

GROUP COGNITIVE THERAPY: TREATMENT OF CHOICE OR SUB-OPTIMAL OPTION?

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Abstract. In the present climate of limited resources and long waiting lists, it is not surprising that there is more emphasis on making sure that psychological treatments are not only clinically sound but also cost-effective. One solution to this is to provide time-limited, focused interventions such as cognitive therapy. Another obvious solution is to deliver treatment in groups rather than individually. However, what evidence is there that therapy can be delivered as effectively in groups as individually? This review will look at which different formats have been tried, what the advantages and disadvantages of those formats might be, which client groups have been targeted for cognitive-behavioural group therapy (CBGT), and whether a group format in general offers any advantages over individual CBT. Outcome studies and their implications for the use of CBGT are considered. Results suggest that, in most client groups, there is little difference in efficacy between group and individual CBT, although there is some evidence that results for some types of patient can be disappointing in CBGT. It may be that the best compromise in terms of cost-effectiveness between quality of therapy and quantity of patients treated is offered by large-scale psychoeducational didactic group therapy.

Keywords: Group therapy, cognitive-behavioural, psychoeducational didactic therapies, cost-effectiveness, clinical effectiveness.

Introduction

Although cognitive therapy was originally developed as an individual therapy, by the late 1970s and early 1980s, this approach was also spreading to group-work. Groups were run on the same principles as the individual model, i.e., identification and modification of dysfunctional thoughts, assumptions and beliefs, relying on techniques such as self-monitoring of activities, affect and cognitions; education; behavioural experiments to assist reattribution. Early studies of efficacy of cognitive-behavioural group therapy (CBGT) mainly focused on depression (Hollon & Shaw, 1979; Rush & Watkins, 1981; Shaffer, Shapiro, Sank, & Coghlan, 1981). Over time, as cognitive therapy models were extended to cover other disorders, group therapy has developed for patients with panic disorder, agoraphobia, GAD, social anxiety and obsessive-compulsive disorder. In the last 10 years, this list has also included bipolar disorder and schizophrenia. In many of these studies, treatment outcome has been similar to that reported from individual CBT in that generally a reduction in

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symptomatology has resulted. This review looks at which group formats have been tried, which of those would seem to be the most useful both in terms of clinical and financial efficacy, and whether group CBT is the way forward for the future or a less satisfactory alternative to CBT tailored to the individual. It is not intended to be an exhaustive review of every group study of CBT, due to the large volume of published material, but rather to provide representative samples of formats and efficacy. Although cognitive therapy was developed primarily as an idiosyncratic therapy, this aspect necessarily becomes less of a focus when offered in groups, but some would argue that what group therapy lacks in depth would seem to some to be compensated for by the advantages offered by the nature of a group format, e.g., O'Hara & Rehm (1983, p. 70) with reference to a group for depression: "A depressed client often does not believe he or she can meet the goals the therapist has set for him or her. The group allows the individual to interact with others who are similar in terms of how they feel. As group members see each other making changes, their own sense of hopelessness usually diminishes enough so that they try out new ways of thinking and new behaviours."

As the format, frequency and time involved in groups can vary considerably, it would be useful to first consider what options there are for different types of groups. Table 1 lists a variety of different formats for cognitive therapy groups. As can be seen from the table, there are advantages and disadvantages in all of the formats, so the choice of format will tend to be made rather by the needs of the situation (inpatient versus outpatient; therapist time available) than an inherent advantage of any one of these. The programmed group is the one that is closest to the current trend for large psycho-educational groups.

Practical considerations

Therapists

The consensus of opinion in published articles (Covi, Roth, & Lipman, 1982; Hope & Heimberg, 1993; Freeman, Schrodt, Gilson, & Ludgate, 1993) appears to be that it is better to have a co-therapist rather than try to run a group single-handed, partly because there can be a considerable amount of written material (e.g., dysfunctional thought records) to go through at the beginning of a session, which could be done by the co-therapist. This avoids a certain amount of boredom and waste of time for the group members. If there is no co-therapist available, six would appear to be the maximum number practical for a single therapist to handle (Hollon & Shaw, 1979), although this would not apply to psychoeducational groups where much larger numbers can be treated.

Frequency

Closed groups can vary from 12 to 20 sessions. The length and frequency of group meetings is dependent on a number of variables, including duration of hospital stay (if an inpatient group), therapeutic focus, hospital schedule and space restrictions. Researchers appear to be fairly evenly divided on the subject of length of time of the sessions. Some use a one-and-a-half hour session (Rush & Watkins, 1981; Telch et al., 1993; Heimberg, Salzman, Holt, & Blendell, 1993; Heimberg & Juster, 1994; Freeman et al., 1993) and the others a two-hour session (Covi et al., 1982; Heimberg et al., 1990; Free, Oei, & Sanders, 1991; Krone,

Himle, & Nesse, 1991). This allows time to set an agenda, to do meaningful therapeutic work and to close the session with homework and review. Shorter groups of 45 minutes to one hour may have difficulty in developing and gaining closure on therapy topics (Freeman et al., 1993). Most outpatient groups would meet once weekly but groups that are a primary component of in-patient stay are often held twice to three times weekly.

Group selection

In general, this would be partly determined by the function of the group. Numbers in the group are usually from 6 to 12 (with the aforementioned exception of psycho-educational groups). Patients usually regarded as unsuitable would be those with organic brain syndromes, acute psychosis or mania. One reason may have been the fact that it was felt that these patients would not necessarily benefit from CBT (though this would be challenged now by the work currently being done on CBT with psychotic patients), that they are not suitable cases for brief therapy, and lastly that they might well have a disruptive effect on the group. In spite of the fact that patients with severely disruptive personality disorder are usually excluded from CBT groups, Linehan (1987) has described a CBT group for borderline personality disorder that works well on an outpatient basis.

Why use group therapy?

Perhaps the most immediately obvious advantage of group therapy is the possibility of treating more patients in a shorter period of time. The assumption is that, if group and individual cognitive therapies are equally effective, then therapists could adopt a group format, thereby seeing more patients and presumably reducing the cost per patient. Other widely recognized general advantages of the group format are group cohesiveness, imitative behaviour, interpersonal learning and recognition of similarities in others (Yalom, 1970). Advantages specific to cognitive-behavioural groups include:

- the opportunity to demonstrate the relationship between thoughts and feelings through the negative thoughts of the group members (Hollon & Shaw, 1979; Shaffer et al., 1981; Rush & Watkins, 1981).
- it is easier for the patient to recognize the cognitive distortions of others, which then facilitates recognition and re-evaluation of his own cognitive set (Hollon & Shaw, 1979; Hope & Heimberg, 1993; Heimberg et al., 1993).
- group members can be used as co-therapists (Hope & Heimberg, 1989; Heimberg et al., 1993).

Disadvantages of the group format

Disadvantages appear mainly to be those that could be found in any type of psychotherapeutic group. Several of these are listed by Hollon and Shaw (1979). There is always a danger of one individual monopolizing the group. Care must be taken to ensure that everyone has an opportunity to have a say. Confrontation by group members must be looked out for and avoided if possible. In larger size groups, care must be taken to avoid the development of sub-groups. As the weeks go on, the different improvement rate of the members can pose a problem, as some may feel discouraged that they are not progressing as fast as

others in the group. Lastly, there can be a tendency in some groups to lapse into “small-talk”. In addition to these points, in a group situation individuals may be reluctant to discuss disturbing core beliefs. However, if these are not dealt with, there is the possibility that the person may retain a vulnerability to the recurrence of their problem. On a purely practical basis, the most obvious disadvantage is that it is often difficult to arrange a day or time when the majority of the people selected for the group can attend.

Disorder-specific formats of CBGT with outcomes

The structure of CBGT is similar across client groups but there are some differences in emphasis due to the differences in symptoms, automatic thoughts and beliefs particular to each disorder (though many of these are shared) and the type of intervention that would be most appropriate to these. Differences and similarities in efficacy can be seen in the outcome studies listed in Table 2.

Depression

A typical example of such a group is described by Hollon and Shaw (1979). One to two preparatory interviews are given before the member joins the group, focusing both on assessing the level of depression and educating the member in the cognitive model. The BDI would normally be administered at the beginning of each session. At the first session, general structure is dealt with and ground rules and individual goals established. Ground rules would include confidentiality and structuring time so that each member gets a chance to have his say. Looking at individual goals helps to eliminate unrealistic expectations early on and to elicit any pessimistic expectations. It was illustrated how useful it was to elicit those feelings in the first session and to demonstrate how negative self-appraisals operate. They asked each participant to rank all the members of the group, including themselves, in terms of who they thought would benefit most from the group. Naturally, each one put himself or herself at the bottom of his or her own list. In the discussion that followed, it was clear that there were obvious similarities in how members of the group viewed themselves in relation to others. Up to this point, they had assumed that they were thinking factually about themselves, but pointing out this similarity in the way they think about themselves facilitated the identification of their negative cognitive distortions. Concrete examples are taken from the participants' experience to demonstrate thinking errors and self-fulfilling prophecies. Homework is assigned in each session and reviewed at the beginning of the next session, and members did not move on to a different task until previous tasks had been mastered. As in individual cognitive therapy, sessions would follow the pattern of measuring mood, setting the agenda, reviewing the homework, dealing with that week's topic and setting homework assignments (Hollon & Shaw, 1979).

The efficacy of CBGT for depression has been established in papers such as Free et al. (1991) where depression scores, as measured by the BDI and the Zung Self-rating Scale for depression, decreased markedly over the course of therapy. Their groups ran for 2 hours over a course of 12 weeks with 2–8 patients in each group. However, as there was no comparison group in this study, it is not legitimate to conclude that the improvement would not have occurred without the therapy. Some papers have attempted to compare the efficacy of CBGT with individual CBT or to compare both with some other treatment such as

Table 2. Outcome studies of group cognitive therapy

Study	Population	N	Control group	Treatment	% improved post-treatment	Comments
Rush & Watkins, 1981	Depression	44 (28, 9, 7)	N	CBT, CBGT & CBT+anti-dep.	43.5, 37.5 & 71.4	Numbers small in groups 2 & 3. Not completely randomised.
Shaffer, Shapiro, Sank, & Coghlan, 1981	Depression anxiety & miscellaneous	44	N	CBT, CBGT & IPGT	All improved, no significant difference	Some elements of CBT present in IPGT
Brown & Lewinsohn, 1984	Depression	80	W/L	CBT class one to one telephone	No significant differences between txs	Coping with depression course. Explicitly educational
Covi & Lipman, 1987	Depression	90 (24, 32, 34)	Y	CBGT, CBGT + Imipramine, non-directive GT	51.8 CBGT alone	CBGT & CBGT + Imipramine superior to traditional group therapy
Heimberg et al., 1990	Social phobia	49	Y	CBGT, placebo group therapy	81 47	Educational supportive group psychotherapy developed as control for therapist attention, credibility of treatment, etc.
White & Keenan, 1990	GAD/Panic	30	N	CBGT	Overall improvement	Pilot study for psychoeducational group
Scott & Stradling, 1990	Depression	1)67 (17, 27, 23) 2)36 (23, 13)	1) W/L 2) N	1) CBGT, CBT 2) CBGT, CBT	1) 100, 84, 53 2) 70, 77	CBGT & CBT equally effective with CBGT saving 42% of therapist contact time.
Free, Oei, & Sanders, 1991	Depression	35	N	CGBT	73	Psychoeducational. Follows format of coping with depression

Table 2. Continued

Author(s)	OCD	N	CBGT	17	Treatment
Enright, 1991		24	CBGT	17	Treatment very non-specific. More behavioural than cognitive. Outcome more a general enhancement of mood.
Evans, Holt, & Oei, 1991	Agoraphobics	97 (74, 23)	CBGT (2 day workshop)	85	Psychoeducational. Lectures, group discussions, exposure
White, Keenan, & Brooks, 1992	GAD	110	CT, BT, CBT, SCR	6m - 63-66 2yr - 60-83	Psychoeducational. Highly significant change on all measures. No significant change between 4 conditions post-therapy.
Heimberg, Salzman, Holt, & Blendell, 1993	Social phobia	49	CBGT		Only a portion of original sample followed up at 5 years (19 out of 40 who completed)
Wilfley et al., 1993	Bulimia	56 (18, 18, 20)	CBGT, IPGT, W/L	64 64 11	
Scholing & Emmelkamp, 1993, 1996	Social phobia	73	CBT, CBGT Exp. in vivo, CBT + Exp. CBT->Exp.	Improvement on all modalities, no sig. difference	Exposure group most improved, combined groups benefited least, but numbers small (only 5 in exposure group) and some had had further CT. Follow-up ratings still significantly higher than normal.

Table 2. Continued

Telch et al., 1993	Panic	67 (34, 33)	W/L	CBGT	85 (0 controls)	Panic inoculation training			
Hope, Heimberg, & Bruch, 1995	Social phobia	40	Y & W/L	CBGT, Exp.	37.5	High drop-out for CBGT			
Palmer, Williams, & Adams, 1995	Bi-polar disorder			CBGT	62.5	Only 4 completed			
Eldredge et al., 1997	Binge eating disorders	46	W/L	CBGT 12 weeks CBGT 12 wk + (24)	Results very mixed 50 66.7				
Kuehner, Angermeyer, & Veiel, 1996	Depression	32	Y	Coping with depression course	56.2 (37 controls)	Non-randomized but matched pairs design. Mainly effective in preventing short-term relapse in 6-month treatment period.			
Oei, Llamas, & Evans, 1997; White, 1998	Panic disorder + or - agoraphobia	106	N	Brief intensive CBGT (BIGCBT)	Significant improvement ($p > .001$) for all groups with and without medication	Psychoeducational 3-day workshop format. No control group. No random allocation.			
Gledhill, Lobban, & Sellwood, 1998	Schizophrenia	5	N	CBGT	All improved on depression & self-esteem	Number very small			
Brown, Cochrane, Mack, Leung, & Hancox, 1998	Anxiety	124 (36, 36, 52)	W/L	CBT educational workshop	Both large massed group and small spaced groups improved equally	Results suggest that large-scale workshops can be as effective as the more usual spaced groups.			
Heimberg et al., 1998	Social anxiety	133	Y	CBGT PZ placebo, ES	75 77 41 35	Both associated with high rate of response at 12 weeks. Phenelzine was superior to CBGT on several measures.			

Table 2. Continued

Leibowitz et al., 1999	Social anxiety	41 maintenance 21 Tx-free f-up	NA	CBGT PZ	Relapse rates same for both Trend for greater relapse with PZ Post-Tx 44 12 mth 64	One-year follow-up of previous study.
Salaberria & Echeburua, 1998	Social anxiety	71	W/L	CBGT Exp	No difference between groups. Self-help manual also used for half of each group but did not add anything to result of treatment.	
Chadwick, Sambrooke, Rasch, & Davies, 2000	Auditory hallucinations	22	N	CBGT	63% showed improvement in target beliefs	Main target was weakening of beliefs in omnipotence and control.

Abbreviations: CBT – cognitive behaviour therapy; CBGT – cognitive-behavioural group therapy; IPGT – interpersonal group therapy; W/L – waiting list; GT – group therapy; CT – cognitive therapy; BT – behaviour therapy; SCR – subconscious retraining; Exp. – exposure; ES – educational-supportive group therapy.

pharmacotherapy, interpersonal group therapy or a credible placebo therapy (see Table 2). Rush and Watkins' pilot study (1981) suggested that individual CT leads to greater improvement than GCT. However, this was not borne out by two subsequent studies (Shaffer et al., 1981; Brown & Lewinsohn, 1984) and it is possible that their results were affected by the small size of their sample. Strict randomization was not feasible and follow-up data were incomplete.

The Sank and Shaffer Coping Skills Group accepted patients with symptoms of depression, of anxiety, problems with assertiveness and "problems in living" (to do with work, finance or relationships). There was perhaps a stronger behavioural component in these groups than most CBT groups in that they contained a relaxation module and an assertiveness module in which the emphasis is more on supplying deficient skills than on cognitive restructuring. These groups formed the basis of a study comparing group versus individual CBT, and comparing both of these to an interpersonal group therapy approach (Shaffer et al., 1981). This study supported the hypothesis that CBT in a group format was as effective as individual CBT for the symptom clusters mentioned (depression and anxiety). Outcome was measured by the Beck Depression Inventory, the Spielberger State and Trait Anxiety Inventory, and the Adult Self-expression Scale (Gay, Hollandsworth, & Galsssi, 1975). One-way analyses of variance were calculated for the first and second assessments of each dependent measure by treatment (CBGT, IGT, and individual CBT) and no significant differences were found. Repeated measures analyses were carried out on all self-report measures. All treatments resulted in a significant reduction in depression, state and trait anxiety, and an increase in assertiveness by the end of treatment. Pre- and post-treatment results were most effective for depression but there was no significant difference found between CBGT, IPGT (interpersonal group psychotherapy) and ICBT (individual cognitive therapy). The writers felt that this may be due to common elements in the therapies confounding the results. It was suggested that perhaps there would have been more significant differences if a more homogeneous patient sample with more pronounced symptoms had been used, as it was felt that the sample used may not have provided sufficient potential range for improvement. Also numbers were small: in CBGT, $N=10$; in IPGT, $N=13$; in ICBT, $N=12$. Brown and Lewinsohn (1984) found no difference between individual and group formats. Covi and Lipman (1987) found that both GCT and GCT plus Imipramine were more effective than traditional non-directive group therapy for depressed adults, which supports the cognitive approach in groups but sheds no further light on whether individual therapy might have been even more effective. More recent studies by Scott and Stradling (1990) compared group and individual cognitive therapy for depression in both a population referred by an inner-city general practice health centre and one referred by the occupational health services of large employers. Small group cognitive therapy was as effective as individual and treatment gains were demonstrated at 6 months. It is worthwhile noting that a high initial level of patient contact was provided by three individual sessions of therapy at the start of treatment, enabling a certain amount of idiosyncratic tailoring of treatment to be carried out. Nevertheless, it was calculated that for the average group size of six patients, there was a saving of 42% of therapist time, and for eight patients that figure would be 50%, so their conclusion was that delivery in group mode was more efficient. It would appear from these results that, for this population, group cognitive therapy is as effective as individual.

Bipolar depression

There are several reports published on groups for bi-polar depression, but only one that describes a CT group. Palmer, Williams and Adams (1995) tried a 17 session group plus six follow-ups at monthly intervals for patients with bi-polar depression. Treatment was aimed at increasing awareness of onset of symptoms (for both low and high mood), increasing skills and strategies for dealing with both low and high mood, and a reduction in symptomatology. Content of sessions included an overview of the cognitive models of depression and of mania; identification and challenging of negative automatic thoughts and dysfunctional beliefs; vulnerability factors; Circadian rhythm disorganization; and strategies for the manic phase. However, only four patients completed this trial and results for them were very mixed, so it is not possible to draw any conclusions from these results. Patient feedback identified benefits from the group format as being able to talk about experiences, including hallucinations and delusions, with fellow sufferers because they were seen as not likely to be rejecting. It was noticed that attempts to help by carers were resisted as threats to autonomy, but if a group member pointed out the effects of hypo-manic behaviour, it was accepted.

Social anxiety and social phobia

One of the main sources of group studies in this area is the social phobia protocol developed by Heimberg et al. (Heimberg 1989; Heimberg et al., 1990; Hope & Heimberg, 1993; Heimberg et al., 1993; Hope, Heimberg, & Bruch, 1995). The program consists of 12 weekly sessions given by two therapists and is comprised of several components:

- Development of a cognitive behavioural explanation of social phobia.
- Training of patients in the skills of identifying, analysing and challenging problem cognitions.
- Exposure of patients to simulations of anxiety-provoking situations during treatment groups.
- Use of cognitive restructuring procedures to teach patients to control their maladaptive thinking before, during and after simulated exposures.
- Homework assignments for actual exposure to situations already confronted during exposure simulation.
- Teaching a self-administered cognitive restructuring routine for use before and after completion of behavioural assignments.

Social phobics, almost by definition, find it difficult to discuss their fears with anyone and consequently believe that their problems are unique. The group provides a useful opportunity for members to discover that others have similar thoughts and problems. The main difference between these and groups for depression lies in the exposure element (which calls for considerable courage on the part of the participants). Otherwise, similar procedures to those in other CBT groups are followed.

Many outcome studies have been carried out in this field. In the Heimberg et al. studies (1990 and 1993) outcomes for CBGT for social phobia were assessed. In the first study, 49 patients participated in a study where CBGT was compared with a credible placebo control (lecture-discussion and group support). At both post-test and follow-up, CBGT patients

were rated as more improved than controls and reported less anxiety before and during the behavioural test. These same patients were re-contacted approximately 5 years later, and were again assessed. Patients who had received CBGT remained more improved than patients who had the alternative treatment. However, due to the long follow-up time, only about half of the original sample (19 out of 40) could be assessed, so there have to be some reservations about these results.

A more recent paper (Hope, Herbert, & White, 1995) found that both generalized social phobia (patients have fears in all major situational domains) and non-generalized social phobia (having fears in multiple domains but having at least one unaffected domain) responded positively to group social intervention. Generalized social phobics were more impaired prior to treatment and they continued to be more impaired after treatment on some measures. It was concluded that it was ‘‘likely that the broader range of feared situations may require a longer or more intensive course of cognitive therapy’’. However, an equally valid hypothesis might be that those people might respond better to individual cognitive therapy. In an effort to separate out which were the most effective components of their CBGT social phobia package and to find out if cognitive restructuring was necessary to good outcome, this study compared CBGT to an exposure-based treatment without formal cognitive restructuring and to a wait-list control (Hope et al., 1995). Subjects in the active treatment conditions improved and those in the wait-list condition did not. Results suggested that subjects in the exposure alone condition (EAs) showed more broad-based change on the social phobia measures. At 6-month follow-up, all differences had disappeared and both treatment groups were improved. However, both cognitive theory and previous studies would have predicted superiority of cognitive restructuring over exposure alone. For example, Heimberg et al. (1990) reported an 81% response to treatment for CBGT subjects, whereas in this trial the rate is only 36%. Possible explanations suggested to account for this result are that numbers were very small (e.g., in the cognitive group $N=13$) and the CBGT group had been affected more than the other by dropout due to factors unrelated to the therapy, thereby disturbing group cohesion. They argue that, in spite of the poor response to CBGT in this study, it would be premature to conclude that the cognitive component of treatment is unnecessary and that it is possible that some cognitive change may have occurred in the non-cognitive condition, due to successful experience allowing more functional information processing. It is not possible, on the basis of the small numbers involved in this study, to draw any conclusions about the relative efficacy of cognitive versus exposure based treatment. More recently, further studies from this group (Heimberg et al., 1998; Liebowitz et al., 1999) have compared pharmacological and cognitive-behavioural treatments for social phobia. They compared CBGT, phenelzine therapy (PZ), placebo administration and educational-supportive group therapy (ES), an attention-placebo procedure. CBGT consisted of 12 sessions of 2½ hours each in groups of 5 to 6 patients. ES, in the first half of the session, consisted of topics relevant to social phobia (e.g., fear of negative evaluation, conversation skills) and in the second half supportive group therapy. Both phenelzine and cognitive therapy seemed to be effective in treating social phobia. Seventy-seven percent of patients receiving PZ and 75% of patients undergoing CBGT who completed treatment were classed as responders. Rates of response were different in that 52% of those taking PZ but only 28% of those undergoing CBGT were classed as responders after 6 weeks, but by 12 weeks this had evened out. Subsequently, responders were allocated to a maintenance phase for 6 months, followed by a treatment-free phase for another 6

months. PZ patients entered the maintenance phase more improved than their CBGT counterparts, but then PZ patients showed a trend towards greater relapse during treatment-free follow-up. They concluded that their findings of greater symptom reduction with PZ but greater long-term retention with CBGT suggests that a combination of the two might be a helpful way of tackling this problem.

Another investigation of the effectiveness of CBGT for social phobia (Scholing & Emmelkamp, 1993, 1996) employed a more long-term follow-up (18 months) and compared both group and individual therapy, while also comparing exposure *in vivo*, cognitive therapy followed by exposure *in vivo*, and a CBT in which both strategies were integrated from the beginning. Results from patients who completed the long-term follow-up showed that all ($N=50$) demonstrated significant lasting improvement compared with the pre-test. The most effective was exposure *in vivo* in group with the least effective being the integrated group treatment. The individual treatment conditions came somewhere in between. All conditions showed improvement by post-test and no significant changes were observed later on. However, the exposure group yielded the most effective results. The authors mention that those patients who were significantly more depressed formed the bulk of the non-participants (i.e., refused any further cooperation) and drop-outs, and therefore concluded that the results were more representative of social phobics without comorbid conditions. It is difficult to attach much importance to these results because of the small number involved. For example, although the exposure group yielded the best results, the size of this group was only five patients, three of whom had received further treatment between both follow-ups. The treatment that was received by those who felt a need for further treatment was cognitive in nature. Therefore it seems impossible to continue to view this group at follow-up as representative of solely exposure based treatment. Taking the study as a whole, the mean follow-up ratings on a social phobia scale were still significantly higher than normal. This would agree with the Feske and Chambless (1995) comment that more powerful strategies are needed to achieve higher rates of clinically meaningful improvement for social phobia. A more recent study with this client group, but with a larger sample ($N=71$), also compared exposure alone, CBGT plus exposure, and a waiting-list control group (Salaberria & Echeburua, 1998). Most patients treated showed improvement (64%) but there were no differences between the two therapeutic conditions. Therefore the authors conclude that adding cognitive therapy to exposure does not result in an increased therapeutic effect. On the other hand, as suggested before, an alternative hypothesis might be that more idiosyncratic interventions are necessary, which would be more easily attained in individual therapy. The ongoing Oxford study (Wells et al., 1995) provides treatment on an individual basis. Idiosyncratic beliefs and safety behaviours are identified and targeted, helped by use of video and third-party feedback. Preliminary results are encouraging and may prove to be more effective in both level of improvement and in relapse prevention.

Panic disorder

An early study (Telch et al., 1993) compared cognitive group treatment ($N=34$) with a delayed treatment control group ($N=33$). Treatment was delivered in small groups ranging from four to six patients per group. Subjects received 12 treatment sessions of 90 minutes over an 8-week period. Treatment consisted of (a) education and corrective information, (b) cognitive therapy, (c) training in diaphragmatic breathing, (d) interoceptive exposure.

Treatment followed the cognitive model of panic (Clark, 1986), although the current version of this model would not recommend training in diaphragmatic breathing, viewing it now as yet another safety behaviour. Post-treatment at 9 weeks, 85.3% were panic-free compared to 30.3% of delayed treatment controls. Taking more stringent criteria of recovery (i.e., had to be showing normal functioning on all three measures of panic attacks, anxiety and avoidance), 63.6% of these patients who had group treatment were judged as panic-free against 9.1% of the control group. At 6-month follow-up, the figures for the group patients who were panic-free were only marginally less (83.3%). These figures appear to be comparable to those obtained in studies of individual therapy. For example, in a study comparing individual CBT for panic disorder with applied relaxation, Imipramine and a wait-list condition (Clark et al., 1994), 86% in the CBT condition were judged panic-free at post-treatment compared to 48% who had applied relaxation, 52% on Imipramine and 7% on the waiting-list. At one-year follow-up, the percentage of patients panic-free were 76%, 43%, and 48% respectively. An earlier study by Beck, Sokol, Clark, Berchick and Wright (1992) comparing individual cognitive therapy (CT) with supportive therapy (ST) found 94% of the CT group to be panic-free post-treatment and 25% of the ST patients. A recent study by Arntz and van den Hout (1996) comparing individual cognitive therapy with individual applied relaxation (AR) and wait-list found 78% of the CT group were panic-free post-treatment compared to 47% of the AR group and 28% of the wait-list group. It seems that for this client population, group cognitive therapy results are comparable to those of individual therapy, but there is a need for further studies of panic groups to determine whether this is consistently upheld.

Obsessive-compulsive disorder

So far, only two group studies that could be considered cognitive-behavioural have been published (Enright, 1991; Whittal, McLean, Taylor, Sochting, & Anderson, 1997). Although a few behavioural studies have included some cognitive work (e.g., Krone et al., 1991), this would not be sufficient to be regarded as a cognitive-behavioural group. The content of the group as described contains no attempt to identify and/or modify the patients' beliefs or negative appraisals about having the intrusive thoughts or having to carry out the rituals. In the Enright study, the author does not at any point state what theoretical approach is taken by the programme, although he does say that "none of the clients had received any previous cognitive-behavioural input to their problems", which would suggest that is what they would be receiving in this programme. However, the content of the sessions seems more eclectic than cognitive (e.g., presentation and discussion of theories of obsessive-compulsive disorder, including biomedical, psychoanalytical, behavioural and mood state) and very general (assertiveness, stress management and progressive relaxation). The programme consisted of nine treatment sessions conducted weekly for an hour-and-a-half. As only one of these sessions could be considered to be cognitive therapy, and in the absence of any continuing "thread" of CBT throughout these sessions, this cannot be taken to be a representative example of a CBT group for OCD. Results were very non-specific. Patients reported an increase of hope, understanding and control, enhanced mood and a reduction of the disabling effects of the symptoms, but there was no direct reduction of the symptoms themselves. A second study (Whittal et al., 1997) used a group format to compare the efficacy of cognitive therapy with standard behaviour therapy. The content of this group was much more cognit-

ive, including education about the cognitive model, thought monitoring, general cognitive errors as well as specific obsessional appraisals, in session behavioural experiments, identification and modification of obsessional beliefs leading to the appraisals and homework directed at behavioural and belief change (including exposure and response prevention). At post-treatment the behavioural group was doing better than the cognitive on the YBOCS obsessional and total scores but not on compulsions. Since traditionally behavioural treatment has not made much impact on obsessions in comparison to compulsions, this result is contrary to expectations. This may highlight difficulty in delivering CBT in a group format relative to exposure and response prevention. Individual cognitive therapy for OCD on the other hand (van Oppen et al., 1995; Ladouceur, Leger, Rheaume, & Dube, 1996) has shown a statistically significant decrease in symptomatology, e.g., 50% recovered and 75% significant change as rated on the Y-YBOCS (van Oppen et al., 1995). There is a need for more studies comparing individual and group CBT for OCD, but the evidence so far would suggest that individual CBT may be a more effective medium for change in the treatment of OCD.

Variations on the theme

The coping skills group

This was devised by Sank and Shaffer (1984). As already mentioned, this differed from the majority of CBGT in that almost 50% of the input appeared to be skills training (relaxation, assertiveness, etc.). Another variation on the standard group for depression was the approach taken by O'Hara and Rehm (1983), self-control group therapy for depression. This was based on a more general model of self-regulation proposed by Kanfer and Karoly (1972) which suggests that certain behaviours are maintained by three interconnected cognitive behavioural processes (self-monitoring, self-evaluation, and self-reinforcement) operating in a closed loop feedback system. They include a 10-session manual chapter that presents the following program: self-monitoring; mood and events; immediate versus delayed consequences; attribution of causality; goal setting; overt self-reinforcement; covert self-reinforcement; review and consolidation. Although this approach is rather more behavioural, it seems to have been very effective for the participants.

Cognitive milieu

The logical extension of CBGT is the cognitive milieu described by Wright, Thase, Ludgate and Beck (1993). They do not suggest a program of "cognitive therapy only", but suggest incorporating other useful therapeutic methods such as biological psychiatry. However, they do think that cognitive therapy principles can serve as the major operational constructs for an inpatient unit. Suggestions are made for promoting the growth of the milieu such as re-aligning standard activities (unit-community meetings and psychoeducational sessions) to support the cognitive therapy perspective. Treatment planning offers another opportunity for this. They conclude that a cognitive therapy orientation appears to offer a pragmatic solution to the problem of providing an effective psychotherapy in a short period of time.

Large group didactic therapy

Another method of delivering cognitive-behavioural therapy in group format is large group didactic therapy, such as the work of White and colleagues (White & Keenan, 1990; White, Keenan, & Brooks, 1992; White, Brooks, & Keenan, 1995; White, 1998) with generalized anxiety disorder (GAD) patients. This was developed as a pragmatic approach to coping with the large number of GAD patients referred to a clinical primary care service and took the form of an educational/self-help package, delivered rather like an evening class in 6 two-hour evening sessions. Groups were of 20–24 members. Five treatment groups were compared: cognitive therapy, behaviour therapy, cognitive-behaviour therapy, subconscious retraining (a placebo treatment) and waiting list. Booklets were available for each patient in each condition. This cannot be regarded as true cognitive therapy as it disregards the idiosyncratic nature of CT and patients were actually instructed not to discuss their individual problems. Nevertheless, it could be a very cost-effective way of delivering therapy and results have been encouraging. In the Stress Control 6-week course, there were reductions on all measures across the four treatment groups. By 6-month and 2-year follow-up (White et al., 1992, White, 1998) significant change criteria had been met by 53%–66% and 60%–83% across the four groups. There was no significant difference between the four treatment categories but it was interesting that there was a trend for better results in the CT option (66% and 66% than in the combined option of CBT (53% and 60%). White suggests that these results may be accounted for by non-specific factors e.g., offering the patient a personally relevant, easily understood way of why they feel the way they do and offering a therapy consistent with this. This is supported by the fact that even the placebo treatment was as effective as the others. While it would be desirable to have further research on this to identify the active ingredients, it appears to be a good compromise between pressures to provide a quality service and to treat a large number of people quickly.

Brief intensive group cognitive therapy

Although traditionally group anxiety management training has taken place in weekly sessions, some have combined the large-scale psychoeducational format of the White groups with a workshop format. Larger-scale interventions have aroused interest as a possible way to meet the need for mental health services in those who are not referred on by GPs, either because the individual has been unwilling to consult their GP in the first place or because their GP has not recognized the problem as a mental health one. One such study (Evans, Holt, & Oei, 1991) consisted of a 2-day workshop format using a psycho-educational model, similar to the above, aimed at encouraging independence and self-reliance in agoraphobic patients. This involved lectures about anxiety disorders, drugs useful in their treatment and principles of learning theory, behaviour therapy and cognitive therapy; skill acquisition mainly in the form of anxiety control techniques; *in vivo* exposure; group discussion about the experiences during the *in vivo* sessions. This approach also loses the idiosyncratic focus of cognitive therapy, but could be another cost-effective method of treatment. Results at 5-year follow-up (Oei, Llamas, & Evans, 1997) indicate that 83% of the participants met criteria for being recovered or significantly improved. A product of the work of this group has been a treatment manual for group cognitive therapy (Free, 1999) which, rather than following the brief intensive therapy format, describes a more traditional 12 session psycho-

educational program aimed at participants suffering from emotional disorders, including depression, anxiety disorders and excessive anger. A more recent study (Brown, Cochrane, Mack, Leung, & Hancox, 1998) compared the results from large-scale full-day workshops with results from more traditional weekly anxiety management groups. The workshop group was referred to as the LMS group (large, massed and self-referred), the weekly group as the SSR group (small, spaced and referred), and there was also a waiting-list self-referred group (WLS) as a control. The stress workshop programme ran over one day from 9.30 a.m. to 5.00 p.m., had 20–24 participants in each group, was held in a leisure centre and run by a team of four psychologists. Both groups completed evaluation forms after 3 months and both groups had improved equally. This result held even when a more distressed sub-group had been separated out by identifying those with higher Spielberger State scores that were comparable with those in the referred group. This suggests that large-scale psychoeducational groups can be as effective as the more traditional spaced groups. On a practical level, they are likely to reach more people as there is less need for special arrangements (time off work, childcare, etc.) and as this format avoids the perceived stigma of association with mental health services.

Cost effectiveness

From the results shown in the last two examples, these approaches would appear to be highly cost-effective. It may be that level of improvement is not as high as that obtained by individual therapy or by more traditional group CBT, but in terms of providing some degree of improvement and return to a reasonable level of functioning for a large number of people, it would be hard to ignore what these approaches can offer to hard-pressed psychology departments, CMHTs or primary care centres. Looking at cost-effectiveness in a more explicit way, Antonuccio, Thomas and Danton (1997) have used outcome studies as a basis for a cost-effectiveness comparison of drugs and cognitive behaviour therapy in the treatment of unipolar depression. Results showed that, over a 2-year period, fluoxetine alone could result in 33% higher expected costs than individual CBT treatment, and the combined treatment (medication plus CBT) could result in 23% higher costs than CBT alone. Supplemental analysis showed that group CBT may only result in a 2% saving as compared to individual therapy. (Costs were quantified by taking into account not only health care costs but also lost wages from time off, lost productivity, etc.) They suggest that this is due to the fact that as group therapy is usually a 2-hour session and individual therapy one hour, this results in more time off work, more lost wages and “more direct cost to the community”. Obviously running evening groups would overcome these points, providing there is access to premises for out-of-hours work. A possible obstacle to that is the fact that many potential sites such as primary care centres and community team bases are not insured for after hours work. In contradiction to these conclusions, a meta-analysis by Gould, Buckminster, Pollack, Otto and Yap (1997) also calculated the cost-effectiveness of individual and group CBT and pharmacological treatment for social phobia. Results indicated that CBGT was the least costly intervention. This meta-analysis did not attempt to work out the more hidden costs (such as lost wages, lost productivity) that Antonuccio, Thomas and Danton (1997) included, but did consider that individual CBT requires more therapy visits, more transportation costs, more time spent on homework assignments and more interference with daily activities. Considering this meta-analysis in conjunction with the estimate made by Scott and Stradling

(1990) that there is a saving of 42% of therapist time in group work, there is support for the cost-effectiveness of CBGT, but the less obvious factors such as the need for more preparation time on the part of the therapist(s) and those listed by Antonuccio et al. cannot be ignored.

Discussion

One problem in drawing conclusions about results in these studies comparing two active treatments and a control group is the relatively small numbers in each cell (e.g., Scholing & Emmelkamp, 1993, 1996). However, the numbers required to achieve greater statistical power would necessitate much larger amounts of time and money than are likely to be available. In general, outcome studies support the efficacy of CT delivered in a group and for the most part do not suggest a particular advantage for either individual or group CBT (See Table 2). Miller and Berman (1983), in their meta-analysis of 48 studies, concluded that studies involving group therapy revealed about the same efficacy for cognitive behaviour therapy as those involving individual treatment. Studies since 1983 have not altered that finding, although some of the disorder-specific issues previously mentioned may make group or individual treatment more or less appropriate. A meta-analysis by Taylor (1996) of cognitive-behavioural treatments for social phobia combined group and individual therapies (25 group but only 4 individual) as he found that effect size in each did not differ significantly. (Many would have regarded this as contrary to expectation in social phobia because of the benefits of a group format providing a continuous opportunity for experiments to disconfirm the participants' beliefs.) There is some evidence that effectiveness of group CBT is less in more severely impaired patients. Heimberg et al. (1993) found, when carrying out a 5-year follow-up, that there was a high degree of attrition, and the long-term follow-up sample differed from the other patients who had dropped out in several ways, including being less impaired prior to treatment and at 6-month follow-up. They concluded that CBGT had long-term effectiveness for patients who were less severely impaired and that statements about effectiveness of CBGT for more impaired patients would need to await further research. It is possible that this group would benefit by more opportunity to tackle core beliefs, which is obviously more difficult in a group situation. In addition, several studies have suggested that group interventions are less effective for severely depressed patients (Nietzel, Russell, Hemmings, & Gretter, 1987; Vander-Vort & Fuhrman, 1991; Wilson, 1989). So while most studies report good outcomes for cognitive therapy delivered in groups, these studies sound a note of caution. One must consider the possibility that these patients may have shown more improvement in individual CT. Results in the panic trial (Telch et al., 1993) were also favourable though one reported trial does not give sufficient basis for generalization. The benefits for an OCD group are less obvious. Again it is impossible to generalize on the basis of two groups, one of which cannot be considered particularly cognitive. In the Enright (1991) group, patient ratings were highest for non-specific effects so there was no obvious effect on the obsessional symptoms. He suggests that there may be an important pre-treatment role for this sort of group, but it would seem that, unless it could be shown that it actually reduces the time spent on cognitive therapy afterwards, it is not time well spent. The study by Whittal et al. (1997), while raising problems as to why obsessionals benefit more from ERP than CBT, used a more cognitive approach and both groups show improvement in the interim results. There is a need for more studies of this

client population and more strictly focused cognitive interventions. It is also possible that due to the diversity of symptoms in OCD and their extremely idiosyncratic nature, it may be preferable to offer individual therapy to this group.

Conclusion

In general, it would appear for the most part there is little difference in results between group and individual treatment studies. However, depending on the client group, for example patients who are more severely impaired, more depressed or have an obsessive-compulsive illness, it may be that sometimes the advantages of an individual approach to therapy outweighs the advantages of the group condition. On the other hand, clinical effectiveness is not the sole criterion in today's mental health departments. In the present economic climate, both in the NHS and in Managed Care in the U.S., since there is pressure to treat patients effectively but in as short a time as possible, a brief therapy that is economical of therapist's time is going to find favour. It is also possible that some of the benefits are more imagined than real. Given that the groups that appear to be most effective tend to have allocated one or two individual sessions to patients before the group starts, this immediately makes them more labour intensive than those with only group sessions. In addition, given that groups are likely to take more therapist time in preparation, total therapist hours involved may be higher than they would at first appear, which seems to be a factor often overlooked. The exceptions to this are the psycho-educational didactic approaches where no individual sessions are given and large numbers can be included in one group. On consideration of the literature, it would appear that there are two main options for effective delivery of CBT in groups. One is where group members have between one and three individual sessions before joining the group, both socializing them to the cognitive-behavioural model and identifying idiosyncratic areas to target. This method fulfils the traditional ideographic requirement for cognitive therapy but loses some of the benefit of lower cost. The other is large-scale didactic CBT, which would provide the possibility of symptom relief and improvement in functioning for the maximum number of people at the minimum level of cost both financially and in terms of therapist time. Ultimately, the decision whether to treat patients in a group or individually may have to rest with the time available and financial considerations.

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