headings.

All the interventions should be employed while balancing structure, process, and content variables (Friedberg & Crosby, 2001). Structure refers to interventions, activities, and exercises group therapists employ, such as thought diaries, self-instructional practices, and behavioral methods. Content represents the material elicited from or emitted by the patient, such as thoughts and feelings by these methods. Process variables are the ways patients respond or complete the interventions, such as avoidance, opposition, non-compliance, irritation and engagement.

Group cognitive-behavior therapists should adhere to the fundamental notions of collaborative empiricism and guided discovery (A.T. Beck et al., 1979; J. S. Beck, 1995). By adhering to collaborative empiricism, group therapists actively involve patients as partners and make therapy observable. Group cognitive therapy is characterized by a guided discovery process propelled by empathy, Socratic dialogues, and behavioral experiments. Through collaborative empiricism and guided discovery, therapists act as coaches who help patients build their own data bases to cast doubt on their assumptions.

Group CBT typically integrates skill acquisition and application. Skills are acquired via psychoeducation, where therapists directly teach coping skills. Youngsters may be given reading material, sample worksheets, or see a skill demonstrated. Once the skill is acquired, the next phase requires application. In this more difficult phase of treatment, the skills become more portable and individualized. Children use the skills to cope with their own particular aversive circumstances, distressing emotions, and inaccurate appraisals, and replace problematic behavior with more functional alternatives. Application is enhanced through practice in the context of negative affective arousal. Simply, children should experiment with the acquired skills when they are feeling badly, both in session and through homework assignments

Introduction to Treatment/Self-Monitoring

The initial treatment module involves an introduction to treatment and self-monitoring. Early group sessions should expose youngsters to the nature and rationale of treatment. Young patients need to know the "rules of the therapy game." More specifically, therapists need to communicate that CBT focuses on physiological, emotional, cognitive, and behavioral symptoms. Further, they need to let youngsters know how the group processes will facilitate the acquisition and application of coping skills. Clarke and colleagues (2003) suggest therapists initially encourage patients to at least experiment with each skill once before they decide to accept or reject the tool.

Priming and Problem-Solving

Priming techniques ready the child's cognitive processes for direct interventions. They are designed to "loosen up" children's rigid cognitive processes. Additionally, they can stimulate group discussions and get children talking about non-threatening issues. *Are*

you an egg is a problem-solving intervention modified from Vernon's (1989) creative workbook. In this exercise, the group therapist brings a raw egg and a bowl to group. She initially explains that the members will observe an experiment today. The therapist shows the egg to the group and generally asks one group member to examine the egg to verify its authenticity. The egg is then cracked on the side of the bowl and the results are shown to the group members. The therapist then asks the members to report their observations (e.g., What happened?). After the results are collected, the therapist then asks, "But did the egg choose to break?" The discussion continues with a dialogue on how they are similar and different from an egg. The exercise playfully illustrates the notion of choice in a non-threatening way.

Download This is an updated modification of a technique initially developed for inpatient children (Friedberg, Mason, & Fidaleo, 1992). The task presents groups members with \$100.00 dollars of group money and a list of various musical artists. Their job is to spend exactly \$100.00 downloading music from various artists. The artists are grouped in three different price categories (\$20.00, \$10.00, and \$5.00), and the list includes some artists teenagers would typically prefer as well as many artists adolescents would not prefer.

The task is completed in three phases. In Phase I, children make their selections and share their choices aloud. The group therapist lists the choices by group member's names on a poster board or white board. After all the selections are shared and recorded, the group therapist instructs the patients to look at the lists on the board and asks them, "How many lists are identical or exactly the same?" There will be few if any identical lists. The next question is, "How many of you have the identical or exactly the same problem to solve?" Of course, they all did! The therapist then asks the synthesizing question, "What does it mean that you all had the same problem but came up with very different options?" The take away message from Phase I is that problems have many solutions.

Phase II builds on Phase I, as the therapist begins by asking each group member to identify which artists on their list they would spend their own money to buy. There will be some non-preferred choices on each child's list. Once all the children have identified the artists they would not buy on their own, the therapist asks, "What was it like to choose among things you did not like?" The point in Phase II is most times you have to choose among undesirable alternatives. This counters the common teenage belief that a choice has to occur among only desirable options.

Phase III involves the application phase. The therapist then invites the group members to experiment to generate a broad list of alternatives to their pressing problems. This list should include both ways they would prefer to solve the problem and solutions they would not like. Finally, they try to select productive alternatives from the preferred and non-preferred choices.

Building the Tool Kit is an excellent problem-solving and coping skills technique (Goldberg-Arnold & Fristad, 2003). Young patients create four categories of coping skills titled creative, social, physical, and rest and relaxation. Children then add strategies in each category. To make the activity more engaging, fun, and simple, the therapist could use colored adhesive labels with each category represented by a different colored adhesive label. The patient then only has to write the strategy on the label and then place it on an activity to record its use.

Behavioral Tasks

Behavioral skill training is another important module in group CBT. Social skills training, relaxation training, and pleasant activity scheduling are examples of behavioral interventions. Cartledge and Milburn's (1996) program contains many social skills training exercises that are culturally responsive, as well as ideal for outpatient groups. Completing a joint project is an excellent task that builds social skills and a sense of group "community." Each child is given an individual part of the group project to complete. The task requires the children to work together and offers *in vivo* practice opportunities for social skills (e.g., giving/receiving compliments/criticism, sharing, asking/getting help).

Relaxation training can also be done in groups. Developmentally appropriate procedures and scripts similar to the ones created by Kendall and colleagues (1992) are recommended for different ages and skill levels. Simple relaxation interventions are generally preferable to more complex ones. For example, Wexler (1991) created a *Ten Candles* exercise. Children imagine 10 lit candles in a row. Then, they blow out each candle with an effortful exhale. *Ten Candles* is useful because it combines imagery and controlled breathing, and it keeps the child engaged in the therapeutic task.

Self-Instruction

Self-instructional procedures change a child's inner dialogue. The focus of self-instruction is on replacing inaccurate appraisals with more accurate explanations and problem-solving strategies that guide adaptive coping. Therapeutic use of board games also lends itself nicely to outpatient CBT groups. Berg (1990a, 1990b, 1990c) has created several fun cognitive-behavioral games that are ideal for group work. Children take turns responding to various prototypical scenarios. The cards ask the child to identify and modify inaccurate thoughts. Therapists then can use the group process to help young people develop alternate self-instructions and problem-solving strategies. Further, once the common scenario is sufficiently processed, the therapist asks the children to apply the skill to their own lives (e.g., When have you felt like this? What popped into your head? What is something else you could have said to yourself?).

Changing Your Tune (Friedberg et al., 2001) is a general self-instructional technique useful for a variety of problems. The skill is taught via skill acquisition and application phases. In the acquisition phase, the analogy between troubling negative automatic thoughts and irksome song lyrics repeating in their mind is presented. Then, a simple self-instruction is taught. Next, prototypical situations, feelings, and negative automatic thoughts are presented. The child's task involves supplying an alternative response to common problematic situations. Once the children acquire the skill, they are given the applied assignment to complete a *Changing Your Tune* diary based on their individual experiences.

Goldberg-Arnold and Fristad (2003) described a very clever, yet simple self-instructional tool called *Naming the Enemy*. Children are given a sheet of paper, which they divide into two columns on both sides. One column on one half of one side of the paper is labeled, "Things I like about me." The child then turns the paper over and labels the other column on the opposite side, "My symptoms." The children are invited to list all of their symptoms (e.g., impulsivity, depression, not listening, irritability, etc.)

under the labeled symptoms. The children then turn the paper over and list their positive qualities (e.g., smart, good at sports, etc.). Next, they fold the symptom column over the strength column literally hiding the strength column. Children now have a concrete referent for the way symptoms camouflage strengths. The group then discusses the way symptoms can cover up positive characteristics.

Shout Out is a self-instructional technique based on the cognitive-behavioral protocol developed by March and Mulle (1998). The idea is to "boss back" the negative automatic thought and shout it out. The procedure makes use of the Beatles classic song *Get Back*. Shout out is a fun and active way to teach self-instruction. Singing/Shouting "Get Back" interrupts the chain of negative thoughts, empowers the child, and initiates the process. It is a way to "jump start" the self-instructional process. During the priming stage, the children listen to the lyrics and then sing along with the chorus, "Get Back, Get Back to where you once belonged." During the application phase, children identify their negative automatic thought and begin the self-instructional process by shouting/singing, "Get Back." After they shout out, the children construct their self instruction (e.g., "Being worried is also a feeling. It does not mean something bad will happen.").

Rational Analysis

Rational analysis techniques focus on modifying the illogical process of children's and adolescents' thoughts. Typically, constructing a Socratic dialogue that casts doubt on patients' assumptions is a pivotal task. A group format is well-suited to rational analysis because ideally the questioning and feedback comes from group members, as well as the therapist. Clarke and colleagues (2003, p. 125) remarked, "Even if teens like and trust the group therapist, they nonetheless may discount the therapist's feedback because she or he is an adult. Feedback from the other adolescent group members may be more palatable as it comes from a peer who understands my life." Indeed, when group members begin to question each other's conclusions Socratically, the group therapist is assured they have internalized the process of evaluating one's thoughts and started to apply their newly acquired skills.

Thought Digger is a rational analysis tool used with elementary school children in outpatient groups (Friedberg et al., 2001; Rambaldo et al., 2001). *Thought Digger* is presented in acquisition and application phases. In the acquisition phase, children are presented with 11 samples of Socratic questions, including: "What good things about myself am I ignoring?"; "Am I confusing maybe with forever?"; "Am I expecting too little from myself?"; and "Am I using my feelings as facts?" In the application phase, children record their problematic situations, feelings, and thoughts and circle thought digger questions that can help them rationally analyze their conclusions.

Goldstein and colleagues (1987) recommend a very innovative moral reasoning group intervention for aggressive youngsters. The program is based on Kohlberg's (1984) theory of moral development and includes several moral dilemmas. In their *Aggression Replacement Therapy* (ART), Goldstein and his colleagues provide adolescent group members moral dilemmas to resolve. The goal is to raise the youngster's levels of moral reasoning through group discussion, feedback, and rational analysis. While the Goldstein text includes prototypical vignettes, therapists need not be constrained by these stories. Using the game of *Scruples* is a nice alternative.

Performance Attainment and Experiential Activities

The *Circle of Criticism* (Feindler & Ecton, 1986; Feindler & Guttman, 1994) is an activity that encourages aggressive youngsters to demonstrate their coping skills. Patients are instructed to sit in a circle and make provocative slurs to each other (e.g., "You smell," "You are stupid," etc.) and the recipient responds with fogging, assertion, or any other anger control technique. Indeed, their exercise is an opportunity to practice the skills learned previously.

Say Cheese is a performance attainment exercise used in the CAMP program. Since socially anxious children are often uncomfortable posing for pictures and asking others to be in their pictures, children are instructed to ask each other to be in group pictures. The photographer selects the group and instructs them to make a silly pose. Children record their thoughts and feelings as the group members process any inaccurate appraisals and then problem solve difficulties.

Sharing the Persian Flaw is an experiential exercise inspired by the television series *Joan of Arcadia*. In one episode, Joan frets about making mistakes, being perfect, and trying to control everyone and everything around her. She learns that when Persian rugs are made, the rug-maker purposely creates a flaw in the rug as a defining feature and as a way to embrace humility. The Persian Flaw suggests that life must be lived and tolerated through its imperfections and unpredictability. This exercise is ideal for children plagued with perfectionism and an excessive need for control. A design is presented to the group members and they are instructed to complete the design and include a defining flaw. They can color outside the lines, rip, and crumble the paper, or even elect not to color it all. After they have finished the exercise, they must describe their flaw to the other group members. In sum, the exercise gives young people practice in making mistakes, going public with their mistake, evaluating people's reactions, and coping with possible negative reactions.

CHALLENGES TO OUTPATIENT GROUPS

Group cognitive-behavior therapists need to set rules and limits when groups begin. Friedberg and Crosby (2001, p. 78) noted, "Rules and limits allow the therapeutic process to unfold." While this process appears simple and straight-forward at first blush, clinical experience reveals it is a deceptively difficult practice. A few basic rules should be prepared by the therapist before the first group and then presented to the group members. It is generally best to collaboratively process and develop the rules. For instance, a prepared rule may be read aloud and then group members are invited to express their agreement or disagreement with the rule. In this way, the rules become an initial issue for group processing. After the prepared rules are discussed, children are encouraged to add their own rules. Of course, group therapists maintain "veto power" over the rules.

The rules should be recorded in written form, signed by the children, and each group member retains a copy. Poster boards displaying the rules may be hung on the walls and point charts reflecting children's compliance with the rules could be displayed (Lochman et al., 2003). Once the rules are established, they must be enforced. When therapists fail to enforce limits and rules, they sabotage children's sense of safety. In fact, therapists are teaching patients they cannot be trusted or relied upon. When enforcing the rules,

group cognitive-behavior therapists should remain faithful to the notions of guided discovery and collaborative empiricism. If the rules are initially transgressed, therapists should gently remind the offending member about the rules, process the reminder with the individual child (e.g., "What went through your mind when I reminded you about the rules?"), as well as elicit the thoughts and feelings from other members (e.g., "What popped into your mind when I reminded Joaquin about the rules?"). If transgressions continue, consequences need to be meted out (e.g., loss of points/tokens, time outs, or in severe cases removal from group).

Lack of rules and limits may reinforce deviancy training (Lochman et al., 2003). Lochman and his associates refer to deviancy training when group therapists unwittingly reinforce children's problematic thoughts and behaviors. This seems particularly likely when working with youngsters who have conduct, oppositional, and behavior problems. Moreover, this is precisely the reason group therapy with conduct disordered youngsters is contraindicated (Dishion, McCord, & Poulin, 1999). In these groups "gone wild," contagion effects predominate and young patients "catch" each other's dysfunctional attitudes, feelings, and actions. Lochman et al. advocate making clear expectations, using co-therapists, and dividing into subgroups as ways to inoculate the group from this contagion.

These problem strategies raise additional challenges involving the number of therapists in a group. Ideally, groups should be co-led. Fortunately, working in an academic or clinical training institution permits trainees to act as co-therapists. However, private practitioners and institutions without trainees may not enjoy the luxury of a co-therapist.

Regardless of whether the therapist has a "co-pilot" or "flies solo," clinical flexibility is a challenge. While homogeneous groups are the rule in Randomized Clinical Trials (RCT), they are commonly the exception in most practice settings. Addressing varying levels of psychopathology and cognitive emotional maturity is a pivotal task (Rambaldo et al., 2001). Therapists need to tailor techniques, exercises, and activities so that children with different problems can profit from the group experience. Further, the therapist must balance clinical tasks, such as delivering psychoeducation, Socratic processing, limit setting, and reinforcement.

Deciding between open and closed groups is another key issue. In closed groups, group membership remains constant throughout the course of group treatment. Thus, no new members are added once the group begins. In open groups, members continually enter and the group composition repeatedly changes. Time-limited versus open ended formats are frequently associated with decisions about closed and open groups. Time-limited groups impose a session limit (e.g., 8, 12, or 20 sessions), whereas in on-going groups, there is no set end point. Generally, time-limited groups lend themselves to closed enrollment, whereas an on-going group may more readily accommodate changing group composition.

The group structure and goals also impact decisions on open or closed enrollment. For instance, the group component of the Penn State University Milton Hershey Medical Center *Child Anxiety Management Program* (CAMP) includes eight sessions of group CBT. CAMP offers a sequential and structured approach in which each week builds upon the previous session. Since the curriculum is set, it is counterproductive to add patients in after the second week. However, a new group cycle begins every 8 weeks or so, and new groups are formed at that point.

Group size is another consideration. Size will depend on the number of therapists

and costs. Larger groups with six or more children are likely best served with co-therapists. Therapists in outpatient settings may need to be mindful of the net revenue figures in order to set a minimum number of patients in a group.

Managing crises and intense emotional arousal in groups are additional challenges. Often, these considerations are shaped by group size, level of functioning, and number of available therapists. Therefore, groups need to be small enough for only one therapist to effectively manage and care for a member in crisis. If these groups are too large, then another therapist must be added. Therapists must take care there are not too many labile and vulnerable patients in one group. Not only will these patients' agendas overwhelm the group, but they will likely flood the therapist's resources. When individual issues predominate in a group context and consistently necessitate a therapist's "special attention," it is a recipe for disaster.

SUMMARY

CBT's landscape offers an expanding horizon. The range of applications appears quite wide and now includes work with bipolar depression, autism/aspergers disorders, and schizophrenic spectrum patients. CBT is transcending the traditional boundaries of individual therapy and is now being delivered in group and family formats. Indeed, group CBT in outpatient settings is an emerging and exciting clinical frontier.

While this chapter presented cognitive-behavioral approaches to group therapy in a common setting, proper application of group CBT may be an uncommonly productive intervention. Practitioners can reach more children in fewer clinic hours and equip them with empirically-tested skills. Young patients can profit from group support, peer feedback, and simply knowing they are not the only child who struggles with their particular emotional challenges. Continued theory building, clinical innovation, and empirical investigation will serve to bolster group cognitive-behavioral interventions. Collaboration between basic researchers, clinical scientists, and practitioners will propel group CBT toward even wider vistas.

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