HANDBOOK OF Cognitive-Behavior Group Therapy with Children and Adolescents

Specific Settings and Presenting Problems

Edited by

Ray W. Christner • Jessica L. Stewart • Arthur Freeman

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My wife, Andrea, and my girls, Alyssa and Sydney, provide me the inspiration and love that guide and make my life so meaningful and rewarding. They are the motivation for everything I do. And to my parents, Ray and Theresa, and to my grandmother, Pauline, to whom I dedicate this book, thank you for believing in me and encouraging my scholarship. Finally, to the children and families who continually inspire me and let me be a part of their life…thank you.

—Ray W. Christner

In dedication to my mother, Sally Stewart, for my sincere and unending appreciation of her sacrifices, generosity, and guidance…without which I, thankfully, can only imagine a life less directed and rewarding. And for the children, families, and adults who have allowed me the honor of sharing in their intimacy and vulnerabilities, and to benefit professionally and personally from their strengths and resilience.

—Jessica L. Stewart

I dedicate this book to my family, who are my supports, and to my colleagues and friends at the Philadelphia College of Osteopathic Medicine, who over the years contributed and collaborated on many new and exciting projects.

—Arthur Freeman

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Part One

GROUP THERAPY ESSENTIALS

Chapter One

An Introduction to Cognitive-Behavior Group Therapy with Youth

Jessica L. Stewart, Ray W. Christner, & Arthur Freeman

Cognitive-behavior therapy (CBT) with youth clients has received considerable attention and support over the past several years for a variety of presenting problems experienced by youth, including depression, anxiety, anger and aggression, eating disorders, and such (Ollendick & King, 2004). With the growing interest in CBT among practitioners, a number of experts in the field have compiled thorough and useful resources for implementing CBT with child and adolescent clients (see Kendall, 2000; Reinecke, Dattilio, & Freeman, 2003). Not only has CBT been applied to a variety of presenting problems experienced by youth, but also there is growing implementation of CBT interventions in a variety of settings in which youth interact. Recently, Mennuti, Freeman, and Christner (2006) offered a resource specifically for addressing child and adolescent issues a school setting.

The focus for a number of the CBT resources for youth clients, however, is mostly on individual psychotherapy or intervention; yet, many professionals in the field are being faced with greater time constraints and increasing numbers of referrals. For this reason, therapists are looking for alternative and time efficient ways to work with youth. Freeman, Pretzer, Fleming, and Simon (2004) suggest that cognitive-behavior group therapy (CBGT) can be a natural alternative, or in some cases, a supplement to individual treatment. To date, there is a growing evidence-base for CBGT, as it has shown positive outcomes with youth for a variety of issues, including anger and aggression (Feindler & Ecton, 1986; Larson & Lochman, 2002), depression (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999), and anxiety (Albano & Barlow, 1996; Flannery-Schroeder & Kendall, 2000; Ginsburg, Silverman, & Kurtines, 1995). Others have contributed excellent practical resources (Dryden & Neenan, 2002; Rose, 1998). Given the opportunities that CBGT offers for clinicians in a number of settings, it is only fitting that a comprehensive resource be available.

Our goal when deciding to develop this handbook was to fill the void for a comprehensive resource that presents not only the theoretical constructs of CBT and group therapy, but also to capture the innovative practices of CBGT with various presenting

problems and in specific settings. As such, we hope this volume offers a complete guide designed to provide professionals working with youth a focused and structured model of group intervention, guided by cognitive-behavior theory, principles, and strategies. Whether experienced in CBT or new to the model, each chapter provides a basic review of the components of CBT relevant to the treatment being discussed and direction on how to apply them effectively in group therapy with youth. However, we encourage readers to also consult the already existing guides that present many of the essential tenets of using CBT with children and adolescents (see Friedberg & McClure, 2002; Reinecke, et al., 2003).

BRIEF HISTORY OF THE GROUP MODALITY

The modern form of group psychotherapy was pioneered by Joseph H. Pratt in the 20th century in the United States (Dreikurs & Corsini, 1954). On July 1, 1905, Pratt used group education to treat groups of patients with tuberculosis. The original intent of this approach was to expedite educating his patients on their condition of pulmonary tuberculosis. He quickly realized, however, the psychological benefits this approach demonstrated with his patients and proceeded to generalize this approach to other medical populations. Pratt later went on to work with psychiatric patients where he began to focus more on the emotional responses to their illnesses and the impact the illness had on the patients' psychological condition. This occurred in the group setting and eventually became one of the staples to Pratt's work in therapy (Pratt, 1945; Blatner, 1988). Although Pratt was most likely unaware at that time, he had created a methodical approach to the use of groups as a treatment modality.

Between 1908 and 1911, not long after Pratt began utilizing group methods, Jacob Moreno implemented the idea of creative drama with children in Vienna. This was among the first group methods implemented that did not focus on the concepts of individual therapy (Dreikurs & Corsini, 1954). Creative drama has become a valuable vehicle for teaching social skills, self expression, and ways of learning to groups of children. Compiling his insights from this process, in 1912 Moreno began the first known self-help group. He gathered together a group of prostitutes in Vienna to discuss their concerns, health issues, and life problems. During this group process, Moreno expected that each woman would become the therapeutic agent for the other women by sharing stories and experiences to which each woman could relate. These groups brought about a sense of community, of self-awareness, and an enhanced ability to solve problems. Moreno later applied the process of group psychotherapy to working with inmates in the prison system, focusing on the interaction between group members with less emphasis on education. In presenting this work at the American Psychiatric Association conference in Philadelphia in 1932, Moreno used the terms "group therapy" and "group psychotherapy" for the first time.

Group Therapy with Children

Alfred Adler was most likely the first psychiatrist to use the group method in an orderly and prescribed way in his child guidance clinics (Dreikurs & Corsini, 1954). In 1921,

Adler and Rudolph Dreikurs engaged in the first family oriented group work which consisted of counseling and case planning for children and their families. Adler's early work, consistent with his social philosophy, consisted of service within the poorer sections of Vienna, focusing on children in schools. He believed that "people are understood best in relation to their social environment" (Sweeney, 1999, p. 427), and therefore established child and family education centers where Adlerians worked with children, their parents in child-rearing groups, and marriage discussion groups. This work carried over to the United States when Dreikurs established these services in Chicago.

In 1934, Slavson initiated a shift from group therapy with adults to group therapy with children. At his child guidance clinic, he worked with groups of children to provide them with a myriad of tools for creativity. As a psychoanalyst, his group work consisted of goals similar to individual therapy that included the resolution of unconscious conflict that was blocking the function and productivity of the children in home and school settings. Slavson had two foci in his work. The first was on the group treatment of children who were judged as disturbed. A second focus was to work with parents of troubled children in what he termed child-focused group treatment of adults. In 1943, Slavson introduced the idea of activity group therapy (AGT) for children in *The Introduction to Group Therapy* (1943), and addressed the importance of understanding child development because of the constant change and growth. He believed that it was important to address the differences among age and developmental trends in childhood in play therapy, particularly when using play therapy in a group setting. He believed that children will have the greatest benefit from participating in a group with peers who have skills which fall within their own realm of understanding and by being challenged in a way that will allow a child to be successful. Other early group work with children includes Lauretta Bender's use of play therapy groups for emotionally disturbed children at Bellevue hospital (Bender, 1937, Blatner, 1988).

"Certain problems, especially involving social skills, empathy, and interaction problems are best dealt with in a group setting. Groups are also used to facilitate discussion, to provide support, to normalize disorders, and to motivate otherwise disinterested children" (Kronenberger & Meyer, 2001, p. 34). By putting children together in a group they can see that their behaviors, feelings, thoughts, and families, are not strange or "weird." It also allows children to see the impact of their behavior on other children. Whether or not this will add to their insight, help them change what they do, or effect a change on their out-of-group behavior is unclear. Yet, it is the contention of an ever-growing body of literature, and the authors and editors of this volume, that such a process is a viable and effective option for improving the service delivery of psychological services to children and adolescents.

BENEFITS AND CAUTIONS OF COGNITIVE-BEHAVIOR GROUP THERAPY

Group treatments can have a number of distinct advantages for clinicians, as well as clients. However, clinicians must use their judgment in determining the appropriateness of group intervention for particular clients, as it is not always the treatment of choice. We offer several thoughts for clinicians to consider when deciding to provide CBGT services. Some of these highlight the inherent benefits, while others draw attention to particular cautions.

Convenience

A primary benefit of the group modality is simply the capability to reach a large number of children and adolescents at one time. For some professionals, this has become a primary modality as a matter of necessity, based on healthcare limitations and restrictions on resources, rather than a desire to work with groups of clients. Yet for other clinicians, group interventions afford them the ability to deliver therapy to multiple clients within a limited timeframe, thus maximizing efficiency while not compromising effectiveness. While this is convenient from time, space, staffing, and financial standpoints, groups also (and more importantly) allow clinicians to begin seeing clients sooner to prevent the increase in difficulties or the decline in coping that may arise during a long wait period (Freeman et al., 2004). This issue of convenience can also have some disadvantages, as well. For instance, although clinicians may be able to see individuals in group sooner, it also means that there will be less time devoted to each individual client.

Ongoing Assessment

Many child and adolescent patients who present for therapy do so because of difficulties interacting with others. This may manifest for some through social anxiety, while for others may relate to being disrupting or disturbing, as is the case with children with anger problems or difficulty with behavioral inhibition. In individual therapy, it is difficult to see patients demonstrate skills with others and more challenging to facilitate the generalization of skills outside of the therapeutic setting. Goldstein and Goldstein (1998) suggest that interventions must occur in a setting in close proximity to where the problem occurs. In this case, a group format offers an ideal way for clinicians to directly observe participants' emotional and behavioral reactions and interactions with peers. This affords valuable information regarding members' repertoire of interpersonal responses and skills (e.g., decision making, coping, problem solving, communication), as well as their abilities to implement them successfully. Clinicians can use this information to refine their ongoing conceptualization of the client, as well as to monitor his or her progress. For children or adolescents with social problems, monitoring can occur with specific skills (e.g., listening to others when they are talking, making eye contact) by establishing a baseline during the initial one or two group sessions and then collecting data on the skills through observations. This information can be tracked and compared to baseline data over the course of the group treatment.

Psychoeducation

Groups also provide an increased emphasis on psychoeducation, which facilitates *skills acquisition.* This is a primary premise to providing psychotherapy to children and adolescents—that is, educating them about specific skills they can apply to their daily life in order to deal with their presenting problem. It is implausible to expect children and adolescents to apply skills that they have not yet mastered, or in some case have not yet learned. Thus, group interventions often begin by simple teaching of the skills necessary to remediate deficits or just to refine their existing skills for effectiveness.

In addition to building skills, it is important when conducting CBGT to orient the children or adolescents to the CBT model (described in further detail below)—teaching them to recognize that a relationship exists between situations, beliefs, emotions, and behaviors. Subsequently, sessions will involve exercises used to modify their thoughts and acquire skills. We suggest that when socializing children and adolescents to the cognitive-behavioral connections, it is best to begin by using generic situations, different from their own, albeit situations they understand. For instance, with younger children we use stick figure drawings of common situations, such as a child holding a present, playing with a dog or cat, or swinging on a swing, with an empty thought bubble to demonstrate how changing thoughts may change feelings and behaviors. Friedberg and McClure (2002) explain a similar procedure in their book, *Clinical Practice of Cognitive Therapy with Children and Adolescents: The Nuts and Bolts*. For adolescents, while the pictures can be used, we often use a diagram demonstrating the interaction and select common scenes for the adolescents to discuss (e.g., talking on the phone, shopping at the mall, playing a sport). Figure 1.1 is an illustration of the diagram used.

Another area in which psychoeducation is useful is to expose the clients to facts and basic information regarding their diagnosis, symptoms, or experiences that have led to inclusion in group therapy. Many group programs include the presentation of written materials or working folders or notebooks at the start of group for the development of skills in an orderly sequence.

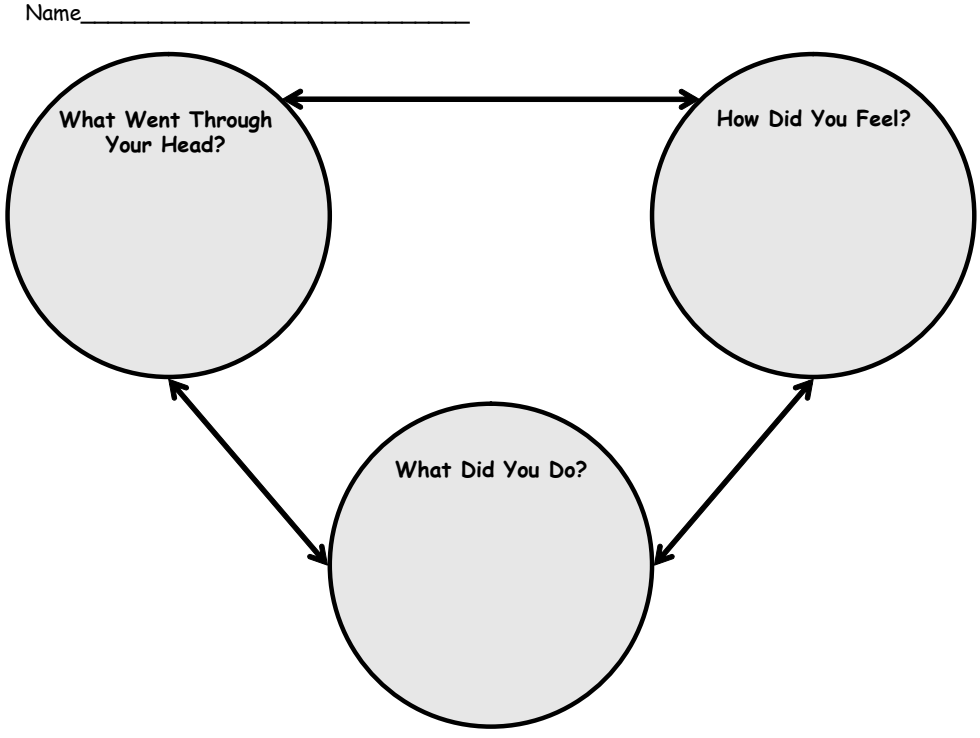

Figure 1.1 Thought-Feeling-Behavior Connection. (© 2004 R. W. Christner. This form can be copied for clinical use. All other situations, please contact the author.)

Social Comparison and Support

According to Festinger's (1954) social comparison theory, change is internally motivated and occurs more readily when relevant others are available for social comparison, particularly in the presence of an ambiguous situation. The situations that typically produce the emotional and behavioral disturbances for young people are oftentimes new and ambiguous to them, as they are largely unaware of their mental processes (Reneicke, et al., 2003). Observing and hearing others who are similar to them, in terms of presenting problems or circumstances, affords group members reference points to offer information and increase motivation to adapt to their challenges and difficulties, as well as to help normalize what makes members feel "different" or alone. Yalom (2005) offered that "normalizing behavior" promotes a sense of universality that is one of the most helpful features of group therapy. It is common, especially in working with adolescents, for patients to discount the therapist's ability to understand what they are "going through." However, the group setting makes it less feasible for members to dismiss the observations of others who share similar problems.

In general, this is a significant benefit to group interventions, though for some youth, there can be a negative impact. We recall a 10-year-old boy in group who became very discouraged because he did not see himself as making similar gains as his groupmates, though his progress was commendable on an individual level. For him, this reinforced his thought, "I'm a failure." To overcome this, we recommend setting specific goals for each child and having a target that they should meet for themselves. This requires celebrating the moments that each client achieves the steps leading to his or her goal.

Natural Laboratory

As noted earlier, group therapy settings offer a unique opportunity for clients to interact and practice skills in a safe setting. In essence, the group therapy setting serves as a natural laboratory in which members can "test out" their beliefs, as well as newly acquired strategies and interventions they have learned during the *skill acquisition* phase. This *skill implementation* aspect of group therapy offers an environment for group members to have the opportunity to experiment with new behaviors. This can occur naturally during group interactions or through role-play and practice activities used to prepare them before trying the new skills out in the "real world." While members may practice any number of skills, the group setting is especially beneficial for experimenting with effective coping strategies (e.g., relaxation, feeling identification and tracking, goal setting, problem solving) and interpersonal skills (e.g., appropriate self-disclosure, effective communication and listening skills, developing empathy, conflict management). As participants often model the behaviors of other group members or the therapists, group facilitators must be mindful, however, of the potential for ineffective or dysfunctional thoughts and behaviors to be repeated and strengthened, or acquired by other members. Group therapy requires that therapists have strong management skills to avoid being sidetracked and to be cognizant of negative patterns occurring within the group. One individual can negatively affect the experience for the entire group (Freeman et al., 2004).

Engagement and Motivation

Many children and adolescents presenting for group therapy may have no prior experience with psychological intervention nor desire any. They may not be familiar with the process or their role in effecting change, and, therefore, may be more passive than active if left without guidance on this matter. The group therapy environment encourages members to be active participants in their treatment, as this expectation is modeled by the facilitator and other members. Members are encouraged to participate actively in defining goals, exposing thought patterns and irrational beliefs, practicing skills in group exercises, offering feedback and support to others, and developing homework to continue practicing new skills outside of session (Freeman & Stewart, in press).

BASIC TENETS OF COGNITIVE-BEHAVIOR GROUP THERAPY

Discussing all aspects of the CBT model and its basic components is beyond the scope of this chapter. There are many outstanding texts available that are resources on CBT in general (see J. Beck, 1995; Freeman et al., 2004), as well as on CBT specific to child and adolescent treatment (see Friedberg & McClure, 2002; Reinecke et al., 2003). Readers are referred to those volumes for a more detailed review of CBT. However, before using the resources provided within this handbook, we feel it is important to offer a brief review of the basic goals, structure, and components of CBT, specifically as they relate to group therapy with children and adolescents.

Brief Overview of CBT

The aim of CBT in general is to identify and restructure irrational or distorted beliefs and schema related to the self, others, and the world that produce emotional distress and maladaptive behaviors (Beck, Rush, Shaw, & Emery, 1979; J. Beck, 1995). This same fundamental goal is maintained for each participant when CBT is provided in a group format, though the group modality offers the additional benefits of support, peer modeling, a sense of commonality, and an environment in which to practice the variety of skills acquired. Through CBT and CBGT, each individual is encouraged to be active in the collaborative process of therapy, even when working with young people. However, the therapy process is typically guided by the clinician, which, as noted above, is essential in group therapy to avoid disruption.

CBT is often described in a linear manner, in which situations, thoughts, feelings, and behaviors are connected. For instance, a youngster who is afraid to give a speech in the front of the classroom (situation) begins to think he is going to embarrass himself or throw-up in front of the class (thought), and subsequently, he becomes nervous and afraid (feelings) and refuses to get in front of the class and walks out of the room (behavior). For most situations with children and adolescents, this clear and direct connection is not as simplistic. Instead, these factors likely influence and, at times, exacerbate each other (e.g., the feelings of anxiety make his stomach upset, which in turn, reinforces his thoughts he will throw-up). Thus, clinicians must be aware of the multiple, interacting

factors affecting children and adolescents (Murphy & Christner, 2006). Readers are encouraged to reference the case conceptualization framework developed by Murphy and Christner, specifically designed for therapeutic work with youth clients.

In general, the CBT model postulates that the way a child responds to situations depends on the ways in which he or she interprets those experiences (Friedberg & McClure, 2002), and that these interpretations and responses can have an effect on each other. Distorted thinking will, naturally, result in irrational and unnecessary emotional reactions and exaggerated behavioral responses. These are usually the symptoms that result in referral for psychological intervention and, in this case, inclusion in group psychotherapy. CBT aims to use the therapeutic situation to identify distorted thinking and responding to modify both. The identification of distorted perceptions and beliefs may be direct or indirect, depending on the age and cognitive flexibility of group members (discussed in more detail below). Modification of beliefs can be through various cognitive techniques and means, or through behavioral experiments that result in "evidence" that counters or corrects distorted thinking. Similarly, ineffective emotional and behavioral responding can be modified through behavioral techniques and interventions that aim to build more effective coping and skills. The inherent benefits of the group setting highlighted above facilitate the goals of identifying and restructuring distorted perceptions and beliefs and facilitating the development of more effective skills, making CBGT a natural extension of individual CBT.

There are two primary elements in CBT or CBGT—(1) cognition and (2) behaviors. The CBT literature uses numerous terms to describe the various levels of cognition (e.g., core beliefs, schema, intermediate beliefs, irrational beliefs, automatic thoughts). To simplify these terms for use in working with young people, we suggest using two levels—schema and automatic thoughts. *Schemas* are an individual's basic beliefs or assumptions through which he or she perceives and interprets various events (Freeman et al., 2004; Friedberg & McClure, 2002; Young, 1999). They are shaped by our life's experiences and are often reinforced throughout our development. They are, essentially, the lenses through which people view themselves, others, the world, events, and interactions. Schema are not easy to identify in younger children, and in many cases, their schema are just developing. However, it is much easier to identify *automatic thoughts*, which are the immediate, superficial level of cognition (Beck, 1995; Freeman, et al., 2004).

Automatic thoughts are situation specific and occur spontaneously without cognitive effort (Freeman, et al., 2004; Friedberg & McClure, 2002). These thoughts typically produce immediate emotional or behavioral responses to a particular situation, are usually easy to identify, and provide a basis for the patterns in thinking that identify schemas to target for change. When a child's or adolescent's thinking affects his or her behavior, there are two possible cognitive explanations—*cognitive deficiencies* and *cognitive distortions* (Kendall & MacDonald, 1993). *Cognitive deficiencies* refer to a deficit in a child's or adolescent's cognitive-processing ability (Kendall & MacDonald, 1993). For instance, consider the child who responds impulsively without thinking in social situations, which results in peer conflicts. The second cognitive factor is *cognitive distortions*, which generally refers to errors or inaccuracies in thinking (Freeman, et al., 2004). These errors lead to the child misperceiving or misinterpreting a situation that subsequently alters his or her feelings and behaviors. For example, an adolescent girl is waiting outside of school and her best friend walks past her without saying hello. The girl thinks, "Jenny must be mad at me; she didn't say anything to me," without consider-

ing other more reasonable options, such as, "Jenny must not have seen me waiting for her." Not all cognitive distortions are negative, though individuals tend to alter incoming information to fit their schema.

Several experts in the field have identified a number of cognitive distortions or errors in thinking common to several disorders (J. Beck, 1995; Burns, 1999; Freeman, et al., 2004). These distortions serve to invalidate or modify information that poses a threat to a person's existing schematic framework so that the incoming information is, instead, compatible with what the person already believes (even if that framework is irrational or maladaptive). In Table 1.1, we offer a sample of common cognitive distortions we have seen in our work with children and adolescents in both individual and group settings. Not only may the cognitive distortions of youth clients influence their feelings and behaviors in general, but they may also effect the youth's group participation (e.g., "If I say the wrong thing, the group will make fun of me," "The other kids are going to think my problems are silly.").

The second element to CBT and CBGT is the focus on behaviors. This also can be broken down into two areas—*skills deficits* and *skills application difficulty*. Those children with skills deficits are viewed as not having particular skills, and through

Table 1.1 Common Cognitive Distortions of Children and Adolescents

1. *Dichotomous thinking*—The child views situation in only two categories rather than on a continuum. The world is either black or white with no shades of gray. For example, "I'm either loved or I am hated."
2. *Overgeneralization*—The child sees a current event as being characteristic of life in general, instead of one situation among many. For example, "Because she didn't invite me to the party, I'll never be invited to anyone else's either."
3. *Mind reading*—The child believes he or she knows what others are thinking about him or her without any evidence. For example, "I just know that my mother is disappointed in me."
4. *Emotional reasoning*—The child assumes that his or her feelings or emotional reactions reflect the true situation. For example, "I feel like no one likes me, so no one likes me."
5. *Disqualifying the positive*—The child discounts positive experiences that conflict with his or her negative views. For example, "Doing well on those quizzes was just because the teacher helped me and I got lucky."
6. *Catastrophizing*—The child predicts that future situations will be negative and treats them as intolerable catastrophes. For example, "I'm going to strike out and no one will want me on their team."
7. *Personalization*—The child assumes that he or she is the cause of negative circumstances. For example, "Michelle wouldn't talk to me in the hall today. I must have done something to make her so mad at me."
8. *Should statements*—The child uses should or must to describe how he or she or others are to behave or act. For example, "I must always say yes when my friends ask for my help, because I shouldn't be selfish."
9. *Comparing*—The child compares his or her performance to others. Oftentimes, the comparison is made to higher performing or older children. For example, "I can't read as well as my older sister. She must be smarter than me."
10. *Selective abstraction*—The child focuses attention to one detail (usually negative), and ignores other relevant aspects. For example, "My teacher gave me an unsatisfactory on the last assignment, so this means I must be one of his worst students!"
11. *Labeling*—The child attaches a global label to describe him or herself rather than looking at behaviors and actions. For example, "I'm a loser" rather than "Boy, I had a bad game last night."

skills acquisition exercises will learn new ways to approach situations. The simplest example is what we see in typical social skills groups. *Skills application difficulties*, on the other hand, are seen in children who have acquired the skill and can use it effectively in certain situations (e.g., the child who can use diaphragmatic breathing well in the session), yet they do not apply it to general situations. For children at this level, *skill implementation* exercises are essential for them to make progress.

CONSIDERATIONS FOR THE PROVISIONS OF CBGT WITH YOUTH

In applying CBGT with children and adolescents, professionals must consider several important components to the structure and process of service delivery. Each chapter reviews unique considerations fundamental to the specific setting or presenting problem discussed, though there are a number of common factors within CBGT that cross all settings and problem areas. Each of the considerations discussed are important to the flow and process of therapy, as well as to the general conceptualization of the group.

Therapeutic Relationship

Perhaps the most important tool a child and adolescent therapist can rely on is his or her working relationship with the youth. Those not familiar with cognitive-behavioral approaches often assume CBT or CBGT ignore the "therapeutic relationship," yet this is not accurate. In fact, Beck and his associates (1979) have stressed the importance of active interaction between client and therapist, and the therapeutic alliance or working relationship is a key element to effective CBT and CBGT. A number of experts have asserted that a positive, authentic connection between client and therapist can produce an opportunity for the client to make notable change and to enhance overall outcome (Corey, Corey, Callanan, & Russell, 1992; Mennuti, Christner, & Freeman, 2006).

In his influential work, Bordin (1979) identified the "working alliance" as the most important tool in effecting therapeutic change. He outlined three important components to its effectiveness, including (1) an agreement on goals, (2) an agreement on assigned tasks, and (3) the development of a personal bond. In order for intervention to be successful, clinicians need to attend to these components and monitor them throughout therapy—as one must not assume that just because a positive relationship has developed that it will be maintained. In the group context, the development of bonds relates not only to the relationship between the therapist and each child, but also between each of the group members as well. These dynamics will play an important role in the comfort level of each participant to engage in the process of therapy to the extent that change will be possible and lasting, and that will facilitate group cohesiveness and shared responsibility.

Cohesiveness and Shared Responsibility

Effective CBGT with children and adolescents promotes collaboration between members through goal setting, the establishment of rules for group, agenda setting, feedback and

sharing of ideas, role-playing, and practice exercises. These ongoing opportunities for members to work together for the betterment of each other promotes a cohesiveness, which facilitates each member taking an active role and a personal investment in his or her own success and that of the group and other participants. This investment ideally leads each member to share in the responsibility for the group's maintenance, progression, and successful completion. Facilitators should monitor the degree to which members are actively collaborating and portraying an interest in working together, offering feedback to others, and working to meet group goals, so that challenges to group cohesiveness may be detected and addressed early and directly. Some members may be less willing than others to assume responsibility for their own progress, let alone the growth of the group as a whole. Facilitators must be cognizant of the motivation of these members to actively participate in the change process, which should be evident if the conceptualization of each group member's presentation and the group dynamics as a whole is adjusted for accuracy throughout the group process.

Types of CBGT Groups

One factor that can have a major impact on cohesion and sharing is the type of CBT group. Freeman and colleagues (2004) describe closed and open groups. Closed groups often have a set number of sessions and timeframe, and once they begin, no new members are added to the group. In this case, there is a greater chance for group unity, and the therapist has the opportunity to sequentially process through topics. With open-ended groups, conversely, new members may be added on an ongoing basis. While this may impact group cohesion, it does offer group members an opportunity to practice new skills, and in some cases, teach the new members what they have learned. Open groups are more likely seen in short-term settings, such as on inpatient units or in hospitals.

Another option for group format is a *rotating group*. In rotating groups, therapists design the group based on an 8 to 10 week cycle, and each session serves as a module of treatment. No matter when a new member enters, he or she remains in the group until they complete the full course of sessions. This format is ideal in some settings. For instance, we have used this approach in schools, as an alternative to suspension. Students would be assigned to the group for certain disruptive behaviors (e.g., anger outbursts) and they would be required to attend the full eight week program, which consisted of eight lessons, including relaxation training, understanding and modifying thoughts, social problem solving, self-monitoring, self-instruction, stress management, communication skills, and planning for the future. No matter where the student began the group, they continued until completing all modules.

Setting an Agenda

No matter which group type or format you use, consistent with individual CBT, CBGT relies on the use of session agendas. Freeman and colleagues (2004) note that some alterations will be necessary. The agenda helps structure the group format, though clinicians must be flexible to allow content and process to emerge. It is important to have a basic idea of the agenda for each session, though the session should be established and

Table 1.2 Examples of CBGT Agendas at Different Stages of Therapy

First Session	Middle Sessions	Last Session
Introducing the therapist	Greeting	Greeting
Setting agenda	Setting agenda	Setting agenda
Clarifying group rules	Eliciting feedback from previous session	Eliciting feedback from previous session
Getting to know you activity	Reviewing between session work	Reviewing between session work
Socializing to CBGT	Conducting activities	Developing a maintenance plan
Providing a summary	Obtaining examples from group	Identifying group members' plan for success
Developing between session work	Providing a summary	Providing a summary
Eliciting feedback	Developing between session work	Eliciting feedback
Adjourning	Eliciting feedback	Adjourning
	Adjourning	

implemented in a collaborative manner. Some of the common elements include checking in since the last session, reviewing between session work, discussing specific issues planned for the session, obtaining feedback from the members, setting new between session work, and adjourning. White (2000) suggests an alternative approach of having group members determine the agenda. While setting the agenda collaboratively is recommended, White's alternative approach could be counterproductive with youth clients. Instead, we suggest that therapists using CBGT with children and adolescents should have a relatively standard agenda, but allow the opportunity for the group to discuss and negotiate tasks. In Table 1.2 we offer a suggested agenda format for various stages of group. This is a guideline that therapists can use in planning their sessions.

Goals and Treatment Plans

The CBGT model is solution-focused and time-limited, and also relies on the development of specific goals to direct the implementation of interventions. This remains an important component in all treatment, but perhaps even more so when the modality is group therapy. Goals for group treatment may vary, and for some groups the goals may be established before the children or adolescents arrive. This is especially true for groups that have a specific purpose in mind (e.g., CBGT to reduce social anxiety). However, we believe it important to also maintain some focus on obtaining goals for each individual group member, as it will give them a sense of ownership. In addition, individual goals provide a benchmark for youth clients to try to achieve on an individual basis rather than competing against each other. We often use a metaphor for establishing goals, called *Raise the Bar* (Christner, 2006). We talk to the group members about high bar jumpers, and how they must clear one height before moving on to the next. CBGT is the same in that we look at what "height" you have cleared so far, and then set the next height for you to achieve. While in some cases, individual member goals are identified in the initial interview, in other cases this will be done in a group setting. At these times, it is important to include each member in the establishment of goals, as collaborative goal setting facilitates not only the working relationship but also provides the motivation for members to be personally invested.

Assessment and Group Inclusion

A thorough assessment of group members is crucial to the development and conduction of any group therapy. This assessment may vary based on the setting or presenting problem, and thus, readers are encouraged to review specific chapters in this handbook. Clinicians must consider multiple factors that may influence group composition and make-up (e.g., developmental level, individual experiences, ethnicity and cultural factors), as well as presenting symptoms and their severity, desired goals for treatment, and readiness to engage in the therapeutic process. Assessment should include standardized objective measures, observations (when possible), and a comprehensive interview with potential group members, their families, teachers, etc. The information gathered guides the clinician in formulating a thorough and accurate conceptualization of the presentation, needs, skill deficits, competencies, and strengths of each member through the CBGT framework. Once an individual is determined to be appropriate for group, additional baseline data not included in the initial assessment must be considered for progress monitoring. For instance, the *Beck Depression Inventory—Youth, Second Edition* (BDI-Y; Beck, Beck, & Jolly, 2005) is an excellent tool for assessing and monitoring relevant symptoms in youth with depression.

Interventions

The selection of specific interventions and techniques will depend on the group's focus, setting, and goals, as well as on the individual factors of members (e.g., age, developmental level, availability of supportive resources). Interventions may be more cognitively-based for some, while more behaviorally based for others. We suggest that child and adolescent clinicians determine the mixture of cognitive and behavioral interventions based on the client's age (e.g., younger clients use a higher ratio of behavioral to cognitive interventions) and symptom severity (e.g., more severe behaviors may initially require a greater proportion of behavioral to cognitive strategies to stabilize symptoms). In all cases, we believe that treatment should involve a combination of both. There are a number of resources available on CBT interventions in general (Freeman, et al., 2004), as well as specifically with children and adolescents (Friedberg, Friedberg, & Friedberg, 2001; Friedberg & McClure, 2002; Vernon, 2002). While it is beyond the scope this chapter to offer a full description of all interventions, we list some general strategies we have found useful within our group sessions in Table 1.3. The previous resources mentioned also offer some fun and unique ways of presenting and implementing these interventions to children.

Homework

The inclusion of between-session practice (typically referred to as "homework" in CBT) is a primary component of the CBGT model, given that the emphasis is on skill building, making newly learned skills automatic, generalizing skills across settings, and altering the ways in which group members perceive events within their environments. Essentially, homework attempts to "put in action" the skills discussed and learned in group. Home-

Table 1.3 Specific Interventions for Use in CBGT with Youth

Behavioral
Systematic Desensitization
Exposure
Relaxation Techniques (Progressive Muscle Relaxation, deep breathing)
Social Skills Training
Social Problem Solving
Activity Scheduling
Communication Skills
Cognitive
Self-Monitoring
Self-Instructional Training
Dysfunctional Thought Record
Problem-Solving Skills Training
Thought Stopping
Socratic Dialogue

work is often first practiced within a group session, then planned for practice between sessions, and finally reviewed in the following session. Members work together to learn and practice skills and then support and provide feedback to one another on the success or failure of completion of homework. Homework in CBGT has particular value, as it offers members the chance to learn from one another's experiences.

An important consideration for facilitators, beyond the assignment of meaningful homework, is how to handle the situation when group members fail to follow-through with between-session work. This consideration is one that cannot be underscored enough, as it contributes to the perceptions and beliefs that members have about themselves, others, and the process of therapy. If a particular member is having compliance difficulty, the facilitator must seek to accurately understand his or her difficulty, rather than automatically attributing noncompliance to behavioral difficulties or resistance. Some group members may have difficulty with follow-through because of a lack of support or resources outside of group (e.g., a reliable adult to help facilitate the assigned activities, lack of opportunities to generalize the skills). Others may be experiencing self-doubt, feelings of incompetence, or confusion about the assignment that must be understood as part of the conceptualization of the automatic thoughts and schemas of the individual members at work within the group.

Reasons for missed homework must be accurately and directly ascertained and addressed by facilitators within the group, to prevent the members from perceiving that homework is not important. Also, understanding the reason for noncompliance can be an assessment tool to help determine factors that may hinder or impede an individual client's change. In addition, it can lead the group to help the one member by sharing ideas to overcome particular obstacles. When a therapist does not address issues of completion of between-session work, it may lead to members feeling that the therapist "doesn't care." For example, consider a socially rejected child who is not completing assignments but the therapist does not directly address the issue. The child may perceive, "She really doesn't care that I am a member of the group" or "She doesn't even notice me." These perceptions result from and, worse, reinforce his beliefs that he is worthless, dispensable, and lacks value in the eyes of others.

Social Loafing

Whether related to compliance with homework or in-session exercises, the social psychology concept of social loafing is important to consider within the group modality. Essentially, facilitators must be cognizant of the possibility that when involved in a group, each member may potentially experience the perception that he or she does not need to engage in an activity because other members will and that will be enough to guide the exercise. This concept of social loafing exists given that, by nature of a group, members' individual identity is lessened to the extent that they contribute to the identity of the group as a whole. Therefore, the sense of individual responsibility or contribution is lessened also, as the emphasis typically shifts to the production of the group as a whole. It is important for facilitators to actively address members' perceptions of their accountability to individual growth and goal-attainment, and to the simultaneous contribution of the success of other members. By being cognizant of drawing attention to individual contributions and gains, facilitators help to minimize the likelihood that members will engage in social loafing.

One way we have found to encourage participation from all members is to use the members' real life experiences for group problem-solving, but to do so in a manner that gives all members a chance—even those who may not be that outgoing. We use a technique called *This is My Life* (Christner, 2006) in which all group members are given a 3 × 5 card as they come into the group session and are asked to briefly write down one recent personal situation related to the topic being discussed (e.g., "Write down a situation that made you angry this week."). All of the cards are then placed into a paper bag, randomly selected, and read out loud to the group without identifying the group member. As a group, they begin talking about thoughts, feelings, and behaviors (both positive and negative) related to the chosen situation and work to come up with a positive thought-feeling-behavior connection. This is a form of group problem-solving. Then, the person who wrote the situation identifies him or herself and describes what he or she did in the situation and then evaluates how he or she thinks the group's suggestions would help him or her next time.

Readiness to Change

The idea of readiness to change is not a new concept to psychotherapy, as it has been supported in the literature for a number of years (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992), and has been applied to a number of psychological, psychosocial, and medical issues (see Prochaska, Redding, Harlow, Rossi, & Velicer, 1994). Freeman and Dolan (2001) provided a revision to the original model, including the following 10 stages: (1) Noncontemplation, (2) Anticontemplation, (3) Precontemplation, (4) Contemplation, (5) Action Planning, (6) Action, (7) Prelapse, (8) Lapse, (9) Relapse, and (10) Maintenance. See Freeman and Dolan (2001) for a thorough review of each stage.

Despite literature focusing on these stages, there remains minimal data on the use of this very important model with children and adolescents. The group context presents an additional dynamic, as the stage of change of each member potentially influences the stages of others (both in positive and negative directions). In a positive way, for example,

a member who is just thinking about the need to change but has yet to take action may move more quickly toward the action planning and action phases by observing the successes of other group members. However, we have had cases where the opposite has occurred and members' reluctance to attempt change strategies occurs because of a negative report of another member. It is necessary for the group therapist to be aware of this possible dynamic and use session time to problem-solve less than positive experiences and to encourage further attempts.

Challenging Group Members

When we think of challenging group members, the term *resistant* often comes to mind. Malekoff (2004) noted that *resistance* can be manifested in a number of ways, including denial of the problem, superficial compliance, testing the limits, silence, blaming others, and so forth. However, while on the surface these resistant behaviors appear planned and deliberate, in many cases, these behaviors stem from sources outside of awareness (Yalom, 2005). Although *resistance* is a commonly used word, we feel it is pejorative and blaming of the client. Thus, we prefer to use the term *challenging*. In our experiences, disruptive and challenging behaviors in group may be the result of a number of cognitive errors or distortions.

Take for instance, the group member who needs to be "the center of attention." This is the child who responds to every question, but does so in a manner that is disruptive and often superficial (e.g., "If I look like I know this stuff, I won't get put on the spot."). Sometimes, however, there is another need being met for this child (e.g.,"I need to be noticed, or people will forget about me."). Another common presentation within child and adolescent groups is the *silent challenger*. This is the child who attends every group, but rarely responds, and if he or she does, it is usually, "I don't know." Many of these children have concern regarding social perception in the group (e.g., "I don't want to embarrass myself."). However, in our work, we have seen a number of children and adolescents whose silence was because they did not believe the intervention would work for them. We recall one adolescent in a depression group who, while discussing his silence individually, reported having thoughts of, "I've screwed up so bad, nothing will make it better." By addressing the underlying cognition, we were able to work with him to alter his perception serving as a barrier to his participation and treatment. Finally, there is the *active challenger*. This is the participant who is more actively noncompliant and often disruptive. Again, there are many thoughts that may be contributing to the behavior. We have had some clients who have expressed thoughts like, "If I change I will be vulnerable," or "If I try in group, I'm admitting I have a problem." These are just a few basic examples and we encourage therapists to explore the cognitive factors that may be at the root of challenging behaviors.

In addition, while the individual is often looked at when a client's behavior is challenging, we suggest that therapists also look at other potential factors that may impede change. These can include family factors, systems or setting factors, peer factors, and provider factors (e.g., teachers, nurses, physicians), to name a few. Each of these, as well as other potential influences, should be considered when a client presents as challenging in group. We have found that through keeping an open mind and exploring various factors, we can often identify the reason for the challenge and work with the child or adolescents individually to overcome the difficulty.

Therapist Cognitions

Finally, when conceptualizing the needs, participation, and progress of each group member, facilitators must consider the influence of their own cognitions on the functioning of group members. Just as the schemas, automatic thoughts, and resulting emotional and behavioral responses of members influence one another, so do these factors of the group facilitator. As clinicians, we often take for granted that we are just as likely to possess our own less-than-entirely-accurate perceptions that may negatively impact our responses. When conducting group therapy, it is especially important to be mindful of our beliefs related to our competencies and abilities and the intentions, motivations, behaviors, and abilities of others (namely, our group members). The group setting creates a very different situation with an additional set of challenges than individual therapy and may activate underlying schema that would otherwise be less of an issue in a one-to-one situation. For example, beliefs related to incompetence are more salient in the group setting, as the idea of making a mistake or not being skilled enough, for example, is far more threatening given an audience of six to eight children as opposed to one. Facilitators may also possess beliefs related to their ability to work with a cofacilitator, which is often a benefit or even, at times, a necessity in certain group programs. Another example may relate to our beliefs about the intentions or motivations of youth in our group, in that we may maintain the assumption that adolescents would be resistant to engaging in role-play exercises and, therefore, be less likely to assign these practice situations. Maintaining an awareness of the impact that our own cognitions, attitudes, and behaviors may have on the dynamics of the group or the participation or progress of individual members is crucial to the effectiveness of group therapy.

SUMMARY

CBGT offers a systematic, theoretically driven model that allows for appropriate conceptualization of information related to each participant and to the group as a whole, anticipation of obstacles, and determination of structured intervention approaches. Throughout this chapter we have mentioned the importance of an accurate, adjustable conceptualization of each member's presentation and of the group as a whole. The individual chapters to follow will highlight this conceptualization according to specific presenting problems. What we have emphasized is that the needs and goals for each member should be viewed through the CBGT framework so that thoughts, emotions, and behaviors at work in the presentation of each child and within the dynamics of the group as a whole can be understood by facilitators in a way that guides the group program and selection and application of specific interventions and strategies. This includes the facilitator's own cognitions and behaviors influencing group dynamics and the success of members. As the CBGT model emphasizes the interaction between thoughts, feelings, and behaviors, within the group setting this potentially includes dozens of reactions influencing each other at any given time.

It is our hope that throughout this handbook, readers will recognize that, while the application of CBGT with children and adolescents presents some challenges different than those of individual therapy, it also presents many benefits especially relevant for work with children and adolescents. These challenges are more than manageable within the framework of the CBGT model so long as facilitators maintain an awareness of these

potential obstacles, adhere to the guiding principles of CBGT, work to maintain an accurate conceptualization of the various factors influencing the group dynamics, and direct the group toward the accomplishment of defined goals for individual members and the group as a whole.

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Chapter Two

CBT Group Treatment with Children and Adolescents: What Makes for Effective Group Therapy?

Mark H. Stone

Effective group treatment with children and adolescents rests upon three essential considerations: the clients that compose the group, the therapists responsible for conducting the group, and the setting in which the group occurs. Careful attention to each factor is important in order to assure the most beneficial treatment possible, as each element enhances or inhibits the others. This chapter will discuss the impact of these three major considerations on the process of group therapy with children and adolescents, and in particular discuss the specific issues related to each factor that must be considered from the initiation and design of group treatment through maintenance and eventual termination. As this handbook outlines the application of the cognitive-behavioral group therapy (CBGT) model to group therapy with children and adolescents, the influence of these client, therapist, and setting variables will be discussed within this theoretical framework.

Youth client variables to consider include age, gender, education level, developmental level, race, culture, ethnicity, socioeconomic status, personal attributes, psychosocial strengths and weaknesses, the presenting problems, and levels of cooperation and motivation. For group therapy to be effective, these issues must be taken into account (Cohen & Rice, 1985). Variables related to the therapist(s) conducting group therapy with children and adolescents relate to skill level, personal attributes, and approach to the role assumed, as group success initially rests upon the role of the therapists. Several references address this matter in detail (Bates, Johnson, & Blaker, 1982; Durkin, 1964; Weiner, 1983). Leaders must model behavior for the group members and facilitate the cognitive-behavioral treatment approach. Leaders must also recognize that growth and change are the result of their modeling and the progressive interactions of group members as they gain insight and skills and, therefore, leaders must monitor these processes and guide in the direction of conceptualization as needed. Finally, the setting in which the group operates may facilitate or impede group progress. The importance of the setting cannot be minimized because it bears a close relationship to group outcome. The setting

must support the role of group treatment by commitment to the treatment goals and process. This includes practical considerations to accommodate the group, but especially the commitment of the organization and leaders to the role of CBGT.

Effective group psychotherapy requires that each of these three elements be considered in more detail. The specific issues outlined below are meant to guide the reader by providing further explanation of the importance of addressing these three broad factors in the provision of CBGT with children and adolescents. Topics are not necessarily presented as specific to only one of those factors, as some issues relate to both client and therapist variables, for example (i.e., ethnic diversity considerations). The dynamics of group treatment with children and adolescents comprise similar manifestations to group work with adults. While consideration of age and development are important to bear in mind when working with children and adolescents, the generic operation of effective group psychotherapy rests upon broad and general principles. References for further reading are given within these sections. Some of the classic references in group psychotherapy are also provided because they have chapters that discuss various issues of group treatment important to working with children and adolescents (Alonso & Swiller, 1993; Corey, 2000; Dies & MacKenzie, 1983; Gazda, Ginter, & Horne, 2001; Kaplan & Sadock, 1993; Vanderkolk, 1985; Yalom, 1994). This chapter concludes with a checklist for effective practice to summarize all the issues discussed.

CONSIDERATION OF POTENTIAL GROUP MEMBERS

A careful assessment of the behavior of each participant will facilitate the group process. This is especially important given the range and variability in social and emotional development for children and adolescents. Maladaptive behaviors may suddenly erupt in group to the surprise of leaders unless this assessment is made (Stock, Whitman, & Lieberman, 1958). An individual interview prior to inclusion in group is useful in order to make an initial assessment and diagnosis of each individual to determine their appropriateness for participating in group therapy and individual goals, strengths, and weaknesses that may impact the overall group (Piper & Perrault, 1989). In general, almost all persons can profit from group treatment; however, there can be an individual whose behavior and goals do not coincide with the mutual benefit of others, or whose social skills are very limited (Stock et al., 1958). Those individuals with severe psychopathology or antisocial tendencies can present problems to the development of group cohesion, and therefore, therapists should remember that group therapy is not possible with every individual (Stone, 1993). While rare, these persons ought not to be included in the typical group, and/or the leaders must be aware of the potential difficulty that any child with a severe emotional disturbance may present in a group that is not comprised specifically of similar peers. Careful initial assessment usually keeps this problem from arising unexpectedly, and allows for a better fit of individual needs and goals for all members when the degree of pathology, skill levels, maturation, and social skills are considered.

It is useful to establish limits or conditions during this individual session, and especially to be explicit with the child or adolescent regarding the process, rules, procedures, and expectations. Children will generally accept these conditions without much ado, but adolescents may sometime resist any constraint on what they consider their freedom. Each member of the group should be assessed as to their readiness for successful group participation and potential for contributing to the group process. Where time is limited

for this task, even a short individual session pays off greatly in beginning a successful group. The leaders can appraise the status of the individual, and tentatively determine which behaviors seem most important to address with each member. An individual session with each participant allows the leaders to enter the first session without becoming subject to any unknown factors that could have disastrous consequences, and which could have been foreseen, as well as afford each group member with enough information to make transition into a (perhaps) unknown situation more successful from the onset.

ESTABLISHING SPECIFIC, OBTAINABLE, AND MEASURABLE GOALS

Effective treatment requires that specific goals be determined. Furthermore, these goals must be clearly expressed, and they must be measurable. These tasks, when carefully addressed, are the hallmarks of successful group treatment. The leaders and participants will be gratified when they can see progress and ascertain movement. Everyone understands the function of a ruler for measuring length. The ubiquitous ruler is a simple analogy to assist the leaders and participants, especially young people, to develop and affirm mutually determined goals that can be measured as progress is monitored.

Begin with the obvious, but necessary first goal, which is attendance. This is an important goal, but also illustrative of a clear and simple goal. Attendance is indispensable to group facilitation and progress. It is vital for the group that members be regular and committed to group attendance. Keeping attendance records is a simple task, but useful to illustrate the clear and measurable goal of commitment to the group.

Successive goals can be developed by the group and the leaders. Many ideas might be suggested. The group can begin its first work by determining which of these ideas are most useful to serve as the group goals. Do not underestimate the capacity for children and adolescents to address and help monitor this task. They can be successful in developing goals that are clear and specific. Leaders can add more expertise for how they will be explicitly stated and measured. Who in the group is to be responsible for implementing and recording these goals must be designated. Some measures can be monitored by group members so as to facilitate commitment to the group. Other measures may be the responsibility of the leaders, developed by and solely for the leader's use only. Nevertheless, mutually determined goals are exceedingly useful for the group to develop collectively, and these become the group members' responsibility for maintaining and sharing with other members of the group. Developing measurable goals is a very useful initial group task and one in which most participants can make an immediate contribution, which assists in the development of the collaborative relationship that is central and necessary for effective cognitive-behavior therapy (CBT). Goal-setting tends not to be a threatening task to most individuals, and it is one that participants immediately recognize as relevant and useful.

ASSESSING INTERACTIVE PATTERNS AMONG GROUP MEMBERS

The essence of group treatment is mutual interaction. This can take the form of affirming support, providing information, and raising questions. There are a host of negative behaviors that can be observed also (Bion & Rickman, 1943). The group is a micro-cosmic

example of interactive living. It is an experimental setting by which participants can gain insight into the behavior of others and that of their own selves. The leaders have the task of appraising the level of insight observed in each participant who interacts with the other group members. The leaders also have the task of conveying these insights to the group, and to an individual member when appropriate. Members may bluntly or more skillfully convey their insight. Leaders have to take into account the skill levels evident in different individuals in order to utilize their input effectively. Each member has considerable influence upon the other members, so leaders must sometimes temper a group member's remarks. Effective groups are those in which useful input by any participant is skillfully utilized by the leaders to the benefit of all. Leaders influence, first and most important, by their modeling of appropriate group behavior. Participants learn from this modeling how to improve their skill levels. Specific tasks, exercises, and leader input will further add to these developing skills, and this is especially true with children and adolescents who are familiar with learning environments that utilize exercises and concrete examples to gain skill and knowledge.

DIVERSITY: TAKING INTO ACCOUNT GENDER, RACE, ETHNICITY, AND CULTURE

Groups tend to be diverse, but they often do not reflect the full range of diversity. Diversity is often a function of the setting and the auspices under which the group occurs. By diversity it is not simply meant of racial, ethnic, cultural, or social background, but also in terms of diversity of experience, history, or perspective. The appreciation of individual differences can be effectively enhanced when the participants represent the many aspects of diversity. This is an ideal, but sometimes groups are only what they come to be according to the setting. Even then, diversity can be addressed, but not as richly as by utilizing participants who are reflective of greater diversity than can occur in a group merely by talking about the issues of diversity (Lazerson & Zilbach, 1993).

It is effective to have diverse co-therapists. Often this can be accomplished most easily in terms of gender, by having both a male and female group leader. The unique tasks of co-therapy are discussed in more detail later, but it is important to mention in reference to diversity that it is useful when the co-therapists can represent different aspects of diversity. Every individual member's comments or questions represent one or more aspects of diversity. Effective groups are those that profit from drawing upon the resources available through these diverse viewpoints. Group leaders should not simply acknowledge the viewpoints expressed, but plumb the underlying bases and circumstances that give rise to these expressions of opinion and differences. An essential role for leaders is to skillfully probe a response for the underlying issues, and not simply rely upon the expression itself as sufficient (Whitaker, 1985). In general, the more diversity represented in the group, the richer and more effective the group process will be. Sometimes this can be arranged through pre-selection, and at other times, this is not an option given setting or population limitations so groups must operate as initiated. Sometimes, however, a group that is too heterogeneous may distract members from developing cohesiveness and similarity in purpose or goals.

Group process becomes a powerful tool for addressing what lies beneath expressions of intolerance in any aspect. Expressions of intolerance should not be dismissed,

but explored in order that those who express these thoughts and those who hear them learn the proper forms for expression and listening. The group cannot adopt a single moral viewpoint, but two essential attributes are especially important to effective group interaction: (1) the paramount importance of reason guiding actions, and (2) proper respect for every member. Leaders must take the initiative, and lead in the adoption of these two essential behaviors. The discussions of the group, however, must not be allowed to invade the fields of politics, sociology, law, and the like, but to focus upon the interactive elements within the confines of group interaction. The role of the group is not to lament the current ills of society, their future, or the causes, but to address interaction by group members whose goals support the affirmation of everyone. Though this may be less of an issue, per se, for group therapy with children and adolescents, this notion of focus and purpose to discussion is relevant in that youth may also be prone to diversion to social chatter or discussions of dissatisfaction with teachers or staff (i.e., in school or inpatient settings). Leaders have to be alert to this tendency for comments to move off-center to the goals of the group. This tendency should be identified when it occurs so that participants learn what facilitates group progress and what defeats it. Group goals should not be sacrificed to pursue hidden or private agenda (Rosenbaum & Berger, 1963).

Leaders who are unfamiliar with or inexperienced working with the diversity represented in their groups can utilize other persons as possible resources to the group for insight and information. Leaders should also seek supervision from other persons with insight into the diversity represented in their groups if this is the case. Useful resources include Salvendy (1999) and Weinberg (2003).

SETTING THE GROUP AGENDA AND ESTABLISHING NORMS

As is the case in individual CBT, the agenda is a useful tool to aid in outlining the process of group sessions and in maintaining focus and best use of limited time for all group members. There are certain agenda issues that must be clearly established by about the end of the first or second sessions. This process can be enhanced through the use of the individual screening that was advocated earlier. The leaders have the obligation to set certain rules for the behavior of participants in the group. These should be few in number, but explained as the essential ones for group success. Attendance is vital and the conditions for absence should be clearly explained. Verbal participation is best facilitated and not demanded. It is not useful to require overt participation. Children and adolescents vary in their level of verbal skills, group experience, and anxiety among other personal qualities that may inhibit participation, none the less of which may be the social pressures that are inevitable given this developmental level. Many participants learn from careful listening and reflection. Those who talk the most are not always insightful. Support and careful solicitation of responses will generally work with almost every person, although some persons will require more time and encouragement than others (Gans, 1996). Moderating the group in this respect depends greatly upon the skill of the leaders in orchestrating the participants as working members of a group.

Some groups establish specific rules against meeting or communicating beyond scheduled times. This is a useful rule although participants may not understand it at first. The most useful approach is to show how external meetings defeat the group process

by the formation of pacts that may or may not be known to the other group members. Fundamental group interaction occurs within the group, and when these are usurped by pacts, the group process is endangered. Members usually subscribe better to a rational explanation of how this behavior adversely affects the group as a whole, than to offer a consequence for these external meetings. This may also be difficult to prevent or monitor in some settings whereby the children and adolescents may attend school together, share a room if in an inpatient or medical settings, be neighbors in a community mental health group, or the like. By directly addressing the potential negative consequences of external communication related to internal group happenings, many youth may be able to maintain that boundary on their own successfully even if interacting socially outside of group.

ETHICAL CONSIDERATIONS

Core Ethics for Leaders and Members

There must be mutual respect for everyone in the group. Those not present as well as the external diversity represented in society at large deserve respect. Reason and rational means must always be employed to engender an effective group so as to reconcile differing views. The ethical treatment of all persons is a fundamental aspect of the group process. Lakin (1986) and Mullan (1988) deal specifically with such ethical issues in group psychotherapy.

Ethical Issues for Group Members

There is no end to a list of ethical issues that might occur. To lead an effective group the emphasis must be upon establishing the fundamental ethical guidelines for group process. Most group members voluntarily choose to subscribe to the group norms as the only means for effective interaction. During the individual assessment session, it can be stated that any member's concerns and problems can and should be raised in the group, or possibly by requesting a meeting with the leaders to first discuss the matter. Early establishment of these conditions usually prevents many problems from occurring that would otherwise impede the progress of the group.

LEADER STYLES AND TASKS

Good leadership is indispensable to effective groups (Kotter, 1994). Preference is for co-facilitators. The tasks of leadership are far too complex to be assumed adequately handled by one person working alone. Sometimes groups must be operated with only one leader, but this should not be considered optimum for effective group interaction to occur. A rousing group of children or teens will challenge even two leaders, and two facilitators allows for greater objectivity, observation, and better conceptualization of the process and interactions within the group.

Co-leadership, however, can present special problems. How two leaders behave

toward each other in the presence of the group is evident for all to see and hear (Rice, 1995). Because modeling is so important, it is paramount that the leaders work together so as to present a facilitating role for group members to emulate. Working together effectively requires a pre-session meeting and a post-session review for leaders. Slighting these meetings will not facilitate cooperative leadership, and may eventually slow group progress.

Sometimes there is a clear hierarchy in the two leaders because of their titles and roles. One leader may be more experienced, the senior by training, or administratively assigned this role. Even in these situations, cooperation is essential. Pre-session meetings to anticipate the issues and goals of the upcoming session and to evaluate the status of the group are very important. Post-session meetings to process and evaluate each session are likewise essential. These meetings need not be long in time, but they should never be neglected or minimized. When cooperation in the group declines or fails to progress, it is usually because good communication between the co-therapists has been neglected.

Co-Leadership

Co-leading a group requires more than just having two leaders present in the group. This is especially true in the provision of CBGT, given the importance of both members having familiarity with the underlying tenets of this model. Co-leaders can often make better observations, stimulate interaction, encourage participation, and keep the group focused. Modeling by both leaders is important. The group members will be looking to the leaders, as well as observing them overtly and clandestinely to see how they behave. This is especially true for children and adolescents in group treatment, who are often adept at observing and learning from the interactions of parents and other influential adults.

If one leader is clearly senior with respect to experience and training, then the hierarchy is established even though this does not imply domination or one-sidedness in operating the group. However, it does indicate which of the two likely bears ultimate responsibility. In most circumstances, it is important for the two leaders to know one another as well as possible. This should include both their personality attributes and clinical skills. This working relationship requires something more than just a superficial acquaintanceship. The leaders should determine the roles of each in the group, and especially, how to handle the dividing and triangulating behavior that manipulating children and adolescents may frequently engage in with adults.

Leaders should share a common orientation to group treatment. Leaders must also have knowledge of the common impediments that may occur between leaders so as to establish a clear method for how to handle these problems when they arise. Above all, they must commit to the treatment modality goals undergirding cognitive-behavioral treatment. The pre-session meetings and post-session reviews will maintain good communication between leaders and usually forestall any potential problems (Nobler, 1983). Above all leaders must have the willingness and forthrightness to raise issues and resolve them. One matter in particular that is usually problematic occurs when the words, actions, or behavior of one leader raise an issue with the other. Good sense requires them to work out such matters between them at a later time and in a private conference. They might choose to inform the group of what happened in order to utilize that experience

for the benefit of all. However, this should not be attempted until the matter between them is thoroughly resolved and comfortable to both. Co-leadership provides the group members with an abundance of skill and insight, but it also contains problematic issues that must be prepared for by close communication between the two leaders (Beck, Dugo, Eng, & Lewis, 1986).

Leaders should use the time immediately after each session to record notes of interaction and progress. Do not wait until later. Using just five minutes immediately after a session is worth many more minutes of time spent trying to recollect events much later, or worse yet, forgetting important matters altogether. Leaders who share this time together make this process invaluable and contribute to a more accurate recollection and perspective of the interaction in the group and process for each of the individual members.

SUPERVISION: CLINICAL AND ADMINISTRATIVE

Everyone needs supervision although not everyone believes they do. Wise leaders know they can profit from the insight and guidance that a capable supervisor can provide and, more importantly, so can the children and adolescents they service. The role of a supervisor is varied. Sometimes, it is to offer another viewpoint, to confirm an interpretation, or to suggest alternative strategies. Sometimes specific guidance and skills can be enhanced by supervision with an expert in CBT. At other times, simple assurance that one is on the right track conceptually and in implementing appropriate strategies is often all that is required. Supervision, however, requires advanced planning, and the details should be worked out ahead of time so as to avoid an emergency. A simple contract is useful and helps keep everyone on track.

Sometimes, administrative oversight requires contact with agency heads. Wise managers will not request confidential information, but they ought to be forewarned of any serious difficulties, and no administrator wants to be caught blind-sighted. Many group leaders need assistance in coping with the unique needs of children and adolescents. Good supervision by persons experienced in working with children and adolescents is necessary for effective group growth with the youth population to result.

GROUP STRATEGIES AND INTERVENTIONS

Cognitive-Behavioral Group Strategies

The essence of effective group treatment rests upon employing specific strategies. CBT has shown itself to be an effective approach in clinical treatment, and no less so in group therapy (White & Freeman, 2000). Many, if not most, of the CBT strategies employed for individual treatment have their analog or similarity in group work. Most strategies can be adopted with allowance for the consideration that leaders are addressing the group even when focusing upon an individual.

CBT directly addresses the manner in which individuals think, act, and behave. Unless they have productive ways of behaving, most children and adolescents get into trouble. Children and adolescents especially need to cultivate appropriate ways of think-

ing and behaving. A few of them may already have this insight, while others may have adopted maladaptive strategies. CBT group therapy offers a useful approach to fostering productive behavior.

CBT addresses the basic assumptions and core beliefs that are central to the perception and interpretation of life's experiences. These core beliefs serve as the rules for living as formed by the child early in life in combination with their upbringing. These core beliefs (schema) serve to guide and dominate one's mode of behaving. They give structure and meaning to life as viewed from the subjective perspective of the individual. Schema serve as a blueprint encompassing the belief system of the person. Such an understanding may become so ingrained that they operate as automatic thoughts, which function without conscious monitoring. In this sense, they become dogma and dictate a subjective understanding of how to behave according to these inner rules.

When children and adolescents have learned a mode of behaving that is self-serving, but not truly effective, they do not know what to do about changing. Hence, they lack support to learn and try alternative ways. CBT offers very specific skills that are easily learned by most children and adolescents. CBT focuses first upon what thoughts are initiated, and how those thoughts maintain behavior. CBT group therapy seeks to make the group a working laboratory by which to understand what causes people to be dissatisfied and unsuccessful and how to better themselves. It does so in a setting that confronts, but does so supportively, and in a context of helping children and adolescents understand their behavior and initiate change.

Change can be threatening, which is usually why most people persist in their learned behaviors. The group format facilitates the normalizing of issues members are struggling with, and supplies an instant network of relevant peers from whom to gain support, examples, models, and practice. Leaders introduce CBT concepts and strategies to assist in developing alternative solutions (Brandler & Roman, 1991). Many presenting problems are complex. Leaders will assist group members by breaking large problems into separate, manageable tasks that are prioritized for action. The group will serve as a supportive laboratory for action steps in addressing these initial changes. Group members will collectively learn these skills, and each member will apply these new skills to problems of their own and work them out in the supportive environment of the group.

The process of rational problem-solving and skill-building is the focus of CBT interventions. This structured approach is applied to problems presented by group members. Developing a systematic approach to problem-solving and skill-building is the essence of treatment. This approach is frequently oriented to social skills training because children and adolescents often lack insight into their social behavior, cannot correctly interpret communication from others, and therefore, behave with little success. Leaders assist cognitive restructuring so that participants learn how to understand the misguided self-talk and misguided logic directing their maladaptive behavior. Multiple observations of this process in action are a decided advantage of working in a group. This is why the group process can be so effective. Members learn about their own faulty styles of thinking and acting, but they also have the opportunity to observe this over and over again as other members work on their problems.

The utilization of homework by advocating bibliotherapy, and utilizing audio and video tapes can reinforce new learning. Such techniques must be enhanced by ample preparation and follow-up or else this homework will be neglected in a manner similar to school assignments. Make these activities interesting, and don't call them *homework*.

Devise useful, but clear and simple tasks, and refer to them using terms such as "experiments" or "between session practice" (Mennuti, Freeman, & Christner, 2006). For example, "Observe how you respond to your friends versus how you respond to your parents. Determine what is different, what is the same, and report back to the group."

Strategies from Other Theoretical Approaches

There are many other theoretical approaches for group therapy. Some approaches blend nicely with CBT, while many other approaches are too disparate to match well with this model. The best and most effective approach is not to introduce disjuncture by a hodgepodge mixture of modalities, but to supplement and utilize, if needed, those models that might be employed without disorienting everyone in the group or detracting from the style and method of CBT. Two modalities are given for illustration of approaches that augment CBT, including Gestalt group psychotherapy and Adlerian group psychotherapy.

Group therapy understood from a Gestalt perspective can offer insight to children and adolescents. With this modality, the behavior of group members is thought to reflect how they deal with the world. Issues and needs move to the forefront or back according to the demands of the situation and the personality of the person. Gestalt therapy fosters expression of thoughts and feelings. These thoughts and feelings can be "acted-out" in gestalt group treatment using informal drama exercises that allow the participants to express themselves, but more importantly, to eventually understand the meaning of their behavior. Expression and observation combine to foster a better understanding of the operating motives in their behavior. Participants learn that these behaviors are created and constructed. They can be controlled. Alternatively, better models of behaving can also be constructed that serve the person more usefully. Understanding the levels of revealed behavior can be insightful when identified and illustrated productively by the leaders. There are many exercises that can be utilized from Gestalt group therapy that are exciting and useful for children and adolescents. Blatner (1996) and Kipper (1986) are useful resources for ideas that can be incorporated in CBT group sessions.

Adler used a group approach to the treatment of children in Vienna as far back as the 1920s. Adlerian group psychotherapy dovetails closely to CBT, in fact, much of CBT has its roots in Adler's Individual Psychology (Corsini & Rosenberg, 1955; Dreikurs, 1957). Adlerian group therapy may, in fact, be the earliest systematic use of groups in treatment. The essence of Adlerian group treatment is the identification of one's Life Style and how that Life Style influences thoughts and behavior. One's Life Style expresses the "marching orders" that guide a person's thoughts and actions. Life Style analysis identifies what CBT explains as *schema*. In Adlerian treatment the focus is upon recognizing the 'guiding line' of orientation that dictates behavior. One comes to rationalize thoughts and behavior so completely that any challenge to their foundation can appear as a revelation. Adlerian treatment is designed to make this revelation manifest rather than allow it to remain latent and unrecognized. Life Style analysis addresses the latent operating motives of the person so as to make them recognized and understood. Life Style analysis can be revealing to each person. Understanding birth order and its influence upon self-understanding is also enlightening to children and adolescents because they experience these issues daily in dealing with siblings. Children and adolescents learn that one's interpretation of birth order can produce a perspective on self and others

that needs to be recognized and understood. It may need to be changed. Addressing the family atmosphere and the faulty premises underlying many so-called family values is also important. These values may embody virtuous goals, but more frequently they represent hidden agenda about perceiving others behavior and the surrounding world. Often these interpretations are faulty and only serve to mislead the person. These perceptions are misinterpretations and most noticeable in social interactions where children and adolescents present with little insight and maturity.

GROUP DEVELOPMENT: PROCESS AND STAGES

Therapy usually progresses in stages and group therapy especially so. This is because many persons participate in the process, and that makes stage analysis more evident. Group development is generally considered to progress in an orderly fashion through successive stages; however, no rigid parameters should be expected and stage theories have themselves been critiqued for being too rigid. Even so, it is useful to model stage progression as a guide for treatment only so long as it is not treated too rigidly. While much of this theory and research has been done with adults, the general implications are no less important in working with children and adolescents. Research by Beck, Dugo, Eng, and Lewis (1986) identified several stages. Other theorists and different models can be found in Beck and Lewis (2000).

The initial stage, usually occupying the first few sessions, is generally exploratory as the group members look to the leaders for direction and affirmation. This is the time for the leaders to clarify the rules and goals of the group. Trust and openness need to be established and this takes time. Defensiveness, resistance, and reticence need to be worked through. How the leaders handle these issues will determine how quickly this stage progresses. Group members may explore roles, but they will initially express their standard operating mode for dealing with others. The developing task in this stage is to move the focus of the group from the leaders to the collective membership of the group (Lewis & Beck, 1983). This progresses by developing trust and respect, and when the members feel mutual support from one another.

As this stage evolves, more exploration is evident by members. This is important because the group should now be at a place where new behaviors can be initiated and explored. The group should become a safe haven for such exploration. This atmosphere allows the development of new alternatives in thinking, feeling, and acting. Group members will vary in how much exploration they engage in, but when these initiations are greeted by support and interest, their tentativeness can move to new levels of awareness and self-improvement. During this period, indications of closeness and trust should become more evident. Leaders should observe that the members occupy more of center stage than occurred in the initial sessions. A more cohesive and work-oriented stage becomes evident when a deeper level of communication is evident in the group.

A time-oriented commitment makes everyone aware of the end of the group's meetings. This can be difficult for some due to the high level of commitment made to group members and the support received. Termination can appear ominous (Kauff, 1977). This is the time for the leaders to affirm the growth and progress of the group. Reporting by leaders on previous assessments of progress may assist the group to see how much was gained by working together. This matter is discussed further under evaluation. Identifying

progress and offering strategies for the future are important tasks for the leaders so that group members do not feel abandoned. An unpublished research study recently completed by Stone, Lewis, and Beck (2005) has identified three stages that evolve as groups work through their issues. The data documents and supports the evolving stage model discussed.

Group Dynamics and Interactive Patterns

Careful observation and attention to group dynamics is essential. Group dynamics tap the forces and processes that evolve in the life of a group (Bion & Rickman, 1943; Greenberg & Pinsof, 1986). Group leaders essentially initiate and drive these forces in the initial stage. The power of group processes occurs when members adopt and utilize them, transforming the process from one or two initiates to everyone. Group leaders remain part of this process, but group members will adopt more and more useful influence as the group progresses. While leaders initiate the process, it is the members who will drive the process forward in successive sessions.

The dynamics of the group may begin in usefully advantageous ways, but groups can regress and blunder as they work their way along. It is the role of the leaders to offer insight into the course of the group endeavors with respect to these dynamics (Lewis, 1984, 1985). These insights on dynamics are important because they supply the group members with knowledge about how their work is progressing and what these dynamics mean for progress to occur. In this way, group members learn more productive ways to function, and they can abandon old or ineffective ones.

The dynamics and interaction of group members encompass verbal and nonverbal behaviors. Physical manifestations and bodily positions and gestures are important to understand. The leaders will want to identify manifestations of these behaviors and offer illustrative interpretation so that the group members can learn from these illustrations.

Role behavior is important for leaders to understand to facilitate effective group therapy, and there are several models for describing the interactive process of individuals in group treatment. Among these models, Beck et al. (1983, 1986) identify four emergent leadership roles, including, Task, Emotional, Scapegoat, and Defiant, and a nonleader remaining member role. These are hypothesized to be role-consistent during the life of the group. These roles are, however, informal, emerging roles and are not the fixed, formal roles that might be assumed to exist. Research has suggested validity to this model and the roles assumed to operate (Brusa, Stone, Beck, Dugo, & Peters, 1994). Helping children and adolescents understand past roles and how they can change and modify their behavior into new roles offers a powerful incentive to members when they come to understand that they can change and have the tools to do so.

TYPICAL AND UNIQUE PROBLEMS

There are a variety of problematic situations that can arise in group treatment. Initial screening can help identify most of them, but many behaviors do not make their appearance until the dynamics of the group bring them forth. Chapter 5 in Yalom's classic text (1994) identifies the major ones. The most difficult individuals are those whose personal-

ity and character challenge the general goodwill of most group members (Gans & Alonso, 1998). While this might not be fully expected in most young children and adolescents, it can appear as full-blown pathology (Silverstein, 1997). This phenomenon often occurs because process in group treatment may uncover or bring to the surface problematic situations such as abuse, neglect, and such. Interestingly, many of the psychoanalytically oriented texts and articles often deal insightfully with how leaders can recognize and deal with problematic situations when they arise (Rosenbaum & Berger, 1963).

EVALUATING THE EFFECTS OF GROUPS

The key to evaluating the effects of cognitive-behavioral group therapy is to work from clearly established and measurable goals (Dies & MacKenzie, 1983; MacKenzie & Livesley, 1986; Stone, Lewis, & Beck, 1994). The importance of making these goals clear and measurable was discussed in an earlier section. Clear, measurable goals allow specific determination of what has or has not occurred. Evaluation need not be esoteric or overly sophisticated. Simple counts will suffice for producing data. However, these counts must be based upon a standard method for determining them. To use attendance as an example, we record absent/present with a 0/1 count. We place these counts in a two-way matrix similar to a checkerboard so that the rows are persons and the columns are the meeting dates. The sums of each row give the attendance by person and the sums of each column give attendance by date. Tabulation and reporting is simple and straightforward for the counts and their conversion to percentages.

Each goal to be measured must be clear so there is no ambiguity about what is counted. It can be objective such as attendance or follow some similar strategy. Consider the following four criteria for group participation: (1) alert and listening attentively, (2) accepting of other members comments, (3) making supportive statements to other members, and (4) productive personal work. These can be rated 1/0 for each session, or 1, 2, 3 for gradations of success. Ask each member to rate themselves on the 3rd, 6th, 9th, and 12th sessions on each criterion. This simple scale can be modified in any way for use by children or adolescents. Some instruction and practice would be needed to orient and train members to use the scale. On the specified days, each member would rate themselves. The ratings are tallied by person and session date on a matrix similarly to the way attendance was recorded and summarized. As the group gains insight and skill, we would expect the ratings to improve as the sessions progressed. Members would also become more accurate in recording their ratings with greater insight and understanding as time progressed. This should be taken into account in reviewing the data. Similar goals could likewise be determined and measured. Corcoran and Fischer (2000) offer a large selection of informal measures that can be employed directly or adapted to serve local requirements. Sociometric-oriented procedures are very useful in evaluating group process and progress. For whatever methods are selected, the group should be evaluated using simple tools that can easily be incorporated into the sessions without consuming large amounts of time. Keeping the measures short and simple will encourage their use. They can provide both members and leaders with useful information about what has occurred. Evaluation is important for effective group psychotherapy to occur.

A checklist for effective group practice with children and adolescents that follows a CBT approach is provided as a summary in Figure 2.1. Use the checklist as a guideline

	Planned/ Awareness	*In Progress*	*Complete/ Operating*
Individual assessments prior to group sessions	1	2	3
Clear and measurable goals for treatment	1	2	3
Constant observation of interaction among participants	1	2	3
Diversity sensitivity	1	2	3
Ethical issues for leaders and group members	1	2	3
Co-leader facilitating by pre- and post-session meetings	1	2	3
Supervision	1	2	3
Implementing CBT strategies and interventions	1	2	3
Supplementing with other interventions	1	2	3
Observing group development/stages	1	2	3
Attending to group/individual dynamics	1	2	3
Preparing for problems to occur	1	2	3
Evaluating the effects of group treatment	1	2	3

Figure 2.1 A Checklist for Effective Group Therapy.

to establishing more effective group therapy, as well as to ascertain both the current and optimum status for improving upon the effectiveness of group treatment. A copy of the research report can be obtained from carolmlewis@sbcglobal.net or markhstone2@sbcglobal.net.

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Chapter Three

Developmental Considerations for Group Therapy with Youth

David C. Hill & Diana Coulson-Brown

Group interventions with children and adolescents have the potential to mobilize the power of prosocial peer influences, positive peer and adult role models, and the persuasive power of a social interaction and informal contracting process in the service of impressive therapeutic change among child and adolescent clients. At the same time, the inherent frustrations and setbacks that often characterize any therapeutic work with youth are frequently present in the context of group work as well. The power of peer influence can be positive or negative depending on the complex set of factors that interact within the therapeutic process in a child or adolescent group. This chapter addresses a number of important developmental considerations that are necessary in designing and implementing interventions for children and adolescents utilizing cognitive-behavioral techniques within a group modality. We present the major implications of theory and research in child-adolescent development and developmental psychopathology for Group Cognitive-Behavior Therapy (G-CBT) with youth by outlining considerations, implications, and recommendations related to current knowledge of the following specific factors: (a) current compelling epidemiological issues affecting children and adolescents; (b) biological, genetic, and neurological influences; (c) psychological, cognitive, and affective (emotional) developmental considerations; and (d) social, contextual, and cultural factors.

CURRENT ISSUES AND EPIDEMIOLOGY OF VARIOUS DISORDERS

This section provides an overview of the most important mental health problems, physical health problems, and sociocultural-contextual challenges (i.e., media influences, family dissolution/divorce, peer culture) confronting contemporary children and adolescents as they engage in the process of development. We also consider some of the implications of these problems and trends for psychotherapeutic group work with youth.

Recent Epidemiological Evidence

The *Diagnostic and Statistical Manual of Mental Disorders-IV-Text-Revision* (*DSM-IV-TR*; American Psychiatric Association, 2000) provides prevalence estimates for the various categories of mental disorders, including those that clinicians frequently diagnose and treat in children and adolescents. Although the diagnostic criteria for most disorders are the same regardless of age of the client being diagnosed, for certain disorders the *DSM-IV-TR* provides some developmental guidelines (e.g., the note that a depressed mood related to a Major Depressive Episode "in children and adolescents, can be irritable mood," or that one may "consider failure to make expected weight gains" when establishing the specific criterion related to weight loss or weight gain for children; American Psychiatric Association, 2000, p. 356). *DSM-IV-TR* also provides a separate section for disorders usually first diagnosed in infancy, childhood, or adolescence, but clearly specifies that clinicians may diagnose these disorders later in life providing that, in the opinion of the diagnosing clinician, the person's pattern of thoughts, feelings, and behavior met the diagnostic criteria within the specified developmental time period. Another example involves the diagnostic criteria for the Personality Disorders. The criteria for Antisocial Personality Disorder require that the person is at least 18 years of age and has a history of Conduct Disorder symptoms prior to age 15. For all of the other Personality Disorders, *DSM-IV-TR* does not expressly prohibit diagnosis under age 18, but does caution that diagnosing a Personality Disorder in people under age 18 requires that the "features must have been present for at least 1 year" (American Psychiatric Association, 2000, p. 687) and Personality Disorder features that appear under age 18 "will often not persist unchanged into adult life" (American Psychiatric Association, 2000, p. 687). The key point here is that *DSM-IV-TR* addresses developmental differences and concerns, but leaves a great deal of room for clinical judgment on the part of diagnosing clinicians.

Epidemiology of mental disorders affecting children, adolescents and adults. In a recent epidemiological study, Kessler and colleagues (Kessler et al., 2005) surveyed almost 10,000 adults. They found that approximately 25% of those surveyed met diagnostic criteria for at least one *DSM-IV* diagnosis at the time of the study (point prevalence). In addition, 46% of the respondents had met criteria for a *DSM-IV* diagnosis at some point during their lifetimes (lifetime prevalence). Of particular salience for this exploration of mental health factors affecting group work with adolescents is the fact that three-fourths of the respondents reported that they had developed symptoms of one or more disorders prior to the age of 24 and fully one-half of them had symptoms before age 14! These data have compelling implications for therapeutic work with youth, in that they emphasize the need for the earliest possible identification, evaluation, intervention, and treatment because these symptoms begin to develop so early—often before 14 years of age—and can result in impairment in social, educational, occupational, and other important areas of functioning (as is a diagnostic indicator for a large majority of the diagnostic categories in *DSM-IV-TR*; American Psychiatric Association, 2000).

Other Important Recent Issues

Obesity epidemic among children and adolescents. Media reports have highlighted the emerging epidemic involving the related conditions of overweight, obesity, Type

II diabetes, and metabolic syndrome not only among adults but among children and adolescents. Lifestyle choices, parental modeling of eating and self-care behaviors, media and advertising influences, peer influences, and biological-genetic predispositions all contribute to these interconnected problems. One recent analysis (NHANES, 2001) found that the prevalence of being overweight between 6 and 11 years of age increased 325% between 1974 and 1999 and that being overweight at 12 years of age means a 75% chance of being overweight as adults. The psychological consequences of this epidemic are many, ranging from depression to anorexia to binge-eating. The medical consequences including hypertension, diabetes, metabolic syndrome, hypercholesterol, cardiovascular disease, and stroke are widely publicized. Psychotherapeutic work with children must consider carefully this epidemic and the physiological, emotional, social, and behavioral effects being overweight may exert on children and adolescents as they relate to the development of youth and their participation in group therapy situations.

Epidemic of alcohol, drug, and tobacco addiction among children and adolescents. Extensive surveys of 50,000 adolescents (Johnston, O'Malley, & Bachman, 2004) revealed that drug and alcohol use among adolescents continues to be a significant problem despite some slight downward trends in the past 5 years. These surveys identify the United States as having "the highest rate of adolescent drug use of any industrialized nation" (Santrock, 2006, p. 375). The surveys most likely underestimate the extent of drug and alcohol use in the United States because they do not include school drop-outs who have higher alcohol and drug use patterns (Santrock, 2006, p. 375). Alcohol, drugs, and tobacco provide adolescents with an escape from tension, frustration, and boredom. Substances are also taken for social reasons allowing the adolescents to "fit in" with their peer group or as a means of escape from pressures bestowed by the peer group or other persons. This means of temporary escape carries with it a lasting price tag. The adolescent may become dependent on these substances, become disorganized socially and personally as well as predispose the adolescent to serious and sometimes fatal diseases (Gullotta, Adams, & Montemayor, 1995). Wodarski and Hoffman (1984) found that when adolescents discuss alcohol-related issues with peers in a school-based program, they reported less alcohol abuse at a 1-year follow-up than did peers who were not involved in these peer discussions. All group and individual psychotherapy with children and adolescents must recognize the widespread use of drugs and alcohol among both youth and their parents and guardians. Issues related to substance use by clients, parents, or both generally sabotage any attempts at cognitive restructuring, insight-building, self-exploration, and motivation enhancement, thus drastically weakening the prognosis of the psychotherapeutic process.

Epidemic of sexually-transmitted diseases (STDs), AIDS, and pregnancies among adolescents. The National Center for Health Statistics (NCHS) reported that the number of live births to 15–19 year olds in 2003 was 414,580, resulting in a birth rate for 15–19 year olds of 41.6 live births per 1,000 population (National Center for Health Statistics 2004). This number represents approximately a 21% decrease in the birth rate for adolescent girls 15–19 years of age since 1991. This is an encouraging trend, but "the United States continues to have one of the highest adolescent pregnancy and childbearing rates in the industrialized world today" (Santrock, 2006, p. 372). In addition, fully 25% of sexually active teens develop at least one Sexually-Transmitted Infection (STIs; Centers for Disease Control and Prevention, 2004). Among these, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) continues to proliferate among