



Processes in Group Cognitive and Behavioral Treatment for Hoarding

Cristina Sorrentino Schmalisch, *The Lydian Center for Innovative Medicine*
Christiana Bratiotis and Jordana Muroff, *Boston University*

Processes that emerge in the course of group treatment, such as universality and mutual aid, have been posited to promote therapeutic change (e.g., Yalom, 1995); however, they have received relatively little attention in the group cognitive behavioral treatment (CBT) literature (Rose, 2004). Group CBT interventions have been successful in alleviating symptoms of mood and anxiety disorders, such as major depression and obsessive-compulsive spectrum disorder (e.g., Anderson & Rees, 2007; Himle et al., 2001). A specialized group CBT protocol has been developed to treat hoarding (Muroff et al., 2009; Steketee & Frost, 2007), characterized by excessive clutter in the home, difficulty discarding objects that appear of little value, and often excessive acquisition, resulting in significant distress and/or impairment (Frost & Hartl, 1996). Individual (Tolin, Frost, & Steketee, 2007) and group (Muroff et al.) CBT for hoarding have shown promising effects. An examination of group process factors relevant to hoarding, however, is critical in order to further understand and tailor group interventions for this complex problem. The current paper characterizes four group processes specific to group CBT for hoarding: (a) universality or inclusion may reduce stigma and shame about having hoarding; (b) cohesion seems to support attendance and to provide positive peer pressure to motivate change; (c) the opportunity to give mutual aid seems to instill hope and motivate change; (d) social contact and socializing may reduce social isolation, a characteristic of this population. Discussion includes specific case examples illustrating these group processes and their potential complexity, within the context of group CBT for hoarding. Recommendations are advanced for future directions in evaluating group CBT for hoarding, particularly the formal study of group process variables with this population.

GROUP processes (e.g., cohesion, mutual aid) have received little attention in the group cognitive behavioral treatment (GCBT) literature, despite the recognition across a number of theoretical orientations of their importance to group work (e.g., Oei & Browne, 2006; Yalom, 1995). The limited discussion of GCBT has focused on more general issues (Bieling, McCabe, & Antony, 2006; Rose, Tolman, & Tallant, 1985) and on particular disorders, such as anxiety and depression (see Oei & Browne; Woody & Adessky, 2002). Little is known as to the extent positive outcomes associated with GCBT for anxiety and mood disorders are a result of group process variables, which specific processes contribute to positive outcomes, and how group processes function. A developing area of GCBT is for hoarding. Recent studies have begun to evaluate the outcomes of this specialized GCBT protocol (Muroff et al., 2009). The current paper complements this work by characterizing group processes that develop during GCBT for hoarding and also gives some attention to the specificity of these processes to CBT and to hoarding. Better understanding of relevant group processes has the potential to enhance the development

of group treatment for hoarding and improve clinical outcomes.

Hoarding is characterized by an overabundance of possessions that often appear to others to have little or no value (e.g., junk mail, outdated clothes, broken appliances, trash). To reach a clinical level, hoarding must result in cluttered living or work spaces and cause significant distress or impairment to the sufferer (Frost & Hartl, 1996; Frost, Krause, & Steketee, 1996). Although hoarding is currently classified as a subtype of obsessive-compulsive disorder (OCD) and as a feature of obsessive-compulsive personality disorder (*DSM IV-TR*; APA, 2000), there is a growing body of evidence to suggest that it is a syndrome in its own right (e.g., Saxena, 2008). Hoarding is estimated to affect 5% of the population (Samuels et al., 2002). It often onsets in early adolescence and reaches clinical levels in the 4th or 5th decade of the sufferer's life. It is associated with urges to save, clutter, excessive acquisition, exaggerated fears of losing important items, perfectionism, indecisiveness, and lateness (Saxena, 2008; Steketee & Frost, 2003). Hoarding puts the health and safety of individuals, families, and the community at risk, and may result in homelessness and death (Tolin, Frost, Steketee, & Fitch, 2008). It is a public health concern that taxes community resources (Frost, Steketee, & Williams, 2000).

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According to the cognitive behavioral model of hoarding initially proposed by Frost and Hartl (1996) and further developed by Steketee and Frost (2007), there are five major contributors to the hallmark manifestations of hoarding (i.e., clutter, saving, and acquisition): (a) personal vulnerabilities, (b) difficulties processing information, (c) beliefs and appraisals about objects, (d) emotions related to objects and, (e) positive and negative reinforcers of hoarding beliefs, emotions, and behavior. Individuals with hoarding often have one or more vulnerabilities that may include genetics and family history and comorbid mental or physical health problems (e.g., depression, personality disorders, physical disability). These individuals often exhibit information processing problems such as difficulty sustaining attention, categorizing, and making decisions that interfere with sorting, discarding, and organizing their possessions.

Individuals with hoarding hold beliefs and have emotions about objects that contribute to hoarding. Common beliefs influence saving and acquiring behavior and relate to memory, safety, comfort, identity or potential identity, and responsibility. These appraisals are often accompanied by strong positive and negative emotions in relation to possessions, such as joy, pleasure, and excitement, or shame, guilt, and sadness. The four components of the model mentioned above form feedback loops that contribute to clutter, saving, and acquisition. For example, beliefs about the comfort of possessions contribute to saving behaviors and positive emotions about acquisition contribute to acquiring behaviors. Similarly, difficulty sustaining attention and negative emotions related to discarding objects contribute to avoidance of sorting and decision-making about possessions.

A specialized individual CBT protocol for treating hoarding (Steketee & Frost, 2007) has shown moderate effectiveness in reducing the symptoms of this disorder (Tolin, Frost, & Steketee, 2007). In this protocol, clients receive psychoeducation about hoarding and beliefs that maintain hoarding behaviors and engage in CBT techniques for modifying beliefs, such as asking Socratic questions to challenge beliefs and weighing evidence (Beck 1995; Padesky & Greenberger, 1995). Clients are also taught skills such as sorting, organizing, and decision making, and they practice exposure to discarding and not acquiring new possessions. This protocol is being modified and tested for GCBT for hoarding. Initial pilot testing showed modest improvement in hoarding symptoms (Muroff et al., 2009). These groups were generally 16 to 20 weekly sessions with two home visits, which is a lower treatment dosage, shorter treatment time period, and involves fewer home visits than the individual treatment protocol (Steketee & Frost, 2007). Group members'

absences, lateness, fluctuating motivation, and limited insight may also contribute to more moderate treatment response. However, a 16-week GCBT for hoarding that applied a more formalized clinical research protocol, including a more detailed screening procedure, a CBT group manual and treatment workbook (Steketee & Frost, 2007), and a more efficient process for collecting data to minimize missing data, demonstrated promising outcomes (Muroff et al.), similar to individual treatment data (Steketee, Frost, Tolin, Rasmussen, & Brown, 2010; Tolin et al., 2007). Nonetheless, our current research is focused on maximizing benefit through, for example, more group sessions and home visits (Muroff et al.).

Group work has a number of advantages that motivate adapting Steketee and Frost's (2007) individual CBT protocol to the group modality. Evidence suggests that GCBT interventions are successful in alleviating symptoms of disorders comorbid or related to hoarding, such as major depression and OCD (e.g., Anderson & Rees, 2007; Himle et al., 2001). Also, a pilot study found GCBT to be helpful for reducing acquisition of items, increasing awareness about problematic beliefs about saving, and improving participants' ability to organize (Steketee, Frost, Wincze, Greene, & Douglass, 1999). GCBT is cost-effective and efficient in that more patients can be treated in a given period (by one estimate, 50% more) (Morrison, 2001) and is also an efficient use of scarce resources, such as access to CBT-trained therapists (see Weissman et al., 2006). Given the relative recency of empirically tested protocols for hoarding, therapists trained in CBT for hoarding are scarcer still, as evidenced by our extensive waiting list for treatment.

Another advantage of the group modality is the unique opportunities it provides for interactions among group members and group facilitators that are not present in individual treatment. In the group work literature, these interactions are broadly referred to as *processes* (e.g., Yalom, 1995) to distinguish them from session content, such as psychoeducation and use of Socratic questions (Beck, 1995; Padesky & Greenberger, 1995). A core feature of hoarding is excessive emotional attachment to possessions, along with strong feelings of comfort from possessions (Frost & Hartl, 1996; Steketee & Frost, 2003, 2007; Grisham et al., 2009). Alongside this—and possibly as a consequence—individuals with hoarding may have difficulty forming and maintaining relationships with people (Frost, Steketee, Williams, & Warren, 2000). They are often socially isolated and may have social anxiety (Samuels et al., 2002; Steketee, Frost, & Kim, 2001; Steketee & Frost, 2003). They typically have entrenched beliefs about possessions, such as the need to keep them in sight (Frost & Gross, 1993; Steketee, Frost, & Kyrios, 2003; Steketee & Frost, 2007). GCBT for hoarding gives rise to rich interactions that may reduce feelings of

isolation, help destigmatize the disorder, and improve well-being (Bieling et al., 2006; Rose, 2004). Group processes, then, may be important contributors to the therapeutic change that treatment is intended to foster.

The GCBT literature has emphasized the effect of treatment content on clinical outcomes while giving comparatively little attention to group processes and their effect on clinical outcomes (Rose et al., 1985). The present article makes a unique contribution to the literature by characterizing four processes specific to GCBT for hoarding: *universality*, *cohesion*, *mutual aid*, and *social contact*. Universality refers to the experience of members recognizing that they are not alone in suffering from hoarding by virtue of meeting others with the disorder. Cohesion is the connectedness that develops within the group—the connection of members to one another, to the group, and to the therapeutic process. Mutual aid refers to the instances whereby group members offer help to one another, such as sharing advice and experiences. Social contact and socializing refers to the range of social exchanges in which members engage, both within and between group sessions. Although Yalom (1995) proposed nine group processes, we selected these four because of their salience in our observations of GCBT for hoarding. Their relevance is also highlighted by the cognitive behavioral model for conceptualizing hoarding introduced earlier (Frost & Hartl, 1996; Steketee & Frost, 2007), particularly as it relates to beliefs about emotional attachment to possessions. In addition, the therapeutic effect of these particular processes for those with hoarding may derive at least in part from their social and interpersonal nature. In particular, interpersonal connectedness and cohesiveness between members may enhance their capacity to view circumstances, decisions, and other such elements from another's perspective and consider changing behavior and/or thinking. While there are other important and relevant processes, such as the instillation of hope and interpersonal (or imitative) learning (Yalom, 1995), we chose to focus on four in greater depth due to space constraints. Using clinical observations, we suggest how these four processes develop, highlight their links to the cognitive behavioral model of hoarding, illustrate them using case examples, and discuss their possible therapeutic and countertherapeutic effects. Our hope is that shedding light on these processes will lead clinicians and researchers to attend to group processes in developing and improving GCBT interventions for the complex problem of hoarding and, by extension, for other relevant psychological disorders.

The observations in this paper are based on the authors' reflections from hoarding CBT groups conducted through a university-affiliated hoarding research project. The groups were 16 to 20 weekly sessions with two

home visits and averaged 6 to 8 participants in size. Participants were approximately 50 to 55 years old, predominantly female, Caucasian, and highly educated. About a third of group members were employed part- or full-time, just under a third were single or never married, and just over a third had no dependents. All group members were research participants and had been assessed and screened as part of one of two studies of hoarding and its treatment. Their primary mental health disorder was hoarding according to the Hoarding Rating Scale (Tolin, Frost, & Steketee, 2008); to be eligible, participants had to score 4 or higher on the clutter, difficulty discarding, and distress or impairment questions on this scale. Comorbid diagnoses were assigned using the Anxiety Disorders Interview Schedule (ADIS; Brown, DiNardo, & Barlow, 1994). Individuals were included in the group treatment even if they were taking medication; however, they were required to be on a stable regimen, taking the medication for at least 2 months prior to commencing group treatment and expecting to continue for at least 6 months. Exclusion criteria included evidence of organicity or psychosis, current bipolar symptoms, serious cognitive impairment, substance use disorders within the previous 6 months, and hoarding symptoms judged to derive primarily from other OCD symptoms (e.g., contamination fears or checking rituals). In addition, participants were excluded if they were deemed inappropriate for group treatment due to severe interpersonal difficulties and/or if they were in need of case management services or a higher level of treatment. In such cases, referrals for individual treatment and appropriate services were provided.

Processes in GCBT for Hoarding

Universality

A common experience of individuals as they engage in group treatment for any number of disorders is the feeling of “being in the same boat” as others, a process that has been referred to as *universality* (e.g., Rose, 2004; Yalom, 1995). Hoarding carries considerable stigma and shame and individuals with this disorder often do not reveal it to family members, let alone others whom they do not know. Potential group members are often drawn to group treatment at least in part because of their desire to meet others with difficulties similar to their own. Encountering a group of like others is a powerful experience for individuals with hoarding.

Pam received a phone call from one of the group facilitators about the start of the hoarding group treatment. She expressed excitement to meet others who have trouble with hoarding but she was also nervous about talking about it and being judged. During the first couple of sessions, the group facilitators reiterated that all members of the group have a hoarding problem and facilitated discussion

about the definition of hoarding. As the group facilitators characterized hoarding, Pam and others found themselves nodding, smirking, or reflecting on how the general description applied to them. "That's me," Pam stated nodding her head. Seeing others' responses of recognition and agreement eased Pam, enabling her to feel more comfortable openly sharing with the group how the description provided by the group facilitators applied to her.

Perhaps the principal therapeutic benefit of universality is the reduction in the stigma, isolation, and shame sufferers feel in relation to their symptoms and behaviors (Bieling et al., 2006). Individuals with hoarding are aware that their behavior is generally looked down upon by society, even evoking feelings of disgust and rejection by others—commensurate with the experiences of people with schizophrenia (Tolin, Frost, Steketee, & Fitch, 2008). Those with the problem often internalize these judgments and feelings. Our observation is that universality in GCBT for hoarding often occurs immediately; group members seem to experience strong feelings of relief that they are not alone in suffering from hoarding.

While universality is a process general to group treatment, perceived similarity among members may contribute to this process. In our setting, the relative homogeneity in age among group members was noted in "first impressions" among members of these groups. Illustrating this, as one middle-aged client entered the group room at the start of her first session, she remarked, "Wow—this looks like a Baby Boomers group!" Perceived similarity may also arise as members learn about the Steketee and Frost (2007) model of hoarding early in the treatment. Not only do members come to understand the model as it applies to them, they also come to understand that they have a shared experience insofar as the model applies to the other group members as well. These perceived similarities among group members may contribute to universality and provide members with reinforcement to attend the group, to be receptive to group content, and to engage in the group process.

Another therapeutic benefit of universality is that it gives rise to hope that change is possible, which is an important precursor to the change process itself.

During the first night of group introductions Iris stated, "I am bringing my optimism that everyone can do this!" She gestured with an arm swing while declaring "all for one and one for all."

When Therese described the homework she had completed the week prior, Wilma reflected, "I did not do my homework this week, but hearing about your successes makes me think I can do it too..."

In addition to the above therapeutic effects, universality may also facilitate self-disclosure, which can help

establish safety in the group. In the first session of one group, four of the six members spontaneously acknowledged having trichotillomania, and two of these members shared that they had not previously disclosed this to anyone but their doctor or individual therapist.

While universality is generally desirable for group work by virtue of its direct and indirect benefits, it does have the potential to be countertherapeutic. Universality may contribute to negative group norms. In CBT groups for hoarding, members share many beliefs, behaviors, and emotional reactions that contribute to their difficulties. One such belief is that an item should be put to good use, leading to saving behavior, and strong negative emotions at the thought of discarding an item. Through the process of universality (together with group cohesion, described below) a group may develop the norm of saving rather than discarding items. Group facilitators do well to monitor such beliefs early in the group work, incorporating them into cognitive restructuring exercises, for example, so as to shift this norm to one of discarding.

Depending on the characteristics of the group, some members may not experience universality to the same degree as the rest of the group. This may occur when particular members do not share the same characteristics (e.g., age, culture) or perspectives as the majority of the group (e.g., readiness for change). These differences may lead to a lessened experience of universality relative to others in the group. Such an experience may be countertherapeutic by detracting from members' enjoyment of the group, possibly leading them to discontinue participation. This highlights the importance of group composition and diversity in group membership to maximize universality.

In people with hoarding, comorbid difficulties, such as social anxiety and paranoia (Frost, Steketee, Tolin, & Brown, 2006), may be significant detractors from given members' experience of universality and its benefits.

Unlike other members in the group, Martin did not reveal details of his hoarding problem until the third group session. He explained that although he "knew" all members had hoarding, he felt anxious about whether his hoarding was worse than others. He felt more comfortable and safe enough to briefly self-disclose about his problems when another group member, Sue, showed photographs of her home to the group. Martin saw from the photos that Sue also had numerous tall stacks of newspapers, making it difficult to move through the home.

As this example illustrates, Martin's concern about others' judgments of him, further exacerbated by his social anxiety, interfered with his experience of universality and certainly slowed the development of one of its benefits, namely his feelings of safety and comfort.

Through the sharing by his fellow group member of the state of her home, Martin was able to challenge his own anxiety about being judged and join with the group in sharing details about his difficulties.

Cohesion

By promoting feelings of belonging, universality sets the stage for cohesion. Cohesion refers to the connectedness of members to one another, to the group, and to the therapeutic process. It arises from the extent to which members affiliate with the group and the effect of this relative affiliation or lack thereof on members and their treatment. Clinicians have characterized cohesion as including “mutual liking of members for one another and the group facilitators” (Rose, 2004). It has also been conceptualized as an attachment bond, or emotional connection, of members to the group (Mikulincer & Shaver, 2007). Cohesion is thought to contribute to sharing of relevant personal information (Budman, Soldz, Demby, Davis, & Merry, 1993). It encompasses feelings of comfort, belonging, and acceptance of one another by group members (Bieling et al., 2006). Cohesion is thought to help attenuate difficulties with attachment to others (Brook, 2008).

Members in GCBT for hoarding demonstrated cohesion in a variety of ways. Statements such as, “You guys get it,” “You understand me,” and “You don’t judge me” communicated feelings of affiliation with the other members. The sharing of personal information also attested to these feelings. One member demonstrated her connection to the group in the following manner:

Madeleine shared with the group that she was at a workshop a year or so previously and the facilitator asked for participants to imagine their safest place. At the time her mind went blank, as she could not think of one. She then shared with the group that she now imagines the group room as her safest place.

Members demonstrated their connectedness to the group by lingering after the group to talk with others or agreeing to meet before the group for a meal. In one group, a member contributed to the group’s connectedness by suggesting names for the group, such as “The Higher Order of the Hoarder.” Members also demonstrated their connectedness to the group by referring to it as a “class.” Although the group facilitators never referred to the treatment in this way, group members mutually and implicitly arrived at this description of treatment, possibly to reduce stigma or shame or perhaps due to the setting (i.e., on a university campus) or the format of the treatment (i.e., with a workbook, homework, psychoeducation, etc.). For example, if a member could not attend a session, he or she might leave the group facilitators a message such as, “I can’t make it to class tonight.” In

session, a member might say, “I forgot my book for class” or “I didn’t do my homework for class.”

Connectedness to group process was suggested by the group’s response to exercises designed to help them overcome problematic behaviors, such as saving possessions and avoiding discarding.

During a discarding session, Rhonda brought in a grocery bag full of shoulder pads to discuss discarding. Many members shared that they also saved their shoulder pads from their 1980s garb, just in case shoulder pads came back into fashion. This topic elicited much enthusiasm and interest. After a review of questions about possessions, Rhonda discarded the bag of shoulder pads. She even went so far as to remove the shoulder pads from the shirt that she was wearing to group and discard them as well. Christine noted, “Well, now that you got rid of your shoulder pad stash, I can clean out my 3 dresser drawers full of shoulder pads!” Rhonda replied “We are all without our shoulder pads now.”

Group members connected to the exercise of discarding and inspired one another to practice this new behavior. Members also inspired one another by sharing their developing skills with the group.

During check-in, Madeleine proudly told the group about how she had been at a fair and had resisted the urge to accept (acquire) a glossy full-colored tri-fold brochure from a vendor. She shared with the group that she was very tempted due to the bright colors and smooth texture, however, she declined. Madeleine acknowledged that she still thinks about the brochure but that she felt good about resisting the strong urge to acquire it. Maryann remarked to Madeleine, “You are brave!”

A range of factors can influence the development and maintenance of cohesion. When group members are similar in terms of demographics, cohesion tends to increase (Rose, 2004). The relative homogeneity of age in the hoarding population seeking treatment is likely a source of cohesion in GCBT for hoarding. The somewhat higher proportion of women to men in the treatment groups at our setting may also contribute to cohesion. Beliefs and emotions central to hoarding can also contribute to cohesion insofar as they are widely shared among group members. These include beliefs about identity and responsibility and emotional attachment to possessions (Frost & Hartl, 1996; Steketee & Frost, 2003; Steketee & Frost, 2007). Group members often echoed one another in their statements of beliefs. Where one member expressed responsibility about an item with the words, “I don’t want to waste it,” another member said about an item, “I have to recycle it—I cannot just trash it.” Members also showed their understanding of one another’s emotional attachment to possessions through their verbal and nonverbal responses. For example, when

a member stated, "I can't discard this! I am keeping it so I can fix it and use it," group members nodded in understanding. Members' affinity for one another seems deepened by their sharing of similar beliefs and emotions about possessions.

Formal and informal group norms also affect cohesion. Regular attendance by group members tends to foster cohesion. Individuals with hoarding often struggle with punctuality and group facilitators do well to establish this norm, together with attendance. However, in our experience, the norm of punctuality does not always come from group facilitators. As individuals with hoarding often have high standards and a strong sense of responsibility, members themselves may establish this norm. During one of the groups at our setting, on the first occasion a member was late, the member stated, "I am sorry to disrespect the group." Being late evidently became interpreted by the group members as disrespectful to the whole group and to the individual speaking at the time the tardy person arrived. The group developed a norm of punctuality and members upheld and referred to the notion of "disrespect" at being late. In general during group check-in, members sometimes expressed concern for missing members, attesting to group cohesion.

Norms and agreements about confidentiality affect the development and maintenance of cohesion. These norms lay the foundation for safety in the group and trust in others to keep personal information private. As group cohesion grows, members are more likely to disclose information. This was evident in CBT groups for hoarding. Members often demonstrated a high level of comfort in revealing comorbid health conditions such as depression, anxiety, gambling, overeating, and trauma. In one group, when a member disclosed, "My trauma plays a significant role in my hoarding problem," three others nodded in agreement.

Groups may also fail to develop cohesion or may lose cohesion. Groups with poor attendance, for example, may never develop cohesion or may lose cohesion over time as attendance deteriorates. Members engaging in countertherapeutic roles can detract from cohesion. This can occur when a member tends to be a dissenter in the group, disagreeing with the co-facilitators or with other group members in a manner that creates distance within the group. The loss of group members is another important detractor from cohesion. In one group, a tension developed between the priorities of the group, which tended to focus on both group process (e.g., interpersonal aspects of group membership and progress) and group content (e.g., CBT-specific skills, such as examining beliefs about possessions, practicing discarding), and the priorities of a particular group member, who wished to focus principally on content. The tension

between processing emotions and skill-development came to a head midway through the group treatment protocol.

In the previous week's session, members engaged in a nonacquisition exercise involving office supplies brought to session by the group facilitators. The goal of the exercise was to resist acquisition of these items but one member could not resist and elected to acquire an item. Reflecting on their experience from the previous week, members shared feelings about the exercise, such as frustration at being "tempted" by the items or chagrin at having resisted a compelling item. Frank had been absent during the previous week and as the members discussed the session, Frank apparently ignored the group, sorting among his notes. When a member challenged Frank for his apparent inattention, he said to the group that he was listening to what was being discussed and then added, "We are here to discuss hoarding and talking about other stuff is taking us away from this topic." The discussion between Frank and the rest of the group became quite heated with Frank ultimately leaving the group during the session and not returning. In a discussion with one of the group facilitators at a later point, Frank again stated that he felt the group's discussion of process detracted from the content of the work.

Cohesion can be countertherapeutic. The beliefs and emotions that group members have in common by virtue of being hoarders may unite them in resisting rather than embracing change. For example, one group member beautifully captured the links between perception, emotion, and behavior that contribute to an acquisition problem in hoarding (Frost & Hartl, 1996; Steketee & Frost, 2007). He described his acquisition by stating, "I see it, I want it, I buy it." His urges to acquire were so strong and his acquiring behavior so immediately compelling that he failed to gain insight into the problematic nature of this "must have" belief. This member's commitment to acquisition and to the positive emotions that he experienced during the course of acquisition was infectious and seemed to weaken this group's commitment to nonacquisition. In another group, members cohered around the rejection of the exercise of sorting possessions brought from home in session, a mainstay of CBT treatment for hoarding. From the earliest sessions, most members simply failed to bring items to sort. This group was quite cohesive in terms of connectedness to one another (e.g., members typically lingered for up to 45 minutes after the group to chat with one another), and also cohesive in terms of attendance and punctuality. However, while the group was receptive to virtually all the session topics and exercises, they nonetheless rejected the exercise of bringing items and sorting in session. This may indicate that the different components of cohesion—to the extent that they are empirically valid—may operate with some independence from one another.

Cohesion may be interrelated with mutual aid: as a group becomes more cohesive, members seem more likely to offer one another mutual aid, and as members offer one another mutual aid, the group seems to become more cohesive.

Mutual Aid

Mutual aid occurs through interactions in which group members help one another (e.g., Bieling et al., 2006; Rose, 2004; Yalom, 1995). Group members may engage in mutual aid by offering one another direct advice or sharing an experience, tool, or strategy in relation to a problem.

Lisa told the group about her involvement in a number of legal proceedings related to the settlement of the estates of some family members. She described the cases as complex and protracted, with no resolution in sight after several years. She shared that due to her strong emotional reactions to letters from lawyers, she avoided opening them. Alison revealed that she had gone through a complicated and acrid divorce and had initially experienced strong emotions when she received legal correspondence. She said that by making herself open the letters, the intensity of her reaction diminished over time (i.e., an example of habituation through the behavioral method of exposure). Ed shared that he had accumulated debt at one point and experienced strong emotional reactions to receiving letters from his creditors and bill collectors. He said that he began to state to himself thoughts like, "I'm not going to let them get the better of me." In so doing, he found that his reaction to the letters diminished (i.e., an example of a coping statement and habituation). These comments seemed to help Lisa to take the step of opening her mail.

Mutual aid also occurs when members offer support, empathy, and understanding to one another. In the above example, by sharing similar difficulties, Alison and Ed communicated to Lisa a sympathetic understanding of her difficulty. Mutual aid can also occur through the practice of CBT techniques. For example, Socratic questions about possessions are introduced in both individual and group CBT for hoarding. These include questions such as, "How many of these do I really need?" and "Will discarding this item solve my hoarding problem?" (Steketee & Frost, 2007). In one group, the week following the introduction of Socratic questions, a member brought in colored sheets of paper, each with a question printed on it, and told the group that she planned to hang the sheets around her home to prompt her to discard items. Mutual aid confers a therapeutic benefit to the receiver in that he or she typically experiences positive emotions at being emotionally supported as well as the positive effects of being directly helped. Mutual aid also provides opportunities for members to gain new insights and perspectives from the experiences and advice of others struggling with similar problems.

Mutual aid has been referred to as "altruism" (e.g., Bieling et al., 2006; Yalom, 1995), a selfless concern for the welfare of others, highlighting the benefit to the receiver of the help of another. However, our experience is that mutual aid imparts considerable benefit to the "giver" in GCBT for hoarding. As the CBT model of hoarding highlights, individuals with hoarding have a preoccupation with saving and acquiring possessions, experiencing greater than average emotional attachment to their possessions, and deriving considerable comfort from them (Frost & Hartl, 1996; Frost, Hartl, Christian, & Williams, 1995; Grisham & Barlow, 2005; Steketee & Frost, 2007). Evidence suggests that attachment to possessions occurs very quickly and grows stronger over time (Grisham et al., 2009). As group members engage in the experience of being of help to others, they have the opportunity to broaden their focus to include people and to experience positive effects from this. Offering mutual aid, then, seems an important opportunity to develop attachment to others. In a number of the groups at our setting, members are encouraged and often agree to coach one another while sorting and discarding, not only during but also between group sessions.

Ilene coached Paula in clearing an area in front of her bed at home. At the next group session, Paula expressed her deep gratitude to Ilene because this area had been cluttered for years. Paula told the group that after Ilene left her home, she was so happy about the empty space that she vacuumed it and then got on the floor and rolled around with glee in the cleared area! She beamed and giggled while relaying this to the group. Ilene, in turn, looked pleased at the success of her coaching expressed by Paula.

In the above example, Paula, the receiver, clearly experienced a benefit from Ilene's help. At the same time, Ilene experienced positive emotions, such as gladness, at being of help to Paula. Givers of mutual aid may feel validated at witnessing the usefulness of their contribution to another and conclude that they have much to offer (Bieling et al., 2006). Individuals with hoarding often express that they harbor feelings of low self-worth and some recent evidence indicates that there is a relationship between hoarding and self-ambivalence, which includes doubts about and preoccupation with self-worth (Frost, Kyrios, McCarthy, & Matthews, 2007). When givers observe another change through their contribution, they may feel both hope and optimism about the change process, improving their mood and feelings about their self-worth. This may enhance their motivation for overcoming their symptoms of hoarding, in addition to their motivation for helping others (Bieling et al., 2006).

While mutual aid can promote change and improve well-being, it can also hinder these. One complication of

mutual aid is that by adopting a helper role, a member can be side-tracked from his or her own difficulties. For example, a number of individuals who are professional organizers privately struggle with hoarding.

One group member, Shannon, stated with frustration and anger, "Why is it that I can work as an administrative organizer and book-keeper daily at work but I can't organize my own home to save my life?" Karl noted, "I have a similar problem in that I can maintain my boss' schedule but not my own."

During group sessions, we have observed members offer help to others while neglecting their own work. Indeed, Ilene struggled with this problem, as she confided to the group. Mutual aid may thus serve as a form of avoidance. Another potential negative of mutual aid is that it may actually deepen depression. This can occur when a member observes the progress of others and perceives him- or herself as not making similar progress, thus lowering mood and confirming beliefs about low self-worth. One group member expressed just this reason for choosing to leave the group.

Mutual aid can also conflict with therapeutic norms and agreements. A group agreement—"no trading items with other members"—pits the value of helping one another against the behavioral change of discarding that is necessary for overcoming hoarding.

While Dan was at Matt's house coaching him on discarding, he saw that Matt, who loves music, had three turntables that are no longer on the market. Dan told Matt that he had the same brand turntable at home but that he could no longer use it because the stylus and arm had broken. The two discussed Matt's giving Dan one of his turntables for parts and brought this issue to the next group session.

Interestingly, during the group discussion of the conflict between the "no trading with group members" agreement and Matt's helping Dan by giving him one of his turntables, it became clear that Matt was not ready to discard any of his turntables! In this case, the group agreement protected Matt from negative feelings that could have arisen had he yielded to pressure from mutual aid and given Dan one of his turntables. Mutual aid can also lead to difficulties when expectations of help between sessions are not met.

At the end of a group session, Linda and Iris agreed that they would call each other during the week to help each other stay motivated to complete their goal for the week. At the following group session, Linda expressed her disappointment about Iris not returning her calls. She stated with hostility, "I really wanted to talk to you, Iris. I even called a few times. What happened?" Iris responded blandly, "My son was sick." Linda replied, "Sorry

about your son, but I just wish you told me. I was having a rough week and didn't get my stuff done."

Linda was clearly hurt and disappointed by her expectation of help from Iris, who either could not or would not keep to the agreed plan for between-session coaching. As this example further illustrates, mutual aid does not occur in a vacuum but rather is interwoven with social contact and socializing.

Social Contact and Socializing

Group treatment provides rich opportunities for interacting with peers on an equal footing, in contrast to individual treatment that centers on the client and therapist relationship, characterized by a power differential. Treatment groups are considered to be social environments in their own right because of their similarity to the social world outside of the group. They are a contained and relatively safe setting in which group members can learn and practice social skills (Bieling et al., 2006; Rose, 2004; Yalom, 1995). The social support offered in group treatment, together with limits and agreements developed by the group and its facilitators to ensure appropriate boundaries and safety, promote the formation of relationships with others (Brook, 2008).

As already noted, individuals with hoarding often have comorbid social anxiety (Frost, Steketee, et al., 2006; Samuels et al., 2002; Steketee et al., 2001; Steketee & Frost, 2003), and social isolation is highly characteristic of this population. Many clients with hoarding also have personality disorders or features of disorders (Frost, Steketee, Williams, & Warren, 2000; Mataix-Cols, Baer, Rauch, & Jenike, 2000; Samuels et al., 2002; Steketee & Frost, 2003). Perfectionism, rigidity, or emotional dysregulation characteristic of those disorders may interfere in forming friendships and getting along with others. Although the emphasis in GCBT for hoarding is not necessarily on overcoming interpersonal difficulties, our observation is that group members are drawn to the social contact and socialization that the group provides. Like mutual aid, the social contact and socializing outside of group sessions provides an opportunity for group members to shift their focus from relating to their possessions to relating to others. The group is a setting wherein they can learn to manage their own and others' social skills deficits and build upon their strengths. The structure and regularity of group sessions together with the relatively small number of group members evidently scaffolds this process.

In groups at our setting, members sometimes arranged to travel together to and from the group sessions. Group members often spontaneously arranged to call one another between sessions for support around completing homework. Some group members met between sessions

to coach one another on sorting and discarding. In more than one group, members decided to meet before the group sessions for coffee, lunch, or dinner. Members of one of these groups decided to attend a separate monthly support group together after treatment ended and arranged to meet for dinner before that group. In another group, members consistently lingered in conversation for up to 45 minutes after the end of the session, resulting in the group facilitators ushering the members out of the office to lock up.

Social contact and socialization arising from GCBT for hoarding seem to have a number of positive effects on participants. Group members are not only sources of concrete help and emotional support, they are potential friends. The socialization provided by group treatment may motivate members to attend sessions regularly, permitting them to derive further benefit from the treatment.

One group member, Ann, was very tuned in to others' progress. She stated to the group, "Besides the progress that I am making on my own stuff, part of why I am able to make the long trip to group week after week is how happy it makes me to see others' changes, like hearing about what was discarded or organized—even haircuts and clothing changes! I want to see those positive changes too!"

Group treatment sessions may thus serve as a social outing, a form of behavioral activation, and may reduce feelings of isolation and loneliness and improve mood. A client in one of our groups demonstrated this nonverbally during the course of treatment. She began the group with her hair down covering her face and wearing glasses. By the end of the group treatment, she had her hair pulled away from her face and wore contact lenses. Socializing and connecting with others may spark motivation to work on hoarding, which may lead to reductions in clutter and other gains. At the same time, progress on overcoming hoarding may itself increase an individual's comfort with and tendency to socialize. Clients in more than one group invited group members to their homes for a group session to enjoy their de-cluttered living rooms, which typically had not been used as intended for years. Others noted having a friend or family member over to their home for a visit because they "now had a place for a visitor to sit," often for the first time in many years.

As with the other group processes, social contact and socializing may have negative effects on members. Closeness between some members in the group and not others could result in the experience of negative social comparison on the part of members not included in the closer relationship. Members may also experience hurt and disappointment from cancelled plans for between-session coaching or from unreturned phone calls, as was the case

for Linda. These and other experiences in the group setting may perpetuate past experiences of hurt, disappointment, or rejection, rather than helping group members transcend these experiences. This was possibly the case for Frank, whose departure from the group was preceded by a few occasions in which his attempts to joke with some of the other group members seemed to cause offense. Although the group members did not wish for Frank to leave, neither the group, nor Frank, nor the group co-facilitators were able to convince him to stay. Frank's experience of leaving the group in anger may be a replication of past experiences of rejection and disappointment.

Development of Group Processes

Although we have considered universality, cohesion, mutual aid, and social contact and socializing separately, these processes are interrelated and influence one another. By fostering belonging, universality not only contributes to cohesion but also to mutual aid and social contact and socializing. In the illustration of universality in which Sue's bringing photos of her home to the session permitted Martin to feel "in the same boat," Sue's behavior and Martin's response also constitute mutual aid. As universality fosters cohesion and members feel safe and self-disclose, they will be more likely to offer one another mutual aid and to socialize outside of group. These four processes may also interact with other group processes, such as opportunities for interpersonal learning and the process of imparting didactic information (Yalom, 1995).

The development of group processes is also affected by the extent to which group sessions are structured, emphasize CBT content, and promote interactions between group members and between members and group facilitators. Group work in other orientations, such as psychodynamic and interpersonal, tends to have relatively unstructured sessions and facilitators tend to deemphasize content and emphasize and facilitate extended interpersonal interactions (e.g., Bieling et al., 2006; Yalom, 1995). This allows for complex process development, which is theorized as the primary contributor to therapeutic change (Yalom). By contrast, GCBT sessions are necessarily structured and include content, such as psychoeducation and skill development; this may diminish the development of some processes, such as cohesion and mutual aid. Of course, the structure and goal-setting aspects of GCBT carry many benefits and, in contrast to groups that primarily emphasize process, GCBT has the potential to provide benefit from *both* content and process. Further, as noted above, the structure and content of GCBT may facilitate the development of processes like social contact.

Another factor that may influence group process development is the behavior of the group facilitators. Group facilitators differ in their style and may fall on a spectrum of individual-directed (group interactions

primarily occur through the mediation of the facilitator) to group-directed (the facilitator encourages clients to directly relate with one another). These styles may be associated with the spectrum of focus on content (individual directed) to focus on group process development (group-directed). Limiting member interactions during group to focus group discussion on session content may, as suggested above, decrease cohesion and opportunities for providing mutual aid. By contrast, encouraging members to engage in between-session coaching, for example, may foster the development of socializing among group members, which may in turn promote self-disclosure by members in session, increasing cohesion.

Concluding Comments: Future Directions in Understanding Processes in Group CBT

This article illustrates and discusses four specific group processes—universality, cohesion, mutual aid, and social contact and socializing—within the context of GCBT for hoarding and based on the theoretical model of hoarding developed by Frost, Hartl, and Steketee (Frost & Hartl, 1996; Steketee & Frost, 2007). The GCBT treatment literature focuses on clinical outcomes and improvement related to the specific CBT skills applied in the group treatment with less investigation of how specific group processes may contribute to outcomes and interact with the CBT content. Drawing from our clinical observations, we suggest that group processes may have an effect on reducing hoarding symptoms as well as possibly improving associated features, such as social anxiety. It is hoped that the observations and discussion in this article will stimulate research of processes in GCBT for hoarding and other disorders. Research examining the development and function of group processes as well as the effect of group process variables on CBT outcomes may pave the way for enhancements of GCBT for hoarding and other disorders.

Formal study of group processes depends both on their operationalization (Oei & Browne, 2006; Woody & Adessky, 2002) and on the reliability and validity of instruments designed to study group processes. Several instruments for measuring cohesion, mutual aid, and social contact already exist (e.g., DeLucia-Waack, 1997; DeLucia-Waack & Bridbord, 2004; Macgowan, 1997; Paine, Suarez-Balcazar, Fawcett, & Borck-Jameson, 1992) and could be further developed. Instruments for measuring universality could also be developed. These instruments could then be administered together with measures of improvement in hoarding symptoms, such as the Hoarding Rating Scale (Tolin, Frost, & Steketee, 2008) and the Clutter Image Rating (Frost, Steketee, Tolin, & Renaud, 2008) to examine the relationship between group processes and treatment outcome. Evaluating the variation in treatment outcome that is attributable to each process would also help determine, for example, whether

one process (e.g., mutual aid) confers any therapeutic benefit over and above a benefit conferred by another group process (e.g., cohesion). Such measures may be used as feedback about groups' development and to identify and address group dynamic issues during the course of treatment. Since group process and group content are likely highly interconnected in GCBT, measurement of group process alongside measurement of group content would elucidate the relative contribution of process and content to treatment outcomes. Group processes may enhance engagement and mastery of CBT skills. While the group content is manualized and thus relatively stable, the imparting of content is itself a group process (Yalom, 1995), affected by the characteristics of group members and facilitators. In general, salient group processes for any particular group may vary; however, systematic patterns in the relationship between processes and content may emerge and bear study.

Our clinical observations suggest that group processes may not only enhance improvement in hoarding, but they may also have beneficial effects on associated symptoms, such as low mood, social anxiety, and low self-worth. Further empirical study is warranted. Group CBT treatments for depression and social anxiety disorders have been shown to be as effective as individual CBT treatment, the gold standard for treating these disorders (Fedoroff & Taylor, 2001; Heimberg, 2001; Heimberg, Salzman, Holt, & Blendell, 1993; Herbert, Rheingold, & Goldstein, 2002; Morrison, 2001; Petrocelli, 2002). A number of validated measures of mood, social anxiety, and self-worth have already been developed, such as the Beck Depression Inventory (Beck, Steer, & Brown, 1996), the Social Interaction Anxiety Scale (Mattick & Clarke, 1998), and the Self-Ambivalence Measure (Bhar & Kyrios, 2000; Frost et al., 2007). Such measures, along with a measure of mutual aid, for example, could formally assess the extent to which providing mutual aid is associated with an improvement in mood, social anxiety, or self-worth. Similarly, a measure of social contact and socializing could be administered together with a measure of social anxiety to assess whether the development of this group process is associated with a reduction in social anxiety.

Another possible future research direction is to formally study the factors that contribute to the development of the different group processes. Based on our observations, punctuality and attendance may contribute to the development of cohesion, as may members' tendency to self-disclose. Of course, these relationships may be bi-directional insofar as cohesion may contribute to punctuality and attendance and to self-disclosure. These and other possible contributors to group processes could be measured (see Bieling et al., 2006).

Other important factors that may influence the development of group processes are the characteristics

and behavior of the group facilitators. Scales measuring facilitator characteristics have been developed (e.g., group-directed vs. individual-directed style, empathy) (see DeLucia-Waack, 1997; DeLucia-Waack & Bridbord, 2004) and could be used to examine the effect of facilitator style on group process development. GCBT for hoarding also provides many opportunities for interpersonal exchanges—for example, through in-session and out-of-session coaching and sorting. These features of GCBT for hoarding may foster group process development in contrast to more structured and individualized group protocols and could be formally assessed. Future research may use group process measures such as the Group Attitude Scale (Evans & Jarvis, 1986), Perceived Cohesion Scale (Chin, Salisbury, Pearson, & Stollak, 1999), the Client Satisfaction Questionnaire (Nguyen, Attkisson, & Stegner, 1983), and/or develop new assessment scales specific to GCBT for hoarding.

GCBT for hoarding appears to provide many benefits, such as opportunities for socializing and treatment cost-effectiveness. Insights from research of processes in GCBT for hoarding may help elucidate the underpinnings of this treatment and for whom it may be the treatment of choice. Future research may determine those group process effects that may be unique to GCBT treatment for hoarding and those that may be general to GCBT interventions for other disorders. What is more, further research and measurement of group process variables relevant to GCBT for hoarding may help improve this treatment and enhance outcomes for this complex psychiatric problem.

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Address correspondence to Cristina Sorrentino Schmalisch, The Lydian Center for Innovative Medicine, 777 Concord Avenue, Suite 301, Cambridge, MA 02138; e-mail: csorren@alum.mit.edu.

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