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CLINICAL PRACTICE GUIDELINES

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PREFACE

The development of these guidelines was begun under the leadership of Dr. Robert Gleaves as part of The Society of Group Psychology and Group psychotherapy's petition to the Council for Recognition of Specialties and Proficiencies for Professional Psychology (CRSPPP) for recognition as a specialty. Dr. Gleaves was president-elect of The Society, but because of illness could not assume the presidency or finish the project. The Group Specialty Council assumed the responsibility for completing the draft.

The Council adopted a perspective that practice guidelines are an evolving work in progress, and are changed in response to the emerging empirical evidence, and the needs of constituents. Thus, what is presented here is intended to serve as a basis for current best practices and are subject to changes.

Our thanks are extended to Dr. Gleaves who began this very important and essential work, and to the members of the Group Specialty Council who contributed to its development and review.

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CLINICAL PRACTICE GUIDELINES

TABLE OF CONTENTS

Introduction: Clinical Practice Guidelines, Efficacy of Group Treatment

Mechanisms of Change – Section 1: Facets of Group Treatment

- Group developmental stages
- Use of the group leader's self and transparency
- Therapeutic factors
- Culture and diversity

Mechanisms of Change – Section 2: Managing and Enhancing the Group and Ethics

- Group process
- Group as a whole
- The interpersonal environment
- Group cohesion
- Ethical practice

Mechanisms of Change – Section 3: Leader Tasks

- Selection of group members
- Composition of the group
- Preparation and pregroup orientation

Mechanisms of Change – Section 4: Group Facilitation

- Verbal interaction
- The therapeutic alliance
- Building cohesion
- Therapeutic leader-member processes
- Leader/member roles

Mechanisms of Change – Section 5: Leader Interventions

- Executive function
- Caring
- Emotional stimulation
- Member self-awareness and insight
- Group norms
- Interpersonal feedback
- Use of the here and now
- Termination

Other Considerations

Concurrent and conjoint therapies

DRAFT: Clinical Practice Guidelines Group Psychology and Group Psychotherapy 2018

Introduction Description

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.

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.

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 each group has unique properties, 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.

Mechanisms of Change 1 – Facets of Group Treatment

The pivotal theory and research associated with group psychology and psychotherapy is associated with facets of multi-person treatment. There are three facets of theory and research from which evidence based principles are founded and attendant skills and interventions addressed. The first is how to structure multi-person treatments, the second is handling the verbal interaction in multi-person treatment in a therapeutic manner and third is creating and managing the therapeutic relationships. The empirical literature for each of these domains were summarized by Burlingame et al (2002).

This 100-year history of group treatment (cf. Burlingame and Baldwin, 2011) demonstrates the tension between attention to individual-member needs and group dynamics. The management of individual and and system propertie is a core knowledge and skill area in all multi-person treatments (couple and family therapy as well as small group treatment). The management of the multiple alliances inherent in multi-person treatment using theory and empirically-supported interventions has a long-tradition and finds its roots in general systems theory. A key facet of multi-person treatment is the strategic composition of groups to balance the intrapersonal needs of individual members while also paying equal attention to the larger goals of group treatment. Yalom’s classic text—*Theory and Practice of Group Psychotherapy*—summarized the theoretical underpinning of composition and over five editions summarized key research to support group leaders strategic use of composition in creating a healthy treatment system.

Stages of 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.

There is strong consensus for a five-stage model of group development; forming, storming, norming, performing and termination. 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. 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. 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. 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. 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.

The Group: Leader Transparency and Use of Self

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.

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 group leader and member in question have a positive therapeutic alliance, and the group leader 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.

Therapeutic Factors

The importance of factors conducive to promoting therapeutic progress, healing and change for group members has received attention in the literature. (Corsini & Rosenberg 1955, Kivlighan & Mulligan 1988, Colijn et. al. 1991, Kivlighan & Goldfine 1991, Crouch et. al. 1994, Fuhriman & Burlingame 1994, Yalom 1995, MacKenzie 1997, Dies 1997, Fuhriman 1997, Kivlighan et. al. 2000, MacNair-Semands & Lese 2000, Kivlighan & Holmes 2004, Tschusckke & Dies, 1994) What has emerged from these studies and reviews are confirmation of the impact of behaviors and attitudes that are clustered as categories for therapeutic, curative and change; some are common and valued for all types of groups, some differ in their importance and value depending on the type of population; and that there are few guidelines for leaders on how to foster and encourage the emergence of these factors.

These factors have been given various titles, but can be generally categorized as Yalom (1995) presented them. These eleven factors are universality, instillation of hope, altruism,

interpersonal learning, guidance or imparting of information, catharsis, corrective recapitulation of the primary family group, imitative behavior, existential factors, and socializing techniques.

Culture and Diversity

Fowers, and Davidov (2006) categorize the multicultural conceptualization and research models to date as having three components: Awareness, Knowledge, and Skills. Professional organizations, such as the Association For Specialists In Group Work, The American Counseling Association, and The American Psychological Association have adopted guidelines for multicultural competencies expected of mental health professionals. Arredono et. al. (1996) developed and presented guidelines that are organized by characteristics and dimensions. The characteristics are cultural self-awareness, awareness of other cultures, and appropriate intervention strategies. The dimensions are attitudes and beliefs, knowledge, and skills. Whaley and Davis (2007) propose that cultural competence and evidence-based practice be integrated, and advocate a culture-specific approach for treatment. Clinicians are encouraged to consult “Multicultural Guidelines: An Ecological approach to Context, Identity and Intersectionality” (2017) at www.APA.org.

Mechanisms of Change 2 – Managing and Enhancing the Group

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).

Group Process and Process Illumination

Process refers to the relationship being expressed in the here and now. The relationship may be between individuals, between subgroups, or between the group and the leader. Although reasons for expression of the relationship may have antecedents from past relationships, such as

parental, or from past experiences, the focus for using process relies on here and now expressing. The focus and emphasis are on what is taking place in the group at the present time, not why.

Highlighting process tends to promote understanding for both personal individual issues, and for group issues. Chapman (1971) proposes that “personality consists of the relatively long-term ways in which a person engages in interpersonal relationships” and, “can be studied, understood and sometimes changed only in the context of interpersonal relationships”. Observing interpersonal relationships in the group provides a mechanism for some understanding of what life experiences have formed the individual.

Process illumination or commentary can focus on what is happening between group members, or in the group-as-a-whole. Some unconscious, non-conscious, and unspoken relationships between members that can form the basis for process commentary can be a need for connection, avoiding intimacy, attempts to dominate or control, or seeking support. Some unspoken needs or desires for the group-as-a-whole can be safety, trust, resistance, aggression, fear of engulfment, fear of exclusion, depression, clarification of norms, feelings of helplessness, or fear of destruction. (Brown, 2003, 2011)

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 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.

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.

The Interpersonal Environment

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. 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.

Group Cohesion

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).

The Ethical Practice of Group Psychotherapy

Achieving ethical competence includes gaining knowledge about professional guidelines, federal and state statutes, and case law related to practice. 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. 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.

In addition, the following can help ensure ethical practices and help to prevent adverse outcomes.

1. Begin treatment with a clear statement about diagnosis, recommended treatment and the

rationale for treatment. Keep specific treatment notes for individual members and do not refer to other members by name.

a. 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.

b. Finally, it is critical that 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.

2. 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).

a. 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.

b. Recent years have seen a few more studies examining deviancy and deterioration with clinically oriented groups (Hoffman et al., 2007). Empirically-based instruments for tracking group processes and member selection may be used for identifying high-risk clients in an effort to prevent dropout or other adverse outcomes.

3. 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.

a. 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.

b. 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.

4. Therapists should discuss with potential group members the problem of protecting clients' confidentiality, 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).

a. 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). Client agreements serve to protect the frame of therapy.

b. 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).

5. 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). 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).

Mechanisms of Change 3 – Leader Tasks

The first two editions of Bergin and Garfield's *Handbook of psychotherapy and Behavior Change* (1986) described the theory and research on the importance of creating the "container" of group treatment before the group begins. (Bednar & Lawlis, 1971, Bednar & Kaul, 1978) Roles and group norms are established in the first group session and, if properly set, lead to better group outcomes and processes. When properly implemented, pre-group preparation leads to higher levels of group performance and increased levels of member outcome.

Selection of Group Members

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, Burlingame et al. 2015. Kusters, et al.,2006)).

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.

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).

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.

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). There is strong agreement emerging from both expert consensus and research findings that all therapy groups profit from preparation of its members.

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).

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: the therapeutic alliance, reduce anxiety, provide relevant information, and set collaborative goals.

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 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).

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.

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).

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 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)

Mechanisms of Change – 4 – Group Facilitation

The use of group structure has its theoretical and empirical roots in Kurt Lewin's work on group dynamics at the University of Chicago. As one of the pioneering social psychologists, Lewin laid out both the structural aspects of how small group function as well as the dynamic interplay of members—i.e., managing the verbal interaction and climate. Burlingame and colleagues summarized three evidence-based principles to guide how group leaders structure their groups. These find their roots in Lewin's original group dynamic theory and research. What follows is a summary of these principles followed by a brief summary of the theory and research supporting each.

Verbal Interaction

A second area of specialized knowledge is the management of verbal interaction in multi-person treatments. Like other multi-person treatments (couples and family), verbal interaction between multiple member can often feel chaotic and derails the goals in group treatment. Lewin's pioneering work on group dynamics spawned a number of theoretical model on managing verbal interaction with most addressing the balance between the task and relationship dimensions of small group treatment. Beck and Lewis (2000) edited book summarized the major theoretical models of verbal interaction in the literature along with the empirical support of each. The models address how group leaders can and should managed interpersonal feedback amongst members.

Rex Stockton and Keith Morran contributed over three decades of experimental and clinical research on the effect use of feedback in small group treatment. This research produced a series of evidence-based intervention principles (Morran, Stockton and Teed, 1998) that have been integrated into the group practice guidelines.

Stockton and colleagues demonstrated the interaction between feedback interventions changing as groups develop over time. This theory and research providing evidence-based principles for interpersonal feedback timing and delivery such as the timing for the most effective interventions for leader-modeling. This research was highlighted in the group treatment chapters in the 3rd and 4th editions of the Bergin and Garfield Handbook by Bednar (Bednar & Kaul, 1986; Kaul and Bednar, 1994).

The Therapeutic Relationship

Like individual treatments, the management of the therapeutic relationship in multi-person treatments is directly related to treatment success and failure. Indeed, there is good evidence that the therapeutic relationship in group treatment predicts more of the variance in outcome than the theoretical orientation used by the group leader (Burlingame, et al, 2004, 2011, 2013). Like other multi-person treatments (couples & family), the theory and skills in the creation and

management of the the therapeutic relationship is different than individual or dyadic treatment. The two primary facets involve self-awareness and management of the leader's role in the multi-person therapeutic relationship and each of the individual members. However, unlike couple and family therapy where members bring a personal history and daily interaction patterns, group members each bring their own unique

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.

Building Group Cohesion

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).

Therapeutic Leader-Member Processes

The group leader 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.

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.

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.

Leader and Member 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.

Section 5 - Mechanisms of Change: Leader Interventions

Four basic functions of the group leader: executive function, caring, emotional stimulation, and meaning-attribution.

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.

Emotional Stimulation.

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” 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.

All of the basic group leader functions (executive function, caring, emotional stimulation, and meaning-attribution) are of significant importance. The group leader 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 self-awareness or insight, establishing group norms, interpersonal feedback, use of the here and now, and the group leader transparency and use of the self.

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 this and 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.

Interpersonal Feedback

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 group leader 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 group leader 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".

Use of the Here and Now

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.

Termination, Closure and Endings

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 phase or termination is best viewed as its own unique stage with its own goals and processes that includes a review and reinforcement of change in the individual members, processes which help group members to resolve conflicted relationships with one another and the leader, and guidance for group members to anticipate stress and practice coping skills which have been developed in group and will be applied in the future.

There are also special considerations for the time limited group, premature termination, departure from an open group, and the leaving of a co-leader. In a time limited group, the leader pays particular attention to the movement of time and the dissolution of the group as a whole. Premature terminations are disruptive to the development of cohesion and trust in the group. It is important that 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. A successful departure from an open ended group becomes a therapeutic learning experience for all in the group. The departure of a co-leader requires thoughtful therapeutic management

Other Considerations

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; Nevonen & 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 press 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; Burlingame et al. 2015) 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)

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.

Combining Group Therapy and Pharmacotherapy. The majority of group therapists will have clients in their groups who will require pharmacotherapy. 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).

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.

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