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REVIEW/*DERLEME*

Delivering Group Cognitive Behavioural Therapy – Competencies and Group Processes

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Abstract

Cognitive Behavioural therapy (CBT) is an empirically validated psychotherapy and the most researched therapeutic modality that has shown to be effective in treating a range of psychological disorders. Group therapy is a common and powerful modality of treatment which is increasing in popularity due to its evidence base and cost effectiveness. In the current economic climate and pressures on services to meet targets, CBT group therapy is being considered as an alternative to individual therapy. In CBT group treatment models have been adapted from the individual treatment models unlike traditional psychotherapy modalities that focus on the group process as a medium of change. Current training in CBT and the assessment of CBT competencies using validated measures do not focus on the development of the core competencies for group therapy facilitation as traditionally CBT has been offered as an individual based therapy. It is important to develop these core competencies in facilitating group processes and CBT skills to modulate change. There are similarities and differences between traditional group therapy and CBT. The combination of group processes and the manulised CBT approach can add benefit to provision of group based CBT. There is a need for development of further training, development of a validated assessment tool on CBT group therapy and supervision for CBT therapist to skill therapist in provision of group therapy focussing on key CBT skills and group processes as a medium of change. **(Journal of Cognitive Behavioral Psychotherapy and Research 2014; 3: 150-155)**

Keywords: Cognitive behavioral therapy, group processes, group psychotherapy

Özet

Bilişsel Davranışçı Grup Terapisi Yapmak – Yeterlik ve Grup Süreçleri

Bilişsel davranışçı terapi (BDT), üzerinde çok sayıda bilimsel çalışma yapılan ve bir dizi psikolojik hastalıkların tedavisinde etkili olduğu gösterilmiş, deneysel olarak geçerliliği olan psikoterapi çeşitidir. Grup terapilerinin kanıta dayalı olması ve maliyet etkinliği nedeni ile tedavide yaygın ve etkili bir yöntem olarak popularitiesi artmaktadır. Mevcut ekonomik şartlar da hedefe ulaşmak için, BDT grup terapisi, bireysel terapiye alternatif olarak kabul edilmektedir.

Geleneksel psikoterapi yöntemleri aksine, grup BDT bireysel tedavi modellerine göre uyarlanmıştır. Güncel BDT eğitimleri ve BDT yeterliliğini değerlendirmede kullanılan geçerli ölçümler; kolaylaştırmayı hedefler ve geleneksel bireysel BDT'de olduğu gibi temel yetikinliklere odaklanmamaktadır. Grup yaklaşımını kolaylaştırarak temel yetkinlikleri geliştirmek ve BDT becerilerindeki değişikleri uyarlamak oldukça önemlidir. Geleneksel grup terapisi ile BDT arasında benzerlikler ve farklılıklar vardır. Grup BDT becerileri ve süreçleri ile ilgili süpervizyona, ileri eğitimlere ve geçerli değerlendirme araçlarının geliştirilmesine ihtiyaç vardır. **(Bilişsel Davranışçı Psikoterapi ve Araştırmalar Dergisi 2014; 3: 150-155)**

Anahtar kelimeler: Bilişsel davranış terapisi, grup işlemleri, grup psikoterapi

INTRODUCTION

Cognitive behavioural therapy (CBT) is an empirically validated psychotherapy that has shown to be effective in over 325 outcome studies (Butler et.al. 2006). Over the last 20 years since the introduction of CBT in the treatment of depression, advances have

been made in the development of CBT treatment models for other psychological problems such as anxiety disorders (Clark and Wells 1995, Ehlers and Clark 2000) and personality disorders (Beck and Freeman 1990, Young 1999). CBT has been and remains the most researched modality demonstrating efficacy and its application to a wide range of psychological difficulties (Pucci 2005). In the United Kingdom guidelines published by the National Institute of Clinical Excellence (NICE) recommends individual and group based CBT for the treatment of a wide range of psychological disorders (NICE 2004a, 2004b, 2005a, 2005b, 2010). These guidelines have been developed through the systematic review of published outcome literature meeting their stringent criteria.

In recent years there has been an increasing use of structured, topic focussed groups in various areas of health and social settings (Greif and Ephross 2004, Letendre 2007, Salloum A et. al. 2009, Muroff et. al. 2009, Whitfield 2010, Huntley et. al. 2012). Group therapy is a common and powerful modality for treatment of psychological disorders which is evidence based and cost effective. Even thought CBT traditionally has been practiced as an individual therapy format however the classic text for depression (Beck, Rush et. al. 1979) has a chapter on group CBT. The emphasis of the provision of group CBT for depression has been for economic benefit and efficiency in terms of the larger numbers of patients treated and in meeting targets of number of individuals receiving treatment for their psychological problems. There has been a slow growth in the development group CBT treatment models for a range of disorders such depression, social phobia, obsessive-compulsive disorder and hoarding. Current CBT group treatment models have been adapted from the individual treatment model to a group setting unlike traditionally psychotherapy or process groups that focus on the group processes as a medium of change (Puskar et. al. 2012).The group process is the relationship between the therapist and the group and with individual group members (Yalom and Leszcz 2005).

Core Competencies For Group Therapy Facilitation

A competency is defined as a capability or ability. Yalom and Leszcz (2005) describe one of the core competencies in group facilitation is to be the group process which can be described as the relationship between the therapist, the group and individual group members. The therapeutic relationship between the therapist, group and individual members enables the development of trust, disclosure, emotional experience that enables the group to function therapeutically. The therapist needs to have the core competencies to be able to facilitate the group processes described below.

The experience for individuals in a group sharing or experiencing similar experiences is called universality. Individuals are drawn to group therapy often to meet others who have similar difficulties as themselves. It is a general process in group therapy but the perceived similarities among members contribute to this process. The therapeutic effect of universality is the reduction of stigma, isolation and shame which contributes to group process. The reduction of stigma, isolation and shame enables the group to develop cohesion between the group members for the group to function as a group. Other therapeutic effect of universality is that it instils hope with the potential for change, which is a powerful process. Additionally, it enables self-disclosure, which can help to establish safety within the group.

Cohesion is another group process, which is set by universality. Cohesion is the connectedness of group members to one and another. Cohesion is created by universality where group members are able to relate to one and another, sharing similar experiences and having a common ground. Cohesion is formulated as an attachment bond or emotional connection between group members (Milkuliner and Shaver 2007). Cohesion contributes and enhances the sharing of personal information within the group (Budman et. al. 1993). Additionally, cohesion creates a sense of comfort, belonging and acceptance of one and another by the group members (Beiling et. al. 2006) whilst reducing difficulties of attachment with one and another (Brook 2008).

Mutual aid is another group process, which develops through the interactions where group members help one and another (Beiling et. al. 2006, Rose 2004, Yalom 1995). Beiling et. al. (2006) and Yalom (1995) define mutual aid as selfless s concern for the welfare of others. Mutual aid is achieved through the supportive group climate that is achieved through the cohesion. Mutual aid begins when group members by offering one and other advise, sharing experiences, and ways of dealing with problems. Additionally mutual aid occurs when group members directly or indirectly offer support, empathy to one and other.

Another aspect of group therapy is social contact and socialising. The group provides opportunities for individuals to interact with peers on an equal playing field with the power imbalance often experienced in individual therapy. Groups are considered social environments as they reflect the social world externally. This micro social environment is contained in a safe setting where group members can learn and practice social skills (Beiling et. al. 2006, Rose 2004, Yalom 1995). The safe environment is developed through the facilitators setting of boundaries, limits and safety promoting the formation of relationships with others (Brook 2008).

These group processes interact with each other to create a climate where interpersonal learning and the opportunity for the sharing of information (Yalom 1995).

CBT Competencies

In terms of CBT, Roth and Pilling (2007) identified the core competences required to deliver effective CBT within five domains: general therapeutic competences, basic CBT competences, specific CBT techniques, problem specific competences and metacompetences. The successful outcome in CBT necessitates the adherence to the treatment model and competent delivery of the specific techniques (Dobson and Singer 2005, McGlinchey and Dobson 2003).

The use of standardised scales to evaluate therapist's skill within treatment sessions can be an effective method of directly of assessing the therapist competence. One such scale is the Cognitive Therapy Scale Revised (CTS-R) (Blackburn et. al. 2001) remain the main assessment tool for measuring competence in CBT both trainees and trained therapist. This scale measures a number of domains that have been identified as core competencies for the practice of CBT. The CTR-S (Blackburn et. al. 2001) is used actively in the development of competence for trainees and consistency of therapy offered by trained therapist through the rating of the scale in live supervision. Live supervision provides direct observation of the therapist's performance within the therapeutic session. With the development of disorder specific models however, this scale does not assess the disorder specific strategies and techniques that are central to the mechanism of change in CBT (Fairburn and Cooper 2011).

There has been the development of disorder specific (Huppert et. al. 2001, Haddock, Devane et. al. 2001) CBT treatment scales to measure competence based on Carroll et. al. (2000) Yale Adherence and Competence scale for the treatment of addictions. However, these measures are restricted to a number of disorders and have had limited psychometric evaluation outside research settings.

Other methods of measuring competence in CBT include clinical supervision which is carried out retrospectively on the basis of the supervisors' observations in supervision over a period of time. Clinical supervision is part of normal practice in CBT that includes a range of methods such as life supervision (audio/video recordings), case reports and discussions. The use of case reports discussions have a number of failings as this process is based on second hand reporting rather than direct observation and therapist may not report key information, difficulties or failings within the therapeutic session (Landy et. al.1996).

The British Association of Behavioural and Cognitive Psychotherapy (BABCP 2013) accreditation process stipulate that therapist competence is assessed over a period of time through live supervision by measuring competence by using a validated competence assessment measure such as CTS-R (Blackburn et. al. 2001).

Similarities And Differences Between Group Therapy And Cbt

Yalom (1995) describes content consists of the spoken words, issues covered and the debate that arise with each discussion. In CBT the content is based on the agenda set at the onset of the session having a clear focus for therapy involving a collaborative dialogue between the therapist and patient. The group process is the relationship between the therapist, the group and individual group members. In CBT it is the collaborative relationship between the therapist and patient. The collaborative discussion based on the agenda forms the basis of the debate and discussion within session. The collaborative dialogue is important in CBT as it contributes to the development of universality with the normalisation of patient's difficulties which is developed from the patient's own understanding and framework.

Group therapy format within the psychodynamic and interpersonal modalities tend to be unstructured, facilitators tend to deemphasize content but facilitate interpersonal interactions (Beiling et. al. 2006, Yalom 2005). Both individual and CBT group therapy format

is structured and CBT content focussed which has an impact on the group process. With the focus on content there is little attention paid to group processes, interactions between the facilitator, group members and each other. Group therapy tends to be of longer duration over a longer period of time allowing for facilitation the working of the group in comparison to group CBT a time limited, problem and goal orientated model.

In group therapy members are drawn together due to their similar problem, which facilitates the development of universality within the group. However, in CBT group therapy creates universality through the selection of group members experiencing similar presentations e.g. depression or anxiety problems. The therapist rather than the purpose of the group, which recruits individuals who have similar needs, does this selection process. Despite experiencing similar presentation for CBT group therapy, there may be other factors that impede development of universality due to individual problems, goals from therapy and personality factors.

Both group therapy and CBT group therapy develops cohesion between group members, which are influence by a number of factors. Rose (2004) states that cohesion tends to enhance when group members are similar in terms of demographics. Other factors are such group norms (ground rules), regular attendance that fosters cohesion. The group norms such as confidentiality are important to establish a sense of security and trust which enhances cohesion and enables disclosure within the group.

Mutual aid develops in both group therapy and CBT groups. This occurs when group members offer support, empathy, compassion, understanding, normalising experiences to one another for example by sharing similar difficulties or coping mechanisms that they have found useful. The experience of helping others helps broaden their focus to include other people and experience the positive effects of this. In terms of CBT groups the act of helping others enables individual group members to practice their skills that they have developed within the group, as the focus of therapy is to enable them to deal with their difficulties more effectively.

Group treatment offers the opportunity for interacting with peers on an equal basis. Individuals often feel isolated, both group therapy and CBT groups provide the opportunity to reduce this sense of isolation and normalisation of the difficulties through social contact and socialising. Often the micro group environment reflects the social world outside the group. This is achieved through the social support offered within agreed boundaries of the group, which offers safety, promoting the formations of relationship with their peers (Brook 2008).

Group Processes In CBT Group Treatment

Yalom (1995) describes that group therapy is associated with targeted mechanisms of change that are specific to a group format. In terms of CBT group therapy the therapist can apply these mechanisms of change. The use of Socratic dialogue and guided discovery is a skill that can be used with CBT group therapy to develop and enhance participant optimism towards recovery and inclusion within the group, developing universality, cohesion and mutual aid. The use of didactic psychoeducation by the therapist, feedback from other group members, observation, experiential and problem solving promote group-based learning (Beiling et. al. 2006). The shifting of focus from on individual to other group members and the group as a whole facilitates group members in providing reflection, support, reassurance, sharing ways of coping. The act of reflection, support, empathy, compassion, reassurance, sharing ways of coping help develop group cohesion. Other factors that therapist can aid with group cohesion is ensuring group homogeneity, consistent attendance, provision of a safe environment for self disclosure and ensuring acceptance, empathy and constructive feedback.

The group provides an environment for corrective social learning experience for dealing with maladaptive interpersonal patterns. The ability to practice skills within the safety of group aids social learning. This is further reinforced by the setting and review of homework within the group. The balancing of the agenda with dealing with cognitions and emotions among the group members in the here and now is line with goals of CBT is able to help with the emotional processing as the group promotes open expression.

DISCUSSION

Within the current group CBT treatment framework little or no attention is paid to group processes. The CBT group treatment models tend to be manualised and attending to a specific agenda or topic for each week. Group therapy is a complex and the lack of sensitivity and attendance to the group processes limits

its therapeutic value, which potentially weakens the impact on the participants. CBT therapists are able to facilitate the development of group processes within the CBT framework. However in relation to CBT there is a clear emphasis in the measurement and development of the therapist competence in the ability to deliver CBT effectively through clinical supervision such live supervision, case reports, discussion and the use of the empirically validated measures such as the CTS-R (Blackburn et. al. 2001). However there are limitations as to application of the CTS-R (Blackburn et. al. 2001) to the group therapy setting as it does not measure the therapist competence in facilitating group processes.

CONCLUSION

Group therapy is a powerful modality in the treatment of psychological problems which is both evidence based and cost effective and undertaken in a variety of settings. However, traditionally CBT based group therapy has been provided as means of being cost effective and treating larger number of patients. There has been little or no attention to the group process and its impact on the group dynamics. CBT competence is actively measured through live supervision and the use of the CTS-R (Blackburn et. al. 2001). An empirically validated specific measure needs to be developed for CBT group therapy to measure and develop competence for therapist engaged in facilitating group therapy. The impact of group process in group therapy cannot be underestimated and needs to be attended to in CBT group therapy to enable the group to be effective at a number of different levels. There needs to be further training, development of a validated assessment tool for CBT group competencies and supervision for CBT therapists to be appropriately skilled in facilitating CBT group therapy that focuses on the group processes.

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