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Providing Cognitive Behavioral Group Therapy via Videoconferencing: Lessons Learned From a Rapid Scale-Up of Telehealth Services

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In response to the coronavirus disease 2019 (COVID-19) pandemic, federal, state, and local governments in the United States implemented restrictions on in-person gatherings and provided recommendations for minimum distance between individuals to minimize the spread of severe acute respiratory syndrome coronavirus 2. These restrictions necessitated an unprecedented scaling up of telehealth services across the health care system, including in mental health and substance use disorder care. The learning curve for clinicians—many of whom had no prior experience with telehealth—has been steep. The rapid shift to remote services required adjusting to technical and clinical challenges as services were being provided. The lessons learned during this time have potential to continue to inform telehealth services, even after the acute need for social distancing has abated. In this article, we aim to share some of our lessons learned during this period from providing group-based cognitive–behavioral therapy. We discuss both technical and clinical challenges in conducting remote cognitive–behavioral groups via videoconferencing software, as well as successes and failures in adjusting to these challenges.

Clinical Impact Statement

This article provides tangible technical and clinical recommendations for providing group-based cognitive behavioral therapy (CBT) using videoconferencing during the coronavirus disease 2019 (COVID-19) pandemic. Many experiential and didactic exercises can translate well, with modifications, to an online CBT group.

Keywords: telehealth, video conferencing, cognitive-behavioral therapy, group therapy, emergency responders

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Telehealth platforms for the delivery of mental health care have tremendous promise to overcome barriers to psychiatric treatment, such as stigma and limited availability of locally accessible services (Kazdin & Rabbitt, 2013; Ramos & Chavira, 2019). An extensive body of literature, spanning the past few decades, has documented the efficacy of telehealth-delivered psychotherapy as an alternative to in-person services (Fletcher et al., 2018; Gros et al., 2013; Nelson & Duncan, 2015). Reviews of the efficacy of telehealth psychotherapy consistently report comparable outcomes to in-person psychotherapy for a range of psychiatric conditions, such as substance use disorders, anxiety, and depression (Fletcher et al., 2018; Gros et al., 2013; Nelson & Duncan, 2015). For example, empirical studies found similar improvements in anxiety and depression between in-person and videoconferenced individual cognitive behavioral therapy (CBT) and between in-person and videoconferenced relapse prevention group therapy (Gros et al., 2013; Hilty et al., 2013). Additionally, studies have demonstrated similar levels of alliance between in-person and videoconferencing psychotherapy (Cook & Doyle, 2002; Simpson & Reid, 2014). Videoconferencing appears to be a particularly promising platform for the delivery of mental health services as it allows for synchronous delivery of services while allowing patients and therapists to communicate both verbally and nonverbally. Both clinicians and patients report positive experiences using videoconference-based therapy (Kruse et al., 2017; Lindsay et al., 2019) and it is now well-established that this format is acceptable and efficacious for an array of psychiatric disorders (Fletcher et al., 2018; Lindsay et al., 2019; Nelson & Duncan, 2015).

Despite decades of research on the efficacy of remote delivery of mental health services, however, the use of these services has been very limited. Before the pandemic, fewer than 1% of mental health visits were conducted using telehealth platforms (Huskamp et al., 2018; Patel et al., 2020). Videoconferenced mental health sessions were primarily conducted in underserved populations, such as individuals living in rural settings, correctional facilities, and veterans receiving services through Veterans Affairs hospitals (Kane & Gillis, 2018; Nelson & Duncan, 2015; Shore, 2013). The unprecedented societal and health care disruption caused by the COVID-19 pandemic sparked a tremendous effort to rapidly scale-up telehealth services to minimize disruptions in the availability of mental health care. In addition to the rapid changes in regulatory, payor, and information technology practices, this has also required clinicians to adjust to an entirely new delivery platform in a matter of days. In this article, we will provide a description of lessons learned from the rapid adjustment of cognitive–behavioral group therapy from in-person to videoconferencing in a residential mental health treatment program.

The Law Enforcement, Active Duty, and Emergency Responder (LEADER) Program at McLean Hospital provides psychiatric care to emergency responders and active duty military struggling with an array of psychiatric needs. The LEADER Men's Residential Program is an eight-bed program that provides intensive residential care, including medication management, individual and group therapy, and case management services with an average two-week duration of stay. Presenting conditions vary, but often include substance use disorders, depressive and anxiety disorders, and posttraumatic stress disorder. Group therapy is a substantial component of the program and consists of an array of approaches including dialectical behavior therapy, mindfulness-based therapies, and CBT, all using a transdiagnostic approach. In this article, we will integrate examples from several CBT-based groups, such as CBT for stress management, CBT for insomnia, and behavioral activation. These groups all use a combination of didactic and experiential elements (e.g., development of a coping plan, progressive muscle relaxation).

Following restrictions on the number of clinical staff permitted on campus in mid-March of 2020, several groups were rapidly (i.e., within 2 weeks) modified to be provided by clinical staff who were working remotely and to accommodate patients who were receiving care remotely (off-campus). In the following sections, we discuss challenges and lessons learned during this transition, focusing separately on technical and clinical challenges. Our objective is to provide a description of strategies that we have found to be successful (or unsuccessful) in delivering CBT via videoconferencing across levels of care that we hope may be useful to others transitioning to telehealth services. Some of the recommendations made in this article reflect access to resources available in our hospital within a large health care system (e.g., the use of peripheral devices or certain technical features); however, we note alternatives to our recommendations should certain technologies or support not be available. Additionally, other principles and recommendations may be

more broadly applicable for the application of telehealth services.

Some recommendations for utilizing telehealth have previously been published; for example, the American Psychiatric Association (APA) and the American Telemedicine Association (ATA) have provided comprehensive guidelines for providing mental health services via telehealth platforms (Shore et al., 2018; Yellowlees et al., 2010). The ATA and APA guidelines cover security, technical considerations, and regulations. These guidelines on technical considerations include: both patients and providers have their faces clearly visible on the videoconference screen, share information using a common whiteboard, and mirror the group leader's computer screen for group members (Shore et al., 2018; Yellowlees et al., 2010). In this article, we aim to complement these guidelines by providing technical and clinical recommendations based on our experience rapidly transitioning to provide remote cognitive–behavioral group therapy in a residential treatment program embedded within a hospital-based setting. Describing solutions to the obstacles encountered in this process is particularly important given the ability of telehealth groups to be disseminated widely and to increase access to high quality mental health care both during and after the current public health crisis.

Technical Challenges and Opportunities

Among the most prominent technical challenge in conducting a rapid scale-up of telehealth is the need to obtain effective and secure platforms for service delivery. In our large health care system, we were fortunate to have a robust Information Systems department that was able to quickly scale-up HIPAA-compliant videoconferencing software to providers. Our services included both groups within a residential program, where group members were on-site at the hospital (where adequate Internet connection strength and computing resources were available) as well as groups conducted with all participants remote. These delivery methods are associated with both similar and unique challenges, which are described in detail below. Table 1 provides an overview of technical challenges and potential solutions.

Staffing considerations may be important to overcome technical challenges that arise when conducting group therapy using videoconferencing. In line with recommendations both from the ATA (Yellowlees et al., 2010) and others who have adapted in-person groups to telehealth groups (Gros et al., 2013; Morland et al., 2011; Shore et al., 2018; Yellowlees et al., 2010), we found that having an on-site staff member was helpful in conducting group therapy for our residential program. First, the staff member on site was necessary to start the videoconference feed for the patients and troubleshoot any technical issues that may have arisen during the course of the group. Logistically, we found that this staff member was also helpful for getting group participants into the room on time for the group, distributing worksheets (e.g., behavioral activation schedules), and for making sure there were materials like pencils and paper in the group room. The ATA also recommends that the inclusion of any on-site staff into the telehealth group should be balanced with the consideration for the privacy of the patients (Yellowlees et al., 2010).

For our outpatient groups in which both group members and the group leader were remote, we found that communication between group members and the group leader was important to address potential technological difficulties. Similar to recommendations by Shore and colleagues (2018), for our outpatient groups, we found it helpful to familiarize new patients to features of the videoconference software and make sure that the client had access to the relevant technology. The group leader would review instructions for how to access and use the videoconference software as part of the standard screening process to participate in the remote outpatient group. This orientation before the group member joined the group served as a helpful "dry run" for when the group member would join the group and allowed the clinician to troubleshoot any issues the patient had with the technology in a personalized way. The group leaders usually allotted the first few minutes of the group time for group members to navigate calling into the videoconference. Additionally, in our outpatient telehealth groups, we found that the group leader needed to be more active before the group in reminding participants to have writing materials handy for group exercises. We found that if a group member forgot or did not have these materials then they used a notes feature on their phone to still complete the exercises. Finally, we echo APA/ATA guidelines (Shore et al., 2018) that recommend having a backup plan for the videoconference platform, typically a telephone session, in case there are issues with the audio or video in the videoconference.

Table 1
Challenges and Potential Solutions

Technical challenges	
General recommendations	• Set ground rules at the start of group for how group members participate to avoid common challenges and remind group members of these ground rules periodically during the duration of the group • Such rules include having group members raise their hands when speaking, limit side conversations, and speak as loudly and clearly as possible • Have a staff member available on site with group members to troubleshoot any technical issues (if possible) • Include training on the use of the videoconference technology as part of the screening process for the cognitive behavioral therapy (CBT) group
Audio and visual challenges	• Before the start of the group, check in on group members' availability of needed software, hardware, internet connection, and private space. • Maintain eye contact with the computer's camera whenever possible • If using a secondary device for any reason (e.g., a tablet to annotate slides), position this device directly below the computer's camera to reduce having to switch your gaze • Have patients use an external speaker • Test audio on the therapist's end and consider any needed modifications to enhance quality and clarity of sound (e.g., use of headphones rather than the computer microphone)
Software challenges	• Familiarize yourself with the software features (e.g., "whiteboards," slide presentations, annotation features) that may enhance the presentation of group material • Practice using any technical features before using them in a live group to troubleshoot challenges • When using any software features, have a backup plan, such as writing on a blank sheet of paper, should the software feature glitch during the group • Consider tradeoffs, such as reduced ability to see group members, when using a technical feature of the software • When providing instructions for an exercise, consider an introductory slide that participants can read as the therapist describes the exercise verbally • This instruction slide could be left up during the exercise
Security and privacy concerns	• Familiarize yourself with current professional association (e.g., American Psychological Association) guidelines on telehealth • Ensure software is compliant with any pertinent federal and state laws and local institutional policies regarding confidentiality and security • Determine any additional security features of the videoconference software, such as password protecting the group meeting and "locking" the meeting to new participants to further enhance protections • Verify the identity of all participants and introduce any providers (e.g., group coleaders, supervisors) to ensure only people who are authorized to attend the session are connected
Clinical challenges	
Establishing therapeutic alliance remotely	• Welcome and thank group members for their engagement in a telehealth group • Validate the difficulties of engaging in mental health care (especially remote mental health care) • Consider use of ice-breaker exercises or other informal discussions to begin the group to increase comfort in the group
Replacing nonverbal communication	• When several seconds have elapsed after asking a question to the group, ask if participants heard the question to ensure there was not a technical glitch in the audio • Call on specific group members • Ask specific follow-up questions to specific group members such as "was there something you wanted to add?" or say: "it seems that there is something you wanted to say"

Table 1 (*continued*)

Clinical challenges	
	• Explicitly ask group members if they want to share what they were saying if side conversations occur during the group
Keeping participants engaged	• Include open-ended questions as standalone text on a slide or on a piece of paper that is displayed to the group while posing them to the group verbally • Balance one to two slides of psychoeducational content with one slide of didactic engagement • Use multiple forms of engagement, such as having a slide or animation guide participants through an exercise while simultaneously explaining the exercise verbally • Ask for feedback after the exercise, including what the group members might modify about the exercise • Directly question group members for both positive and negative reactions after an exercise or worksheet • Ask regularly if group members are encountering obstacles in completing an exercise or worksheet
Providing clinical supervision	• Gain additional training, if needed, in technical features of the videoconference software • Incorporate supervisors with relevant specialties into remote supervision • When providing live supervision, the supervisor should introduce him- or herself so that participants are aware of their role • After introductions, use the audio only feature of the videoconference software when providing live supervision

Audiovisual Challenges: Seeing and Hearing Each Other

One of the earliest challenges in conducting group therapy via videoconference was how to see and hear participants most effectively. Even when a large screen is available, faces are often relegated into small boxes that make it difficult to detect nonverbal behavior or to see who is speaking. This is a particular issue for group-based services and required several adjustments.

Difficulty determining who was speaking at a given time during the group sessions constrained our ability to ensure that all group participants had an opportunity to contribute to the group discussion. We also found it challenging to call on patients by name and refer to individual contributions. Although this was exacerbated by current public health guidance requiring the use of face masks and social distancing (when group members were all in the same room and the group leader was remote), this issue is salient anytime faces are difficult to see (e.g., a small screen, poor Internet connectivity). To work around the challenge of seeing group members clearly on the screen, group leaders first explicitly identified the difficulty of engaging in remote group therapy and presented "ground rules" for accommodating this challenge. Ground rules included: (a) speak as loudly and clearly as possible, (b) raise your hand when you start speaking to help the group leader identify the speaker, and (c) avoid "side conversations" that are not shared with the full group. By setting a structure at the beginning of each group, regardless of the format, leaders were able to address patients by name and refer to their contributions throughout the session. Requesting that the group try to adhere to ground rules was positively received by the patients. After implementation of ground rules, patients consistently gestured with a hand and spoke up clearly and directly in the direction of the screen and microphone. They also began to engage in peer-monitoring. Patients either pointed or reminded one another to raise a hand. They also reminded each other to speak loudly and clearly by saying things like, "She cannot hear you mumbling." In addition, side conversations became rare after introducing the ground rules. When patients in groups did engage in side discussion, we found that a group member often stepped up to share the joke or question. We also found that it could be difficult to hear a particular group member when multiple members were speaking at once or when a group member and group leader were speaking at the same time. To address this issue, the group leader took an active role in calling on a specific group member to speak first.

The ability to observe participants was particularly important for some experiential exercises, such as progressive muscle relaxation, where observation of the proper use of the skill is important. Seeing all participants in full also allowed the group leader to check that patients were writing on notepads or worksheets (e.g., written coping plans) during group exercises. Accordingly, when the group members were all together in the same room, we arranged the group members' chairs to ensure that we could more fully observe group members. When the ability to observe all participants is limited, we also found it helpful to ask for additional feedback after an exercise or worksheet. For example, we would ask if everyone completed the worksheet or ran into any obstacles during an exercise.

Additionally, as with in-person CBT groups, it is important to make and maintain eye contact with group members. When conducting a group remotely, there were many potential distractions and it was easy to fail to notice when the therapist's gaze was diverted. When using peripheral electronics, such as tablets to present group material (e.g., to write on using a whiteboard feature), this setup required repeated diversion of the therapist's gaze. Echoing recommendations from others (e.g., Shore et al., 2018), we found that the positioning of the camera to allow for the therapist's gaze to most closely approximate eye contact was helpful with this issue. To address this, we positioned these devices directly in front of the screen with the camera, which required less switching of the therapist's gaze while maintaining the benefits of using a peripheral device. If no tablet is available, it is possible to draw on a sheet of paper and show it to the camera or ask participants to write down the group material themselves.

To overcome audio issues, we also found that using an external speaker (not just the built-in computer speaker) was beneficial to increase the volume so that the group leader could be heard as clearly and loudly as possible. Additionally, while we often found that the use of headphones by the therapist enhanced the audio connection, wireless headphones should be avoided due to both potential for poor audio connection and security issues (e.g., with Bluetooth-enabled headphones). In these instances, it was important for therapists to be preemptively prepared by knowing how to quickly disconnect their headphones from the computer without the telehealth website needing to restart. Additionally, if therapists were not using headphones, it was important to have a white noise machine to maintain privacy because patients' voices were now projected through the therapist's computer speakers.

When using a headset, it is critically important to troubleshoot problems with headphones and poor audio connection before the actual group. As the host, the group leader can begin the session early, before admitting the group into the meeting space, and test that their speaker and microphone settings are working properly. Patients also indicated that they felt more secure seeing those who joined the videoconference using headphones because it indicated an additional layer of privacy, which was especially important because patients could not see who else might be in the same room as the group leader and who might be able to overhear. Thus, use of headphones was recommended whenever therapists were working remotely, even if they were in a space alone. We found that these changes facilitated active and engaged listening on the part of the group leader and the group members.

Know the Features of Your Software

Another challenge of remote delivery of CBT was the loss of the ability to use a physical whiteboard or other resources available in the group therapy room for presenting materials. Many of the major telehealth software platforms have an array of technical features that can be used to mimic certain aspects of a traditional in-person group. Videoconferencing technology also affords opportunities to present material in novel ways to patients, although features and technical specifications will vary based on the specific delivery platform used. Below, we describe some applications that were successful in our adjustment to remote services.

When presenting psychoeducation, as per recommendations made by others (e.g., Shore et al., 2018; Yellowlees et al., 2010) we often would use a whiteboard to present information in real time and to incorporate patient suggestions. For example, in a group on sleep, we engage the group through a discussion of healthy and harmful sleep behaviors. This includes listing elements of both sleep hygiene and stimulus control that later serves as a foundation for each group member's sleep behavior modification plans. When delivered in an in-person group, the therapist simply draws a line dividing the whiteboard in half (healthy vs. harmful) and adds to either side as the group leader works through a didactic discussion with the patients. This process facilitates the engagement of group members more than providing a prewritten list, while still providing multiple ways

for patients to receive the information (verbal and written). In adapting this exercise to telehealth, our videoconferencing software had a whiteboard feature that allowed our therapists to type and display the list to group members synchronously. However, we found that using this feature came with the trade-off of the therapist and patients now only being able to see each other within small boxes at the corner of their screens. Additionally, if clinicians are using a platform that does not have this whiteboard feature or do not feel comfortable using the whiteboard feature, we found that using traditional handwritten notes held up to the screen could replace this feature. Additionally, the clinician could also cue group members to write or draw particular parts of the psychoeducational material or didactic exercise (e.g., write out a coping plan).

Weighing the costs and benefits of this trade-off may be informed by several considerations, such as (a) is there relevant clinical information which requires the therapist to carefully observe the patients in that particular moment?; and (b) are there safety concerns (are on-site staff available to address any concerns if they are missed by the group facilitator)? In other words, the use of these features requires balancing the benefits of the ability to display information on the screen with the costs of losing some clinical data and nonverbal communication achieved by clearer views of the group members. Some therapists found that they could not be as effective in generating an active discussion and building rapport when they could not see the patients in a larger box on the screen and similarly, be seen by the patients in a larger box. Therapists in our program were mixed in their opinions about the value of these features and have varied in their use. Therapists who did not continue using this strategy implemented alternative approaches to share information, such as suggesting that group members take notes during the discussion, providing handouts with the information, or verbally reminding/summarizing the information at the end of the discussion.

Other group leaders have found that in certain circumstances the benefits of these tools outweighed the benefits of seeing group members on a larger screen. As we learned more about the features of our videoconferencing software, we were able to improve on the use of this feature through use of additional add-on components. In addition to the whiteboard feature, the videoconferencing platform we used also had an annotate feature, which allowed group leaders to "draw" on a shared screen. Both the annotate and the whiteboard features work with a mouse or touchpad on most devices. Alternatively, tablets with a touch screen can be used for videoconferencing groups to allow the group leader to "write" on the tablet screen in real time and have writing appear on the shared slide synchronously. One group leader found a substantial benefit from using a tablet and stylus in combination with slide presentation software. Specifically, she used the videoconference desktop client to connect a tablet to a computer wirelessly (by using a screen mirroring feature) or with a cable. The group leader found that this solution replicates drawing and handwriting on a shared screen most naturally and regularly used this feature in her groups. This allowed the group leader to maintain observing patients in a full screen box on one device, while presenting psychoeducational material on the connected device. This allowed for the therapist to not have to decide between enhanced psychoeducational material, or more clear visualization of the patients.

Even if group leaders have familiarity with features of their videoconferencing software and have access to such technology, such features are subject to unanticipated technical glitches. For example, in one session, the therapist was unable to use the whiteboard feature as planned because the patient-facing computer glitched and would not transition to the feature. While it was heartwarming to see her patients jump to her rescue and offer to look into why the computer would not transition, the therapist knew she did not want to waste too many valuable group therapy minutes. Instead, she drew on a blank piece of paper sitting next to her desk to then show the patients through her computer's camera. A modification as simple as keeping a piece of paper and marker close by can save a session from being thrown off course by a technical malfunction. Overall, a similar strategy that we used in in-person groups of trying to continue with the group as much as possible should a problem arise also proved helpful in telehealth groups. Having a "Plan B" and even a "Plan C" although always useful in a clinical setting, may be particularly important when using telehealth platforms where technical problems can threaten to derail a group.

Not All Tech Is Good Tech

In an early group on CBT for stress, the group leader tried to use a gif (graphics interchange format) of a ball shrinking and growing to guide a paced breathing exercise. We expected that the use of a visual aid would compensate for unanticipated

issues with sound quality and perhaps make it easier to learn the technique remotely. Paced breathing (labeled "tactical breathing" for this population) was historically very well-received in group as a simple exercise for reducing autonomic arousal. However, several participants provided negative feedback to the exercise when paced using the gif. For example, one patient said that the breathing exercise made him feel like he was wearing his firefighter's mask. In trouble-shooting this unanticipated feedback, we discovered that the gif was set at a pace almost twice as fast as our typical breathing exercise. We thought we had an innovative way of presenting something, but we were just forcing patients to breathe too fast! Piloting new tech innovations—preferably with others on the clinical team before rolling them out to patients—can be indicated to ensure similar issues do not arise. We also found it helpful to (a) provide a slide of instructions for an experiential exercise (in this case tactical breathing) for group members who might not find the animation helpful before the start of the animation, (b) slow down the animation, and (c) encourage group members to stop if they felt discomfort. The changes we made to this exercise led to more positive reception in subsequent groups. Additionally, if this setup is not possible during the group, it may be helpful to have participants download and use free smartphone apps that provide guided breathing and mindfulness exercises. The use of smartphone apps to deliver self-help exercises, including meditation and mindfulness exercises, has gained increased popularity. It appears that users of smartphone apps that provide guided meditation and mindfulness use them to augment or replace traditional psychotherapy and active engagement in these apps is positively correlated with improvement in psychological health (Stawarz et al., 2018). Additionally, research is growing that supports that the use of meditation and mindfulness apps lead to reductions in distress and anxiety (see Gál et al., 2021; Linardon, 2019, for reviews).

Security

The potential for unintentional disclosure of protected health information is a significant potential weakness of telehealth services. Yet, security protection is complex and ever-evolving and can serve as a barrier to telehealth use, particularly outside of large, well-resourced health organizations. On March 17, 2020 the Office of Civil Rights in the U.S. Department of Health and Human Services announced that it would waive HIPAA penalties for health care providers who were conducting services during the COVID-19 pandemic. The decision of the Office of Civil Rights (OCR) to suspend the enforcement of HIPAA violations in this emergency situation did not preclude the need to take every reasonable step to protect the confidentiality of patients and the security of therapeutic communications. Indeed, the guidance from OCR specified that providers must be acting in good faith and provided examples of acceptable and unacceptable technologies during this time. The Office for Civil Rights at the Department of Health and Human services has provided a list of acceptable videoconference technologies on their website dhhs.gov. As such guidance will likely evolve over time, providers are urged to seek up-to-date guidance before utilizing any platform.

Security considerations include compliance with local, state, and federal regulations as well as efforts to minimize exposure when providers are conducting services from home in situations where family members, roommates, or neighbors may overhear discussions. The American Psychological Association has reviewed videoconferencing software with respect to cost, quality, and security and this information is publicly available at apaservices.org. Many videoconferencing services offer tiers of products, not all of which are HIPAA-compliant, which can lead to substantial confusion in selecting appropriate services. Free, HIPAA-compliant options are available in addition to higher cost options that may afford additional protections (e.g., location within a hospital or organization's firewall).

Although flexibility was afforded to allow for minimal interruption of clinical services during the COVID-19 pandemic, it is essential for providers to conduct due diligence by informing themselves about the security protections of their chosen software and to communicate this clearly to patients during the informed consent process. Even for secure sites and platforms, additional options and preferences may further enhance security, such as disabling videorecording, "locking" meetings to new participants, password protecting sessions and having clear procedures for ending a meeting if an unauthorized participant joins. For group sessions, it is essential to confirm that only authorized participants are attending, such as by having the meeting be password protected and/or utilizing a waiting room feature so that the group leader can individually admit group members into the larger meeting.

Understanding the default preferences of software programs and options for optimizing protection is a responsibility of providers before using any new videoconferencing or telehealth platform. Furthermore, ensuring adequate safety protections of Internet connections (e.g., use of password-protected, encrypted WiFi networks) and hardware (e.g., avoiding use of Bluetooth or other wirelessly connected devises) is both a responsibility of the provider and something that should be reviewed with patients.

Assessing Patient Experiences

As a final note, the importance of gathering patient feedback in groups should not be underestimated, particularly when conducting psychotherapy groups via telehealth. We echo and extend the points raised by others about the importance of frequently assessing patient experiences and given the relationship between patient experience and positive patient outcomes (Doyle et al., 2013; Woodward et al., 2017). In online groups, assessing patient experience is of even greater importance due to the lack of ability to assess nonverbal behavior that might give clinicians important information on how the group is progressing and because of the previously discussed added difficulty in establishing therapeutic rapport. We learned the importance of eliciting and encouraging such feedback early in the transition to telehealth following a progressive muscle relaxation exercise in a group in our residential program. Due to the aim of the camera used for a group, we were unable to see the lower extremities of patients in the group. Following the exercise, we gathered feedback from the patients. We were informed that nearly half of our patients could not extend their legs (that is a part of the exercise used to generate tension in leg muscles) due to a footrest that was not visible on our display. In an in-person group, we would have easily noticed and addressed this concern before conducting the exercise. This experience taught us not only to be sure to elicit feedback to prevent such issues in the future, but also think through experiential exercises from the viewpoint of the patient, checking that the environment allows participants to follow the verbal instructions for each exercise. Additionally, through eliciting feedback, we learned that many of our first responders worked alternating shifts that vary from 1 week to the next, making joining group virtually from a private location within their home often not feasible. This flexibility is likely necessary in other professions as well. Relaxing requirements regarding the location of the patient was helpful in this regard to support more regular attendance at groups. Even while at work, many of our patients have "down time" in which they chose to join groups virtually from a private location (e.g., gym at the fire house) or in their parked patrol vehicle. To maintain safety and privacy, we found it useful to provide frequent reminders during group for patients to temporarily log off the videoconferencing software if they needed to attend to a call, drive their vehicle, or were interrupted for any reason.

Clinical Challenges

The use of telehealth programs also raises several clinical challenges that are unique to this delivery method. One significant consideration is the management of clinical emergencies. In our implementation of telehealth in a residential treatment setting, on-site staff and emergency response systems could be quickly activated in the case of an acute exacerbation of symptoms or other emergency. Clinical emergencies are a greater challenge when participants are located off-site, at home or at another location and require advanced planning for management remotely. As such, it is important that clinicians and group members have a shared and clear understanding of risk management procedures when patients are not on site. Ideally, this conversation occurs as early as possible, typically during the intake and screening process. In this section, we describe clinical challenges we encountered transitioning from in-person CBT groups to telehealth groups. These clinical challenges and lessons learned are also presented in Table 1.

Establishing Therapeutic Alliance Remotely

One of the main challenges in a telehealth group is that the group leader could have minimal to no contact with group members before the group itself, and as a result struggle to get to know the group members. There have been a number of recommendations in the literature to help facilitate a strong working alliance via telehealth and videoconferencing platforms, including: adopting a warm and conversational tone, explicitly asking for clarification if unsure of something the patient said, and validating the patient's experience (Cowain, 2001; Simpson & Reid, 2014). There are several strategies that we used

to facilitate a warm communication style. We found it particularly helpful to be explicit in expressing gratitude to our patients. We often thanked them for seeking therapy at this time when the format of health care is changing rapidly and for the strength that it takes to share openly with someone on a computer screen whom they have never officially met in person. At the same time, we did not want to spend too much time in our telehealth groups emphasizing the difference between in-person and remote groups in case this emphasis implied that telehealth groups were inferior to in-person groups. Overall, we are reminded that for many patients, sharing their mental health issues is not always easy and we tried to keep this in mind as we proceeded with this new format.

Another strategy we found particularly helpful in establishing rapport and getting to know each other was to start the group with an introduction exercise in which all attendees of the group, including the group leader, shared his or her response to an open-ended question. For example, at the start of one of our groups, the group leader asked everyone to share one meaningful thing that happened to them that day. Everyone, including the group leader, shared their responses, such as: "we got a shipment of fresh fruit" and "I spoke to my kids today." As with in-person groups, the use of these "ice breaker" questions was a helpful way to have the group leader and group members get to know each other, to become comfortable sharing personal experiences in a telehealth group, and to establish rapport. These icebreaker questions gave each participant their own space to speak and also allowed for the facilitator to identify and quickly resolve any issues with audio or visual issues that would arise before the starting the main content of the group.

Establishing rapport remotely may also entail some self-disclosure from therapists to humanize the face on the screen and build rapport. One of our therapists practiced this principle through engaging group members in conversation before the beginning of each group, with patients who had logged on early. Conversations ranged in theme, but generally entailed shared interests, hobbies, and activities. During these conversations, the therapist intentionally disclosed activities of their own such as exercise routines, fishing, and hiking. Another simple yet effective way we practiced more self-disclosure in group therapy was for the therapist to provide personal examples before asking open-ended questions for psychoeducation purposes. For example, in our CBT for Sleep group, before one group leader asked, "How has COVID affected your sleep?" the leader chose to share that she'd noticed greater difficulty disconnecting with technology in advance of bedtime due to the volume of COVID-related news circulating. These additional self-disclosure practices functioned as a model by which patients in telehealth group therapy based their responses and participation while also establishing rapport. We found the practice to be especially helpful in groups where patients were located in the same room together while the therapist was in a remote location.

We also found that validation was a key strategy to establish rapport during telehealth groups. Validation is known to help quickly establish therapeutic rapport and facilitate engagement (Fruzzetti et al., 2018) and this is especially important in telehealth groups when the group leader could be "seeing" group members for the first time. We found it helpful to discuss both shared experiences, such as the ongoing social distancing during the pandemic, while also highlighting the distinct experiences of the group members who were working as first responders during this public health crisis. For example, when presenting psychoeducation about managing stress, we found it beneficial to validate the personal experiences of our first-responder patient population. A portion of the stress group is dedicated to proactive coping strategies—we began by acknowledging the hardship of erratic sleep schedules that are often a feature of a first responder's job that can then exacerbate stress. One group member shared: "That kind of stress keeps me up at night and then I'm tired and on edge all the time." Adopting this style of highlighting shared and unique experiences led to visibly more engagement in writing exercises and more feedback after experiential activities in groups.

In our experience with telehealth group therapy, just as in in-person group therapy, rapport among group members, and between group members and the group leader(s), was a key part of the therapeutic process. One of the main advantages of videoconferencing, as opposed to other forms of telehealth such as text message support or telephone calls, is that videoconferencing allows the group members and clinician to both see and hear each other in real time. Videoconferencing also provides the shared experience of seeing the same slides and interacting with the same virtual whiteboard.

In summary, we found that validation, increased use of open-ended and ice breaker questions, and increased self-disclosure greatly improved the

feeling of rapport between group members and the group leaders. Although some of these activities can take time away from the more directed content of the group, this time was well-worth it in our experience to engage patients and to achieve a level of comfort and buy-in before beginning the group content.

Nonverbal Communication: Making the Nonverbal Verbal

In conducting groups by video conference, we were reminded how commonly therapists rely on nonverbal communication. Even simple behaviors and gestures like head-nodding, making eye contact and leaning in toward group members cannot be relied on when the clinician is on a screen, especially when confined to a small box on a screen. In determining how best to modify or replace these nonverbal communication strategies, we first considered the function of these behaviors to determine potential modifications.

One example of this is pausing to allow for a period of silence. In a telehealth session, a pause can easily be misinterpreted by patients as a technical glitch rather than an intentional communication strategy. In some circumstances, this behavior is used after a difficult disclosure from a patient to allow the patient a moment to either continue to speak or to ensure that the therapist is not moving on too quickly (potentially invalidating the patient). In other circumstances, periods of silence are used to give group members the opportunity to think about a question before answering. These two functions required different replacement behaviors. In the case of allowing a silence following a difficult disclosure, more direct and verbal validation or noticing the moment may be indicated (e.g., "thank you for sharing that," or "it sounds like you have been feeling really overwhelmed"). Encouraging patients to speak, on the other hand, may simply require either repeating the question or calling on a particular group member to answer.

The importance of nonverbal communication flowing from patients to therapists was another factor that we needed to start thinking about differently. We had not realized just how clinically valuable it was to catch the subtle expressions of our patients, which can prompt us to ask things like: "Did you have something you wanted to add?" or "It seems like maybe you had something else to say." This may be particularly important for patients who are more reserved or who struggle with social anxiety. With patients' faces being somewhat blurry, too small to decipher, or hidden by a mask, we have learned to rely much more on circling back to a patient's previous comments, calling on specific group members more often than we normally might in an in-person group, and leaving more space for patients to speak up by asking questions like: "Any other thoughts on that?" Likewise, asking specific patients if they have anything to add when they have been quiet during the group can be a useful strategy in this setting.

One issue that arose across groups was group facilitators occasionally noticing patients holding brief side conversations with other patients (when in the residential program). We frequently could not hear what was said during these conversations, which made it difficult to discern if the content was relevant for the group. We found a few considerations useful during such instances. To our knowledge, this issue has not been addressed in prior literature. First, it is possible a side conversation is related to a common difficulty with a group exercise (e.g., "I do not understand what we are supposed to be doing."). Side conversations also may occur following one of the aforementioned technical issues or being unable to hear the group leader. In our totally remote outpatient groups, side conversations also were more common because group members are participating in groups while at home or in an environment where other nongroup members are present. We were careful to remind ourselves that many cues we might otherwise easily notice could be imperceptible or distorted through our videoconferencing software, so hasty conclusions that a patient's conversation was unnecessary or disruptive could be inaccurate. Given these considerations we found that taking an approach of genuine curiosity when addressing such issues was useful. When the group leader noticed a side conversation between group members, he or she would explicitly ask about the nature of the conversation, or, if the group leader suspected that a technical glitch had just occurred, he or she would explicitly ask if the audio or video stream had cut out.

Didactics—Strategies to Keep Participants Engaged

Didactic and psychoeducational groups can be difficult to lead in the best of circumstances. Skilled group leaders are able to "read the room" and adjust pacing and style to optimize engagement and learning. This becomes much more challenging via videoconference.

One important lesson we learned was that we needed to change how we asked open-ended questions to the group once we transitioned to providing group therapy via videoconferencing. In an in-person group, we simply would ask the group open-ended questions when providing psychoeducation or when debriefing after an experiential exercise (e.g., "What was challenging about the deep breathing exercise?"). We found this challenging in a telehealth platform due to technical difficulties that led to uncertainty over whether participants were not responding because they did not hear the question or because they were reticent to respond. We discovered that an effective modification of asking open-ended questions was to add the open-ended question into a slide presentation—for example: "What was challenging about the deep breathing exercise?" appeared as stand-alone text on a slide that followed the breathing exercise. Alternatively, group leaders could hold up a sheet of paper displaying the open-ended question.

Another strategy we found particularly helpful was balancing one to two slides of psychoeducational content (e.g., the body's physical response to stress) with one slide of engagement (e.g., asking the group "how do you feel stress in your body?"). For example, after providing a model of how anxiety can lead to changes in physical sensations, thoughts, and behaviors, the following slide included text under each of these headings explicitly asking participants in the group to comment on how they experienced that particular facet of anxiety. For example, under physical sensations, text appeared asking: "What physical sensations do you notice when you feel anxious?" This format also helped with the flow of the group as patients began to anticipate this back-and-forth interaction and may increase motivation to attend to the didactic component of the slides.

Another way that we kept participants engaged was to gather information at the start of the group that would allow us to personalize content later in the group. Circling back to patient's previous comments also proved useful in our CBT for sleep group. At the start of this group, the leader asked each participant to share their name, profession, and how the patient's own sleep has been. It was helpful for the group leader to explicitly return to the experiences each group member had shared as they discussed psychoeducation on sleep and skills for improving sleep, which allowed for group members to be more fully engaged, to show the applicability of the group content, and to create a more conversational discussion.

Experiential Exercises—Engaging From a Distance

Experiential exercises are another challenge. Strategies we might usually deploy, such as walking around a room to check on progress or modeling an exercise are limited in a videoconferencing format. We noticed that when we engaged patients in experiential exercises, they benefited from using multiple modes of communication. This included using the slides or whiteboard feature, a handout (if possible due to on-site staff), or a video of the exercise depending on its complexity. Checking in frequently with questions about an exercise or confusion about the exercise was also essential. For example, before the tactical breathing exercise, the group leader first provided a slide walking through the exercise and asked: "What questions about the exercise do you have?" Once the exercise started accompanied by a gif animation to help with pacing, the group leader verbally counted the in-breath and out-breath to provide guidance during the first few breaths. After the exercise, the group leader probed for what modifications the group members would suggest to make the exercise more beneficial to them. In our experience, pausing for questions and providing guidance before, during, and after experiential exercises enhanced our ability to engage participants in these exercises.

In response to patient feedback, we expanded our use of worksheets. Of note, patients provided consistent, positive feedback about written exercises, which is generally in contrast to our experience with in-person groups. For example, in one group, participants completed a stress coping plan consisting of individualized strategies for distraction, seeking social support and ways to combat anxious thoughts. As the group leader was verbally walking through how to complete the worksheet, text of the particular section of the worksheet that she was describing simultaneously appeared on the screen (e.g., "Distraction") and she used the annotate feature to write group members' examples underneath the heading. In an in-person group, group leaders can easily see if a particular group member was struggling to complete a worksheet. If the clinician does not have access to technology that would allow for slide sharing, the leader can hold up the worksheet and circle or point to which part of the worksheet he or she is describing or write out group members' responses and hold the piece of paper up to the camera.

Given the difficulty seeing participants in a small box on a videoconference screen, we found it helpful to check in with group members' progress more frequently than we would in an in-person group. For example, while participants were completing the coping plan worksheet, the group leader asked at regular intervals: "what questions do you have?" and "any challenges you're running into when completing this?" Soliciting examples from group members' coping plans after they completed the worksheet was another helpful way to troubleshoot and correct any issues that arose when group members completed worksheets. Overall, we found that group members had positive feedback about "putting ideas on paper" and having a tangible worksheet to take with them from the group.

Negative nonverbal reactions to experiential exercises, such as deep breathing, are much easier to assess in an in-person group because they can be more easily seen. When conducting experiential exercises in a telehealth group, we recommend that the group leader explicitly solicit both positive and negative reactions to the exercise from the group and to respond nondefensively when patients dislike an exercise. For example, after a group leader conducted a progressive muscle relaxation exercise, she asked the group members what benefits they noticed ("It was relaxing") and what obstacles they encountered ("It made me almost take a nap" and "It was difficult to do that on this particular couch").

Conclusion

In conclusion, while the rapid transition from in-person to telehealth CBT groups was unanticipated, we found that we learned key lessons that will shape our provision of clinical services even once the current public health crisis has abated. On the technical side, we found that trial and error and practice allowed us to harness technology and features of the telehealth platform. Exploring these features was not without challenges, and we discovered that practicing these features in advance, having a backup plan and weighing the pros and cons of any new feature were useful in navigating our use of technology. One of our biggest take-home lessons was the need to be flexible and adaptable as unanticipated challenges arose and continue to arise over time. This will continue to occur as new features and platforms are developed and as policies related to the utilization of telehealth continue to evolve.

It is important to note that although telehealth is a valuable resource, there continue to exist barriers to its use. A significant concern as telehealth services expand is issues with equitable access to these services. Our experience in a large, well-resourced health care setting provided many advantages for the ability to expand telehealth services rapidly. These advantages were not only technical (e.g., access to software and hardware, technical support) but also logistical (e.g., adequate time for staff to prepare materials, residential treatment format). Furthermore, at our site, most patients had some basic knowledge of technology and access to necessary equipment (either provided on-site or available off-site). Numerous barriers, such as inadequate access to hardware (e.g., web camera, laptop, or smartphone), software and high-speed Internet disproportionately affect certain groups. Although providing telehealth services may remove some transportation-related barriers, it can also bring new challenges, such as the need for a safe and private location for patients to engage in care. It also does not preclude barriers to mental health care in general, such as the need for child or elder care, or irregular or lengthy work schedules. As such, many health care centers, such as those in rural areas or urban areas with higher rates of scarcity, may not have the resources to mobilize telehealth rapidly, and many patients may not be able to capitalize on such interventions even if they are available. Such issues of equity will be essential considerations in the expansion of telehealth.

Overall, the delivery of clinical services was, in many ways, more similar than we initially expected. We were able to retain the array of didactic and experiential exercises as well as interactive groups discussions that we used during in-person services. Nonetheless, we had to make adaptations to our delivery style to reduce reliance on nonverbal communication while still maintaining fundamental principles of treatment delivery, such as demonstrating warmth and developing a therapeutic alliance with the group members. Likewise, we had to be more explicit in our assessment of group members' experiences due to difficulty observing their nonverbal behaviors.

In conclusion, we would like to acknowledge that the use of telehealth to provide mental health services is ever-changing and that maintaining knowledge of best practices is ongoing. Clinicians should remain alert to the most recent technical and clinical recommendations and be aware of newly arising challenges in each group session. Soliciting

feedback and advice from group members can be a valuable resource in striving to remain creative and flexible. While the landscape of telehealth mental health services has changed and continues to change rapidly, we hope that these technical and clinical lessons learned prove useful to clinicians who will be providing telehealth group therapy for many years to come.

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