The Potential Power of Virtual Group CBT

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Cognitive behavioral therapy (CBT) is an effective treatment for common mental health conditions such as depression and anxiety. Yet, there is a shortage of mental health providers[1] who can offer CBT, which has only been compounded by the COVID-19 pandemic with increasing mental health distress, increased isolation, and a disruption of many health services.[2] Postpartum individuals have been exceptionally affected during the pandemic, as they have been required to transition to motherhood and/or caring for a vulnerable newborn, often with limited support from family members and community due to social distancing recommendations. It is not surprising that rates of postpartum depression and anxiety have increased over the pandemic.[3] Given this context, I greatly appreciated reading about the randomized controlled trial conducted by Huh et al of their online nurse-delivered group CBT (gCBT) for postpartum depression.[4] There are 4 key aspects of the study intervention that I find particularly exciting. Each of these 4 elements point to implications for further research and potential for enhanced access to effective mental health treatment beyond the perinatal population, and an intervention that integrates all 4 aspects seems highly innovative and promising given Huh and colleagues' findings pertaining to improvement in mental health outcomes.

First, the *group-based* feature of this intervention is efficient in serving more individuals in need within a given timeframe. Additionally, the group aspect provides built-in peer support and sharing, which has the potential to decrease isolation that is detrimental to well-being.[5] New mothers are prone to experiences of loneliness and isolation,[6,7] and thus applying the value of peer support services[8] may be considerably beneficial to the postpartum population. Members of gCBT can provide validation and normalization of experiences, and the group can allow for sharing of how participants have found application of CBT skills helpful or applicable. The Huh et al findings of a significant decrease in depression for gCBT participants are promising; future research is needed to explore for whom group vs individual CBT may be most effective or appropriate. Additionally, further attention to studying potential unintended consequences of groups (eg, the possibility that some participants feel more isolated if they are not "relating" to members of the group, or occurrence of unhelpful comparison thoughts during the group) and guidance on how to clinically manage such issues are needed.

Second, it is worth highlighting that there may be a range of support groups that exist for postpartum women, but not as many that *provide CBT,* as is done in the Huh et al intervention. In addition to the value of increasing access and providing peer connection through a group format, this intervention also provided participants with CBT skills that are known to be effective for a range of mental health conditions. Such points to the potential of a comparable intervention to be offered for other mental health conditions for which CBT is an effective treatment, such as anxiety disorders in the postpartum. Given that CBT has also been found to *prevent* future episodes of depression,[9,10] it's also worth considering whether a group-based CBT intervention could be delivered in pregnancy among at-risk individuals to prevent postpartum depression, or depressive relapse in other at-risk populations.

Third, this gCBT intervention was effective at decreasing depression and worry *when delivered by* a *non–mental health professional.* The feasibility of having facilitators other than mental health specialists deliver this intervention speaks to the potential for broader dissemination and scalability. Huh et al specifically utilize public health nurses (PHNs) to deliver their virtual gCBT program, pointing to the possibility of other clinical or even lay professionals being capable of effectively delivering such an intervention. There has been promising research on peer-delivered CBT for postpartum depression as well[11]; efforts to share or shift tasks (ie, mental health care) from more to less highly trained individuals can be cost-effective and broaden availability of such services.[12] Huh et al note that they did not include formal measures of fidelity for intervention delivery due to resource constraints in the pandemic and that formal psychotherapy supervision was not provided to the group facilitators. Further guidance and implementation

research, including intervention fidelity assessments, would be beneficial to identify necessary training and supervision structures for when such interventions are delivered by non–mental health specialists. This could also include a structured safety protocol that would be utilized in the context of interventions for depression when there are concerns of suicidal ideation or self-harm.[13]

Finally, the *virtual* nature of the gCBT intervention reported on in Huh et al is exciting and aligns with other research supporting the effectiveness of virtually delivered CBT.[14–17] The field would benefit from additional research comparing virtually delivered group CBT to in-person group CBT. The COVID-19 pandemic prompted a need for virtually delivered therapy, and the benefits of such a delivery format may very well extend beyond the pandemic due to the improved feasibility of participant attendance. Particularly for the postpartum population, for whom balancing childcare concerns or logistics of travel and time are often challenges, the convenience of being able to access effective mental health interventions from one's own home is appealing and may enable more patients to access care more consistently. Further implementation research on virtually delivered group therapy would be helpful, in terms of navigating potential distractions at participants' homes and navigating individual participant-level needs (eg, suicidality) or other issues (eg, participants' feelings of openness to disclose or share when family members are nearby/in another room) that might arise. Assessment of barriers and exploration of whether certain populations are more or less likely to engage in virtual group therapy is needed.

I am impressed by Huh and colleagues' innovative and timely approach to addressing postpartum depression through the virtual group CBT intervention. Their findings are encouraging and point to a hopeful model for expanding access to effective evidence-based interventions (eg, CBT) serving populations beyond postpartum women and for conditions other than depression. Key areas for research going forward could include hybrid effectiveness-implementation designs, which blend design components of clinical effectiveness and implementation research and can provide benefits over pursuing these lines of research independently (eg, more effective implementation strategies, more useful information for health care stakeholders).[18] Additionally, research inspired by precision medicine (eg, determining for whom group CBT interventions are most effective) and research on possible unintended consequences of virtual group therapy are needed. Furthermore, in a time when many health care providers are experiencing burnout,[19] there needs to be adequate incentives and billing options for health care providers to be able to facilitate (or supervise, in the context of lay-professional facilitators) such groups to ensure sustainability of having such services offered.

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