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Patient Acceptability of Group Transdiagnostic Cognitive-Behavior Therapy for the Treatment of Anxiety Disorders in Community-based Care: A Qualitative Study

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Abstract

Objective: Cognitive-behavior therapy (CBT) is a research-supported treatment for anxiety disorders. Transdiagnostic CBT protocols have been recently developed to manage multiple anxiety disorders. The efficacy of transdiagnostic CBT is directly dependent on acceptability as perceived by patients and health care providers. In this study, we sought to examine the acceptability of transdiagnostic CBT from the patient perspective within the context of a community-based group delivery for mixed anxiety disorders. *Method*: An embedded qualitative study was conducted as part of a pragmatic randomized clinical trial of group transdiagnostic CBT for anxiety disorders. Semi-structured interviews were conducted based on a meta-framework of the concept of acceptability. Acceptability of the therapy was examined with a thematic analysis of interview verbatims. *Results*: Seventeen patients were interviewed. Patients' perception of acceptability of tCBT was classified into eight themes: 1) therapy features; 2) intervention components; 3) group format; 4) group cohesiveness; 5) co-therapists with different expertise; 6) quality of therapeutic alliance; 7) perceived effectiveness; and 8) access to the therapy. *Conclusion*: The acceptability of transdiagnostic group CBT for patients was generally perceived as adequate in the context of a community-based therapy. Recommendations to enhance acceptability of the group therapy were related to group size, group dynamics and exposure.

Keywords: anxiety disorders, group therapy, patient acceptability, qualitative study, transdiagnostic cognitive behavioral therapy.

Key Points

What is already known about this topic:

- Transdiagnostic group CBT is an effective treatment for anxiety disorders.
- Studies generally report good acceptability for CBT, but dropout rates suggest a potential area for improvement.
- To date, few studies have examined the comprehensive concept of acceptability of CBT from the patients' perspective.

What this paper adds:

- A qualitative study was conducted with a meta-framework of the concept of acceptability in the context of a community-based therapy.
- The acceptability of transdiagnostic group CBT for patients was generally perceived as adequate.
- Recommendations to enhance acceptability emerged from participants' experiences concerning the topics of group size, group dynamics and exposure.

Patient Acceptability of Group Transdiagnostic Cognitive-Behavior Therapy for the Treatment of Anxiety Disorders in Community-based Care: A Qualitative Study

Recent advances in the delivery of CBT are marked by a growth in transdiagnostic treatment protocols. Unlike conventional CBT protocols for specific anxiety disorders, transdiagnostic CBT (tCBT) works from the premise that the cognitive and behavioral processes common to different anxiety disorders are of greater clinical importance than the differences in their causes and maintenance factors (Norton & Roberge, 2017). tCBT for anxiety disorders uses a single protocol involving evidence-based intervention techniques, including psychoeducation, cognitive restructuring, exposure, and relapse prevention, common across the anxiety disorder spectrum (Norton & Roberge, 2017). The efficacy of tCBT has been established for the treatment of anxiety disorders and related comorbid emotional disorders, and tCBT can be delivered in individual, group and digital formats (Newby et al., 2015; Newby et al., 2016; Pearl & Norton, 2017; Reinholt & Krogh, 2014). As well as clinical treatment outcomes, the potential for successful dissemination and implementation of tCBT requires a careful examination of the intervention, including treatment acceptability from both health care provider and patient perspectives (Proctor et al., 2011).

Research examining CBT modalities have mostly focused on efficacy, adherence and, to a lesser extent, treatment perception measures to demonstrate the acceptability of the theoretical approach, treatment modalities and specific components for patients. A meta-analysis of 115 studies has examined dropout rates of CBT for a range of mental disorders and reported estimated dropout rates of 15.9% at pretreatment and 26.2% during treatment (Fernandez et al., 2015). The authors also provided dropout rates specifically for

anxiety disorders (11.4% and 19.6%) and group interventions (14.5% and 24.6%). Dropout rates highlight a potential area for improvement in treatment outcomes with CBT interventions. However, observed behaviors (e.g., dropout rates, discontinuation) only provide an indirect measure of acceptability as there are several reasons for discontinuation, such as study participation burden or improved health status (Bentley et al., 2021; Roberge et al., 2020; Sekhon et al., 2017).

Studies generally report good perceived acceptability, credibility, and satisfaction for CBT in a range of formats, including individual, group and digital therapies (e.g., Andrews et al., 2018; Deacon & Abramowitz, 2005). Moreover, CBT is the treatment preferred by patients over pharmacotherapy (McHugh et al., 2013). However, few studies have examined challenges in uptake and treatment adherence from the patient perspective to provide insights for improvement for anxiety disorders in adults (Fernandez-Alvarez et al., 2017; Naik et al., 2013). In an exploratory study of a group delivery of the unified protocol, patients with anxiety disorders and comorbid depressive disorders reported good acceptability and satisfaction rates (Bullis et al., 2015). An examination of client perception of group tCBT in a clinical trial found that having a supportive therapist was rated as the most helpful. Specific treatment components were also considered helpful, but in-session exposure exercises were rated less favorably than cognitive restructuring (Smith et al., 2013). A particular area that has drawn attention regarding CBT acceptability concerns patient perception of exposure-based interventions. Most studies in that area have been conducted with therapists to examine negative beliefs, perceived fear of harms and underutilization of exposure and response prevention (e.g., Deacon, Lickel, et al., 2013; Gunter & Whittal, 2010; Olatunji et al., 2009). There is little empirical data addressing this

acceptability concern from the patient standpoint, and they suggest that patients perceived this component as effective and that it outweighs concerns about perceived risks and distress (Becker et al., 2007; Cox et al., 1994; Norton et al., 1983).

In the present study, we sought to broaden our understanding of acceptability from the patients' perspective. We relied on an extensive multi-construct conceptual meta-framework for the acceptability of healthcare interventions developed by Sekhon et al. (2017) to characterize acceptability in terms of behavioral, affective or cognitive responses to the intervention. The qualitative study is embedded in a pragmatic clinical trial of tCBT for anxiety disorders (Roberge et al., 2020), which provides an opportunity to examine acceptability as it relates to an evidence-based transdiagnostic protocol for anxiety disorders (Norton, 2012a), to a group modality, as well as to treatment delivery in community care.

Method

Study design

This descriptive qualitative study (Sandelowski, 2000) was embedded in a multicentre pragmatic randomized controlled trial (Roberge et al., 2020) conducted in Québec (Canada). The trial aimed at examining the effectiveness of group tCBT (Norton, 2012a) as a complement to treatment-as-usual (TAU) for mixed anxiety disorders: generalized anxiety disorder (GAD), social anxiety disorder (SAD), panic disorder (PD) and agoraphobia (AGO). A brief overview of the clinical trial is presented below, and complementary information can be obtained from the published study protocol (Roberge et al., 2018). The research protocol was approved by local ethics review boards.

Overview of the randomized controlled trial

Participants. Participants were recruited in the community through advertisement on bulletin boards and geo-located Facebook and Google AdWords. The clinical trial included adults aged 18 to 65 years old, fluent in French, whose primary diagnosis was one of the four targeted anxiety disorders according to a clinical severity rating (CSR) $\geqslant 4$ for the Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5) (Brown & Barlow, 2014). It excluded individuals who had had active suicidal ideation, psychosis, bipolar disorder, or an active substance abuse disorder, cognitive impairment or who had consulted a psychiatrist in the past year. Participants meeting eligibility criteria (n = 231) were randomly assigned to group tCBT + TAU or TAU. Randomization at the patient level was stratified by site. The tCBT intervention was carried out with groups of 7 to 12 participants in weekly two-hour sessions over 12 weeks (i.e., larger group sizes than recommended in Norton, 2012a).

Intervention. The intervention was based on a group tCBT protocol for the treatment of anxiety disorders (Norton, 2012a). tCBT included psychoeducation (1.5 session), anxiety-specific cognitive restructuring (1.5 session), graduated exposure (6 sessions), schema-based cognitive restructuring of core beliefs (2 sessions), and relapse prevention (1 session). We conducted 12 groups facilitated by dyads of accredited psychologists or psychotherapists, the first with at least two years of clinical experience in CBT and the second from community-based care with mixed CBT experience. Initial training was provided with a 2-day workshop (PJN), and consultation (MDP) was provided through case discussions (pre-treatment, between sessions 3–4, 6–7, 10–11, post-

treatment). Therapeutic treatment adherence and competence was only assessed at the end of the trial by a random review of audio recordings.

Procedure. Assessment of participants was conducted at 4 months (posttreatment), 8 months and 12 months with both patient- and clinician-reported measures.

Embedded qualitative study

Participants. Recruitment was carried out at the three sites of the RCT, from August to November 2017. Our embedded study applied the same eligibility criteria, but also required that participants had completed at least three of the 12 tCBT sessions to ensure at least a minimal experience with the intervention. Participants were recruited among the experimental group using a maximum-variation purposive sampling strategy based on three variables: sex, primary diagnosis, and treatment adherence. Participants were considered adherent (9 to 12 sessions), moderately adherent (6 to 8 sessions), or non-adherent (3 to 5 sessions). They were invited by email or telephone by the research coordinator, and interviews were scheduled with consenting participants. Participants were recruited until data saturation had been reached (Guest et al., 2006).

Data collection & instrument. The semi-structured interview guide was based on the Sekhon et al. framework (2017) consisting in seven constructs: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy. Questions concerning themes related to tCBT components, group format, tCBT transdiagnostic aspect, therapists, didactic material provided, homework and exercises, efforts required, and perceived effectiveness were added to the interview guide.

The guide was pre-tested with a participant and the data obtained were integrated into the analyses. Supplementary Table 1 presents an overview of questions by themes.

Procedure. Participants were met at the four-month post-intervention interview, which lasted on average between 45 and 60 minutes. The interviews were conducted either in person, by telephone, or via an Internet platform by the principal author as part of her master's work, and she was not involved in any phase of the RCT. The interviews were audiotaped and transcribed. The audiotapes of the first interviews were listened to and feedback was provided by two co-authors (PR, IG) to ensure the rigor of the interviews.

Data analysis

The interview corpus was analyzed according to an interactive thematic analysis model (Miles et al., 2014). The initial coding tree was developed using the Sekhon et al. (2017) conceptual framework and the interview guide, with new codes emerging during the transcript coding process. The verbatim transcripts were coded and analyzed by the principal author and three interviews were co-coded (PR and IG). Field notes taken right after the interviews also assisted with preliminary data analysis. Regular team meetings were held to ensure the confirmability and credibility of the findings. Matrices cross-referencing the themes among themselves or the themes with participants' characteristics were generated to verify emerging hypotheses and enrich the analyses. The NVivo software (QSR International Pty Ltd. Version 12) was used to facilitate data coding.

Results

Among 30 patients approached, seventeen from five different tCBT groups, spread among the three sites, underwent individual interviews. The participants' mean age was 33

(±12) years, and most participants were women (n = 13), with a principal diagnosis of GAD (n = 10), and comorbidity with other anxiety disorders (n = 15). The majority reported having consulted a psychologist (n = 13) or used an antidepressant medication (n = 12) in the past 12 months. Table 1 summarizes the participants' characteristics. The factors contributing to the intervention acceptability among participants were classified under eight themes: (1) therapy features, (2) intervention components, (3) group format, (4) group cohesiveness, (5) co-therapists with differing expertise, (6) therapeutic alliance, (7) perceived effectiveness, and (8) access to therapy.

Insert Table 1

Theme 1: Therapy features

In general, the interviewees reported being very satisfied with their group tCBT experience because they perceived a decrease in their anxiety symptoms post-therapy. At the onset of therapy, upon learning from other participants about the heterogeneity of anxiety disorders experienced within their treatment group, a few participants were afraid that they would derive limited benefit from therapy. However, these fears dissipated for the vast majority as they engaged in treatment, and some even reported an appreciation of both differences and commonalities in the broader view on the nature of anxiety shared by others.

> *"It helps you understand [that there are] other things as well, [that] it's not just your own fear, or your own anxiety."* (P6, adherent)

In addition, the participants reported that a certain distance in the experiential knowledge of anxiety allowed for a lesser shared emotional burden and a capacity to provide genuine solutions or perspectives that had not occurred to these other participants. One participant reported that meeting people with other anxiety disorders had enabled her to accept her own disorder and stand up for herself when she felt she was being judged. Another participant mentioned that even when she did not identify closely with the experience recounted by another person with a different anxiety disorder, she still learned about anxiety and took away some useful strategies to manage anxiety given by others.

> "*There were people who had a panic disorder, others who had... it was [diversified]. However, we had the same fears, the same physical reactions, the same emotional reactions. It was reassuring, [and it allowed us to create] a bond with the other participants."* (P11, non-adherent)

Theme 2: Intervention components

Perceived acceptability of tCBT varied across the four components of the treatment protocol (Norton, 2012a). Psychoeducation was appreciated by all participants as it helped improve their understanding of the nature and causes and symptoms of anxiety in a reassuring manner from a reliable source:

> *"[I'd already read about anxiety before], but just the fact of hearing it from professionals, that makes it a little more credible. Sometimes, the [information] sources you read are not always the best."* (P7, adherent)

Prior literacy about anxiety disorders among participants was fragmented. The participants reported that the therapists' skill in presenting the information in accessible terms and providing graphic examples helped truly understand the learning content,

regardless of their prior level of knowledge about anxiety and CBT. Also, the therapists' explanations were given in such a way that no one was made to feel stigmatized.

Graduated exposure to anxiety-inducing situations could be described as a state of ambivalence for most participants in terms of appreciation and delivery. Even though they recognized it as a credible and essential strategy to help reduce their anxiety symptoms, affective attitudes regarding exposure were mixed. While acknowledging that exposure exercises offered some benefits, the emotional discomfort and high levels of anxiety experienced during the exposure exercises were often mentioned. Among factors raised by participants with regards to the lived experience of carrying out and persevering in exposure exercises, the group therapy experience was mostly perceived as a facilitator. The presence of other participants provided encouragement and support, while at the same time exerting a certain amount of peer pressure to face their fears and not disappoint others. They appreciated having to do exposure exercises on site during the sessions, as it fostered engagement and participation. The graduated hierarchy, the ability to restructure negative and catastrophic thoughts and the little push from the therapists were also reported as helpful. The perception of credibility of the therapy was enhanced as exposure exercises were associated with a decrease in anxiety levels. Among facilitators external to therapy, participants mentioned their personal commitment to therapy and motivation to overcome anxiety, as well as the support and encouragement provided from family.

The experience of conducting exposure exercises in a group format was also perceived as challenging for some participants, as they were cognizant that targeting the optimal exposure exercises is associated with improved clinical outcomes. They reported that exercises conducted within the constraints of the time and place of therapy were

sometimes suboptimal in terms of appropriateness and degree of difficulty with regards to their own anxiety profiles, as well as for the diversity of feared situations experiences by their peers. For example, some interviewees who had done imaginal exposure or role-playing exercises reported not finding these exercises helpful in terms of desensitizing them to the anxiety-inducing situation because they did not generate a high enough level of anxiety, required a level of concentration difficult to attain in the group context, and were believed less realistic and relevant than *in vivo* exposure in some cases.

> "*I understand that we are limited in situations like this, but I found it a little difficult to play a role. [I was] not in the real awkward situation. It's difficult for me to pretend and have the same symptomatology as if I were in the real situation*." (P5, adherent)

By contrast, two interviewees reported finding the exposure exercise experience too anxiety-inducing; in fact, it caused them to suffer a panic attack and was very distressing to them. One participant gave this as the reason for her decision to drop out of the therapy.

The cognitive restructuring components of the intervention were reported as the most appreciated by many of the interviewed participants. They found cognitive restructuring most useful, because as it provided tools and concrete strategies for identifying and confronting automatic thoughts. Some participants reported that it would have been beneficial to have had a few additional sessions devoted to this component and reported having been unable to work on and explore their thoughts sufficiently due to a lack of time.

"Well, one of the things I found was that, the therapy put a lot of emphasis on exposure

and less on restructuring thoughts. Personally, I would have needed more sessions on restructuring my thoughts." (P15, adherent)

In addition to group sessions, the tCBT intervention also involved self-monitoring, cognitive restructuring, and exposure exercises between the therapy sessions. Despite their awareness of the considerable time and energy demanded by the tCBT exercises, the participants found the workload reasonable.

Theme 3: Group format

Participants reported several benefits derived from the group format, such as identifying with others, breaking their isolation, and receiving peer support. Despite their different types of anxiety, participants reported having identified with and recognized themselves in the experiences of others, and no longer feeling alone in experiencing anxiety in certain situations, which helped to "normalize" and destigmatize the experience of anxiety.

> *"It's [reassuring] to see that we're not alone with certain behaviors that we sometimes find ridiculous, but that we just can't handle otherwise. […] The impression of not being an alien."* (P11, non-adherent)

Apart from the benefits, some of the interviewees reported that the group format made it harder for them to share their own lived experience. They felt somewhat uncomfortable about "baring their souls" in front of strangers by disclosing personal information, exposing vulnerability, and possibly risking being hurt by the comments of other participants:

> *"I think that group therapy is good, because we hear others [talk], and then we can relate this to ourselves, but I didn't say everything in detail that I would've said if I'd been alone with the therapists."* (P16, moderately adherent)

Revealing sensitive information in front of the group was particularly difficult for some interviewees with social anxiety disorder because it was reported as extremely anxiety-inducing. However, those who were willing to experience some discomfort reported having found this therapy particularly helpful since the group format meant continual exposure to anxiety-inducing situations. Participants also mentioned having wished for some one-on-one time with one of the therapists to confide personal information that they felt uncomfortable about sharing with the entire group.

Lastly, several participants stated that the group format created some irritants, such as unequal speaking time for all the participants, having to listen to redundant experiences, or feeling moments of boredom. They sometimes had to wait for others to finish their exposure exercises or listen again to information repeated for late arrivals or participants who had missed the last sessions.

Theme 4: Group cohesiveness

Perceived levels of cohesiveness varied across the therapy groups. In the three groups where the participants qualified the cohesiveness as very good, the participants appeared to have formed strong bonds. These participants stated that they supported each other, helped each other out, and were understanding of and respectful toward each other's experiences. They reported appreciating greatly the group format and saw it as having mostly benefits. In the other two groups, a few participants regarded some of their peers' comments as judgmental of their feelings and experiences. In fact, one participant said that

she had dropped out of the therapy mainly because of the attitudes and behaviors of certain other participants in the group.

The size of the group was mentioned as a relatively important factor in the acceptability of the group format and in the group cohesiveness. The interviewees mentioned greater appreciation for the sessions with fewer participants because they felt more comfortable about revealing themselves under these conditions, not to mention the fact that they had more time to speak.

Theme 5: Co-therapists with differing expertise

One of the features of the delivery of tCBT in this pragmatic trial was the co-facilitation by therapists with different levels of CBT expertise. The interviewees did not perceive any differences in the two therapists' skills and competency levels. Nearly all the participants greatly appreciated the co-therapist teams, perceiving the therapists as being complementary:

> *"[One therapist had] a way of explaining things that we found harder to understand. But then, the other person would come along with a different way of explaining it or with a different example. And sometimes, it was the opposite."* (P6, adherent)

Theme 6: Quality of the therapeutic alliance

Several of the interviewees reported having developed a good therapeutic relationship with at least one of the therapists. Among the factors identified as having fostered the therapeutic alliance, participants emphasized good listening skills of therapists as well as attitudes marked by empathy, kindness, non-judgment, and authenticity. One-

on-one time with therapists was also valued, including the pre-therapy telephone contact and availability after sessions to discuss personal issues.

Theme 7: Perceived effectiveness of the tCBT

While certain participants reported skepticism about the potential effectiveness of the tCBT before they began, the vast majority perceived it as being very effective in helping them manage and reduce their anxiety. Several participants mentioned that the therapy reassured them, as it helped them understand the experience of anxiety, take time to reflect, compare their perceptions of themselves and of their anxiety to what other participants in the group perceived, and lastly, regain control of their lives. A few participants reported the therapy as having completely changed their lives in a positive way:

> *"For me, it was REALLY positive. I would say that it changed my everyday approach to life… nearly 100% my way of thinking […], it allowed me to work, do activities and stop feeling anxious all the time."* (P1, adherent)

Theme 8: Access to the therapy

Many interviewed participants mentioned the facilitated access to the tCBT sessions offered in the clinical trial as the determining factor in their decision to start the therapy. They appreciated that the group therapies were offered without costs in their community, were delivered at a convenient time in their schedule, and generally began promptly after they had requested help (i.e., waiting period ranging from one to three months).

Discussion

The study findings show that tCBT was generally perceived as having good acceptability. Below, we discuss our findings according to overarching themes from our

results and examine how they relate to previous studies on the acceptability of CBT and group interventions.

The participants in our study reported the group format as offering several benefits that outweighed limitations. The benefits identified included the peer support that reduced the feelings of isolation, the mutual help received, the feeling of being able to identify with others, and the peer pressure that encouraged them to confront the source of their anxiety. Previous studies have also reported that group CBT helps patients feel less alone and reduces stigma and feelings of guilt, and this in turn fosters group cohesiveness (White & Freeman, 2000; Whitfield, 2010). An exploratory study of a group approach with Barlow's unified protocol for emotional disorders (2017) found that most of the patients regarded it as helpful to learn about the experiences of participants with other emotional disorders (Bullis et al., 2015).

Looking at the interaction between the group modality, group cohesion and therapeutic alliance, some of the treatment groups appeared to have performed better in providing a beneficial group dynamic, which seemed associated to acceptability and treatment adherence. We hypothesize that this could be due to the delivery of the intervention in community-based care. Participants were not highly selected and this led to heterogeneity in group composition (e.g., anxiety symptoms, sociodemographic characteristics, interpersonal skills, previous CBT experience). Therapists had a diverse background relating to anxiety disorders, CBT, and group interventions, and none of the therapists had prior experience with the tCBT protocol. Furthermore, the training and supervision of therapists was less intensive than for clinical trials conducted in specialized university clinics. Therapist training in the public sector has been reported as a domain for

improvement (Fernandez-Alvarez et al., 2017). Variability in treatment group experience could also be related to the range of group sizes (7 to 12 participants), and fluctuations across groups and sessions due to non-attendance or dropouts. tCBT in clinical trials is usually conducted with groups of six to eight patients (Bullis et al., 2015; Norton, 2012b; Norton & Barrera, 2012). Therefore, patient experience with the intervention may not have been equivalent to tCBT delivered in specialized mental health clinics.

Results suggest that the transdiagnostic approach combined with the group modality delivery has influenced tCBT acceptability for participants, notably for cognitive restructuring and exposure. For cognitive restructuring, it is possible that the perception of insufficient time dedicated to this component may be associated with having to share intervention time with other participants. Regarding the exposure component of tCBT, some participants reported that the fit between exposure exercises and their experience of anxiety was sometimes suboptimal. This might suggest a key area for improvement in community-based care delivery. It is not possible from the study to disentangle the impact of group size, heterogeneity of fear hierarchies for participants within groups, as well as therapist experience and attitudes regarding exposure. Contrary to diagnostic-specific CBT for anxiety disorders and to the individual format, this could be a challenging approach to implement exposure exercises personalized to each patient's fear hierarchy, and within the constraints of treatment setting with a large group. To compound the problem, this may also be related to therapists' ambivalence regarding exposure strategies in CBT for anxiety disorders. Even those trained in CBT and exposure are not always comfortable using exposure therapy and often do not deliver it with high intensity, which may impact treatment outcomes (Deacon, Farrell, et al., 2013; Deacon, Lickel, et al., 2013). Therefore,

enhancing therapists' training regarding the exposure component could be beneficial for both patient acceptability and outcomes of tCBT.

Patients accounts of the intervention provide insights on potential improvement in the context of community-based mental health care and may not apply to delivery in specialized mental health settings. Among recommendations for large-scale implementation of tCBT in non-specialized mental health clinics, our results suggest that it may be preferable to reduce group sizes, even if it is not as conducive to widespread dissemination of tCBT for anxiety disorders. To a lesser extent, it might also be relevant to explore group composition. We also recommend further strengthening the therapists' training in group dynamics to provide them with the optimal tools for group management, which may also involve in some cases steering certain patients toward another form of therapy or treatment more appropriate for their needs. Finally, advanced training in exposure therapy would appear to be particularly beneficial to therapist providing group tCBT in the community.

While this study helps further knowledge in an as-yet under investigated area by providing enriching and nuanced results for group tCBT acceptability, the following set of limitations should be considered. Saturation was only reached with the adherent and moderately adherent participants, as only two non-adherent participants of the clinical trial agreed to be interviewed. Therefore, reasons for non-adherence could not be explored in depth. While our data tended to show no association between the participants' sex or primary diagnosis and the acceptability of tCBT, the composition of our sample was not sufficiently balanced in terms of these variables to allow us to advance this hypothesis with any certainty. Moreover, further studies should also explore transferability to specific

underrepresented groups in primary care.

Group tCBT is an effective treatment for anxiety disorders, and research aiming at improving components of accessibility directly contributes to better treatment adherence and outcomes. The results of this study show that most of the interviewed patients perceived the tCBT as appropriate, practical, and effective in the context of a treatment delivery outside of a specialized mental health clinic. While some issues were raised about the transdiagnostic group approach, they provide an opportunity to highlights factors that may increase its acceptability in community-based settings. To further enhance our understanding of factors associated with community-based care implementation, future studies should explore the clinicians' perspective, seek a better understanding of the perspective of non-adherent patients, as well as experiment with smaller groups and enhanced training for therapists on group dynamics and exposure.

Declarations

Statement of Ethics

The protocol was approved by the ethics review boards of the Integrated Health and Social Services Centers in Estrie (#MP-22-2016-570), Québec City (#2017-166) and Laval (#2016-2017-C54). All participants provided written informed consent.

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Disclosure Statement

In accordance with Taylor & Francis policy and our ethical obligations as researchers, we are reporting that PJN receives royalties from Guilford Press for sales of "Group Cognitive Therapy of Anxiety: A Transdiagnostic Treatment Manual". The authors declare that they have no other competing interests.

Data availability statement

The authors do not have permission to share data.

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writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

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Table 1. Socio-demographic and clinical characteristics of participants

Participant	Group	Age	Gender	Principal diagnosis	Secondary diagnosis	Anxiety Severity	Psychologist (past 12 months)	Medication		Treatment adherence
								ATD	BZD	
1	1	25	M	SAD	GAD	Severe	N	Y	Y	Adherent
2	2	36	F	GAD	SAD	Mild	Y	Y	Y	Adherent
3	2	36	F	GAD	PD	Mild	Y	Y	Y	Adherent
4	2	40	F	GAD	SAD	Severe	Y	Y	Y	Adherent
5	2	58	M	SAD	GAD	Mild	Y	Y	N	Adherent
6	2	47	M	GAD	SAD	Mild	N	Y	N	Adherent
7	3	41	F	GAD	AGO	Mild	N	N	N	Adherent
8	4	18	F	GAD	PD; AGO; SAD; OCD; PTSD; Depression	Severe	Y	Y	Y	Moderately adherent

9	4	63	M	GAD	SAD	Mild	Y	Y	N	Adherent
10	3	33	F	GAD	none	Mild	Y	Y	N	Non-adherent
11	3	45	F	SAD	GAD	Severe	Y	Y	N	Non-adherent
12	3	23	F	GAD	PSTD	Mild	Y	N	Y	Moderately adherent
13	3	23	F	SAD	PD	Moderate	Y	Y	Y	Moderately adherent
14	5	30	F	PD	GAD; SAD; AGO	Moderate	N	N	N	Adherent
15	4	31	F	SAD	GAD; AGO	Moderate	Y	N	N	Adherent
16	5	37	F	GAD	SAD; Depression	Moderate	Y	N	N	Moderately adherent
17	5	35	F	SAD	PD; AGO	Moderate	Y	Y	N	Moderately adherent

Note: Treatment adherence: Adherent (9 to 12 sessions), moderately adherent (6 to 8 sessions), or non-adherent (3 to 5 sessions). ATD: Antidepressant; BZD: Benzodiazepine; SAD: Social Anxiety Disorder; GAD: Generalized Anxiety Disorder; PD: Panic Disorder; AGO: Agoraphobia; OCD: Obsessive-Compulsive Disorder; PTSD: Post-Traumatic Stress Disorder

Supplementary Table 1: Themes of the interview framework

THEMES	SAMPLE QUESTIONS
tCBT components	▪ *Could you talk about your experience of the sessions where the therapists provided information about the nature of anxiety?* ▪ *What did you think of the exposure sessions, i.e., where you had to deal with situations or physical sensations that cause you anxiety?* ▪ *What did you think of the sessions on cognitive restructuring?*
Group format	▪ *What was your experience of speaking in front of a group?* ▪ *What did you think of the number of participants in your group?* ▪ *How did you find group cohesion in general?*
tCBT transdiagnostic aspect	▪ *What do you think about being in the same group with people that experienced different types of anxiety?*
Therapists	▪ *What was your experience of having two therapists leading the group?* ▪ *Were you able to create a connection with the therapists?* ▪ *What are the reasons that have prevented (or helped) you from connecting with therapists?*
The didactic material provided	▪ *What was your appreciation of the participant manual?* ▪ *In terms of support for therapy?* ▪ *In terms of ease of use?*
Homework and exercises	▪ *The group therapy you have recently attended are very much based on self-observation exercises and homework. Can you tell me what you thought about these exercises and homework?*
The feeling of overload	▪ *Can you tell me about the extra effort you had to make to participate in the therapy?* ▪ *Did homework and exercises require a lot of time?*
Ethical aspect	▪ *How did you find the therapy in relation to your personal values?* ▪ *Was the intervention in harmony or against your personal values?*
The coherence of the intervention	▪ *What did you think of the relevance of this therapy for the treatment of your anxiety?*
Perceived effectiveness	▪ *What did you think of the effectiveness of this therapy in reducing your anxiety?*
Costs involved	▪ *Can you tell us about the personal costs involved so that you could attend this therapy?*

The feeling of self-efficacy	▪ *Since therapy can be challenging in terms of relationships with others, personal disclosure, efforts, etc., did you feel confident during this therapy, that you had all the necessary skills to participate in it?*
Patients' experiences with therapy in general	▪ *Would you recommend this therapy to a friend who has an anxiety problem?*