PhD Thesis
Anne Bryde Christensen

Patients’ and Therapists’ Experiences of Group CBT for Anxiety and Depression in Danish Mental Health Services

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The current PhD thesis is comprised of four articles:

**Article 1**

“Does One Treatment Benefit All? Patients’ Experiences of Standardized Group CBT for Anxiety and Depression”

Status: Submitted

**Article 2**

“Therapists’ Perceptions of Individual Patient Characteristics that may be Hindering to Group CBT for Anxiety and Depression”

Status: Accepted for Publication in Psychiatry (Interpersonal & Biological processes)

**Article 3**

“Despite the Differences, We Were All the Same: Group Cohesion in Diagnosis-specific versus Mixed-diagnosis CBT Groups for Anxiety and Depression: A Comparative Qualitative Study”

Status: Submitted

**Article 4**

“Dos and Don’ts for group psychotherapists: patients’ perspectives on helpful and hindering aspects related to the therapists in CBT groups for Anxiety and Depression”

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1. Intro

Patients’ and therapists’ experiences has been highlighted as an important research topic within psychotherapy (Macran, 1999; McLeod, 2001). For more than fifty years, psychotherapy as a research field, has tended to focus on ‘how much’ psychotherapy can do or through which specific mechanisms it works, paying little attention to what this interpersonal phenomenon really is (Rodgers & Elliott, 2015). Qualitative methods are useful for exploring what phenomenon are and how they operate in a contextualized world. This methodology is highly relevant to the psychotherapy field as it values the importance of human experience, reflexivity, human emotion, language, autonomy and agency. Concepts that are all central to psychotherapy (McLeod, 2001).

Whilst the research into patient and therapist experiences is starting to accumulate, there are still only very few studies looking into the experience of delivering or participating in group CBT.

This thesis was carried out within the context of a large, multicenter RCT study that investigated the effect of transdiagnostic CBT compared with diagnosis specific CBT for patients with MDD, social anxiety disorder, panic disorder and agoraphobia (Arnfred et al. 2017).

The current thesis set out to investigate both patients’ and therapists’ experiences of a 14-week group CBT course either in diagnosis-specific groups or in transdiagnostic groups. Furthermore, the thesis also investigated the patients’ experiences of the standardized, time-restricted treatment format and of the Danish MHS more broadly.
2. Background

2.1. Anxiety Disorders & Depression

Anxiety disorders and MDD are highly prevalent psychiatric disorders that are associated with massive personal, societal and economic costs (Gustavsson et al., 2011; Johansson & Werbart, 2009). Affecting approximately 350 million people globally, MDD has been identified as the main cause of disability across the world (World Health Organization, 2001). Across countries, it has been found that Panic-disorder had a lifetime rate between 1.4%-2.9% of the population and social anxiety disorder had a life-time rate of 0.5%-4.1% (with higher % in the Western world) (Lépine, 2001). Furthermore, it has been established that anxiety disorders and MDD are highly comorbid, approx. 50% of patients with MDD have or have had a previous anxiety disorder (Kaufman & Charney, 2000). The disability induced by MDD and anxiety disorders is comparable to that induced by chronic somatic illness. Comorbid psychiatric disorders or the presence of a psychiatric and a chronic somatic illness together, represent the maximal level of disability in an individual (WHO, 2001). Furthermore, individuals suffering from anxiety and MDD have lower quality of life and low level of functioning (Comer et al., 2011; Hendriks et al., 2016; Johansson & Werbart, 2009). Psychiatric populations with MDD and/or anxiety disorders are at high risk of being treatment resistant (Maunder, Wiesenfeld, Rawkins, & Park, 2016). Thus, clinical guidelines have been developed in order to provide evidence-based treatments for individuals affected by these disorders (NICE, 2004a; NICE, 2004b; Sundhedsstyrelsen, 2020; 2016).
Table 1 DSM-5 criteria for MDD, panic disorder, agoraphobia and social anxiety disorder

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>DSM-5 diagnostic criteria</th>
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<td><strong>MDD</strong></td>
<td>5 or more of the following symptoms for a two-week period (and a change from previous functioning)</td>
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<td>- Depressed mood</td>
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<td>- Loss of interest/pleasure</td>
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<td>- Weight loss/weight gain</td>
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<td>- Insomnia/Hypersomnia</td>
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<td>- Psychomotor agitation or retardation</td>
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<td>- Fatigue</td>
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<td>- Feelings of worthlessness/inappropriate guilt</td>
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<td>- Decreased concentration</td>
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<td>- Thoughts of death/suicide</td>
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<td><strong>Panic disorder</strong></td>
<td>Recurrent and unexpected panic attacks (see below)</td>
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<td>Attack has been followed by 1 month or more of one or both of the following: persistent concern about additional</td>
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<td>panic attacks or their consequences and/or a significant maladaptive change in behavior related to the attacks</td>
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<td><strong>Panic attack</strong></td>
<td>An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and during which time</td>
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<td>4 or more of the following symptoms occur</td>
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<td>- Heart palpitations, pounding heart or accelerated heart rate</td>
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<td></td>
<td>- Sweating</td>
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<td>- Trembling/Shaking</td>
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<td>- Sensations of shortness of breath or smothering</td>
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<td>- Feeling choking</td>
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<td></td>
<td>- Chest pain or discomfort</td>
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<td>- Nausea or abdominal distress</td>
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<td>- Dizziness, feeling unsteady, lightheaded or faint</td>
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<td></td>
<td>- Derealization or depersonalization</td>
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<td>- Fear of losing control or going crazy</td>
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<td>- Dear of dying</td>
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<td></td>
<td>- Paresthesias</td>
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<td>- Chills or heat sensations</td>
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<td><strong>Agoraphobia</strong></td>
<td>A marked fear of anxiety about 2 or more of the following situations:</td>
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<td>- Using public transportation</td>
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<td>- Being in open spaces</td>
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<td>- Being in enclosed spaces</td>
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<td>- Standing in line or being in a crowd</td>
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<td>- Being outside the home alone</td>
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<td></td>
<td>The situations are avoided or else endured with marked distress or anxiety about having a panic attack or panic-like symptoms or require the presence of a companion</td>
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<td></td>
<td>The agoraphobic situations almost always provoke fear or anxiety</td>
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<td></td>
<td>The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to socio-cultural context</td>
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<td></td>
<td>The fear, anxiety or avoidance is persistent, typically for more than 6 months</td>
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<td></td>
<td>The fear anxiety and avoidance causes clinically significant distress or impairment in important areas of functioning</td>
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<tr>
<td><strong>Social anxiety disorder</strong></td>
<td>Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others i.e.</td>
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<td>- Having a conversation</td>
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<td>- Meeting unfamiliar people</td>
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<td></td>
<td>- Being observed (i.e. when eating or drinking)</td>
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<td>- Performing in front of other (i.e. giving a speech)</td>
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<td>The individual fears that he/she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e. will be humiliating or embarrassing; will lead to rejection or offend others)</td>
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<td></td>
<td>The social situations almost always provoke fear or anxiety</td>
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<td></td>
<td>The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context</td>
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<td></td>
<td>The social situations are avoided or endured with intense fear or anxiety</td>
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<td></td>
<td>The fear, anxiety or avoidance is persistent, typically for more than months</td>
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<tr>
<td></td>
<td>The fear anxiety and avoidance causes clinically significant distress or impairment in important areas of functioning</td>
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* (American Psychiatric Association, 2013) DSM-5 diagnostic criteria were used for the inclusion of patients in TRACT-RCT.
2.2. Treatment Guidelines for Depression and Anxiety

It has been established that both individual and group psychotherapy are effective treatments for MDD (Cuijpers, van Straten, & Warmerdam, 2008) and anxiety disorders (Barkowski, Schwartz, Strauss, Burlingame, & Rosendahl, 2020). In Danish treatment guidelines psychotherapy (primarily CBT) and pharmacotherapy are recommended as evidence-based treatments of anxiety and MDD (Sundhedsstyrelsen, 2020; 2016). Therefore, the outpatient clinics in Danish MHS deliver psychotherapeutic interventions alongside medicine management.

2.3. Traditional CBT, the third wave and transdiagnostic CBT

Cognitive behavioral therapy (CBT) has been established as the gold standard psychotherapeutic treatment for the anxiety disorders and MDD (NICE, 2004a, 2004b). CBT is a class of psychotherapeutic interventions characterized by a common understanding that cognitive factors are at the core of psychological suffering, distress and psychopathological disorders. Traditional CBT models propose that non-adaptive or flawed cognitions are the central mechanisms in causing and maintaining emotional distress (Beck, 1989). Cognitions and emotional distress affect the behavior of the individual in non-adaptive directions, which becomes a further maintaining factor (Beck, 1989). The classic CBT model suggests that changing faulty cognitions can lead to the easing of psychological distress and the improvement of maladaptive behaviors (Beck, 1989). Since the development of the first CBT manual, numerous protocols have been developed for specific diagnostic groups, particular processes or behavioral problems (Hayes & Hofmann, 2017). Whilst the specific protocols may be different in terms of the specific techniques they recommend, the core model of cognitions affecting emotions and behavior goes across all of them (Arendt, 2017). The goal in traditional CBT is to make the client more flexible in their thinking, by identifying, challenging and replacing negative, unrealistic and unhelpful thoughts with more adaptive ones. According to the cognitive model, this will lead to a reduction of negative
emotions. The therapist can also choose to focus on the other factors in the model (emotions, behavior and physical reactions), but always with the goal of creating cognitive changes in the individual. Beck’s model is diagnosis-specific, meaning that he thought that one could recognize each disorder by its skewed cognitions (Beck, 1989) i.e. in depression the cognitions are about loss and guilt, in anxiety the cognitions are about threats, in eating disorders the cognitions are about control in relation to food etc. As a consequence, traditional CBT protocols need to be adapted to fit each disorder’s set of cognitions.

In recent decades a new range of CBT therapies have developed due to new beliefs surrounding the underlying mechanisms of change within the CBT (Hayes & Hofmann, 2017). Characteristic of these was, a focus on the individual’s approach towards their emotions and thoughts more so than the content of their thoughts (Churchill et al., 2013; Hunot et al., 2013). These have been named the third-wave CBTs therapies and have tended to focus on topics such as emotion, mindfulness, relationships, acceptance, goals, values and meta-cognitions (Hayes & Hofmann, 2017). The concept of third wave CBT was controversial as some perceived the metaphor of the wave as something that washed away the previous lines of CBT, however, the intent and the result of third wave CBT’s was rather to integrate and include previous techniques into new therapies (Hayes & Hofmann, 2017). Third wave CBTs are presently used for a variety of disorders (Churchill et al.; Hayes & Hofmann, 2017; Hunot et al., 2013; Linardon, Fairburn, Fitzsimmons-Craft, Wilfley, & Brennan, 2017)

CBT has been the primary choice of psychotherapy for treatment of anxiety and MDD in MHS (Danske Regioner, 2017a; 2017b; NICE, 2004a; 2004b ) due to its efficacy (Driessen, 2010; Hofmann, Asnaani, Vonk, Sawyer, & Fang; 2012) and its overall aim to reduce symptoms and improve functional level in patients (Arendt & Rosenberg, 2017). It is a compelling choice of therapy in MHS due to its brevity, the manualized format and documented effects (Hofmann,
Asnaani, Vonk, Sawyer, & Fang, 2012; Whitfield, 2010). However, the continuous development of CBT protocols has been questioned because it does not appear to move the field forward or create better outcomes for patients (Hayes & Hofmann, 2017). Furthermore, we are currently seeing an increased focus on making patients or clients thrive rather than merely remove or reduce a set of psychopathological symptoms (Hayes & Hofmann, 2017).

The introduction of the third wave CBT’s and the renewed focus on underlying processes in psychopathology has led to the introduction of transdiagnostic CBT’s. Transdiagnostic refers to the idea that one approach can treat several disorders by focusing on underlying mechanisms of psychopathology rather than the disorder-specific symptoms (Barlow, Allen, & Choate, 2004). Examples of such underlying mechanisms could be neuroticism, perfectionism, or rumination (Barlow et al., 2010; Shafran, Cooper, & Fairburn, 2002; Watkins et al., 2007). Transdiagnostic therapies are not new as a concept, in fact, psychodynamic and existential therapies have traditionally been transdiagnostic in nature (Foulkes, 1986; Yalom, 1995), but to CBT it is a new idea, since the core aims of CBT has traditionally been symptom reduction (Arendt & Rosenberg, 2017).

The Unified Protocol for the emotional disorders is a transdiagnostic treatment approach developed by Barlow and colleagues (Barlow et al. 2004). This particular therapy focuses on emotion-regulation strategies with the aim of targeting neuroticism. The protocol applies evidence-based techniques and strategies from both traditional CBT and third wave CBTs i.e. cognitive restructuring, mindfulness, exposure exercises and education about the natural function of emotions (Steele et al., 2018).

2.3.1. Cognitive therapy in groups

CBT in groups has become increasingly widespread, due to the format’s ability to provide evidence-based treatment for more individuals and due to the limited resources in MHS (Oei,
Bullbeck, & Campbell, 2006; Whitfield, 2010). Many outpatient clinics now offer group CBT as either a supplement or an alternative to individual therapy (Whitfield, 2010). In the UK the IAPT program has the goal of delivering evidence-based treatments to a greater number of individuals suffering from depression and anxiety disorder (NICE, 2004a; NICE, 2004b) and the application of group CBT has been seen as a cost-effective way to offer CBT to more individuals (Whitfield, 2010). Group CBT has been established as an efficacious treatment, with some evidence suggesting it is equally as good as individual therapy, however, the evidence-base is not robust compared with that for individual CBT (Cuijpers et al., 2008).

In Denmark group-based treatment has traditionally been the choice, perhaps due to a combination of cost-effectiveness and the tradition of delivering psychodynamic therapy groups in Danish Mental Health Services (Mellergaard, 2008). Group psychotherapy stems from the psychodynamic tradition and was developed prior to the rise of CBT. Classic group therapy is based on the assumption that the interactions and relationships between group members is the main mechanism of change (Whitfield, 2010). Classic CBT groups however, works on the assumption that the cognitive model (described above) is the main mechanism of change and is more important than the interpersonal relations and interactions between group members (Bieling, 2009). The educational mindset of CBT makes it highly applicable to groups and its collaborative, structured, time-restricted nature does as well (Fennell, 1989). However, as in individual CBT, therapeutic change is not solely about techniques, education and taught skills. Non-specific factors, also referred to as common factors are also present and active in group CBT programs (Whitfield, 2010). The common factors has received less attention in CBT research compared with other therapeutic directions, instead the CBT research has focused on CBT-specific factors (Whitfield, 2010).
2.4. Common factors in group psychotherapy

Common factors refer to a set of therapeutic variables that are common across therapeutic orientations, the most researched common factors include, alliance, empathy, collaboration expectancy, group cohesion (Wampold, 2015). It has been suggested that common factors account for more of the variance in psychotherapeutic outcome than the specific therapeutic intervention (Levitt, Pomerville & Surace, 2016; Wampold, 2015; Wampold & Imel, 2015). Whilst there is a staggering amount of research into the effects of common factors such as alliance and expectancy in individual psychotherapy, the research into common factors in groups is less common. Group therapy is also thought to have much more complex therapeutic processes due to the many interpersonal relationships, the relationship to the group as a whole and the relationship to the group leader(s) (Kivlighan, 2004). Researchers from this paradigm has called for more research looking into these aspects of psychotherapy (Paquin, 2017).

Common factors specific to group psychotherapy were first described by Corsini and Rosenberg (1955). However, Yalom’s work on group therapeutic factors has been the dominating framework within this field (Whitfield, 2010). Yalom’s framework consists of eleven distinct therapeutic factors that are thought to exist in group therapy. These are theorized to be present

<table>
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<th>Box 1</th>
<th>Yalom’s Group Factors (Yalom, 1995)</th>
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<td>Installation of hope</td>
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<td>Universality</td>
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<td>Imparting Information</td>
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<td>Altruism</td>
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<td>Corrective recapitulation of the primary family group</td>
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<td>Development of socializing techniques</td>
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<td>Imitative behaviors</td>
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<td>Interpersonal learning</td>
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<td>Group Cohesiveness</td>
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<td>Catharsis</td>
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<td>Existential Factors</td>
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across different therapeutic orientations, because they, in and of themselves, constitute therapeutic change. Yalom has described the curative factors as the vehicles of therapeutic change (Yalom, 1995) See Box 1.

Others have also argued that these group therapeutic factors may be relevant across psychotherapeutic orientations (Whitfield, 2010). The argument being that whenever you create a group, there will be group processes at stake, that can affect both the group as one united entity, but also affect the ways in which individual members participate in- and benefit from the therapy (Burlingame, Fuhriman, & Johnson, 2001). Some factors are more relevant to group CBT than others, however all of them can be translated into a CBT relevant language and context (Bieling, 2009). A range of common factors (Yalom’s and others) have been identified as important for CBT groups specifically: group cohesion and task-focus has been emphasized as the two most important (White & Freeman, 2000), normalization through identification with others (Laberg, Törnkvist, & Andersson, 2001; MacMahon et al., 2015; Newton, Larkin, Melhuish, & Wykes, 2007; Whitfield, 2010) positive reinforcement through vicarious learning (Antonacci, Davis, Lewinsohn, & Breckenridge, 1987) and the experience of mastery or agency (White, 2000). Previous research has also pointed out that the group context has the opportunity to strengthen particular aspects of CBT such as behavioral experiments that may have a larger effect when there is a whole group that may essentially act as co-therapists in challenging negative automatic thoughts (Heimberg, Salzman, Holt, & Blendell, 1993) and in-vivo exposure in groups may also add another layer to the experience of exposure i.e. for patients suffering from social anxiety disorder the group context in itself can be understood as in-vivo exposure (Whitfield, 2010).

2.5. Therapist effects

A significant amount of the variance in psychotherapy outcomes can be subscribed to the individual therapists (Baldwin & Imel, 2013; Barkham, Lutz, Lambert, & Saxon, 2017; Huppert et
al., 2001; Kim, Wampold, & Bolt, 2006; Wampold, 2001) and this effect appears to account for more of the variance than the specific type of psychotherapeutic intervention (Wampold, 2001). Much of the existing literature had focused on between therapist variables such as demographics and level of experience (Beutler, Machado, & Neufeldt, 1994; Huppert et al., 2001), which school of psychotherapy the therapist subscribed to (VociSano et al., 2004), personality/characteristics (Zeeck et al., 2012), interpersonal skills (Moltu, Binder, & Nielsen, 2010) etc. Less attention has been given to the way each therapist adapts and develops with their patients over a psychotherapy course, which may be referred to as within therapist variables (Kivlighan, 2014). The role of therapist effects within group therapy is not well understood (Chapman, Baker, Porter, Thayer, & Burlingame, 2010), but researchers in the field emphasize that the therapists’ role is much different in group therapy compared with individual therapy, due to the many relationships and interactions that occur in group therapy (Neimeyer & Merluzzi, 1982; Tucker, 2016). Furthermore, using co-therapists in groups is an established practice (Luke & Hackney, 2007). A review of the literature on co-therapists called for empirical studies in the field as it was based on anecdotal and theoretically based publications (Luke & Hackney, 2007). To our best knowledge no studies has investigated the role of co-therapists in CBT.

2.6. The role of the qualitative paradigm in Psychotherapy research

While some of the first pioneers in psychotherapy research such as Freud and Rogers made use of qualitative methods in their iconic case studies, which laid the foundation for many of the psychotherapeutic interventions we know today, modern psychotherapy research has been dominated by quantitative studies with the aim of assessing the efficacy of various therapeutic interventions (McLeod, 2001). CBT research has been the frontrunner within this paradigm and in establishing its own efficacy. Several qualitative researchers have attempted to challenge the quantitative paradigm as the only way of conducting respected research (Polkinhorne, 1991; Stiles,
Qualitative studies provide the opportunity to create deep descriptions and rich accounts of these processes (Macran, Ross, Hardy, & Shapiro, 1999). Kazdin (2008) argued that in order to understand session-to-session processes, we must have thorough descriptions of what occurred, alongside explanations of why and how it happened that way. The purpose of conducting qualitative studies in psychotherapy is to provide information about the ways in which psychotherapy works, evaluate why interventions are effective or ineffective, and gain insight into overlooked components such as dissatisfying or harmful elements of therapy (Elliott, 2008). Furthermore, in qualitative research the study object is understood within a context (Goering, Boydell, & Pignatiello, 2008; Levitt et al., 2018; Rodgers & Elliott, 2015; Sandelowski, 1991; Stiles; Whitley & Crawford, 2005) and human experiences are perceived as real just like observable behaviors, however, they are bound to context to a higher degree (Stiles, 1993).

Whilst the quantitative field’s goal is to verify, qualitative research aims to discover, uncover and explore everyday phenomena in non-linear ways (McLeod, 2001; Stiles, 1993). The development within the field, with the overarching focus on verification has moved the research in psychology and psychiatry away from practice, as it is inevitably detached from everyday practices due to the rules and rigor of experimental methods (Goering et al., 2008; McLeod, 2001). There appears to be forming a common consensus in recent years, that in order for the field to move forward, both quantitative and qualitative studies are needed (Elliott & Timulak, 2005). Qualitative methods are well-suited for developing, evaluating and implementing clinical programs and have the potential of bridging the gap between research and practice by including therapists and patients (Goering et al., 2008). Whilst quantitative studies can produce generalizable figures, it also minimizes the voices of the patients through its methodology, since the researchers control what participants are asked about and when they express this. This way of conducting research, may potentially leave out important aspects of the human experience of psychotherapy (McLeod, 2001).
It has been suggested that qualitative approaches switches the positions so that the participant is the expert and the researcher is the layman (Whitley & Crawford, 2005). With this approach we can move towards a fuller and richer understanding of how the therapy worked, why it did or did not work, for whom it worked and what we may do to improve outcomes. Kuhnlein, a qualitative outcome researcher, said as follows:

“It is not appropriate for psychotherapy research to concentrate predominantly on objectifiable expert evaluations and on the change of isolated single spheres of life or modes of behaviour. We have to acknowledge that the adequacy of thinking, feeling and acting cannot be measured by universal standards, even within the same social and cultural context.” (Kühnlein, 1999).

Thus, it is important to focus patients’ and therapists’ experiences in psychotherapy research.

2.7. Clients’ experiences with psychotherapy

The research into clients’ experiences of psychotherapy was first carried out more than seventy years ago by Lipkin (Elliott, 2008), in his study, looking into clients’ experiences of person-centered therapy. Forty years later, Elliott and James (Elliott & James, 1989), synthesized the qualitative studies on client experiences that had formed at the time. They identified 9 domains essential to the client experience of psychotherapy. Five of the domains were related to experiences of the clients own intra-personal processes in psychotherapy such as; (1) their emotions, (2) intentions, (3) concerns, (4) ways of relating to the therapist and (American Psychiatric Association) ways of relating to themselves. The remaining four domains relating to (6) the therapist, (7) helpful aspects of therapy, (8) change & (9) impact (Elliott & James, 1989). Elliott (2008) later carried out a similar synthesis on updated research and summarized the helpful and
hindering aspects that had been found across five studies, in different contexts with different populations, underlining the generalizability of these (Elliott, 2008). The helpful factors identified in this paper were: the therapeutic relationship, the therapist listening/being empathic & validating, specific techniques for dealing with problems. The hindering aspects in the same paper were, the therapist being judgmental or imposing their views on the client (Elliott, 2008). The study also found trends that patients tended to refer to improvement in presenting issues and increased self-acceptance as important outcome factors. Elliott emphasized the potential for quantitative studies to make use of the outcome variables identified as meaningful for clients. Other studies have emphasized the importance of clients having agency when facing difficult moments in therapy, such as moments with strong negative emotions (sadness, anger, shame) and moments of disappointment or dissatisfaction with the therapist (Levitt, Pomerville, & Surace, 2016). Furthermore, Timulak (2007) conducted a meta-analysis on client-experience based qualitative studies and found 9 central themes across studies, these were; (1) awareness/insight/self-understanding, (2) behavioral change/problem solution, (3) empowerment, (4) relief, (5) exploring feelings, (6) feeling understood, (7) client involvement, (8) reassurance/support/safety, and (9) personal contact (Timulak, 2007). The findings of Elliott’s meta-synthesis and Timulaks meta-analysis appear to be strikingly similar. These two studies underline some of the core features that clients described throughout many qualitative studies, when speaking of their experiences. An initial insight into problems must form, then the problems must be identified and new solutions/behaviors must be learned, agency appears to help the process, exploring feelings, being recognized and understood produces relief and the client’s own involvement alongside the therapist’s ability to provide support, safety and good personal contact aids the process. These descriptions of therapeutic processes are useful and informative, especially since they are based on studies of varying populations and
psychotherapies including CBT. However, to our best knowledge, no systematic reviews has been made on the basis of group therapy studies.

2.8. Patients’ experiences with Group CBT

Whilst the research into group CBT has continuously found CBT to be efficacious, it is also consistently found that approx. half of patients do not benefit from this treatment (Hofmann et al., 2012.). Quantitative studies have struggled to find explanations why. To my best knowledge, no qualitative studies have been carried out looking at group CBT for depression and anxiety disorders in the MHS. In the following sections, I will visit the literature closest in nature. Starting with the common findings across individual and group CBT studies, some main conclusions can be drawn. Thus, in all of the studies, patients described both positive and negative aspects of their experiences with the therapy (Hodgetts & Wright, 2007; Laberg et al., 2001; McManus, Peerbhoys, Larkin, & Clark, 2010; Messari & Hallam, 2003; Morberg Pain, Chadwick, & Abba, 2008). Patients tended to emphasize both CBT-specific techniques and common factors as important for the outcome of treatment (Clarke, Rees, & Hardy, 2010; Hodgetts & Wrigh, 2007t; Laberg et al., 2001; McManus et al., 2010; Morberg Pain et al., 2008). Several aspects of CBT have been highlighted as particularly helpful, this includes; exposure exercises (Clarke et al., 2004; Nilsson, Svensson, Sandell, & Clinton, 2007), the case formulation (Clarke et al., 2004; Morberg Pain et al., 2008), and higher self-awareness (Berg, Raminani, Greer, Harwood, & Safren, 2008a; Clarke et al., 2004). External factors have also been identified by patients as influential on the CBT course, i.e., network and social support as well as financial stability and employment (Ringle 2015; Bystedt et al., 2014; Hynan, 1990; Berg et al., 2008). When looking to the research on hindering factors emphasized by patients, the brevity of treatment is at the top of the list (Berg et al., 2008; Clarke et al., 2004; Laberg et al., 2001). Several studies have emphasized the need to work with patients’ attitudes
towards and expectations of the therapy, as there appears to be initial scepticism in patients (pretreatment) across studies (Berg et al., 2008; Clarke et al., 2004; Morberg Pain et al., 2008) or, conversely, unrealistically high expectations (Mason & Hargreaves, 2001). When looking specifically at group CBT, another set of common findings apply, namely, that patients felt supported by fellow group members, felt normalization through experiencing that others felt the same and experienced a sense of bonding and group cohesion that impacted the CBT course positively (Bottomley, 1998; Gledhill, Lobban, & Sellwood, 1998; Laberg et al., 2001; MacMahon et al., 2015; Newton et al., 2007; Nilsson et al., 2007). Common to the findings from qualitative psychotherapy studies on patient experiences, both CBT and other psychotherapies, group and individual formats is, that patients emphasize both specific and common factors of therapy as being important.

2.9. Therapists’ experiences

The research into therapists’ perspectives is even more understudied than the patient perspectives (McLeod, 2001). The therapists hold knowledge about many different aspects of psychotherapy and exploratory interviews has been suggested to be the best way to elicit this information (Currell et al, 2016; McLeod, 2001). Therapists are knowledgeable about understudied aspects of psychotherapy such as deterioration, dropout from treatment or lack of improvement (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Lambert, 2013). Qualitative psychotherapy studies based on therapist interviews have revealed a number of patient related factors thought to be associated with negative outcomes, such as low agency, psychosocial stressors, comorbidity and complex psychopathology, low readiness to change, low motivation and low cognitive ability (Bystedt, Rozental, Andersson, Boettcher, & Carlbring, 2014; Ringle, 2015). Furthermore, CBT research into therapists’ perspectives has informed us about negative effects of CBT (Bystedt et al., 2014),
helpful and hindering factors (Ringle, 2015), outcome-related factors (McGowan, Lavender, & Garety, 2005) and reflections of the therapist’s own role in CBT (Gale & Schröder, 2014).

2.10. The current thesis and research questions

The current thesis used a range of qualitative approaches to explore the gaps in the literature concerning group CBT for anxiety disorders and MDD in a MHS context. The thesis focused on the overall experience of treatment, patient-characteristics, CBT-specific factors and common factors in relation to the outcome of a 14-week group therapeutic context. The studies were carried out within the context of the TRACT-RCT study (See section 4.1.1.). This thesis consists of four distinct articles, each shedding light on the overall research question from each their angle:

*How do patients and therapists experience a 14-week group CBT course for social anxiety disorder, panic disorder, agoraphobia and/or depression?*

This research question was approached by investigating different research questions in each article. The findings of the four papers collaboratively attempts to answer the overall research question.

1. The first paper explored twenty-three patients’ narratives of their participation in standardized, time-restricted group CBT within the psychiatric system and was driven by the research questions:

   - *How is group CBT experienced by patients in the services?*
   
   - *How do service-related factors influence the experience of group CBT in the services?*
2. The second paper focused on the therapists’ perception of patient-characteristics that may be hindering to a good outcome from group CBT and was driven by the research question:

- Which obstacles do therapists experience when delivering group CBT for a range of anxiety disorders and depression in Danish MHS?

3. The third paper looked into patients experiences of group cohesion in heterogeneous versus homogeneous groups and was driven by the research questions:

- What is the role of group cohesion in CBT groups for anxiety disorders and depression?
- Is group cohesion experienced differently by patients in mixed-diagnoses versus same-diagnoses group - and if so, how?

4. The fourth paper explored what patients experienced as helpful and hindering factors related to the therapists in the group and was driven by the research question:

- How do patients describe the therapists’ role in group CBT and what are the helpful and hindering aspects related to the therapists?
3. Epistemological considerations, positioning and choices

In the following sections, the researcher outlines her epistemological considerations, preconceptions, methodological path and choices and terminology, to the extent that is considered important for the research process and the results. These clarity processes have also been referred to as, reflexivity, and it is recommended that these are described in qualitative studies. Skewness and biases is therefore taken into consideration rather than eliminated (Malterud, 2001).

3.1 Epistemological considerations

Qualitative research can be used for many purposes and can be guided by different theoretical and epistemological frameworks (Whitley & Crawford, 2005). However, most of the qualitative research within psychological and medical research tends to explore how social phenomenon are constructed and have meaning for human beings (Malterud, 2001). Thus, there tends to be an underlying assumption that we exist in a constructed world that is multiplex and manifold and where our personal, interpersonal and relational worlds are multi-constructed (Levitt et al., 2018; McLeod, 2001). Qualitative research is interested in the ways that individuals experience the social phenomenon of interest (Malterud, 2001). Our many-faceted worlds are formed through language, culture, memory and the physical manifestations that we exist within. Due to the complexities of the constructed world, there are many ways to access information about phenomena (McLeod, 2001). In qualitative psychotherapy research the dominant perspective has been the individual’s subjective experience, accessed through interviews, in which the focus is on the meanings that form the individual’s experiences (Levitt, Farry, & Mazzarella, 2015). Implicit to qualitative psychotherapy research is the notion that we can never achieve full knowledge of any phenomenon. There is an overt aim to change and improve practices, deconstruct and reconstruct psychotherapy (McLeod, 2001).
Due to the very limited qualitative literature on group CBT, I wished to give voice to the patients and therapists within the services and give them the opportunity to influence future directions in psychotherapeutic treatment in the MHS. The overall approach was inductive and explorative and upon review of the material the sub-studies were approached in ways that were seen as the most fitting given the character of the research question and the data, See supplement one for overview of analyses. Article I took a fully inductive approach, Article II took an inductive-deductive approach, whilst Article III and Article IV were inductive-deductive-inductive. This means that there was an exploratory first step in which the research question was developed, then a deductive strategy in the coding of the material and then again an inductive and explorative approach to understanding the coded material. These strategies were chosen in order to shed light on both the patients’ overall experience and particular aspects of psychotherapy that were understood as both essential in the dataset and provided new findings to the field.

My epistemological position was critical realist, which is (arguably) situated between relativism and realism (Moran, 2018; Sonne-Ragans, 2012). This can be considered further to the middle compared with the traditional social constructionist paradigm usually employed within this field (McLeod, 2001; Malterud, 2001). In accordance with this stance, throughout my studies I have assumed that patients had access to their own experiences and could articulate these. Furthermore, I assumed that what the patients told me about their experiences was reflective of their actual experiences. This epistemological stance also emphasizes that the world is dynamic and complex and that knowledge develops in a social context. It acknowledges that the researcher chooses specific properties that identify the phenomenon of interest, in order to make the research possible, and therethrough also leaves out other aspects of the phenomenon (Sonne-Ragans, 2012). From this position, I searched for the patients’ and therapists’ true experiences and acknowledged that I as a researcher co-created the knowledge that aspired from these interviews.
The object of knowledge in this thesis was the experiences of group CBT as described by patients and therapists in the services. I had an explicit focus on therapeutic factors and any information that was in line with qualitative psychotherapy research’s overt goal to improve practices, meaning any information that could contribute to an understanding of how psychotherapeutic practices can be improved. I acknowledge that many other aspects of the material such as topics of identity and diagnosis, stigma, society and life stories were relevant and important, but this thesis focused on the therapy and aspects related the therapeutic course, due to the underlying aim of improving practices.

In all of the sub-studies I aimed to stay on a relatively descriptive level due to the lack of research in the field and the wish to really give voice to patients. I acknowledge myself as part of the process in which this knowledge was created and as the lead in the analysis. Thus, this product can be seen as a dialogue-based collaboration in which knowledge is the product. My foci and underlying assumptions have inevitably formed and shaped the findings presented in this thesis (Tanggaard, 2010). This means that, the four articles should be read with this in mind and should be understood as results of collaborative research.

### 3.2. Preconceptions

Having acknowledged that my active participation in the creation of knowledge will inevitably have affected the results of this thesis, I will try to come nearer how my preconceptions may have influenced my research. I am trained as a clinical psychologist and as a research psychologist from Universities in the UK and Denmark. My key interests are within psychotherapy research and psychopathology research, which leads me to one of my main preconceptions: I believe in psychopathology as a phenomenon and I mostly agree with the assumptions surrounding psychopathology, that it is abnormal psychology, that disorders are characterized by symptoms and
specific behavioral patterns and that it is caused and maintained by bio-psycho-social and contextual factors. However, I do not think that we necessarily research psychopathology in the most optimal ways and I believe that we are only beginning to understand psychopathology. I am critical of categorical models of psychopathology, as I lean more towards dimensional models. Furthermore, I am critical towards pure biological/neurological understandings of psychopathology.

This brings me to my second level of preconception, I believe that most individuals with psychopathological disorders can be treated through psychological, social and humanistic interventions. I believe in combined efforts between stakeholders in the patients’ lives. I think that making the patient an active participant in their treatment is essential and I believe inclusion of the patients’ immediate network is important. I do not have a strong preference for any specific psychotherapeutic directions, but I believe that therapist preference and patient preferences are important for good therapy and I think that common factors play an important role in any type of psychotherapy. I also think that socio-cultural factors have an important role to play when it comes to choosing therapist and therapy type for any given patient. I am opposed to the time-restricted standardized treatment packages currently being delivered in Danish Mental Health Services, as I think this model fundamentally takes away the option for patients to steer their treatment in ways that are meaningful and helpful to them. That said, I do think that a lot of patients benefit from this system and that there is a ‘fairness-factor’ in providing everyone with the same treatment. This is however, ambivalent to me, because I, despite acknowledging diagnoses, believe all humans to be fundamentally different and I believe the reasons and paths leading to psychopathological disorders are widely different, and therefore, psychotherapeutic treatment should be sculpted to the individual. I acknowledge the difficulty in providing both fairness and individualization within a public system with limited resources, yet I question if anyone gets and optimal treatment when everyone is treated the same. I generally believe the psychotherapeutic treatments in the current
model are too short and too limited in terms of format and flexibility. I also believe the mental health services to be underfunded, underprioritized and stigmatized politically (Stenberg, 2020).

My third level of preconceptions surrounds the research in psychotherapy. I find myself wanting the field to generally take a more bottom up approach and become more practice oriented. My natural approach as a researcher is to want to uncover and shed light on psychotherapy as a phenomenon. I identify as a psychotherapy researcher, not as a CBT researcher, as I believe CBT to be a psychotherapy that works in much the same way as other psychotherapies and for common factors to be equally important in CBT. I fundamentally think that the use of the classical evidence hierarchy in psychotherapy research is a problem as I believe it encourages reductionistic research within a complex human study arena. I believe that efficacy studies need to be backed up by research into the human experience of the given phenomenon due to the complexity of the nature of our study object.

I do, without a doubt have a range of other preconceptions that have influenced my way of being a researcher, but I found the three levels of preconceptions presented above, to be the most central, that I have access to. I acknowledge that I am blind to many aspects of my preconceptions and the levels identified above were merely the preconceptions I became aware of through reflection. I acknowledge that I exist within several overarching systems that affect my preconceptions and that make me blind to the same, some of those systems are: the psychiatric system, the healthcare system, a welfare system, a research system and a university system. Furthermore, I am aware that my personal position as a white, middle-class, academic female is a position of privilege and I am unlikely to fully understand the positions and personal experiences of individuals from minority groups and stigmatized groups (such as psychiatric outpatients).

These preconceptions have shaped the foci of the interviews, the analysis and the results. My main focus was on psychotherapy and its mechanisms as well as broader psychiatric treatment
and on improving practices. This has given this thesis a psychological, clinical and practical character that I have directly steered. The material also touched upon interesting topics such as the wider welfare system, stigmatization, gender, identity and psychopathology, having focused on either of these would have given the studies a fundamentally different character and implications.

### 3.3. Methodological path and choices

The thesis in its current form is rather different from the project defined originally. When starting the project, the aim was to employ thematic analysis with three different populations: the therapists, patients who had completed treatment and patients who had dropped out of treatment. Thus, three separate interview guides were developed to supplement the quantitative results from the TRACT-RCT with information from qualitative sources. As I started interviewing, I found that across the therapist interviews and the patient interviews, there were consistent themes and subjects, parallel narratives and stories that went beyond what the initial research questions were looking to answer. The interviews with patients who had dropped out were extremely hard to collect, due to non-response and no-shows for interview appointments, we tried to shift to telephone interviews, but were still unsuccessful. The combination of a failed recruitment strategy and the pictures the collected material was starting to draw, made me rethink. This is when I shifted from making a thesis that was steered by predefined topics and article themes, to a thesis where the article themes were steered by the emerging data. I redefined my research questions and then I redefined the analytical strategies to fit the new research questions. At this time, I had already gone through the process of thematically coding the full material, sentence by sentence, I had also had a second coder, separately code six full transcripts from the patient interviews and we had reached consensus in the coding. When I looked at the overarching codes from the thematic analysis such as “The Group”, “Techniques”, “Diagnosis” etc., I saw that the story that I has been told repeatedly by the
patients, was not captured, the story was fragmented into individual pieces, that did not deliver the overall message that I had been told so many times. It did not capture that whilst the treatment was experienced as positive, other factors made the overall feeling an ambivalent one. This led to a shift to the narrative phenomenological analysis for article I. This analytical strategy attempts to capture the story of each individual rather than sub-divide each interview into categories and then subsequently looks for a common narrative across the interviews. In the same way, thematic coding did not serve well in trying to extract particular patient characteristics that the therapists highlighted. Thus, a shift was made towards a deductive framework, a strategy looking specifically for those patterns and the descriptive analysis fitted that research question. I also found that the thematic coding work that had been done was useful. Through that process I had familiarized myself thoroughly with the data. When carrying out the analysis for Article III and Article IV, I could extract the material on all relevant codes and carry on from there. This was a long qualitative process, decisions and counter-decisions on foci, research questions and analysis strategies were made numerous times to arrive at the final methodological choices. I found myself in a conflict between what I had originally set out to do and what I perceived as more important topics in the data-pool. In the end, I went with the overarching, themes that I saw emerging, in order to stay close to the overall aim of giving voice to the participants.

3.4. Terminology

3.4.1. Patients

The term patients was used to describe the participants in this thesis. This choice of words can be seen as controversial as it bears strong associations to the medical model and patients being in a passive role in which treatment is prescribed to them (Speed, 2014). Currently, a variety of terms are being used to refer to individuals engaged with mental health services, with the UK
Medical Council referring to individuals under treatment with a doctor as patients, the British Psychological Society refers to clients and the British Association of Social Workers using the term service users (Simmons, Hawley, Gale, & Sivakumaran, 2010). In a study looking to assess how ‘individuals using services’ would prefer to be termed, patient came out as the preferred term, service user was disliked by individuals seeing health professionals (not social workers) and there was a significant number of individuals, though a minority, who would like to be termed user or survivor (Simmons et al., 2010). Within recovery-oriented practices terms such as service-user, user, people with lived experience or survivors is often used (Speed, 2014). The problems attached to the term patient is acknowledged and understood as a real and serious matter, see section 6.3.3. where the passive role of ‘a patient’ is discussed. The participants of the current study were perceived as help-seekers, patients and clients, this is elaborated on in the discussion. However, the term patients was used throughout the thesis and the four articles, because the standard term for individuals using Danish MHS is patients, it is the word that the therapists and other staff use, and it is the label that the ‘users’ have already had placed upon them. For this reason, the thesis remained consistent with the language that is used in the services.

The word ‘client’ will appear when speaking of non-clinical or partially non-clinical samples or when citing works where this terminology is used.

3.4.2. Therapists

The choice of the term therapist as opposed to staff or psychologists was chosen as it was the only term that described all of the interviewed staff whilst excluding the non-therapeutic staff in the services. Due to the various educational backgrounds in the sample (clinical psychologist, psychiatric nurse, occupational therapist) the name of one professional group could not be used. Furthermore, there are many other staff that patients meet in the services who are not their therapist
i.e. doctor, assessment team etc. As the current thesis is focused on psychotherapy it was also deemed the most appropriate term for the staff involved in psychotherapy practice.

### 3.4.3. Medical Model

Throughout this thesis, the phrase medical model is used in reference to delivering psychotherapy within a context that is based on classical medical assumptions. This is defined by the therapists and other staff in the services being comparable to a medical doctor in that they are experts on the patients’ problems and they know how to alleviate those. They assess the patient to reach a diagnosis and subsequently prescribe the treatment fit for that diagnosis. The interventions are expected to remove diagnosis specific symptoms and thereby install change in the patient (Bohart, 1999). The medical model as defined above have been criticised for a number of reasons, namely, that it does not do well at describing what psychotherapy is or how it works, it has dominated the field due to its ties with medicine and science rather than its fit with psychotherapy as a phenomenon, it confuses psychotherapy with a type of medical treatment as opposed to an interpersonal process and it cannot account for the large numbers of individuals without mental illness who seek psychotherapy (Elkins, 2009)

### 3.4.4. Roles

In the discussion the term “roles” is used. When using this term, it is in referral to the definition from Miller-Keane’s dictionary of Medicine, Nursing and Allied Health (Miller):

“A pattern of or behavior developed in response to the demands or expectations of others; the pattern of responses to the persons with whom an individual interacts in a particular situation”

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It is therefore not used with deeper theoretical ties than that and is not used in reference to the research fields of patient roles, help-seeker roles, staff-roles etc.
4. Methods

4.1. Context

4.1.1. TRACT-RCT

The TRACT-RCT study was a multicenter randomized clinical trial investigating whether transdiagnostic group CBT was non-inferior to standard diagnosis-specific group CBT (Arnfred et al., 2017). The trial was carried out in 4 clinics across the Region of Zealand, the Capital Region and the Middle Region of Denmark. Patients with a primary diagnosis of MDD, panic disorder, agoraphobia and social anxiety disorder were included. The main paper has been submitted (Reinholt et al., 2020). The results of the trial were revealed after the interviews had all taken place and the analysis for article 1-3 had been carried out and written. The TRACT-RCT was the mother-study to the current thesis and the author of this thesis carried out many tasks within the RCT study. The overall patient sample in the TRACT-RCT study was characterized by high-level of functional impairment, long-lasting/chronic symptoms and several previous treatment attempts (Reinholt et al., 2020).

4.1.2. The treatment manuals

The psychotherapeutic treatments delivered in the TRACT-RCT were based on four established CBT manuals adapted to the Danish MHS. The four manuals were:

- Diagnosis-specific group CBT for depression, adapted to TRACT-RCT. (Due Madsen, 2008)
- Diagnosis-specific group CBT for panic-disorder and agoraphobia, translated and adapted to TRACT-RCT (Barlow, 2006)
• diagnosis-specific group CBT for social anxiety disorder, translated and adapted to TRACT-RCT (Hope, 2006)
• The Unified Protocol for emotional disorders, translated and adapted to TRACT-RCT (Barlow et al., 2010)

All of the manuals consisted of a pre-group case-formulation session for each individual patient and 14 group sessions. The therapists were trained in the manuals prior to delivering therapy. The therapists delivered either transdiagnostic therapy or one or more of the diagnosis-specific treatments. Throughout the therapists’ participation in the trial, they received monthly supervision, specific to the manual they were working with.

4.1.3. Danish Mental Health Services

The treatment was delivered in the outpatient clinics in Danish MHS. The clinics treat patients with a variety of non-psychotic disorders such as anxiety disorders, depression, personality disorders, PTSD etc. The MHS deliver time-restricted standardized psychotherapeutic treatments along with medication management. The services are free of cost to the patients as they are publicly financed. The standardized treatment packages differ for the different diagnostic groups i.e. depression amounts to a treatment package of a total of 18 hours including assessment, psychotherapy, medicine appointments and one hour for relatives (Danske Regioner, 2017b). Panic disorder (and agoraphobia) and social anxiety disorder each amount to a package of 15 hours (Danske Regioner, 2017a). The outpatient clinics are under the legal requirement in Denmark to start treatment within 30 days of referral. The patients in the services are referred from their general practitioner or other sections of the MHS and the outpatient clinics accept patients who have completed several treatment attempts (psychotherapy from the primary sector i.e. private
psychologist or psychiatrist or medicine) with no substantial improvement, patients with a high level of functional impairment and patients with high severity and high distress levels. Furthermore, patients can be referred if there is a need for diagnostic assessment (Danske Regioner 2017a; 2017b).

4.2. Participants

Thirty-five interviews were conducted with 23 patients and 12 therapists who had participated in the TRACT-RCT study. The interviews took place between January 2018 and February 2019. This made up the data for the four articles that this thesis consists of. For each article, a subsection of interviews was chosen for analysis. No article included all 35 interviews.

4.2.1. Patients

Twenty-three patients were interviewed for approximately 60 minutes at their treatment center. The number of participants in the sample was chosen to ensure that there was data saturation for all three sub-studies, due to the nature of study III, which was comparative (meaning that the data was split in two) a larger sample was required. The recruitment strategy was purposeful/strategic sampling (Kuzel, 1999) and the procedure was split in two stages. For the first half of participants, all patients who had completed treatment were contacted via telephone and invited to participate. For the second half, I invited selected patients with non-represented characteristics in the data, i.e., patients of older age, patients with specific diagnoses or patients whom has participated in a specific type of CBT group. This was done to ensure a sample consisting of many differences between participants to heighten the level of transferability (Malterud, 2001). For the third paper, we had a comparative strategy, meaning that we aimed at getting a minimum of 10 participants from transdiagnostic groups and 10 from diagnosis-specific groups, we also aimed at having a relatively even distribution of patients with anxiety and
depression in each sub-sample. All the participants had a primary diagnosis of MDD, panic-disorder, agoraphobia or social phobia. A full list of patient characteristics can be found in article 1 and 3.

4.2.2. Therapists

Twelve therapists were interviewed for 60-90 minutes at their workplace. Data saturation (Faulkner, 2017) was reached at about 10 interviews and the final two was carried out because they had already been booked. The recruitment strategy was convenience sampling and the therapists were contacted via email or in person advertising at the center. Eight of the therapists who signed up had delivered the transdiagnostic CBT (Unified Protocol) whilst 4 had delivered diagnosis-specific CBT. The interviewed therapists represented all 3 clinics involved in the TRACT-RCT and had various educational backgrounds and levels of experience (3-26 years of experience, median=10 years of experience). Nine of the participants were clinical psychologists, one was an occupational therapist and two were psychiatric nurses. All participants had delivered a minimum of one treatment course (14-sessions) prior to being interviewed. All of the participants were women as there was only two men delivering therapy at the time of the interviews, one of whom did not sign up and the other had not yet delivered one full treatment course.

4.3. Interviews

The interviews were all carried out by the author of this thesis. All interviews were based on a semi-structured interview guide, one for patients (Article I: Supplement I) and one for therapists (Supplement II). The interview guides were built up in an exploratory way, in which the first section of the interview was based around open exploration; the first question “tell me about your experience with the therapy course, just say anything that comes to mind” was followed by curious and detailed asking about the topic(s) brought to light spontaneously by the participant. The
following sections would ask questions about a range of topics such as the group, changes, significant moments, expectations etc. The third section of the interviews was related to the specific type of therapy the participant received or delivered and questions about how the research project influenced the experience. The final section of the interview was a closure section, aimed to ensure that no key elements of the experience had been left out and the participant got free opportunity to provide final remarks, clear up anything they had said prior and to express whether they felt that the interview has covered the most essential aspects of their experience. All interviews were audio-taped and transcribed verbatim by staff in the TRACT-RCT team. All interview data were analyzed through the NVivo software.

4.4. Ethics

All participants were given detailed information about the aims and purposes of the interviews, the ways in which data would be managed and used and how they could retract consent. All participants provided written consent. No participants withdrew their consent. Due to the sensitive nature of the topics of the interviews i.e. suffering from mental health issues, receiving treatment in the psychiatric system, work-place related issues etc. all participants were debriefed at the end of the interview. The interviewer’s educational background as a clinical psychologist made her capable of carrying out such debriefs in a responsible manner. One patient interview was ended after 30 minutes due to the cognitive difficulties experienced by the patient, making it difficult for the participant to remember much from the course, and one therapist interview was cancelled as the participant did not feel comfortable being interviewed upon having reviewed the interview guide. All transcribed data was only accessed by the first author and the staff who transcribed the interviews. Afterwards, all the data was pseudo-anonymized, meaning that all names and other characteristic information that could lead back to the participant, was replaced with false
information, that did not alter the meaning of the interviews. Extracts chosen for the articles were carefully chosen so that they could not lead back to the interviewee.
5. Summary of Results

5.1. Article I

“Does One Treatment Benefit All? Patients’ Experiences of Standardized Group CBT for Anxiety and Depression”

In this article, a phenomenological narrative analysis was used. See Supplement III for a description of narrative synthesis. The analysis revealed a common narrative across the 23 patient interviews. The narrative consisted of six themes, presented in chronological order, in accordance with the participants accounts. The themes were:

1. How did I get here?

Participants expressed feeling scepticism prior to starting/in the beginning of the therapy course. The scepticism was rooted in a lack of information about the therapy course, confusion around the role of different stakeholders, i.e., general practitioner, psychiatrists, psychologists etc. or previous non-helpful therapy experiences. Participants often described not knowing what they were going into, arriving upon the first session.

2. Being seen, heard and recognized

Participants explained how their initial scepticism was replaced with positive surprise, as they experienced normalization, recognition, a free space to talk and a non-judgemental attitude. They described how this was healing in and of itself and how it made participants develop a sense of belonging to the group.

3. Shared responsibility of problems and solutions

Participants described another helpful feature of the group therapy, that was, the feeling of lifting together as a group and having a responsibility towards the group. They expressed feeling a
common will or motivation to get better and explained how they felt obliged to challenge themselves and get better for themselves and for the group.

4. Education & tools

The participants explained how they expected to gain tools, how they learned new things about themselves and their struggles and how they used that knowledge and those tools during and after the end of therapy. Participants preferred different techniques and tools and viewed the group therapy as a toolbox from which they could pick and mix the tools and techniques that they felt were the most helpful. There was a general feeling, that more time was needed to really get the techniques ‘under their skin’.

5. Limitations of this group format

Two different types of limitations of the group format were highlighted. The first relating to a sense of self-monitoring, in regards to how much time each participant spent talking in the group, some participants expressed feeling stressed about taking up too much time and therefore limited their contributions. The second limitation was that some patients felt that there were topics that were too private, emotional or painful to share in the group and that some participants therefore, did not share their central problems in the therapy course.

6. Launchpad

The Launchpad referred to the feeling that participants were left with upon completion of the therapy course. They expressed how they had gotten new insights, tools and had experienced normalisation and support, but also how they felt they were being launched into a world on their own, that they were not yet ready for. They shifted between passivity and agency when talking about the future and expressed both hopefulness and hopelessness at the same time.
5.2. Article II

“Therapists’ Perceptions of Individual Patient Characteristics that may be Hindering to Group CBT for Anxiety and Depression”

In this article, a deductive descriptive analysis was used to identify individual patient characteristics that therapists considered to be hindering to a good outcome of group CBT. Upon coding of the material, four distinct characteristics were identified. The four characteristics were:

1. Complexity & severity

The therapists described how patients with more complex and severe psychopathology were harder to treat during the group therapy course. They explained how the standardized, time-restricted format was too short for the patients with more severe and complex psychopathology. Comorbidity and chronicity were also highlighted as hindering factors.

2. External circumstances

Stressors and stressful circumstances residing outside of the therapy room was highlighted as hindering factors to the group-CBT course. The therapists described that patients should ideally have a relatively calm outside environment in order for the therapeutic processes to work as it was hard for patients to engage in therapy if their minds were elsewhere. External circumstances include occupational and financial stressors, interpersonal problems, crises, societal and systemic stressors and traumatic events.

3. Attitudes & coping

This theme encompassed constructs such as motivation, readiness to change, coping mechanisms and attitudes. The therapists spoke about these constructs interchangeably and as one whole construct. Negative attitudes, lack of agency, low motivation and low engagement were seen
as barriers to good outcomes. This therapists described as a minimum prerequisite for the treatment to be able to work. Therapists highlighted that for patients with negative attitudes, low motivation and non-active coping styles, individual treatment with this specific focus should be carried out prior to patients entering the group therapy.

4. Cognitive ability & reflection level

The therapists perceived cognitive ability and reflection level as important factors for the outcome of the group course. They explained how it was problematic if patients’ cognitive abilities were lowered due to psychopathology and if their general reflection level was not high. They explained that for such an information-loaded therapy with ‘read and write’ homework assignments, cognitive abilities and reflection level in the normal range was important.
5.3. Article III

“Despite the Differences, We Were All the Same: Group Cohesion in Diagnosis-specific versus Mixed-diagnosis CBT Groups for Anxiety and Depression: A Comparative Qualitative Study”

In this article, a comparative thematic analysis was carried out to investigate how group cohesion was experienced in CBT groups, and if there were differences between diagnosis-specific and mixed diagnoses groups. See supplement IV for description of analysis. The analysis uncovered 3 themes and highlighted differences between the groups. The themes were:

1. From differences to similarities

The participants described how they initially detected differences upon meeting their fellow group members. Participants also explained how they did not see the differences as problematic, and they quickly started to detect similarities as time went on. Noticing these similarities made most participants feel belonging to the group and a sense group cohesion. Some of the participants from the diagnosis-specific group felt different and struggled to feel belonging, as they felt that their symptoms were different. Participants from the mixed diagnoses groups tended to speak directly about how diagnostic differences did not matter. Thus, there were differences between the groups in the importance placed on being symptomatically different or similar.

2. The role of group cohesion in group CBT

Group cohesion helped patients to feel supported, understood, less stigmatized and less lonely. It also made participants feel a responsibility toward their fellow group members, pushing them to engage actively and not let the group down. Seeing that other people experienced similar problems directly impacted some of the participants sense of self-worth in a positive direction and “it made the burden easier to carry”. Group cohesion was experienced as healing in and of itself.
3. Factors helpful and hindering to group cohesion

Three factors were pointed to as either helpful or hindering in the development of group cohesion. (1) The motivation of fellow group members was identified as important. Participants explained how motivation in other group members could rub off on everyone and accelerated the development of group cohesion. (2) The mid-session breaks were perceived as helpful as it allowed time to talk about “normal things” and “just be normal humans”. (3) Group members who were perceived as unable or unwilling to share was experienced as hindering as it caused frustration and “a feeling of a stranger in the room”.
5.4. Article IV

“Dos and Don’ts for group psychotherapists: patients’ perspectives on helpful and hindering aspects related to the therapists in CBT groups for Anxiety and Depression”

This article employed a thematic analysis to explore how patients experienced the role of the therapists in group CBT and to investigate which helpful and hindering aspects related to the therapists they brought forward as important. See supplement IV for description of analysis. The analysis uncovered 4 themes related to the group therapists. The themes were:

1. The dynamic duo

The patients emphasized the importance of the interplay between the two co-therapists. The collaboration between therapists was experienced as positive when there was a harmonic and/or dynamic interplay and evenly split work tasks. It was experienced as hindering when the therapists had an uneven work division or a dynamic that was hard to make sense of. Patients highlighted the need for therapists to be explicit about their role division if it was not even.

2. The way to communicate

Under this theme, patients highlighted aspects related to communication that were considered helpful i.e. clear and concise communication, validation through language, using socratic questioning and using language to create bonding through a focus on similarities between group members. Communication was thought to be highly important for the development of a positive emotional climate in the group. The patients found it hindering when therapists were perceived as pushy, pressing or judgmental in their communication style.
3. Steering time and goal setting elegantly

Goal setting and time management was experienced as highly important for the group therapy. However, the patients emphasized the therapists’ ability to use timing elegantly when managing time. They expressed how it was experienced as problematic when the therapists pushed the agenda at times of high emotional intensity. Furthermore, goal setting should be steered by the patients as it was perceived as negative when the therapists steered the patients’ goals and was inflexible in adapting goals throughout the treatment.

4. The therapists as group facilitators

In the final theme, the patients expanded on their perceptions of the therapists’ role. The therapists’ ability to create a safe space with a good atmosphere was highlighted. Furthermore, the therapists should be able to switch between focusing on the group as a whole and the individual group-members when needed. There should be common goals that bound the group together and the therapists should facilitate this, according to patients. The patients also highlighted the therapists’ ability to include everyone and to keep creating openings for group members who were unable to share.
6. Discussion

6.1. Original Findings

The current thesis found several original results. Throughout the following sections these will be highlighted:

6.1.1. The impact of a standardized, time-restricted treatment format on the experience of group CBT

The current thesis emphasized how the patients experienced the standardized time-restricted treatment format as inflexible, rigid and leaving them feeling like “another one in the line”. They explained how it directly influenced their experience of and participation in their psychotherapy course, as there was a general sense of confusion and scepticism prior to beginning in therapy and a feeling of anxiety and abandonment both before beginning and after the end of the therapy course (Article I). This was understood as a manifestation of unsuccessful negotiations of expectations (Wampold, 2015), more specifically, an absence of explanation of distress models and treatment strategy and a lack of general information about treatment, the roles of various staff and the reasoning behind treatment choice. Furthermore, the confusion and scepticism was understood as an expression of frustration with a treatment model that was generally insufficient for many of the interviewed patients.

6.1.2. The ways in which common factors directly influence CBT processes

The results revealed that patients experienced direct connections between common factors and CBT specific processes (Article I; Article III; Article IV). Patients highlighted that a strong sense of group cohesion gave motivation and inspiration to individual group members (Article III). This is in line with Yalom’s view that group cohesion is at the core of all other group related
processes (Yalom, 1995). Group cohesion has also previously been related to participation in therapy, attendance, dropout and increased personal support (Burlingame, McClendon, & Yang, 2018; Joyce, Tai, Gebbia, & Mansell, 2017; Taube-Schiff, Suvak, Antony, Bieling, & McCabe, 2007; Tschuschke & Dies, 1994). The sense of a ‘lifting together as a group’ gave patients a sense of responsibility and discipline in carrying out their homework assignments and in being open and honest with the group (Article I). Previously, CBT in groups has been emphasized as having unique characteristics because of the positive effects that socialization and modelling behaviors may have on the individual patient (Bieling, 2009). The current study found that group cohesion, universality and alliance directly influenced the patients’ participation in and utilization of CBT specific techniques.

6.1.3. The role of the therapist and the interplay between the two therapists in group CBT

The current thesis revealed how patients experience the role of the therapists in group CBT. Patients highlighted structuring and goal setting skills, communication skills, individual characteristics, and interestingly, the interplay between the two therapists (Article IV). The focus on the dynamic between the pair of therapists and the impact it has on patients’ experience of and participation in therapy is a novel finding. The study also highlighted how different aspects of leadership skills such as facilitation of emotional climate and structuring behaviors (Article IV) were important for the therapy outcome and the development of group cohesion (Chapman et al., 2010). The therapists’ ability to employ different leadership skills at different points in the therapeutic course was found to be important. Furthermore, the therapist’s ability to collaborate in generating goals and to be supportive and encouraging throughout the course, affected engagement in therapy (Article IV). This echoes the findings of a qualitative study in which patients with eating disorders emphasized the therapist’s ability be supportive of each individual group member (Laberg et al., 2001). The study highlighted the individual therapists’ ability to use timing and to sense the
important issues in the room as key to the patients’ experiences of the therapists. This particular point has previously been raised by Kivlighan who emphasized within-therapist variables and the concept of timing (Kivlighan, 2014). This study also found *within therapist variables* such as being able to display different leader behaviors at different times, to be important for outcome. Furthermore, it was also underlined that the therapists have an effect on other common factors such as group cohesion (Article IV).

6.1.4. *Group cohesion is linked to distress explanations and therapy type*

The results revealed that group cohesion and other group related processes were considered one of the most important, if not the most important, aspects of psychotherapy from the patients’ perspective (Article III). The patients explained how group cohesion developed through a process of initially seeing differences, then seeing through differences to see similarities and then to feel a sense of group cohesion that was healing in and of itself. Interestingly, patients from the mixed diagnoses groups verbalized similarities more directly and expressed how diagnostic differences were not important, whilst some of the patients from diagnosis specific groups experienced being different in terms of psychopathology (Article III). We subscribed this difference between groups to the underlying distress models in the treatment manuals that differed between the transdiagnostic therapy and the diagnosis-specific therapy (distress as the result of neuroticism, distress as a result of a particular disorder). The link between disease models, distress explanations and the development of group cohesion is a novel finding.
6.2. Support for existing findings

Many of the results that emerged in the current thesis echoed previous results and thereby provided support for those existing findings. These will be elaborated on in the sections below:

6.2.1. Common factors are experienced as important in group CBT

The results showed that the patients put greater emphasis on common factors, especially group-related processes compared with CBT-specific factors (Article I; Article II; Article III). This is in line with the theoretical standpoints of much group therapy research (Burlingame et al., 2018), however, it is interesting in a CBT context. Although CBT research into the effect of group related common factors is sparse, all of the qualitative studies detected found similar results, i.e., that patients place great emphasis on the group, the therapists and their expectations compared with manual-specific factors (MacMahon et al. 2015; Newton et al. 2007). Thus, group CBT should have an overarching focus on facilitating productive group processes as these are directly linked to the overall experience and outcome by patients (Article I; Article III; Article IV).

6.2.2. Patient characteristics can be important for outcome in standardized treatment

The interviewed therapists pointed to a range of individual patient characteristics that they understood as important for outcome, specifically in a standardized, time-restricted treatment model. The therapists pointed to agency, motivation and active coping styles this is in line with findings from previous qualitative studies (Lynch, 2012; Ringle, 2015; Bystedt et al., 2014; Sharf, 2009). Furthermore, both therapists and patients have previously pointed to external difficulties or situational constraints as their main reason for dropout (Hynan, 1990; Thomas, 2006). Cognitive abilities within the normal range was perceived as important for the outcomes of group CBT, previous studies have also found clinicians to perceive educational level, reflexivity and cognitive ability as important factors (Lynch, 2012; Wiebe & Greiver, 2005). Finally severity, complexity and
chronicity was experienced as obstacles to a good outcome of this treatment, these factors are well described in the literature as predictors of poorer outcomes and have previously been highlighted by clinicians (Hamilton & Dobson, 2002; Mululo, Menezes, Vigne, & Fontenelle, 2012; Newton et al., 2007; Ringle, 2015; Stern, 2015). All of the identified factors and has been deemed relevant in regards to patients’ responses to CBT (Moorey, 1996) and to psychiatric outpatient treatment in general (Maunder et al., 2016). This study, however, gave insight into the ways the therapists tied various constructs together and described the multiplying effect that the therapists believed these characteristics to have. It also highlighted the need for new, more comprehensive treatments for several subgroups of patients (Anand, Sudhir, Math, Thennarasu, & Janardhan Reddy, 2011).

6.2.3. The patients experienced CBT tools as helpful and applicable

The vast majority of the interviewed patients found CBT techniques such as exposure exercises and cognitive restructuring helpful and applicable in their everyday lives. There were large discrepancies in the techniques and tools highlighted as the most helpful for each individual, indicating that the different exercises had different meaning and utility for each individual. Patients described the therapeutic tools as a toolbox from which they would pick and mix the techniques most relevant to their situation (Article I). Patients also highlighted needing more time to get the techniques ‘under their skin’, which has also been found in previous qualitative CBT studies (Laberg et al., 2001). Previous patient experience studies have highlighted different aspects of CBT such as exposure exercises (Ayers, Bratiotis, Saxena, & Wetherell, 2012), the case formulation (Clarke et al., 2004) and the educational aspects that leads to higher self-awareness (Berg et al., 2008a; Clarke et al., 2004). Thus, the finding that various techniques and tools were pointed out as helpful is consistent with previous literature.
6.3. Understanding the results – theoretical perspectives

The original findings as well as the support for existing findings produced in this thesis do not just provide segmented micro-findings. When pulling the findings together, they provide opportunities for understandings of psychotherapy within a MHS context in an integrated way. In the following sections, a model will be presented.

6.3.1 Integrating the findings

A model of the factors impacting on psychotherapy outcome, identified in this thesis, was developed to integrate the findings in the current thesis. The model proposes that system-related factors specific to the given context of therapy sets the frame for the therapy and directly influences both therapists and patients throughout the entire duration of a psychotherapy course, indirectly affecting overall experiences and outcomes of the intervention (Article I). Psychotherapy outcome is further dependent on four major aspects, namely, common factors, manual specific factors, individual patient characteristics and therapist variables (Article I; Article II; Article III; Article IV). It is the interplay between these four aspects, which the current thesis has described as complex and interrelated in many ways e.g. that group cohesion (common factor) impacts on patients’ participation in exercises and homework (manual specific factors), which is also influenced by the patients’ ability to actively engage and take responsibility (individual patient characteristics) and the therapists’ ability to facilitate (therapist variables) group cohesion (common factor) and motivation (individual patient characteristic) and adapt the content (manual specific factors) to the individual (therapist variables). The model is representative of the findings in the current thesis, but also echoes many of the aspects included in previous integrative psychotherapy meta-models such as the generic model of psychotherapy (Orlinsky, 2009) and the contextual model of psychotherapy (Wampold, 2015).
An integrated model of the results

Previously, the literature within the field has tended to focus on one main aspect’s simple relation with another or with outcome for example:

- For whom (individual patient characteristics) does CBT work?
- What is the role of alliance or group cohesion (common factor) in CBT?
- What is the role of homework (manual specific factor) in patient’s outcomes?
- How does the therapist’s interpersonal skills (therapist variables) influence alliance (common factor)?
- What makes some therapists more successful in creating good outcomes than others?
- Which common factors are the most important for outcome?

This findings in this thesis makes it apparent that in order to understand how psychotherapy works we must integrate all of these aspects. Both patients and therapists in the current study have
continuously and consistently linked all of these aspects together as interdependent, interrelated and working all together at once, and importantly, within a context. Context, in this model described as system-related factors, is rarely included in psychotherapy models. However, in article I and article II, it was evident how the frame of psychotherapy (imposed by the system) directly influenced patients overall experience, preliminary attitudes and outcomes as well as the therapists’ perceptions of whom benefitted from such a therapeutic course. A recent meta-analysis concluded no factors, neither common nor specific, have met the criteria for an empirically validated causal factor in patients’ recovery (Cuijpers, Reijnders, & Huibers, 2019). These results propose it is not isolated single common factors and/or manual specific factors that affect change processes for the patients but rather a complex interplay of these, alongside individual patient characteristics, therapist variables and the system-related factors that in combination appeared to facilitate or hinder change.

This is in correspondence with previous integrative psychotherapy models (Orlinsky, 2009; Wampold, 2015). The generic model of psychotherapy includes all of the aspects below the psychotherapy bar in this model and connects them in a more detailed and elaborate way (Orlinsky, 2009). The contextual model of psychotherapy proposes that the real relationship, expectations and specific ingredients are the working mechanisms of importance (Wampold, 2015), all elements that are also included in the current model under the psychotherapy bar. However, previous integrative models may have underestimated the importance of the system in which the therapy is delivered whether that be, private practice, public systems, insurance systems etc. This aspect may have previously been left out as it does not cover mechanisms in psychotherapy per se, however, in the current study/setting, it appears to be a factor that very much interferes with the mechanisms proposed in previous models. Thus, the inclusion of this element is seen as an addition to the understanding of psychotherapy.
Furthermore, this model also emphasizes the link between the manual specific factors, the therapists and the patient. Previous models assume that the therapists use the model they subscribe to and that they need to make the patient cooperate within that framework (Orlinsky, 2009) or that they need to align patients’ expectations (Nissen-Lie, Havik, Høglend, Rønnestad, & Monsen, 2015). However, none of these models consider that the therapists may deliver models that they do not necessarily see fit for the presenting problems, as we saw in Article II. This leaves one wondering, if it is possible for the therapist to create successful collaboration and negotiate expectations, if they themselves do not see the treatment model as the best choice. This is a further indication of the importance of the system-related factors.

6.3.2. Group Psychotherapy in a MHS context

The presented model illustrated many factors and aspects that influence the outcome of psychotherapy in a broad and general way. When pulling together the findings in the current thesis, we also gathered valuable information about the relationships in group therapy and how they were influenced by contextual factors. Interestingly, it was found that both the path to the MHS and the MHS itself directly influenced patients’ attitudes, expectations and preconceptions of the group therapy course, usually in negative directions (Article I). Uncertainty created prior to accessing the system and within the psychiatric system tended to create negative attitudes and scepticism, which directly influenced patients’ openness to the group and willingness towards the therapy and the therapists (Article I). This is illustrated below:
6.3.3. Relationships within the group

Zooming further in on the group therapy room, the results indicated multiple, complex relationships that were experienced as important for outcome both by therapists and patients (Article I; Article II; Article III; Article IV). The patients highlighted a sense of belonging to the group as a whole (group cohesion), but also the individual relationships to other group members, alongside their relationship with the therapist and the therapist’s relationship with one another (Article III; Article IV). Patients also highlighted the therapists’ ability to include and encourage all members of the group and finally the therapists pointed to individual patient characteristics that were experienced as obstacles to group CBT or hindering for the patients’ individual outcomes (Article II). These findings underline the complexity of group therapy with many layers of relationships interacting with one another. This may be an indication that the way the field has defined and researched group cohesion and alliance in group therapy up until this point is simplified.
and that perhaps a construct that encompasses both of these in an interactional way may be more relevant to group therapy, this idea is echoed within the group literature (Krogel et al., 2013)

**Illustration of relationships in group therapy**

6.3.4. *The many roles of the individual patient*

Up until this point, the many complex relationships and contexts that the patient is placed within, have been presented. The individual patients play a role within a group with many interacting relationships, they are psychotherapy clients with a relationship to the therapists, they are patients in the MHS and they have been active help-seekers in order to get to that position. Each context that the patient exists within, expects them to take on different roles. The help-seeker needs to be active in order to receive help, the patient in the MHS passively receives a standardized treatment offer, the psychotherapy client is expected to be motivated and be self-help oriented and the group member is expected to be open, honest and supportive. This complex and, in some ways,
A self-conflicting system of expectations that surrounds the individual patient may be helpful in explaining some of the ambivalence that emerged throughout the current thesis (Article I). The ambivalence that emerged was centered around being positive towards the group therapy, but feeling uninformed prior to therapy and abandoned by the MHS post group therapy (Article I). The medical model underpinning MHS is interesting, because it is fundamentally conflicting with the concepts of many psychotherapies, including CBT, in terms of the role it expects the patient to take on. What happens when we deliver a type of psychotherapy in which agency, motivation, self-help and self-care is at the core, in a system that fundamentally views patients as passive receivers of treatment? We create an arena where patients are expected to be active within the therapy frame, but to remain passive in regard to all other aspects of their treatment i.e. what therapy they want, their diagnosis, if they want to focus cognitions, emotions or practicalities, if they want more general support or active psychotherapy etc. This presents a tension point in which the patients has to operate. The findings of the current thesis, indicate a high level of ambivalence, previously seen in qualitative studies on psychiatric outpatient care (Fallon, 2003) that may be explained by these conflicting positions that the patient has to navigate.

Illustration of the varying roles of the individual in outpatient care
6.4. Theoretical perspectives

In the following sections, the results and explanations provided above will be discussed in relation to existing theoretical frameworks.

6.4.1. Standardized versus individualized treatments

Throughout this thesis, the context of the treatment systems has been shown to be important for the patient’s experience of treatment (Article I). In this thesis, I have understood the patients’ varying roles (active/passive) as one of the sources of the ambivalence that patients felt about treatment (Article I). At the core of this tension is the medical model, which is manifested in MHS. The Danish MHS is physically manifested in hospitals and clinics, to which the entry ticket is a diagnosis. This inevitably creates a medical context, whether our distress understanding encompasses social and psychological factors or not. Whilst our understandings of mental illness may have become more humanistic, the patient still remains a passive figure within parts of the system. The patient receives a diagnosis, is provided with a treatment plan and is offered the psychotherapy that the system deems appropriate for her/him. The individual then enters a group where they are expected to have goals, agency, be a supportive and active group member and use techniques to move forward. Accordingly, the patient exists in an arena where position shifts are expected without instruction or negotiation. Recovery oriented practices have attempted to solve this problem, by shifting the whole underlying strategy to a humanistic one. The recovery movement was built on the idea that individuals with mental health problems should be acknowledged as capable and whole human beings with resources, rather than being seen as patients whom passively receives treatment (Davidson, Harding, & Spaniol, 2005; Slade et al., 2014). The recovery movement shifted attention away from ‘the broken brain’ model and towards autonomy and personal goals, hope installation, well-being and social inclusion (Davidson et al, 2010; Repper & Perkins, 2003). Recovery based services thereby challenged paternalistic
psychiatry models and suggested treatment models based on collaboration, individual autonomy, personalized treatment and interdisciplinary efforts from service providers (Sowers, 2005). Furthermore, recovery models challenge the concepts of dependency and chronicity and attempts to make the individual active rather than passive (Sowers, 2005). The recovery approach is fundamentally more in line with the concepts of psychotherapy as it encourages the patient/individual to be active on all levels and focuses on empowerment, agency and personal autonomy. Furthermore, in recent years we have seen a general shift towards recovery-oriented and individualized treatments (Jacob, 2015; Slade, 2014). This is interesting, as the Danish MHS have chosen to move in the opposite direction with a standardized, time-restricted treatment model that maintains the passive-active conflict described above. The results of the current thesis (Article I; Article II; Article IV) support the need for a more comprehensive, flexible an interdisciplinary treatment model, in which the patient has influence on the treatment course. A recovery-based approach to mental health may serve as a better fit as an underlying model for such changes.

6.4.2. The role of the standardized, time-restricted treatment in the contextual model of Psychotherapy

In previous sections we looked into how the medical model at the core of the system created contradictory expectations of the patients in the services. We suggested that this may have been at the root of the ambivalence described in article I. Furthermore, the standardized, time-restricted treatment format, where psychotherapy in provided in predefined dosages (in line with the medical model) was also found to be problematic in other ways (Article I; Article II), these will be outlined below.

The results in the current thesis informed us that patients felt poorly informed and prepared before starting in the group therapy (Article I), in fact, every single interview disclosed a level of scepticism prior to starting in the group. This is a significant problem, as expectancy and belief in
the psychotherapeutic intervention are factors directly related to the outcome of treatment (Wampold, 2015). Furthermore, Wampold (2015) specifies three distinct components of psychotherapy, the real relationship, expectations and specific ingredients. According to Wampold’s contextual model of psychotherapy, an initial therapeutic relationship must be formed between therapist and patient (alliance), before the actual therapeutic work begins. Wampold argues that a level of trust in the therapist has to have evolved before the therapeutic work starts and that the first meeting is crucial for the patient in establishing the human connection. The lack of this, is one of the main causes for dropouts after session one (Wampold, 2015). Although this is derived from a model of individual psychotherapy the establishment of trust and interpersonal connection is also important in group therapy (Burlingame et al., 2001). The second path, expectations, refers to the idea that patients arrive at treatment with a number of explanations for their own distress, these explanations are typically non-adaptable in nature meaning that they often do not present solutions to problems, but rather, maintain unhealthy behaviors in the individual (Wampold, 2015). Psychotherapy can help provide patients with more adaptive distress explanations and strategies that can help them to overcome their problems. However, in order for the patient to successfully enter into new explanations of distress and try out new adaptive strategies, they must believe in the explanations given to them and the strategy imposed to change maladaptive behaviors (Wampold, 2015). Alliance is a good indicator of the patient’s acceptance or rejection of the explanations given to them. Thus, the expectations path is about a collaborative effort to align distress understandings and treatment strategies. When the real relationship is established and the expectations path has been aligned, the therapist makes use of the third path specific ingredients which refers to the health promoting strategies in the chosen type of psychotherapy. For CBT therapies this would be correction of maladaptive thoughts and behaviors.
When looking at the findings of the current thesis through the lens of the contextual model, various problems become apparent. Firstly, within the current standardized time-restricted treatment format there is just one session with one therapist and the patient prior to the beginning of group therapy, this session has an agenda of creating a case formulation that will be worked on in the group. This means that the first two processes, creating an initial relationship and expectations is not included in the preparation for group. One may argue that the therapist can establish trust and align expectations within that first session, however, if the patient has a different understanding of their own distress or does not agree with the chosen treatment strategy, it appears highly unrealistic that all of these discrepancies can be untangled in just one session. This is in line with the results from article IV in which the patients highlighted the importance of the therapists knowing them and letting them steer the goal setting and the work agenda. Furthermore, in article III we learned of the importance of agreement about the diagnosis and the distress model for the development of group cohesion. This means, that in the current system, patients are placed within the specific interventions, without having negotiated distress explanations, without having created belief in the treatment model and without a strong alliance between patient and therapist. This may be a further explanation for the negative aspects of treatment that the patients experienced (Article I).

6.4.3. Change models and group therapy

The lack of focus on the expectations process described above is not only problematic in terms of individual patient outcomes. It presents another problem to group therapy. That is, different group members will inevitably be on different motivational levels and have different attitudes coming into the treatment. In the transtheoretical model, also known as the stages of change model (Prochaska & Velicer, 1997), five distinct (6 in some versions) stages have been identified as important in behavior change, namely, precontemplation, contemplation, preparation, action and maintenance stages. The stages of change model has received criticisms for assuming
that intention and attitudes will lead to behavior change, when the opposite has been found (West, 2005) and many consider it representative of the state readiness to change (West, 2005). Readiness to change was pointed out by the therapists in the current study as important for outcome (Article II). I use the model as a description of motivational stage and do not proclaim that the model encompasses all of the information relevant to motivation nor to behavior change and I do not make use of the causal inferences implied by the model. It does however provide insight into differences in levels of motivation or readiness to change which has been deemed important in the current thesis (Article II). The results from the current thesis revealed that it was challenging for therapists and patients, if there were large discrepancies in motivational stages (Article II; Article III). Patients in these groups appeared to represent all of the change levels in the circle, even precontemplation (i.e. I am aware I have a problem, but do not have intentions to be active in change). It has previously been argued that focusing on active behavior change, in other words, targeting the therapy towards the action stage and the maintenance stage can be demotivating and cause dropout for patients who find themselves in the earlier stages in the change processes (Norcross, Krebs, & Prochaska, 2011). This is in line with Wampold’s argument that jumping to the implementation of specific ingredients before establishing alliance and working with expectations can cause dropout (Wampold, 2015). Furthermore, the current thesis found that it can be disturbing for the development of group cohesion if group-members are unable/unwilling to share or try out the interventions (Article III). Furthermore, conflicts between therapist and patient may arise if they do not agree on the direction or the goals of the therapy (Article IV). Thus, including a treatment module with a focus on expectations, alliance and motivational stage may be beneficial in optimizing the development of group processes, bettering experiences and outcomes and reducing dropout in the current context.
6.5. Methods Discussion

6.5.1. Meeting the standards for good qualitative research

As previously mentioned, the scientific standards for quantitative methods does not apply well to qualitative studies (Levitt, 2018). Thus, several qualitative researchers have proposed alternative frameworks for assessing the standard of qualitative studies (Bengtsen, 2015; Levitt et al., 2018; Lincoln & Guba, 1985; Malterud, 2001)

**Confirmability** is a criterion related to the objectivity of the findings (Lincoln & Guba, 1985). This criterion is relevant as it ensures that the findings are reflective of the data as opposed to a reflection of the presumptions held by the researcher. **Reflexivity** (Malterud, 2001) can be seen as a first step towards confirmability as it emphasizes openness regarding the researcher’s position, preconceptions and background (Malterud, 2001). These were described in detail in sections 3.1., 3.2., 3.3.. Furthermore, each article made use of strategies such as: double coding (Article III & Article IV), independent coders (Article II), group-based development of coding manual (Article II), group-based analysis (Article I), close supervision in the process of narrative synthesis (Article I) and continuous discussions and debates regarding findings in relation to my own preconceptions (Articles I, II, III, & IV). Furthermore, the articles include detailed accounts of the steps included in each analytical procedure and the findings are presented with verbatim quotes. This thesis’ analysis supplements (Supplement 1,3, 4) provided further transparency and therethrough attempted to reach higher confirmability.

**Transferability** refers to the degree to which the results of qualitative studies may be transferrable to other settings (Lincoln & Guba, 1985; Malterud, 2001). Transferability is dependent on an adequately sized and varied sample (Malterud, 2001). The researcher is unable to determine the
transferability of her own research (Shenton, 2004; Lincoln & Guba, 1985), she can however, present the characteristics and context of the sample in order for others to be able to determine the level of transferability. The current thesis consisted of two samples, namely, the therapist sample and the patient sample (see below). Both samples were part of the TRACT-RCT study and operated within a range of outpatient clinics in Danish MHS. Thus, the results are tied to a MHS context operating with time-restricted, standardized treatment packages for patients with anxiety disorders and depression. Furthermore, one should pay attention to the specific limitations that the RCT-framework imposed on the results. The study procedures such as fidelity measurements may have affected the therapists’ ways of being a therapist and the patients may subsequently have felt this. Trial procedures may have limited therapist’s flexibility, foci and timing in the sessions, which was deemed of importance in article IV. Whilst the interviews asked the therapists about being part of an RCT, it did not explicitly focus on how that may be different from every-day practice, this knowledge would have been valuable.

The therapist sample was limited in a number of ways: (1) the recruitment strategy was convenience sampling which is problematic because it does not ensure a varied sample and therapists who actively signed up my present one distinct perspective (2) there were no male therapists in the sample (3) there was only one therapist who worked with depression on a daily basis (4) eight of the twelve had delivered the new transdiagnostic treatment. The therapist sample was also strong for a number of reasons: (1) it included therapists from different professional backgrounds: clinical psychologist, psychiatric nurse and occupational therapist (2) the sample included therapists subscribing to different therapeutic orientations (3) the sample included therapists of various levels of experience (4) the sample included therapists from three treatment
The sample had reached saturation by the time 12 interviews had been carried out, meaning that no new topics or information came up (Faulkner, 2017).

**The patient sample** was collected using a strategic recruitment strategy in order to gain a high level of variability in the sample. Thus, the patients who participated in the current thesis represented various diagnoses, demographics, treatment centers and all of the different types of CBT delivered. The data reached saturation at approximately 15 interviews, however, the recruitment continued in order to ensure saturation in the subdivisions of the material as well (for the comparative analysis in Article III). The recruitment strategy and sample size are considered a strength to the current thesis. However, the patient sample is also characterized by limitations: (1) The current study did not include patients who had dropped out of treatment. This is a limitation as it is highly possible that these patients would have added a different perspective on the experience with group CBT in the services. Furthermore, this sub-group of patients might have added valuable information about reasons for drop-out, how to prevent drop-out and specific suggestions to changes in the services that may have aided their treatment. (2) The current study did not uncover whether participants were part of a minority group. This is a limitation to the current study, as individuals from minority groups may have added different perspectives to these studies. Furthermore, qualitative research has been highlighted as especially useful in giving voice to minority groups (Levitt et al., 2018). Thus, it would have been valuable to know if the participants were part of a minority group and if there were aspects to their experiences that were fundamentally different to the other participants.

6.5.2. **Supplementary criteria for qualitative analysis**

As a supplement to the well-established criteria of good qualitative research such as reflexivity, transferability and confirmability, Bengtsen & Munk (2015) have proposed another four criteria to ensure the quality of qualitative studies. These have been translated into English for this purpose:
Wear & Tear (Slid), Imprint (Aftryk), Habitation (Beboelse), Peculiarity (Særhed).

Wear & Tear: Refers to the idea that good qualitative research is characterized by ‘wear and tear’, in other words, if you get the impression that the study has undergone a research process. A study meets this criteria if it is visible in the data collection and analysis that the study object has met the method and affected it (Bengtsen, 2015). The current thesis has visible marks from the meeting between study object and method, this is described in detail in section 3.3. of this thesis.

Imprint: The good qualitative study should be marked by the study-object’s character. This may collide with the initial plan for the interview and the predefined topics chosen for this, but it is often in this process that new dimensions of the study-object or its context are uncovered (Bengtsen, 2015). This process was clearly present in the current study, where the importance of the context of the MHS and treatment model became a focus area (Berg, Raminani, Greer, Harwood, & Safren), and when the therapists continuously brought up individual patient characteristics despite not being asked about it (Article II).

Habitation: A qualitative study should be habitated by one or more researchers, in a way that one can sense their presence and their decision-making processes throughout the planning execution of the study. Furthermore, the path from theoretical standpoint to operationalization rarely comes with a manual and there can be many directions one can take (Bengtson & Munk, 2017). The decisions and related reflections for this thesis are described in section 3.3 of this thesis.

Peculiarity: this criterion relates to one of the main assumptions in qualitative research, an understanding that things often change in time, this makes it hard to predict how the study object will act or respond. This means that the study-object can often appear peculiar and resistant to our theory and research strategy. However, the good qualitative study should embrace this peculiarity that humans embody (Bengtsen & Munk, 2015). One example of this from the current thesis, is
when patients would bring up the breaks in therapy as meaningful for the therapy (Article I), this at first appeared peculiar, but as more and more patients brought it up and elaborated on the matter, it made sense that the break represented the place where the group members could talk freely, therethrough informing us about the importance of being able to talk freely and ‘just as normal human beings’ in group therapy.

6.5.3. Analytical Strategy & Triangulation

All of the studies remained on a relatively descriptive level of analysis, this was done in order to stay close to the spoken word of the participants. However, different types of analysis such as discourse analysis or interpretive phenomenological analysis may have uncovered other and interesting aspects by using a deeper level of interpretation. The current thesis is built on four articles, which represent four distinctly different analytical strategies. This variation of analytical strategies with different quality and consensus measures presents a strength to this thesis. However, this could also be understood as a lack of theoretical consistency. With that said, the analytical strategies were chosen as per best fit for the research question. This is consistent with the strategy to stay close to data and let the patients’ and therapists’ voices steer the process.

Triangulation has been defined as an overriding type of validity in which information is gathered from multiple data sources, multiple methods and multiple interpretations (Stiles, 1993). The current thesis consists of both therapists’ and patients’ experiences and has employed different strategies to analyze different research questions and has employed different research groups’ interpretations for the analysis (Article I; Article II). This does give this thesis a level of triangulation. However, ideally the participants themselves being involved in the interpretation would have created a higher level of triangulation. Different data sources such as audio/video data
from therapy sessions, focus groups or therapist-patient interviewed together would have also heightened the level of triangulation (Stiles, 1993).

6.6. Future research directions

The current thesis has generated new ideas and research questions within the field of psychotherapy research. Below I will specify some of the future directions thought to be meaningful based on these.

One of the main limitations of the current paper was that the trial procedures in the RCT study may have influenced the therapists’ natural flexibility and timing, which was specified as important by the patients (Article IV). Due to the importance of context in qualitative studies (Levitt et al., 2018; Malterud, 2001) qualitative studies of group CBT in MHS should be carried out under naturalistic circumstances, in order to see if the same problem areas are highlighted when the therapists have more free range. Furthermore, qualitative studies that are carried out within the framework of RCTs should ask directly about how trial practices may be different than therapists’ natural way of working. We also recommend that qualitative studies are always included in large RCT studies in order to gain better understandings and be able to develop explanatory models of the results. This has been found to be a valuable way to strengthen the evaluation of RCT’s and teams who have previously used qualitative studies in combination with RCT's have described the qualitative component as essential to the overall study (O'Cathain et al., 2014).

Future qualitative studies into group psychotherapy and MHS should include patients who drop out of treatment prematurely. Understanding the experiences at the core of a decision to drop out of treatment could help generate knowledge and subsequently improve services in regard to preventing dropouts. Whilst studies have started looking into this, especially for internet-delivered therapies (Johansson, Michel, Andersson, & Paxling, 2015; Khazaie, Rezaie, Shahdipour, &
no studies on dropout from group therapy for anxiety and/or depression was detected. Such studies are relevant, not only in terms of understanding the reasons people drop out, but also in order to understand unhelpful mechanisms in therapy.

In the current thesis, we zoomed in on several processes in psychotherapy i.e. group cohesion (Article III) and alliance (Article IV). In order to get a better understanding of how these processes work, we suggest qualitative or mixed methods studies that investigate these processes act over time i.e. by interviewing pre-, during- and post treatment, or by employing video or audio material to take the interviewee back to specific moments in therapy. Such techniques have been developed for therapist training purposes i.e. the \textit{interpersonal process recall method} in which an independent ‘interrogator’ guides the patient through audio/video sections of therapy in order to gain knowledge about what happened at specific moments (Kagan, Schauble, Resnikoff, Danish, & Krathwohl, 1969). This type of method may add tremendously to the research field. Furthermore, it has the opportunity to provide detailed information about micro-processes and their connections to other psychotherapy processes. We also suggest new research designs are carried out in which the therapists and patients participate in new ways i.e. by being interviewed together, by analyzing transcriptions or video/audio material from therapy sessions, by involving the participants in the analytical procedure or focusing on one whole group by interviewing all its members, therapists and assessing transcripts from therapy. These types of triangulation would heighten the validity of the findings (Stiles, 1993) in the qualitative group therapy field.

Furthermore, the qualitative group psychotherapy literature is nearing a place where it would be relevant and highly useful to conduct a meta synthesis or a review of the results so far, the same way it has been done within individual client experiences (Elliott, 2008; Elliott & James, 1989; Hodgetts & Wright, 2007; Levitt, Pomerville, & Surace, 2016). The results of findings
between individual therapy and group therapy should be compared. As expected, the group studies so far (MacMahon et al., 2015; Newton, 2007) have found results that are somewhat similar to those found in the individual literature, whilst also themes that are different due to all the group-related processes and the framework of the given group therapy, thus a synthesis of these results is needed.

6.7. Clinical implications & Recommendations

The current thesis can be seen as a critique of the current treatment model that is based on a standardized, time-restricted treatment format. It is proposed that a more individualized treatment model is implemented, however, we also bring forward recommendations that may improve the services in their current form:

The results revealed that both patients and therapists experienced the current standardized, time-restricted treatment format as insufficient for many of the patients in the services (Article I; Article II). The therapists identified specific subgroups of patients for whom different treatment offers should be provided, these included patients with severe, complex and chronic psychopathology, patients with multiple ongoing stressors, patients who had a low level of motivation, readiness to change and agency as well as patients with cognitive deficiencies related to psychopathology or below average stable cognitive abilities. The therapists highlighted that these individual patient characteristics had a multiplying effect meaning that, the more was present the worse prognosis (Article II). Thus, these characteristics should be considered when deciding on treatment options for any given patient. Furthermore, the therapists and the patients called for more comprehensive, interprofessional and supportive treatment offer in which individual and group therapy is combined, to optimize outcomes for these subgroups of patients (Article I; Article II).
The current treatment model does not consider basic aspects of psychological change models and psychotherapy models (Article I). Groups consisting of patients on differing motivational stages presents a large challenge to therapists and patients (Article II; Article III; Norcross et al., 2011). Furthermore, the current model does not include an organized effort to align expectations, even though this is a central aspect of psychotherapeutic treatment (Orlinsky; Wampold, 2015a). Not only is such an effort not present in the current treatment model, the lack of negotiation of expectations led to negative attitudes and scepticism in patients (Article I), which has been found to be negative for the outcome of psychotherapy (Wampold, 2015b). Therefore, it is recommended that an individual motivational module with focus on treatment strategy and aligning expectations is delivered prior to the group intervention.

Across the interviews with patients and therapists, a common finding was that they called for more individualized treatment with flexibility to provide the interventions deemed necessary by the patients and the staff in the services (Article I; Article II). This goes against the idea of a fully standardized, time-restricted treatment package. The president of the Danish Psychiatrist Society has just recently called for a shift in strategy and the removal of the standardized, time-restricted treatment format (Stenberg, 2020). Patients often called for more individual sessions which is in line with previous qualitative studies (Laberg et al., 2001) and more information prior to start (Article I), whilst the therapists, in addition, called for inter-disciplinary team-work between stakeholders in the patients, lives i.e. the family & network, social worker, general practitioner, the job-center etc. This is fundamentally more in line with the ideas of the recovery-oriented treatment (Davidson et al., 2005; Slade et al., 2014) in which the individual is at the center of treatment and all relevant stakeholders are included in a collaborative effort (Slade et al., 2014). Such a model appears to be a better fit. Furthermore, if the current treatment model remains, it is recommended that individualization and flexibility is implemented around the standardized, time-restricted group
CBT by providing more individual sessions, a motivational module prior to treatment start and a continuation of treatment for patients who have not improved.

7. Conclusion

So far, the research in the psychotherapy field has been largely focused on what happens inside the therapy room. That may relate to interpersonal processes, manual specific mechanisms or common factor processes. This thesis showed how the context of the treatment system directly interferes with these therapeutic processes.

The standardized, time-restricted group-CBT model was experienced as helpful in creating relationships, lay the foundation for group cohesion, mutual aid and hope generation and gave participants concrete tools, techniques and insights that they could use in their everyday lives. Participants underlined the importance of both CBT-specific factors and common factors in their therapy course. However, there was a general wish for longer treatment, for more individual sessions and for individual needs to be met to a higher degree. Expectations had not been successfully negotiated, leaving participants feeling sceptical at first and feeling abandoned in the end. Thus, the overall experience of treatment was an ambivalent one, in which the therapy course itself was experienced as applicable, useful and helpful, but the time-restricted format and lack of individualization was pointed out as problematic.

The therapists found the therapy course to be one that required some specific prerequisites of the patients in the services and explained how the standardized, time-restricted treatment format was not appropriate or helpful for specific subgroups of patients. They also emphasized that the more of these factors were present in a patient, the worse prognosis, in their perspective. They called for new treatment formats and strategies for the patients who were perceived as not benefitting from the current treatment offer.
Group related processes such as universality, mutual aid, hope generation and support, which can be understood as manifestations of group cohesion, were found to be important to patients in the services. Cohesion in the group was described as important for the participation and engagement with therapy. Differences were detected between diagnosis-specific and mixed groups in the importance placed on the similarities or differences in psychopathology.

The therapists’ role in group CBT was clarified through the patients’ perspectives. They emphasized various important aspects related to the therapists. The therapists’ ability to communicate clearly and concisely in warm and empathetic ways was considered helpful, alongside the therapists’ ability to foster a safe environment in which group cohesion could develop smoothly. The patients emphasized the therapist role as a guide who should assist them in creating goals and aims meaningful to each individual, as well as help define common goals for the group. Underlining the need for the patients’ own agency to be encouraged and supported. Patients responded negatively when therapists imposed their views, tried to make the patients fit into the technique rather than vice versa and when they were inflexible and unadaptable in goal setting and time management.

This thesis provided new information about the ways that common factors and CBT-specific factors operate in the therapy room. Furthermore, the importance of context-specific factors was underlined as it was emphasized by both patients and therapists as a major factor in the overall experience of psychotherapeutic group treatment in Danish MHS. Future research is needed to triangulate results and synthesis of qualitative group studies are needed. The current thesis provided specific recommendations for how the current treatment model could be improved, whilst giving an overall recommendation to work on replacing the time-restricted, standardized treatments and move towards individualized treatment in the services.
8. Summaries

8.1. English summary

This thesis explored 23 patients’ and 12 therapists’ experiences of having received or delivered group CBT in TRACT-RCT. Data was collected through semi-structured interviews that focused on the overall experience of receiving treatment in MHS, psychotherapeutic factors and individual patient characteristics, in relation to outcome. A variety of qualitative methods were used to analyze data.

The results were presented in four distinct articles. Article I focused on the patients’ overall experience of receiving treatment in Danish MHS. Article II presented the therapists’ perceptions of a range of individual patient characteristics deemed important for outcome of group CBT. Article III compared patients’ experiences of group-related processes and group cohesion in diagnosis specific groups and mixed diagnoses groups respectively. Finally, Article VI revealed which therapist-related themes, the patients pointed to as important for their therapeutic course.

The results revealed that the standardized, time-restricted treatment format directly impacted the experience of group CBT. Furthermore, the results shed light on the ways in which common factors such expectancy, group cohesion and alliance directly impacted on CBT-specific processes. The importance of the dynamic between the therapists and the therapist-variables considered helpful and hindering to group CBT was described. Finally, the current thesis found group cohesion to be directly linked to distress explanations and therapy type.

It was discussed how the treatment model in Danish MHS does not include basic and central elements of ‘what makes psychotherapy work’. Furthermore, the MHS as a context imposes negative effects on both the experience of being in treatment in the services, but also on the outcome of treatment, according to therapists and patients. Based on these analyses, it is recommended that MHS modify the psychotherapy service provision, adapting a more
comprehensive and flexible model, in which there is time and resources allocated to align expectations and carry out motivational work prior to the beginning in group therapy. The patients would probably benefit from receiving a more comprehensive, individualized psychotherapy, where agency and empowerment are at the core. Future studies should focus on triangulating the current findings within the field and meta-syntheses are needed.
8.2. Dansk Resumé

I denne afhandling undersøgte vi 23 patienters- og 12 terapeuters oplevelser af at have deltaget i et gruppe KAT forløb i TRACT-RCT. Data blev indsamlet via semi-strukturerede interviews, som fokuserede på den overordnede oplevelse af behandlingen i regionspsykiatrien, psykoterapeutiske faktorer og individuelle patient karakteristika i forhold til udbyttet af behandlingen. En række forskelligartede kvalitative metoder blev brugt til at analysere data.


Denne afhandling påviste, at den nuværende behandlingsmodel i den danske regionspsykiatri, ikke inkluderer basale og centrale elementer af 'hvad der får psykoterapi til at virke’ og psykiatrisystemet som kontekst kreerer negative effekter hele vejen ind i terapirummet. Herunder både på oplevelsen af at være i behandling i psykiatrien, men også udbyttet af behandlingen. Der anbefales et skift hen mod en mere fleksibel model, hvori der er afsat tid og
ressourcer til at forventningsafstemme og lave motivationsarbejde før opstarten i gruppeterapi. Ydermere anses faste individuelle sessioner, sideløbende med gruppeterapien, som nødvendige. Endeligt vil patienterne drage fordel af en mere omfattende og individualiseret psykoterapi hvori patienternes selvstændiggørelse og selvhjælpsorientering understøttes. Fremtidige studier bør fokusere på at triangulere de nuværende fund indenfor feltet og der er brug for meta-synteser der opsamler resultaterne.
9. List of Abbreviations

CBT: Cognitive Behavioral Therapy

MHS: Mental Health Services

MDD: Major Depressive Disorder

DSM-5: Diagnostic and statistical manual of mental disorders 5th Edition
10. References


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### 11. Supplements

#### 11.1. Supplement I

**Overview of analyses**

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<tr>
<th>Article</th>
<th>Dataset</th>
<th>Type of analysis</th>
<th>Exploration</th>
<th>Validity Procedures</th>
<th>Data Approach</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Patient interviews</td>
<td>Phenomenological Narrative analysis</td>
<td>Inductive</td>
<td>Parallel narrative synthesis by two researchers for the first two interviews</td>
<td>Narrative synthesis of all interviews</td>
<td>Comparison of narratives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Wider research group for analysis of common narrative and division of themes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Therapist interviews</td>
<td>Descriptive analysis</td>
<td>Inductive-Deductive</td>
<td>Wider research group defined codes for coding manual</td>
<td>Coding via manual</td>
<td>Frequency of codes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Independent coders</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Wider research group for interpretation of results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Patient interviews</td>
<td>Comparative thematic analysis</td>
<td>Inductive-Deductive-Inductive</td>
<td>Double coding of 26% of material by coder 1 and 2</td>
<td>Descriptive coding and division of dataset</td>
<td>Comparison of coded material between datasets</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Establishement of coding guidelines for remaining material carried out by coder 1</td>
<td></td>
<td>Thematic division of codes</td>
</tr>
<tr>
<td>IV</td>
<td>Patient interviews</td>
<td>Thematic analysis</td>
<td>Inductive-Deductive-Inductive</td>
<td>Double coding of 26% of material by coder 1 and 2</td>
<td>Descriptive coding</td>
<td>Thematic division of codes</td>
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<td>Establishement of coding guidelines for remaining material carried out by coder 1</td>
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</tbody>
</table>
11.2. Supplement II

**Supplement II**

**Therapist Interview Guide**

<table>
<thead>
<tr>
<th>1. Open talk</th>
<th>7. The UP manual*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please tell me about how it was to be the therapist in the groups you have had, just tell me what comes to mind.</td>
<td>What are your thoughts on the transdiagnostic approach?</td>
</tr>
<tr>
<td><strong>Note:</strong> make the participant elaborate on points and explore the topics they bring up.</td>
<td>Do you believe in the theory that the mechanisms in anxiety and depression are similar? How? How not?</td>
</tr>
<tr>
<td>2. Preliminary thoughts</td>
<td>How are the diagnoses different? And how are they similar? And did it become apparent in the groups?</td>
</tr>
<tr>
<td>Do you remember your thoughts on this therapy manual before starting? What were they?</td>
<td>What was good about the manual? What aspects worked?</td>
</tr>
<tr>
<td>Were your expectations confirmed or did they change? How?</td>
<td>Was there anything that was not good or that did not work well?</td>
</tr>
<tr>
<td>Did your opinion of the therapy change over time? How and why?</td>
<td>Were there any aspects of the therapy that you experienced as negative or harmful to the patients?</td>
</tr>
<tr>
<td>3. The group</td>
<td>Were there any sessions where the patients seemed to learn something particularly important?</td>
</tr>
<tr>
<td>How did it feel to be in this group?</td>
<td>What did you think of the structure of the manual?</td>
</tr>
<tr>
<td>How did you experience the differences and similarities between the patients?</td>
<td>Do you think UP therapy can add anything to psychotherapeutic treatment in MHS? Why/why not?</td>
</tr>
<tr>
<td>How was the group dynamic</td>
<td>Which patients are suitable for UP? And are there any that are not?</td>
</tr>
<tr>
<td>Did you see the patients take on roles in the group?</td>
<td>Which elements in the manual worked best? And is that different from what works best in the therapy you usually work with?</td>
</tr>
<tr>
<td>If you could put together groups just the way you wanted, how would you pick which patients were in a group together?</td>
<td>RCT</td>
</tr>
<tr>
<td>Was it different working with transdiagnostic groups? How and how not!*</td>
<td>How was it, working as a therapist in an RCT?</td>
</tr>
<tr>
<td><strong>Note:</strong> if the therapist had multiple groups ask about each group</td>
<td>What was good? What was not?</td>
</tr>
<tr>
<td>4. Change</td>
<td>How was it for you, having to be audio-taped?</td>
</tr>
<tr>
<td>How do you see the patients changing throughout a course like this? Tell me about 1 patient who improved and 1 who did not?</td>
<td>If you were to deliver this therapy outside of an RCT, what would you do differently?</td>
</tr>
<tr>
<td>What do you think the causes of change are?</td>
<td>Drop out</td>
</tr>
<tr>
<td>5. Good psychotherapy</td>
<td>Why do you think some patients drop out of the groups?</td>
</tr>
<tr>
<td>What do you think makes psychotherapy work? Why?</td>
<td>How do you think we can keep them involved?</td>
</tr>
<tr>
<td>What are the most important factors</td>
<td>The end</td>
</tr>
<tr>
<td>How does group therapy differ from individual therapy?</td>
<td>Can you please summarize for me, what you experience was, working with these groups and this manual?</td>
</tr>
<tr>
<td>Can you deliver good therapy within this context? Why/why not?</td>
<td>Is there anything important we have not touched upon?</td>
</tr>
<tr>
<td>What would you change in order to provide the best possible therapy?</td>
<td></td>
</tr>
<tr>
<td>6. The therapists</td>
<td>*only for UP therapists.</td>
</tr>
<tr>
<td>How did you collaborate with your co-therapist?</td>
<td></td>
</tr>
<tr>
<td>What is the importance of the pairing of therapists?</td>
<td></td>
</tr>
</tbody>
</table>

*only for UP therapists.
11.3. Supplement III
The steps in narrative synthesis

Step 1: Highlight all units of text considered essential for the experience.

Step 2: Cut and paste all highlighted units to new document.

Step 3: Cut out all repetition.

Step 4: Rearrange into cohesive Narrative.

Step 5: Translate to English.
Example of a synthesized narrative

I waited a little long to get in. I didn't really know what was wrong. It was of course hard in the beginning, because when you are in a group, you have to feel safe. I guess what I realized the most was that it opened up a lot of stuff, that I am now having a hard time containing. I was always happy when I walked over here, but as soon as I had been here half an hour, my shot nurses were up here. My stomach hurt, I couldn't deal with it all, so I had to just sit and hold myself together. When I went home I was absolutely exhausted.

In a group, you have to be considerate of one another, and maybe you sit there and have had a terrible bad week. You have to be conscientious about what you say in the group, so you don't take the word all the time. In the beginning we were all insecure. But they were engaged and worked as much on it as I did. There was a will, to want this. The youngest was 21 and I am 52 and I thought 'wow do we have anything in common?' It didn't feel unnatural despite that. And many of the were students or academics and I am an artist. And have, of course, sometimes a different understanding of the world. It is interesting to hear what kind of things you can be battling. We had different problems, but at the foundation, anxiety and depression and so on, it was very similar, but we came with some different background and things that had triggered our problem. The fact that we were as poorly as we were, meant that we had a lot of practical problems also. When you don't have peace to just get well. Because there are so many practical things you have to fight. That we had in common, a lot. The system around us. There was a pressure. From outside. We are fighting basic survival stuff. That has been my escape through life, to start doing practical stuff, to not feel all these things. I have just walked around and been kind of sad you know? Not really felt that I was alive and found it hard to see what the future could bring. I have been in multiple therapy courses. And also medicine. So I have just thought, it is me who is fragile and now I need to pull myself together, there was a loneliness surrounding that. So to be able to sit an talk to someone. That was actually nice.

Before I came, I had no idea what emotions were, there had been a lid on, you know? I think that has been the hardest thing to handle. Afterwards. That you have been opened up to some of these things, and now there is nobody. I have learned that I have been very skilled at keeping the facade for many years. Then you start to open up many chapters from your life all of a sudden, and think 'wow' how could I have done and why? so many questions came up. And the therapy course didn't really focus on that. Going back and picking in your bellybutton. But I had to spend time on that at home. Because I couldn't understand the mechanisms that had been started. I had this sense, that I was a happy child and positive and excited and curious. 'No, I was taught to put a lid on my emotions in my childhood'. If I was angry, If i was sad, then my parents would start fighting. So I simply learned to be happy and positive and never have a problem with anything, because then I guess I thought there would be peace in the house. That pattern, I have repeated and repeated. And when I first got that real AHA experience… I dreamt a whole year after. I had a nightmare about that place and I wanted to scream at them all the time. So it was something that took a lot of space up in my life, and really 'I just wish I had known this'. I am craving it now, to get those good feelings again. Not to walk around and be scared all of the time. To dare to through yourself into things, to take chances. To have energy for other people and happiness. I have a child with anxiety, and it was mostly for his sake I had to become stronger, because he is very sensitive. I mean we talk about it. Because in our home it is okay to feel all kinds of stuff. My children are allowed to feel all kinds of stuff.

I myself, could have perhaps, been more open. Because… I have a hard time saying it… But I have lives in a physical and psychologically violent relationship. I didn't tell that. And I don't really know what to do about it now. There is so much stress in my body still, so when I hear the door go around the time he would normally come home, I still get heavy heartbeating, you know? Because I can feel, it is like a bombscare. There is some stress that has sat there for many years. It is like I have lived in a trench constantly. I have had this experience that, my language has been disappearing over these years, because I had to all of a sudden be very silent, to not provoke anyone. As the course went on and on, I wanted to share it, but I couldn't really, because it wasn't the place to do it. They actually finished my treatment. And I don't think I have formulated myself clearly about this. How hard it actually is. I have been telling myself off, because I have been a wimp.

I could see that I needed to be nicer to myself. That was the feeling I sometimes got here. I was a allowed to be proud of who I was. I sometimes also have this thing about having to do stuff perfectly the first time. And then I have taken too much mouthfuls. And then it has become a defeat. It was fine to learn 'it is okay to take it easy'. I have become much smarter, but also maybe more annoying, because I just say stuff now. But that is just how that is going to be. People will have to live with that. I cannot keep going around an putting lids on things. I think I am smarter, but I am battling a lot. I simply cannot find out what will be good for me now. I fight a lot with my self-worth. And people can actually treat me pretty badly, because then I don't have to put myself down. It is only just now the work begins, you could say. So now you are standing here with everything and thinking 'okay, what do I do now'.
11.4. Supplement IV
From text to theme in thematic analysis.

**Step 1**: Code every sentence in material with a descriptive label and with overriding labels

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Codes</th>
</tr>
</thead>
</table>
| R: Well it was probably, well it was both a mix of... well the first time I came there I was really poorly. I have a bit of anxiety about meeting people I don’t know, so I was crying constantly and couldn’t even say anything to the people in there. And they could see that on me. There was one person who gave me a hug and the others... she could see that it was really hard for me to be there. and it was simply because I didn't know the others. I thought it was extremely intimidating to have to talk about myself, and the stuff that is hurting, in front of a bunch I don’t know. But all the other times were really fine, and I have felt safe. So it has been nice to come here and listen to some of the others, listen to someone who has the same symptoms and problems as yourself. Because you can’t avoid, when your walking around on your own, feeling like you are the only one. So it has been great to come here and just say whatever you felt like. And I guess that is it, what made me keep coming. That I thought it was nice to be here. If I had a problem, then I could say it there, and then everybody has helped me, on how I could get through that. And that has been a safety for me. | The first session  
Anxiety meeting the group  
Couldn’t speak  
Being seen  
Support from group members  
Being seen  
Anxiety meeting the group  
Opening up  
Being vulnerable  
Felt safe  
Listening to others  
Same symptoms  
Feeling alone  
Free space/Free talk  
What made me come back  
Atmosphere  
Free space/Free talk  
Support from group members |
**Step 2:** Get overview over codes and divide them into preliminary categories:

**Example:**

<table>
<thead>
<tr>
<th>Positive group features</th>
<th>Starting in group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from group members</td>
<td>First session</td>
</tr>
<tr>
<td>Felt safe</td>
<td>Couldn’t speak</td>
</tr>
<tr>
<td>Free space</td>
<td>Anxiety meeting the others</td>
</tr>
<tr>
<td>Free talk</td>
<td>Opening up</td>
</tr>
<tr>
<td>What made me come back</td>
<td>Being vulnerable</td>
</tr>
<tr>
<td>Atmosphere</td>
<td></td>
</tr>
</tbody>
</table>

**Step 3:** Review preliminary categories:

<table>
<thead>
<tr>
<th>Positive group features</th>
<th>Starting in group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Differences</td>
</tr>
<tr>
<td></td>
<td>Similarities</td>
</tr>
<tr>
<td>Stigma outside understanding inside</td>
<td>Feeling alone prior to therapy</td>
</tr>
<tr>
<td></td>
<td>&amp; Motivation Peer pressure</td>
</tr>
<tr>
<td></td>
<td>Being outside therapy together</td>
</tr>
</tbody>
</table>

**Step 4:** Connect categories that are overlapping into overarching themes:

1. Positive group features
2. & Motivation Peer pressure
3. Stigma outside understanding inside
4. Feeling alone prior to therapy

The role of cohesion in group CBT
12. Appendices
Article I
Does One Treatment Benefit All? Patients’ Experiences of Standardized Group CBT for Anxiety and Depression

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Abstract

Cognitive behavioral therapy (CBT) is recommended as the frontline treatment for depression and anxiety disorders and has been implemented in a wide range of mental health care contexts. In Danish mental health services, group CBT is the most common psychotherapeutic treatment format. Recently, a standardized, time-restricted treatment format has been implemented. No studies have investigated the patients’ experiences of group CBT in such a format. Furthermore, few studies have investigated patients’ experiences of group CBT for anxiety and depression. The current study set out to explore patients’ experiences of group CBT for anxiety and depression and the role of a standardized, time-restricted treatment format, using a qualitative framework. We explored the experiences of 23 patients with a primary diagnosis of social anxiety, panic disorder/agoraphobia, or depression. Data were collected through semi-structured interviews. Data were analysed using phenomenological narrative analysis. The results revealed a common narrative across the 23 interviews. The narrative was made up of six distinct themes, namely: How did I get here?; Being seen, heard and recognized; Shared responsibility of problems and solutions; Education and tools; Limitations of this group format; and Launchpad. The results indicated that the patients found group CBT helpful due to a range of factors, both common factors and treatment-specific factors. Patients expressed scepticism towards group CBT prior to beginning, because of a lack of information and previous failed treatment attempts. Many described feeling abandoned due to the sudden ending of a treatment course that was generally considered insufficient.
Introduction

Psychotherapy is an effective treatment for the anxiety disorders and major depressive disorder (MDD). Many studies have found robust positive results for both individual and group psychotherapy, specifically CBT (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012) and in national guidelines, CBT is recommended as a first-line treatment for the anxiety disorders and MDD (NICE, 2004a, 2004b). Because the number of patients seeking treatment in mental health care systems has increased, there has been a shift from individual towards group-based CBT, due to the potential cost and time saving benefits (Oei, Bullbeck, & Campbell, 2006 2010). Furthermore, group CBT has the benefits of providing a social context, from which patients can acquire a range of communicative, problems solving, and social skills through interpersonal collaboration (Laberg, Törnkvist, & Andersson, 2001). In the Danish Mental Health Services (MHS), group-based CBT in a standardized, time-restricted format has been adopted as the standard treatment for anxiety disorders and MDD (Sundhedsstyrelsen, 2016). The system operates by having a defined treatment package pre-assigned to a given diagnosis (Danske Regioner, 2017a; 2017b). For example, an MDD diagnosis amounts to a package consisting of assessment, medical consultation, group or individual psychotherapy and a session for relatives amounting to 18 hours in total (Danske Regioner, 2016). In this standardized system, all patients within a diagnostic group receive very similar treatments.

Psychotherapy is an exceedingly complex study object as it is a profoundly individual experience that happens within and between people. In the last fifty years, the focus in the field has been largely on ‘how much’ psychotherapy can do, rather than on understanding ‘what it is’ (Rodgers & Elliott, 2015). Qualitative research provides the opportunity to explore what phenomena are and how they exist in a contextualized world (Rodgers & Elliott, 2015). The qualitative methodology can also be seen as fundamentally more in line with the concept of
psychotherapy, as it emphasizes human agency, emotion, reflexivity, language, and the validity of human experience (McLeod, 2001).

Qualitative research into experiences of group CBT is accumulating, with a significant number of studies looking into the experience of group CBT for eating disorders, anger management problems, schizophrenia, auditory hallucinations, and somatic disorders, such as cancer and hot flashes (Laberg et al, 2001; MacMahon et al, 2015; Bottomley, 1998; Gledhill et al, 1998; Newton et al, 2007). These studies point to the importance of both common factors, especially those related to group processes such as universality, normalisation and support, as well as specific CBT techniques. This is notable as group CBT manuals do not tend to target common factors explicitly. Very few studies have investigated the experience of group CBT for anxiety and MDD in a psychiatric outpatient setting. Furthermore, no study has explored how a standardized, time-restricted treatment format may influence the experience of group CBT in MHS.

In order to gain a deeper understanding of the complicated processes involved in the behavioural and cognitive changes that may or may not occur during group CBT, we approached the research questions using an exploratory qualitative framework, with the main focus being on process rather than outcome. In the context of a multi-centre randomized controlled trial, patients from Danish MHS were interviewed for the purpose of answering the original research question:

*How is group CBT experienced by patients in the services?*

Furthermore, throughout the initial familiarization with data, it became clear that service-related factors were a central aspect in the patient experience of group CBT in the given context. Therefore, in order to stay as true to the patients’ experience as possible, we decided to attempt to answer a secondary research question, namely:
How do service-related factors influence the experience of group CBT in the services?

Methods

**Context**

The study was conducted in the context of the TRACT-RCT study (Arnfred et al., 2017). The treatment was delivered in three different outpatient clinics in Denmark, in the Capital Region, Central Region and Region of Zealand. The outpatient clinics are publicly financed services for individuals suffering from moderate to severe non-psychotic disorders, including anxiety disorders, MDD, trauma-related disorders, eating disorders and personality disorders. In order to get a referral for an outpatient clinic, individuals need to present with high severity or have several failed treatment attempts behind them, i.e., psychotherapy courses with a state-subsidised private practitioner and/or medical treatment.

**The treatment**

The standardized treatment offered in the clinics is group CBT and medication management. For individuals with MDD and anxiety disorders, treatment courses are typically 10-16 weeks of group CBT. In the current study, all patients participated in 14 weeks of group CBT. Sessions were two hours long and offered weekly. The CBT groups typically consisted of eight patients and two therapists. Participants in the current study had received either standard, diagnosis-specific group CBT (for social anxiety, panic disorder/agoraphobia, or MDD) or transdiagnostic CBT in mixed diagnostic groups that comprised patients diagnosed with MDD and anxiety disorders.
Recruitment

The recruitment procedure had two stages. In the first stage, all patients who finished treatment in the first quarter of 2018 were contacted via phone and offered the opportunity to participate. Everyone who agreed to be interviewed was interviewed. The second recruitment stage used targeted convenience sampling, so only patients with specific demographics, diagnosis or specific treatment groups were contacted, in order to obtain a broad representative sample.

Participants

Twenty-three participants were interviewed for the current study. All of the interviewed patients had completed treatment as a participant in the TRACT-RCT study. Completion of treatment was defined as having participated in 8+ sessions and not having discontinued treatment. The patient sample in the TRACT-RCT study was characterized by long-lasting symptoms, recurrent episodes, and high functional impairment (Reinholt et al., in review). Participants had a primary diagnosis of MDD, social anxiety disorder, panic-disorder, or agoraphobia. Many had comorbid disorders. Twelve of the patients had received the transdiagnostic CBT treatment, specifically the Unified protocol for emotional disorders (Barlow, Allen, & Choate, 2004) and eleven of the patients had received diagnosis-specific CBT for their primary diagnosis. See Table 1 for patient characteristics.

Ethical considerations

Participation in the current study was voluntary and participants were provided with detailed information about the aims and focus areas of the interviews prior to participation. All participants provided written informed consent. Data were anonymized. Full original transcripts were only accessed by the first author and research assistants who transcribed the data. Participants were
instructed to share only what they felt comfortable sharing. The interviewer was a clinical psychologist and conducted a debriefing after each interview. In one case, the interviewer provided a participant with referral information and emotional support, as the interview revealed untreated trauma that the participant had not previously shared with anyone else. Patients were offered the opportunity to see the interview guide prior to participation, but no participants requested this.

**Interviews**

Semi-structured interviews were used to collect data. The interviews were carried out by the first author throughout 2018 and in January 2019. An interview guide was used to steer the interviews (Supplement 1). Participants were interviewed in order to explore their overall experiences of the group treatment, helpful and hindering aspects, as well as their overall attitudes. The interview guide was designed to capture patients’ overall experiences with an open-ended question in the beginning, then moving into open-ended questions about a range of therapeutic factors, to then move on to specific factors and any other useful feedback about the treatment. The interviews inductively explored various aspects of treatment and several different analysis strategies were used to highlight different aspects of the material and answer a range of research questions, the aforementioned being just a subsection of them. Patients were interviewed once upon completion of the treatment course. The interviews were held at the clinic in which the patient had received treatment. Interviews lasted between 33 and 96 minutes, most of them were around one hour of duration. All interviews were audiotaped and transcribed verbatim.

**Analysis**

Qualitative data were analyzed with procedures derived from an empirical phenomenological framework in which narrative analysis was used to identify and delineate the
common structural elements that were found across the individual narratives (Davidson, 2003). See Figure 1 for an illustration of the process. A detailed description of analysis steps follows:

1. Two full transcripts were translated from Danish to English and read through independently by the first and second author. First-person narrative syntheses of each transcript were constructed to identify major themes of each transcript (Sells, Topor, & Davidson, 2004). Both authors highlighted units of meaning essential to the experience of the individual. The authors met and compared highlighted material and discussed any inconsistencies in chosen meaning units. No text was added, only full paragraphs and sentences were included in the narratives. Text units were put together to create a clear chronological narrative.

2. The first author completed the same procedure with the remaining 21 interviews, which took approximately one month. The first and second author had weekly meetings to discuss any doubts and difficulties and to ensure that the narratives stayed true to the individual experience of each interview. In this part of the process the transcripts were in Danish, the short narrative was created in Danish and then translated to English.

3. The 23 short narratives were thoroughly read through by a larger research group consisting of four researchers. Each analyst took notes about what they considered to be patterns across the dataset. The research group went through the central points of each of the narratives to determine whether a common narrative was present. Upon completion of this step, a common narrative emerged, and the research group defined six themes that went across the dataset and created this common narrative.

4. The six themes were described in detail using verbatim quotes (from the original transcripts) to illustrate central points.
Results

The analysis found a common narrative across the interviews that consisted of six themes, namely, *How did I get here?*; *Being seen, heard and recognized*; *Shared responsibility of problems and solutions*; *Education and tools*; *Limitations of this group format*; and *Launchpad*. Verbatim quotations will be used to illustrate the themes.

*How did I get here?*

The first theme relates to the process from referral to the actual therapy room. A high level of confusion occurred during this time. Participants felt that they had not received the relevant information about treatment options and had experienced a lack of communication expressed frustration and missing information between different stakeholders and personnel in the healthcare system. Some stated that they were not aware they could receive help in the psychiatric system, had spent substantial financial means with private practitioners, or received help from non-profit organisations prior to being referred. Others had completed treatment attempts within the psychiatric clinics and had been re-referred to other treatments within psychiatry. Participants often felt they had to fend for themselves, which generated hopelessness and scepticism.

“Then you go in this box with depression otherwise you go in this box with anxiety or like, it has been a little hard, like, for them to place me (...) then waiting three months to be able to start the course, where, you didn’t get any help in those three months. It was hard going from, that you had met once a week, with them, and then to, that you stood alone again and still had some problems, that you hadn’t really been told, what it really was.” Barbara
Participants met for assessment sessions, meetings with psychiatrists and pre-group sessions with the group therapists. It appeared that there was a general lack of information at this stage, leaving them feeling confused about the role of the staff they met and the purpose of the meetings, and uncertain about the treatment.

“Yeah well, I met the doctor to start out with. And didn’t really know anything about anything out here. And I had an idea, that he was more than just a doctor. And that he would ask about some of the different things, about how I was and stuff. Like I had been through before. So I didn’t really understand his role and I didn’t feel that when I asked, that I got a clear answer. So I was very confused the first couple of times I met him and actually got a little irritated, that he didn’t really find out who I was, but that I felt like just another one in the line (...) that it was something else that I was going to afterwards that was the real treatment. With people who actually talked to me about my situation. So, I was pretty confused ... I had some different ideas about how things would work. But that a lot of the things were stuff I had to realise on my own. Yea... I just wasn’t that well informed, particularly in the beginning. It wasn’t until I really arrived at the first group meeting that I got an understanding of what it was all about” . Michelle

The lack of information and confusion fostered scepticism and hopelessness in most of the participants. The participants explained how they had low expectations due to previous experiences with psychotherapy that was unhelpful. Another reason for scepticism was a preconception that group therapy might not be helpful, as the patients did not see the point in listening to other people’s problems, some of them expressing that they thought it would make them feel worse, due to the pain it would inflict to take on other people’s suffering. Patients felt uninformed as to the type
of therapy they were entering as well as the goals of the group therapy and the format (e.g., the number of patient and therapists).

“I didn’t really know if I was ready to sit in a group with a lot of people, it was both if I could use it for anything and if those I had to sit with were annoying... I have fought with depression for many years. And it has been like a very steady depression for many years. So that is pretty heavy, but I was also still pretty sceptical towards it, because I have tried a lot, that didn’t work. I am still in doubt, how much it has helped me, in regards to the depression. I feel better now, but that could be because of a range of things.” Emma

2. Being seen, heard and recognised

This theme encompassed the positive feelings that followed the initial scepticism of the therapy course. Participants expressed feeling relieved, unburdened, and positively surprised to meet other people who were struggling with similar problems. Many expressed having felt like ‘the only person in the world’ who had that type of experience. Furthermore, the mirroring in others relieved feelings of shame:

“It has been incredibly nice to be with people who feel the same way. So you don’t feel all crazy in the head, right? It has been a hugely freeing ... I was in this group that had both anxiety and depression and I think they follow each other, it is also because, when I get anxiety I blame myself a lot and then the depression comes. So it is all connected for me. You feel all alone in the world when you finish in this kind of thing. Also because, it is like a free space where you can come and say anything to the group, right? Because no one makes a face or thinks ‘Holy fuck, what is she doing?”’ Victoria
The ‘free space’ that was created in the group appeared to be experienced as a sharp contrast to the stigma experienced in the ‘outside world’. Participants frequently spoke about people in their lives who did not understand them, others thinking that they just needed to pull themselves together, having to hide their struggles, and the struggles of having an ‘invisible illness’.

“There are several people who have encouraged me to hide that I have been unemployed in 2018 and I shouldn’t tell people that I have been sick ... I mean, I can say I have had cancer in the brain, that’s okay ... It is stigmatizing to have been in the psychiatric system. It is the biggest taboo. And I find that very frustrating. That you fight, and fight your way back. People think you just need to pull yourself together. People don’t understand.” Camilla

Many of the participants conveyed an overarching gratitude for the attention that they received, being grateful for both the treatment package and for feeling understood by the group and the therapists. Throughout the interviews, very few of the participants were critical towards the treatment and when they were, they tended to attribute any negative experiences to themselves. For example, one participant explained not feeling understood by the therapists, but attributed that to her own negative thought patterns. Whenever negative situations were described, participants tended to wrap it up in a positive explanation or an inward-turned attribution.

“They would recommend I was sent in another treatment offer here in the clinic. Because they could see that fourteen sessions, was like shitting in the ocean... That was a huge, huge relief, that I didn’t have to say ‘come on and help me’ (cries) they saw it, and they acted on it. And they took the burden of responsibility away from me. It didn’t become my job to get help for me (cries). To be
cared for... to be accepted ... And that I got this offer. That I have waited so many years without knowing that this is what I needed. And then suddenly it's there, and more is coming. I mean, that is so huge. It is a higher power where it all meets, but the fact that they contained my shit, got it sorted out and handed it back to me in the right order, I thought that was freeing. I feel freed from the chain inside my head.” Karen

3. Shared responsibility of problems and solutions

In addition to being positively surprised by the normalization processes brought about by the group, another positive dimension that was described was the shared responsibility for problems and solutions. The burden of illness was made lighter by the feeling of lifting together as a group. There was a sense that the group worked together to solve their common problems. Participants expressed how they felt like it was a huge task to solve their problems alone and the support from others made it easier. There was a feeling of being responsible towards the group and that you could be letting down the group and negatively affect the group’s motivation and wish for change if you did not keep up your end of the deal (e.g., by carrying out homework exercises). The participants often explained that there was a common will to get better—a drive or an internal motivation that they shared and that bound them together.

“I have tried going to a psychologist alone and there, I always went home with a feeling like ‘wow this is a really big job this and I have to do it all myself’. I didn’t feel like that here... I mean, I could share those frustrations a little about the week I had had, when I had tried out some of those things, right?... It was a really big relief, because we were all in the same place, right?” Eva
4. Limitations of this group format

Whilst the group was consistently highlighted as one of the most helpful factors of treatment, there were also some limitations that were highlighted throughout the interviews. These limitations fell into two main categories 1) referring to a sense of self-monitoring in the group setting and 2) topics they could not bring up in the group.

The self-monitoring related to participants’ awareness of their own position in the group. Some expressed that they were always monitoring for how long they talked and what topics they chose to bring up, out of respect and courtesy of the other group members. This led to some participants feeling stressed and restrained at times, leading to them limiting their sharing with the group. Participants in groups with high drop-out expressed gratitude for the smaller group as it left time for everyone to get in depth with their problems.

“We have been a little privileged, because we weren't that many. The last three times there were only four of us, I think. And we started out with eight … I found it great personally, that you can actually work on the things you bring up that day … there is more time for it. So it can be analysed … compared to if there are eight of you. And that is also one of my problems, I become a little pressured, right” Laura

The second limitation was a feeling that some topics or problems felt too heavy to share in the group. That is, they were too big to share, without taking time away from the others and also they were too painful, private or emotional for participants to be shared with several people.

Participants highlighted that they would have been able to share these in an individual session with the therapist. Some said that they had finished treatment without being able to share the most difficult issues, because they had not found a space where there was room and time for it. One
disclosed during her interview that she had been living for twenty-five years in an abusive marriage. This was the first time she had said it out loud, because it would have been ‘too big a parcel to unfold’ in the group and the initial individual sessions were very structured with clear agendas in the form of either assessments or group preparation.

“I myself, could have perhaps, been more open. Because … I have a hard time saying it … But I have lived in a physical and psychologically violent relationship. I didn’t tell that. And I don’t really know what to do about it now. There is so much stress in my body still, so when I hear the door go around the time he would normally come home, I still get heavy heartbeating, you know? Because I can feel, it is like a bomb scare. There is a kind of distress that has been there for many years. It is like I have lived in the trenches constantly. I have had this experience that, my language has been disappearing over these years, because I had to all of a sudden be very silent, to not provoke anyone. As the course went on and on, I wanted to share it, but I couldn’t really, because it wasn’t the place to do it. They actually finished my treatment. And I don’t think I have formulated myself clearly about this. How hard it actually is. I have been telling myself off, because I have been a wimp.” Eva

5. Education and Tools - use and non-use

Education and tools were continuously brought up throughout the interviews. That is, participants expected to gain tools, to learn something new, and they talked about the use of the tools during and after the end of therapy. Participants commonly expressed having become more aware of themselves and their challenges through the educational aspects of the therapy. Learning the natural function of emotions, their behavioural patterns, and the origins of their symptoms tended to lead to better understanding and empathy for one’s own state. Participants spoke about
tools as tangible techniques they could use in their daily lives to ease symptoms or increase functional level. For example, being able to analyze situations in an objective way when they were in difficult situations helped them to get through the situations despite discomfort.

“We worked a lot with exposure exercises, where we did these weird exercises like running up and down the staircase to lose our breath and get the heart pumping and then we had to notice the symptoms and recognize that ‘yes my heart is pumping, but that doesn’t mean I am about to die’ and that did a lot. The whole way of thinking, that these physical symptoms are something, they aren’t some things that are harmful to me ... I would use the same techniques and I would calm down and think ‘well... I am not going to die from this’. When I have been down, it is like everything is just one big mayhem, so this way of thinking objectively about it and separating it somehow, that was something that I really liked.” Marcus

Participants explained how they were presented with a range of tools and that they knew best which ones worked for them, implicitly saying that not all of the techniques were useful to them. The participants saw the therapeutic techniques as a toolbox from which they could pick and choose which ones they wanted to incorporate into daily life. There was a common experience that more time was needed in order to get these techniques really ‘under their skin’ and be able to use them in a more natural/automatic way in daily life.

6. Launchpad

The sixth element to the common narrative was named the launchpad, which referred to how participants felt in completing the course of therapy. The therapy had been a launchpad, from which
they had gotten a ‘toolbox’, new insights and a sense of normality and universality connected to their illness.

“This thing about … learning to love yourself the way you are. And not pack it away, that you have a hard time with some things. And then to have gotten some tools to lower the anxiety ... You have to be, at all times, what can you say, focused on yourself, and what you feel and your emotions. You use your self in a completely different way ... I stood here with a feeling like, now it is over and you have to, somehow, take care of yourself, right?” Laura

Participants described still struggling with a range of problems and that it was now their own responsibility to solve those problems. Whilst the participants accepted and endorsed the treatment, they also described how it was not really sufficient for them. Some of them felt unsure, unprepared and with a rather passive attitude with regard to how they should actually continue the process on their own. Thus, the launchpad created a foundation for improvement, but also launched people into insecurity, anxiety and the unknown. It appeared that participants shifted between agency and passivity in the way they talked about the future. There was a sense that they had been abandoned before they were ready to take on the responsibility fully of their future path.

“But it isn’t like a way, where I, in a general life situation, am on my way to a place that they have helped direct me to. In that way I don't feel like I have received help because it isn’t like I feel they have given me some kind of golden cure that really changes my life ... So it is me who has the responsibility of finding out what will happen ... But I am going traveling for three months in January. And I hope to find myself on that trip and get calm and get away and feel normal somewhere else. I hope it can help me figure out who I am and how to have an opinion of my own
and not just follow others because I have lost myself completely. But I hope time will do a lot.”

Michelle

Discussion

The analysis found six themes that created a common narrative, some shed light on the experience of receiving services, some on the experience of the group CBT and, finally, some raised possible limitations of this group format.

The first and last themes in the common narrative, How did I get here? and Launchpad, were highly related to the psychiatric services and the path to treatment. The first theme, How did I get here?, demonstrated how patients expressed a feeling of lack of information, a slightly chaotic start and uncertainty about the treatment type, goals and format. This led to highly sceptical attitudes prior to beginning the group CBT. Every interview revealed initial scepticism towards the treatment. This is problematic, as it has been established that expectancy and preliminary attitudes influence the outcome of psychotherapy (Wampold, 2015). In Wampold’s contextual model of psychotherapy, expectations refer to the idea that patients in distress have ideas, attributions and explanations for their distress when entering psychotherapy. These beliefs are idiosyncratic in nature but are also affected by social norms and cultural conceptualizations of psychopathology and distress. Importantly, for the expectation element to work, patients must believe the explanations of distress given to them, must perceive the treatment as relevant to their situation, and there must be agreement between therapist and patient about the goals of treatment. The contextual model gives a relevant perspective on the current findings, related to the services. It appears that almost all of the frustration and scepticism was generated from uncertainty, as the negotiation of expectations had not been experienced as fulfilling by the patients. Whilst the patients had participated in a group-preparing session with the therapist, there had not been designated time or a coordinated effort to
align patients’ understanding of their own distress and their expectations of treatment with the treatment package that was provided. This was evident throughout the material, where several participants highlighted that they were still not sure about their diagnosis or if group therapy was the right treatment for them post treatment.

Expanding on that, *Launchpad* showed us how patients felt uncertain and apprehensive about finishing treatment, even though they had gained some new skills and perspectives. Many of them simply stated ‘it just wasn’t long enough’ or ‘I just wish it was much longer’. Similarly, patients who participated in group CBT for eating disorders explained how they needed more time to learn particular skills (Laberg et al., 2001), indicating that they would have liked more time to practice the skills they learned in therapy, also manifesting that the patients perceived the given techniques as useful. This suggests a conflict between the positive experiences of the tangible tools delivered through group CBT and the negative experience of the time-restricted format of the intervention.

The themes, *Being seen, heard and recognized, Shared responsibility of problems and solutions* and *Education and tools* informed us about therapeutic factors highlighted as important helpful aspects in the CBT groups.

*Being seen, heard and recognized* concerns the patients’ experiences of being accepted and becoming accepting of themselves and their distress through the group-mediated process. The experience of not being alone and discovering that others feel the same way was underlined as extremely important by all of the participants. This particular process is well described in the group psychotherapy literature and has been referred to as universality (Yalom & Lezcz, 2005). It is also a well-known theme from other qualitative studies looking into patients’ experiences of group CBT for eating disorders, schizophrenia, anger-management, hot flashes and for young people with auditory hallucinations (Gledhill, Lobban, & Sellwood, 1998; Laberg et al., 2001; MacMahon et al.,
Further, this theme has also been detected when interviewing patients with borderline personality disorder about their experiences with psychiatric services more broadly (Fallon, 2003).

*Shared responsibility of problems and solutions* was also a theme related to group processes. In this theme patients described that they had a common responsibility towards the group and towards the other group members to do their very best and to do their home work assignments. Patients often described ‘lifting the burden together’. Looking back to Yalom’s therapeutic group factors, one may understand this theme as a manifestation of group cohesion, interpersonal learning, imitative behavior and hope generation (Yalom & Lezcz, 2005). The CBT literature has generally not addressed group-mediated processes extensively, mainly due to the focus on disorder-specific interventions and the role of specific tools and techniques. However, Schamlish and colleagues highlighted universality, mutual aid, group cohesion and socialization as group-mediated processes, thought to be particularly relevant for group CBT for hoarding (Schamlish et al., 2010).

Interestingly, the same concepts were found to be helpful for the patients in the current study.

The third theme related to helpful aspects of the therapy was *Education and tools*. This theme illustrated how patients viewed the therapy as a toolbox from which they could pick and mix the tools and techniques relevant to them. All of the patients described specific techniques that they found useful. The techniques that patients brought up as most helpful differed markedly, indicating that the different tools had different meanings and utility for each participant. However, all the patients appear to have accepted the concept of using concrete tools in their real world lives in order to alleviate distress or cope in more adaptive ways. Still, some of the interviewed patients expressed a wish for more time to talk openly in an unstructured way and without agenda sometimes. This is in line with the findings from a study comparing CBT and psychodynamic therapy qualitatively, in which it was found that the patients who expected and had a wish for open talk and introspection,
perceived psychodynamic therapy positively. Correspondingly, patients who came with an expectation and a wish for tools, tended to be very positive towards CBT. In the same study they found that patients who had been ‘paired’ with the therapy that did not match their wishes were frustrated (Nilsson, Svensson, Sandell, & Clinton, 2007). It may be that for a number of the patients, a different type of psychotherapy would have been more appropriate. The final theme that emerged from the analysis was the Limitations of the CBT group format. This is a continuation of the previous point, with some patients expressing that they had particular problems that were essential to them, but that they could not share, either because they were too painful or private or because they felt like those stories would take up too much time in the group. These findings appear to be consistent with Laberg and colleagues’ (2001) explorations into the experience of group CBT for eating disorder, in which patients expressed that a major limitation of the group format was that there was less room for personal issues. They followed up this point by underlining the importance of individual sessions in the overall experience of the treatment (Laberg et al., 2001). In the current setting, patients were informed that they could ask for individual sessions if needed. Yet several of the interviewed patients described that it was extremely difficult for them to allow themselves to ask for that. This difficulty leads back to the lack of negotiation of expectations.

When looking at the results as a whole, it appears that the standardized group CBT package is somewhat successful in establishing meaningful relationships and group cohesion that is healing in and of itself. Furthermore, the therapy is successful in delivering education, techniques and tools to the patients that they find useful and relevant. Importantly, the current study also found that patients emphasized both common factors and CBT-specific factors as helpful and explained how group-mediated processes aided the learning of CBT-specific tools and techniques. However, many of the patients interviewed expressed a need for additional individual sessions. Further, expectations
had not been successfully negotiated prior to treatment or renegotiated during or after treatment, leaving patients uncertain and feeling abandoned post-treatment. This led to an overarching ambivalence about the overall experience, where the patients overall found the therapy itself highly useful and applicable, but were less satisfied with the format and the lack of flexibility of the treatment. Such ambivalence has been seen before, in a study by Morgan (1999), in which approximately half of the outpatients asked were unable to say whether the psychiatric outpatient services had helped them or not due to a general discrepancy between the services provided and patients’ circumstances, long-standing problems and their hopes for treatment. Furthermore, the ambivalence regarding the psychiatric system is mirrored in a study exploring the experiences of patients with borderline personality disorder, who valued their treatment in the system despite negative experiences (Fallon, 2003).

The patients in the present study were characterized by a high level of functional impairment, long lasting symptomology and had several failed treatment attempts previously (Reinholt, in review). It may be relevant to look to CBT models that have been successful in treating more severe psychopathology, such as CBT for eating disorders (Cooper & Dalle Grave, 2017) and dialectical behavioral therapy for borderline personality disorder (Dimeff, 2007), in which the treatment model comprises both individual and group therapy, in order to draw on the strengths of both dyadic therapy and group-mediated processes combined with specific CBT techniques. This is supported by a qualitative study finding that patients with eating disorders had a positive experience of an integrated package of individual and group CBT (Laberg et al., 2001). It is likely that, if such an integrated model was implemented in the treatment context of the present study, patients’ wishes for treatment could be fulfilled to a larger degree and the limitations to the format could be overcome.


**Limitations**

In the current study, no patients who had dropped out of treatment were interviewed. This presents a constraint, as one might suspect that the patients who dropped out would have had other perspectives on the treatment and the services.

The interviewer is a clinical psychologist, who is trained in CBT and has delivered CBT in groups and individually. This meant that the interviewer had strong background knowledge of the field, the treatment and the clinics involved. It also meant that the interview dynamic might have mimicked one of a clinician and patient. Patients may very well have understood the interviewer as a part of the psychiatric system, which may or may not have influenced answers. It also meant that the interviewer’s focus was on clinically relevant data, which may have limited the areas of exploration that the interviews went into. On the other hand, the study may have reached a more detailed level of description due to that same familiarity.

Many of the interviews unfolded the distress experienced by patients and their frustration with having finished treatment. The patients’ distress has undoubtably informed and shaped the first author's own understanding of treatment in the Danish psychiatric system. Thus measures were taken to carry out the analysis with independent researchers who did not know about the system.

Since the current study was carried out in the context of a large RCT study, it cannot be ruled out that some of the patients’ experiences may have been influenced by trial procedures. It appears likely that therapists may have made efforts to stay more true to the manual content due to fidelity procedures, and this may have compromised how the therapists would carry out the treatment in a more naturalistic context. Furthermore, the therapists may have been less likely to offer individual sessions in an attempt to uphold trial rigour.
Finally, the current study was carried out in context of a Danish MHS setting and cannot necessarily be generalized to other contexts. Still, the results appeared to echo previous findings from other patient groups in outpatient psychiatry in the Western world, thus it may be particularly relevant for that context.

Clinical implications & recommendations

The current study explored how group CBT was experienced by patients in the services. The key findings were that the therapy itself was helpful due to group-mediated processes and CBT specific processes. Furthermore, the current study found that patients were sceptical prior to the beginning of therapy due to a perceived lack of information. Finally, patients felt, to some extent, abandoned at the end of treatment, due to the abrupt ending of a treatment course that was generally experienced as too short.

The interviewed patients came with a range of suggestions to help solve these problems. We have combined these with our own understanding, informed by the theoretical framework presented above. Our suggestion is that the services should consider emphasizing:

1) Thorough information about the role of staff (e.g., psychiatrist, nurse, group-therapist) that patients will meet throughout treatment, at the first meeting with psychiatry as well as a thorough explanation of diagnosis, distress model and treatment strategy.

2) Setting sufficient time off for a dialogue with the patient about group CBT (including the session format, the rationale and expectations of the patient) to ensure that a consensus-driven strategy for therapy is established prior to the beginning in group therapy. Furthermore, the healing processes mediated by the group should be emphasized prior to entering the group to alleviate anxiety about the group format.
3) An integrated treatment model consisting of both individual sessions and group therapy should be provided, in order to draw on strengths of both dyadic therapy processes and group-mediated processes for this group of patients with rather chronic conditions and recurring episodes.

*Perspectives*

The proposed clinical recommendations illustrate a need to individualize treatment courses to the patients, at least to some extent. It becomes clear that the services are currently built on a classical medical model with the main focus being on diagnoses and standardized treatments. This appears to work on some levels, but also seems to leave patients feeling like ‘another one in the line’ and longing for their individual needs to be met. Individualization is in line with the ideas of the schools of recovery and personalized medicine, ideas about how to treat human suffering in more person-centered ways in which treatments are molded to fit the individual and the patient becomes an equal stakeholder in their own treatment. Whilst fully personalized treatments may be unrealistic given the limit on resources in this publicly financed system, it appears that the current model is experienced by patients as rigid and in many ways insufficient. We recommend the application of a more comprehensive model including personalization of treatment in order to effectively improve the outcomes for this group of patients in the services.
References


**Supplement 1**

**Interview Guide**

1. **Open talk**
   - To begin with, I would like you to tell me about your therapy course, just tell me whatever comes to you naturally.

   Note: make free talk last as long as possible, listen to the points brought up by the participant (on their own initiative) and keep asking about that, ask obvious questions, make sure to get a full understanding of the stories they tell and the terms they use.

2. **Expectations**
   - What were your expectations before you started in therapy?
   - Were your expectations met? How? How not?

3. **Group**
   - How did it feel to be in this group?
   - What did you think about the other group members?
   - What were the differences/similarities between you?
   - When did you notice the differences/similarities between you?
   - How were these people compared with other people in your life?
   - Did you feel you connected with the others?
   - Did you notice if people took on different roles within the group?
   - Do you feel like there was room for everyone in the group?
   - Was everyone seen, heard, recognized?
   - Do you feel like the other group members could give you valuable feedback?

4. **Important moments**
   - Are there any particular moments in the therapy that you remember especially well?
   - Did you experience AHA-moments?
   - Did anything particularly important happen for you in your life outside of therapy in this period? Elaborate...

5. **The Therapists**
   - How did you find the therapists?
   - Were there any particularly important moments regarding the therapists, that you remember especially well, why?
   - Did you feel like it was a collaboration between the therapists and yourself?
   - Did you feel like the therapists could give you valuable feedback, when you shared in the group?

6. **Change**
   - Do you feel any different now, compared to, when you started here?
   - What do you think has changed?
   - What do you think the reason for change/lack of change is?
   - Has other people in your life noticed a change, if yes, explain...

7. **The therapy**
   - When you think back on this therapy course, what was the biggest help for you?
   - Did anything happen during the therapy course that either was not helpful to you or negative/damaging to you? Explain...
   - Was there anything you missed in this therapy course?
   - When you think back on the therapy, what were the most positive elements?
   - When you think back on the therapy, what were the most negative elements?

8. **Manual-specific factors**
   - Can you tell me about what you have learned in this therapy course?
   - Were there any specific techniques/exercises that you found particularly helpful? Why?
   - How did you find the homework? Was it useful for you?
   - What did you think about the way the course was constructed? The specific topics covered, the order in which they were presented, the structure of the sessions etc.
   - Did you understand the vocabulary and techniques presented to you?

9. **The end**
   - It is now the end of the interview, do you feel like I have gotten a good understanding of your experience?
   - Is there something we have not covered, which was important for you?
   - Is there anything you would like to add?
Figure 1
Steps in the analysis process

- Transcription of interviews
- Translation of two full transcripts
- Condensation of two full transcripts
- Condensation of remaining transcripts and translation into English
- Analysis of short narratives
- Write up and selection of verbatim quotes

Note: This figure illustrates the steps of the data analysis and demonstrates who carried out which tasks in the process.
Table 1

Participant characteristics

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<th>Comorbid diagnosis</th>
<th>Length of current episode</th>
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Note: MDD=Major depressive disorder, PD=Panic disorder, AGO=Agoraphobia, SA=Social Anxiety, GA=Generalized anxiety. UP=Unified Protocol, CBT=diagnosis specific CBT for primary diagnosis.
Article II
Therapists’ Perceptions of Individual Patient Characteristics that may be Hindering to Group CBT for Anxiety and Depression

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Abstract

**Objective:** Individual patient characteristics are important in trying to understand why people respond differently to group CBT. Only a few studies have explored therapists’ perceptions of within-patient attributes that may be hindering in group CBT in a mental health setting.

**Method:** We explored the perception of individual patient characteristics and related obstacles in 12 psychotherapists in Danish Mental Health Services through semi-structured interviews. The interviews were analysed using a descriptive qualitative framework.

**Results:** The results revealed four distinct themes that the therapists pointed to as important for the outcome of a 14-week group CBT intervention for social phobia, panic disorder, agoraphobia and major depressive disorder. The four themes were *Complexity & severity, External circumstances, Attitudes & coping* and *Cognitive ability & reflection level*. The therapists explained how they perceived higher complexity and severity in the patients as an obstacle, they highlighted that a calm and stable outside environment aided therapeutic change, whilst stressors were hindering. They perceived active coping mechanisms, positive attitudes and high readiness to change as positive factors, whilst dependent and hostile coping mechanisms and negative attitudes were seen as obstacles. Finally, the therapists pointed to cognitive abilities and reflection level, explaining how it could be difficult to obtain good outcomes for patients who’s cognitive abilities were debilitated due to psychopathological factors or for patients with a generally low reflection level.

**Conclusions:** The results indicated that the therapists experience group CBT as an intervention that requires certain prerequisites of the patients, and that the four themes should be considered when deciding on treatment options for any given patient. The clinical utility and theoretical implications of the results are discussed.

**Keywords:** cognitive behavioural therapy, group psychotherapy, mental health services, patient characteristics, clinician perspectives.
Introduction

Cognitive behavioural therapy (CBT) is recommended as a first-line psychological treatment for anxiety and major depressive disorder (MDD) in national clinical guidelines (NICE, 2004a). CBT has been implemented in a variety of mental health settings such as university clinics, community-based services and mental health services (Fernandez, Salem, Swift, & Ramtahal, 2015). In Danish mental health services (MHS), group CBT is the standard treatment for anxiety and MDD. Group CBT has the advantage of being more cost-effective than individual psychotherapy (Okumura & Ichikura, 2014; Tucker & Oei, 2007). Furthermore, group therapy facilitates processes like normalization, peer support, modelling, and other interpersonal processes (Lambert, 2013). However, a recent meta-analysis found that the average during treatment dropout rate was approximately 25% for both individual and group CBT (Fernandez et al., 2015 & Ramtahal, 2015). Furthermore, a significant proportion of patients experience negative effects such as a lack of change or deterioration (Lambert & Ogles, 2004). In a recent group CBT RCT in Danish MHS, the drop-out rates were even higher for outpatients with MDD or anxiety. The patients were characterized by severe functional impairment, long-standing symptomatology, and with a lack of response to previous treatment attempts (Reinholt et al., in review). Most therapists are familiar with impediments such as a lack of improvement, deterioration, and dropouts among their patients (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Lambert & Ogles, 2004). Recent studies report that therapists have identified a range of within-patient attributes that are seen as barriers to CBT, namely, comorbidity, having low agency, complex psychopathology and recurrent psychosocial stressors, low cognitive ability and low motivation (Bystedt, Rozental, Andersson, Boettcher, & Carlbring, 2014; Ringle et al., 2015). Studies of therapist perspectives on CBT have shed light on adverse effects of psychotherapy (Bystedt et al., 2014), barriers and
Qualitative methods have the potential to provide insight into the experiences of therapists engaged in CBT, and, accordingly, to understand the difficulties that may lead to dropout or reduced treatment effect. More specifically, studies of therapist perspectives on CBT are important since therapists hold insights about multiple aspects of psychotherapy (Currell, Christodoulides, Siitarinen, & Dudley, 2016; McLeod, 2001) and therapist interviews has been put forward as the most sensitive way to elicit information about negative aspects of the treatment (McLeod, 2001).

We aimed to explore therapists’ experiences of group CBT for outpatients with social anxiety disorder, panic disorder, agoraphobia or MDD in Danish Mental Health Services. We were interested in the therapists’ views on helpful and hindering aspects of CBT and their overall experience of delivering the therapy. Throughout the interviews, it became clear that the therapists continually spoke about obstacles that they felt contributed to patients’ lack of improvement, negative responses or dropout from treatment. This was not prompted through the interview guide, meaning that no questions were asked about it, but surfaced on its own in a clear and distinct pattern. Therefore, this became the focus area of the current article. By choosing this focus, we hope to contribute to understanding which obstacles might face clinicians when delivering manualized group CBT in MHS, and through these explorations discuss the clinical implications. Therefore, the current study aimed to answer the question:

*Which obstacles do therapists experience when delivering group CBT for a range of anxiety disorders and MDD in Danish MHS?*
Materials & Methods

Context:

Treatments

The therapies were conducted within the TRACT-RCT study (Arnfred et al., 2017), where therapists delivered a 14-week CBT intervention in either diagnosis-specific or transdiagnostic groups. The groups consisted of approximately eight individuals and two therapists. The treatment was delivered in either diagnosis-specific groups for social anxiety disorder, panic disorder/agoraphobia, or MDD or in transdiagnostic mixed anxiety and MDD groups using the The Unified Protocol (Barlow et al., 2010). The treatment protocols were based on established diagnosis-specific CBT manuals (Due Madsen 2008; Craske & Barlow, 2008; Turk, Heimberg & Magee, 2008) but were adapted to this particular context and patient population. The treatments were similar to the standard treatment courses delivered in the Danish MHS. The outpatient clinics are publicly financed services for individuals suffering from moderate to severe non-psychotic disorders. In order to be referred, individuals must have a high severity level or have previous treatment-attempts (psychotherapy or medication) without remission.

The patients

The patients treated in the RCT all had a primary diagnosis of MDD, social anxiety disorder, panic disorder or agoraphobia. The sample was characterized by high functional impairment and high levels of comorbidity, approx. half of the patients in the RCT were not in employment or education (Reinholt et al, submitted). They were screened as per standard procedures in the clinics and in an RCT inclusion interview where they were assessed with MINI-International Neuropsychiatric Interview, screening for personality disorders and data on previous episodes, duration of symptoms, medication history etc. was retrieved.
**Ethical considerations**

All participants volunteered to participate in the study and were given detailed information about the purposes and practicalities of the study. All participants provided written consent. Data were pseudo-anonymised. The interviews did touch upon potentially sensitive topics related to workplace, co-workers, management and the psychiatric system. The interviewer informed the participants about their right to share however much or little they felt comfortable with. The interviewees were given the opportunity to see the interview guide prior to the interview.

**Participants**

The study recruited twelve therapists from three clinics in Denmark. Recruitment was made through email advertisement and in-person advertising. The sampling of therapists was pragmatic, meaning that the therapists who signed up were interviewed. The sample consisted of females only, at the time of the interviews only two males delivered therapy, one of whom had only delivered a half therapy course and one who did not sign up. The therapists had various educational backgrounds, the sample included: nine clinical psychologists, two psychiatric nurses and one occupational therapist. The experience level, in terms of delivering psychotherapy, ranged from 3 to 26 years (Median experience=10 years). The interviewees had conducted at least one full treatment course in the trial when interviewed.

**Data collection**

The data were collected through semi-structured interviews. The interview guide was designed to capture the experience of therapy by focusing on the overall experience, common factors & manual & context specific factors, (table 1). The data was analysed with different
strategies and focuses in order to shed light on various aspects of the material. The therapists’ perceptions of individual patient characteristics being just one of them. There were no questions in the interview guide about patient characteristics, this was a subject brought up by every single participant without prompting. This particular topic was approached through the analytical steps outlined below. Interviews were carried out throughout 2018 and January 2019. The first author who is a clinical psychologist, conducted all of the interviews. She was known to all of the participants as a member of the TRACT research group and was a day-to-day colleague to three of the interviewees. The interviews were carried out in the interviewee’s offices and lasted between 50 and 90 minutes. The interviews were carried out in Danish, all interviews were audiotaped and transcribed verbatim. The quotations presented in the results section were translated by the first author and checked and approved by the co-authors.

**Data Analysis**

The data analysis was inspired by the guidelines for descriptive qualitative enquiry (Colorafi & Evans, 2016). The current study made use of a deductive analysis to extract information about the particular area of interest. The deductive framework was chosen due to the narrow scope of the research question. The descriptive enquiry was chosen to ensure that the findings were reflective of the therapists’ actual spoken word. The researchers were focused on extracting the patient characteristics identified as meaningful for the treatment course by the therapists. The data analysis consisted of several steps described below. (Figure 1).

In the first step, the first author carefully read through the transcriptions and documented the patient characteristics that were apparent throughout the material.

In the second step, a ‘thematic division’ was made. This was based on a collaboration with a wider research group. Two meetings were held where the initial impressions were discussed and
thematic categories were identified. This formed the basis for a coding manual with five codes: *Psychopathology, External circumstances, Attitudes & coping, Life story, Intelligence & cognitive functions,* (table 2).

Step three was the meticulous coding of the material carried out by research assistants (RA’s). The RA’s were trained in the coding manual by the first author. The RA’s coded all meaningful units concerning obstacles and within-patient attributes throughout the entire dataset. The first author and the RA’s collaborated on the coding process and were physically together creating a space for reflection and debate of the material. The RA’s documented the details into a code table.

Upon completion of the analysis it turned out that the code *Life story* was only coded seven times throughout the dataset and was therefore not brought forward as ‘an obstacle’, meaning that although it at first glance appeared to be a theme, when coders meticulously went through the material it was not present as actual descriptions.

Upon completion of the coding, the data were reviewed and described in terms as close to the original text as possible. The themes were given names that were more reflective of the therapists’ actual words.

**Results**

Our analysis identified a range of patient characteristics or obstacles pointed out by the twelve therapists in the current study. Four themes emerged from the analysis (1) *Complexity & severity,* (2) *External circumstances,* (3) *Attitudes and coping,* (4) *Cognitive ability & reflection level.* The themes are defined, explained and explored in detail and are presented using verbatim quotes.
**Theme 1 – Complexity & severity**

Therapists referred to two distinct psychopathological factors that were seen as a hindrance to therapy, namely, *complexity and severity*. From a therapist perspective, more complex and severe psychopathology made it harder to bring about meaningful change with group CBT and dropout was consistently linked to severity across the interviews. The therapists acknowledged that severe and complex psychopathology can be treated successfully with psychotherapy, but it was experienced as difficult to achieve in the framework of group CBT:

*I simply think, that it is an illusion to think, that we can keep the most ill patients engaged in these tight programmes. In those cases, we need to provide something else.* (Therapist 4).

There was consensus that in order to reach better results for patients with more severe psychopathology, more comprehensive interventions are needed. The therapists describe how group CBT is not the right fit for patients with complex and severe psychopathology, mainly due to the format of the intervention. The therapists described how the relatively short amount of sessions combined with the lack of individual sessions prior to, during and after group therapy made it hard to reach good outcomes. Therapists highlight the need for more substantial treatment offers for these patients, for example individual adaptation with additional individual sessions, team-based care or rehabilitation-support.

**Theme 2 - External circumstances**

*External circumstances* refer to psychosocial stressors that reside outside of the therapy room. The therapists describe the importance of relatively stable outside environments for the therapeutic processes to be able to work. Psychosocial stressors disturb therapy and engagement.
External circumstances may include home life, interpersonal issues, occupational stressors, societal systemic stressors, acute crises, financial difficulties, and traumatic events:

*I think it will be a theme, in regard to what the patients say [in their interviews] that in order to get a good outcome, some of these external circumstances have to be in order, because if not... then it is pretty hard to make changes, if you come home and then there are fires everywhere* (Therapist 10).

There was also consensus that stressors have a multiplying effect, the more stressors that are present, the more likely they are to interfere with a positive psychotherapy process. A therapist described a patient whom she worried had not benefitted from therapy because of psychosocial stressors. These circumstances were described as hindering for two reasons 1) his mind was preoccupied and 2) he did not have the time between sessions to engage with homework assignments:

*He was also in a stressful life situation that probably blocked him from really making changes in the group, so he was very preoccupied with the circumstances in his life, with a sick wife and a small child and an unemployment situation, that made him… different... and he had to take care of the child and there wasn’t so much time for, that he had time for himself and could do some things. And that is probably what we should have realized, how do we really get someone with a strained life situation to be in the group and get the maximal outcome* (Therapist 4).

External stressors were seen as an obstacle to positive change. The therapists found it hard to do the manualized group CBT treatment with the patients that had many external stressors and
found that it was not the right fit. Furthermore, the therapists highlighted that in order to make progress, the patients need to be in a place where there is time and resources to engage with the therapy.

**Theme 3 - Attitudes and coping**

*Attitudes and coping* cover a range of constructs such as motivation, readiness to change, agency and attitudes. In this study, it was understood as one combined theme because the therapists used these terms interchangeably and in connection with one another. Overall, therapists experienced positive attitudes and beliefs, active coping styles, resilience and high motivation as key factors in a positive psychotherapy process whilst a lack of these or opposing attitudes was seen as an obstacle. The therapists referred to the patients’ attitudes towards and belief in a positive outcome as important for treatment. It was also described as the minimum requirement for the therapy to work:

> Having a belief in what you are doing, or to some extent at least, that is a minimum, that you have some belief, that this is actually something that can help me, I think that is necessary (Therapist 12).

There was consensus, that motivation is a key factor in both positive and negative outcomes of therapy and especially in regard to dropout:

> I think in reality, it's not so much about the different diagnoses, it is mostly about motivation. And then…how much responsibility they are used to taking... That is what is mainly
coming to me, and I think in some of them [the groups] where I have experienced a large dropout, motivation was the greatest factor

(Therapist 2).

Moving into the area of coping, the therapists describe the importance of having active coping styles. Being used to taking responsibility, having agency and being self-help-oriented is seen as positive for treatment. Having active coping styles is understood as a necessity in benefitting from therapy, on the other hand having helpless, dependent or passive coping styles is seen as problematic.

Are they agents in their own lives, or do they sit down and expect that things will be done for them? (...) I mean, do they have an, what could you call it, active axis in their lives in trying to handle things, and then they can of course get hit by illness, but, can they handle it? or are they more towards the, what could you say, dependent, helpless side, which makes them unable to. Or maybe they never have been able to or willing to, because then I think that it is more personality based, what you need to work with(...) Are they in on the fact that they have to show up, first of all, every single week, fourteen times and [can you be] really really sure that they understand that and can do that. And that they can also handle a certain level of challenge and still want to participate anyways
(Therapist 4).

The therapists placed high importance on the patient’s ability to enter into such an ‘active’ type of therapy and underlined that it is not for everyone. When asked to identify the type of patient that would benefit from group CBT, the therapists highlighted that patients need to be able to take responsibility, have agency and high motivation, have a certain level of resilience and believe in the treatment. Patients with aggressive and passive coping styles as well as patients with high levels of
hopelessness and a lack of belief in positive outcomes were experienced as harder to treat in the given framework.

**Theme 4 - Cognitive abilities & Reflection level**

*Cognitive abilities and reflection level* encompass two sub-themes 1) *cognitive abilities* that may or may not be debilitated due to psychopathological factors and 2) general *reflection level* referring to the patient’s mental capacities in a more stable and long-term sense. There is an overlap between the two sub-themes and one gets the sense that some therapists use the term *cognitive abilities*’ and *reflection level* when referring to general intelligence.

A particular characteristic of this theme was that while almost all of the therapists brought up cognitive abilities as a factor, only four therapists brought up reflection level. Thus, there appeared to be consensus that cognitive abilities are important whereas the patients’ general level of reflection appeared to be perceived as very important by a smaller number of therapists but not by the other therapists.

**Subtheme 1 - Cognitive ability.** This sub-theme refers to cognitive deficiencies related to the psychopathology of the patient. There is a broad consensus amongst the interviewed therapists that patients who are experiencing cognitive deficits tend to obtain worse outcomes, mainly due to the high level of psycho-educative content in CBT as well as the large amount of written work both in session and in homework assignments. One therapist explained how it felt slightly pointless to present large amounts of theoretical material to patients with cognitive deficits:

*I mean, if you are so depressed, and then receive this information overload, can you even contain it inside your head? I mean, I think, when you are laying low cognitively, right? I mean, if*
you are at your absolute worst and then have to sit there and receive the most information, it is completely conflicting with what you are capable of cognitively (Therapist 4).

**Subtheme 2 - Reflection level.** In this theme, the therapists highlighted that CBT is intellectually demanding and requires a certain reflection level. One of the therapists explained that a normal reflection level is important because it can be hard for some patients to understand the key content of the therapy. This therapist also pointed out how it can be difficult for patients to speak freely about struggling to understand the content of the therapy:

*But it is obvious, that reflection-level-wise, there can be a challenge for those, who do not have that high of a reflection level… Because even though you are here where you can say what you want to, and we encourage that, that you can speak freely, it is still a taboo not to be able to follow or if it does not make sense to you* (Therapist 11).

The sub-group of therapists that brought up this obstacle emphasized it strongly and highlighted that CBT may not be the treatment of choice for patients with low reflection levels.

**Discussion**

In the current study, we investigated therapists’ experiences of individual patient characteristics perceived as potential obstacles to a group CBT course in Danish MHS. Four distinct themes were identified, namely, **Complexity & severity, External circumstances, Attitudes & coping** and **Cognitive ability & reflection level**. Therapists described that the delivered treatment was not suitable for the patients with highly severe, complex and chronic psychopathology. Furthermore, a
relatively calm outside environment was important for a positive change process, alongside the
patient’s intrinsic motivation and engagement in therapy, active coping strategies and belief in
treatment outcome. Finally, some of the therapists pointed out that the delivered treatment required
certain abilities of the patients, i.e., reflection level and cognitive functioning within the normal
range.

The therapists’ experiences with Complexity and severity are consistent with previous
qualitative studies, in which particularly comorbidity with personality disorders or severe anxiety
levels were identified as obstacles (Ringle et al., 2015 Stern, 2015). This is also consistent with a
range of quantitative predictor studies on anxiety and MDD (Hamilton & Dobson, 2002; Mululu,
Menezes, Vigne, & Fontenelle, 2012; Newman, Crits-Cristoph, Connolly Gibbons, & Erickson,
2006). Some of the therapists suggested that for this group of patients, a more comprehensive and
inter-professional intervention is needed including involvement from psychiatry, social support,
communication between stakeholders i.e. psychiatry, job-centre, support/counselling staff. This is in
line with previous research demonstrating that collaborative team-based community interventions
for patients with MDD lead to significantly better outcomes and that these effects were even larger
for patients with comorbid anxiety disorders (Katon & Seelig, 2008).

The therapists pointed to External circumstances as an obstacle to treatment. This is in
accordance with Lambert’s estimate that extra-therapeutic factors account for 40% of change during
psychotherapy (Lambert & Ogles, 2004). Other studies have confirmed that therapists perceive
extra-therapeutic factors as important for outcome (Thomas, 2006). Furthermore, it is consistent
with reports by patients who dropped out of treatment, who often attributed dropout to situational
constraints or external difficulties (Hynan, 1990).

Looking at Attitudes and coping, the qualitative studies in this field have found that
therapists identify motivation, psychological mindedness, readiness to change and related constructs
as factors that impact the outcome of psychotherapy (Bystedt et al., 2014; Lynch, 2012; Ringle et al., 2015). One may argue, that this is especially relevant when looking at high-structured group therapy, as patients might be on different motivational levels. Looking to the transtheoretical model of change, group members on different motivational stages may present a challenge to therapists. Norcross and colleagues (2011) have argued that an extensive therapeutic focus on behaviour (targeting action and maintenance stages of change) can cause patients in earlier stages (precontemplation, contemplation and preparation stages) to drop out of treatment or become unmotivated. Since the treatment manuals in the current study were predefined, it may be that the therapists were experiencing that the manual content was not appropriate for the group members, given their motivational stage. This might also explain why the therapists often expressed a wish to do motivational work prior to group and more individualized therapy for individuals with ‘low motivation’.

Results from predictor studies of psychotherapy confirm that patient attitudes and positive expectancy are predictive of positive outcomes in anxiety and depression (Glenn et al., 2013; Westra, Dozois, & Marcus, 2007). A meta-analysis investigating drop-out from psychotherapy found that patient motivation, self-efficacy and patient hostility were all associated with drop-out (Sharf, 2009). Thus, there appears to be consistent findings that the constructs identified under the factor Attitudes and coping are related to the outcome of CBT. The current study provides insight into the way these constructs are tied together by the therapists. The therapists understood these as part of a more global construct that must be present in the individual in order for them to profit from CBT.

Looking at the influence of Cognitive abilities and reflection level, therapists have previously highlighted clients ‘reflexivity’ as a major factor in facilitating good outcomes (Stern, 2015) and good cognitive abilities have been considered by therapists as a positive factor for
outcome (Lynch, 2012). In a study assessing barriers to delivering CBT in general practice, family physicians identified low education level as a barrier to positive outcomes (Wiebe, 2005). This is interesting, as other studies have found that CBT is a promising intervention for individuals with intellectual impairments, although adaptations must be made (Unwin, Tsimopoulou, Kroese, & Azmi, 2016). Thus, it appears important to underline that it may not be the case that cognitive abilities and reflection level is hindering for good outcomes of group CBT per se, but rather that the therapists experienced it as hindering within this context where no adaptations were made.

The study gave insight into how the therapists experienced this group CBT intervention as a treatment that requires certain prerequisites of the patients and may not be sufficiently comprehensive for certain subgroups of patients. The therapists explained how the identified obstacles interfere with the therapy and offered suggestions as to how to solve these issues by combining individual and group CBT, providing other types and more long-term therapy, enhancing interprofessional collaboration and providing sessions of a more supportive counselling nature. Finally, therapists often stated, “it is just not enough”, referring to the 14-week group treatment. Here it may be relevant to refer to the NICE guidelines in which group therapy, though classified as high-intensity, is recommended for mild-moderate severity, whilst individual CBT is recommended to moderate-to-severe MDD and anxiety (NICE, 2004b). Considering the severe and complex psychopathology of the population in Danish MHS, it appears that 14-week group CBT without additional individual sessions or other interventions may not be enough to reach satisfactory outcomes.

**Perspectives**

When looking to the literature on treatment resistance in psychiatric outpatient populations, several individual patient characteristics have been identified, for MDD, factors such as recurrent...
episodes, comorbid anxiety disorders and previous failed treatment attempts have been identified (Souery et al., 2007). Furthermore, Maunder and colleagues (2010) identified a range of patient-related factors associated with poorer outcomes and difficulty in treating psychiatric outpatients, many of the factors were similar to those identified in the present study, especially, 2+ episodes, 3+ diagnoses, treatment resistance, unemployment, poverty or financial problems, lack of agency, strong negative expectations, lack of independence (high on the dependence trait), intellectual impairment or cognitive deficits. Furthermore, Moorey (1996) identified a range of variables that could impair the response to CBT, these were comorbidity, chronicity, severity, psychosocial factors such as relationship problems or ongoing stress, little motivation and difficulty understanding CBT models. Whitfield (2010) identified a further range of variables, such as communication problems, suicidal ideation, conditions making the individual unlikely to identify with the problems of fellow group members, dominance, fear of group setting and the preference for individual therapy or other treatment modes was identified as especially relevant for group CBT. Studies have also revealed that group CBT was not as efficacious as individual CBT for panic disorder and social phobia (Sharp, Power, & Swanson, 2004; Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003). This puts into question whether group CBT on its own, is the best choice of treatment for this treatment population in Danish MHS, with rather chronic and severe psychopathology.

The literature indicates that the experiences of the therapists in the current study aligns with findings from previous quantitative studies. It highlights the importance of looking into these characteristics when deciding on a treatment plan for each individual patient. There appears to be overlaps and similarities across findings in both quantitative and qualitative studies. More research into the field of patient characteristics and patient-related factors may provide opportunities for
improvement for the large proportion of patients who currently do not benefit from treatment. When investigating how to improve outcomes, we must not only think in terms of identifying characteristics that are associated with poor treatment responses, but also think in terms of how treatment should be adapted to cater for the patients in the services.

**Limitations**

We used convenience sampling in order to recruit therapists to participate in the current study. Only one of the interviewees was working with patients with MDD on a daily basis and none of the interviewed therapists had delivered the diagnosis-specific CBT for depression in the study. This limits the generalizability of the results to CBT for depression. The self-selection of therapists and the lack of male therapists in the sample could have skewed the results.

Researcher familiarity presented another limitation to the current study. The interviewer was known to the interviewees as a member of the TRACT-RCT team. The familiarity with these interviewees could have compromised full disclosure.

The first author was part of the TRACT-RCT team and had several different roles within the research team. Furthermore, the RCT group may have had beliefs and attitudes that will inevitably have shaped the conversations, processes and foci of the current study.

The fidelity requirements imposed by the trials i.e. strictly sticking to the manual content and always using a CBT way-of-thinking and communicating may have constrained the therapists from using their ‘clinical instinct’ and making changes and shifts in therapy content and therapeutic approaches fit to the specific patients, this may have led the therapists to feel limited in the intervention and therethrough see more/other obstacles than ordinarily.
The translation process from Danish to English, may have affected subtle points or meaning units. The translation of metaphors and Danish expressions will inevitably have impacted the ‘feel’ of the included quotations.

The chosen analysis strategy did not capture what was said vaguely, what was not said or give weight to the way in which things were said, but looked only at clear descriptions of obstacles and patient characteristics. This limits the depth of the findings. We recommend other types of qualitative analysis are carried out in this field in order to gain deeper explanations.

The interviewer is a clinical psychologist, who works in one of the clinics from where therapists were recruited. This meant that the interviewer had strong background knowledge of the field, the treatment and the clinics involved. This might have influenced the interviews and might have compromised the level of exploration in the interviews.

Finally, the current study was carried out in context of a Danish MHS setting and cannot necessarily be generalized to other contexts.

**Clinical Implications**

The overall finding in this study is that the therapists expressed that short-term group CBT requires that patients have some prerequisites and circumstances for the intervention to make sense and that group CBT is not the optimal choice of psychotherapeutic treatment for all patients.

Qualitative research based on clinicians experiences has the capacity to provide clinical recommendations (Levitt, Farry, & Mazzarella, 2015). Therefore, we suggest that when deciding on treatment options, clinicians should consider the complexity and severity, the external circumstances surrounding the patient, their attitude towards therapy, their coping mechanisms and finally their current and stable cognitive abilities. Using these to identify who may or may not
benefit from group CBT, may be a way to make services more cost-effective and reduce negative outcomes such as lack of change, deterioration or dropout.
References


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<table>
<thead>
<tr>
<th>Topic</th>
<th>Subtopic</th>
<th>Example of question</th>
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<tbody>
<tr>
<td>The overall experience</td>
<td>Open enquiry into experience</td>
<td>“Can you tell me about the therapy courses you were involved in, just say whatever comes to mind…”</td>
</tr>
<tr>
<td>Common Factors</td>
<td>Expectations, the group, change, the therapists</td>
<td>“What where your expectations before you started?”</td>
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<td></td>
<td></td>
<td>“How would you describe the group?”</td>
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<td></td>
<td></td>
<td>“Did you see change happen? Why? How?”</td>
</tr>
<tr>
<td>Manual and Context</td>
<td>The manual, being part of an RCT, drop-outs</td>
<td>“How did you find the manual you worked with?”</td>
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<tr>
<td></td>
<td></td>
<td>“How was the materials you worked with?”</td>
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<tr>
<td></td>
<td></td>
<td>“Tell me about being part of an RCT”</td>
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</table>
Table 2

Example of coding manual

1. **Psychopathology** (identification of symptoms, diagnoses and severity as important factors for the treatment course)

<table>
<thead>
<tr>
<th>PPA</th>
<th>Psychopathology - Diagnoses:</th>
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<tbody>
<tr>
<td></td>
<td>Expressing that particular diagnoses or combinations of diagnoses can influence the course of treatment + or DO*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PPB</th>
<th>Psychopathology - Severity:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expressing that the severity of symptoms, the time period of their presence and the complexity of the symptoms in the patient can influence the course of treatment + or DO*</td>
</tr>
</tbody>
</table>

*DO=Drop-out, + indicated positive for outcome, - indicated negative for outcome.

This table illustrates one section of the coding manual. The full coding manual included sections for Psychopathology, External circumstances, Attitudes & coping, Life story, Intelligence & cognitive functions. The codes would be applied to the transcripts when a text unit was matching a code.
**Figure 1**

Steps in data analysis

- **Familiarization with data** (first author)
- **Discussion of themes** (research group*)
- **Development of coding manual** (first author)
- **Training research assistants in coding manual** (first author)
- **Coding** (research assistants*)

Note: This figure illustrates the steps of the data analysis and who carried out which tasks in the process.

* The Research group members were trained in CBT (N=2), CBT + third wave CBT’s + MBT, systemic therapy + narrative therapy + existential therapy (1), CBT + psychodynamic therapy + UP (1), CBT + Gestalt therapy (1)

* The Research Assistants were masters level psychology students
Article III
Despite the differences, we were all the same: Group cohesion in diagnosis-specific versus mixed-diagnosis CBT groups for anxiety and depression: A comparative qualitative study

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Abstract

**Background:** Group cohesion has been associated with better outcomes, lower drop-out rates, more interpersonal support and better participation in psychotherapy. Nevertheless, the role of group cohesion in CBT has not received much attention. The rationale for delivering CBT in groups is that patients can model themselves through each other due to their similarity in symptoms. However, there has recently been a shift towards transdiagnostic CBT protocols, in which patients with varied diagnoses participate in the same groups. This challenges the rationale of delivering CBT in groups, and it is therefore highly important to understand if and how group cohesion develops in mixed diagnoses groups.

**Objective:** The current study used a qualitative comparative framework to investigate the patients’ experiences of group cohesion in diagnosis-specific versus transdiagnostic CBT groups.

**Method:** Twenty-three patients were interviewed with semi-structured interviews upon completion of treatment. Participants had a primary diagnosis of MDD, panic-disorder, agoraphobia or social anxiety disorder. A comparative thematic analysis was carried out.

**Results:** Three themes were found: *From differences to similarities, The role of group cohesion in group CBT* and *Factors helpful and hindering to group cohesion.*

**Conclusions:** Group cohesion developed and was considered highly important in both diagnosis-specific and transdiagnostic groups. There were differences between the two treatment groups, in terms how individual differences and the process of developing group cohesion was experienced.
Introduction

Therapist alliance has been found to be an important, if not the most important, non-specific factor in individual CBT (Flückiger et al, 2018). However, in group therapy there are multiple systems of interpersonal relationships and interactions that are far more complex than a single dyadic relationship. Previous studies have found that the non-specific therapeutic processes for individual therapy and group therapy differ (Kivlighan, 2004). Clients participating in group therapy tend to place higher importance on the relationships with fellow group members compared to the therapist/group leader (Kivlighan, 2004). Group cohesion can be understood as the we-ness of the group, the qualities that binds the members together and fosters liking, warmth, comfort and a sense of belonging. Group cohesion may also refer to interpersonal support, acceptance and esteem within the group (Burlingame, Fuhriman, & Johnson, 2001).

Group cohesion has been understood as one of the key therapeutic processes in group psychotherapy and the foundation for all other group-related processes (Yalom, 1995). It has been defined in various ways, ranging from the ‘attractiveness of the group’, to a ‘unifying force’ and again to a more generic sense of support and belonging (Kivlighan, 2004). It has been argued that group cohesion is to group therapy what therapeutic alliance is to individual therapy (Yalom, 1995). In other words, in group therapy the relationships with fellow group members carries the therapeutic relationship whilst the relationship with the therapist does the same in individual therapy. Some have argued, that group cohesion is more complex than that, as it encompasses both the individual relationships to each of the other group members, as well as, the relation to the group as a whole and the relationship with the group leader(s) (Burlingame et al., 2001). The lack of clarity in definition has led to criticisms surrounding the construct itself.
Group cohesion is understood as a key element in a range of therapies, i.e., existential and psychodynamic group psychotherapy (Yalom, 2005; Foulkes, 1991). However, in Cognitive behavioral therapy (CBT) group cohesion has not traditionally been considered a central aspect. CBT is oriented towards disorder specific symptoms and an underlying belief that symptoms can be relieved through specific interventions such as cognitive restructuring and exposure (Beck, 1989). In other words, the focus of CBT is on specific factors and symptom relief (Gaudiano, 2008) rather than on common factors.

Group cohesion is related to higher attendance rates, increased interpersonal support and augmentation of active participation in therapy (Taube-Schiff et al, 2007). A recent meta-analysis found group cohesion to be positively correlated to the outcome of psychotherapy (Burlingame, McClendon, & Yang, 2018). Furthermore, higher group cohesion has been related to positive psychotherapy outcomes and reduced drop-out rates (Burlingame et al., 2011; Joyce, Piper, & Ogrodniczuk, 2007; Tschuschke & Dies, 1994).

CBT has been established as an efficacious treatment for major depressive disorder (MDD) and the anxiety disorders, in both individual and group format (Hofmann et al, 2014). Due to an increasing number of clients seeking treatment for these disorders, there has been a shift towards group CBT as it is potentially more time-saving and cost-effective than individual treatment (Oei & McAlinden, 2014). Furthermore, it has been argued that group CBT is advantageous over individual CBT due to mutual support, modelling and a feeling of responsibility towards fellow group members (Johnson, 2010). Therefore, it is important to understand how group processes work in CBT. Much research has looked into treatment-specific factors in group CBT for anxiety and depression, i.e., homework adherence or reduction of depressive thoughts (Oei, Bullbeck, & Campbell, 2006). Furthermore, research into the non-specific factors such as therapist alliance and
expectancy in group CBT has started to accumulate (Kaufman et al., 2005). However, group cohesion has still not been studied extensively within CBT research.

The research into group cohesion in CBT for anxiety and depression has shown mixed results. Woody and Adessky (2002) found that group cohesion was not related to outcome in group CBT for social anxiety disorder, whilst Taube-Shift and colleagues (Taube-Schiff et al., 2007) found that higher group cohesion was related to symptom reduction for patients with social anxiety disorder. In a study from 1974, Hand and colleagues found that in CBT groups for agoraphobia, patients from more cohesive groups had better results at follow-up, however, this effect was not present at the end of treatment (Hand, Lamontagne, & Marks, 1974). Most recently, Norton et al. (2016) reported that group cohesion was associated with anxiety symptoms in the next session, albeit only in later sessions in the therapy course, in transdiagnostic CBT for anxiety disorders. Group cohesion has been established as a factor that is positively associated with outcome and lower drop-out rates in psychotherapy in general, but the results for CBT are mixed and the number of studies is low. Thus, there is a need for further studies in order to understand how group cohesion may or may not affect processes of change in CBT groups.

Recently, there has been a shift away from diagnosis-specific CBT protocols, towards transdiagnostic CBT (tCBT) protocols (Barlow et al., 2010; Norton, 2012). tCBT offers a range of advantages such as potentially treating comorbid disorders simultaneously, reducing waiting time in clinics and training therapists in just one manual. tCBT has been found to be non-inferior to diagnosis-specific CBT for a range of anxiety disorders in individual therapy (Barlow et al., 2010) and for social anxiety disorder, panic-disorder/agoraphobia and MDD in group therapy (Reinholt et al, under review). One of the main arguments for delivering standard diagnosis-specific CBT in groups is that patients may experience normalization through similarities in symptoms and disorder-related experiences (Bieling, 2006). In group tCBT patients may potentially have widely different
symptomology and disorder-related behaviors and experiences. This challenges the arguments outlined in CBT research for delivering therapy in groups. Thus, in addition to the need for research on group cohesion in diagnosis-specific group CBT, there is a further need to investigate how group cohesion may be experienced in groups where patients have different psychopathological profiles and treatment needs.

Qualitative research provides the opportunity to explore phenomena bottom up and to access patients' experiences with psychotherapy. Furthermore, qualitative studies can help us understand the ways in which group cohesion is related to other therapeutic processes and outcome. The patients are not typically favorable towards specific processes or therapy types, the same way that researchers and clinicians are and can therefore provide valuable descriptions of processes in a spontaneous and informative manner (McLeod, 2001).

To the best of our knowledge, no previous qualitative studies focusing on the patients’ experience of group cohesion in CBT or in transdiagnostic CBT exist.

The aim of the current study was to explore how patients in public Mental Health Services (MHS) experienced group cohesion in diagnosis-specific and transdiagnostic CBT groups respectively. The research questions were:

What is the role of group cohesion in CBT groups for anxiety and depression? And is group cohesion experienced differently by patients in mixed-diagnoses versus same-diagnoses groups? And if so, how?
Methods

**Context: TRACT-RCT**

The current study was carried out within the TRACT-RCT (Arnfred et al., 2017) a multicenter, naturalistic, non-inferiority randomized clinical trial. The therapy delivered in the TRACT-RCT was weekly group CBT over 14 sessions. The participants received either diagnosis-specific group CBT for either social anxiety disorder, panic disorder/agoraphobia or depression or transdiagnostic CBT through *the unified protocol for emotional disorders* (Barlow et al., 2010). All manuals were adapted to the context of group therapy in Danish MHS. All transdiagnostic groups consisted of both patients with primary anxiety disorders and patients with a primary diagnosis of MDD.

**Treatments**

The delivered treatment was similar to the standard treatment in Danish outpatient clinics. The clinics are publicly financed secondary services for individuals suffering from moderate to severe non-psychotic disorders. The clinics offer a standardized, time-restricted treatment format (Danske Regioner 2017a; 2017b).

**The interviewer**

First author ABC carried out all of the interviews. ABC was not known to the participants prior to the interview. ABC is trained as a clinical psychologist worked in one of the participating clinics on a day-to-day basis. ABC was interested in how group cohesion developed in homogenous and heterogenous groups, without preference to either treatment, she curiously took on the analysis, with a preconception that the development of group cohesion would probably develop faster and easier in homogenous groups.
Participants

The current study included 23 patients from four psychiatric outpatient clinics in Denmark. All of the patients had participated in the TRACT-RCT. Participants in the TRACT-RCT were contacted by telephone upon completion of treatment and asked if they wished to participate in an interview regarding their experiences with the therapy. The sampling was targeted so that there would be an equal division of patients from the transdiagnostic therapy groups and the diagnosis-specific groups, as well as an equal division of patients with a primary anxiety diagnosis and a primary diagnosis of MDD. The sample ended up consisting of 12 patients who had received treatment in transdiagnostic groups and 11 who had received treatment in diagnosis specific groups. See Table 1 for patient characteristics. All of the included patients had completed the fourteen-week therapy course at the time of the interview. Completion was defined as having participated in 8+ sessions and not having discontinued treatment.

Ethical considerations

Participation was voluntary. All participants gave written informed consent. The data was anonymized. The original transcripts were only accessed by ABC and three research assistants who transcribed the audio-files. All participants were debriefed by ABC upon completion of the interview. ABC’s training as a clinical psychologist made her capable of carrying out such debriefings in a responsible manner.

Data collection

The data was collected through semi-structured interviews. An interview guide was designed to explore several aspects of the patients’ experiences of psychotherapy, group cohesion being just one of them. See Table 2 for interview guide.
The interviews were carried out in the clinics throughout 2018 and in January of 2019. The participants were interviewed one time and the interviews lasted approximately one hour in duration. All interviews were audiotaped and transcribed verbatim.

Data analysis

The data analysis was inspired by Braun & Clark’s thematic analysis (Braun & Clark 2006), however, several additional steps were added in order to strengthen the analysis and to add the comparative component. The analysis was carried out with NVivo software. The analysis consisted of the steps outlined below:

1. All of the transcripts were read through thoroughly in order for the first author to familiarize herself with the data.

2. Two full transcripts were coded on a sentence to sentence basis by the first author and the second author separately.

3. The first and second author held a meeting in which they went over every single code, discussing and debating in order to reach consensus, if any discrepancies were present.

4. Step 2 + 3 was repeated twice, meaning that 6 full transcripts were consensus coded (26%), on the sixth interview, only 5 codes differed between the coders, indicating very high consensus in the coding. The first author coded the remaining transcripts.

5. A list of group cohesion related codes was created and all of the material labelled with those codes was extracted from the full dataset. The group cohesion related quotes were chosen by going through the coding set and firstly choose all the codes that had the word group in it i.e. group dynamics, the group, group members etc. Secondly, ABC went through all remaining codes and
read the related material, all codes that had group related content were included i.e. the breaks, normalization and similarities & differences.

6. The codes were revisited in the search for overarching themes. An inductive approach was taken, meaning that no theory was driving the process.

8. The dataset was divided into two a) the data belonging to patients who had been in diagnosis-specific groups and b) the patients who had been in mixed diagnoses groups. This was done in order to detect if there were differences between the groups within each theme.


Results

The analysis revealed 3 emerging main themes: From differences to similarities, The role of group cohesion in group CBT and Factors helpful and hindering to group cohesion. The themes are linked in a chronological order and presented with verbatim quotes and a model of the process of the development of group cohesion. A model of the development of group cohesion was developed based on these results (figure 1).

Theme 1: From differences to similarities

The interviews revealed that the patients described differences between themselves and the other group members in the first sessions of therapy. There was an overarching consensus that the noticeable differences in the group were variables such as age, gender, occupation, severity of symptoms and ‘life stage’:
I: How did you experience the other group members?

Caroline, UP group: Well, we were at different places in life. Some had not yet started education. Some of us had been on the labour market for many years. Some could not work and had tried to get early retirement. So, we were a very mixed group. And then we were only women... but our group worked. Despite all these differences. Because it was not those differences in our private lives, in that way, that was the reason why we were here. We just had, many of us, the same symptoms… and fundamentally for most of us, those were about the same things.

I: How did you experience the other group members?

Cecilia, Panic-disorder group: It was very varied, in terms of, how burdened they were by their symptoms, I think. And that was actually pretty positive, that we weren’t all equally well or unwell. Because, then you could say, that you can kind of put yourself into perspective in relation to them, like ‘that person is that well and that person has come that far’, I mean not in a negative way, but, more… like it gave a sense of lifting each other up, and that you could each see positive things in the others, so you got a sense that ‘oh well then I can also do it’ (...). There were probably more differences than similarities. Because there was differences in terms of ehm... Well, age, gender and where people were on all levels, it seemed. But it wasn’t something I had really thought that much about (...). Again, I think it is positive, because you can put it all into perspective and it gives you a feeling that ‘oh well we are not just all the same’ but ehm... it’s all kinds of people, who feels this way in each their way, and yeah, I thought that was positive.
Caroline pointed to differences in occupation and ‘life stage’, and Cecilia also pointed to the group members being different in terms of age, gender and ‘where they were on all levels’. All these factors were commonly pointed to as differences across the interviews. Both of the women highlight that the detected differences were not seen as a problem and Cecilia went on to explain how the diversity could actually work as a motivator, by showing the different ‘stages’ in illness. Most of the patients described how the differences between themselves and others was the first thing they registered when walking into the first group session, which explains why the visible differences such as age and gender were amongst the most frequently mentioned differences. The majority of the patients described how the initial impressions of many differences, were quickly replaced by a sense of detecting similarities:

Katrine, UP group: *It was a really good group. We have agreed, that we will meet up in two weeks time, in order to keep it maintained… or to support one another. I mean, we were wildly different all of us. I mean, really wildly different and different ages and did completely different things and also had different diagnoses, but we worked pretty well together*

I: Yes?

Katrine, UP group: *I mean, we could recognise ourselves in each other and in the problems that we have had, even across diagnoses.*

I: *So it wasn’t something that stood in the way?*

Katrine, UP group: *Not at all*
Katrine described how the differences were not experienced as a problem, because the patients recognized themselves and their problems in each other, despite diagnostic differences. Most of the interviewed patients described starting to see through differences already in the first or second session. A small number of patients said that it took longer:

Karen, UP-group: ‘’At one point, one of the others was like ‘why do I have to sit with those who have anxiety? I have a depression’ and I had both diagnoses and some only had the anxiety diagnosis…and all of a sudden it occurred to her, that the things that I said, when I described how the anxiety affected me, then she said ‘that is exactly how I feel and God, that is the same. And that’s when we figured, that, that is why they are trying to put these two things together in the treatment, because it is so similar in structure. And that’s when it suddenly occurred to her, I think it was the fifth or sixth session, when she saw the light, like ‘wow, it is the same’’

This extract shows that there were different routes to the experience of similarity. The patients did not need to share diagnoses or specific symptoms, but realized that the way their problems affected them and their lives was similar. It also pinpoints the process of seeing through differences and focusing on the characteristics that connected group members, rather than those that separated them. The process of seeing through initial differences appeared to be key in establishing a sense of connection to the group and enforcing a belief in the treatment. The experience of realizing similarities brought a feeling of safety and comfort to the patients that made them engage in the therapy in new ways. There was a subgroup of patients who struggled with a feeling that their specific symptoms or illness made them different from the other patients. Interestingly, all three patients had participated in the diagnosis-specific groups:
Michael, Panic-disorder group: *I mean, we were all very different, right? And the others, I felt like, they suffered from other things than what I had. I tend to get like, I can get uncomfortable and unwell out of nowhere, and that is also difficult to match... and then I struggle a lot with my breathing... and... ehm... I feel like there is a brick, lying on top of my lungs, right? 24/7. And that is difficult. It was like difficult in the beginning, because I felt a little... I couldn’t help but feel like an outsider, because some of my symptoms weren’t mentioned, right? But then some of my things were in there, it got better, cause they could relate to me, so then it wasn’t totally stupid what I was saying (laughing)... They had totally different things. One of them had trouble just walking her dog or going out at night. I don’t have any problems doing that. On the other hand, had there been a huge group of people, then it would have been difficult for me, so its stuff like that, you know? Where we differ.

Michael’s experience of having a different set of symptoms compared to his fellow group members was echoed by two other patients who had attended diagnosis-specific CBT groups. Michael’s statement illustrates how these differences directly influenced his feeling of belonging to the group and how it made it difficult for him to share his experiences in the group. The three patients who described feeling different in terms of their symptoms also struggled to see similarities and feel cohesion for the same reasons. The patients who felt different consisted of Michael, who was unsure if he had a somatic illness at the core (i.e., a heart condition), Kristine who had an ADHD diagnosis and identified strongly with that diagnosis (more so than the social anxiety disorder), and David who felt his social anxiety was strictly related to his studies and not to other areas of his life.
Theme 2: The role of cohesion in group CBT

Having seen through the differences that separated themselves from the others, most of the patients went on to explain how the discovery of similarities sparked group cohesion through factors such as universality and mutual understanding. In the following extracts, Sara and Eva explain what group cohesion added to their therapy experience:

Sara, Depression group: *It gave me, how do I explain it?, you feel like you are all alone in the world somehow, prior to coming. And I found that difficult. I mean... it feels like a taboo, when you speak to others, friends as well... When you speak to friends, there isn’t really anyone to mirror yourself in. So, when you start in this group, even though I was one of the youngest, it was still really nice to have these people here to mirror yourself through. And we could talk together, and we were in the same place. And knew the problems, even though the causes were different. And I found that incredibly comforting. I thought it was great and it gave me a lot, this thing about mirroring yourself in someone else. Even though it is negative, it is just really nice to know that you are not all alone in it.*

Eva, UP group: *In the beginning, we were all insecure. But they were engaged and worked as much on it as I did. There was a will to want this. The youngest was 21 and I am 52 and I thought ‘wow do we have anything in common?’ It didn’t feel unnatural despite that. And many of them were students or academics and I am a musician. And have, of course, sometimes a different understanding of the world. It is interesting to hear what kind of things you can be battling. We had different problems, but basically, anxiety and depression and so on, it was very similar, but we*
came with different backgrounds and things that had triggered our problem. The fact that we were doing as poorly as we were meant that we had a lot of practical problems too. When you don't have peace to just get well. Because there are so many practical things you have to fight. That we had in common, a lot. The system around us. There was a pressure. From outside. We are fighting basic survival stuff.

Sara explained how feelings of stigma and taboos around mental health were relieved by meeting others who suffered. Likewise, Eva explained that despite differences between group members, suffering, distress and struggling with ‘the system’ was the same for all. Both women contrasted being inside the group against being in the outside world, indicating a strong sense of belonging to the group. They both went on to explain how, just being able to meet others who have similar problems had removed feelings of loneliness and provided a place where you could talk about suffering with others who understand. We understood these types of statements as manifestations of group cohesion. Group cohesion made patients feel a responsibility towards the group that in the end pushed their own improvement forward.

Peter, depression group: I had felt very alone in it. Alone with my struggles (prior to beginning in the group). Even though I am not directly comparable with everyone, then... the story is the same, but the details are different. I think, when I was out here in sessions on my own, I felt very alone in it all. But being put in a group also creates group pressure somehow, that makes it easier to get homework and tasks done, I would say.

I: Because?
Peter, depression group: *Because, then there is a whole group you can disappoint all of a sudden. And that is kind of positive. A little bit of peer pressure. Whatever works, you know?*

I: *Okay, and being together about it, not being alone, how does that impact you?*

Peter, depression group: *It does a lot for your sense of self-worth. Seeing that it is normal, that other people fight it too. I am not a uniquely bad human being. There are tons of people who feel this way, and they are not bad people, therefore... and so on. I think about it as in, your shoes become less heavy, it is like there are springs in your step when you walk. That you are no longer dragging yourself, all the time.*

Peter explained how group cohesion creates a sense of responsibility towards the group that motivated him to do his homework assignments by adding *‘a bit of peer pressure’* and how he viewed that as a positive thing. He also went on to explain how group mediated processes has impacted his feeling of self-worth directly, by making him see that others who feels like himself are not bad people. He metaphorically summarizes how that eased the burden of having a depression. Patients often described *‘lifting the burden together’* and helping each other through mutual responsibility, respect and support towards the group.

**Theme 3: Factors helpful and hindering to group cohesion**

All of the interviewed patients described group related processes such as normalization, support, belonging and mutual aid as being important, if not the most important elements of treatment. We understand these constructs together, as a manifestation of group cohesion. Several of the patients highlighted three distinct factors that impacted this process in either a positive or
negative direction. These were a) the motivation of the other group members and b) the breaks, which were seen as helpful factors in aiding group cohesion and c) group members who were perceived as unable to share, which was seen as a hindering factor. Group cohesion appeared to form despite the issue of members that did not open up in the group (through the help of the therapist), but it tended to cause frustration and insecurity. The motivation or readiness to change in the other group members was highlighted as a helpful factor as it created the sense of collaboration and lifting together in the group:

Tina, UP group: *We had a lot of the same ways of thinking and ways of seeing the world. We were all there because we had some problems that we couldn’t solve on our own, and we wanted help and we had a wish for things to get better. We wanted to work and make things better. I feel like that really tied us together.*

Several patients mentioned the 10-minute breaks in the middle of the therapy session as a factor that aided group cohesion:

Jonathan, depression group: *The biggest help... has actually perhaps been, even though I didn’t say that much, just meeting the other and hearing about and listening to their stories. I think, the breaks were the biggest help. It was a joy to meet likeminded.*

The breaks were highlighted by patients, because the breaks provided a space for free talk and being ‘just human’ with one another. Several patients explained how the breaks gave group
members a chance to bond over other aspects than illness and made them connect on a different level.

The analysis also detected one commonly mentioned factor that was experienced as hindering the process of developing a sense of group cohesion:

Peter, depression group: *There was especially one person, that I am thinking of now, who weren’t really there. Or who was very shy or holding back, had a lot of barriers. I actually felt like it was hindering to creating an optimal good dynamic. I do think the Clara (the therapist) was really good, even though this person didn’t say anything, she kept making openings for the person... and it took the time it took, but I feel like, when she did that, it helped a lot on the dynamic, when everyone shared, it was easier to share more. At least it made it feel safer. That there wasn’t a stranger in the corner who didn’t say anything.*

This extract illustrates how insecurity and safety was compromised when one or more members of the group were perceived as unable to share. While this factor was echoed by others throughout the material, it was not an overarching theme.

Discussion

The current study aimed to explore the role of group cohesion in patients’ experiences of group CBT for anxiety and depression in a MHS context. Furthermore, the study set out to compare data from 12 patients who had participated in mixed diagnoses, transdiagnostic CBT groups with the data from 11 patients who had participated in diagnosis-specific group CBT for MDD, social
anxiety disorder or panic-disorder/agoraphobia. When discussing the results in the following sections, we define group cohesion as a feeling of belonging to the group and being mutually supported and supportive of the group.

The results showed that group cohesion and other group related processes was experienced as a major, if not the most important factor in the group therapy. Patients tended to notice how they were different to other group members in the beginning, then quickly started to see through the differences and experienced the similarities that bound them together, and this laid the foundation for group cohesion. Group cohesion was developed through a range of group related processes such as normalization, anti-stigmatization, mirroring, support, encouragement and understanding. The sense of belonging to the group and being mutually supportive and supported by the group led to higher motivation to attend the therapy and to do homework assignments, a larger willingness to share in the group and gave renewed hope for the future according to the patients. This is consistent with the assumptions made about the positive features of group cohesion in previous studies (Taube-Schiff et al., 2007; Burlingame, 2001).

While group cohesion appeared to develop successfully and to be identified as a highly positive factor by patients in both treatment types, there were differences across the two groups. There were patients from the diagnosis-specific CBT groups who felt different to the others, and struggled to feel true belonging to the group, due to feeling different in terms of symptoms and psychopathology. Furthermore, patients from tCBT groups tended to speak more directly about how diagnostic differences did not matter.

Whilst it might seem counter-intuitive that there would be a higher degree of ‘feeling different’ in groups where patients were diagnostically more alike, it is likely that this finding reflects differences in the underlying understanding of psychopathology in the two treatment
approaches. The therapy delivered in the diagnosis-specific groups was based on a classical medical model, according to which depression refers to a specific set of symptoms and the treatment manual educates about those symptoms and provides techniques aimed to reduce those specific symptoms. Thus, patients who fit the diagnostic criteria very clearly and/or who identify with the diagnosis will probably resonate well with this type of treatment. Conversely, patients whose symptoms match the diagnostic criteria less precisely or who may not agree with or accept their diagnosis might not resonate as well with the distress explanations and techniques provided in the standard-CBT treatment.

The patients in this study, who felt different, did not fully identify with the given diagnosis of depression or anxiety and perhaps therefore struggled to mirror themselves in their fellow group members and in the explanations of distress given to them in therapy. They all explained in their interviews that, at times, they ‘fought’ the therapy and/or the therapists, which may again be an expression of not agreeing or recognizing oneself in the explanatory models provided in the therapy.

While the transdiagnostic therapy (The Unified Protocol) is also a type of CBT, the underlying model is fundamentally different. The UP manual does not focus on disorder-specific symptoms or psychopathological categories. Instead, both depression and anxiety disorders are seen as expressions of underlying neuroticism, which makes patients at risk of experiencing ‘negative emotions’, such as anxiety and sadness, as uncontrollable, dangerous and overwhelming. This experience leads to the development of non-adaptive coping strategies that reinforces the same negative emotions the patient was trying to avoid in the first place (Barlow et al., 2010). The manual is designed to treat patients with different symptomology within the same groups. Accordingly, this treatment perhaps embraced differences between patients to a higher degree and explicitly helped the patients to understand and verbalize the different symptomologies as different
expressions of the same thing. This was illustrated in the language that the patients from the UP groups adopted, e.g., “depression and anxiety, at the core, they are the same”. It may also be that the therapists who delivered this therapy were highly aware of zooming in on similarities between patients, in order to create cohesion despite diagnostic differences.

What is particularly interesting here is that the patients’ experience of group cohesion appears to be linked to the extent of their identification with their diagnosis and the distress model of the treatment approach. This relationship appeared to be self-perpetuating in the sense that patients who accepted the distress model tended to see similarities in spite of differences, while patients who did not fully accept the diagnosis or disease model tended to see differences despite similarities. It is interesting that our findings speak against the disease model at the core of CBT and that although the Unified Protocol is identified as a type of CBT, there are some key differences in the understanding of psychopathology. It appears that tCBT’s focus on underlying mechanisms, which some may call, a more humanistic version of CBT, makes the patients see similarities despite diagnostic and symptomatic differences and thereby experience group related processes in a different way.

The idea that the model of distress can influence the course of psychotherapy can be found for instance in Wampold’s contextual model of psychotherapy (Wampold, 2015), in which one of the essential components is the creation of expectations through explanation of disorder and treatment. However, it is a novel finding that this component may directly influence and be influenced by group cohesion.

Moving on from the differences between the groups to the common findings across the dataset, group cohesion was experienced as a core healing factor in the therapy, as well as a factor
that motivated and assisted patients in attending to the therapy, engaging in the therapy and adopting the manual specific techniques.

Several previous qualitative studies have found that patients highlighted group mediated factors as positive and essential to the experience of group CBT for anger-management, schizophrenia, auditory hallucinations, eating disorders and hallucinations (Gledhill, Lobban, & Sellwood, 1998; Laberg, Törnkvist, & Andersson, 2001; MacMahon et al., 2015; Newton et al., 2007). The role of group mediated processes such as group cohesion, universality, mutual aid, interpersonal learning and renewed hope have been well described in the psychotherapy literature by Yalom (Yalom, 1995). However, these concepts are derived from psychotherapies with fundamentally different theoretical underpinnings. Nevertheless, although the group is not recognized as an independent healing constituency in the CBT literature (Bieling, 2006), but rather as a factor that may help optimize outcomes, it appears to be experienced that way by the patients. This is consistent with previous literature that found that clients in group therapy tended to see the other group members as, at least as, beneficial as the group leaders (Kivlighan, 2004).

Group cohesion appeared to be connected to the patients’ engagement in therapy. This is consistent with research demonstrating the effect of group cohesion on outcome and in reducing drop-out rates (Burlingame et al., 2011; Joyce, Piper, & Ogrodniczuk, 2007) Thus, it appears that group cohesion can impact outcome through two routes a) a direct impact of the positive factors associated with group cohesion, and b) the indirect impact of group cohesion on therapy engagement and compliance.

Norton et al. (2016), found that group cohesion impacted outcome in the next session, but only in later sessions. This is an indication that group cohesion takes time to form and when it does it can impact outcome. This is consistent with the findings of the current study, in which patients
explained that it took some time to see through the differences and feel belonging to the group. There were many individual differences in terms of how long it took to feel belonging to the group, although most of the participants expressed starting to see similarities already in the first session.

The current study also found several factors to be helpful in the creation of group cohesion. The first factor was the motivation or readiness to change in the other group members. This factor is similar to Yalom’s factors, *mutual aid* and *imitative behavior*, and can be seen as one of the strong benefits of group therapy (Yalom, 1995).

In the current study a hindering factor was brought to light, i.e., that patients who appeared unable to share created a breech in the development of group cohesion and made group members feel unsafe and like “there was a stranger in the corner”. This illustrated how patients experienced the group as a place where all must invest in order for it to be safe and the dynamic to be optimal. One may look to the model described by Poulsen (2004) in which two key concepts are thought to be central for the group’s developmental processes, namely ‘de-privatization’ and ‘emotional presence’. The model describes how recognition in fellow group members initiates the process of de-privatization through which the patient will open up due to the normalization and anti-stigmatization that recognition provides. On the contrary, if the patient does not experience recognition, the de-privatization process will not initiate. The de-privatization process is largely dependent on the emotional presence of the group members and the group climate (Poulsen, 2004). This could explain why it feels like a hindering factor when others do not share.

Although the de-privatization model was based on a qualitative study of short-term psychodynamic therapy, it appears to fit well with the concepts identified in the current CBT study. This highlights that although CBT research has not traditionally been interested in group processes, they play a role in therapeutic processes and they look much the same in group CBT and in other
fundamentally different types of therapy. Thus, we recommend that future research focuses on the role of common factors (other than alliance) in CBT.

Interestingly, several patients brought up the breaks, as well as the time before the session started and after the session ended, as helpful for creating group cohesion. These time-slots were described as a time where the patients had a space to talk about other aspects of their lives and bond on a different level. It may well be that the highly structured and content-loaded approach of CBT did not leave much space for this type of interaction to take place within the therapy-room, and that, accordingly, it was particularly important for the patients to seek out this type of interaction in other ways, i.e., in the breaks.

The research into how group cohesion impacts group CBT and transdiagnostic group CBT has been sparse and results have been inconclusive. The current study found that patients when describing their experience, highlighted a number of group-related factors, that can be understood as group cohesion. This was described as essential as well as an aiding tool for adherence and engagement in therapy. Differences were detected between groups, indicating that transdiagnostic CBT may be better suited to patients who had comorbid disorders or did not identify with a specific diagnosis. Furthermore, the current study recommends that group therapists in both diagnosis-specific and transdiagnostic groups focus on verbalizing similarities between patients, not just in terms of symptoms, but in terms of human distress and how mental health disorders affect people in their lives. This is thought to aid the process of creating group cohesion.
References


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Note: PD=panic disorder, AGO=agoraphobia, SA=social anxiety, GA=generalized anxiety
Table 2
Interview Guide

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<th>Topic</th>
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<tr>
<td>1. Open talk</td>
<td>Tell me about your therapy course, whatever comes to mind.</td>
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<tr>
<td>2. Expectations</td>
<td>What were your expectations prior to starting in the group? Were these expectations met?</td>
</tr>
<tr>
<td>3. Group</td>
<td>How did it feel to be in this group? How were the other group members?</td>
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<tr>
<td>4. Important moments</td>
<td>Were there any specific moments from the therapy that you remember especially well?</td>
</tr>
<tr>
<td>5. The therapists</td>
<td>How did you find the therapists? Were there any moments with the therapists you remember particularly well?</td>
</tr>
<tr>
<td>6. Change</td>
<td>Do you feel different now compared to when you started? If so, how? Why do you think that is?</td>
</tr>
<tr>
<td>7. The therapy</td>
<td>What was the biggest help for you? Did anything happen that was negative for you?</td>
</tr>
<tr>
<td>8. Manual specific factors</td>
<td>Where there any specific techniques you found especially helpful?</td>
</tr>
<tr>
<td>9. The end</td>
<td>Do you feel like I have a good understanding of your experience? Have we missed anything that was important for you?</td>
</tr>
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</table>
Figure 1
Development of group cohesion

Differences:
Age, gender, severity of symptoms, willingness to share, background, resources

Seeing through differences

Similarities:
Having difficulties, suffering, feeling alone, feeling different, experiencing stigmatization

Group Cohesion:
Recognition, understanding, empathy, normalization, support, encouragement, free space, responsibility towards other group members, mutual aid

Engagement in therapy, attendance, homework adherence, increased sharing, increased self-compassion, confidence in own abilities

DS-GROUPs = diagnosis-specific groups
Article IV
Therapist Dos and Don’t’s: Patient Perspectives on Helpful and Hindering Aspects Related to the Group Therapists in Group CBT for Anxiety and Depression.

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Abstract

Background: The therapist effect has been found to explain a significant part of the variance in psychotherapy. However, the degree to which has been found important has been varied across studies. The literature has previously focused on what makes some therapists better than others and there has been less focus on how each therapist develops over time and employs different strategies in a therapy course. Furthermore, the therapist effect in groups is even more complex as it encompasses many relationships i.e. therapist-individual, therapist-group and therapist-therapist. The therapists role has been found to influence group cohesion, which in turn influences outcome of group psychotherapy. However, few studies have investigated how any why this is. Qualitative methods provide the opportunity of exploring phenomenon bottom up and provide rich descriptions of psychological constructs. This article aimed to explore patients experiences of helpful and hindering factors related to the group therapists in CBT groups for anxiety and depression in Danish mental health services.

Methods: Twenty-three patients were interviewed post treatment, using a semi-structured interview guide. The data was analyzed using thematic analysis with double coding of 26% of the material to increase the validity of the findings.

Results: The results found four distinct themes related to the therapists. The themes were (1) the dynamic duo, (2) the way to communicate, (3) steering time and goal setting elegantly and (4) the therapists as group facilitators. Helpful and hindering aspects were detected within each theme.

Discussion: The results of the current paper highlighted the importance of the pairing of therapists, clear and concise communication delivered in warm and empathetic ways, the ability to structure sessions and set goals with good timing and flexibility and the importance of therapists focusing on the development of group cohesion. The results are discussed in relation to previous findings and theoretical considerations.
Background

The individual therapist has been shown to account for a significant part of the variance in psychotherapy outcome studies (Baldwin & Imel, 2013; Barkham, Lutz, Lambert, & Saxon, 2017; Huppert et al., 2001; Kim, Wampold, & Bolt, 2006; Lutz & Barkham, 2015; Wampold, 2001). Furthermore, the therapist who delivers the psychotherapeutic intervention appears to be more important than the specific type of therapy delivered (Wampold, 2001). This has also been known as the therapist effect. The therapist effect explains the variability that can be accounted for by the individual therapist (Wampold, 2001). However, there is no consensus regarding the strength of the therapist effect (Crits-Christoph & Gallop, 2006; Johns, Barkham, Kellett, & Saxon, 2019) and some studies have reported very small therapist effects (Cella, Stahl, Reme, & Chalder, 2011; Huppert et al., 2014). Studies looking into this effect have reported that it accounted for anywhere between 0 and 50% of the variance in outcome (Crits-Christoph & Mintz, 1991). The most recent meta-analysis also reporting large heterogeneity in results with 0.2-0.29% of the variance explained by the therapist effect across studies (Johns et al., 2019). This effect have been found to be largest (and arguably most relevant) in naturalistic studies (Baldwin & Imel, 2013) and less so in manualized and highly structured therapies (Baldwin & Imel, 2013; Crits-Christoph et al., 1991; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997). Furthermore, there results appear to differ depending in the chosen outcome measures and analytical strategies implied, i.e. Huppert (2001.) documented large therapist effects, whilst Huppert (2014.) reported small therapist effects based on an adjusted statistical analysis.

Despite the varied results, therapist effects provides an opportunity to shed light on how this particular common factor affects psychotherapy processes and outcome. Furthermore, this field of study and redirects research towards the influence of non-specific/common factors as opposed to manual specific factors (Johns et al., 2019) therethrough opening up a research arena with the potential to improve psychotherapeutic treatment for patients whilst improving the competencies of the individual therapist (Johns et al., 2019).

Previous literature has tended to focus on, what seperates the good therapists from the less good therapists, in other words, between therapist variables such as demographics, which has been found to be
insignificant for other purposes than matching client and patient (Beutler, Machado, & Neufeldt, 1994), therapeutic orientation (Vociusano et al., 2004), experience level (Beutler et al., 1994; Huppert et al., 2001; Stein & Lambert, 1995), application of methods (Moltu, Binder, & Nielsen, 2010), interpersonal skills (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016) and individual therapist characteristics (Nissen-Lie, Havik, Høglend, Rønnestad, & Monsen, 2015; Zeeck et al., 2012). There has been less focus on how each individual therapist develops with their patients over time and how they can improve in a given therapy course, in other words within therapist variables (Kivlighan, 2014). There has also been little focus on the therapist effect in group psychotherapy yet the therapist still seems to affect the patients’ outcome (Chapman, Baker, Porter, Thayer, & Burlingame, 2010).

This discrepancy in the literature on therapist effects in individual therapy versus group therapy can probably be explained by the difference in meaningful factors between the two therapy modes. A group consists of many relationships, between patients, between patient and therapist(s) and between the patient and the whole group and the therapist and the whole group (Johnson, 2007). Furthermore, it is a complex study object as the therapist’s interventions are not experienced the same by all the members in the group (Billow, 2017). The patients’ experiences of the therapy and their outcome from it, is not only dependent on the relationship with the therapist, but also on the relationships with the fellow group members and the group as a whole entity (Yalom, 1995). An important common factor in group therapy is group cohesion, which refers to a sense of belonging to the group and the positive factors that binds the group together i.e. normalization, anti-stigmatization etc. Group cohesion has also been found to be important for the outcome of group therapy (Burlingame, McClendon, & Yang, 2018).

The therapists role is fundamentally different in group therapy compared with individual therapy, For example, leadership skills, rated by independent assessors has been found to correlate with patients’ ratings of group cohesion, which indicates that patients are sensitive to the leaders behavior in the group (Tucker, 2016). If the group leader can affect the experience of group cohesion then a natural question to ask is, how we can optimize the therapists ability to encourage group cohesion. Studies have pointed out the importance of the therapist being able to quickly create a safe space in the group in order to prevent drop-out,
due to the large anxiety that is connected to starting in a group for many patients (G. Burlingame, Fuhriman, & Johnson, 2001; Neimeyer & Merluzzi, 1982; Xiao, Hayes, Castonguay, McAleavey, & Locke, 2017). Furthermore, Johnson (Johnson) found group cohesion, alliance, group climate and empathy to be constructs important for group therapy, the research into the effect of these constructs in group therapy have however found mixed results.

The therapists role in group therapy is highly complex and to further complex matters, the use of two or more co-therapists is an established practice (Davis & Lohr, 1971). The research into the area of co-therapists in groups stems from the psychodynamic therapy field, the writings on the matter are aged and the literature is sparse. However, those who have written on the matter, tend to be positive towards the method (Davis & Lohr, 1971). Several aspects of the co-therapist technique have been emphasized as valuable, namely, co-leadership tends to decrease anxiety in new therapists (Block, 1961), being more than one therapist makes limit-setting the capacity to set limits for more ‘disturbed patients’ (Block, 1961), the therapists can act as observers to one another and due to their belonging to the group, they can observe processes and interactions without ‘stepping out of character’ (Lundin & Aronov, 1952). It has previously been described that the dynamic between the therapists can be either a helpful or hindering factor to group processes (Luke & Hackney, 2007). Furthermore, in a review of the literature, there was a call for empirical studies looking into the topic of co-therapists as most of the literature stems from anecdotal or theoretical writings (Luke & Hackney, 2007).

CBT group treatment is highly structured and emphasizes goals, tasks and direction more so that interpersonal dynamics and emotional climate (Johnson, 2007; Woody & Adessky, 2002) and in CBT groups there are usually common goals and tasks and the focus is less on the bonding, the interactions and the cohesion in the group (Oei & Shuttlewood, 1997). The results from studies looking into the therapist effect in group CBT also appear to be less conclusive compared with other types of group therapy (Krupnick et al., 1996; Raue, Castonguay, & Goldfried, 1993; Woody & Adessky, 2002). However, there is still good reason to believe that the therapist plays an important role in group CBT, i.e. in a study into the patients experiences of group CBT for postnatal depression, patients emphasized feeling safe in the group, being encouraged to be...
honest and not being made to feel guilty as some of the most helpful features. These factors can be linked
directly to the emotional climate of the group (Scope, Booth, & Sutcliffe, 2012). Furthermore, in a
qualitative study looking into group CBT for eating disorders it was found that the patients placed
importance on the therapists ability to respond to and give attention to each member of the group, and
expressed feelings of jealousy and abandonment if the therapist did not succeed in doing this. Patients also
emphasized the therapists ability to make individual problems relevant for everybody in the group. Further,
they felt it was the therapists responsibility to create structure and had high expectations of the therapists
(Laberg, Törnvist, & Andersson, 2001). In a large CBT study for patients with chronic depression, it was
found that the most influential factor was the level to which the therapist considered the therapist-patient
relationship important (Vocisano et al., 2004). Furthermore, therapists who were also supervisors and
therapists who identified as psychodynamic rather than CBT oriented had patients with better outcomes for
their patients (Vocisano et al., 2004). This indicates that the CBT therapist benefits from focusing on being
flexible, focusing on the emotional climate and valueing the interpersonal relationships.

The aspect outlined above is concerned with, what can be be observed about therapists in relation to
outcome, another aspect is how patients’ experience therapist related factors. Patients’ experiences of the
therapy, the alliance and outcome has been shown to be a much better predictor compared with the therapists
experiences (Burns & Auerbach, 1996; Huppert et al., 2014). Therefore, the patients experiences of the
therapists role in group CBT are highly relevant. Qualitative research has rarely been applied to group CBT
research and provides a unique opportunity to understand the processes related to the patient-therapist,
group-therapist relations. The findings we can uncover with qualitative frameworks differs fundamentally
from those we can uncover with quantitative methodologies (Laberg et al., 2001) and qualitative methods are
especially helpful in trying to understand phenomenon we do not know much about, such as the therapist
effect in groups, as experienced by patients. Thus, the current study employed a qualitative framework to
investigate the research question:
How do patients describe the therapists role in group CBT and what are the helpful and hindering aspects related to the therapists?

Methods

Context

The present investigation was conducted under the mother-study TRACT-RCT (Arnfred et al., 2017). A clinical trial investigating the effect of transdiagnostic CBT versus diagnosis-specific CBT for panic-disorder, social anxiety disorder and major depressive disorder (MDD). The CBT group courses consisted of a pre-group individual session and 14 group sessions. There was typically eight patients and two therapists in each group. The participants were randomized into either transdiagnostic CBT in mixed diagnoses groups or diagnosis-specific CBT for one of the abovementioned disorders. All treatment manuals were based on established manuals (Barlow et al., 2010; Barlow, M., 2006; Due Madsen, 2008; Hope, 2006) but was adjusted to the Danish Mental Health Services (MHS) and the group format. In Danish MHS group CBT is recommended as the standard treatment offer for anxiety disorders and MDD (Danske Regioner, 2017a; 2017b; Sundhedsstyrelsen, 2016; 2020). The patients were treated in publically financed psychiatric outpatient units across the country. The services offer a standardized time-restricted package treatment. All of the participants had a primary diagnosis of social anxiety disorder, panic-disorder, agoraphobia or MDD. The therapists in the study ranged in experience level, educational background (the vast majority were clinical psychologists) and therapeutic orientations. All therapists were trained in the manual(s) they were to deliver in the trial. All therapists had monthly supervision specifically tailored to the delivered manual throughout their participation in the trial.

Participants

Twenty-three patients from the TRACT-RCT were interviewed for the current study. The patients came from four Danish outpatient clinics, namely, Psychiatric Clinic Slagelse, Psychotherapeutic Clinic Nannasgade and two clinics at Aarhus University Hospital. Patients were contacted on telephone after
completion of treatment and asked if they wanted to participate in an interview about their experiences. The sample was selected strategically to be broad in terms of demographics, diagnosis, treatment site and type of CBT group. All participating patients had completed a full therapy course (defined as 8< sessions and no discontinuation).

**Ethical considerations**

Participants were provided with extensive information prior to the interview. All participants gave informed consent and no participants withdrew consent. All data was anonymized, meaning that names, places or other pieces of information that could lead back to the participants was replaced with false information that did not obscure the meaning. Due to the sensitive nature of the topics surrounding psychotherapy, psychiatry and mental health problems, all participants were debriefed upon completion of the interview. The first author who conducted the interviews is a trained clinical psychologist, used to working in the psychiatric environment, and was therefore capable of carrying out such debriefs.

**The Interviews**

The interviews took place at the treatment center where the participants had received treatment. The interviews covered various topics related to group therapy and was steered by a semi-structured interview guide (See table 1). The interviews were typically around 60 minutes in duration, with the shortest being 35 minutes and the longest being 96 minutes. All interviews were audiotaped and transcribed verbatim.

**Data analysis**

The analysis for the current study was a thematic analysis (Braun & Clarke, 2006), which had a double coding strategy to strengthen the validity of the findings. The data was managed in NVivo software. The steps in the analysis were:

1. Familiarization with data: the first author read carefully through all of the transcripts.
2. Double coding: the first author and a research assistant separately coded six interviews (26% of data), the two coders discussed coding everytime they had both completed 2 full transcripts, in consensus meetings they would discuss and debate codes until agreement was reached. In the last consensus meeting, just 5 codes were different between coder 1 and coder 2, demonstrating high level of agreement. This was done to ensure that coder 1 did not drift or get tunnelvision. The first author coded the remaining transcripts in compliance with the coding principles outlined in the consensus meetings.

3. An initial overview was made of all the codes in the dataset.

4. All data related to the therapists was pulled from the dataset, this was done by pulling all codes with the word ‘therapist’ in it. Afterwards, the first author read through the full material and pulled all other codes that were somehow related to the therapist, i.e. group cohesion, atmosphere, structure of sessions, opening up, atmosphere etc.

5. All of the pulled codes were divided into subcategories and the final themes emerged, the themes were defined and named.

Results

The results of the analysis revealed four distinct domains relating to the group therapists. Patients highlighted multiple aspects of the therapists role, these were divided into four themes, namely, (1) the dynamic duo, (2) the way to communicate, (3) Steering time and goal setting elegantly and (4) the therapists as group facilitators. In the following sections we will present the helpful and hindering aspects related to the therapists, as well as the patients perception of their role in the group.

Theme 1: The dynamic duo

The relationship between the two therapists was continously brought up by the patients in the current study. Patients highlighted that it was experienced as positive and safe when the two therapists had a harmonic and/or dynamic collaboration. This was identified by an even workdivision, when they appeared as a team, added to each other with different styles and characteristics and when the transition between work
tasks between them appeared smooth. Some patients explained how they liked that the two therapists had different styles. This particular patient explains how the difference in therapeutic style made a dynamic duo and that each patient had a preference for one or the other style, meaning that it was important that both was represented. He further elaborated, that he had felt a stronger attachment to one of the therapists due to his preference for her individual style:

Niels: There was a little bit of ‘good cop – bad cop’ about them (laughs). Ehm... I dont know, well I thought alot about how, maybe they had recieved different education or... Because, what is her name, Claire, I don’t remember their names, but one of them, she was a lot with like eye contact and bend forward and welcoming and made her presence known verbally like “mhh... mmhh” all the time. Whereas the other one, she was leaned back and then she would maybe share her observations afterwards. And she was also better at letting people know if they were late and stuff, and that it wasn’t a kindergarden and that you had to attend and participate and stuff. But in a good way of course. No one was upset by that, but it was a little bit like ‘good cop – bad cop’ it was a very good dynamic between them somehow.

Another patient explains how it is important for the patients to understand the work division between the two therapists. This patient had experienced one therapist as the leader and the other as ‘the other therapist’, he explained how ‘the other’ felt like a stranger in the room and that the leader felt overdominating, this meant that he spent time during therapy trying to deciphle their dynamic and understand their roles. He explained feeling frustration with both of them:

Peter: I couldn’t figure out the dynamic between them, Susan was very in charge and then I don’t know what the other one did. I was in doubt about who was running the course and sometimes the other one would just break into the conversation and ask questions and I didn’t feel safe because I didn’t know her. I didn’t know who she was, so if she asked a question I would be less willing to answer, most of all, she sat there like a
foreign presence. Susan talked the most, it was her who went through struff. I had a hard time figuring out... if Susan didn’t let the other one participate or if she just didn’t want to.

This indicates that it is important for patients how the therapists are together in the group and highlights the need to clearly communicate the roles of each therapist i.e. if one is leading and one is under training. This section showed us that the dos for cotherapists are clear roles, harmonic collaboration, empathy and structuring, the don’t’s included a passive style and unclear/unequal therapist roles.

**Theme 2: The way to communicate**

The second theme to emerge from the analysis was centred around communication styles. The patients brought up many dos and don’ts relating to the way the therapists communicated and what, how and when they communicated it. When looking to the specific points brought up regarding communication style, the patients expressed that it was important that: (1) the therapists communicated clearly, calmly and directly, (2) that they were curious and asked many questions, (3) that they used validating language to make the patients feel understood and recognized and (4) that they used their natural language and communication style rather than use a ‘professional tone’ Finally, the patients highlighted the therapists ability to be flexible and understand each individual. It was experienced as positive when the therapist would adapt their questioning to the individual patient, whereas it was experienced as a negative factor if the therapist was unflexible in their way of questionning or in their use of technique, as it could make patients feel like they were giving wrong examples:

Michelle: *There were sometimes where you didn’t feel totally understood and then other times where you felt like they really came with some really cool comments for you, that made you reflect when you went home. But I guess, I had also expected that. That there were some times where you would ask a question and you got the feeling that maybe it it just wasn’t that important for them, but more often than not, they were really good. (...) I think it was often hard to answer the questions because we hadn’t agreed at any point what I was*
I got the sense that when I said something, it could feel like, they thought, that it was a bad example, where I thought “but that’s what’s important for me”. But that could have also just been my interpretation of it because I was more emotional at the time.

Most of the patients explained that they preferred for the therapist to ask questions that made them reflect and find solutions on their own rather than provide solutions or give advice, however, some patients would have liked for that to be communicated clearly in the beginning, i.e. “we will not provide answers but help you find them”. They also emphasized that the therapists should make clear that there were no right or wrong answers and give praise even if the patient is not providing ‘the optimal answer’ or if they have not managed to complete homework assignments successfully:

Victoria: I think I would have liked, if sometimes, I would have gotten an answer from them. But yea, then one of them said that she wasn’t just some kind of person who could tell you what to do, so I think I have found out now that, that is just the way it is. But I think that would have helped me, I think it would have been good if they would have said, “you need to know that we do not bring you solutions” but I know that now, I mean they will guide you and give you advice on how to do exposure exercises, and that was fine, so I hope it will get better now.

The patients explained how it was important the the therapists could detect patterns in their thoughts, emotions and behaviour and deliver their points back to the patients in understandable and empathetic ways. Some patients highlighted that they liked when the therapists ‘dared say what we did not’:

Katrine: There were situations where I would have gone home and thought about a problem that I had mentioned (in the group). And then Anna would have asked me “I wonder why you feel that way” and then I would come back, having thought about it and having had some kind of epiphany like “Ahhh THATS why!” and then she would just look at me and say “that makes a lot of sense Katrine, with the upbringing that you have had” or something along those lines, where I was like “wow” It was reallt nice that she could see that,
that was exactly why – and because, she had interviewed me for the introduction session, so she knew what I had said then at she could tie it together, and I just thought “wow does she really remember that” and it was really, really nice that she could connect it and she could understand my reflection. (...) and she might have already seen the ‘epiphany’ I got, but she, and they both did that a lot, just asked a lot of questions and if you said “I really don’t know” you could almost sense they wanted to say “its because of this, this and this”, but instead they just said “well okay, why dont you reflect on that”. They didn’t bring the solution. I had to go home and think from week to week. They were like curiously wondering like “oh thats interesting, I wonder why that is” and that was just really great.

As for the don’ts, the patients made clear that it was hindering for their participation in therapy and interactions with the group if the therapist was pushy, pressing or judgemental. If the questions were asked in unempathitic ways making it feel like ‘an exam’ or if they imposed their opinions about the patients behavior.

**Theme 3: Steering time and goal setting elegantly**

The third theme was centered around the ways in which the therapists structured the sessions and used goal setting in the therapy. The patients experienced it positively when there were goals for the individuals and for the group as a whole because it tied the group together, yet still left space to focus on individual problems. They explained how it was important that the therapist really listened when they set these goals, a couple of the interviewed patients had experienced that the therapist had set goals for them and that it was hard to make them understand that they wanted to work on other things, which made their therapy experience hard:

Peter: *She had a folder with a box called goals. We had talked about what I had experienced loosely, and then she wrote that down, and then that was all she would refer to, whatever is in her folder. And I found that...*
difficult, that even though I said directly “that is not what I want to work on, I would like to work on this” then it was very difficult to make her relate to me in stead of her document.

Interviewer: So you felt that the therapist had a different agenda than you did?

Peter: yes my feeling was, that whatever it says in the folder counts, it doesn't matter what I say. Often when they spoke to us, it was through the folder. That could feel like, like we were just numbers on a paper, I think. I realize that she can’t remember all her clients, but I wish she could have faked it better. That she was more descrete looking to the document, more present. (...) I felt that I had to supress my irritation and try to be professional and polite and nice and sometimes I wanted to scream “shut up! this is what i want”. The pulling back and forth was irritating.

Interviewer: and what to you think that has meant for you therapy course?

Peter: I have to admit that it has been rather negative. Well... It became better halfway through when we were on the same side. But she made me feel like she wasn’t really there. She was a farmer and we were just caddle. And that is how I think about her, because I had such a bad impression (...) I had the feeling that she wanted to treat the fire in the doghouse, even though I am pointing at the mainhouse.

This underlines the need for the therapist to let the patient lead in the goal setting, but also be flexible along the way if patients express that they want to work on other areas than what was registrered in the pregroup session. In other words, the patients expressed that it was helpful when the therapists empowered the patients to use their agency in their personal recovery:

With regards to the structuring of sessions, the patients highlighted that the therapists need to really keep an eye on time, as they feel stressed if the agenda was slipping. However it was also frequently expressed that the therapist should not shut down emotional moments due to time, prioritizing the agenda over a patient having a difficult moment can be experienced as harsh and unempathitic. All the patients highlighted that the therapists must focus on providing time and space for everyone in the group.

Furthermore, they underlined the importance of the therapist remembering what each patient said from week
to week, as it could feel like they were not important to the therapists if they forgot, which was understood as a breach of trust that in turn made patients hold back. It was important for patients that they seemed important for the therapist:

Kristine: *When you sit in this group, then, you dig down into stuff, but it is timed, and I think it was Sophie’s (therapist) job, to control the time, and sometimes I don’t think it was done elegantly, sometimes they would give a lot of space and then all of a sudden shut it down, where I just thought, that must have been hard for the people that had something they needed to come out with, and then all of a sudden we had to move on and I think that is something, I spoke to one of the others about, you are aware that there are many things they need to get though, but when you are sat there in a very vulnerable place, it is really hard if they can’t remember what you said last time or if they shut you down. I know, that a lot of people reacted to being forgotten, and then its fair enough because you expect it but then still you kind of expect them to remember because you don’t want to repeat it every time, and there was just a little bit too much of that. And you could see people pulling back, because Sophie forgot what we talked about last time.*

**Theme 4: The therapists as group facilitators**

The final theme to emerge from the analysis was centred around the therapists ability to facilitate healthy group processes. They underlined that it was very positive when the therapists were able to remember each individual in the group but also focused on tying them together as a group. Other patients spoke about the therapists ability to create moments of mirroring between patients. It was also highlighted, that the therapists should focus on creating a safe space and good atmosphere in the first sessions in order to make patients open up and keep attending:

Tina: *I really liked them alot (the therapists) ehm and I felt that we were on the same wavelength, I felt like they saw me and they understood. No one spoke down to you, and you felt included and welcomed.*

Interviewer: and what did that mean for your therapy course?
Tina: *It just makes it so, you feel much more safe and therefore you can open up faster. And it also makes you more open towards what is going to happen in the room, that you feel safe and in capable hands, and that they are competent, when you are really vulnerable, that they can deal with that in a sensitive and good way. Ehmm... and I think that every time that one of us cried, or someone really, where it was really... we got an anxiety attack or something. They were really good at handling that every time, both by, talking individually to you, when you needed that, but they were also good at including the rest of the group in it. I remember those moments.*

Furthermore, the patients brought up a range of points related specifically to the group set-up i.e. patients expressed that the therapist needed to spend a lot of time in the beginning on making introductions and on verbalizing similarities and differences between patients as it increases the sense of belonging to the group. Furthermore, the patients explained how it is important to get individual feedback every week, even if they had not succeeded with the homework assignment. They also expressed that it was important that the therapist involved the group and drew strings between different patient’s problems, but emphasized that when a patient is having a intense emotional moment, the therapists need to give full attention to that particular patient and speak directly to them. With regards to the relationship between the patients and the therapists, many of the patients expressed that they needed the relationship to be a collaboration and that the therapists should be a ‘guide’ who helped them in how to use tools and how to reflect. Furthermore, they highlighted empathy, warmth, the ability to remain calm and in control in high intensity moments, trustworthyness, realness and humour as important helpful therapist factors. The patients also expressed a need for the therapists to rephrase if the patient could not answer the questions asked, as extended periods of silence of repetition of the same question which remained unanswered created anxiety and awkwardness in the group:

Peter: *I actually think it was a bit difficult to get an optimal, good group dynamic. I think Clara was really good, even though there was this person who did not say anything, she kept creating openings for the person, like “what do you think” and took the time that was needed. And I think, when she did that, it helped the*
dynamic, that everyone shared, and then it was easier to share more. At least it made it safer, that there wasn’t a stranger in the corner who hadn’t said anything. We had all been vulnerable and then there was someone who wasn’t, and I do think it was the best sessions when Clara dragged things out of people.

Discussion

The current study set out to investigate the role of the group therapist(s) in CBT groups for anxiety and depression and had a focus on helpful and hindering aspects related to the therapists. A thematic qualitative analysis was carried out, based on 23 patient interviews. Four main themes emerged from the dataset, namely, the dynamic duo, the way to communicate, steering time and goal setting elegantly and the therapists as group facilitators. The results underlined the complexity of the therapist(s)’s role in group CBT and found specific factors that the patients experienced as important for outcome and group dynamic.

The first theme, the dynamic duo, revealed that patients found the interplay between the two group therapists to be important. Some highlighted that it was beneficial when they were harmonic, others highlighted a dynamic interplay in which each therapist brought a different style. Indeed, one of the main benefits of co-leadership is that the patients may find more safety in one of the leaders and the patients have options for the leadership style they relate to the most (Luke & Hackney, 2007). Some patients experienced frustration with the therapist pair, due to their individual styles, when the dynamic was not clear or when one was in charge and one was passive. These challenges have previously been described in the co-leader literature, in which the combination of a senior therapist and junior therapist, although the most used combination of co-leader in a group, tends to present problems regarding responsibility, coordination and the patients experiences of power issues between the therapists (Luke & Hackney, 2007). These findings shed light on a whole new aspect of the therapist effect, that to our best knowledge, has not been researched before in a CBT context. It also adds to the complexity of understanding the therapists role in group therapy. From the current study we see indications that relatively even work-distributions between the therapists was
positive, acceptance between therapists was experienced as positive and communication to the patients about the roles of the therapists was lacking in the groups where the therapist pairing was seen as problematic.

In the second theme, *the way to communicate*, patients spoke about the helpful and hindering ways in which the therapists communicated. Under this theme, we saw some well known constructs being brought to light, i.e. empathy, clear and concise language, normalizing human distress, using language to bind the group together, being sincere and using natural language. In accordance with the socratic method in the cognitive model (James, Morse, & Howarth, 2009), many patients expressed that they liked when the therapist asked many questions and did not provide answers. An interesting point here is, that some patients raised the importance of communicating this clearly at the beginning of therapy. Patients also placed importance on verbalising the similarities and differences between group members and spending a lot of time on introductions and creating a safe space in the first sessions of therapy, this is consistent with the idea that the therapist must be able to quickly establish a safe atmosphere in psychotherapy groups in order to minimize anxiety and drop outs (Burlingame et al., 2001; Neimeyer & Meruzzi, 1982). Furthermore, it may explain Tucker’s (2016) findings in which a high level of therapist structuring behaviours in the first session had a negative impact on group cohesion. This indicates that the first session of group therapy benefits from focusing on creating group bonding and a sense of belonging before moving onto highly structured sessions. Some research has looked into this, Chapman et al. (2010) identified three domains of therapist leadership skills related to outcome: *group structuring*, *verbal interaction* and *maintaining emotional climate*. They found that therapists that implement structure, facilitates positive interactions between group members and interacts with a warm and empathetic interpersonal ways tend to have groups with better outcomes. Furthermore, group therapists that are caring, warm, less controlling and sets a clear agenda tend to have more cohesive groups and better outcomes (Antonuccio, Davis, Lewinsohn, & Breckenridge, 1987; Burlingame et al., 2018). Interestingly, Tucker (2016) found that the therapists ability to facilitate an emotional climate and engaging in structuring behaviours did not in itself predict group cohesion, conversely, she found that structuring behaviours in the first session had a negative effect on group cohesion, an effect that was evened out if the therapist had many emotional climate behaviours (Tucker, 2016). The
two types of therapist behaviour interacted with one another, from which we can understand the complexity of successfully delivering therapy in a structured way, but with room to focus on the emotional aspects and interpersonal relationships in the group. It also shows, that leader/therapist behaviour is not static but can develop over time in a group and that the good therapist may need to emphasize different leader behaviours at different points in the therapy. When looking to Chapmans group leadership model (Chapman et al., 2010) we may underline the concepts of verbal interaction and maintaining emotional climate as key in the beginning of therapy. This theme also showed us how the communicational tools employed by the therapists directly affected normalization, belonging to the group, mirroring between group members, self-compassion and the ability to actively participate and share in the group.

The third component of Chapman’s model group structuring was also highlighted in the current study, in the third theme Steering time and goal setting elegantly. It became apparent that the patients saw structure and time-keeping as essential for a good therapy group, but also that the therapists needed to be flexible and adaptable and respond to what happened in the room as the first priority. This finding is similar to the findings from a qualitative study investigating CBT for eating disorders, in which patients emphasized and expected structure to be upheld by the therapist(s). Structure appeared to be important after an initial safe atmosphere was created in the group. This is in line with the idea that one of the key competencies of a therapist is to be able to use intuition and to adapt the therapy in important moments or for specific clients (Miller, Hubble, Chow, & Seidel, 2013). It also underlines, the need for the therapist to use different strategies at different points in a therapy course. Kivlighan & Kivlighan (2016) highlighted the concept of timing in therapy, and argued that it is important not to think of therapists as context-independent. A lot of the therapist effect in groups may be subscribed to the individual therapists ability to use different leadership behaviours at different times in an intervention and to be focused on different aspects at different times i.e. emotional climate in the beginning and then a larger focus on structure later on. Furthermore, this theme illustrated the importance of goal setting in therapy, the patients expressed the need for individual and common goals and a clear direction to steer them. Furthermore, the results showed the importance of the
patients setting their own goals in a collaboration with the therapist, this is in line with the ideas of CBT theory in which the case formulation is intended to be created in a collaboration between patient and therapist and should be revisited and adapted throughout therapy (Kuyken, Padesky, & Dudley, 2009). In the current study, we saw an example of the frustration and resistance it can create when the therapist is non-adaptable in this regard. Overall, the patients did experience the therapists as goal-oriented, time-keeping and directional guides.

The fourth theme, the therapists as group facilitators, highlighted the therapists ability to create a safe space that fostered bonding between group members. This is consistent with previous literature that found group cohesion to be linked to the therapists leadership behaviour (Tucker, 2016). Furthermore, the patients in the current study expressed the importance of making time and space for introductions and creating a good atmosphere in the first sessions. This is in line with previous literature, which has emphasized the importance of quickly establishing safety in the therapy room in order to decrease drop-outs (Burlingame et al., 2001; Neimeyer & Merluzzi, 1982; Xiao et al., 2017). Furthermore, the patients in the current study highlighted the therapists ability to involve all group members in dialogue and to also provide individual emotional support when needed. This is similar to the findings in a previous qualitative study, in which patients with eating disorders expressed the importance of the therapists ability to provide attention to all of the group members and to be able to make the individual topics applicable to all members (Laberg et al., 2001).

The patients in the current study described a range of individual therapist factors throughout the four themes. These echoed much of the ‘between therapist’ research that has been carried out (Moltu et al., 2010; Nissen-Lie et al., 2015; Zeeck et al., 2012) and highlighted constructs such as empathy, therapeutic style, the therapists emotional investment, their ability to remember the patients, their presence and their personality. Further, to the individual characteristics and traits of the therapists, the patients highlighted the adaptability and timing of the therapist, for example, by explaining how the therapist should adapt the techniques to the patients not vice versa. Previous studies have found both the emotional presence of the therapist and the way
in which they used techniques as important factors in psychotherapy (Moltu et al., 2010). The level to which
the therapist appears invested and finds the patient-therapist relationship important has previously been
highlighted in both qualitative and quantitative CBT studies (Laberg et al., 2001; Vocisano et al., 2004)
especially, the feeling that the therapist cared and was collaborative was highlighted as very important in the
current study. This is also echoed in the research on the working alliance in psychotherapy (Fish, 2011) With
these results, patients added to the research suggesting that the therapist effect may be comprised by
between-therapist factors and within-therapist factors by suggesting and interplay between the two. We
further suggest that the therapist effect is further made up by the match of client-therapist. When looking at
group psychotherapy we may then add group-therapist relations and patient-group relations making the
concept of the therapist effect in groups with 8 patients and 2 therapists an extremely complex matter. What
we gather from the results of the present paper is that ‘the good therapist’ is not a categorical matter, it is a
matter of possessing certain qualities and interpersonal skills, being able to structure and direct a group, have
a sense of timing regarding which leaderskills to employ when and being adaptable and putting the patients
emotional states at the front of it all. Thus the group therapist effect may be a fluid construct that needs more
phenomenological clarity.

Limitations
The current study was carried out within the context or a large RCT study. This presents a range of challenges.
Firstly, the first author had varied roles within the trial team and beliefs and opinions of the research group
have influenced the development, process and results of the current study. Furthermore, the trial imposed strict
fidelity requirements on the therapists which may have caused them to be less flexible or restraining them from
relying on their ‘therapist instincts’ which the patients may have experienced.
The extracted quotations included in the results section were translated from Danish to English which will
inevitable have impacted the feel of wording and meaning.
The thematic analysis did not consider patients ways of speaking or the unsaid. This limits the depth to which
the results went.
The interviewer is a clinical psychologist and was therefore focused on clinically meaningful topics in the interviews, this may have left out other interesting and relevant aspects of the experience of receiving psychotherapy in a mental health context. It may also have formed the conversations with the patients in that, they may have mimiced one of patient-psychologist.

The interviews were all carried out at the end of treatment, which did not allow us to see how the patients experience of the therapists may have changed over time, we had to rely on a historic narrative when looking into the within therapist variables.

We did not have specific or detailed information about the content of the supervision provided to the therapists or about their relationship with their supervisor. We only know that it was case-supervision based on the given manuals. It may be that the type of supervision and the supervisor-supervisee relationships have impacted the way the therapists carried out the treatment.

Conclusion

The current study identified a range of dos and don’ts for therapists delivering group CBT. Some of these were related to the therapist-therapist relation, some to the therapist-patient relation and some to the therapist-group relation. The patients highlighted a harmonic and/or dynamic relationship between the therapists as important for the feel in the group. Furthermore, patients wondered when the work division was uneven or when there was one dominating therapist and a passive therapists. Patients expressed a need for the therapist pair to explain their work division if it was uneven as it could take away focus from the therapy if they did not. The patients also highlighted the therapists ability to collaborate on goal setting and steering time elegantly. It was considered a big don’t when therapists set the goals for patients and was unflexible in changing the goals throughout. Furthermore patients did not like it when therapists abruptly changed topic if there was intense emotions at stake in the room, timing was considered key. Patients highlighted the therapists ability to communicate clearly and ask many curious questions. Communication should be delivered in warm and empathetic ways and not be judgemental, pressing or imposing views on the patient. Finally therapists ability to create a safe space and inspire bonding and sharing across the group, was
considered highly important for the development of group cohesion. These findings brings new perspectives to the idea of the therapist effect within CBT and proposes that the construct is highly complex and consisting of many relationships.
References


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Note: the approach to the interviews was explorative meaning that the interviewer explored all the topics that the patients brought up in a curious, bottom up manner. The interview guide served as a framework, but the interviews focused on the topics the patients brought up on their own accord to a large degree.