

**PRACTICE GUIDELINES FOR GROUP  
PSYCHOTHERAPY**

**THE AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION**

**SCIENCE TO SERVICE TASK FORCE**

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## **PREFACE**

It is a pleasure both personally and on behalf of the American Group Psychotherapy Association (AGPA) to provide a preface for this important document.

This thoughtful, scholarly document has been developed by a blue ribbon Science to Service Task Force under the talented leadership of Melyn Leszcz, M.D. FRCPC, CGP, and Joseph C. Kobos, Ph.D, ABPP, CGP, FAGPA. The Task Force was assembled in an effort to bridge the gap in the group psychotherapy field between research and clinical practice. The guiding thought was that developing a heightened awareness and capacity for integrating science with ongoing clinical practice is not only consistent with national trends in health services, but also a useful means for persuasively demonstrating the effectiveness of group psychotherapy and for improving the quality of care that is being delivered.

The Task Force was given the following broad charge: (1) formulating a relevant and useful set of practice guidelines for group psychotherapy; (2); building atop the seminal work of the CORE – R Battery Task Force by field testing the CORE-R Battery (Burlingame et al., 2006) and then supporting its wider implementation (3) developing a practice-research network; and (4) supporting AGPA’s commitment to its membership and to the field to accrue and demonstrate evidence for the effectiveness of group psychotherapy

This compilation of practice guidelines that follows constitutes our first integrated organizational response to address the challenge and growing demand for accountability. By incorporating research findings as the bedrock for developing these guidelines, AGPA is seizing the initiative on behalf of both providers and consumers to establish more firmly evidence-based practices for conducting effective group psychotherapy.

All of AGPA can take pride in this important contribution. Assembling this comprehensive set of practice guidelines, coupled with a set of assessment tools to permit careful, standardized evaluations and feedback for ongoing clinical intervention, constitutes a giant leap forward for us and for the field of group psychotherapy.

Robert H. Klein, Ph.D., ABPP, CGP, LFAGPA

## INTRODUCTION

The Clinical Practice Guidelines for the Practice of Group Psychotherapy are a product of the Science to Service Task Force of the American Group Psychotherapy Association (AGPA). This Task Force was formed in 2004 at the recommendation of Dr. Robert Klein, who was then President of the American Group Psychotherapy Association. The Task Force is part of AGPA's response to the recognition of its responsibility to support its membership and all practitioners of group psychotherapy to meet the appropriate demands for evidence-based practice and greater accountability in the practice of contemporary psychotherapy (Lambert and Ogles, 2004). The Task Force was composed to reflect the full breadth of scholarship and expertise in the practice and evaluation of group psychotherapy, combining researchers, educators and leading practitioners of group psychotherapy. Membership of the Science to Service Task Force is noted at the conclusion of this introduction.

These clinical practice guidelines address practitioners who practice dynamic, interactional and relationally-based group psychotherapy. This model of group psychotherapy utilizes the group setting as an agent for change and pays careful attention to the three primary forces operating at all times in a therapy group: individual dynamics; interpersonal dynamics; and, group as a whole dynamics. The task of the group leader is to integrate these components into a coherent, fluid and complementary process, mindful that at all times there are multiple variables, such as stage of group development, ego strength of individual members, the population being treated, group as a whole factors, and individual and group resistances, that influence what type of intervention should be emphasized at any particular time in the group. Clients seeking group psychotherapy in this context experience a broad range of psychological and interpersonal difficulties encompassing mood, anxiety, trauma, personality and relational difficulties along with associated behaviors that reflect impairment in regulation of mood and self. These guidelines may also have utility for a range of group oriented interventions. Many of the principles articulated here are relevant to diverse group therapy approaches which employ a variety of techniques, with various client populations, and in a variety of treatment or service settings.

Multiple perspectives on evidence-based practice have been articulated in the contemporary practice of psychotherapy. One approach emphasizes the application of empirically supported therapies, predicating treatment decisions upon the efficacy data emerging from randomized control trials of discrete models of intervention applied to discrete syndromes and conditions. This is a disorder-based approach. An alternative approach to evidence-based practice integrates the best available research with clinical expertise applied within the context of client characteristics, culture, and preferences (APA, 2005). This is a client – based approach and is the model we have employed.

. This clinical practice guidelines document is intended to support practitioners in their practice of group psychotherapy. It is intended to be a relevant, flexible, accessible and practical document that respects practitioners and the clinical context of their work. It can be readily linked with a second AGPA resource, the CORE-R Battery (Burlingame et al., 2006), which assists in the accrual of data regarding the effectiveness of treatment and provides outcome and process feedback for therapists regarding their clinical work.

Clinical practice guidelines are distinct from treatment standards or treatment guidelines. They are broader and aspirational rather than narrow, prescriptive and mandatory and address the broad practice of group psychotherapy rather than specific conditions. Clinical practice guidelines also respect the strong empirical research supporting the role of common factors in the practice of psychotherapy (Norcross, 2001; Wampold, 2001). The aim of clinical practice guidelines is to promote the development of the field by serving as a resource to support practitioners as well as a resource for the public so that consumers may be fully informed about the practice of group psychotherapy. The intent of these clinical practice guidelines is to augment, not to supplant, the clinical judgment of practitioners.

These clinical practice guidelines were constructed in the following fashion. The scope of the Clinical Practice Guidelines document was determined by consensus of the Task Force members. Each member of the Task Force, writing in pairs, assumed responsibility for one or two of the ten specific sections of the clinical practice guidelines. Each pair of authors reviewed the empirical and clinical-theoretical literatures comprehensively seeking to integrate the empirical research with expert clinical experience. In the next step the Task Force as a whole assumed responsibility for every section in the document, recognizing that in those situations in which the empirical literature might be an insufficient guide, expert clinical consensus would

serve as a reasonable alternative. The final document reflects both extensive review of the scholarly, empirical group therapy literature and expert consensus. This approach was also employed to reduce the risk of bias or undue influence of particular models or approaches to group psychotherapy. Many Task Force members have published textbooks and papers in the field of group psychotherapy and these are referenced as appropriate throughout the text. There is no other evident area of potential conflict of interest or disclosure.

Clinicians can actively link this document, to other American Group Psychotherapy Association resources, including the CORE-R Battery (Burlingame et al., 2006); the Principles of Group Psychotherapy (2006); Ethics in Group Psychotherapy (2005b); The International Journal of Group Psychotherapy; and, the range of educational opportunities provided through AGPA's annual meeting of the AGPA and at regional affiliate societies. The Task Force also notes that documents such as these require regular revision and would recommend a sunset clause on this document, necessitating its revision by the year 2015.

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## CREATING SUCCESSFUL THERAPY GROUPS

Overview. Creating a therapy group that has the potential of becoming an effective treatment for clients, a rewarding experience for therapists, and an accessible intervention for referral sources is a complex endeavor. Whether the group is part of the therapist's private practice, managed care contract, or clinic caseload, this endeavor actually involves the creation of two groups. The first group of course is the group of clients who have come for treatment. The second and less obvious group is the group of colleagues of the therapist whose decisions regarding clients greatly affect the viability and success of the therapy group. After initially screening clients for suitability and preparing them for the possibility of group therapy, clinical colleagues refer clients to the group therapist or group therapy program within which the therapist works. Administrative colleagues in clinic or managed care settings provide tangible physical resources that are required of therapy groups and sometimes intangible institutional support for the group or program. Each of these two groups (clients and colleagues) requires preparation and education by the therapist. The better informed that clients are about the objectives and processes of the group, the smoother will be their entry into the group, and the more likely they will attend, work, and remain. The more informed that colleagues are regarding the objectives and processes of the group, the more likely the referrals will be appropriate and the more likely the group will operate smoothly without internal or external interference or disruption. In addition, in institutional settings, advocates or champions of group therapy may need to be developed within the institution to sustain the group therapy enterprise (Burlingame et al., 2002).

Although colleagues of the therapist may be less salient in creating a private practice group compared to creating a therapy group as part of managed care arrangements or a clinic program, they are very much present. While the therapist can and should engage in further client selection and preparation processes after the referral, there are almost always limits to the extent to which he or she can generate additional referrals: Rarely does a single therapist evaluate sufficient initial referrals to supply an entire therapy group with suitable clients. Thus, in most cases, a therapist is dependent on referrals from others.

In contrast to selection and preparation of clients, which have generated considerable published literature, Klein (1983) observed that relatively little had been written about the crucial task of ensuring enough suitable referrals for one's group(s). This tendency seems to have persisted. It is true of journal

articles and to some extent is true of otherwise comprehensive books that address the topic of starting groups.<sup>1</sup>

Starting Well-Client Referrals. Suitable referrals are the life source of a group. In addition to being required for the beginning of a group, they are frequently required to replace dropouts from therapy groups. Most dropouts, which often involve 30-40% of a therapy group, occur early in the life of a group (Yalom and Leszcz, 2005). Some therapists initially accept several more clients than they regard as an ideal number for a new group in anticipation of several dropouts. It can be argued that a successful therapy group has not really been created until it has experienced, addressed, and successfully weathered one or more initial dropouts.

Friedman (1976) distinguished three types of referrals. Using his terminology, there are legitimate referrals, which are clearly appropriate for the clinical objectives of the group; nonlegitimate referrals, who may or may not be appropriate for the clinical objectives of the group but who clearly were referred for other reasons such as training; and, there are also illegitimate referrals. These illegitimate referrals are usually a product of the referrer's countertransferential rejection of the client or the therapist's sense of emergency that new clients be added as quickly as possible after the group has experienced multiple dropouts. Training centers sometimes have a high proportion of nonlegitimate referrals. To decrease the number of inappropriate referrals, Klein (1983) suggested some simple procedures, including a brief telephone conversation between the referrer and the therapist prior to the referral and a brief note from the referrer stating the purpose of the referral.

It is important to note that group therapists may encounter resistance from fellow clinicians making referrals to their groups even with clear and specific their communications with colleagues and prospective group clients. Both professional colleagues and the broader public may have their own apprehensions and skepticism about the usefulness of group approaches. Many colleagues are not well disposed to group therapy, because of their unfamiliarity with it, a negative stereotype they carry about it, a belief they have that it is not really useful (the data notwithstanding), or for some other reason. Group therapists are encouraged to take the long view that over time they will be able to educate some of their colleagues about the efficacy of what they have to offer. They may be accomplished by virtue of the clinical work they do, the presentations they make, and the outcome data they can provide. They may have to accept the fact that they will never be able to overcome the resistance of some colleagues.

The overall objectives of the group, the required processes to attain the objectives, and the recommended roles of the clients and the therapist should be conveyed clearly to all of the parties who

are involved in creating a therapy group. A needs assessment regarding target client populations or a formal review of existing groups can be very helpful in suggesting the type of groups that should be developed (Schlosser, 1993). It may suggest important areas that are neglected in the community or clinic. Piper and colleagues (Piper et al, 1992) described how the creation of a new program for clients experiencing complicated grief came about after observing how often the topic of loss came up in short-term therapy groups that were being conducted in the clinic.

Starting group therapy is almost always a very anxiety - provoking experience for the client. Despite reasonable efforts at preparation, many uncertainties remain. Often, due to anxiety or preoccupation, the client is only partially listening to or absorbing verbally conveyed information; thus, there is a need for written materials. For the client, the structure and framework of the group should be crystal clear. This means being informed about such items as the location of the group, the time and day that it meets, the duration of sessions (generally one and a half to two hours), the duration of the group, if time-limited, and the size of the group (generally seven to ten participants). Policies concerning eating or drinking during the group, notifying the group if an absence is anticipated, and leaving the group should also be clear. Clients often have mistaken conceptions about these concrete and essential practical factors. Other policies such as the mechanism for paying the therapist can also be specified in writing and can form part of an initial contract or agreement between client and therapist.

Clients can also benefit from the therapist reviewing expectations concerning therapist behavior in the group. This may range from practical issues such as the placement of chairs and number of chairs in the event of a client's absence or departure from the group to technical issues concerning therapeutic interventions. As an example, Rutan and Alonso (1999) provide a brief, clear, and useful set of guidelines concerning a psychodynamic orientation to group therapy. Clients pay close attention to the therapist's behavior, particularly at the beginning of a group. Therapist behavior should be consistent with the client's expectations and with his or her own. Specifying the therapist guidelines in written form is an easy way to keep them in the forefront. For many current short-term group therapies, therapy manuals are available for this purpose (e.g., McCallum et al, 1995; Piper et al., 1995).

Good record-keeping from the beginning of the referral process to the onset of the group is also an important aspect of creating a successful therapy group. Price and Price (1999) provide useful examples of how to keep track of important referral information such as who provides suitable referrals and who does not, and the attendance of clients at initial pre-group individual sessions as well as at treatment sessions once the group begins.

Starting Well – Administrative Collaboration. In clinic settings, where a variety of groups are available, a program coordinator has been regarded as essential by therapists who have had considerable experience in such settings (Lonergan, 2000; Roller, 1997). Ideally, he or she should be both an effective therapist and an effective administrator. The coordinator serves as a crucial, ongoing communication link between the therapists and the two groups of clients and of colleagues.

Involvement with clinical teams that make decisions about the treatment disposition of clients provides excellent opportunities to clarify selection criteria for group therapy. Collaborative planning with senior administrators does much to enhance the profile of the group program and the ability to acquire needed resources. This can include the sometimes not so simple matter of securing a group room of adequate size, with seating that is sufficiently flexible to promote discussion and interaction.

A number of authors have emphasized the desirability of the therapist forming a strong collaborative relationship with administrators (Cox et al, 2000; Lonergan, 2000; Roller, 1997). Similar arguments have been made for the importance of a close working relationship between administrators and therapists in school (Litvak, 1991) and university (Quintana et al., 1991) settings where therapy groups are provided. In the past, this primarily has involved the therapist's relationship with senior administrators of clinics. In recent years, this also involves the therapist's relationship with administrators of managed care companies. Among other things, such administrators determine whether treatment sessions qualify for reimbursement. While this additional step further complicates and may delay the initial creation of therapy groups, there is little doubt that a collaborative relationship is essential in developing and sustaining psychotherapy groups.

Roller (1997) and Spitz (1996) provide useful suggestions on building collaborative relationships between clinicians and administrators. Inevitably, it involves clinicians educating themselves about the responsibilities and challenges that administrators face, and, as noted, in some cases establishing and occupying positions such as "group coordinator" within large managed care clinics. For coordinators to have the authority to make important decisions concerning the allocation of resources, they must earn the respect and trust of higher level administrators. This can be established over time and grows out of coordinators or potential coordinators attending meetings where decisions about referrals and about support of group therapy are deliberated. Although this may involve sitting through parts of meetings that are not addressing group therapy issues directly, the investment of time usually proves to be well worth the effort. Creating therapy groups that have the potential to be successful from the perspectives of the clients, therapist, and administrators clearly requires a significant investment of time. By

facilitating communication among the various parties, the therapist can increase the likelihood that the potential will be realized.

#### Footnotes

1. Examples of such books are Price, Heschels, and Price's (1999) *A Guide to Starting Therapy Groups*, which serves as a general guide, and both Roller's (1997) *The Promise of Group Therapy* and Spitz's (1996) *Group Psychotherapy and Managed Care*, which serve as specific guides to starting groups within managed care systems.

#### Summary

1. Creating a successful therapy group from the perspectives of clients, therapists, and referral sources is a complex endeavor.
2. Both clients and referral sources require education by the therapist.
3. Suitable referrals are the life source of a therapy group.
4. Both clients and therapists benefit from specifying important information and guidelines in writing.
5. A collaborative relationship between therapists and administrators is highly recommended.
6. In institutional settings, a group coordinator can serve many useful functions.

## **THERAPEUTIC FACTORS and THERAPEUTIC MECHANISMS**

Understanding mechanisms of action in group psychotherapy. Seasoned group therapists recognize that the success of individual group members is intimately linked to the overall health of the group-as-a-whole. Indeed, a sizable portion of the clinical and empirical literature delineates therapeutic factors and mechanisms that have been linked with healthy well-functioning therapy groups. Mechanisms of action are interventions or therapeutic processes that are considered to be causal agents that mediate client improvement (Barron & Kenny, 1986). These mechanisms take many forms, including experiential, behavioral and cognitive interventions, as well as processes central to the treatment itself, such as the therapeutic relationship.

Debate about the existence and operation of unique therapeutic mechanisms of action for group therapy has a continuous, complex and contradictory history in the professional literature. Some group therapists have argued that there are unique mechanisms of action intrinsic to all group therapies. An early voice noted that groups have unique properties of their own, which are different from the properties of their subgroups or of the individual members, and an understanding of these three units is critical in explaining the success or failure of small groups (Lewin, 1947). Indeed, later writers argued that a sound understanding of group dynamics was as important to a group therapist as knowledge regarding physiology is to a physician (Berne, 1966) Thus, the conventional clinical wisdom for decades has been that if one is going to offer treatment in a group, one must be aware of the intrinsic group mechanisms of action responsible for therapeutic change in members.

A contrasting perspective suggests that group theorists and clinicians have overemphasized group-specific mechanisms of action. Over 40 years ago, Slavson (1962) noted that the group psychotherapy literature often seems obsessed with attempts to appear original, contrasting itself with dyadic therapies. Horwitz (1977) noted that some group writers and clinicians anthropomorphize the group so that it becomes the patient, leading the therapist to focus solely upon group-level interventions at the expense of individual members.

Addressing this conundrum, Fuhriman and Burlingame (1990) reviewed the empirical literature to compare putative therapeutic mechanisms of action in group and individual treatments, reporting support for both positions. Table 1 reflects a consensually accepted list of therapeutic factors and a brief definition of each.

**Table 1. The Therapeutic Factors (Yalom and Leszcz, 2005)**

<b>Therapeutic Factors</b>	<b>Definition</b>
Universality	Members recognize that other members share similar feelings, thoughts and problems
Altruism	Members gain a boost to self concept through extending help to other group members
Instillation of hope	Member recognizes that other members' success can be helpful and they develop optimism for their own improvement
Imparting information	Education or advice provided by the therapist or group members
Corrective recapitulation of primary family experience	Opportunity to reenact critical family dynamics with group members in a corrective manner
Development of socializing techniques	The group provides members with an environment that fosters adaptive and effective communication
Imitative behavior	Members expand their personal knowledge and skills through the observation of Group members' self-exploration, working through and personal development
Cohesiveness	Feelings of trust, belonging and togetherness experienced by the group members
Existential factors	Members accept responsibility for life decisions
Catharsis	Members release of strong feelings about past or present experiences
Interpersonal learning-input	Members gain personal insight about their interpersonal impact through feedback provided from other members
Interpersonal learning-output	Members provide an environment that allows members to interact in a more adaptive manner
Self-understanding	Members gain insight into psychological motivation underlying behavior and emotional reactions

Specifically, the distinctiveness of some client characteristics, therapeutic interventions and therapeutic factors (examples include insight, catharsis, hope, reality testing) was not found when comparing major empirical reviews of the individual and group literature. On the other hand, distinctive mechanisms of action emerged when multi-person relationship factors were considered. Participating in a therapeutic venue comprised of multiple therapeutic relationships produced therapeutic factors that were unique to the group format (examples include vicarious learning, role flexibility, universality, altruism, interpersonal learning). Empirical support for this proposition followed in a study (Holmes & Kivlighan, 2000) that found participants reported higher levels of relationship, climate and other-focused processes as responsible for change in group when contrasted with clients participating in individual treatment.

Cohesion - a core mechanism of action. Of the described therapeutic factors (TFs), we consider the mechanism of cohesion to be most central – it is a therapeutic mechanism in its own and it facilitates the action of other TFs. There is growing consensus that cohesion is the best definition of the therapeutic relationship in group (Burlingame et al, 2002; Yalom & Leszcz, 2005). In general, the therapeutic relationship is the ubiquitous mechanism of action that operates across all therapies (Martin et al, 2000). It appears as important, if not more important, in explaining client improvement than the specific theoretical orientation practiced by the therapist (Norcross, 2001). Indeed, in an extensive review, Wampold (2001) argued that common factors such as the therapeutic relationship may account for up to nine times greater impact on patient improvement than the specific mechanisms of action found in formal treatment protocols.

Cohesion defines the therapeutic relationship in group as comprising multiple alliances (member-to-member, member-to-group, and member-to-leader) that can be observed from three structural perspectives—intra-personal, intra-group and interpersonal (cf. Burlingame, et al., 2002). Intrapersonal cohesion interventions focus on members' sense of belonging, acceptance, commitment and allegiance to their group (Bloch & Crouch, 1985; Yalom and Leszcz 2005) and have been directly related to client improvement. For instance, members who report higher levels of relatedness, acceptance and support also report more symptomatic improvement (Mackenzie & Tschuschke, 1993). Intra-group definitions of cohesion focus on the group-level features such as attractiveness and compatibility felt by group-as-a-whole, mutual liking/trust, support, caring and commitment to “work” as a group. This definition of cohesion has been linked to decreases in premature dropout (Mackenzie, 1987) and increased tenure (Yalom and Leszcz, 2005). Finally, interpersonal definitions of cohesion

focus on positive and engaging behavioral exchanges between members and have been linked to symptomatic improvement, especially if present in the early phases of group sessions (Budman et al., 1989).

Relation of cohesion to other therapeutic factors. Cohesion has shown a linear and positive relationship with clinical improvement in nearly every published scientific report (Tschuschke and Dies, 1994). Beyond this evidentiary base, it has also been linked to other important therapeutic processes. High levels of cohesion have been related to higher self-disclosure which leads to more frequent and intense feedback (Fuehrer & Keys, 1988; Tschuschke & Dies, 1994). A positive relationship between cohesion and self-disclosure, member-to-member feedback and member-perceived support/caring has also been demonstrated (Braaten 1990). In addition, early and high levels of engagement may buffer group members from becoming discouraged or alienated when subsequent conflict takes place during the “work” phases of the group (MacKenzie, 1994; Castonguay et al., 1998). Notwithstanding the promising relations between cohesion and other important therapeutic factors, it must be acknowledged that most studies were correlational, making it difficult to determine causality.

The number of articles, chapters and books about cohesion and its relationship to successful groups is so large (MacKenzie, 1987; Colijn et al., 1991) that attempts to derive evidence-based principles for its development and maintenance often seem daunting. Table 2 offers a summary of a recent review of well-researched group dimensions that have been empirically linked to cohesion: group structure, verbal interaction, and emotional climate.

**Table 2 Evidence-based Principles Related to Cohesion (Burlingame et al 2002)**

#### **Use of Group Structure**

*Principle One.* Conduct pre-group preparation that sets treatment expectations, defines group rules, and instructs members in appropriate roles and skills needed for effective group participation and group cohesion.

*Principle Two.* The group leader should establish clarity regarding group processes in early sessions since higher levels of early structure are predictive of higher levels of disclosure and cohesion later in the group.

*Principle Three.* Composition requires clinical judgment to balance *intrapersonal (individual member)* and *intragroup (amongst group members)* considerations.

#### **Verbal Interaction**

*Principle Four.* The leader modeling real-time observations, guiding effective interpersonal feedback, and maintaining a moderate level of control and affiliation may positively impact cohesion.

*Principle Five.* The timing and delivery of feedback should be pivotal considerations for leaders as they facilitate the relationship-building process. These important considerations include the developmental

stage of the group (for example challenging feedback is better received after the group has developed cohesiveness) and the differential readiness of individual members to receive feedback (members feel a sense of acceptance).

### **Establishing and Maintaining an Emotional Climate**

*Principle Six.* The group leader's presence not only affects the relationship with individual members but all group members as they vicariously experience the leader's manner of relating. Thus, the leader's management of his or her own emotional presence in the service of others is critically important. For instance, a leader who handles interpersonal conflict effectively can provide a powerful positive model for the group-as-a-whole.

*Principle Seven.* A primary focus of the group leader should be on facilitating group members' emotional expression, the responsiveness of others to that expression, and the shared meaning derived from such expression.

These dimensions reflect classes of interventions that have direct implications for clinical practice. More specifically, group structure reflects interventions (e.g., pre-group role preparation, in-group exercises, and composition) designed to create specific member expectations or skills used in the group or group operations, including the establishment of group norms. Verbal interaction reflects global principles of how a leader may want to model or facilitate member-to-member exchange over the course of the group. Emotional climate reflects interventions aimed at the entire group experience, with the aims of increasing safety and the work environment of the group. Some of these dimensions are discussed herein and throughout this document, while others are better understood by consulting the original source of Table 2 (Burlingame et al., 2002).

Assessment of therapeutic mechanisms in clinical practice. For those clinicians who have an interest in tracking the therapeutic relationship in group psychotherapy, the American Group Psychotherapy Association (Burlingame et al., 2006) recently released a Core Battery of instruments to assist group clinicians in selecting members, tracking their individual improvement and assessing aspects of the therapeutic relationship. This task force relied upon a recent study that sought to simplify the underlying dimensions used to describe the therapeutic relationship in group and evaluate the group process (Johnson et al., 2005). Taken together, the measures address three components of the group therapy experience: the positive relational bond, the positive working relationship, and negative factors that interfere with the bond or the work of therapy. In addition, each component is addressed in terms of two perspectives: the member's relationship with the therapist and the member's relationship with the group as a whole. Table 3 indicates how each measure (or subscale of a measure) can be used to evaluate each of the six possible component-perspective combinations.

Table 3 CORE Battery Process Measures (CORE BATTERY-R, 2005)							
		Bond Relationship		Working Relationship		Negative Factors	
Measure		Therapist	Group	Therapist	Group	Therapist	Group
<b>Working Alliance Inventory</b>							
	Bond	X					
	Tasks			X			
	Goals			X			
<b>Empathy Scale</b>							
	Positive	X					
	Negative					X	
<b>Group Climate Questionnaire</b>							
	Engagement		X				
	Conflict				X		
	Avoidance						X
<b>Therapeutic Factors Inventory</b>							
	Cohesion		X				
<b>Cohesion to the Therapist Scale</b>							
	Positive Qualities	X					
	Personal Compatibility			X			
	Dissatisfaction					X	

A critical and unique therapeutic mechanism of change in small group treatment relates to the interpersonal environment, often referred to as the social microcosm created when the leader and members join together in a therapeutic collective. In addition to the therapist's clinical sense, empirical assessment tools provide a structured approach to "taking the pulse" of the group interpersonal climate to ascertain what may be obstructing or facilitating interpersonal processes at a group level. Leaders play a pivotal role in modeling and shaping this interpersonal environment (Fuhriman & Barlow, 1983) and are advised to pay careful attention to these particular mechanisms of change. It is particularly wise to focus upon the relational bond, working relationship/therapeutic alliance and negative factors. Attention to these elements underscores the possibility that ruptures in the leader-member relationship may occur which can impede the work of therapy for a member or at times for the group as a whole, and

even lead to the premature termination of members. Therapeutic interventions intentionally targeting different structural units of the group (member-to-member, member-to-group, and member-to-leader) are encouraged as the therapist creates and/or maintains specific mechanisms of change.

### Summary

1. The group psychotherapy literature underscores the importance of leaders having an understanding of mechanisms of change that are unique to group treatment (i.e. therapeutic factors) so that group-level interventions are guided by theory and empirical evidence.
2. Developing and maintaining a healthy group climate involves the therapist monitoring and intervening at three structural levels of the group: intra-personal, intra-group and interpersonal.
3. Group leaders can employ three classes of group-level interventions—structure, verbal interaction and emotional climate—at strategic developmental stages of the group to develop and maintain a health group climate.
4. AGPA has developed the CORE BATTERY-R, (Burlingame et al., 2006) a set of evidence-based measures to assist group leaders in monitoring the therapeutic climate of their groups and their clients' progress with the aim of increasing the overall effectiveness of group psychotherapy.

## SELECTION OF CLIENTS

The starting point of client selection for group psychotherapy is the clear recognition that group psychotherapy can be recommended with great confidence. Research has repeatedly demonstrated that group psychotherapy is an effective form of psychotherapy - as effective, if not more effective, than individual forms of psychotherapy (McRoberts et al, 1998; Burlingame et al, 2004). It is also important to recognize that when entry into group therapy is considered for an individual member, there is much research and accrued clinical wisdom to guide clinicians. As is the case for the entire document, this section will focus on the prototypical, ambulatory group focused on interpersonal learning, insight and personal change. These groups are by definition constructed to be interactive and emotionally expressive. Typically, these groups are composed heterogeneously in terms of personality style and/or problem constellation and aim at addressing a broad range of client difficulties, in contrast to groups that are homogeneous for a particular problem or condition and that may employ psychoeducation and/or skill building techniques. Not uncommonly however, groups that are composed homogeneously with regard to gender, culture, ethnicity, problem or sexual orientation may also address similarly broad therapeutic objectives.

Two important issues stand out: who is likely to benefit from group therapy – the issue of selection; and, what blending of clients will produce the most effective therapy group – the issue of composition. Bringing a client into a group therapy commits not only the group therapist to that client, but also commits the other members of that psychotherapy group to that individual. Having relevant criteria for decision making is therefore useful both at the individual and group level. Group therapists can utilize two distinct but related approaches: clinical assessment and empirical measurements. A trial of group therapy following thorough preparation is an additional approach to consider.

Selection. One way to address the question of who will benefit from group therapy and who should likely be excluded from participation in a psychotherapy group is through the window of the therapeutic alliance. There is robust evidence to support the finding that the quality of the therapeutic alliance is perhaps the most important predictor of positive outcomes in all psychotherapies (Martin et al, 2000). The strongest therapeutic alliance occurs in situations in which the client and therapist agree about the goals of therapy; the tasks of therapy; and the quality of the relationship or bond within the therapy (Horvath & Symonds, 1991; Bordin, 1979).

Clients generally do well in group therapy when their personal goals mesh with the goals of the group. Realistic, positive expectancies of change are more likely with this convergence and there is significant evidence regarding the impact on outcome of positive client expectations at the start of psychotherapy (Seligman, 1995). Attention to the second and third elements of the therapeutic alliance – the tasks of group therapy and the quality of the relationship and bond with the therapist and co-members – can also be important determinants of suitability for group therapy.

Who should be selected for group therapy? Group therapy is indicated for clients with manifest interpersonal difficulties and interpersonal pathology; individuals who lack self-awareness in the interpersonal realm or who manifest ego-syntonic character pathology; clients who are action-oriented; clients who will benefit from the affective stimulation and interaction that group therapy generally provides; and clients who need either to dilute an overly intense and dependent therapeutic relationship or to intensify an arid, sterile therapeutic relationship who will benefit from the presence of peers to support and challenge them (Grunebaum and Kates, 1977; Bellak, 1980; Rutan and Alonso 1982). Many clients may benefit from group psychotherapy even if they do not identify primary interpersonal difficulties, if the interpersonal underpinnings of their psychological difficulties can be identified and articulated in the pre-group assessment and preparation sessions (Horwitz and Vitkus, 1986).

Clients who do well in group psychotherapy are highly motivated (Seligman, 1995) and attracted to the group (Anderson et al., 2001). An ideal prototype is a highly motivated, active, psychologically minded and self-reflective individual who seizes opportunities for self-disclosure within the group. A certain capacity for interpersonal relationships is required to work in the interpersonal forum, a finding demonstrated in psychotherapy trials (Sotsky et al, 1991; Joyce et al, 2000). A cursory review of these statements will underscore the maxim that the rich seem to get richer and many clients who need group therapy and may benefit from it are particularly challenged in these essential domains. Yet all group therapists can attest that many group therapy participants who do not meet these prototypical characteristics benefit substantially from group therapy and a trial of therapy following a comprehensive phase of preparation may be worthwhile. Failure to recognize this clinical fact will likely mean many clients who do not meet these selection criteria would be excluded from a meaningful and effective therapeutic opportunity.

Who should be excluded from group psychotherapy? This answer must be considered relative rather than absolute and may need to be reframed as to what kind of group would be suitable for which particular individual. For example angry, anti-social individuals are typically excluded from group

psychotherapy, but such individuals may do very well in a group that is homogeneous for anti-social participants. Indeed, there is a tremendous breadth of effective therapy groups constructed homogeneously and specifically for individuals who would not meet standard selection criteria for the kind of heterogeneous group addressed here. In brief, clients should be excluded from group therapy if they cannot engage in the primary activities of the group - interpersonal engagement, interpersonal learning and acquiring insight – due to logistical, intellectual, psychological or interpersonal reasons (Yalom and Leszcz, 2005).

Premature Terminators from Group Therapy. Therapists can also learn about inclusion and exclusion criteria from the study of clients who have dropped out of group therapy or terminated prematurely (Yalom and Leszcz, 2005). The phenomenon of dropouts is potentially very disruptive in group therapy and generally there is little positive to extract from a dropout experience. Dropouts generally do not benefit personally from group therapy, and may negatively impact their group. They stimulate poor morale and may produce a negative contagion regarding the ineffectiveness of the group. Individuals who repeatedly engage the group in issues related to their commitment and participation may generate a unhelpful preoccupation and then disappoint and frustrate the group with their departure. Group therapists are advised to consider the risk of early dropout of clients who demonstrate poor psychological mindedness; little self-reflection; poor motivation; high degrees of defensiveness, denial and guardedness; and who elicit angry and negative reactions from others. The therapist's direct experience with such clients in the assessment phase may provide important interpersonal data if it can be harvested by recognition and working through with the client. If not, the hazard is likely that the group will reconfirm for these clients their fundamental negative view of themselves in relationship to the world and reinforce their difficulties rather than create an opportunity for growth or repair.

Intensive individualized preparation, with some skill-building prior to entering into the group, may increase the scope of clients treated effectively in group therapy. Group therapy is a difficult treatment for many individuals to undertake as their first treatment. Individuals who have had a prior successful course of therapy or are in concurrent individual therapy will likely do better in group psychotherapy than clients for whom the group is their first psychotherapy experience (Stone and Rutan, 1984).

Client Selection Instruments. The application of objective measures may supplement clinical judgment in this decision-making process. The Group Therapy Questionnaire (Burlingame et al., 2006) is a self-report instrument that evaluates client variables that may effect group participation. Clients who

manifest extremes of anger and hostility; social inhibition; substance abuse; and a medicalization of psychological problems can be recognized using this questionnaire: they generally do poorly in this form of treatment. The Group Selection Questionnaire (Burlingame et al., 2006) is a self-report instrument that similarly recognizes individuals who are likely to do poorly in group psychotherapy because of problems related to their inappropriate expectations of group psychotherapy; their inability to participate in the group; and an inadequate level of social skills.

A third empirical approach to selection emerges from the use of personality inventories such as the NEO – Five Factor Inventory (NEO-FFI) (Costa and McCrae 1992; Ogrodniczuk et al., 2003). This personality measure suggests that clients who score very high on the Neuroticism Scale, reflecting high levels of distress, vulnerability to stress and propensity for shame, do poorly in group psychotherapy generally. In contrast, individuals who score high on dimensions of Extraversion (verbal, eager to engage; openness: embracing the novel and unfamiliar with creativity and imagination) and Conscientiousness (hard-working, committed and able to delay gratification) do particularly well in group psychotherapy. Allied findings show that individuals with immature interpersonal relations or low psychological mindedness will do poorly in an exploratory, interpersonally oriented group. These individuals may benefit more from a group that is supportive and focuses on skill building (Piper et al, 1994; McCallum et al., 1997; Piper et al, 2001; Piper et al, 2003; McCallum et al 2003).

Other considerations that may anticipate a poor group therapy outcome relates to clients who are unable to participate in the task of the group because they are preoccupied with an acute crisis; or those who may be actively suicidal and require comprehensive management rather than exploratory psychotherapy. Any logistical challenge that prevents clients from attending the group regularly and reliably is likely to undermine the group therapy.

Composition of Therapy Groups. Having articulated guidelines that can be of help in the selection of individuals for group therapy, the second question to be considered is “what blending of individuals is preferable in group psychotherapy?”. Answering this question requires an examination of how each individual client will impact others and interact within the group as a whole. It may seem a luxury to consider composition in the contemporary practice of group psychotherapy, but attention to composition, and to client fit and interpersonal impact, continues to be useful with regard to illuminating group processes for the group therapist.

Clinical experience recommends that groups be composed heterogeneously with regard to the nature of interpersonal difficulties, but homogeneously with regard to the ego strength of the members

of the group. A variety of diagnostic tools may augment practitioners' clinical assessments in determining the nature of interpersonal difficulties that their clients experience, and assist in creating good matches of clients with different interpersonal styles. Interpersonal inventories may be useful in complementing clinical judgment (MacKenzie and Grabovac, 2001; Chen and Mallinckrodt, 2002). These measures categorize individuals' manner of interaction in a way that synthesizes two key interpersonal dimensions: hostile - affiliative and controlling - submissive. Ideally, a group should be heterogeneous with regard to the mix of hostile to friendly spectrum and controlling to submissive spectrum individuals. For example, a group composed entirely of avoidant, compliant and submissive individuals would not generate much interpersonal tension or opportunities for interpersonal learning.

Composition, however, is not destiny – it is merely a starting point and group therapists should be encouraged to facilitate maximal here and now interactions and interpersonal engagement through the articulation and modeling of group norms. It should be expected that individuals will recreate their typical relational patterns within the microcosm of the group. Clients who are rigidly domineering or dismissive may negatively impact the group with regard to cohesion and trust. A group that is top heavy with such members will suffer and not reach a high level of effectiveness. Ensuring the presence of members who are eager for engagement; willing to take social risks; and who manifest psychological mindedness, will increase the likelihood of the group becoming a cohesive and effective forum for growth and development (Yalom & Leszcz, 2005). The presence of group members with more mature relationship capacities will benefit all members, including those with less mature relational capacities (Piper et al, 2007). Similarly, groups benefit from having some veteran membership. Clinical experience underscores that therapy groups can both benefit from and provide benefit to more challenging and difficult clients in these kinds of compositional contexts. A blend of men and women certainly is beneficial for men, increasing their interaction and engagement, but may be less necessary for a maximal benefit for women (Rabinowitz, 2001; Holmes, 2002; Ogrodniczuk et al 2004).

Overall, the therapist's aim in composing groups is bringing together a mix of individuals who will both challenge and support one another and develop and maintain group cohesion. Valuing the group task and being able to commit to it is of enormous importance. In practical terms, group therapists may be best advised to invest time with regard to selection and preparation and look at composition only as fine tuning of what will likely be a successful enterprise.

## Summary

1. Group therapy can be recommended broadly as an effective therapy.
2. The selection process for heterogeneous, long-term outpatient psychotherapy groups demands careful consideration and thorough assessment.
3. Selection criteria are relative and not absolute and therapists should err on the side of inclusivity rather than exclusivity.
4. Objective measures can supplement clinical judgment regarding selection for group therapy suitability.
5. Attention can be productively applied to the client's level of interpersonal functioning, psychological mindfulness, the quality of object relations, motivation and commitment, and previous positive experiences in group.
6. Prospective group members who may be unsuitable for one group could thrive in another group and even enhance the functioning of that group. Groups that are constructed to be homogeneous for the factor that leads to exclusion from a heterogeneous group can be a useful treatment alternative.
7. Individuals who cannot attend to the group tasks due to logistical, motivational or symptomatic factors are not suitable candidates for group therapy.
8. Groups should be ideally composed to reflect homogeneity regarding ego functioning and heterogeneity regarding interpersonal difficulties.

## PREPARATION AND PRE-GROUP TRAINING

There is a strong consensus in the group therapy literature that pre-group preparation can be profoundly beneficial for prospective members and, consequently, for the group as a whole. (Rutan & Stone, 2001; Burlingame et al., 2002; Yalom & Leszcz, 2005). While there is strong agreement emerging from both expert consensus and research findings that all therapy groups profit from preparation of its members, discrepancy exists regarding how much preparation is ideal, and in what specific ways the group and its members profit from its application (Piper & Ogrodniczuk, 2004).

It is well recognized in all aspects of health care delivery that interventions that increase client compliance with treatment recommendations will increase the success rates of treatment (Sapolsky, 2004). Since all forms of group treatment, regardless of duration (short term or long term), setting (inpatient or outpatient) or theoretical model (cognitive or psychodynamic) report benefits from group preparation (Budman et al., 1996; Rutan & Stone, 2001; MacKenzie, 2001), it is useful to identify the common factors that contribute to this effect. Pre-group preparation represents one aspect of a trans-theoretical approach to psychotherapy, inherent in all forms of group and individual treatment, and research aimed at understanding the change process in psychotherapy (Safran & Muran, 2000). It is widely recognized that a prerequisite for effective treatment consists of three interdependent components of the therapeutic (working) alliance: client and therapist agreement on goals, client and therapist agreement on tasks, and the quality of the bond between client and therapist (Luborsky, 1976; Bordin, 1979; Horvath, 2000). Properly conducted pre-group preparation aims to meet all of these prerequisites (Rutan & Stone, 2001; Burlingame et al., 2002; Yalom & Leszcz, 2005).

Objectives of Preparation. There is a great deal of agreement, both from empirical evidence and expert consensus, on the objectives that should be achieved by the preparation process (Rutan & Stone, 2001, & Burlingame, et al, 2002, Piper & Ogrodniczuk, 2004; Yalom & Leszcz, 2005). These goals fall into four general categories:

- Establish the beginnings of a therapeutic alliance.
- Reduce the initial anxiety and misconceptions about joining a therapy group.
- Provide information and instruction about group therapy to facilitate the client's ability to provide informed consent.
- Achieve consensus between group leader and group members on the objectives of the therapy.

Establish a therapeutic alliance. A review of the vast amount of empirical evidence for the positive relationship between the alliance and outcome (Martin et al., 2000) underscores the important role that pre-group preparation plays in the initial establishment of the alliance and subsequent cohesion in group (Rutan & Stone, 2001). The pre-group preparatory meeting not only promotes the initial establishment of the therapeutic alliance between the group leader and prospective group members, it also provides an opportunity for the leader to leverage that relationship into further promoting bonds with the group and other group members (Burlingame et al., 2002). Underscoring scientific support for the robust effectiveness of group therapy is helpful in allaying concerns about group therapy being an economical but second tier therapy. Clarifying expectations of the treatment helps to achieve both patient-therapist agreement and hopefulness (Burlingame et al., 2004).

The first step in the development of alliances in group is the shared mutual identification that the group members have with the group leader (Yalom & Leszcz, 2005). It is recommended that the group leader take advantage of whatever currency he or she earns while establishing an alliance during the preparation phase and parlay that advantage into promoting cohesion in the group and alliances between group members (Burlingame et al., 2002). Should the preparer and the group leader be the same person? It is not always clear in the research literature if the individual doing the pre-group preparation is also the therapist who will be leading the group. Because empirical research on the therapeutic alliance has demonstrated that the alliance forms relatively early in treatment and is predictive of later therapeutic outcome (Hartley & Strupp, 1983, Horvath, 2000), many sources recommend that the therapist doing the preparation and the therapist leading the group be one and the same (Rutan & Stone, 2001; Yalom & Leszcz, 2005).

Reduce client anxiety. Joining a group is stressful and anxiety inducing (Rutan & Stone, 2001, Yalom & Leszcz, 2005). Consequently, one primary goal of pre-group preparation is to help prospective group members modulate the anxiety that usually accompanies entry into a group, through clarification and demythologizing of the group experience. For other members whose anxiety remains out of their awareness, it is important to help them be more conscious of their anxiety, lest they act out these feelings in group in a counter-therapeutic fashion (Rutan & Stone, 2001). Because anxiety about entering group is universal and intrinsic, it is helpful to eliminate iatrogenically induced extrinsic anxiety caused by the lack of clarity about goals, tasks, roles, or the direction of the group (Yalom & Leszcz, 2005).

Provide information. A succinct, simple set of instructions about how group therapy works furnishes a conceptual framework for understanding the roles that the group leader and group members are expected to fulfill. Information is geared towards correcting misconceptions and promoting group development by identifying common stumbling blocks, and mitigating unrealistic expectations about group treatment. Key aspects of appropriate group participation, including self-disclosure, interpersonal feedback, confidentiality, extra-group contact and the parameters of termination, are all defined (Yalom & Leszcz, 2005). Requisite norms for effective group therapy can be described, including issues such as attendance, punctuality, attending group under the influence of substances, sub-grouping, and socializing with other group members between group sessions (Burlingame et al., 2006). Special attention needs to be paid to encourage confidentiality in group and the protection of each member's anonymity (Salvendy, 1993; Rutan & Stone, 2001). The limits of confidentiality in group therapy, relative to individual therapy, must be carefully discussed. Co-members are not legally bound to preserve as confidential the personal information disclosed in the group. Agreement should also be reached regarding the transmission and exchange of information between collaborating therapists in concurrent therapies or for the provision of monitoring medications (Leszcz, 1998).

Consensus on goals. Pre-group preparation provides an opportunity to obtain patients' informed consent and commitment--sometimes written, but usually verbal—for regular attendance, fees, and participation in group for an agreed upon purpose and period of time (Beahrs & Gutheil, 2001). The patient's interpersonal patterns can be identified through careful examination of the interactional processes that occur in the here-and-now of the preparation meeting. This not only helps to provide clarity about the patient's goals, it can also prepare the patient experientially for the therapy group's focus on learning through interpersonal interactions (Yalom & Leszcz, 2005). Attempts can be made to predict the patient's experience in group and assess the impact, both positively and negatively, that the prospective member may have on the group (Salvendy, 1993).

Methods and Procedures. While there is much agreement on the goals of pre-group preparation, there is much diversity in methods recommended for achieving those goals (Burlingame et al., 2002; Piper & Perrault, 1989).

- The number of sessions and times can vary, ranging from one session lasting an hour or less to four meetings (Piper & Perrault, 1989).

- The settings in which preparation is done can also vary from meeting with clients one at a time or with two or more prospective group members in an actual pre-group preparation group (Yalom & Leszcz, 2005).
- Information is usually delivered across a spectrum from passive to more active or interactive formats with behavioral, cognitive, and experiential components (Burlingame, et al, 2006). Combinations of four general methods can be identified: (1) written, (2) verbal, (3) audiovisual, and (4) experiential (Piper & Perrault, 1989).
- Passive procedures usually rely on instructions, delivery of cognitive information related to a model or example, and opportunities for vicarious learning through observation (Rutan & Stone, 2001).
- Active and interactive procedures rely more heavily on behavioral rehearsal and experiential components in which members are provided a brief, structured therapy like experience, role play or watch and discuss a video of group therapy (Piper & Perrault, 1989).
- Adaptations in procedures and special consideration for neophytes to group and new members joining an ongoing group are recommended (Salvendy, 1993, Yalom & Leszcz, 2005). These may include orienting the incoming member to the current issues that the group is addressing.
- Adapting preparation to be culturally attuned to the client may be another important consideration (Laroche & Maxie, 2003).
- A combination of active and passive methods produces the most effective results (Leszcz and Yalom, 2005).

Impact and Benefit. While there is evidence that pre-group preparation strongly enhances some factors of treatment; there are also indications that other factors will be only mildly impacted, and other factors will demonstrate little or no effect.

Strong Effects. The strongest empirical evidence for the benefit of pre-group preparation concerns retention and attendance (Piper & Perrault, 1989). Evidence exists that pre-group preparation is related to more rapid development of group cohesion, less deviation from tasks and goals of group, increased attendance, less attrition, reduced anxiety, better understanding of objectives, roles and behavior, and increased faith in group as an effective mode of treatment (Burlingame et al, 2006). Evidence also exists suggesting client attraction to the group improves retention (Burlingame et al, 2002).

Mixed Effects. Improved therapy process (interpersonal openness, more self-disclosure), increased cohesion, improved working alliance, and more exploratory behavior are generally supported by the

research evidence. Pre-group preparation appears to be dose related: more preparation sessions with experiential and emotional intensity are more likely to produce a positive impact (Yalom & Leszcz, 2005). Pre-group preparation has been linked to the beneficial effects of early leader-initiated group structure, which in turn has been demonstrated to predict other facilitative group processes and beneficial outcome (Burlingame, 2002).

Minimal Effects. While preparation will ensure the prospective group member will be more likely to stay in the group longer in order to be able to derive benefit from treatment, preparation in itself has not been found to greatly impact outcome greatly. The low relation between preparation and outcome can be explained by a number of factors. Regular participation is a necessary ingredient of a successful outcome but it is insufficient in itself. A distant singular event such as a one or two time preparatory meeting will lose its potency over time. Over the course of treatment, other more influential variables (group membership composition, skills of the group leader, cohesion, and match between member characteristics and treatment) will have greater impact and consequently, a much more persuasive influence on treatment outcome. Even without compelling evidence in all domains, there is clear consensus that the relatively small resource expended in pre-group preparation is certainly worth the investment of time (Piper and Ogrodniczuk, 2001).

### Summary

1. Both empirical research and expert consensus endorse the value of pre-group preparation.
2. Effective preparation exerts its effects through enhancing the therapeutic alliance.
3. Effective preparation will modulate client anxiety and provide information that enables the client to provide informed consent.
4. Effective preparation promotes agreement between the therapist and prospective group member on the goals and tasks of group therapy.
5. Methods of preparation range from passive to active and from educational to experiential.
6. Clients who are well prepared for group therapy are significantly more likely to participate meaningfully, comply with treatment and are much less likely to stop therapy prematurely.

## GROUP DEVELOPMENT

Like all groups, therapeutic groups change and evolve over time (Arrow et al., 2004; Worchel & Coutant, 2001). Knowledge of group development can help the group therapist discern if member behaviors reflect personal and individual or group developmental issues. Furthermore, an appreciation of how members cope in the face of group developmental issues can aid the therapist in formulating specific interventions that are specific to the developmental stage of the group.

Questions about group development began to crystallize after LeBon (1910) and Freud (1959/1922) theorized about the dynamics associated with groups engaged in a shared task. Since then, a plethora of models depicting how “groups become groups” have entered the literature. These models generally share the view that development occurs in a systematic fashion, advancing through phases or stages. For example, Bennis and Shepard (1956) outlined a model that included only two stages, dependence and interdependence, whereas Beck (1974) delineated a model comprising nine stages. The models differ in terms of whether the developmental process is seen to be linear (stages occur progressively in an invariant succession), recurrently cyclical (the group may repeat certain stages—or deal with particular issues—at certain intervals or under certain conditions), or a composite of linear and cyclical patterns (Mann et al., 1967). For example, cohesion and relatedness between members tends to increase in a progressive, linear fashion (MacKenzie, 1994), whereas conflict and resolution processes may recur in a fairly regular cycle (Worchel, 1994). Bion’s (1961) well-known depiction of “basic assumption” groups (dependency, fight-flight, pairing, and working) represents a form of cyclic developmental model.

The diversity of developmental models also reflects different types, structures and composition of group therapy approaches. When implementing an outpatient group, the leader establishes certain parameters, including whether the group will be open or closed, time-limited or open-ended, as well as session frequency and duration. Each of these variables influences group development. For example, open groups which continually add and lose new members on an ongoing basis, such as a community-based support group, may not develop through certain stages in the same way as a closed, insight-oriented, interpersonal group. That is, certain stages may be truncated or simply not emerge. In similar fashion, an open-ended group with a fixed membership will be more likely to manifest cyclical patterns of development than a time-limited, fixed membership group. There is also evidence that groups of

different compositions, for example, homogeneous and heterogeneous with regard to member gender, may vary in terms of the durations of each developmental stage (Verdi & Wheelan, 1992).

Models of Group Development: Assumptions. MacKenzie (1994) addressed four assumptions underpinning most models of group development. The first assumption is that groups develop in a regular and observable pattern, allowing for predictions of near-future patterns of group behavior. Understanding the group's developmental status may inform the therapist about the maturity of member-member interactions. However, these observations do not allow for the prediction of long-term outcome. The second assumption asserts that the same developmental features will be evident in all treatment groups that develop in a normative fashion. This may be true for groups with a similar structure, format, and membership composition. However, different clinical contexts and group characteristics will impact group development (Arrow et al., 2004). For example, while most models posit the emergence of conflict in a second stage, Schiller (1995) noted that for groups composed exclusively of women, conflict emerges much later and only after sufficient safety and trust has been established.

The third assumption notes that development is epigenetic, with later developmental stages being contingent on the successful negotiation of earlier developmental crises. This invariant stage progression is unlikely; however, if it is considered that groups occasionally undergo abrupt changes, as may occur in the case of an unexpected departure or death of a member. Consequently, development may tend in certain groups to be discontinuous rather than graduated and incremental. It was noted earlier that most if not all models posit one or more periods of crisis or conflict during the life of a group, variably defined as "resistance" (Klein, 1972) or "storming" (Tuckman, 1965). The emergence of chaos theory to describe self-organizing systems has led some theorists to argue that each group developmental stage involves the transition through a growth crisis (Garland et al., 1973). The fourth assumption of most models is that over time, groups will manifest increased interactional complexity but may, on occasion, exhibit regression and reversibility, recycling back to earlier stages of development. This assumption refers to the natural maturation that occurs in a group that meets for a sufficient period of time. The issue of reversibility, however, is controversial. Though a group may recycle through certain issues or conflicts addressed earlier in its development, it will do so with the skills and experience derived from moving through that earlier developmental stage (Brabender, 1997).

Developmental Stages. Despite variation in the number and naming of stages put forward by the various models of group development, commonalities can be discerned (Wheelan et al., 2003). A general

description of a five-stage sequence follows, with reference to the models of Tuckman (1965), Garland et al., (1973), and Wheelan et al., (2003).

1. At the outset of its life, the group is in a “forming” (Tuckman, 1965) or “preaffiliation” (Garland et al., 1973) stage. The focus is on issues of “dependency and inclusion” (Wheelan et al., 2003). The members will experience anxiety, seek guidance from the group leader(s) on appropriate behaviors, and engage in tentative self-disclosures and sharing.
2. Once established, the group will enter a stage characterized by “counterdependency and flight” (Wheelan et al., 2003), or a “storming” stage (Tuckman, 1965) defined by struggles around the issues of “power and control” (Garland et al., 1973). Competition and conflict among the members, anxiety about the safety of the group and the authority of the leader are common concerns at this stage. Confrontations of the leader reinforce member solidarity and openness. Many theories of group development hold that these struggles over authority and status are essential for the emergence of genuine cohesion and cooperation.
3. In a third stage of “norming” (Tuckman, 1965) or “intimacy” (Garland et al., 1973), a consensus on the group tasks and a working process emerge. The group begins to demonstrate “trust and structure” (Wheelan 2005), cohesion and openness.
4. A fourth stage of “performing” (Tuckman, 1965), “differentiation” (Garland et al., 1973), or “work” (Wheelan et al., 2003) is characterized by a mature and productive group process and the expression of individual differences. The group has the capacity for focusing on the task of therapeutic work and the members engage in an open exchange of feedback. If the group has a time-limited format or certain members prepare to “graduate” during this stage, elements of disillusionment and disappointment can emerge.
5. The final stage concerns the issue of termination, whether of individual members or the group as a whole. Concerns associated with “adjourning” (Tuckman, 1965) and “separation” (Garland et al., 1973) prompt the emergence of painful affects and oscillations between conflict and defensiveness and mature work. The members’ appreciation for each other and the group experience, along with efforts at preparing for a future independent of group participation, also characterize termination sessions.

Studies of group development are generally consistent with the Tuckman (1965) model (Kivlighan, McGovern, & Corrazini, 1984; Maples, 1988; Stiles et al., 1982; Verdi & Wheelan, 1992;

Wheelan & Hochberger, 1996). MacKenzie's (1994, 1997) four-stage model (engagement, differentiation, interpersonal work, and termination) combines the norming and performing stages identified by Tuckman (1965), arguing that in therapeutic groups, normative development and a focus on individual adjustment tend to emerge together. Further detail on each of the five stages described above, with attention to the leader's role and recommended interventions are offered below.

Forming/Preaffiliation. Members' behavior will be marked by an approach-avoidance stance regarding close involvement, and interactions marked by intimacy will be rare. The members will allude to anxiety, ambivalence and uncertainty about the group. Dependence on the leader(s) will be high, alternating with a climate of "flight" from the group situation. Self-disclosure and sharing of therapy goals will eventually emerge, but tentatively. The leader's stance is primarily educative. The leader clarifies the group's purpose and the therapist's role, and offers guidelines for the operation of the group and member participation. Strategically, the leader allows for regulation of interpersonal distance but invites trust, assists the members to identify personal goals, and identifies commonalities between the members. This allows the group interaction to become more structured and predictable.

Storming/Power and Control. The members now begin to engage emotionally. The leader's authority and the safety of the group as a "container" are challenged. Subgroups may emerge as members attempt to establish a status hierarchy. Conflict and the expression of negative feelings of hostility and anger are common. The leader's tasks are to ensure that the group passes safely and successfully through this stage and that a good working alliance begins to emerge amongst the members. The therapist works to reaffirm the group's purpose and the members' common goals. Ground rules and expectations are reinforced. The therapist encourages group cohesion and interpersonal learning among the members. Strategically, the leader elicits the expression of negative affect and assists members to identify and resolve conflict to demonstrate the embryonic group's potential. Behavior that is incongruent with the group purpose is confronted if necessary. The leader avoids labeling individuals in terms of specific roles or rigidly identifying with member subgroups.

Norming/Intimacy. If the group successively negotiates the conflicts of the preceding stage, member trust, commitment, and willingness to cooperate will increase. Norms for group behavior become more firmly established. With this structure, the group is characterized by freer communication and feedback and greater cohesion and openness. Leadership functions become shared by the members; the leader is able to assume a more peripheral and less active role. Strategically, the leader's interventions aim to maintain a balance between support and confrontation. The leader's primary tasks are to facilitate the

working process regarding feedback, promote insight, and encourage problem-solving in an ongoing manner. A “derailment” of the group process during this stage may suggest that the group members are revisiting a previous developmental issue.

Performing/Differentiation. The group has achieved maturity and functions as a creative system of mutual aid. There is a clearer recognition among the members of the group’s strengths and limitations. The process is marked by the open expression and acceptance of interdependence and differences between individuals. The finite nature of a given member’s tenure in the group, or the life of the group itself, may be addressed productively by working through ambivalence or defensively through avoidance or the re-emergence of subgroups. The leader’s focus is on letting the group run itself. At an intervention level, the leader facilitates member-member empathy and assists the members to acknowledge and amplify individual differences. Interventions addressing both member- and group-level issues can be utilized.

Adjourning/Separation. With an ending in sight, the group experiences an upheaval of sadness, anxiety and anger. The member(s) may experience the ending of therapy as a profound relationship loss, especially if the group has become a source of psychological support. Members may experience a resurgence of presenting problems or symptoms. Defensive efforts at denial or flight will alternate with periods of productive work. Additionally, the members will demonstrate a future orientation and plans for continuing the therapeutic process or maintaining gains. Expressions of both sadness and appreciation are common at this stage. The leader’s primary task is to assist with the expression of feelings and attention to unfinished business. The leader facilitates a systematic review and evaluation of the group’s progress, encourages planning for the post-group period, and facilitates involvement in the process of saying goodbye. The latter activity is a critical task—unless the termination is properly managed, the gains achieved during treatment can evaporate (Quintana, 1993).

## Summary

1. There is strong consensus for a five-stage model of group development.
2. The first or forming stage addresses issue of dependency and inclusion. The leader aims to educate the members (group purpose, norms, and roles of participants), invite trust and highlight commonalities.
3. The second or storming stage is concerned with issues of power or status and the resolution of the associated conflicts. The leader aims to promote a safe and successful resolution of conflict, encourage group cohesion, and facilitate interpersonal learning.
4. The third or norming stage reflects the establishment of trust and a functional group structure (norms). The leader aims to facilitate an early working process; interventions reflect a balance of support and confrontation.
5. The fourth or performing stage is characterized by a mature, productive group process and the expression of individual differences. The leader's aim is to allow the group to function at an optimally productive level, and to highlight the individuality of the members.
6. The final or termination stage involves a focus on separation issues, a review of the group experience, and preparation for the ending of the group. The leader aims to encourage the expression of feelings associated with saying goodbye, and to facilitate attention to unfinished business in the group.

## GROUP PROCESS

Introduction. While definitions vary considerably, group process generally refers to what happens in the group, particularly in terms of the development and evolution of patterns of relationships between and amongst group participants (Beck & Lewis, 2000; Yalom & Leszcz, 2005). These processes occur at both observable and inferred levels. Observable processes consist of verbal (e.g. speech content; expressed affects) and nonverbal behaviors that have been conceptualized, operationalized and assessed from fine-grained to very abstract levels of analysis (cf. Beck & Lewis, 2000). Inferred or covert group processes refer to conscious and unconscious intentions, motivations, wishes, and needs enacted by individual participants, dyads, subgroups or the group-as-a-whole. These processes can serve both adaptive, work-oriented, therapeutic ends or defensive, work-avoidant or resistive purposes (Hartman & Gibbard, 1974). Elucidation of group process serves a critical function in group psychotherapy. It contributes centrally to both the successful development of the group itself as a viable and therapeutic social system in which interpersonal interaction occurs and to the individual learning about self in relation to others. These are the mechanisms through which therapeutic change occurs.

Group as a social system. It is useful to view the therapy group as a social system with the group therapist as its manager. The group therapist's primary function in that role is to monitor and safeguard the rational, work-oriented boundaries of the group, ensuring that members experience it as a safe, predictable and reliable container with an internal space for psychological work to occur (Cohn, 2005). The literature describes many group-wide overt behaviors and latent group processes that aim at distorting the established therapeutic boundaries, therapeutic frame or group contract, i.e., the normative expectations and explicit structural arrangements established for running the group. Commonplace examples of these processes include subtly changing the task of the group (known as task drift), acting out against the ground rules of promptness and regular attendance (time boundaries) and confidentiality (spatial boundaries), or resisting work (work role boundaries). Such processes can impede or jeopardize task achievement. There is a growing appreciation of the importance of understanding these overt or covert group processes so that the therapist may modulate anti-therapeutic forces and enhance positive ones (Lieberman, Miles and Yalom, 1973; Ward & Litchy, 2004). This is relevant even in those settings where the explicit examination of group process is not considered part of the usual therapeutic work (such as CBT (Bieling et al., 2006) and psychoeducational (Ettin, 1992) groups).

Work, therapeutic and anti-therapeutic processes. Because of the prevalence of anti-therapeutic and anti-group processes, it is important for the therapist to develop and maintain clear and explicit conceptions of both the primary task of the group - the purpose or goal of the group- and how to achieve it. Clarity about what constitutes therapeutic work for the individual group participant and the group therapist is particularly useful (Newton & Levinson, 1973). That is, the therapist needs to be able to distinguish processes that are work-oriented from those that resist, avoid or defend against therapeutic work. While the capacity of the group to engage in work is directly related to therapeutic outcome (Beck & Lewis, 2000; Piper & McCallum, 2000), the therapist should consider work in a dialectic relationship to non-work processes, and strive for a balance that allows for therapeutic progress but at a pace that participants can tolerate. The therapist should appreciate that containing and working through destructive forces (in the group, the context of the group, or in the group leader) holds the possibility for creative growth and therapeutic change (Nitsun, 1996).

Work processes are defined both by the particular school of psychotherapy or theoretical framework (for example, interpretations of underlying conflicts as dictated by psychodynamic theory) that guides the overall enterprise, as well as by common or nonspecific therapeutic processes, such as cohesion or the therapeutic alliance. Two pantheoretical processes have garnered considerable empirical and clinical-theoretical support as predictors of successful treatment outcome: interpersonal feedback, central to the therapeutic factor of interpersonal learning (Burlingame et al., 2004; Yalom and Leszcz, 2005); and the therapeutic alliance (Joyce et al., in press) between the individual group member and the therapist. Other group process variables that have received some, although mixed, empirical support in terms of facilitating positive outcomes are cohesion and group emotional climate.

The Group as a Whole. Group-as-a-whole processes refer to those behaviors or inferred dynamics that apply to the group as a distinct psychological construction. Cohesion is the most extensively discussed group-as-a-whole process in the clinical-theoretical and empirical literatures. While conceptual and operational definitions of the term vary (Dion, 2000; Burlingame et al., 2002), cohesion generally refers to the emotional bonds among members for each other and for a shared commitment to the group and its primary task (see also the previous section on therapeutic mechanisms). Cohesion is often regarded as the equivalent of the concept of therapeutic alliance in individual psychotherapy and, like that latter term, is the group process variable generally linked to positive therapeutic outcome. Exaggerated forms of group cohesion, however, ranging from such phenomena as massification (Hopper, 2003), fusion (Greene, 1983), oneness (Turquet, 1974), deindividuation (Deiner, 1977), contagion (Polansky et al.,

1950) and groupthink (Janis, 1994) at one extreme, to aggregation (Hopper, 2003), fragmentation (Springmann, 1976), individuation (Greene, 1983) and the anti-group (Nitsun, 1996) at the other extreme, can divert the group from meaningful therapeutic work. The therapist should monitor the nature of the emotional bonds and commitment of the members and help the group attain a dialectic balance between needs for relatedness and communion on one hand, and needs for autonomy and differentiation on the other.

Beyond the level of cohesion, the group-as-a-whole can be perceived, experienced and represented in the minds of the members with a range of positive (e.g., engaging) and negative (e.g., conflictual) attributes (MacKenzie, 1983; Greene, 1999), that the leader needs to assess since they can affect task accomplishment. The group may be experienced as the “good mother” with protective, holding and containing capacities (Scheidlinger, 1974) or as the “bad-mother”, who can engulf, annihilate or devour the individual (Ganzarain, 1989). These contrasting images of the group, formed from socially-shared projections, have been well described in the clinical-theoretical literature. Other collusive group-wide processes and formations have been identified that can serve defensive and work-avoidant needs. For example, Bion’s basic assumptions of dependency, fight-flight and pairing (Rioch, 1970) or devolution to a rigid, turn-taking pattern of communication, often arise in the context of some anxiety resonating among the members. This regressive process needs to be dealt with as a priority, via interpretation or confrontation (Yalom & Leszcz, 2005; Ettin, 1992), in order to allow the group to shift towards more task-oriented, less defensive behavior.

Splits and subgroups. To cope with group-induced anxieties, groups can form us-versus-them or in-versus-out polarities and splits via projective processes where disowned aspects of self, in concert with other participants, are externalized into some other segment of the group (Agazarian, 1997; Hinshelwood, 1987). These internal arrangements are typically seen as defensive arrangements that can subvert task accomplishment and ultimately need to be managed by the group therapist.

The Pair or Couple. The pair in the group (Rioch, 1970; Kernberg, 1980;) can represent a re-enactment and recapitulation of Oedipal-level or neurotic-level wishes and tensions as well as more primitive, group-level defensive processes against underlying depressive or other disturbing affect. Such a dynamic can be acted out via extra-group liaisons (sexual or otherwise) or enactments in the group that can profoundly disrupt the therapeutic framework. The group therapist will likely need to address such potentially destructive processes through exploration, interpretation or confrontation.

The Individual Member and Leader Roles. The formation of the scapegoat (Horwitz, 1983; Moreno, in press) and other nonrational restrictive, delineated roles such as the spokesperson, hero, and difficult patient (Bogdanoff & Elbaum, 1978; Rutan, 2005) are prominent group phenomena. It is important for the therapist to understand that these roles emerge not only from the needs and personalities of the individuals filling them, but also from collusive enactments, co-constructions or mutual projective identifications between the individual and the group (Gibbard, Hartman, & Mann, 1974). Moreover, such unique roles are not “all bad” or destructive; they may serve important functions for the entire group, including speaking the unspeakable, stirring emotions and revitalizing the group, carrying unacceptable aspects of others, and even creating a sense of hope (Shields, 2000).

Beyond functioning as the rational work leader and manager of the social system of the therapy group, the therapist’s role may become endowed, via collective projective processes or shared transferences, with either all-good, idealized or all-bad, persecutory attributes (Kernberg, 1998, Slater, 1966), potentially resulting in non-therapeutic countertransference enactments. The management of the therapist’s countertransference, through the containment of the group’s projections, is related to positive therapeutic outcome (cf. Powdermaker & Frank, 1953). Management of countertransference in the group setting is considered more difficult than in individual therapy, however, because of the multiple and shared transferences directed towards the therapist and because of the public nature of the work. It is paramount for the leader to attend to his or her emotional reactions, especially if they fall outside the norm for the therapist, and to persist in exploring their roots, in an ongoing way. It is important to distinguish, whether these reactions emerge from the therapist’s internal world (“subjective countertransference”) or are induced from the social environment and interpersonal interaction (“objective countertransference”) (Counselman, 2005). Self-awareness and self-care are crucial in countertransference management. Regular consultation with a co-therapist or supervisor/consultant can also be very useful.

## Summary

1. Group process generally refers to what happens in the group, especially in terms of the development and evolution of patterns of relationships between and among group participants.
2. The therapy group is a social system with the group therapist as its manager, whose primary function is to monitor and safeguard the work-oriented boundaries of the group so that members experience it as a safe container with an internal space in which psychological work can occur.
3. The therapist needs to be able to distinguish processes that are work-oriented from those that resist, avoid or defend against work. The therapist should appreciate that containing and working through destructive forces (in the group, the context of the group, or in the group leader) holds the possibility for creative growth and therapeutic change.
4. Cohesion generally refers to the emotional bonds among members for each other and for a shared commitment to the group and its primary task. It is often regarded as the equivalent to the concept of therapeutic alliance in individual psychotherapy and is the group process variable generally linked to positive therapeutic outcome.
5. The management of the therapist's countertransference, through the containment of the group's projections, is related to positive therapeutic outcome. Self-awareness and self-care are crucial in countertransference management. Regular consultation with a co-therapist or supervisor/consultant can also be very useful.

## **THERAPIST INTERVENTIONS**

There are many ways that the therapist role has been defined in the literature over the years. One of the most respected contributions was that of Lieberman, Yalom and Miles (1973) in their publication of a comprehensive study of a wide variety of groups and therapist functions. They identified the groups they studied as “encounter groups,” but in fact they included some groups that traditionally fall under the rubric of therapy groups (e.g. psychoanalytic, transactional analysis, gestalt), along with some that do not (t-group, “Esalen”, personal growth). Despite the fact that only some of the groups they studied were therapy groups per se, all were aimed at being therapeutic for their participants. Utilizing factor analysis as their basic statistical tool, they identified four basic functions of the group leader: executive function, caring, emotional stimulation, and meaning-attribution. Though this work was done more than 30 years ago, no better schema has been developed for thinking about the different matters to which a group therapist must attend. This section will review each of these functions in turn.

Executive Function. “Executive function” refers to setting up the parameters of the group, establishing rules and limits, managing time, and interceding when the group goes off course in some way. All of these functions can be understood as various forms of “boundary management”. The establishment of boundaries occurs when a group is formed, but the maintenance of those boundaries is a priority to which a therapist must attend at all times. When a group is running well, there may be little for a therapist to do in this area, but a competent group therapist must be ever vigilant that boundaries are being maintained, and always ready to invoke them when necessary. A partial listing of the boundaries to which a therapist must attend includes membership (who is in and who is out), time (when the group begins and ends, whether punctuality becomes a problem), subject matter (is the group attending to what is important, and if not, what can be done about it?), affective expression (are the forms of emotional expression facilitative of therapeutic work?), and anxiety level (titrating it so that it is neither too low nor too high). Effective executive functioning is essential for good group psychotherapy; it sets the stage for effective therapeutic work to occur.

Caring. “Caring” refers to being concerned with the well-being of the members of the group, and with the effectiveness of the treatment they are receiving. This is crucial because the therapist sets the tone for how the members of the group treat and regard each other. Without the overarching understanding that group members are interested in being of help to each other, a group will founder and potentially become destructive. This is not to say that members cannot be angry with each other, or give each other

critical feedback, but it is imperative that there always be a substrate of trust that people are committed to trying to be of help to each other. When a therapist senses that this is in question, it is crucial to address it and find a way to reinstitute it in the minds and hearts of the group members. It is imperative for clients to feel that the group and its members are dedicated to trying to be helpful, even when critical feedback is offered. Only in this way can members feel trusting of the group, a necessity for a positive therapeutic alliance between each member and the group to develop. Useful therapeutic work cannot occur without a solid positive therapeutic alliance between each member and the group, including but not limited to the group therapist.

Emotional Stimulation. “Emotional stimulation” refers to the therapist’s efforts to uncover and encourage the expression of feelings, values and personal attitudes. Of course there are some groups that need very little, if anything, from the therapist on this front, because the members bring all the energy and ability to work in this fashion that is needed. Other groups require prodding, modeling, bridging (Ormont, 1990), and other forms of therapist-initiated interventions to move in this direction. Therapy groups work optimally when the therapeutic dialogue is emotionally charged, and yet at the same time controlled enough that group members are able to pull back from the here-and-now exchanges to reflect upon what can be learned about themselves and others in the group.

Meaning-Attribution. “Meaning-attribution” refers to the cognitive aspect of group treatment, and involves the therapist helping members to develop their ability to understand themselves, each other, and people outside the group, as well as what they might do to change things in their lives. It is important to note that the development of understanding, or “insight,” is not an emotionally neutral experience; when insight is most useful, it carries an emotional charge because it centers upon matters that are of great emotional importance to the client. Insight may be facilitated by the therapist’s interpretation, but this is not the only way that insight is developed in a group setting. Members make comments to each other that can facilitate insight. The therapist might play an active role in promoting such an occurrence, or it might happen spontaneously between two or more group members with the therapist having no active role in the interaction.

All of the basic therapist functions (executive function, caring, emotional stimulation, and meaning-attribution) are of significant importance. The therapist may have to attend to some of these functions a great deal in some groups and very little in others. What is crucial is that the group have a healthy balance of leader activity ensuring that it runs efficiently with appropriate boundaries being maintained; that members feel they are in an environment in which they are genuinely cared about by

the therapist and the other group members; and that there is an ability to move back and forth between emotionally charged exchanges and reflection about, and learning from, what transpires in the group. In addition to these four basic therapist functions, the contemporary group therapist also productively addresses the following allied therapeutic considerations.

Fostering Client Self-Awareness. There is a good deal of misunderstanding about the meaning of the term “insight” (Castonguay & Hill, 2006). In the psychoanalytic literature, the word usually refers to what might be called “genetic” insight: coming to understand how some aspect of one’s past is affecting one in the present. This is indeed one form of insight, but it is not the only one. Group therapy is particularly suited for helping participants develop other forms of insight: how other people are affected by them and what is it about other people that elicit particular kinds of responses in them. These forms of insight are more dynamic and are considered elements of “interpersonal learning” that are developed by the giving and receiving of interpersonal feedback (Yalom & Leszcz, 2005).

Establishing Group Norms. Group therapists do not “teach” in the direct sense of imparting didactic information that group members are expected to take in. However, they do establish and reinforce productive group norms that shape the therapy. At times the group norms develop spontaneously. At other times they require direct intervention. This may include directing the dialogue that occurs so that the exchanges are therapeutic for group members. How do group leaders accomplish this? By choosing what to respond to and what to ignore; by framing questions they believe are most worth pursuing; and by encouraging members to interact with each other in particular ways. Of course it is possible that the group therapist’s efforts will be opposed or ignored, but usually groups come to interact in accord with the “shaping” of dialogue that the therapist has engaged in. Why is this so? Because the group therapist’s words carry disproportionate weight with group members by virtue of the therapist’s authority, both in objective terms and rooted in transference.

One of the primary modes of exchange that group therapists are most interested in bringing about in their groups is the giving and receiving of interpersonal feedback. This usually begins when therapists ask questions like “How did people respond to the way Patricia asked Don her question? “, or “Why isn’t anyone saying anything about Linda’s lateness?” Over time, the group picks up on this kind of prompting, and starts responding to each other without the therapist needing to prod.

Exchanging interpersonal feedback is often facilitated by the therapist modeling the optimal response to feedback that may be directed to her. The goal is for members to neither accept nor reject feedback reflexively, but rather to consider such feedback as honestly as they can. Thus, when feedback

is offered to the therapist, or when the therapist asks for it, the therapist strives to be as open and non-defensive as possible. When there is something to be acknowledged, it should be; when the therapist cannot see the validity of what is being suggested, this needs to be said as well, but conveyed with the sense that what has been said has been honestly considered rather than rejected in a defensive way. Often a member's feedback represents a perspective that is different from the therapist's. When the therapist sees it in this way, it should be acknowledged as such and distinguished from rejecting the feedback as "wrong".

Another crucial component of effective group treatment is the use of the here-and-now to illuminate individual, sub-group, and group-as-a-whole themes. Consistent with earlier principles, this is accomplished by the therapist shaping interventions that steer the group, over time, to pay attention to here-and-now phenomena. When therapists ask, at any point in time, how members are responding to what is occurring at that moment, they are shaping the group in the direction of attending to here-and-now phenomena. Talking about how members are relating to each other and to the therapist increases the anxiety level that everyone feels in a useful way, because it makes the opportunity for learning much more powerful. This is not to say that the discussion of historical experiences is without value. In a well-functioning group, there is a healthy balance between the exploration of members' current lives outside the group, historical material, and here-and-now phenomena. It is important to note that the exploration of here-and-now phenomena is not confined to the verbal level. People communicate a great deal about themselves non-verbally, and these communications become evident in the group therapy setting. By commenting on such communications when they occur, the therapist is once again shaping the group in a therapeutic direction.

Therapist Transparency and Use of Self. It is widely recognized that group therapy is a more public form of therapy and that the therapist as a participant and observer is more exposed than in individual treatments. One of the controversial matters pertaining to the group therapist's role and technique is that of therapist transparency and how the therapist uses himself in the treatment (Kiesler, 1996; McCullough, 2002; Yalom and Leszcz, 2005). What should therapists reveal about themselves, and what should they keep private? Two principles are particularly important: Therapists should not reveal anything that they are uncomfortable sharing about themselves; and the only legitimate rationale for the therapist's personal disclosure is the conviction that it will facilitate the work of the group at that moment in time.

Therapists will have different thresholds for what they are prepared to reveal about themselves. Rachman (1990) drew the distinction between “judicious” self-disclosures (appropriate level of detail, focus remains on the client) and “excessive” self-disclosures (self-aggrandizing stories, shifting the focus to the therapist). It is also important to note that group therapists reveal things about themselves in a number of ways, including but not limited to the following: body posture, voice inflection, what they wear, how they set up their offices, how they handle fees and other arrangements, and how they interact with an array of people. All of these are forms of “metacommunication” that all human beings engage in. We reveal things about ourselves all the time; effective group therapists are aware of what they are communicating. Group therapists are more “exposed” than individual therapists because they interact with a variety of people, who elicit different aspects of their identity, simultaneously and in front of everyone in the group.

Sometimes therapist self-disclosure involves telling group members about experiences outside the group that will hopefully be illuminating in relation to what is being discussed at a particular point in time. At other times, a therapist self-disclosure will involve describing his or her experience of someone in the group. Feedback about the group member’s behavior and interpersonal impact can be very useful, particularly if it models for the group the process of feedback and is delivered in a way that is constructive without shaming or blaming the client. If the therapist and member in question have a positive therapeutic alliance, and the therapist offers the feedback in a way that indicates interest and concern rather than anger and a wish to be hurtful, this kind of intervention can be enormously helpful, not only for the individual in question but for the group as a whole.

## Summary

1. The therapist's interventions consist of a range of integrated but distinct actions that are most effective when they are well balanced with one another: These actions also establish the norms for group work.
2. The therapist's executive functions encompass the coordination of the group and regulation of the boundaries of the group.
3. The therapist conveys care directly and also models caring for the group members.
4. The therapist plays an important role in activating emotion within the group.
5. The activation of emotion is ideally followed by the attribution of meaning to the group member's personal experience.
6. These actions contribute to the client's learning and acquisition of insight.
7. The judicious use of self-disclosure by the therapist can have substantial therapeutic impact.

## **REDUCING ADVERSE OUTCOMES AND THE ETHICAL PRACTICE OF GROUP PSYCHOTHERAPY**

It is clear that not all individuals benefit from group therapy. In fact, therapeutic groups can directly contribute to adverse outcomes for some clients, including the experience of enduring psychological distress attributable to one's group experience (Yalom & Leszcz, 2005). It is an expectation of professional practice that the group leader commit to provide quality treatment that maximizes member benefits while minimizing adverse outcomes. This posture reflects an internalized system of values, morals, and behavioral dispositions that contribute to the successful application of ethical standards to the group setting (Brabender, 2002, 2006; Fisher, 2003). Achieving ethical competence not only entails gaining the knowledge of professional guidelines, federal and state statutes, and case law related to practice (Hansen & Goldberg, 1999), but also includes the motivation and skills to apply these standards (Beauchamp & Childress, 2001). Clinician knowledge and moral dispositions acquired through social nurturance and professional education are critical to providing ethical care (Jordan & Meara, 1990).

Prominent frameworks of ethical decision-making, such as the Haas and Malouf (2002) comprehensive two-phased model of firstly gathering information and then delineating a course of action, assist the group leader. For instance, Haas and Malouf recommend that during the information gathering phase, the ethical problem should be identified and defined with the perspective that each stakeholder, including all members and leaders in the group, are likely to be individually affected by the ethical dilemma. Information gathering includes determining whether standards exist to guide decision making. In a situation without an established standard (e.g., dilemmas related to group members communicating through websites or via email) or in which ethical principles and codes are in conflict, ethical principles are first identified. It is then determined whether any ethical principles supersede others to assist in decision making. Following this determination, the group leader generates possible consequences of various actions and evaluates these actions using three specific criteria:

1. Does the considered course of action meet the preferences of the affected parties?
2. Does the considered course of action pose any new ethical difficulties?
3. Is the considered course of action feasible?

Professional Ethics: Principles, Codes, Guidelines, and State Regulations. Ethical principles can be viewed as the underlying tenets of codes. Ethical principles are aspirational in nature and not

enforceable, whereas codes of ethics are mandates for behavior and require strict professional adherence for their memberships. Codes of ethics, such as those published by the American Psychological Association (APA; 2002) and the American Counseling Association (ACA; 1997) are established by professional organizations for their memberships. Ethical guidelines are also developed by professional associations and are not meant to provide specific directives for all potential situations, but instead provide parameters to guide professional behavior (Forester-Miller & Rubenstein, 1992). The American Group Psychotherapy Association (AGPA), for example, is a parent organization that provides ethical guidelines for group therapy to serve professionals in psychology, counseling, social work, psychiatry and other fields (AGPA, 2002). Another organization, the Association for Specialists in Group Work (ASGW), provides ethical guidance with Best Practice Guidelines (1998) and Training Standards (2000). Finally, group leaders must abide by the laws and regulations in the states where they practice and within the parameters of their respective colleges and licensing bodies

Group Pressures. The fact that groups can be powerful catalysts for personal change also means that they may be associated with risks to client well being. Kottler (1994) asserted the importance of developing an ethical awareness as a group leader because of the possible adverse conditions that are associated with group work. These may include:

- Verbal abuse (i.e., in member-to-member exchanges) is more likely to occur in groups than in individual therapy
- The group leader has somewhat limited control in influencing what occurs within the group and outside the group between members
- Member selection and screening processes may be done poorly resulting in bringing into the group clients who have a limited capacity to work productively in group therapy (see also the section on Selection and Preparation)

Roback (2000) similarly recommends improving the risk-benefit analysis through early identification of high-risk members, those who are likely to become “group deviants” and who may need intensive leader intervention to safeguard against a destructive, hostile or rejecting group response. There has been little systematic study of group deviancy in the clinical group literature although this topic has received attention in the social psychological literature (Forsyth, 2006). Unfortunately, the social psychology literature has little to offer clinicians given the disparate types of groups studied (e.g., analogue groups made up of college students as opposed to therapy groups made up of clients). However, recent years have seen a few more studies examining deviancy and deterioration with

clinically oriented groups (Hoffman et al., 2007). Empirically-based instruments for member selection may be used for identifying high-risk clients in an effort to prevent dropout or other adverse outcomes and recommendations of appropriate tools can be found in the APGA CORE-R battery (Burlingame et al., 2006; MacNair-Semands, 2005a).

Identified pressures in therapy groups also include scapegoating, harsh or damaging confrontation, or inappropriate reassurance (Corey & Corey, 1997). Skilled leaders can help members avoid scapegoating by encouraging members to voice any understanding or agreement with unpopular viewpoints or feelings, utilizing the forces inherent in subgroups (Agazarian, 1999) to reduce destructive isolation. In system-centered approaches, for example, leaders manage and direct these forces to drive towards healthy therapeutic development. Additional leader behaviors instrumental in reducing adverse outcomes include identifying group members' vulnerabilities and encouraging members to describe behaviors rather than making judgments. Group members should all be advised that they are free to leave the group at any point without coercion and undue pressure to remain (Corey et al., 1995). Leader behaviors that can be problematic include pressuring members to disclose information with an overly confrontational manner or failing to intervene when a potentially damaging or humiliating experience occurs. Members who are socially isolated or coping with major life problems are particularly at risk for such adverse outcomes after disclosure in a group setting (Smokowski et al., 2001). Leaders should be conscious of the potential for misusing power, control and status in the group. Preventive behaviors by clinicians may include avoiding professional isolation, accepting the demand for accountability, self-reflection on countertransference, and seeking consultation or supervision (Leszcz, 2004).

Record Keeping in Group Treatment. Client records are kept primarily for the benefit of the client (APA, 1993), yet serve a variety of purposes. The clinical record documents the delivery of services to fulfill requirement for receipt of third party payments, provides a summary of services that may be necessary for other professionals, and fulfills legal obligations. In balancing the need for confidentiality with the need to track client progress appropriately, Knauss (2006) recommends that progress notes be written in objective behavioral terms with a focus on facts relevant to client problems rather than judgments or opinions. Clinicians are advised to think out loud in the record by documenting how they intervened and why (Gutheil, 1980). This practice helps ensure that progress notes reflect an active concern for the patient's welfare (Doverspike, 1999). It is also important to develop a diagnostic profile and keep specific treatment notes for each member. Individual notes on members should never refer to other members by name as this is an infringement of the confidentiality of the other member.

It is also appropriate that the treatment record document efforts to obtain past records of new clients as part of the entry into treatment. It is also wise to document clinical interventions along with their rationale and clinical effect. Additionally, the willingness to seek consultation generally implies a high level of professionalism and should similarly be noted in the clinical record.

Confidentiality, Boundaries and Informed Consent. Therapists should discuss with potential group members the problem of protecting clients' confidentiality from one another, since confidentiality in group settings can be neither guaranteed nor enforced in most states (Slovenko, 1998). Group leaders must recognize that confidentiality is an ethically based concept which often has little or no legal basis in group therapy (Forester-Miller & Rubenstein, 1992). Although some states do provide privilege to co-patients regarding confidentiality, as in Illinois, most states do not. Accordingly, a common method of providing informed consent for group members is to have members complete a group confidentiality agreement explaining that co-members have no confidentiality privilege, and describing ways that members can discuss their own progress toward treatment goals without identifying other members. Sample confidentiality agreements are available in the literature (Burlingame et al., 2005; MacNair-Semands, 2005b). Many therapists establish expulsion as a possible consequence of a violation of confidentiality (Brabender, 2002). Client agreements serve to protect the frame of therapy and elicit informed consent about not socializing with psychotherapy group members and, when necessary, reporting any outside contact with the leaders or members in the next group session (Mackenzie, 1997).

Informed consent for group therapy includes a discussion of the potential risks and benefits of group therapy and other treatment options (Beahrs and Gutheil, 2001). Additional considerations include group expectations regarding physical touch, punctuality, fees, gifts, and leader self-disclosure. Boundary crossings are defined as behaviors that deviate from the usual verbal behavior but do not harm the client; boundary violations denote those transgressions that are clearly harmful to or exploitative of the patient (Gutheil & Gabbard, 1998). Consistently maintaining boundaries with a commitment to understanding the meanings of behaviors that violate the therapeutic frame are critical; however, rigidly refusing to cross a boundary that may be appropriate and therapeutic in a specific context could also have a deleterious effect on the therapeutic relationship (Barnett, 1998). Clear, fair and firm billing and payment policies can provide another clear boundary for the group (Shapiro & Ginzberg, 2006).

Dual relationships. Duality may arise in group therapy in circumstances when therapists have collegial or supervisory relationships with each other; when group members or leader(s) have outside contact with each other in a social context; or when multiple roles exist between and therapist and client. It has been

argued that the profession has a significant blind spot about the danger of dual relationships in group psychotherapy (Pepper, 2007). Several ethical codes address dual relationships specifically related to group counseling. The APA's ethical code emphasizes that students participating in mandatory group therapy as a part of training should not be evaluated by academic faculty related to such therapy (cite Standard 7.05, APA, 2002). Along these lines, Pepper encourages caution about dual relationship issues which may emerge following training groups when group clinicians later become colleagues or engage in professional relationships. It has also been recommended in ethical guidelines that group leaders exercise great caution in addressing confidential information gained during an individual session while in a group setting when clients are in concurrent individual and group treatments (Fisher, 2003). Furthermore, therapists working with culturally diverse groups are encouraged to thoughtfully interpret codes about dual relationships, which may take on new dimensions when viewed through a multicultural lens (Herlihy & Watson, 2003).

Preventing Adverse Outcomes by Monitoring Treatment Progress. Group therapists often informally monitor group member treatment progress, adjusting group interventions in accordance with group leader perceptions of client progress. Research has shown that treatment progress can be formally tracked to great benefit because clinicians have difficulty making accurate prognostic assessments regarding which client is most likely to experience an adverse outcome (Hannan et al., 2005). More specifically, not only do clinicians have a difficult time identifying which clients may experience an adverse treatment outcome, but there is substantial evidence in individual therapy that if actual data about client progress is provided to clinicians on a regular basis, a significant reduction in adverse outcomes can be achieved (Lambert et al., 2005). Treatment monitoring with the goal of preventing deterioration in treatment and better predicting outcome has also been successfully applied to children and adolescents (Burlingame et al., 2004; Kazdin, 2005), confirming the notion that identifying potential adverse outcomes before they actually happen may create an opportunity for therapy realignment. This is a clear example of engaging in an evidence-based treatment approach (Hannan et al., 2005).

The CORE BATTERY-R (Burlingame et al., 2006) offers clinicians a set of relevant and applicable measures to track both group process and individual member progress. Preliminary applications suggest that this methodology is helpful to clinicians and well accepted by group members (Wongpakaran et al, 2006).

## Summary

1. Achieving ethical competence includes gaining knowledge about professional guidelines, federal and state statutes, and case law related to practice.
2. Empirically-based instruments for member selection may be used for identifying high-risk clients in an effort to prevent dropout or other adverse outcomes. Recommendations for selection instruments can be found in the APGA CORE-R Battery.
3. Treatment begins with a clear statement about diagnosis, recommended treatment and the rationale for treatment.
4. Therapists should keep specific treatment notes for individual members; individual notes for members should never refer to other members by name.
5. Informed consent for group members can include having members sign a group confidentiality agreement explaining the limits of confidentiality, and describing ways that members can discuss their own experience in group with others without identifying co-members.
6. Leaders should be conscious of the potential for misusing power, control and status in the group. Leader behaviors that can be risky include unduly pressuring members to disclose information or not providing intervention when a potentially damaging experience occurs between members.
7. Monitoring treatment progress with standardized assessment instruments can identify members who are at risk for poor outcomes and provide opportunity for therapeutic realignment.

## CONCURRENT THERAPIES

Although the effectiveness of group psychotherapy as an independent therapeutic modality has been well demonstrated (Burlingame et al., 2004), group therapy clients also may commonly participate in a concurrent form of treatment: individual therapy, pharmacotherapy, or a 12-step group. Group therapists aim at proper integration of these forms of therapy, recognizing opportunities for therapy synergy, complementarity, facilitation and sequencing (Paykel, 1995; Nevenon & Broberg, 2006). Clarity about the principles of integration of modalities is useful in ensuring maximum benefit. Therapy integration increases the scope of clients that can be treated in group therapy and respects client choice and autonomy (Feldman & Feldman, 2005). Combining treatments however carries potential risks and may be contraindicated if the second modality is redundant and unnecessary, or incompatible with the initial therapy, as will be described (Rosser et al., 2004). Concurrent individual therapy may dilute the group therapy intensity by reducing the pressure group members may have to address important material. Engagement within the group may also be diminished if many group members are participants in an individual therapy (Davies et al., 2006).

Concurrent Group and Individual Therapy. Group and individual therapy are generally of equal effectiveness (McRoberts et al., 1998) but achieve their results through different mechanisms and therapist intent (Kivlighan & Kivlighan 2004; Holmes & Kivlighan, 2000). Group psychotherapy tends to emphasize the interpersonal and interactional: individual therapy tends to emphasize the intrapsychic. They may be effectively co-administered. Conjoint therapy refers to situations in which the group and individual therapist are different: in combined therapy one therapist provides both treatments (Porter, 1993) Conjoint therapy may increase the therapeutic power of treatment by adding the power of multiple therapeutic settings; maturational opportunities; transference objects; observers and interpreters, generally adding group therapy atop an established individual therapy (Ormont, 1981). Clarity about the reason for adding a second therapy and agreement about the objectives of treatment between the referring therapist, group therapist and client increases the likelihood of successful treatment. Group therapy may be added to individual therapy to move into the interpersonal and multi-personal from the dyadic and intrapsychic; facilitate interpersonal skill acquisition; or activate the psychotherapy. Individual therapy added to group therapy may help maintain a patient in group therapy who might otherwise terminate the group prematurely, or address psychological issues the group unlocks for the

client that require more focused attention (Yalom & Leszcz, 2005). Simply adding a second therapy is unlikely to remedy a resistance to the first therapy and may encourage avoidance of working through.

Conjoint therapy works best when the client provides informed consent for ad lib communication between the group and individual therapist; recognizes the importance of working in good faith in both modalities; and accepts the responsibility of bringing clinical material appropriately to each setting. A mutual, respectful collaboration between the individual and group therapist reduces the potential for competitiveness, rivalry, countertransference or client splitting and projections of idealization and devaluation to undermine one modality or the other (Ulman, 2002; Gans, 1990). Mutual respect and open dialogue between both therapists, although time-consuming, increases therapy effectiveness. Failure to communicate between therapists may well undermine both psychotherapies.

In combined group and individual therapy one therapist provides both forms of therapy and hence may have fuller and more immediate access to client information than in conjoint therapy. The group should be homogeneous for this dimension to reduce the potential of stimulating envy and generating unequal status of clients in group therapy. Frequency of meetings in conjoint and combined therapy can be determined mutually and may occur once-weekly for both or weekly only for group therapy with the individual therapy occurring at various frequencies. Ending of therapy can be done simultaneously or sequentially, mindful however that each therapy's ending is fully addressed.

Dealing with client information at the interface of modalities may pose a therapeutic challenge that can be best addressed by underscoring the client's responsibility for bridging between settings. The therapist should operate with maximum discretion and judgment but can offer no guarantee of absolute confidentiality across modalities (Lipsius, 1991; Leszcz, 1998). Difficulties in addressing relevant material in one setting or the other is best viewed as an opportunity to understand core difficulties within the client and the feeling of impasse may become an important therapeutic opportunity. Therapists are encouraged to preserve the essence of each treatment modality and explore in detail interface points between the modalities with a view to deepening the work in each. The therapist may encourage the client to address material in the appropriate setting and may ultimately introduce it if therapist efforts to support and facilitate the client addressing the interface through encouragement and gradually increasing the degree of inference in interventions fail. Working through the resistance is generally of greater therapeutic value than merely achieving the self-disclosure.

Combining Group Therapy and Pharmacotherapy. The majority of group therapists will have clients in their groups who will require pharmacotherapy, often for treatment of chronic depression, chronic

dysthymia and co-morbid personality and depressive difficulties (Stone et al., 1991). Often untreated depression is a cause of impasse in psychotherapy and the appropriate use of antidepressant medication may increase the client's access to psychotherapy, creating a level playing field for psychological treatment to ensue (Salvendy & Joffe, 1991). Alternately, group therapy in a post-acute phase of treatment may provide interpersonal and cognitive skills that will improve patient resilience and diminish vulnerability to subsequent relapse (Segal et al., 2001).

If the group therapist is the prescriber of medication, logistical difficulties may arise regarding proper monitoring of the antidepressant medication within the group setting alone (Rodenhauser & Stone, 1993). For this reason a separate meeting is indicated for monitoring of medication. Alternately a colleague may be engaged to prescribe and monitor medications (Salvendy & Joffe, 1991).

In situations in which two treaters are involved, clarity about communication, responsibility for the client and accessibility of the client to the prescriber increases the likelihood of an effective treatment (Segal et al., 2001). Each treater should inform the other fully and operate with a sense of mutual respect and full valuing of both the psychological and biological dimensions of care. Interprofessional practice is predicated upon this kind of mutuality and collaboration (Oandasan et al., 2003). Clarity about the objectives of pharmacotherapy is useful, recognizing that in some instances pharmacotherapy adds little to an already effective psychotherapy (Rosser et al., 2004).

In instances in which medication is clearly indicated, the group therapist should anticipate the psychological meaning and impact of medication on the client's sense of personal self-control and attribution of responsibility, emotional availability, and connection in the group, as well as impact on the logistics of treatment (Rodenhauser, 1989; Porter, 1993; Gabbard, 1990). The prescription of medications may well have multiple meanings that impact the client receiving medication, other clients in the group and the group as a whole, ranging from encouragement and recognition of the therapist's commitment to client care, to feelings of personal shame and stigmatization to discouragement that psychotherapy has been insufficient. In the same way that the group and individual therapists are most effective when they demonstrate mutual respect and valuing, the same is true for the pharmacotherapist and group therapist. Dogmatic overvaluing of one modality and devaluation of the other will create a strain on the client and undermine the synergistic benefits combined treatment may create.

Twelve-Step Groups. The broad reach of 12-step groups and their recognized effectiveness in facilitating abstinence from addictions predict the likelihood that clients that have been in 12-step groups or are currently in 12-step groups will also be in leader-led group psychotherapy (Ouimette et al, 1998;

Lash et al, 2001; Khantzian, 2001). In this instance, as there is no other treater, it becomes the responsibility of the group therapist to facilitate the collaboration between the two models of treatment, building atop the 12-step treatment, by addressing the psychological and interpersonal context of addiction in a complementary fashion.

Two important issues distinguish 12-step groups from group psychotherapy: First, feedback or core cross-talk is virtually absent in 12-step groups in contrast with their high value in group psychotherapy. Second, attitudes toward extra-group contact are very different in 12-step groups. Extra-group contact between members and the sponsor/sponsee relationship are of critical importance in contrast to the less permeable boundary issues around extra-group contact in group therapy. Recognizing these differences, the group therapist can better prepare a client transitioning into a psychotherapy group from a 12-step group environment, anticipating potential sources of antipathy, confusion or apprehension about the different ways in which these two group formats work. The maintenance of sobriety is a key objective in the treatment of clients with addictions, and the group leader may need to pace the process of exploration so that it is containable by the client, cognizant of client vulnerabilities to relapse.

Group psychotherapy and 12-step groups may employ different “narratives of recovery” (Weegman, 2004) but the historical antipathy between mental health treatment and addiction treatment is slowly being replaced by an increasing awareness and respect for the effectiveness of both and for their compatibility. The group therapist will be most effective if he/she has an appreciation for the 12-step program and how these steps and culture can be integrated into interpersonal and dynamic forms of group psychotherapy. The group therapist’s familiarity with the language employed in 12-step groups will also facilitate this process. Group therapy complements the 12-step articulation of the importance of self-repair through relationships; self-reflection; self-disclosure; and personal accountability in the context of trusting relationships (Matano & Yalom, 1991; Flores, 2004; Freimuth, 2000; Yalom & Leszcz, 2005).

## Summary

1. Group therapy is effective as an independent treatment format for many individuals, particularly when the issues are framed in interactional and interpersonal terms.
2. Individuals may be in group therapy in conjunction with individual therapy, pharmacotherapy or other therapeutic formats such as a 12 step program.
3. Conjoint therapy in which different therapists provide individual and group therapy requires a trusting and open relationship between the therapists which has the sanction of the client.
4. In combined therapy, the same therapist provides individual and group therapy to the same set of individuals. It is important for the therapist in this format to keep the treatment formats distinct and to respect the privacy and autonomy of the individuals, allowing them to bring up material at their own pace. It may at times be therapeutically useful to help the individuals address material in group.
5. Whether conjoint or combined, it is essential that both therapies work within their own framework - group in an interpersonal mode and individual on intrapsychic or behavioral issues.
6. Pharmacotherapy and group therapy can be effectively combined.
7. When the therapist is the prescriber, it is helpful to have a separate time to attend to the technical issues related to medication, always recognizing that medication usage has its own dynamic and interpersonal aspects which may also be addressed in the group therapy. When the treaters are different, it is essential that mutual respect and professional collaboration be fostered in order for the benefits of the two treatments to be maximized.
8. In all multiple treatments, the therapists and clients are best served when mutuality and collaboration are the guiding principles.

## TERMINATION OF GROUP PSYCHOTHERAPY

There is growing appreciation in the scientific literature for the lack of attention historically paid to the ending or termination phase of psychotherapy. A recent, comprehensive review of the salient issues associated with therapy termination identifies three key points that termination should address in group therapy.

1. The ending phase includes a review and reinforcement of individual change which has occurred in the therapy;
2. The therapist guides the departing client to a resolution of the relationships with the therapist and group members; and
3. The individual is helped to face future life demands with the tools provided in the therapy (Joyce et al., 2007).

The end phase of an individual's participation in group psychotherapy is typically the capstone of the treatment. While forming and establishing different relationships in the treatment group are crucial and working through conflict is essential, the end stage and the various aspects of the termination process can crystallize individual gains and promote the internalization of the therapy experience. Hence the ending phase is best not casually dismissed but rather embraced as a time for meaningful work.

The ending process in a group may also stimulate a resurgence of presenting symptoms and/or previous conflicts in the group. Moreover, the ending may stimulate unresolved conflicts related to previous losses and separation. Termination can provide reinforcement for change and growth in the clients as they experiment with new behaviors in dealing with the ending, and have the positive experience of completing a task or phase of life. Termination is also an opportunity for the individual patient to reexamine and rework their relationship with the therapist(s) and group members. In this process of reworking current relationships, the individual member is afforded the opportunity to practice new behaviors and develop tools for her future.

Unique aspects of termination in group psychotherapy. In group therapy, the ending process and termination must be examined from three perspectives. One, the time boundary of the group itself must be considered: is the group open ended or time limited? Two, individual clients make their own decisions to become involved and depart on their own terms and in their own way. Three, there are those situations where a therapist who functions alone or with a co-therapist must leave the therapy

group. Each of these aspects, “time boundary”, “individual client behavior”, and “therapist changes” play a role in how termination and the ending process is experienced and worked with therapeutically. Time limited groups. Time limited groups may range from one or 1/2 day workshops of 4 to 8 hours to a set number of sessions (six, eight, twelve or more) over a predetermined number of weeks or months. Typically, such groups are homogeneous on one or more variables: age, gender, presenting problem, experience of loss, shared life circumstance. In the group a common theme emerges, the resulting group interaction will initiate support, energize confrontation of external and internal conflicts, and promote experimentation with new behavior in relationship to the problematic issue around which the group is organized. Individual members will come to experience camaraderie, see similarities and differences in coping styles among the members, and bring to the group their typical expectations of leaders/experts in helping to seek solutions to personal problems.

Endings in time limited groups. There are four levels of focus at the time of ending a time- limited group. One, the group focuses on its own development and the sense of cohesion and group identity which emerges. Leaving therapy after becoming part of a group which is nurturing and supportive may stimulate memories of previous groups which were more or less supportive. Two, the group focuses on individual relationships between members which were supportive and/or conflicted. The leader urges a process of focusing on these interactions and establishing a climate of learning from the experience. Three, the leader engages the group and individuals to process their interactions with the leader. The leader invites the group to process the positive and negative contributions of the leader. In this phase, individuals in the group may rework their typical expectations of authority, leaders and experts, in seeking solutions to personal problems. And four, the leader guides the group to review the respective symptom(s), trauma, or life event which initiated the formation of the group. In this process, members refine or master new coping skills and anticipate how the lessons of therapy can be applied in the future. The leader invites group members to focus upon their relations with one another and with the leader. In this process, individuals may resolve conflicts and distorted perceptions of one another. Group members learn the benefits of mutuality and shared problem solving. They learn how to work with people who are similar and different from themselves. By focusing on the ending process, the leader helps the individuals to see their own style in coping with change and endings. The goal is to help the individuals apply the process of the group ending to future transitions and endings in their life.

Time limited groups are frequently organized around themes and there is a limited focus on screening for dysfunctional behavior. Only over time and during the ending process of a time-limited

group will the leader(s) and individual members become aware that continued therapy and/or evaluation of personal behavior is necessary. The leader(s) of time-limited groups should arrange for referral to adjunct professional services for those individuals who need continued professional intervention.

Open - ended groups. An open ended group is organized to be a continuously functioning therapy group meeting regularly, typically weekly. All members are expected to attend weekly and announce absences in advance. Newcomers are asked to make a trial commitment to the group which is a prelude to making an open ended commitment of a year or more to the therapy process. The therapy group has the related goals of dealing with dysfunctional behavior and seeking personal growth through interactions within the group. The expectation is that individual members will continue involvement with the therapy until they have reached their individual goals. Individual therapy goals are typically established by the client in collaboration with the therapist and with the group as the therapy process evolves. While the group is open-ended, the expectation is that individuals will leave the group and that there will be a leave taking process. This interactional process format allows the development of relationships over time which mirrors the formation of relationships in life. The development of cohesion, emergence and resolution of conflict, shared hopes and fears, and departures of all kinds are expected to occur. Departures may be premature, conflicted, sad, joyous, satisfying, with each posing various challenges and opportunities to the therapist and continuing group. This kind of group therapy provides participants with the unique opportunity of mourning the loss of a therapy relationship while still in the company of others experiencing the same loss.

Premature terminations. Premature terminations may occur at different stages in the development of a group. At the earliest point of group formation a premature termination will challenge the formation of cohesion and may prompt group members to lose faith in the treatment format and question their own commitment. A contagion of “jumping ship” may develop. The therapist’s role is to help the departing individual find alternate treatment formats (if so desired) and leave with dignity, while at the same time assisting the group members to assimilate the experience and to focus on their perceived role in the process of the departure. A premature termination will frequently stimulate the group’s first experience with separation/individuation issues. The therapist has the dual responsibilities of helping the individual client continue to make informed decisions for his or her own benefit and also helping to maintain the integrity of the treatment group.

Premature or unanticipated terminations in the middle and ending stages of a therapy group will have different impact and meaning to the group and its individual members. These departures are more

likely to include some form of acting out by the individual client in which the personal conflicts of the client are intertwined with the current process of the group. In these instances, the therapist should be alert to the multiple meanings of these departures. For example, an involved group member who is making progress may be challenged with a new level of intimacy or personal contact in the group and choose to leave. The therapist's role in these situations is to help the individual and the group examine the process to the extent possible and to learn from its own experience. Negative emotions and reactions associated with unanticipated endings will challenge the group's and the leader's sense of worth and effectiveness. The therapist must be alert to negative reactions in the group and assist the departing member in maintaining their dignity and offering referrals when appropriate. A "premature" termination permits the group members to deal with their own feelings and perceptions of what has happened and also to compare this experience with past relationships in which people have left.

Ending therapy with personal satisfaction. The ideal therapy ending is for the individual client to achieve symptomatic relief and a personal sense that their life is gratifying with enriching personal relationships and/or satisfaction with work. A therapeutic ending in these instances will include taking time to say good-bye and to disengage from the relationships of the group. The therapist provides a structure to the ending process. There is a parallel process in the beginning and end: At the start, the individual makes an initial commitment which leads to a long term stay. In the ending process, the individual is invited to set a deadline which permits the group to work through the departure. The reality of the ending is made clear in setting a date. The ending may be set in weeks, months or longer depending upon the individual client and group and the tenure the member has had in the group. The therapist's role is to set the norms which permit the group to learn from the beginning and ending process.

In contrast to premature endings which frequently stimulate negative and mixed feelings, the planned departure will prompt other developmental and interpersonal issues. In the planned ending, reenactments of positive and negative sibling relationships may emerge. Group members may experience envy with another person's success. Members become more aware of mutual dependency in their relationships. In the successful therapy ending, the therapist is seen less as an iconic figure and is experienced both as a real person and an effective therapist or professional. Again in the ending process, the therapist will address various forms of change which may occur. The departing member may report changes in his emotional and affective experience; changes in how he thinks and perceives people; or changes in his behavior. It is useful for the therapist to remind the client of the problems or

issues which initiated the therapy. This process is applied to all in the therapy group since the departure of one member will stimulate comparable issues in all of the individuals. The therapist is also encouraged to focus on the relationships that the individual has formed with current and past group members. This allows for a reworking of those relationships, particularly with those who are currently in the treatment group. Once again, this process will be shared by all of the members. In this regard, it is helpful to remind the group that the departure is a leave taking from the group as a whole and echoes earlier leave takings, but this time with the opportunity to make the ending as full and complete as possible, leaving as little unsaid and undone as is possible.

A Dilemma of the Open Ended Group. Therapies that are organized to deal with dysfunctional behavior and to promote personal growth are often by definition long-term ventures and the treatment process is measured in months and years. In this treatment environment, an individual may develop a dependent attachment to the group, or her personal conflicts may lead to an avoidance of considering an end to the treatment. In these situations, the therapist has a responsibility to help those individuals who are reluctant to address the issue of termination and the impact this plays in their life and group participation. The therapist should attend to two aspects of this dilemma. One, how does the individual's history, personal conflicts, current life status, symptoms, and current functioning in the treatment group play a role in the individual avoiding the issue of termination? Two, how does the climate and functioning of the group contribute to the individual avoiding dealing with her own separation and attachment issues?

Ending Rituals. The ending of a time limited group and the successful departure of an individual from an ongoing group frequently stimulate questions and concerns among group members about how to say good-bye. It is helpful for the leader to offer guidance and structure to the ending process without imposing a prescribed format. Changes in the frame of therapy related to ending must be carefully considered and explored. Saying good-bye is a complex process which includes cognitive, affective and interpersonal aspects. The major role for the therapist is to help the group learn from the experience by continuing to focus on the current ending, comparing this leave taking to previous departures in the lives of the individuals and guiding the members to address what they expect to take away from the group experience. Gift giving, sharing of food, and physical expressions of positive regard through a hug, embrace or handshake are not uncommon. Frequently group members ask about the protocol of gifts or bringing food. The leader attempts to strike a balance, on the one hand normalizing the expression of positive feelings and sadness associated with ending, and at the same time offering an intellectual

understanding of the process which promotes continued learning and therapeutic gains from the ending. Promoting a warm and engaging good-bye may be an antidote to previously negative or toxic departures and provides a model for future leave takings.

Therapist Departures. There are a variety of situations in which a therapist will leave an ongoing group. These include training situations, groups led in institutions or agencies, a therapist closing a practice and the illness or death of a therapist.

In training situations in which a co-leader is in a student role with a senior therapist, it is essential that the group know the co-leader's status as well as the time commitment of the trainee. This information sets the frame for the members and allows the individuals and group to work with their perception of the trainee, and the relationship between the co-leaders. Additionally, the set time for the departure introduces the opportunity to deal with the therapist's termination. Similar consideration applies to groups in institutional settings in which a group therapist's departure may be imposed due to logistical and practical factors distinct from therapist choice.

A therapist who is closing a practice or ending a group has the responsibility to attend to the therapeutic needs of her clients. The therapist should be prepared to process how group members expect to relate to the therapist in the future. Possible issues may include but are not be limited to:

1. The therapist's availability for future consultation;
2. The disposition of records;
3. The question of a social or friendship relationship post- therapy, and
4. The therapist's future location and whether he will be open to contact from clients

It is useful for the therapist to have available referral sources which could meet the ongoing therapeutic needs of the clients. Therapists should maintain an adequate record of the therapy to assist a new therapist in offering treatment. Ideally, the therapist will announce the closing of the group or practice with sufficient notice that the clients can process their reaction to the change and have time to find realistic therapy alternatives.

Personal illness or emergency may take a therapist away from an ongoing group. While crisis, illness and emergency by definition cannot be predicted or controlled, it is useful for a therapist to consider and make a plan for how ongoing therapy responsibilities will be maintained. Support staff or others will need to contact clients about the unavailability of the therapist and to provide information about the anticipated return. In extended absences, referral to colleagues and agency resources may be appropriate. In any event, these situations stimulate a variety of responses in group members which

range from an experience of traumatic loss to sadness, grief and empathic understanding of the humanity of the therapist.

### Summary

1. The ending phase or termination is best viewed as its own unique stage with its own goals and processes.
2. The ending phase includes a review and reinforcement of change in the individual members.
3. The leader establishes a climate and encourages processes which help group members to resolve conflicted relationships with one another and the leader.
4. The leader guides group members to anticipate stress and practice coping skills which have been developed in group and will be applied in the future.
5. In a time limited group, the leader pays particular attention to the movement of time and the dissolution of the group as a whole.
6. Premature terminations are disruptive to the development of cohesion and trust in the group. The leader helps the group to process the departure as a learning experience and to aid in the process of future new entries to the group.
7. A successful departure from an open ended group becomes a therapeutic learning experience for all in the group.
8. The departure of a co-leader requires thoughtful therapeutic management.
9. Endings in groups are frequently accompanied by rituals which aid the members in learning through the leave taking process.
10. Therapists who stop leading groups through illness, retirement or change in practice pattern have a responsibility to help the members secure continued therapy and consultation.

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