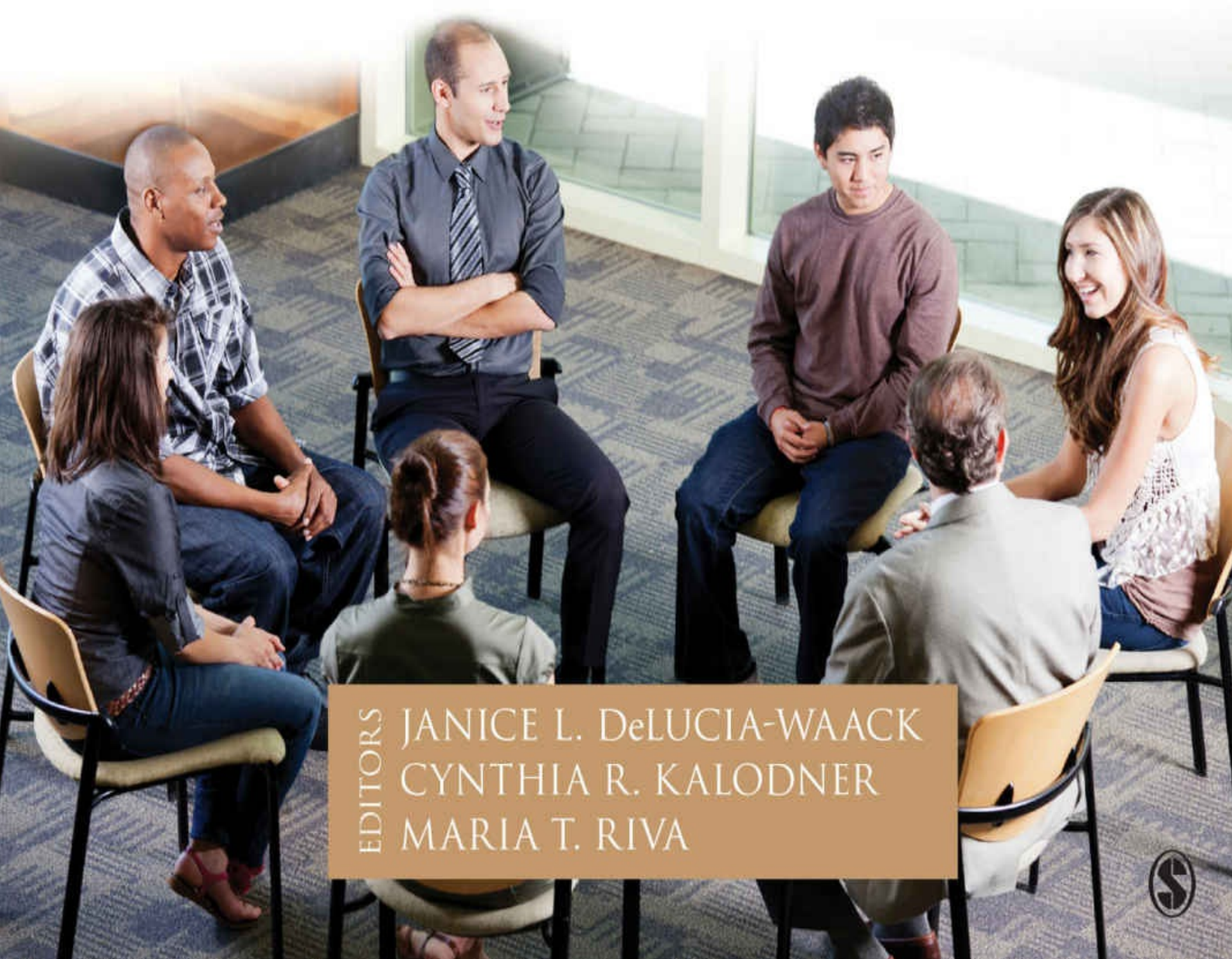
HANDBOOK OF GROUP COUNSELING & PSYCHOTHERAPY

SECOND EDITION



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JANICE L. DeLUCIA-WAACK
CYNTHIA R. KALODNER
MARIA T. RIVA

To my husband, Jim

—Janice

To my son, Noah (because I promised my next book for you)

—Mom (143)

To my husband, Bruce, and our children Erik and Olivia

—Maria

Handbook of Group Counseling and Psychotherapy

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This book has been the culmination of hard work from many people. Our chapter authors were incredibly responsive to and willing to keep revising their chapters to truly make them an integration of science and practice and to suggest guidelines for best practice based on the current research. A great deal of thanks goes to them.

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Introduction to the Second Edition of the *Handbook of Group Counseling and Psychotherapy*

Janice L. DeLucia-Waack
Cynthia R. Kalodner
Maria T. Riva

Groups are ever changing, circling through stages as group members come and go, but ever moving toward the working stage. The development of the body of knowledge on group counseling and psychotherapy seems to parallel group stages. Even further, the writing of this second edition seems to follow a similar path. The field has changed in 10 years with more research support for the effectiveness of specific groups and groups in general. Group is now being recognized as a group-specialty practice in professional psychology with a competency-based training model (Barlow, 2012). New types of groups are being developed and new directions in group research have been pursued. Some areas seem to be more coherent than 10 years ago. And so the composition of this book has changed. There are five sections in this edition compared to seven in the first; there are 46 chapters but several new topics have been included.

It was our goal to further add to the group literature in a way that both group practitioners and researchers would be able to use this book. Our emphasis in each chapter was on identifying key research findings that guide group practitioners to lead more effective groups. Barlow (2012) outlines the common competencies across professional psychology: foundational and functional competencies. Foundational competencies include reflective practice self-assessment, scientific knowledge and methods, relationships (particularly professional relationships) individual and cultural diversity, ethical and legal standards/policy issues, and interdisciplinary systems (p. 444). Functional competencies specific to group include: group assessment and conceptualization, group intervention, group consultation, group research and evaluation, group supervision and teaching, group management and administration, and group advocacy (p. 446). The Barlow article contains tables that articulate clearly the competencies in each of these domains. While we did not read this article before beginning the second edition, we do believe that our chapter authors have addressed these group specialty competencies with their emphasis on summarizing the key literature and how it relates to group practice from screening practices to group interventions to assessment and development of group strategies specific to a subspecialty within a population.

We learned so much about groups as we put this together. Our knowledge about, confidence in, and enthusiasm for groups has greatly increased. We hope you feel the same way after reading this book. And more importantly that you keep returning to this book as you lead new groups and develop more group interventions.

Reference

Barlow S. H. (2012). An application of the competency model to group-specialty practice. Professional Psychology: Research, and Practice, 43, 442–453.

Part I Current and Historical Perspectives on the Field of Group Counseling and Psychotherapy

Maria T. Riva

Introduction

Group counseling and psychotherapy has a vibrant and complex history that is not always known to those persons who conduct and study groups. Yet gaining an understanding of the historical challenges and contributions made by devoted group facilitators, researchers, and teachers provides us with a great opportunity to assess where we are currently. Thankfully, the study and practice of group counseling and psychotherapy has made huge strides in what we know. It now provides us with confidence based on empirical data that groups are effective and, thus, rapidly becoming more respected and widely practiced in the field. We owe much credit to those who have carved out our current and promising future path. Because our present is grounded in our past, the lead chapter of this *Handbook* by Sally Barlow reviews the history of group counseling and psychotherapy. In this chapter, she examines the multifaceted history that includes the key contributors, the wide array of group types, and the evolution of group research across the past 100 years. Guided by these historical roots, Barlow also provides recommendations as to how research and practice needs to move forward, including areas that have had limited attention in the past such as "the underserved and decidedly underresearched segments of our society such as the severely and persistently mentally ill" (Chapter 1). The second chapter describes a unifying theory of group counseling and psychotherapy instead of seeing theories as discreet entities or a view that there is a *best* theory. Susan X. Day states that we need to "reach beyond a list of which theories inform which therapies, and to look for a common foundation from which various approaches are constructed as an organizing structure." This chapter provides a clearly marked road map that will guide group facilitators and those who train group leaders. The next chapter discusses the important topic of group dynamics and group development. Donelson Forsyth and Leann Diederich provide wonderful examples that give a vivid snapshot of how a group develops across sessions. These examples are embedded in the theories of group development and underscore for the group psychotherapist a conceptual filter by which a group can be viewed. Following the information on group development is a chapter that discusses the current theory and research on therapeutic factors. It is clear that groups have components or factors that can increase the effectiveness of the group. More recent research has begun to look more carefully at the number and type of therapeutic factors that occur within groups. Dennis Kivlighan Jr. and D. Martin Kivlighan III help clarify the large and often confusing body of research on therapeutic factors. They offer a hope that researchers will continue to broaden the existing body of literature on these important therapeutic components and that research studies will examine the relationship of these factors with other group processes and outcomes. As with the other chapters in this section, Gary Burlingame, Kaity Whitcomb, and Sean Woodland articulate a current perspective on the status of process and outcome research in group counseling and psychotherapy. In many ways, this chapter brings together what we know about the effectiveness of groups and how group research has become stronger and more rigorous over the past 10 years. These excellent chapters in this section underscore how far we have come as a field and how the emphasis on theory, group development, therapeutic factors, and on processes and outcomes in group psychotherapy are still some of the most essential elements in our group practice and research.

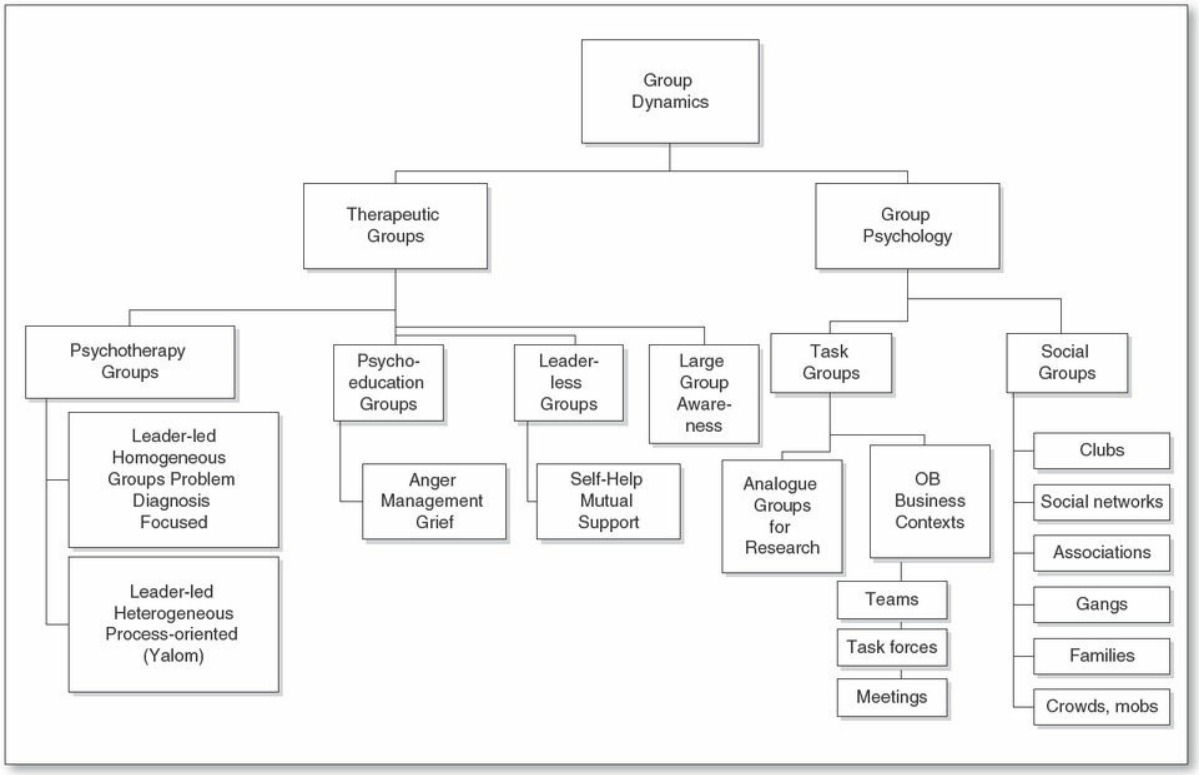
Chapter 1 The History of Group Counseling and Psychotherapy

Sally H. Barlow

This chapter examines historical aspects of group counseling and psychotherapy by presenting key contributors, types of groups, and research (review articles, group vs. individual meta-analyses, themes from small group psychology, and substantive themes by clinical population). Group psychotherapy and counseling have a multifaceted history founded on over 100 years of theory, research, and clinical practice that informs this specialty in evidence-based professional psychology. Medicine, psychoanalysis, theater, communications, social psychology, evolution, and other domains have contributed. *Group counseling, group psychotherapy*, and *group treatments* are terms used interchangeably, although some controversy exists about the exact demarcation between these. Figure 1.1 depicts the placement of these group therapies among other kinds of groups. "Many professional national and international organizations have promoted the place of experts in many kinds of groups by their involvement in the education, training, and credentialing of group leaders, group therapists, as well as promoting groups to the public" (Barlow, 2013).

A brief view of contributions of key figures and their ideas related to group phenomenon include William James' theory of social facilitation, Norman Triplett's first social psychology investigation of groups, Joseph Pratt's first group psychotherapy study, Sigmund Freud's notion of the social as mediator in *Group Psychology: The Analysis of the Ego*, Trigant Burrow's coining of "group therapy," Kurt Lewin's establishment of the Center for Group Dynamics, S. H. Foulkes' establishment of the Institute of Group Analysis, Wilfred Bion's *Experiences in Group*, Henri Tajfel's Social Identity Theory, Irving Janis' *Groupthink*, Urie Bronfenbrenner's Social Ecological Model, Irvin Yalom's text *The Theory and Practice of Group Psychotherapy* (Yalom & Leszca, 2005), and Donelson Forsyth's social psychology text *Group Dynamics* (see Barlow, 2013). Each contributor in turn examined theoretical, empirical, and practical mechanisms of group psychology and group psychotherapy, laying the foundation for group history and research.

Figure 1.1 Group Types Flowing From the Foundations of Group Dynamics



Note: Thank you to Donelson Forsyth for his help on this flow chart.

A Historical Review

Amperican physician Joseph Pratt published his study of treating tuberculosis patients in a group setting in 1905, using "thought control classes," which likely gave the written history of group research a beginning point (Barlow, Fuhriman, & Burlingame, 2000), while Freud (1922), Adler (1955), Moreno and Whitin (1932), in turn, published accounts about the theoretical underpinning of the group "cure." The history of psychotherapy research in general and group in particular can be sandwiched between two physicians working with tuberculosis patients. Archie Cochrane, a Scottish physician, realized he couldn't go on collapsing lungs (one of the two treatment strategies for this illness) if he did not have more empirical data to guide him. He founded what came to be known as the Cochrane Library, an enormous electronic database that rates scientific findings according to a scale that prioritizes the best research available (Cochrane & Blythe, 1989).[1] In the 50-year span of time from Pratt to Cochrane, tuberculosis went from an almost incurable disease to a treatable one with effective vaccines and improved health care; but given antibiotic resistant strains, it still represents a health threat in the medical world. Serious mental health issues represent health threats as well such as depression and schizophrenia, just to name two. Depression is considered a leading cause of the "disease burden," which determines the impact of health problems—for instance, financial costs—by combining quality of life years (QALYs) and disability-adjusted life years (DALYs)—indexes that examine morbidity and mortality rates in North America that are expected to increase worldwide. Like Cochrane, mental health professionals are searching for viable treatments.[2] Efficient and effective treatments for an array of disorders may include the careful use of group treatments for depression, anxiety, schizophrenia, and other mental health issues.

Cochrane was a leading medical health expert who collated all kinds of diseases and their treatments for medical doctors. Psychology is moving in this direction by carefully collating evidence-based treatments, including group counseling and group psychotherapy, so that professional psychologists can access databases that can assist them as they deliver viable treatments.

Group Work: Groups Work (Under Certain Conditions)

Group counseling and psychotherapy research has moved from mere tallies to sophisticated multimethod designs and analyses over the past 110 years of data collection (Burlingame, MacKenzie, & Strauss, 2004). Tables 1.1–1.5 present information culled from filtered and unfiltered databases, including EBSO, ERIC, PubMed Medline, CINAHL, CogNet, Psychnet, and Cochrane covering the time period from 1960 to 2012.

Generally, group process and outcome research focuses on those groups found on the left side of Figure 1.1. Process research can be defined as an analysis of "shared examination of members' relationship in all respects relevant to their interdependence"(Bradford, Gibb, & Benne, 1964, p. 379; also see Beck & Lewis, 2000), often utilizing moment-to-moment measures (see Barlow, 2013, for a list of these measures). Greenberg and Pinsoff (1986) remind researchers not to use too narrow of a distinction between process and outcome. Outcome has been defined as those results that accrue from having examined members on any number of variables (such as symptom reduction). The role of moderators (those variables such as age or gender that interact with an independent variable to influence outcomes on dependent variables) and mediators (specific causal agents that lead to change in the dependent variable) has become critical in group process and outcome research (Greene, 2012).

With those basic distinctions in mind, we turn to Table 1.1 that presents group counseling and psychotherapy systematic review articles that includes reviews from the original Fuhriman and Burlingame chapter in their groundbreaking book, *The Handbook of Group Psychotherapy: An Empirical and Clinical Synthesis* (1994) and additional reviews from 1962 to 2012. Covering a period of 50 years, these group reviews are categorized according to treatment orientation, number of studies in each review, what group was compared to in order to determine effectiveness (wait-list or comparable controls, other group treatment comparisons, including pharmacotherapy, individual therapy comparison, and combined treatment such as group plus individual), population studied, and results. Briefly, taken by each decade, the 1960s produced studies focused mainly on institutions where clear support for one group over another was not evident. Studies in the 1970s demonstrated superior results when compared to controls and indicated improving results. The 1980 studies reflect further refinements, including growing awareness of methodological complications. Combined group with individual treatment resulted in superior outcomes. By the 1990s, reviewers were careful to consider differential as well as general improvement, noting too that the sheer number of variables being studied was rapidly becoming unmanageable. Reviews from the new century include a robust finding for cognitive-behavioral therapy (CBT) groups, with the exception by Shechtman and Pastor (2005) who reviewed studies of children in goal setting and interpersonally focused groups utilizing Benjamin's (1974) Structural Analysis of Social Behavior. In sum, systematic reviews can be helpful in organizing vast amounts of data; still, Mullen and Ramirez (2006) remind us that they possess both promises *and* pitfalls.

Author	Treatment Orientation	Number of Studies	Comparison* WLC, OT, I, COM	Sample	Conclusions
Rickard (1962)	Nondirective, psychoanalytic, psychodrama	22	X X X X	Mixed inpatient and outpatient	Too much variability among patients, therapists, and measures for comparison to be more than tentative. Efficacy of group remains to be empirically validated.
Pattison (1965)	Psychodrama, milieu, analytic	U		Inpatient, prison, addict, delinquent	Group activity is therapeutic using behavioral criteria, disappointing with psychometric criteria, and promising with construct criteria. Notes that the research on individual psychotherapy and small group research has yet to be effectively incorporated into group psychotherapy research.
Stotsky & Zolik (1965)	Psychodrama, round table, and heterogeneous group	U	X X X X	Psychotics	The results of controlled experimental studies do not offer clear support for using group therapy as an independent modality, but they do support group as an adjunctive or helpful intervention when combined with other treatments (drugs, individual, etc.).
Mann (1966)	Psychodrama, nondirective	41	X X X	Mixed diagnosis, adult and children, most institutionalized	Group therapy produces change in behavior, attitude, and personality regardless of orientation, method of comparison, or instruments.
Anderson (1968)	Counseling groups	6	X X X	Elementary students	Group counseling associated with higher grade point average and personality change when compared with control. No difference when compared with other treatment combined.
McRaeff & Kurzreich (1970)	Heterogeneous, expressive, nondirective, systematic, desensitization, behavior, analytic	6	X X X	Hospitalized adults, adult outpatients, children	Eighty percent of adequately controlled studies reviewed showed primarily positive results with both individual and group therapy. Six studies that made direct comparisons between group and individual therapy found equivalent outcomes, with a slight tendency for individual to be more effective.
Bednar & Lawlis (1971)	Heterogeneous, group psychotherapy, self-help, activity milieu, work, insight	38	X X X X	Mixed inpatient, seven outpatients, delinquents, alcoholics, sex offenders, students	Group therapy is valuable in treating neurotics, psychotics, and character disorders. It is a two-edged sword that can facilitate client deterioration.
Luborsky, Singer, & Luborsky (1975)	Heterogeneous	12	X X X	Unspecific	Majority of comparisons showed no significant differences between group and individual treatments. There was a tie in nine comparisons: group was better in two comparisons and individual was better in two comparisons.
Grunebaum (1975)	Unspecified	U	X	Heterogeneous	Only meager data exist comparing group and individual therapies, and the evidence suggests that they are equally effective in most instances. Some findings suggest that benefits may be disorder-specific; for example, individual therapy is better for phobias, and group is more effective for schizophrenic outpatients.
Emrick (1975)	Heterogeneous	384	X X X	Alcoholics	Found a general trend for both individual and group to be effective in treating alcoholism.
Lieberman (1976)	Heterogeneous, psychotherapy, and personal growth groups	47	X X	College students, adults	Group consistently produced favorable outcome over controls. Reported no outcome differences in studies that compared group with individual formats. Noted that the indices used to measure outcome are relatively insensitive to the potentialities of different treatment contexts such as group and individual psychotherapy.
Parloff & Dies (1977)	Heterogeneous, psychotherapy groups	39	X X X X	Psychoneurotics, schizophrenics, addicts, legal offenders	Group has no unique advantage over other treatments with schizophrenic patients, no firm conclusions can be drawn with psychoneurosis, and limited support for effectiveness with addicts.
Bednar & Kaul (1978)	Heterogeneous, behavioral, transactional analysis, unspecific group therapy, and encounter groups	21	X X X	College students, delinquents, prisoners, psychiatric patients	Group treatments have been more effective than no treatment, placebo, and other recognized psychological treatments.
Solomon (1983)	Psychodynamic, aversion	2	X X X	Alcoholics	Combined individual and group therapy is related to poorest outcome, while individual and group as independent treatments showed equivalent outcomes.
Kanas (1986)	Heterogeneous	32	X X	Outpatient and inpatient schizophrenics	Group therapy proved to be superior to controls in 67% of inpatients and 80% of outpatients studied, with long-term therapy being the best.
Kaul & Bednar (1986)	Experimental psychotherapy groups	17	X X	Primarily adult mixed diagnosis	Mixed but favorable outcomes for the efficacy of group psychotherapy.
Toseland & Siporin (1986)	Heterogeneous	32	X X	Heterogeneous	Results of this new review indicated that group treatment was as effective as individual treatment in 75% of the studies included and was more effective in 25%. In the 32 studies reviewed, there was no case in which individual treatment was found to be more effective than group treatment.
Bostwick (1987)	Unspecified	13	X X	Unspecified	Individual treatment had less premature termination than group, while combined individual and group treatment proved superior at reducing dropouts over either modality.
Oesterheld, McKenna, & Gould (1987)	Heterogeneous (e.g., behavioral, insight, cognitive-behavioral, dynamic)	18	X X X	Bulimia	Group seems to be helpful, but methodological limitations preclude robust conclusions.
Zimpfer (1987)	Heterogeneous (e.g., group counseling, multimodal, growth, insight)	19	X X	Elderly	Group seems to be helpful, but methodological limitations preclude robust conclusions.
Freeman & Munro (1988)	Cognitive-behavioral, eclectic, supportive, didactic	13	X X X X	Bulimics	Neither drug nor group therapy was as effective as individual, but all are more effective than placebo. Group is most cost-effective, and combined group and individual is most effective of all treatments.
Cox & Merkel (1989)	Heterogeneous	32	X X X	Bulimics	In a review of 15 group and 17 individual studies (only one study provided a comparison between the two modalities, the rest were inferential), it was concluded that there was no support for the two treatments having any differential effectiveness.
Zimpfer (1990)	Cognitive-behavioral, psycho-educational behavior	31	X X	Bulimics	Regardless of treatment type and outcome criteria, group was shown to be an effective treatment.
Piper & McCallum (1991)	Self-help, consciousness, cognitive restructuring, behavioral skills, dynamic	5	X X X X	Grief	Group treatment has not been adequately tested to determine its efficacy.
Vandervoort & Fuhrtman (1996)	Cognitive-behavioral, psychodynamic, cognitive	12	X X	Outpatients, depression	Group is efficacious in treating depression with little evidence for differences between individual and group.
Piper & Joyce (1996)	Behavior 30%, cognitive-behavioral 26%, interpersonal/psychodynamic 14%, didactic 1%	86	X X X X	Lifestyle problems, medical conditions, mixed psychiatric disorders, mostly adults	A variety of patient problems treated in interactive therapy groups for 6 months or less were examined for evidence of efficacy, applicability, and efficiency of time-limited, short-term group therapy (TSGT). Strong evidence for all three factors was found. Of 50 studies that had TSGT versus control comparison, 48 provided evidence of benefit of group treatment. A difference in benefit was found for the 6 studies that used TSGT versus individual.
Hoag & Burlingame (1997a)	60% behavioral or cognitive-behavioral	56	X X X X	Male and female children and adolescents (4–18), primarily problems of disruptive behavior, self-esteem	Review of studies from 1974 to 1997 of group interventions for children and adolescents (including preventative, psychotherapy, and guidance) revealed that treatments occurred mostly in school setting and groups were beneficial.
Marotta & Asner (1999)	Psychoanalytic, cognitive-behavioral, self-help, psycho-educational	21	X X X X	Adult females	Review of studies from 1978 to 1995 of group interventions for women with incest histories (using a wide array of treatment models)—categorized by six criteria: design, sample, inclusion criteria, replicability analysis, and outcome. 14 were descriptive or case studies. Some support for group treatment was provided. Minimal adequacy of research design.
Harney & Harney (1999)	Cognitive-behavioral, interpersonal transaction (Yalom), information processing, psychodynamic	5	X X X	Male and female adults	Review of studies of trauma survivors assessed important variables along eight domains: authority over memory, integration of memory with affect, affect tolerance, symptom mastery, self-esteem/self-care, self-cohesion, safe attachment, meaning-making. Multidimensional, stage-oriented approaches worked best.
Shechtman (2002)	Educational, counseling, psychotherapy (multi-theoretical and cognitive-behavioral)	U	X X X X	Male and female children and adolescents	Review of studies of group interventions for children found that all three types of groups were effective as long as suitable goals were set. Findings regarding process in children's groups showed that very little research exists.
Lockwood, Page, & Conroy-Hiller (2004)	Multi-theoretical and cognitive-behavioral treatments for schizophrenia in group and individual	28	X X X X	Male and female schizophrenic adults	Longer-term group psychotherapy or modular skills training can be effective overall for symptom reduction and behavior modification. Group psycho-educational training was not effective in improving medication compliance, or in reducing polydipsia.
Pinquart, Duberstein, & Lyness (2007)	CBT, dynamic, reminiscence, exercise, psycho-education	57	X X X X	Clinically depressed older adults	Significant findings for CBT, reminiscence therapy. Almost 20% dropout in group, higher than individual. Authors did not directly compare individual and group.
Himelhoch, Medoff, & Oyesiyi (2007)	CBT and supportive therapy	8	X X	665 depressed mostly males, HIV-infected	CBT groups and supportive therapy groups had pooled ES of 0.37, 0.58. "Of note, women were nearly absent from this study."
Jonsson & Hougaard (2008)	CBT, exposure and response prevention, ERP	13	X X	820 male and female adults with OCD	CBT combined with ERP is effective, better results than drug therapy. Authors suggest next step is to compare group with individual.
Brunwasser, Gillham, & Kim (2009)	Penn Resiliency Program (PRP)—a group CBT intervention	17	X X X X	2,498 depressed youth	Participants reported fewer symptoms at 1-year follow-up. Works best when group leaders are research team members and community providers. Authors wonder if CBT mediates PRP.
Krishna, Inadura, Lepping, Turner, Crossley, & Krishnamoorthy 2010	CBT for depressed older adults	11	X X X X	Older male and female adults (50 years and older)	Although the quality of some studies was not optimal (360 studies were identified initially, but only 11 met requirements for inclusion), results support that group CBT is effective in older adults with depression.

*WLC, wait list controls or comparable control group; OT, other group treatment comparison including pharmacotherapy; I, individual therapy comparison groups; COM, combination; CBT, cognitive-behavioral therapy; OCD, obsessive-compulsive disorder; ES, effect size; U, unknown.

Source: Piperman & Burlingame (1994), adapted with permission. List of references is available from the authors.

* WLC, wait list controls or comparable control group; OT, other group treatment comparison including pharmacotherapy; I, individual therapy comparison groups; COM, combination; CBT, cognitive-behavioral therapy; OCD, obsessive-compulsive disorder; ES, effect size; U, unknown.
Source: Fuhriman & Burlingame (1994), adapted with permission. List of references is available from the authors.

Table 1.2 lists group versus individual meta-analyses from 1980 to 2012. The watershed meta-analysis in 1980 by Smith, Glass, and Miller led the way. Average effect size for individual was 0.87 and 0.83 for groups, remarkably similar. Succeeding meta-analyses generally found overall equivalence between group and individual for male and female adults, older adults, and children/adolescents. In the new century, results were, in the main, similar. A summary statement representative of studies from 2000 to 2012 can be selected from Jonsson, Hougaard, and Bennedsen (2011) where the authors suggested that the disorder they were studying (OCD) could be just as effectively dealt with in group given equivalence with individual treatment as it is both effective and efficient.

Table 1.3 presents group psychology and group psychotherapy themes of interest to researchers over the decades, which yields focus on models or approaches, problem solving and decision making, group structure, group climate, and leadership. By 1970, researchers were interested in all of them. Covering the same time period, Table 1.4 examines group psychotherapy topics such as models, formats, theories, patient populations, therapeutic relationship, therapist variables, therapeutic factors, structure, interaction analysis, client outcomes, and ecosystems. By 1970, all these topics were being intensely studied by most researchers. Tables 1.3 and 1.4 represent the best efforts of combining the interests of group dynamics specialists with group psychotherapy specialists, efforts that have reinforced the important foundation of groups.

Table 1.5 lists substantive themes (models, CBT, short term, pregroup training, etc.) by clinical populations (child/adolescent, medical, depressed, eating disorder, etc.). As this represents the published group research to date, a brief review of the table suggests we need to attend overall to studying more themes with certain populations such as personality disorders and eating disorders. As a model, Gestalt as it is applied to group does not appear to be garnering research attention, whereas CBT has been studied in every clinical population listed.

One likely explanation for CBT dominance is that it avails itself, as a model and a matching methodology, to EST research. Psychoanalytic, interpersonal, and group models do not. Therefore, before we leave this topic, we must consider several methodological concerns: ESTs and statistics for group analysis. A controversy exists about the use of Empirically Supported Treatments (ESTs) and Evidence-Based Professional Psychology (EBPP) labeled nothing short of "culture wars" by Messer (2004). Some claim that to *not* use ESTs is unethical (Wachtel, 2010), while others state that the use of ESTs is *most* ethical (Cukrowicz et al., 2011). Still others state that EBPP is more responsive to culturally diverse clients than ESTs (La Roche & Christopher, 2009); finally, helpful assistance is offered by some (Hunsley, 2007; Norcross, Hogan, & Koocher, 2008) as Evidence-Based Professional Psychology is clearly here to stay. This debate will not end any time soon; group leaders must take care to lead groups that take into account the advantages and disadvantages of interventions based on ESTs or EBPPs.

Many concerns have been raised about the value of meta-analysis, as well as the current controversy about nonindependence in group studies. Space does not permit a thorough treatment of these issues. Briefly, opponents of meta-analysis suggest it may yield misleading findings (Howard et al., 2009; Staines & Cleland, 2007) and a false sense of rigor (Mullen & Ramirez, 2006). Pretreatment nonequivalence leads to the Simpson Paradox (Hsu, 2003); nonindependence of observations (because of the shared environment of groups, group members' scores may become correlated) may confuse actual outcomes in groups and violates a statistical rule (Baldwin, Murray, & Shadish, 2005; Baldwin, Stice, & Rohde, 2008; Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009; Imel, Baldwin, Bonus, & MacCoon, 2008; Kenny & Judd, 1986). Clinically, that group members may become more like one another on process and outcome measures due to the shared climate may actually be a result group leaders would expect; still, this leads to complications with statistical analysis that we have yet to solve.

Author	Treatment Orientation	Group Characteristics	Sample	Conclusions
Smith, Glass, & Miller (1980)	Heterogeneous	Variable	Heterogeneous	The mode in which therapy was delivered made no difference in its effectiveness. Indeed, the average effects for group and individual therapy are remarkably similar. The average ES was 0.87 for individual therapy and 0.83 for group therapy. Of the studies, 43% were individual and 49% were group.
Shapiro & Shapiro (1982)	Heterogeneous	Average time spent in therapy was 7 hours	Heterogeneous	This is a refined meta-analysis of the one conducted by Smith and Glass (1980), who reported that although individual therapy appeared the most effective mode (M = 1.12), it was closely followed by the predominant group mode (M = 0.89), and the only striking treatment mode finding was for couple/family therapy (M = 0.21).
Miller & Berman (1983)	CBT	Duration of treatment relatively short	Adolescents and adults, student/ community volunteers and outpatients, anxious and/or depressed	This meta-analysis of 48 studies reported that CBT was equally effective in group and individual formats when compared with a non-treatment group (individual = 0.93, group = 0.79) and when compared with other treatment controls (individual = 0.31, group = 0.18); it should be noted that none of the studies in the review directly compared individual with group treatment within a single study.
Dush, Hirt, & Schroeder (1983)	CBT self-statement modification	Mean weeks of treatment were 5.9 with a range of 1–26	About one-fourth of studies used outpatients, one-fourth used community volunteers, and half used undergraduate depressed and anxious volunteers	Treatment modality was highly influential with the mean effect for individual therapy nearly double that of group therapy across all comparisons. When compared with no-treatment controls, ES was 0.93 for individual and 0.58 for group; when compared with placebo controls, it was 0.71 for individual and 0.36 for group.
Nietzal, Russel, Hemmings, & Gretter (1987)	CBT and other	Mean number of hours in treatment was 16.3, with a range of 3–69 (distribution between group and individual hours not made)	Individuals with unipolar depression, adults	Reports a reliable difference between individual and group treatments, with group treatment being less effective. Clients treated with group (M = 12.47) reported more depressive symptoms than clients receiving individual treatment (M = 0.06).
Robinson, Berman, & Neimeyer (1990)	Included treatments with a prominent verbal component (i.e., cognitive, cognitive-behavioral, behavioral, and general verbal therapy)	Number of clients per group ranged from 3 to 12 (M = 7)	Depressed individuals	Analysis indicated that both group and individual therapy produced more improvement than no treatment and that the effects of the two approaches were comparable. The 16 studies that compared individual and group therapy with a wait-list control and the 15 studies that compared group with a wait-list control produced nearly equal ESs (0.83 and 0.84, respectively).
Tillitski & Siporin (1990)	Therapy, counseling, psychoeducational	Heterogeneous	Adults, adolescents, children diagnostically heterogeneous	In this reexamination of a subset of the studies looked at by Toseland and Siporin (1986), Tillitski reports finding the same average effect size for both group and individual treatments (1.35) and states that this effect was consistently greater than that of controls (0.18). Also, group counseling was found to be almost twice as effective as either therapy or psychoeducation. Recent studies produced larger ESs, and group tended to be better for adolescents, whereas individual tended to be better for children.
Hoag & Burlingame (1997a, 1997b)	60% behavioral or cognitive-behavioral	79% took place in school groups (focused primarily on disruptive behavior, social skills, self-esteem), average group size was 5–9, average treatment length: 14 sessions	Male and female children and adolescents (4–18)	56 outcome studies from 1974 to 1997 of group interventions (including preventative, psychotherapy, and guidance) revealed an ES of 0.61 for group treatments over wait-list and placebo controls.
McRoberts, Burlingame, & Hoag (1998)	Cognitive, behavioral, dynamic, supportive, eclectic	Average groups of 26 sessions, lasting 90 minutes each, 44% had co-therapists	Adult outpatients with heterogeneous diagnoses	In this meta-analysis of group versus individual therapy, the general finding was overall equivalence (0.01), although under certain circumstances, individual therapy fared better (depression, CBT approach, 0.16); in other circumstances, group fared better (with circumscribed problems, researcher's allegiance to format, attendance of member).
McDermut, Miller, & Brown (2001)	95% behavioral or cognitive-behavioral, 5% interpersonal, psychodynamic, or nondirective	Highly diverse clinical settings, typical group lasted 12 sessions, once a week, and variety of therapists	Male (30%) and female (70%) outpatient adults with diagnosis of depression (mean age 44)	48 studies from 1970 to 1998 examined group therapy for depression. Patients showed clinically meaningful improvement compared with untreated controls, although their scores on Beck Depression Inventory were still higher than normals. Of studies that compared group with individual therapy, slightly more reported individual to be superior.
Burlingame, Fuhriman, & Mosier (2003)	Cognitive, behavioral, dynamic, supportive, eclectic	University, correctional, and outpatient mental health settings	Adult outpatients with heterogeneous diagnoses	Examining 20 years of studies, the report found that patient diagnosis resulted in differential effects, homogeneous groups outperformed those in groups with mixed symptoms, and behavioral fared better than eclectic orientation. Homogeneous topic-centered outperformed.
Aderka (2008)	Cognitive-behavioral	Outpatient	511 adult participants with social phobia	Adults with social phobia were individual and group treatments. Giving video feedback was not a mediator of treatment efficacy, but treatment format was. Larger ES in individual and lower attrition than group.
Payne & Marcus (2008)	Cognitive-behavioral, reminiscence	Outpatient, inpatient medical setting, hospital	Male and female older adults (55 and over)	Groups benefit older adults. Those receiving CBT benefited more than those receiving reminiscence therapies. The older the average age of group members, the less they benefited. Number and length of sessions, living situation were not significant moderators. Overall ES matched adult and child samples.
Waldron & Turner (2008)	Cognitive-behavioral, some motivational interviewing	Outpatient, schools, community, groups averaged 7–12 sessions	Adolescent male (75%) and female substance abusers	Meta-analysis on 17 studies of individual, group and family mostly CBT, inactive control group. 2,307 adolescents total. Group and family therapies emerged as best model, although authors state all active treatments were significantly better than inactive control. ES = 0.62, 0.58, respectively.
Liber Van Widenfelt, Utens, Ferdinand, Van der Leeden, Gastel, Treffers et al. (2008)	Cognitive-behavioral	Routine care settings	Male and female children (8–12 years old) with anxiety	227 randomly assigned children. No significant difference between individual and group CBT (group and individual treatments compared using chi-squared, regression, not meta-analysis).
Jonsson, Hougaard, & Bennedsen (2011)	Cognitive-behavioral	Routine care settings	Male and female adults with OCD diagnosis	110 outpatients were randomly assigned to 15 sessions of either group CBT or individual CBT for OCD. Large pre-post effect sizes were found for both treatments. Authors suggest OCD can be effectively dealt with in group given equivalence with individual treatment. The study was supplemented by a meta-analysis of accomplished comparative studies of group vs. individual for OCD.

Source: Fuhriman & Burlingame (1994), adapted with permission.

Source: Fuhriman & Burlingame (1994), adapted with permission.

	1900–1910	1911–1920	1921–1930	1931–1940	1941–1950	1951–1960	1961–1970	1971–1980	1981–1990	1991–2000	2001–2012
Models/ approaches						X	X	X		X	X
Interpersonal influence	X				X	X	X	X	X	X	X
Problem solving, decision making	X		X	X	X			X	X	X	X
Group structure				X	X		X	X	X	X	X
Group climate				X	X	X	X	X	X	X	X
Leadership						X	X	X	X	X	X

The last two columns show that research reflects the Burlingame et al. (2004) six-component model: FCT, formal change theory; SGP, small group processes; L, leader; P, patient; GS, group structure; GTO, group treatment outcomes.

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The last two columns show that research reflects the Burlingame et al. (2004) six-component model: FCT, formal change theory; SGP, small group processes; L, leader; P, patient; GS, group structure; GTO, group treatment outcomes.
Source: Fuhriman & Burlingame (1994), adapted with permission.

	1900–1910	1911–1920	1921–1930	1931–1940	1941–1950	1951–1960	1961–1970	1971–1980	1981–1990	1991–2000	2001–2012
Formats/theories/ models	X	X	X	X	X	X	X	X	X	X	X
Patient/client populations	X	X	X	X	X	X	X	X	X	X	X
Therapeutic relationship			X	X	X	X	X	X	X	X	X
Therapist variables							X	X	X	X	X
Therapeutic factors	X	X	X	X	X	X	X	X	X	X	X
Structure							X	X	X	X	X
Interaction analysis							X	X	X	X	X
Client outcomes						X	X	X	X	X	X
Ecosystem	X	X	X		X		X	X	X	X	X

Source: Fuhriman & Burlingame (1994), adapted with permission.
Source: Fuhriman & Burlingame (1994), adapted with permission.

	Child/ Adolescent	Medical	Depressed	Eating Disorder	Substance Abuse	Criminal	Inpatient	Family/ Marital	Elderly	Outpatient	Schizophrenic	Sexual Abuse	Personality Disorder	Not Specified	Other
Models/ approaches															
Cognitive-behavioral	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Short term	X	X	X		X		X	X	X	X	X	X	X	X	
Rogerian										X					X
Gestalt											X			X	
Personal growth						X								X	
Psychodrama	X					X	X								
Therapist variables	X	X	X	X	X	X	X	X	X	X	X		X	X	X
Directiveness			X									X		X	
Interpretation												X		X	
Therapeutic factors	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Structure	X	X	X	X	X	X	X		X	X		X		X	
Development						X				X				X	
Pregroup training								X		X				X	
Interaction			X		X	X	X	X	X	X	X	X		X	X

Source: Fuhriman & Burlingame (1994), adapted with permission.

Source: Fuhriman & Burlingame (1994), adapted with permission.

Group Case Example

This chapter presents the extant group history of research, founded on theory and practice. It has implications for everyday practice. Imagine I have a new individual client I believe will also benefit from a good group. Considering that I am intending to continue seeing her in individual therapy and plan on referring her to a group, I review the information in Table 1.1 from systematic reviews that compared combining individual and group treatment to make an informed decision about which treatment modality might be better suited for my client. I know also from Table 1.2 that groups generally work under certain circumstances and particularly will work better for my client, Sara, if her first group experience is more structured, theme focused, and time limited, given her particular struggles. I also know from Tables 1.3–1.5 that her population, diagnosis, and setting (women of color, depression, and outpatient) have been variously studied. Her race/ethnicity is less likely to have been carefully noted by researchers prior to 1980 as psychologists were just beginning to attend to multicultural issues. Because of this, I will take care to discuss with her possible minority/majority group dynamics in the upcoming group, "Recovering From Divorce." Given that the group is purposefully designed for women only, she assures me that she will be alright even if she is the only African American person in the group. We identify the two or three target complaints she wishes to work on interpersonally: being more assertive, grieving the loss of her partner, understanding how the divorce happened with hopes not to repeat such a traumatic experience. She gives me written permission to talk to her group leader.

Once the group starts, I encourage her to talk to me about early struggles she might have while becoming a new group member. Given her interpersonal distresses, I support her in individual therapy as she makes an effort to speak up, disclose her sadness about her loss, and learn how other women have coped with similar circumstances. She is at risk for early drop out—upwards of 30% of members in group can drop out pretermination; thus, I assure her that her anxious feelings and thoughts about group membership are normal and that it is still worth seeing the group through to its end at 8 weeks. I will invite the group leader to contact me should alliance ruptures occur. At pre-, mid-, and postgroup times I will ask her to take a group assessment. Burlingame and colleagues (Krogel et al., in press; Thayer & Burlingame, 2010) have recently developed a group measure that addresses positive bonding, positive working, and negative relationships,[3] as well as individual assessments such as the Outcome Questionnaire.[4]

At group's end, I will ask her if she wishes to attend a less structured group, perhaps a process group with both males and females that lasts longer and acts as a support to her, an invitation to address underlying personality distress, which may require deeper exploration, and the chance to practice new behaviors with males.

Possible Training Activities and Classroom Discussion

According to Taylor and colleagues (Taylor et al., 2001), while more groups are being utilized, fewer group courses are being taught in graduate school. In addition, general training in psychology has come under scrutiny (McFall, 2006) and even attack (Baker, McFall, & Shoham, 2008). If you are one of the fortunate graduate students taking a course in group counseling, let's find a way to make this chapter on group history and research useful; these studies do have something to say to us. Beutler (2009) reminds us that we must make science matter in psychology; Kazdin (2009) reminds us that we must understand how and why psychotherapy leads to change. Current training guidelines include the Rodolfa et al. (2005) "Cube" heuristic, which crosses foundational, functional competencies with professional stage of development. Table 1.6 displays just one segment of that cube by highlighting knowledge-based and applied competencies for supervision and training, which might act as an outline for this exercise.

Imagine you are about to lead your first group as a trainee. Consider first the information from Tables 1.1–1.5. Let's review them: (1) A number of systematic reviews suggest that many models (for instance, CBT, interpersonal psychodynamic, psychoeducational) are represented; an array of group types and group patients has been assessed utilizing a number of comparisons (wait-list controls, other treatments, including medications, individual therapy, combination treatments); (2) meta-analyses comparing individual to group suggest generally equivalent findings; (3) many relevant themes from both group psychology and group psychotherapy over the decades include issues critical to group functioning: interpersonal influence, problem solving, group structure and climate, and leadership; (4) group psychotherapy topics across 110 years include focus on models, patient populations, the therapeutic relationship, therapist variables, therapeutic factors, structure, interaction analysis, client outcomes, and the overall ecosystem; and (5) substantive themes by clinical populations reveal that criminals and outpatients involve the highest number of themes assessed, with fewer themes for child/adolescents, medical, depressed, eating disorders, substance abuse, inpatient, family/marital, elderly, schizophrenic, sexual abuse, personality disorder. An upside of what we might take from this summary is that enough reliable data has been accumulated to support that group treatments work under certain circumstances. A downside is that the particular group you might be about to lead may be subject to fewer studies or that those studies reveal negative outcomes for group.

Type	Content
Knowledge-based competencies	The entry-level group psychologist will have knowledge of: i) Types of students and trainees involved as coleaders in group specialty practice, and their developmental levels from novice to advanced so as to match appropriate expectations of skill development with level ii) Agency issues regarding referral and composition of groups, and which groups are appropriate for trainee participation iii) Research opportunities that students and trainees can be involved in, including designing their own studies of groups in the agencies where they are placed, particularly dissertation projects
Applied competencies	The entry-level group psychologist will be able to: i) Train students, appropriate to developmental level, in clinical group skill application of group roles, norms, and stages, as well as a rudimentary knowledge of verbal analysis systems to track member-member, leader-member, member-leader interactions ii) Expect active participation in supervisory processes including but not limited to observation of actual group being co-led by trainees using DVD, video, audio tapes or transcripts, role-playing alternative intervention strategies using the group supervision participants to demonstrate group dynamics at both process and content levels iii) Be aware of legal and ethical ramifications of supervision in training settings: boundaries, confidentiality, dual roles iv) Demonstrate unique knowledge base of group specialty practice and common knowledge base across foundational and functional competencies of professional psychology v) Model respect for related health fields inside and outside agency including social workers, marriage and family therapists, psychiatrists, nurses vi) Provide effective didactic instruction using modeling in supervision session, playing supervisor tapes of previous groups where available and with written permission vii) Encourage the development of professional attitudes of group specialty practice clinicians and researchers, including appropriate autonomy, independent research, etc.

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Next, think about group psychology's contribution to the importance of roles, norms, stages, and the development of in-group/out-group tension. Consider group psychotherapy research findings regarding the importance of appropriate referral, pregroup training, composition, and therapeutic factors as they are enhanced by appropriate leader interventions. For example, the use of "here and now,"[5] all topics considered by the many researchers in this chapter and dealt with in more detail in this text. If you have the luxury of referring potential group members to your group, think carefully about their readiness. Several studies reviewed in this chapter support that clients who are new to groups will do better in more structured, theme-focused, homogeneous groups. Compose the group carefully with that in mind. Spend time with each client to identify target complaints as well as to help him or her understand the group member role, including reciprocal role-functioning (to both give and get help) and the importance of appropriate self-disclosure and feedback. Once the group starts, be aware of group members via stage development. For instance, the development of the therapeutic factor, cohesion is critical at the beginning, labeled "forming" by Tuckman (1965). Therefore, focus on member-to-member comments that highlight another therapeutic factor, universality, as well as allowing members to retain their individual differences. In the "storming" stage, make certain your conflict resolution skills are at the ready. As the group engages in the "norming" stage, help make implicit norms explicit. Once they are in the "performing" stage, you may sit back a little and let the group work. At the "adjourning" stage help them say useful goodbyes and consolidate gains. Given that you are a trainee, be sure to make some record of the group to show your supervisor; cue the tape or DVD to trouble spots so that your supervisor can assist you with specific skill development with whatever is actually occurring in the group at that time. Find ways to assess your clients, because this kind of information can be useful to you and to them (Davies, Burlingame, Johnson, Barlow, & Gleave, 2008).

Now that you have reviewed useful ideas, think about how you might apply these ideas to skill development. Use Table 1.6 as a guideline for skills you hope to have developed in this area by the time you are an entry-level psychologist. In class, influence your peer group of graduate students (yes, you are all a group, too, subject to group dynamics) to actively practice the ideas above. Your professor might suggest that you role play a beginning group, with all its attendant struggles, where you try out your leader intervention abilities. The beauty of this kind of practice is that afterwards you can receive feedback from your peers and professor about what worked and what didn't work as you engaged in implementing these important ideas. Remember, leading a group of your peers is almost always more difficult than leading a group of clients. Take advantage of this educational setting to reinforce your newly acquired leader interventions before you implement them with actual clients.

Conclusions, Recommendations, and Practice

A great deal of empirical research has accumulated over the past century about the effectiveness and efficiency of group psychotherapy and counseling (with some caveats—see Burlingame, MacKenzie, & Strauss, 2004; Burlingame, Strauss, & Joyce, in press) that could simply yield piles of data if mental health researchers do not adopt Cochrane-like categories for ranking the best studies (carefully conducted research designs, methods, and analyses), which can then be disseminated to the everyday group practitioner. It is helpful to know where we have come from, including research that reports useful group systematic reviews, group versus individual treatment meta-analyses, group therapy and group psychology themes and topics over the decades, and substantive themes by clinical population, which combine to inform practitioners, researchers, and theorists (Tables 1.1–1.5).

But the past need not necessarily predict the future. If we are to meet the needs of the public given that depression and schizophrenia alone represent a significant public health threat, we must apply what we have learned and find even better models to understand which groups help which clients with which particular mental health struggles. We must address underserved and decidedly underresearched segments of our society such as the severely and persistently mentally ill. Additionally, alongside the accumulating quasi-experimental designs, qualitative research needs to take its equal place in research circles (Barber, 2009; Kazdin, 2008). Careful training of group clinicians (see Barlow, 2004) must continue given that groups do work under certain circumstances, and one of those circumstances is the presence of skilled leaders. Together as researchers, theorists, practitioners, and students-in-training, we must possess "a constant and continuing faith in the pursuit of knowledge while acknowledging human contextuality" (Villemaire, 2002, p. 237). In this way, researchers, theorists, clinicians, and students involved in the array of group treatment strategies will help each other and, most importantly, their group clients.

Notes

1. www.thecochranelibrary.com. Also, see history of Cochrane reviews, library, DARE, and so forth at http://www.update-software.com/history/clibhist.htm.

2. A large literature exists covering the development of Evidence-Based Medicine and Evidence-Based Professional Psychology, including the "EBP culture wars" (Messer, 2004). For a brief summary of this see Barlow, 2010.

3. The Group Questionnaire (Burlingame & Thayer, 2012; Krogel et al., in press) is a 30-item self-report measure of the quality of therapeutic interactions (i.e., positive bonding, positive working, and negative relationships) across three structural parameters of the group therapeutic relationship (i.e., member-member, member-group, and member-leader relationships).

4. The OQ (Lambert et al., 1996; Whipple & Lambert, 2011) is a 45-item assessment easily taken and scored that yields three subscales: Interpersonal Functioning, Work, and Symptoms.

5. "Here and now" is a term first coined in the 1850s by George Holyoake (1871/2010) in a treatise on the principles of secularism where he postulates that leaders must be concerned with alleviating suffering "here and now" rather than in the afterlife to develop "the physical, moral, and intellectual nature of man to the highest possible point, as the immediate duty of life" (p. 17).

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Chapter 2 A Unifying Theory for Group Counseling and Psychotherapy

Susan X Day

Maslow (1968) portrayed social belonging as foundational, standing above only basic physical sustenance and safety on his hierarchy of human needs. Murray (1938) listed affiliation as one of the prime motivators of human behavior. Adler (1929) believed that the main positive meaning in life could be found in social interest—that is, cooperation with other people and concern for their welfare. Yalom and Leszcz (2005) saw intense relationships in groups as an adaptation originating in primitive human cultures. It is no surprise that the group is a powerful healing setting. This chapter presents an argument for a unifying theoretical foundation that explains why the group is so potent.

The Role of Theory

In the context of this chapter, the word *theory* refers to underlying principles that explain the restorative ingredients of an effective group. Many traditional psychological theories inform approaches to group counseling—psychodynamic, behavioral, cognitive-behavioral, existential, experiential, and so forth. In the best practice, an underlying theory is intertwined with group purpose and leader techniques (Posthuma, 1999). As expressed in the Association for Specialists in Group Work's *Best Practice Guidelines* (Thomas & Pender, 2008), "Group workers develop and are able to articulate a general conceptual framework to guide practice and a rationale for use of techniques" (p. 2). This conceptual framework is the theory, which makes the group's process more coherent and organized than a purely intuitive or trial-and-error strategy. The intuitive or trial-and-error strategy can confuse group members and impair transfer of learning from the group setting to everyday life, because they are not able to extrapolate basic principles. Table 2.1 relates traditional psychological theories to group focus and characteristic leadership practices. Applications of various theories to specific group needs and leadership techniques are detailed in many chapters of this *Handbook.* The current chapter explores an overarching heuristic.

One effect of theoretical coherence is that clients can grasp the way the group is being conducted and can accept the rationale as valid. Understanding and accepting the principles of treatment are requirements for a successful alliance, according to Frank and Frank (1991, 2004). In a group, this understanding and acceptance acts as a unifying feature that boosts instillation of hope and group cohesiveness, two of the most basic therapeutic factors (Yalom & Leszcz, 2005).

Theoretical Base	Focus	Leader Practices
Humanist (client centered, existential, experiential)	Self-actualization; awareness of subjective experience	Nondirective, active listening, Socratic dialog
Cognitive-behavioral	Specific maladaptive behaviors and thought patterns	Goal setting, planning, reinforcing, modeling, monitoring
Psychodynamic (psychoanalytic, Gestalt)	Insight; resolution of intrapsychic conflicts	Listening, interpreting, confronting, probing, working through, directing enactments
Psychoeducational	Information on specific topics; coping; emotional and practical support	Teaching, modeling, organizing, leading discussion, assessing
Systems (Adlerian, choice/reality, feminist, family, interpersonal)	Positive interaction with social and political milieu; balance between individual and society; social equality	Modeling, analyzing, strategizing, lifestyle investigation, activism

The field of psychotherapy has called for development of unifying theory (Barlow, Burlingame, & Fuhriman, 2000; Wachtel, 2010) and psychological science in general benefits from developing complete, coherent theoretical models rather than seeking fine discriminations among different types of explanatory accounts (Garcia-Marques & Ferreira, 2011). To progress further theoretically, we need to reach beyond a list of which theories inform which therapies and look for a common foundation, from which various approaches are constructed, as an organizing structure. All theories of psychopathology assert a central causal role of learning in the development of affective and behavior disorders and, in turn, posit that everyone who gains from therapeutic interventions has learned something (Tryon, 2000). The richness of social learning theory is well suited to organize conceptually the many facets of group therapy.

Learning Unites Group Theories

Learning is a change in behavior resulting from experience. The group is a therapeutic setting in which each member learns from experience with others in relationships significantly distinct from their relationships in the everyday world. Thus, at its heart it is a learning process in a social setting. Research has strongly supported the fact that learning often occurs outside of awareness and strongly motivates behavior (Westen, 1998). Psychologists like Westen frequently focus on out-of-awareness learning; however, conscious thought also influences behavior powerfully and is affected by direct instruction as well as modeling, persuasion, and conditioning; so conceptualizing both the out-of-awareness and the conscious aspects of learning must be involved in a theory of group counseling. Baumeister, Masicampo, and Vohs (2011) reviewed research demonstrating the observable behavioral effects of conscious thought, including cognitive activities such as reflecting on past experience, problem solving, taking others' perspectives, self-affirmation, goal setting, and mutual understanding. All these cognitive activities are applied in group counseling settings of many different varieties, uniting theoretical bases of groups falling under otherwise divergent categories such as cognitive-behavioral, Gestalt, psychodynamic, family systems, and choice/reality.

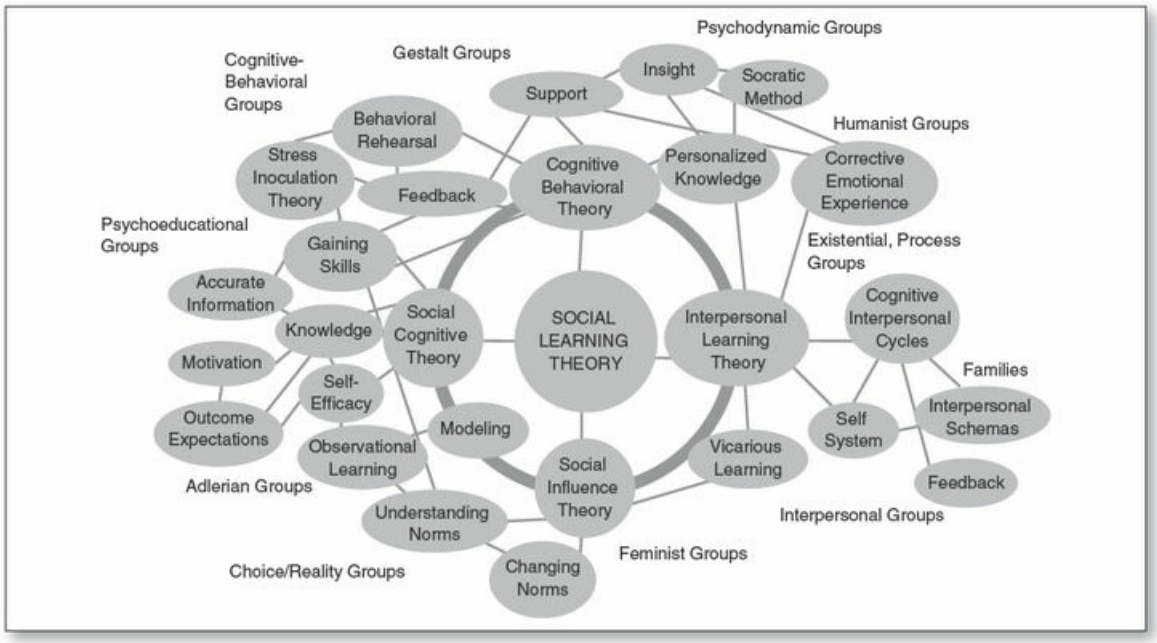
Social learning theory (Bandura, 1986) incorporates many subsets of theoretical thinking, the group dynamics these subsets explain, the activities they involve during group counseling, and the therapeutic factors of group work. Figure 2.1 shows the network of social learning theory concepts (in ovals) and their application to various types of therapeutic groups (in the margins). Thus, it links theoretical frameworks with group practices described and evaluated in research (exemplified in the chapters of this *Handbook*). Figure 2.1 is not offered as an exact geographical map of the system; such a map would be at least three-dimensional, with connections across the two dimensions diagrammed here. The network will be explained and elaborated in this chapter.

Four branches of social learning theory form the inner circle of the diagram: interpersonal learning theory, social cognitive theory, cognitive-behaviorial theory, and social influence theory. As you can observe, the concepts at the next level of generality are highly interrelated, often relevant to several different types of therapy. Ultimately, probably each contributes to most group experiences in some way if all dimensions were representable. However, the inner circle will serve to organize this chapter. Because interpersonal learning theory permeates most basic levels of group counseling no matter what type of group is examined, this branch will be set forth at some length.

Interpersonal Learning Theory

Interpersonal learning theory holds that change takes place through group dynamics. Kurt Lewin (1948) coined the term *group dynamics* to describe all the things that go on in a group, both obvious and subtle. These include how people act toward each other, who has power over whom, what topics are discussed and what topics suppressed, the overall emotional tone, the pace and flow of talk, how people take turns and how long they hold the floor, and who talks and who is silent. The group leader takes much responsibility in establishing the norms of group dynamics (Bednar, Melnick, & Kaul, 1974; Rose & Chang, 2010). Interpersonal learning theory has a large cognitive component because thinking (cognition) always accompanies feeling and experiencing when group therapy is effective (Yalom & Leszcz, 2005). Thus, interpersonal learning theory is also referred to as cognitive-interpersonal theory.

Figure 2.1 Concept Map of Theory and Applications in Group Practice



Group members, over time, come to act and react in the group in ways similar to how they act and interact in the world, and in turn, the group influences how members act and react in the world. Yalom and Leszcz (2005) describe this process wherein the group becomes a social microcosm, in which maladaptive patterns in the world are mirrored in transactions within the group. Identifying and using these patterns therapeutically is a major task of the group leader. Cognitive-interpersonal concepts, elaborated in the next four sections here, can explain this flow of personal style inside and outside of the group counseling setting. Several chapters in this *Handbook* detail how the concepts are put into action in certain types of groups—for example, group work with men (Kiselica & Kiselica, 2014) and group work with children and adolescents (Shechtman, 2014).

Self-System

The term *self-system* includes a person's concepts of who he or she is, especially in relation to other people (Sullivan, 1953). Though the self-system begins in early experiences with caregivers, it evolves through new and more complex interactions with other people. So, for example, an infant whose basic needs are usually met develops trust as part of the self-system. Though this system sets a baseline of trust and mistrust, an adult eventually constructs more detailed rules about who is trustworthy and who is not. These rules are part of the self-schema; they may be accurate, or they may be distorted.

Group leaders are experts in identifying problematic self-systems—for instance, quickly noting the member who operates on the rule that authority figures are always out to exploit and control her. Self-systems are expressed in self-schemas, or usual repertoires of ways we relate to others.

According to interpersonal learning theory, the group provides "a new learning experience in which, contrary to the [client]'s expectations, negative self-schemas are not confirmed. When this learning experience is sufficiently reinforced and consolidated, the [client] is able to accommodate relational information that was previously blocked, and an altered self-schema emerges" (Marziali & Munroe-Blum, 1994, p. 64).

Interpersonal Schemas

An interpersonal schema integrates cognitive and emotional perspectives in "a generic representation of self-other interactions" (Safran, 1990b, p. 107). The schema is a model of what we expect in various relationships: between strangers, between coworkers, between romantic partners, and so on.

We each develop habitual behaviors that enable us to reach out to others for contact and help us avoid having others ignore or reject us. According to interpersonal learning theory, security comes from predicting satisfactory relatedness to others, and anxiety results from predicting weak or broken relatedness to others. We are attuned to possible threats to relatedness and feel anxious when we perceive them. Unfortunately, all of us sometimes create threats to relatedness ourselves.

People who are rigid and inflexible in their repertoire of security operations have interpersonal problems (Kiesler, 1982). One major function of group counseling is to help people become more flexible in their responses. For example, role plays within groups frequently have members act in ways that are outside their usual repertoires, giving them a taste of different ways of responding. Such experiences are a cornerstone of assertiveness training, in which group members practice firm, self-confident behavior during a variety of role plays.

Cognitive-Interpersonal Cycles

Some interpersonal schemas inadvertently bring about the opposite of available, reliable, and satisfying relatedness among people. “Our past experiences skew our present environment and often lead us to create the very conditions that perpetuate our problems in a kind of vicious circle. For example, the people we choose and the relationships we form may confirm the dysfunctional views that we carry forward from our past and that are at the heart of many of our problems” (Arkowitz, 1992, p. 269). A group member who constantly puts herself at others’ service in everyday life, while neglecting her own goals, will act this way in a group, too. When group members enjoy her support and helpfulness yet ignore her needs, her interpersonal schema is reinforced. This is a negative cognitive-interpersonal cycle.

The theory explains bad habits in this context. “The central postulate of an integrative cognitive-interpersonal perspective is that a person's maladaptive interactional patterns persist because they are based upon working models of interpersonal relationships that are consistently confirmed by the interpersonal consequences of his or her own behavior” (Safran, 1990a, p. 97). For instance, the habitually helpful efforts of the group member described above are intended as security operations to ensure acceptance into the group, and to that extent they work, but these same attempts sabotage her being considered seriously as a person with needs herself. She will rarely see support and curiosity offered and so can conclude that she should not show weakness or demand attention, but should continue in her rigid, self-defeating role. A group leader using interpersonal learning theory might design an exercise in which other members offer her support and point out instances when she tries to turn the table and become the helpful one.

The Role of Feedback

The group leader designs a setting in which individuals can get feedback on how their interpersonal schemas are playing out; this feedback is a distinctive quality of a therapy group (Morran, Stockton, Cline, & Teed, 1998). In most interpersonal settings, our social norms discourage us from making honest remarks to each other about how we're coming off. We don't tell a friend that she tends to be self-centered or point out to a coworker that he talks far too long at meetings.

However, in counseling groups this type of honesty is often encouraged, and the givers and takers of such feedback are protected from bad repercussions by the special social norms of the group, which are different from polite society's norms. Members learn from feedback that they would never get in ordinary life. In research studies, feedback has been associated with increased motivation, more awareness about the effect of one's behavior, more willingness to take risks, and more satisfaction with the group (Morran, Stockton, & Whittingham, 2004).

The protected setting, in terms of learning theory, allows for practice without severe retribution for errors. Thus, errors can lead to understanding rather than distress. Group members can practice different strategies for interpersonal relationships, strategies they might never have tried out in the bigger world.

Social Cognitive Theory

Bandura (2001) changed the general name, social learning theory, to social cognitive theory, to emphasize the mental activities involved in social learning. This perspective on what happens in social learning focuses on observational learning—what group members discover through observing other members and the group leader. Modeling can involve imitating what one has learned through observational means: for example, groups sometimes purposely include two leaders who do not always agree, allowing the participants to observe a model of how the leaders manage disagreements in a constructive way (Shapiro, 1999). If the learning situation is enhanced, participants will try out this model, first in group and then in everyday life.

Bandura (1986, 2001) emphasized that learning is enhanced in several different ways, all of which are apparent in group counseling situations. Learning is boosted under certain conditions:

- If you are paying attention. The group therapy setting is distinct from other settings in that distractions are eliminated or kept to a minimum so that members pay more attention to what's happening than they do in most other situations. The small size of most groups in counseling encourages each individual to pay attention more than they would in larger groups, where one person's lack of focus is not ordinarily noticed. Furthermore, the process of feedback, described above, affords members the opportunity to note outright when someone has psychologically dropped out of the session.
- If you are able to remember it. The elements of focus and attention in the small group facilitate memory for what is learned. The early stages of a therapy group's formation demand the leader's efforts to reduce anxiety (MacNair-Semands, 2010; Tuckman & Jensen, 1977). Anxiety is a major interference in the learning process, so its abatement sharpens memory.
- If you have some motivation to learn it. People who sign up voluntarily for group counseling are usually already motivated to make changes in their lives, and leaders are trained to deepen this motivation (Rose & Chang, 2010). Even mandated clients, such as sex offenders court-ordered to group therapy or prison inmates required to complete group counseling, are motivated by goals of staying out of prison in the future (Morgan, 2004). During the course of the group, members are motivated by reinforcements from the group, the leader, and people outside the group. For example, a member who has observed others staying calm during interpersonal conflicts tries to imitate the model in her own life. She finds reward in her friends' positive responses to her new behavior, which motivates her to maintain it and learn more.
- If you believe you are capable of learning it. This is a matter of self-efficacy. Group members provide support and personal examples that help reassure each other that they can attain self-efficacy. In many types of group, successful experiences with practicing a behavior within the group build self-efficacy about practicing it outside.
- If you have some reason to believe you will benefit from learning it. People form outcome expectations about whether learning something will actually bring about meaningful rewards. Observing a group member who has succeeded in making a difficult change allows others to witness the benefits of the effort. Furthermore, a small meaningful reward, such as even slightly shortening the duration of marital squabbles, enhances outcome expectations about further learning.
- If you admire a person serving as a model. The group leader serves as an admirable model, in most cases, as most competent teachers do. In groups, members also learn from other members whom they come to admire. Groups strongly tend to imitate their therapists. Knowing this, group leaders can pass on many messages: stay calm and empathetic during emotional intensity; demonstrate thoughtful, speculative searches below the surface meaning of members' statements; strive for reasonable sharing of time; and in psychodynamic practice, use analysis of historical events to understand current problems (Rutan & Stone, 2001).
- If you perceive the model as someone similar to you. Even when the whole group is struggling with the same problem, such as grief or anger, some members are farther along the road than others. Seeing someone who is just a bit ahead can be more inspiring than seeing someone who has already conquered the problem you're facing, in a vicarious learning process. Yalom and Leszcz (2005) discussed considering a new member's influence on the other members, and how the others can positively influence the new person,

when selecting incoming members to an existing group.

Observational learning, modeling, and vicarious learning augment the effectiveness of all group therapies, though they are most closely identified with social cognitive theory.

Cognitive-Behavioral Theory

An emphasis on how thoughts, emotions, and behavior change through conscious analysis and practice is the hallmark of cognitive-behavioral theory. Albert Ellis (1994) and Aaron Beck (1991) believed that most psychological distress stemmed from faulty or damaging mental processing of experience. Counseling groups devote careful attention to analysis of members' presenting problems, creation of potential alternatives in thought and action, and practice of these alternatives within the group and in the outside world.

Assessment

Group members come into the setting with a broad description of what they want to achieve (better social skills, anger management, overcoming procrastination, becoming happier). Within the group, they are encouraged to break down these broad descriptions into smaller components, because these more concrete components will become the targets of change. Group members help each other do this, serving as a context for defining problems. A problem assessment investigates the matter from various viewpoints:

- When the problem (a behavior, feeling, thought, or combination) occurs;
- How frequently it occurs;
- What usually comes before and after it;
- How behavior, thoughts, and feelings are all involved during the problem; and
- What the client has already tried in order to solve the problem.

While assessment does not always analyze deep motivations and historical antecedents, quite commonly these concerns arise. In some types of groups, such as psychoeducational groups and strictly construed cognitive-behavioral groups, these concerns are usually downplayed, with current problems and solutions being the emphasis. In other types of groups, assessment includes delving into members' reasons for their current behavior, thoughts, and feelings. This is more common in psychodynamic and humanist groups, where insight is considered essential to the process of change.

Insight and Socratic Dialog

Whether the subject of insight is identification of antecedents and consequences in the here-and-now or the personal history behind an irrational belief, exploration often comes in the form of Socratic dialog, a teaching method explained by Plato in his *Dialogues* (350 BC). Socratic dialog is a way of exploring, cooperatively, assumptions that lie under everyday behavior, perceptions, and judgments. For example, a dialog beginning with the famous Adlerian question, "If your problems immediately and completely disappeared, what would be different in your life?" investigates difficulties and goals unequivocally from the client's point of view (Adler, 1929).

Through Socratic questioning, we uncover and articulate views and knowledge we already have, knowledge bases that we usually don't recognize out loud or that we have never put into words or brought into awareness. The Socratic method involves systematic reflection on experience, leading to insights about one's life, values, and behavior. This process often includes challenging a client's system of beliefs or patterns of responses. Socratic method is humanistic, in that truth is sought through investigating the experiences of participants, not through appeal to experts. This kind of questioning keeps turning over the assumptions and cause-and-effect reasoning behind group members' statements, fears, and anxieties. Sympathetic inquiry is modeled by the counselor and learned by group members.

The Role of Practice

The therapy group provides a protected environment in which to practice new responses and investigate old ones. Practice can serve assessment, insight, behavioral rehearsal, modeling, and feedback functions. An outstanding example comes from group specialist David Hutchinson's psychodrama exercise, A Family Snapshot. A group member (the director) invites other members to play the parts of family members. The director provides each character with a motion that is symbolic of who this person is—for instance, one director put his mother at the stove stirring a pot and his father in his easy chair reading the newspaper. The director arranges the family in an open area in a way that symbolizes their psychological relationships to each other. The family portrait is put in motion for a few moments, and then participants and observers share observations. (Thanks to David Hutchinson, personal communication, June 22, 2004.) This type of psychodrama is common in Gestalt therapy, which espouses here-and-now enactments designed to free up blocked aspects of the self. Group members become aware of their own feelings and preferences. On a smaller scale, role-playing between two group members or a member and the leader investigate habitual and experimental interactions. For example, in a group for troubled adolescents, the leader takes the role of a sullen teenager, while the teen member has to experience the role of the distraught parent.

Cognitive-behavioral, psychoeducational, humanistic, psychodynamic, and most other groups arrayed around the perimeter of Figure 2.1 use behavioral rehearsal within the group to prepare members for practicing new skills and responses outside the group. Stress inoculation exercises imitate situations a member will have to encounter, such as asking for a date or going to the hospital for surgery. The rehearsals elicit feedback within a known environment, and they build self-efficacy in the same way we have children solve and check math problems in class before they take similar homework problems away.

Rutan and Stone (2001) explained how vicarious learning and modeling fill an important role. Group members vary in how open they are initially to exploring hidden aspects of their psyches. Open members take readily to such exploration and expose themselves to scrutiny freely. Others, who are fearful of strong emotions, see the open members unharmed in group and even notice that they are drawn closer to their comembers through their frankness. In the process, closed-off members become willing to take emotional chances themselves. Underlying the process is some loosening of anxiety—a feeling that it's not utterly essential to keep a tight lid on one's inner life. The therapist serves as an example of tolerance of strong feelings, an introspective habit of mind, and an effort to understand as well as react to events. This modeling is a subtle but significant influence during practice exercises in group therapy.

Social Influence Theory

Group leaders need to comprehend social psychology's contributions to social learning theory. Social influence theory deals with aspects of group process that depend on persuasion, the reevaluation of attitudes, and the effects of in-group identity (Festinger, 1955; Festinger & Thibaut, 1951). Since therapy is basically a persuasive encounter, understanding the group dynamics that affect persuasion is critical.

Goal setting, a major aim of early stages of group counseling, takes on a new twist in the light of social influence theory. Research shows that when a group is working toward a goal, members who personally accept this goal will remember specific tasks along the way, even when there is an interruption. Members who are not privately committed to the goal tend to forget the specific tasks they are supposed to engage in (Festinger, 1955), to the detriment of the group's progress. For example, in a group with a goal of cohesion where everyone has agreed to address other members directly (rather than speaking mostly to the group leader), members who never really understood or agreed with that goal will not remember at each meeting to address other members directly and will need reminding. The discrepancy between public expression of agreement and private endorsement is always a matter of concern to the group leader, in goal setting and in other discussions where points of view are exchanged.

Groups exert pressure in the direction of establishing conformity within the group, and the group will be able to accomplish uniformity according to how attractive belonging to the group is to its members (Festinger, 1955). Given that much effort is put forth to make a counseling group attractive to its members, and to encourage a sense of cohesion, the sources of pressure to conform need to be carefully analyzed. For example, the group leader is the strongest opinion leader, at least at first, and a leader with a thematized belief about the subject at hand—for instance, that depression is always anger turned inward, or that there are essential differences between men and women, or that the root of mental health is social interest—will surely encounter conformity to this belief, at least outwardly. Other opinion leaders among the group will be those with the highest verbal ability (Festinger, 1955), not necessarily those with the best ideas or the most sensitivity.

If one or more members are unwilling to conform, at least outwardly, the group risks having dropouts and having stable subgroups form. While fleeting subgroups that change membership according to topic are actually lively and healthy, a stable subgroup can polarize the whole and create two in/out groups within it, with all the risks that in-groups and out-groups pose.

Social influence theory explains why some kinds of cohesion are antitherapeutic, such as high cohesion in groups of abusive men, and sheds light on the mixed findings about cohesion and treatment outcome (Burlingame, Fuhriman, & Johnson, 2002). In one study, the higher cohesiveness reported by a sex offender group, the more likely the members were to reoffend (Roether & Peters, 1972). Hornsey, Dwyer, Oei, and Dingle (2009) suggest that there may be a dark side to cohesiveness. It may be a threat to freedom of personal expression. People come to see themselves and other category members less as individuals and more as interchangeable exemplars of the group prototype. While goodwill and comradeship exert forceful attractions, the categorical group identity discourages dissent, inhibits minority opinions, keeps members from delivering challenging feedback, and stifles creativity and originality (Festinger, 1955).

Group leaders must be vigilant for signs of over-conformity, stable subgroups, and undue persuasive power. They can use tactical maneuvers (such as talk tokens to equalize verbal contributions), structural changes (altering the seating pattern to mix up subgroups), and open discussions of topics like pressure to conform to the ideas of the group or the leader. Strategies that emphasize the range of opinions in the group, such as asking members to rank themselves along a continuum, can highlight diversity rather than hiding it. For instance, at the beginning of a conversation about money, a group leader may designate one wall as “super-spender” and the opposite one as “super-saver,” and have members range themselves physically from wall to wall, negotiating their positions through discussion among themselves. This way, diversity is encouraged, and the emphasis is on defining differences rather than suppressing them.

Being aware of the negative aspects of social influence, leaders of many types of groups also enlist its positive and

adaptive aspects. Many group members benefit from exploring what social norms they operate under in the real world; these are examined in Adlerian groups, choice/reality therapy groups, and feminist groups.

Conclusion

Many factors work against the development and testing of unified theories of psychology. The constraints and opportunities of the academic world, the structure of rewards in scholarship, the nature of journal publication, and the immediacy of job requirements encourage us to overplay theoretical features that are distinct, striking, trendy, and unique to certain practices and underplay features that are permeating, classic, fundamental, and ubiquitous in our pursuits. Much can be learned, and many intriguing hypotheses may grow, from unified theories. Social learning theory meets the criteria for such a unifying explanatory system and meanwhile provides models for logical, fruitful research designs in group counseling and psychotherapy.

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Chapter 3 Group Dynamics and Development

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Groups are living systems of interdependent individuals. They acquire and expend energy, maintain their structures and functionalities, and they adapt to changing circumstances. Classical scholars, such as Machiavelli and Shakespeare, remarked on the transformational capacity of groups, for a group that begins as staid and compliant can become turbulent and tempestuous, just as one that seems so unified one day can become completely unglued the next. Theorists of the modern era, including Freud, Maslow, and Lewin, also offered explanations for the natural progression groups follow from founding to dissolution. Freud, for example, was impressed by the group's capacity to become unified, a feat he considered all the more impressive given the inherent selfishness of its members. Lewin used the term *dynamic* to describe groups to emphasize their active, fluid, and changing nature. Cartwright and Zander considered the issue of change to be so central to the study of groups that they defined group dynamics to be the scientific study of groups and "the laws of their development" (1968, p. 7).

This chapter reviews theory and research that examines how and why groups change over time and begins with a description of a treatment group passing through a period of change—a shift from a relatively dependent group into a more dynamic, assertive one. We then sample theories that seek to explain temporal regularities in groups—focusing on theoretical models that have received stronger empirical support and are most relevant to understanding therapeutic groups—before considering commonalities and areas of disputation among these various conceptual models. The final section draws conclusions for practice.

Case Analysis: The Emergence of a Therapeutic Group

The group formed in August and included eight men and women between the ages of 18 and 35, and two therapists: Jacob, the clinic director, and Emily, who was relatively new to working with groups. During the first meetings members spoke primarily about the problems they were having in their lives: Ann was considering leaving her husband; Gene was lonely and doing poorly in his classes; Jerome was drinking too much and it was causing him difficulties at work. At times members gave each other advice, but members wanted to hear what Jacob and Emily recommended. Then, during the group's seventh session, one member (Gene) angrily confronted Jacob for being too aloof and nondirective as a leader. Others joined the discussion with zeal; previously silent members were engaged, members took stances on the points being made, and the group focused on what was happening in the group rather than on previous life experiences or relationships outside of the group. Some members openly discussed their dissatisfaction and anger at what was happening in the group and what was not.

When Emily and Jacob discussed the group after the session, Jacob explained that the group was moving through a conflict stage and would soon develop norms and procedures that would provide the basis of its continuing maturation. Emily acknowledged that the session had disturbed her. She was tempted, more than once, to shift the topic away from its focus on failed expectations because of the strong affect in the room. With Jacob's help, Emily realized that the group's charged atmosphere was part of the process of the group evolving into a more influential, health-promoting force for members.

Theories of Group Development

This case illustrates many important processes that occur in therapeutic groups—guidance, constructive conflict, catharsis, communication, and self-disclosure—but this chapter focuses on one of these core processes above others: group development. Groups may begin as collections of strangers, but over time members become bound to their groups by strong social forces that can promote therapeutic change. Some changes that a group and its members undergo result from the unique characteristics of members, their interactions, and the group's reaction to external pressures that it may encounter. But along with these idiographic changes are more predictable patterns of change that significantly influence the therapeutic outcomes of group treatment. For example, most groups pass through a period of conflict as the members question—sometimes openly—their leaders' competencies and style. Most groups, too, gradually grow more structured as norms, roles, and stable intermember relations emerge.

Some theorists, in their descriptions of these temporal regularities, suggest that group development is similar to the growth and development of an individual. Just as individuals move through stages of infancy, childhood, adolescence, and adulthood as they mature, *successive-stage models* specify the usual order of the phases that groups pass through as they mature. *Cyclical models*, in contrast, suggest that groups repeatedly cycle through periods or phases during their lifetimes rather than just moving through each stage once. Still other theories mix elements of both stage and cycle models and extend these two basic perspectives in various ways. We consider examples of all these approaches here (see Arrow, Henry, Poole, Wheelan, & Moreland, 2005; Brabender & Fallon, 2009; Wheelan, 2005).

Bennis and Shepard: The Dependence/Interdependence Model

Bennis and Shepard's (1956) dependence/interdependence model assumes that groups pass through two discrete phases as members deal directly and covertly with authority issues (dependence) and the interpersonal implications of intimacy (interdependence), but that each phase is marked by briefer subphases. Shifts from one subphase to the next are indicated by what they called *barometric events*: group-level incidents that punctuate a shift in the interpersonal dynamics of the group. In the chapter case, for example, Gene's challenging the therapists signaled a significant change in the group's readiness to confront the group's interpersonal dynamics. Members who initiate such shifts are termed *catalysts.* Like the lonely but self-assured Gene in the case, they are usually relatively unperturbed by the uncertainties provoked by the current stage but are sensitized to those issues triggered by the next one.

Power is a key issue for the group when it first convenes, for members are uncertain of the leader's authority and their own autonomy. During the first subphase of the dependence phase (*dependence-flight*) members discuss the group's goals, procedures, and expectations. In structured groups, the leader satisfies members' needs for clarification openly, but in less structured groups, the members must take responsibility for setting the group's procedures. Members cope by seeking the leader's approval (dependence) or by withdrawing from the interaction (flight), depending on their previous experiences with authority figures.

Increased agitation and even undisguised hostility marks the group's transition from the dependence-flight subphase to the *counterdependence-flight* subphase. Individuals (like Gene) who naturally tend toward counterdependency become more vocal and shift to use more dominant forms of communication within the group (e.g., interruptions, displays of anger, advisory statements) and rebellious coalitions may form. Members may struggle to reconcile their conception of the group's procedures or process with their expectations about authorities, but beneath the surface of this subphase's turbulence, constructive group-level processes are operating to help the group move forward in its development. As members interact and form alliances, the bonds connecting members to one another are strengthening, thus increasing members' trust, reciprocity, and authentic self-disclosure. Individuals who are less conflicted in their dealings with authority figures—those who regularly intervene during this subphase with reasonable suggestions and interpretations—come to be valued more by the group than those who are rebellious, submissive, or merely charming. Eventually these forces will push the group into the final subphase of this phase, *resolution-catharsis.* During this relatively brief but emotionally intense subphase the group resolves the tension between the leader and group. Dynamically, this resolution occurs as the group is transformed from the primal horde led by a father/mother figure into a cooperative, egalitarian community. Interpersonally, the result is a group whose members accept their responsibility for the group's progress, feel comfortable in their relationships with one another and the group's leader, and evaluate contributions based on what is said rather than who says it.

During the interdependence phase, the group begins to work in earnest on its goals but must first move through the *enchantment-flight* subphase: a period of emotional cohesion characterized by laughter, joking, humor, and having fun. Not all members will find this level of intimacy acceptable, and the group will eventually place limits on this affectively intense solidarity. As it shifts into the *disenchantment-fight stage*, members express their unwillingness to go along with the group's interpretations, coalitions form, and the members disparage the group through "absenteeism, tardiness, balkiness in initiating total group interaction, frequent statements concerning worthlessness of group, denial of importance of the group" (Bennis, 1964, p. 267). To reach the final subphase, *consensual validation*, members must deal with the issue of identity, balancing a self-conception based on uniqueness, personal values, and individuality against one based on group membership, collective identity, and community.

Studies of therapeutically focused groups lend general support to Bennis and Shepard's basic assumptions regarding the phase-like quality of group development and the tendency for groups to move through issues pertaining to dependency, conflict, and cohesion (e.g., Burnand, 1990; Mabry, 1975; Spivack, 2008). Kuypers and his colleagues, for example, documented four major themes that emerged and/or declined over the course of

these groups' interactions pertaining to dependency on the leader, conflict, withdrawal, and intimacy. They found that more fully developed groups moved through these phases in the order the Bennis and Shepard model suggests (Kuypers & Alers, 1996; Kuypers, Davies, & Glaser, 1986; Kuypers, Davies, & van der Vegt, 1987).

The model's basic assumptions have also been incorporated into a number of group-level analyses of change in educational (e.g., Sweet & Michaelsen, 2007) and organizational (e.g., Mathieu & Rapp, 2009) contexts and, in the field of group psychotherapy, most prominently in Agazarian's systems-centered therapy (SCT, e.g., Agazarian & Gantt, 2011). SCT assumes that the stages identified by Bennis and Shepard (1956) correspond to unrecognized subsystem goals in the living system of the group that conflict with the group's more general emphasis on improved functioning. Researchers have also confirmed that members, at various transition points, form coalitions based on similarities in subgoals pertaining to dependency, autonomy, intimacy, and the like. These functional subgroups provide members with a secure base within the group and so are associated with enhanced communication and increased solidarity (O'Neill, Constantino, & Mogle, 2012).

Bion: Basic Assumptive Cultures

Emily, the less experienced therapist in this chapter's case study, grew to appreciate the therapeutic benefits of groups the longer she worked with its members. Over time, members came to share their private concerns more openly, they gained insight into their own negative interpersonal behaviors, and they bonded as a unit. But Emily was also surprised when the group would respond, with unexpected intensity, to seemingly minor incidents. When, for example, the group's other therapist (Jacob) mentioned that he was working with two other groups, the group wanted reassurance from Jacob about their group's superiority. When two members, Gene and Ann, were both absent in one session, the group spent much of its time fantasizing about this coincidence, suggesting that some kind of extra-group relationship had formed.

These reactions are consistent with Bion's (1961) assumptive cultures theory. Bion, drawing on Klein's (1948) object-relations theory, suggested that members feel a sense of commonality with others in the group because they project their own psychological states onto others, but they also feel frustrated in groups because their individuality is not sufficiently valued. As they deal with this tension they shift between one of two types of states, or *cultures*: the work group culture and one of the basic assumptive cultures. In the work group culture, members focus on the group's task and its issues, they communicate with each other openly and honestly, and they react rationally rather than emotionally. But when the group arouses fears and anxiety for members, the group is distracted from its task by shared unconscious anxieties. In the *dependency culture*, the group seems to be excessively dependent on the leader or on the group itself. Members may complain of being neglected, misunderstood, or criticized; they may compete like siblings rivaling for a mother's attention; they may idealize the group and its leaders; or they may become passively compliant, even sullen, in response to the leader's requests. In the *fight/flight culture*, the threatened group may feel it must have a powerful leader who will lead members to victory against their enemies or guide the retreat to safety. These unrecognized anxieties trigger considerable conflict within the group. The third basic assumption culture, the *pairing assumption*, occurs when the group's focus shifts from the group-as-a-whole to one (or more) dyadic pairs within the group. During this phase the group members may find themselves discussing romantic expectations and fantasies, speculating about sexual alliances between the group's members, or struggling to create an idea or insight that will resolve their anxieties.

Bion's cyclical theory suggests that groups gradually gain insight into the individual and collective defensive processes that trigger assumptive cultures, learn to control regressive tendencies, and in doing so remain longer in the work group state. However, groups are never completely free of the residual influence of more primitive modes of thinking and feeling, so at any time, and nearly instantaneously, a group may shift from rationality to irrationality. The theory, given Bion's strong psychodynamic orientation, stresses unconscious tension and conflict more than other models and provides an alternative explanation for the emotional lability of groups (see Scheidlinger, 2006, for a critique).

The few studies that have tested Bion's model have supported his prediction that groups eventually learn to deal with distracting tensions and anxieties and so remain longer in the productive work culture (e.g., Stock & Thelen, 1958; Wheelan & McKeage, 1993). Karterud (1989) and Karterud and Foss (1989), for example, used the Group Emotionality Rating System (GERS) to rate groups on five dimensions drawn from Bion's assumptive states (fight, flight, dependency, pairing, and neutrality). They found that even groups that have met for a long period of time experienced sessions when the group cycled back into the fight/flight culture or the dependency culture. The relative dearth of empirical work examining the theory, however, has not interfered with the model's theoretical impact, for it continues to significantly influence analyses of change processes in groups in a wide range of fields (French & Simpson, 2010; Hammar Chiriac, 2008).

Bales: The Equilibrium Model

The therapy group, when it resisted slipping into an assumptive culture, worked diligently exchanging information, comments, and feedback, but it could not maintain a constant focus on its therapeutic goals. When the atmosphere became too charged or the group's energy began to dissipate, the members would shift their focus to the interpersonal bonds linking the members: The group could not endure if members did not feel accepted by the group. Only after the group reestablished and strengthened its bonds and boundaries could members then reengage in its self-, other, and process analysis.

This shift from a task focus to a relationship focus is consistent with Bales' (1965) equilibrium model of group development. The theory assumes that groups, as social systems, require certain structures and processes. They must, for example, adapt to their environment, develop and enact methods for attaining group goals, structure and regularize intermember relations, and satisfy each member's need to feel connected to and not rejected by the group. But Bales noticed that groups shift, repeatedly, between a focus on the task the group is dealing with and socioemotional activities that sustained, strengthened, or weakened relationships within the group. Bales assumed both sets of behavior were essential to the overall functioning of the group, but his data suggested few individuals were capable of contributing, consistently and at high rates, to both categories. This disunion of these two functions, Bales concluded, causes groups to cycle repeatedly between periods of work focus and relationship maintenance. If a group spends considerable time and group energy on work-related matters, it must in time shift to a period where work is suspended so that the group can focus on cohesion-creating, interpersonal activity. Any group that fails to maintain equilibrium between these needs becomes polarized, breaks into subgroups, and may disintegrate entirely.

Bales' distinction between task and socioemotional process is well supported empirically and has informed analyses of such topics as leadership, group cohesion, and sex differences in interpersonal behavior. His assumption of equilibrium is also consistent with studies of within-session shifts in work focus versus emotion focus (e.g., Birnbaum & Cicchetti, 2005), production planning effectiveness (e.g., Gorse & Emmitt, 2009), and polarization in work groups (see Hare, Sj⊘vold, Baker, & Powers, 2005). Punctuated equilibrium models, such as those proposed by Arrow (1997) and Gersick (1989), however, significantly amended Bales' model by suggesting that the equilibrium between task and relationship focus can be disrupted by significant events either internal or external to the group (Chang, Duck, & Bordia, 2006).

Tuckman: The Five-Stage Model

Jacob, the more experienced of the two cotherapists, was not surprised when the group staged a minirebellion against him. It was, as he explained to Emily, a sign of the group's maturation: it was moving from the early, getting acquainted stage to the more emotionally intensive, conflict stage, which was a precursor to the less turbulent stabilization stage.

Jacob's analysis is consistent with Tuckman's (1965) five-stage model of group development. Tuckman, after reviewing previous studies of group development, identified four task stages—orientation, emotionality, opinion exchange, and emergence of solutions—and four corresponding social stages— testing-dependence, intragroup conflict, cohesion, and functional roles. He summarized these stages with mnemonically satisfying labels—forming, storming, norming, and performing—which he later augmented with a fifth (less poetically inspired) stage: adjourning (Tuckman, 1965; Tuckman & Jensen, 1977).

When people first join together in a group, they must become oriented to one another, the leader, and the situation. During this initial *forming stage* members test the boundaries of the situation to determine what sorts of behaviors will be accepted, condoned, and commended by the therapist or other group members. With only rudimentary structure, comprising only the leader(s) and undifferentiated followers/members, members try to identify the ground rules that will guide the group's course and interactions. They likely experience primary tension, which manifests itself in a low level of self-disclosure, inhibited and awkward exchanges, and the discussion of relatively insignificant logistics and personal background information.

As the relatively mild tension and initial inhibitions caused by the newness of a group declines, conflict over goals, procedures, and authority escalates. The hallmark of the *storming stage* is "a lack of unity" (Tuckman, 1965, p. 386), including personal conflicts among members who discover that they just do not get along, procedural conflict over the group's goals and procedures, status rivalries between members and subgroups, and hostility toward the leader. Tuckman suggested that the emotionality of this stage is repressed in task-focused groups, but is relatively overt in therapeutic, self-development groups, and is marked by derogation of others, negativity, arguments, and relatively strong displays of emotion.

If conflict escalates out of control, it can destroy a group. But in most cases this period of interpersonal storming is resolved when the group becomes more cohesive in the *norming stage.* Cohesion requires members to understand one another's perspectives, and such understanding sometimes deepens when hostility has been confronted and resolved. With each crisis overcome, the group becomes more cohesive but also more organized. It resolves the problems that caused earlier conflicts—uncertainty about goals, roles, and authority—and prepares the members to get down to the work at hand. Norms emerge and guide the group members as they interact with one another. Members communicate openly with one another about personal and group concerns; differences in opinions and disputes still arise, but now they are dealt with constructively.

The tasks that face the members of therapeutic groups—self-insight, personal growth, insight into one's personality dynamics, control of emotions, interpersonal skill—become easier when the group is a cohesive rather than emotionally impersonal one. The norming stage thus leads, in time, to the *performing stage*, where group members are able to deal with issues objectively rather than subjectively. The performing group will spend the bulk of its time working in the here-and-now rather than socializing, seeking direction, or arguing.

Tuckman and Jensen (1977) added the dissolution, or *adjourning stage*, to the model, recognizing that as groups near their scheduled conclusion members' interaction often take on a different tone, characterized by self-review, reminiscence, and varying emotional displays. Even when the dissolution is planned and the members are well prepared for termination, the final group sessions may be filled with conflict-laden exchanges among members, growing apathy and animosity, or repeated failures at the group's task. Members may mourn for the group and suffer from a lack of personal support.

The five-stage model has fared well, empirically (e.g., Bonebright, 2010; Fall & Wejnert, 2005; Maples, 1988;

McMorris, Gottlieb, & Sneden, 2005; Miller, 2003; Rickards & Moger, 2000), but it has also been the inspiration for a number of alternative stage-based models (e.g., Lacoursiere, 1980; Sarri & Galinsky, 1974; Wheelan, 2005). MacKenzie (1994, 1997), for example, suggests that therapeutic groups—with their focus on interpersonal processes, growth, adjustment, and self-exploration—rarely separate therapeutic processes from normative ones, so the period of normative development and focus on individual adjustment blend together. During MacKenzie's Stage 1, *engagement*, "the developing group system is accompanied by an early sense of well-being at finding that one is accepted and understood" (MacKenzie, 1997, p. 279). Stage 2, *differentiation*, corresponds to Tuckman's (1965) storming phase. Members must develop "patterns for conflict resolution and tolerance of a negative emotional atmosphere" (MacKenzie, 1997, p. 279). Most outpatient groups meeting weekly need four to eight sessions to move through these stages to Stage 3: *interpersonal work.* During this stage the group is "able to address individual problematic matters in a more vigorous manner. The focus tends to shift to greater introspection and personal challenge" (1997, p. 279). Most groups become more cohesive during this period, and the theme of individual autonomy and group dependence tends to occupy many members' minds. In time, the group reaches Stage 4: *termination.*

MacKenzie's model has stimulated more research than other approaches, in part because of MacKenzie's development of the *Group Climate Questionnaire*, which assesses three aspects of groups that vary with group development: engaged (a positive working alliance in the group), conflict (interpersonal tensions), and avoiding (denial of personal responsibility for the group's outcomes). MacKenzie (1997) found that scores on the engaged scale increase initially but then drop during the differentiation phase. They rise again until the termination phase, although drops occur when the group works through difficult material. The avoiding scale scores decrease over the life of the group, whereas conflict scores peak during the differentiation stage. Kivlighan and Lilly (1997) confirmed these trends, in part, but found that in the groups they studied—where members were relatively well adjusted and recruited from the same college class—the engaged scores did not build during the early group meetings but instead started out high and remained elevated until the differentiation stage. Evidence indicates that members' experience of engagement within the group predicts reductions in anxiety and depression, but that moving through a period of conflict and resolving that conflict is less reliably associated with positive outcomes (Crowe & Grenyer, 2008; Miles & Kivlighan, 2012; Ryum, Hagen, Nordahl, Vogel, & Stiles, 2009).

Moreland and Levine: A Theory of Group Socialization

The members of the therapy group exhibited clear signs of progress the longer they remained within the therapy group. But, such as many groups that meet in clinics associated with colleges and universities, the group adjourned for break over the winter holidays before reconvening in January. At the first session of the semester, Jacob announced two new members would be joining the group, bringing them up to their maximum size of 10. The following week, Sofi shared her anger and fears at learning new members would be joining:

Sofi: I don't want any new members to join our group. It feels like we've been able to get much closer to each other over the past few months. (She frowned a bit and let out a sigh after she finished talking.)

Emily: It seems like you are a bit upset about this Sofi.

Sofi: Yeah, I am. You didn't warn us that we'd be adding new people last fall. We've been able to start opening up and making some progress and I don't want that to disappear. We'll have to go through that whole process again. (Pause.)

Ann: I agree. What if the new members don't fit in with our group? I don't think it's fair that we have to add people now, especially when we've already been together for six months.

Jacob: There seems to be some anger present in what Sofi and Ann are expressing. Does anyone else feel that way? Maybe who else feels this way?

The group continued to process what it's like to feel anger at the group leaders. This level of open disagreement and challenge to the leaders' authority would not have been possible earlier in the group. With further processing, they come to see that there is also a fear of being vulnerable in front of "strangers" or new group members and some beliefs that the leaders should protect the group members from this happening. The group members continue to talk about what the relationships would be like in the group if new members join. The coleaders help the group process some of the emotions that arose when faced with new members joining.

Most theories of group development describe the predictable changes that occur to the group, as a whole, over its life cycle. Moreland and Levine's (1982) group socialization theory, in contrast, predicts the changes in the relationships between each member and the group-as-a-whole. Group development culminates in group-level changes in levels of conflict, cohesion, and productivity. Group socialization results in changes in each member's evaluation of, commitment to, and role in the group and shifts in the group's evaluation of each member.

Group socialization theory is particularly relevant when examining the dynamics of open groups rather than closed ones (Turner, 2011; Ziller, 1965). Open therapeutic groups have permeable boundaries, so new members join and old members leave throughout the course of the group's sessions. Open groups are less likely to move through predictable stages of development, whereas closed groups are likely to display consistency in their development, as individuals are more likely to focus on the collective nature of the group and should be more likely to identify with their group as they work together to accomplish a collective goal (Burnette & Forsyth, 2008).

Because members differ in the length of their tenure in open groups, each member of such groups will likely be at different stages in terms of group socialization: *prospective member, new member, full member, marginal member*, and *ex-member.* When new members join the group (*entry*), their commitment to the group increases and their socialization begins in earnest (Rasmussen, 1999). This transition period can be turbulent, for the full members rarely consider the newcomers to be trustworthy or sufficiently experienced to understand the group's norms, and newcomers tend to remain cautiously aloof or misinterpret other members' reactions. As was seen earlier, Ann and Sofi were upset that new members were going to be joining the group, for they were hesitant to open up and reveal the intimate details of their group experience with the newcomers. New members may also have second thoughts about the group once they learn more about it. If they worry that their future is uncertain, these members' loyalty to the group will wane, and they will begin looking for an alternative (Levine, Moreland, &

Choi, 2001). The theory also describes how members must adjust as the group adds new members and the processes that may prompt the group to resocialize or expel a current member.

Conceptual and Clinical Implications

Theories of group development offer descriptive accounts of the general progression of the typical group by examining what is changing in the group and when this change occurs. In most cases, in offering an explanation of why groups develop as they do, theorists and researchers take an interactional approach that considers the qualities of the individual members, the leader, the group, and the environmental events the group experiences. And once development is described and better understood, one might ask how the psychological and interpersonal forces can be optimized to further increase the effectiveness of groups.

Conceptual Commonalities

Clinical experience, theoretical analysis, and empirical investigations of group development, despite their varied emphases and assumptions, converge on a number of points:

- Nearly all these theories assume that the changes groups manifest over time are relatively predictable. Some theorists endorse a stage-like model that assumes groups progress from one relatively discrete step to the next and others proposing cyclical shifts that can reoccur.
- Most of the theories use the word *development* to describe this change. Group development, as a form of social and psychological development, assumes that a group, through continuous, guided, and examined interaction, will become more able to meet members' needs. Across the life span of the group, individuals experience the development and maturation of relationships with others, and even as it adjourns, members can gain psychologically and interpersonally. The successfully developing group is one that is able to profit at each of its development milestones, but in some cases the course of development may result in a dysfunctional group. Although time is thought to result in a gradual emerging of potential within a group (or in a person), development is contextually dependent.
- Most theorists agree that a group will eventually go through a period of conflict as it develops. For some theories, this conflict is only a stage, but for others, the group will experience recurrent periods of tension as members find that their views, outlooks, or attitudes are not compatible with others in the group. This conflict is most predictably associated with issues of authority and intimacy in the group and suggests that members must come to grips, over time, with feeling comfortable working in a cooperative, egalitarian social structure as opposed to a competitive, hierarchical one.
- Another of-repeated theme pertains to the group's unity, solidarity, and cohesiveness. Cohesion may not be a sufficient condition for effective groups, but it may be a necessary one (Yalom & Leszcz, 2005). Without cohesion, feedback would not be accepted, norms would lack the capacity to influence members, and groups could not retain their members. Cohesive groups tend to provide healthier environments than noncohesive groups, at least at the psychological level. Because people in cohesive groups respond to one another in a more positive fashion than the members of noncohesive groups, people experience less anxiety and tension in such groups (Burlingame, McClendon, & Alonso, 2011).

Theories of group development, as a class of conceptual frameworks, share several limitations. Whereas most theories of group development provide detailed descriptions of the course of change in groups, they are less helpful in terms of predicting, explaining, and controlling this change. When will a group shift from the dependency stage to the conflict stage? Are the stages cumulative, in the sense that a group cannot skip a stage before progressing on to the next, and are they order invariant? And, with the exception of psychodynamic views and functional models, these theories do not provide an overall explanation for why these changes occur or the patterns they follow. More work is needed to develop models that recognize that change in a group context occurs at varying rates and at varying levels of analysis. A multilevel, multidimensional approach recognizes that change occurs within the individual members, within the pairs of association that link members to one another and to the group's therapist, and within the group-as-a-whole and involves shifts in affect, cognition, and behavior.

Clinical Implications

Theories of group development and group dynamics give clinicians a conceptual filter through which to view the group. Even experienced group therapists can find the flow of information in a session daunting, but the theories discussed here provide a framework to understand group interactions. Most theorists would agree groups move through sensitive, critical periods, where their development slows or accelerates: There are better times than others for a group to reach particular therapeutic goals. A developmentally sensitive therapist can facilitate, hasten, retard, and exploit the processes that occur at each stage and those that move the group from one stage to the next. We close with a list of clinical implications from a developmental approach to therapeutic groups.

- *Let the group follow its developmental course.* A developmental approach to therapeutic groups begins with the assumption that time is needed for the group to become a supportive, change-enhancing environment. Through continuous, guided, and increasingly skillful communication, group members come to identify and better understand previously unrecognized (unconscious) motives and emotions, they become more rational in dealing with life problems and acquire valuable interpersonal skills, but these gains will occur at a pace set by the group's gradual development.
- *Consider the timing of an intervention.* In many cases, therapists may recognize that the group should begin work on a particular issue or concern, but they are well advised to consider the group's stage of development when timing their intervention. Kivlighan, McGovern, and Corazzini (1984) confirmed the value of this suggestion by experimentally manipulating therapists' interventions so that they matched the theoretical developmental stage of the group. Some groups were given counseling on dealing with anger, whereas others received guidance with issues of intimacy, and these two interventions were delivered either in the fourth or ninth group session. The information dealing with anger clarified the value of anger as a natural part of group participation and provided suggestions for communicating it. In contrast, the information dealing with intimacy clarified the value of intimacy in groups and provided suggestions for its appropriate expression toward others. Interventions were more effective when members received the information on anger during the storming phase (session four) or the information on intimacy during the norming phase (session nine).
- *Grow through conflict.* Although the empirical findings regarding the value of a period of conflict for a developing group are inconsistent (e.g., De Dreu & Weingart, 2003), most therapy experts note that, despite the temporary disruptions created by conflict, a period of interpersonal tension is an essential one if the group is to mature. Although members often feel uncomfortable when conflicts emerge in their group and their natural inclination is to repress them, developmental theories maintain that the group must deal with unexpressed tensions and disagreements if it is to reach a higher level of facilitative functioning. If hostilities are never expressed in the group, they may build up to a point at which the group can no longer continue as a unit and participation is countertherapeutic to members.
- *Consider the group's stage of development when adding members.* It is obvious that adding a new member during Tuckman's (1965) storming phase would be particularly difficult for the new member. However, other stages of development also would be problematic, for instance, adding a new member may be smoother if the group is not experiencing a period of extreme cohesion—which is typical, for example, of the enchantment-flight subphase in the Bennis and Shepard (1956) model. A new member, too, will likely find it more difficult to join a group that is mired in an assumptive stage of development rather than a work group culture in Bion's (1961) analysis.
- *When faced with the unexpected, consider the developmental status of a group.* Therapists who are well versed in terms of theories of group development will not be surprised by the shifts that take place in the group over time, including challenges to their authority, regression to dependency, polarization around trivial issues, or even full-fledged group revolts.

The Therapeutic Life Cycle

At the end of the academic year, the group said goodbye to three members who would not be returning. Gene had improved his grades and was transferring to a different university closer to his family. Through group, he was able to understand some of the family dynamics that had led him to push people away and his resulting loneliness. He had worked on changing some of the behaviors that prevented him from finding the intimacy he craved in relationships, and he had strengthened his relationships with his siblings. Ann decided to leave her husband. She was starting a new graduate program and was looking forward to her independence and upcoming new career. She had developed closer friendships with classmates over the course of the year and decided to bring her group participation to an end. Jerome had cut back on his drinking but was still struggling with managing his strong, and at times overwhelming, emotions. However, through group he was able to better understand the interpersonal triggers to these emotions and how to reach out to others to receive support during some of these most difficult times.

In the last few groups for the semester, the group members processed what the group experience had meant for them, what it would be like losing three members, and their hopes for the group's future. Jacob and Emily reviewed the gains the group members had made over the course of the year. Group members had come to understand aspects of themselves better, to care for and feel connected to each other, and to tolerate, and some even embrace, confrontation and interpersonal feedback. They were able to express themselves emotionally and be present for others' expression of affect. Throughout the course of the group, members had developed cohesion and safety to delve into topics such as sexuality, religion, and experiences of racism and privilege. Emily was able to understand the group's development and reflected with Jacob on what pivotal moments were for the group.

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Chapter 4 Therapeutic Factors: Current Theory and Research

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In *The Structure of Scientific Revolutions*, Kuhn (1962) argued for an episodic model of science with periods of what he called normal science interspersed with periods of revolutionary science. These periods of revolutionary science occur because scientific anomalies accumulate, showing that the old paradigm is not capable of explaining the new phenomena. In a small way, we believe that research and theory in concerning therapeutic factors (TFs) has been and is undergoing a scientific revolution.

Yalom and Leszcz's (2005) model of 11 TFs has been the predominant paradigm for understanding therapeutic actions in group therapy. However, there have been accumulating anomalies that are causing group researchers and theorists to question the validity and utility of the model containing the 11 TFs. In addition, the dominant paradigm for examining TFs has been to look within a sample at the relative importance of the TFs. Below we review this research that points to a new paradigm for TFs. In addition, we provide best practice guidelines for TF research and practice.

Studies Examining the Ranking of TFs

Yalom and Leszcz contend that 11 TFs provide an exclusive and comprehensive list of the operations and mechanisms that lead to therapeutic change in groups. Although Yalom and Leszcz's compendium of TFs is widely accepted and used, several authors have criticized Yalom's TFs structure. Crouch, Bloch, and Wanlass (1994) suggest that the factors are (a) unbalanced in their scope (e.g., self-understanding is a broader construct than self-disclosure) and (b) overlapping in their content (e.g., cohesion overlaps with several of the other TFs). Dierick and Lietaer (2008) believed that there are disagreements about the number of TFs (e.g., Crouch et al. propose 10 TFs) and an overreliance on preconceived categories in development of TFs typologies, as opposed to developing TF categories inductively from open-ended descriptions of helpful events. Despite these criticisms, Yalom and Leszcz's framework remains an important organizing heuristic for group therapy theory and research. One purpose of this chapter is to update Kivlighan and Holmes' (2004) review of TF research that appeared in the first edition of the *Handbook of Group Counseling and Psychotherapy.*

In a classic study of TFs, Yalom, Tinklenberg, and Gilula (1968) developed a 60-item TFs Q-sort for the factors. Twenty successfully treated group therapy adult clients ranked the 60 TFs Q-sort items from most to least important TF: (1) Interpersonal Learning (input), (2) Catharsis, (3) Cohesiveness, (4) Self-Understanding, (5) Interpersonal Learning (output), (6) Existential Factors, (7) Universality, (8) Instillation of Hope, (9) Altruism, (10) Family Reenactment, (11) Guidance, and (12) Identification.

Yalom et al.'s (1968) paradigm for examining TFs spawned a large number of studies ranking the TFs in a number of different types of groups. In 2004, Kivlighan and Holmes cluster analyzed a data set of 39 of these studies. This cluster analysis revealed four types of groups based on the relative ranking of the TFs: affective insight groups, affective support groups, cognitive support groups, and cognitive insight groups. In *affective insight groups*, acceptance, catharsis, interpersonal learning, and self-understanding are the most important therapeutic mechanisms. In *affective support groups*, acceptance, instillation of hope, and universality are the most important factors. In *cognitive support groups* vicarious learning and guidance are most and self-understanding is the least important. Finally, in *cognitive insight groups*, interpersonal learning, self-understanding, and vicarious learning are most important. Two higher order clusters, support versus insight, encompassed the four clusters. Supportive approaches attempt to bolster psychic structures through "suggestions, reassurance, advice and reinforcement" (Gelso & Hayes, 1998, p. 166), whereas insight-oriented approaches attempt to restructure psychic structures.

Kivlighan and Holmes (2004) hoped that the four-category typology would provide a common language for describing TFs that operate in different groups. They also hoped that TF researchers would not continue viewing each group or each client population as having a unique set of TFs. To some extent, researchers have begun to use the four-category typology to describe the types of groups being examined. For example, Harel, Shechtman, and Cutrona (2011) described the training groups that they studied as affective-insight groups. Other authors have used the typology to provide a context for their studies' findings (Shechtman & Katz, 2007). By using this common language researchers and practitioners can quickly see how studies relate to one another.

Recent Rank-Ordering Studies

Since the publication of Kivlighan and Holmes (2004), six studies have examined the rank-ordering of Yalom and Leszcz's (2005) 11 TFs in various client groups. Shechtman and Halevi (2006) compared group processes (self-disclosure, goals for therapy, client behavior, and ranking of TFs) in personal growth groups for Arabs and Jews in Israel. TFs were derived from open-ended responses to critical incidents questions. Pan and Lin (2004) examined the rank order of TFs in interpersonal growth groups with 32 Taiwanese college students. TFs were assessed using the scale originally developed by Yalom (1985) and later revised by Lee (1992). Roy, Turcotte, Montminy, and Lindsay (2005) asked 71 members of therapy groups for men who batter to rank TFs based in terms of their experience at the beginning of group, because most dropouts occur in this early stage of group development. TFs were collected using a simplified form of the questionnaire "How Encounter Groups Work" (Lieberman, Yalom, & Miles, 1973).

Reimer and Mathieu (2006) used a 60-item questionnaire to examine TFs with 34 sex offenders in an intensive treatment for sex offenders program. Sayin, Karslioğlu, Sürgit, Şahin, Arslan, and Candansayar (2008) used the TFs Q-sort, administered at discharge, to patients in a psychiatric inpatient clinic in Turkey. Patients were asked to refer to their biweekly group experience when responding to the Q-sort items. Finally, Waldo, Kerne, and Van Horn Kerne (2007) had group leaders randomly use a "counseling" approach, for one session, in place of the "guidance" approach typically used in six ongoing domestic violence offender groups. Group members completed the Critical Incident Questionnaire after a "counseling" or "guidance" session.

Spearman's rank-order correlations examined the relationship between TFs rankings in the new studies and the clusters from Kivlighan and Holmes (2004). The Spearman rank-order correlation between the TFs as seen by patients and group therapists in the Turkish therapeutic groups (Sayin et al., 2008) and the rank order of the TFs in the Affective Insight groups were 0.86 and 0.89, respectively. Likewise the rank order of TFs in the Taiwanese interpersonal growth groups correlated 0.84 with Affective Insight groups. This suggests that these groups could all be classified as Affective Insight groups.

The rank order for the sex offenders in Reimer and Mathieu's (2006) groups (Spearman $r = 0.96$), the Arabs (Spearman $r = 0.82$), and Jews (Spearman $r = 0.86$) in Shechtman and Halevi's (2006) interpersonal growth groups, and the domestic violence offenders in Waldo et al.'s (2007) "counseling" sessions (Spearman $r = 0.82$) were correlated with Affective Support groups. The rank-ordering of TFs in Roy et al.'s (2005) groups for batterers correlated 0.80 with the rank-ordering of TFs in Cognitive Insight groups. Finally, the rank-ordering of TFs in Waldo et al.'s (2007) guidance sessions correlated 0.86 with the rank-ordering of TFs in Cognitive Support groups. These results suggest that one of the four group types described by Kivlighan and Holmes (2004) provided an excellent fit for the TF rankings in the new research.

Kivlighan and Holmes (2004) and Kivlighan, Miles, and Paquin (2010) argued that the field did not need any more studies examining the relative rankings of TFs because the Kivlighan and Holmes typology can easily accommodate the new ranking studies. Second, as described below, group members or leaders cannot meaningfully distinguish between 11 or 12 TFs. Third, also as described below, no clear relationship has been established between rankings of TFs and client outcome or group processes.

The Waldo et al. (2007) study is a wonderful example of the type of TFs studies that will advance research in this area. The group leaders studied typically used a "guidance" approach, emphasizing the instillation of hope, providing information, learning new socializing techniques, and modeling new healthy behaviors. These group leaders implemented a counseling approach in randomly chosen group sessions, emphasizing "here-and-now" processing and member-to-member feedback. Because the sessions for implementing the "counseling" intervention were randomly assigned, the authors could conclude with a degree of confidence that using a "counseling" approach caused group members to increase their endorsement of catharsis, cohesion, and interpersonal learning and to decrease their endorsement of hope, information, and existential factors. Like most studies, the Waldo et al. (2007) study has several limitations. For example, the authors did not use an

implementation check to see if the group leaders implemented the "guidance" and "counseling" sessions in the intended manner. Nevertheless, the Waldo et al. study is a wonderful example of how researchers can examine the causal connection between group leadership style and group member perceptions of TFs.

Dimensional Structure of TFs Measures

As early as the mid-1970s, researchers were examining the construct validity of the Q-sort (Yalom et al., 1968). For example, Rohrbaugh and Bartels (1975) conducted a factor analysis of Q-sort ratings, obtained from 72 group members in 13 groups, and found 14 factors that they referred to as revised therapeutic mechanisms. Fuhriman, Drescher, Hanson, Henrie, and Rybicki (1986) also conducted a factor analysis of a revised curative factor instrument using 161 group members in a variety of groups. They found three underlying dimensions, labeled catharsis, cohesion, and insight. Kivlighan, Multon, and Brossart (1996) also used factor analysis to examine TF ratings and found four dimensions: (1) Emotional Awareness-Insight, (2) Relationship-Climate, (3) Other Versus Self-Focus, and (4) Problem Identification-Change. Neither the dimensional structure proposed by Fuhriman et al. (1986) nor Kivlighan et al. (1996) has received much use by other group therapy researchers. For example, only Shechtman and Gluk (2005) examined the TFs present in children's groups using Kivlighan et al.'s dimensions.

In an effort to identify how the TFs are interrelated, Dierick and Lietaer (2008) examined 155 curative process items with 489 group member's perspectives of the TFs across several types of psychotherapy and growth groups. Results from a cluster and factor analysis revealed three levels of abstraction: two dimensions, seven main scales, and 28 basic scales. The two dimensions were *Relational Climate* and *Psychological Work* and the 7 main clusters were *Group Cohesion, Interactional Confirmation, Cathartic Self-Revelation, Self-Insight and Progress, Observational Experiences, Getting Directives*, and *Interactional Confrontation.* Additionally, the three main scales of *Cathartic Self-Revelation, Self-Insight and Progress*, and *Interactional Confirmation* are highly intercorrelated with each other and the remaining main scales, indicating that these three main scales are central TFs.

These findings lend empirical evidence to the interrelated nature of the TFs, while specifically, the TFs Yalom termed Catharsis and Interpersonal Learning were present across several main scales and not homogenous processes. Additionally, Dierick and Lietaer (2008) found that several TFs proposed by Yalom were interrelated: Self-Understanding, Family Reenactment, Existential Responsibility, and Interpersonal Learning-Output loaded on a central main factor termed Self-Insight and Progress. It seems these results may be evident of an emerging theory of TFs that may potentially address the limitations and criticisms of Yalom's (1995) proposed theory.

Only one published study has used Dierick and Lietaer's (2008) framework. Lemmens, Eisler, Dierick, Lietaer, and Demyttenaere (2009) examined helpful and disturbing factors in multifamily groups with hospitalized, depressed patients and their family members. Lemmens et al. found that the frequency of endorsement of most of the TFs increased for both the patients and their significant others as the groups developed over time. The level of endorsement for making progress in trying out new behaviors, getting guidance from the therapist, having insight into the partner's wishes, modeling, self-disclosure, and learning by observation were all positively related with improvement in the patient's depressive symptoms.

Lese and MacNair-Semands (2000) developed the *TFs Inventory* (TFI), a measure of group members' perceptions of TFs in group therapy. Research supported the reliability and validity of the TFI but the large number of items proved to be a major limitation in the use of the TFI in practice and research. Therefore, MacNair-Semands, Ogrodniczuk, and Joyce (2010) developed the TFs Inventory–Short Form (TFI–S), a 44-item scale assessing the presence of TFs. They conducted a factor analysis of the TFI–S with 174 patients in a group-oriented day treatment program finding a four-factor solution: *Instillation of Hope, Secure Emotional Expression, Awareness of Relational Impact*, and *Social Learning.* Concurrent validity was established through positive associations with the Group Climate Questionnaire–Short Form (GCQ–S; MacKenzie, 1983).

Joyce, MacNair-Semands, Tasca, and Ogrodniczuk (2011) continued the development of the TFI–S by conducting a confirmatory factor analysis and further testing the discriminatory and concurrent validity. Confirmatory factor analyses lead to the development of the TFI–19, a new four-factor measure with good internal consistency. Assessing discriminatory validity, three of the four-factors were significantly associated with the Social Desirability Scale; however, correlation coefficients for the three factors were relatively small: *Secure Emotional Expression* (r = 0.26), *Awareness of Relational Importance* (r = 0.17), and *Social Learning* (r = 0.16).

While *Secure Emotional Expression* was associated with the group member's tendency toward Social Desirability, the TFI–19 was relatively independent of Social Desirability. Convergent validation was seen as the TFI–19 was found to be significantly associated with the GCQ–S Engaged subscale.

In many ways the state of the TFs is reminiscent of the personality psychology literature before the emergence of the "Big Five" model (Digman, 1990). There were competing models of personality dimensions with differing numbers of factors and different content among the factors. It was difficult for researchers and theorists to examine convergence of findings across studies because of the different personality measure used in each study. With the emergence of the "Big Five," the problems were resolved and research and theory advanced rapidly.

Group theorists and researchers would benefit from a consensus on the dimensions that are therapeutic in groups. We believe that the model derived by MacNair-Semands and her colleagues is the most promising for several reasons. First, the psychometric development of the inventory has been strong and it is the only model that has been subjected to confirmatory analyses. Second, the inventory has the best network of findings supporting its construct validity. Finally, the inventory is a user-friendly instrument that can be easily implemented by researchers and practitioners. Only time will tell if group therapy theorists and researchers will come to some consensus about the fundamental therapeutic elements in groups. Unfortunately, until this consensus arises theory and research on TFs will continue to be disconnected and defuse.

Thus far, we have reviewed the advancements in the examination and understanding of the TFs in relation to the underlying structure and the development of valid and empirically driven measurements of the TFs. With an emerging evidence base of the structure of the TFs, it is important to examine the relationship between the TFs and psychotherapy outcome in order to deepen our understanding of the curative factors involved in group psychotherapy. This is particularly important because most previous research has examined the rank order of TFs without tying the relative endorsement of these factors to group member outcome at either the session or treatment level.

Dierick and Lietaer (2008) examined the association between their two overarching dimensions and the seven main scales with outcome measures and found significant and positive associations. Correlations between outcome measures (client satisfaction with personal results of sessions, client perception of personal change, and therapist perception of client change) and the two dimensions (*Relational Climate* and *Psychological Work*) and four main scales (*Group Cohesion, Interactional Confirmation, Cathartic Self-Revelation*, and *Self-Insight and Progress*) were moderately high and significant. The remaining three main scales (*Observational Experience, Getting Directives*, and *Interactional Confirmation*) were significantly related to all three outcome measures, however correlations were relatively lower. The only main scale that was not significantly related to an outcome measure was *Interactional Confirmation* and the outcome measure of client satisfaction with personal results of sessions.

MacNair-Semands et al. (2010) tested the validity of the TFI–S, by examining the relationship between TFs and psychotherapy outcome measures. Results indicated that three of the four TFI–S factors were positively associated with post-treatment client-rated improved quality of life: *Instillation of Hope* (r = 0.23), *Secure Emotional Expression* (r = 0.29), and *Relational Impact* (r = 0.20). All four factors were significantly associated in the reduction in Interpersonal Distress, *Instillation of Hope* (r = –0.36), *Secure Emotional Expression* (r = –0.23), *Relational Impact* (r = –0.33), and *Social Learning* (r = –0.30).

In a confirmatory analysis of the TFI–S, Joyce et al. (2011) examined the relationship of the resulting TFI–19 factors to outcome measures and found that the TFI–19 factors were significantly and negatively associated with post-treatment levels of depression, anxiety, general symptomatic distress, and general interpersonal distress. These results confirm earlier preliminary findings on the TFI–S and lend additional support to the predictive power of the TFI–19. These studies provide evidence of the association between TFs and outcome measures in group therapy. While these findings enhance our understanding of the association of TFs and positive outcomes, it is imperative that future research continues to examine this complex relationship. With a deeper understanding of which TFs are related to positive outcomes, clinicians and researchers can advance the effectiveness of group therapy through practice and research.

In this regard, the Kivlighan (2011) study may be particularly instructive. All the reviewed studies examining the relationship between TFs and group member outcome correlated the individual group member's perceptions of TFs with the member's own outcome ratings. What is missing from this approach is the fact that the group member makes her or his ratings of TFs in the context of the other group members rating the TFs.

For example, Jane, a group member in a therapy group, might see catharsis as an important TF, but the other members of her group may see it as not that important. In another group, Sally also sees catharsis as important, but in this group, the other group members agree with Sally's perception about the importance of catharsis. Should we treat Jane's and Sally's reports about the importance of catharsis the same even though their other group members differ dramatically in how they view catharsis? Unfortunately, most researchers treat Jane's and Sally's reports as equivalent.

Studying group members at the individual level, as done in most of the TFs research, is theoretically and empirically problematic. That is because a group member and the other members of her group are involved in relational interactions. By not simultaneously analyzing data from the group member and the other group members, researchers are misspecifying their models of group relationships, which results in biased parameter estimates in their statistical models (Krasikova & LeBreton, 2012). In addition, by not examining the individual group member in the context of the other group members, researchers are neglecting to examine the influence of the group on the member, perhaps the most unique therapeutic aspect of group treatments.

With two exceptions, group therapy researchers have not examined how the perceptions of TFs by the other group members may affect the individual group member's perceptions of the TFs. In an early study, Flowers (1987) found that group members who did not improve ranked the importance of the TFs differently from the other members of their groups. Unfortunately, several limitations (e.g., very small sample size) in the study's design suggest that the Flowers findings be interpreted cautiously. More recently, Kivlighan (2011) examined how a group member's perceptions of the importance of the TFs and how the perceptions of the importance of the TFs as perceived by the other group members were related to the group member's session evaluations (session depth and smoothness). He found that individual group member's perceptions of TFs were not significantly related to session depth or session smoothness. However, other group members' perceptions of TFs were marginally related to session depth and significantly related to session smoothness. Specifically, other group members' perceptions of self-disclosure, acceptance, altruism, guidance, vicarious learning, and instillation of hope were all related to the individual group member's perceptions of session depth. In addition, the other group members' perception of acceptance, altruism, guidance, vicarious learning, and instillation of hope were all related to the individual group member's perceptions of session smoothness.

Kivlighan (2011) showed that it is more important how the other group members perceived the TFs than the individual group member's own perceptions of the TFs. Therefore, we believe that group researchers need to stop studying perceptions of TFs at only the individual level. Examining the context provided by the other group members will help us advance our understanding of how the TFs operate in the group.

TFs and other Group Processes

As noted above, several authors have examined the relationship between individual group member's perceptions of group TFs and their individual perceptions of group climate. This relationship is particularly important because MacKenzie (1983) contends that group climate creates "compatible types of interpersonal events" (p. 159) within each group. Unfortunately, MacKenzie did not link specific group climate characteristics to specific TFs. Researchers, however, are beginning to document such links. Both MacNair-Semands et al. (2010) and Joyce et al. (2011) found that the Instillation of Hope, Secure Emotional Expression, Awareness of Relational Impact, and Social Learning scales were positively and significantly associated with an engaged climate and negatively and significantly correlated with conflict in the climate.

By contrast, Gold, Kivlighan, and Patton (2013) examined both TFs and group climate at the group level. These authors found that group-level conflict was correlated positively with Learning Through Interpersonal Actions and negatively with Acceptance and Universality. Group level Engaged was positively associated only with Altruism. Group level Avoiding did not correlate with any TF. Taking these findings together, the authors argued that the primary driver of members' therapeutic interactions in the group sessions may be conflict resolution in the here-and-now.

It is interesting to see the similarities and differences between group-level and individual-level analyses of group climate and TFs. However, only the individual-level or the group-level analyses can provide misleading pictures of the relationships. It is possible, however, to use the actor partner interdependence model (APIM; Kenny, Kashy, & Cook, 2006) to examine how the group member's and the other group members' perceptions of TFs are related to the group member's and the other group members' perceptions of group climate. We believe that TFs research will be advanced when the individual-level and group-level TFs are examined simultaneously. As noted above, when the APIM was used to simultaneously examine the group member's and the other group members' perceptions of TFs only the other members' perceptions of TFs were related to the group member's perception of session smoothness.

There have also been studies that examine the relationship between individual group member's perceptions of TFs and their perceptions of the group therapist. Specifically, Pan and Lin (2004) examined the relationships between TFs and the counselor rating form. They found that higher ratings on the Counselor Rating Form were associated with higher levels of Altruism, Cohesiveness, Universality, Providing Information, Imitative Behavior, Self-Understanding, Instillation of Hope, and Existential Factors. This finding suggests that the group leader's interpersonal style can affect the type of TFs experienced by the group members. As noted above Waldo et al. (2007) showed that group leader style was related to differential endorsement of the TFs by the group members. Unfortunately, neither Pan and Lin (2004) nor Waldo et al. (2007) used analyses that accounted for the nesting in their data. The members of a counseling or therapy group are nested within the group leader. It is, therefore, not appropriate to treat members as if their data were independent. Multilevel modeling can address the dependencies in this type of group data and should always be used when the research question involves the group leader. We hope that researchers continue to examine the relationship between group leadership and member endorsement of TFs but use appropriate statistical models so that we can have more definitive findings in the important area of TFs research.

Best Practices in Research on TFs

Based on our review of the recent TF literature, we offer several recommendations for future research in this area:

1. Use TF instruments that have well established construct validity. Research clearly suggests that there are a small number of dimensions that underlie different TF measures. In our view, the most rigorous of the factor-analytically derived measures is the TFI–19 (MacNair-Semands et al., 2010). We encourage researchers to use the TFI–19 in future research on TFs.
2. Examine TFs over time. Far too many of the TF studies are cross sectional. Cross-sectional TF data does not comport with group development theory. That groups develop over time is an important construct in group counseling theory. Measuring TFs at only one point in time severely limits our understanding of TF processes. We recommend that future TF studies use longitudinal designs.
3. Use statistical analyses that take into account the nested structure of group data. TF data are often doubly nested. TF ratings can and should be made across sessions, therefore session ratings of TFs are nested within individual group members. In addition, individual group members are nested within counseling/therapy groups. It is now well known that failing to account for these types of nested data structures will lead to misleading statistical conclusions. Multilevel modeling analyses such as hierarchical linear modeling (HLM) can address the data dependencies created by nested data. The Joyce et al. (2011) study is an excellent example of research using this type of analysis. Future TF should use multilevel modeling to address the issue of nested data.
4. Do more TF studies that examine the links between TFs and other group process or between TFs and group member outcome. As noted above there are still far too many TF studies that simply examine TF rankings without any other meaningful comparison.
5. Use statistical analyses that begin to capture the complexities of group processes. Individual group member TFs always occur in the context of TFs experienced by other group members. As noted above the APIM is one model that can allow researchers to simultaneously examine both the individual group member's perception of TFs and the other group members' perceptions of TFs. Kivlighan (2011) is a good example of how the APIM can be used in TF studies.
6. Move beyond correlational designs in TF research. It is critical that we can begin to establish some causal connections in our TF research. The Waldo et al. (2007) study is an excellent example of how an experimental design can be used in TF research.

Best Practices for Group Practitioners

Based on our review of the recent TF literature, we offer several recommendations for using TFs in group counseling and group therapy:

1. Decide which TFs you want to emphasize in your group. Based on the therapeutic factors emphasized groups can either be affective insight groups, affective support groups, cognitive support groups, and cognitive insight groups. The decision about type of group can be made based on either the goals of the individual group members or institutional needs.
2. Emphasize TFs that are related to group member outcome. These included Group Cohesion, Interactional Confirmation, Cathartic Self-Revelation, and Self-Insight and Progress (Dierick & Lietaer, 2008), and Instillation of Hope, Secure Emotional Expression, Relational Impact, and Social Learning (Joyce et al., 2011).
3. Manipulate your leadership style (see Pan & Lin, 2004), the group climate (see Gold & Kivlighan, in press; Joyce et al., 2011; MacNair-Semands et al., 2010) and/or the group structure (see Waldo et al., 2007) to emphasize the desired TFs.

It is important to note that we need much more research that can lead to best practice recommendations. Our hope is that the next reviewers of TF research will be able to create a best practices matrix that links group member needs/goals to the specific TFs, which are in turn linked to specific leadership behaviors, group climates, and group structures.

Conclusion

It is our hope that group researchers continue to expand the existing literature on curative group processes through innovative and empirically sound research directly examining the relationship between TFs, other group processes, and outcome, while paying theoretical and statistical attention to the relational aspects of individual group members and the other group members. It is evident that group research has entered a stage of revolutionary science as scientific anomalies accumulate, thanks to recent innovative research, showing that the old paradigm is not capable of explaining our increased understanding of the TFs in group therapy. Simply put, our hope for the future of TFs research is a continued surge toward the ongoing scientific revolution by group researchers and practitioners committed to current and future clients.

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Chapter 5 Process and Outcome in Group Counseling and Psychotherapy: A Perspective

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Group psychotherapy presents itself as a complex and dynamic endeavor designed to aid those who are in chronic or acute psychological distress. Over the past fifty years, researchers and clinicians have focused on the dynamics of this complexity; specifically in terms of understanding its effectiveness—Does group counseling and psychotherapy work?—and its operations—What are the core therapeutic processes? The contributors to the theory, practice, and research in group work come from a variety of backgrounds, disciplines, and theoretical orientations that have influenced the approaches taken to answering these critical questions. The entity, itself, is also diverse, operating on various levels and engaging multiple players, goals, roles, and relationships, each contributing a singular influence, all shaping an interactive effect. We previously concluded regarding the complexity of group (Fuhriman & Burlingame, 1994):

> … we have a system in which diverse categories of phenomena have the potential to develop simultaneously, and in which there is always a concern as to what constitutes a singular, cumulative, or collective phenomenon. Adding to this multiplicity, the group is a moving, evolving system, comprised of interlocking parts from which, predictably, emerges a catalytic process. The finality of this complexity is that the process and the group can never go back. (p. 7)

As well, the empirical journey toward understanding these process and outcome questions reflects the multiple perspectives of the researchers and the context of the specific groups involved. Understandably, the journey through this landscape has been neither direct nor systematic. Nevertheless, the effort has been constant and, today, presents the field not only with a clearer understanding of the effectiveness of group treatment and the processes involved but with more refined questions regarding the relationship between group processes and successful client change.

The purpose of this chapter[1] is to provide a broad perspective of the group psychotherapy process and outcome research, identify the substantive components studied, and illustrate how these components have evolved or changed over time. Changes over the years can be seen not only in the focus (both content and population) and methodology taken by researchers but in the results and conclusions derived from their analyses. First, we will update our outcome and process findings from our last chapter (Burlingame, Fuhriman, & Johnson, 2004), focusing on research published over the past decade. At the end of this section we provide the reader with a brief clinical example of how process findings are being used to guide group practice. Finally, we end with a commentary on the current state of the process-outcome literature as a whole.

Organizing Outcome and Process Findings

To provide a broad perspective on the recent literature, findings are organized using a two-dimensional scheme applied to the outcome literature (Burlingame, MacKenzie, & Strauss, 2004).[2] The first dimension, *How*, describes whether group treatment was used as the *primary* modality to address client goals or as an *adjunct* modality that augments concurrent treatments. Examples of group as the primary are replete throughout the literature (e.g., depression) while group as adjunct is typically driven by setting (e.g., medical) or severity of the client disorder (e.g., schizophrenia).

The second dimension classifies *What* evidence and is available using three categories. *Very good to excellent* evidence is associated with treatment gains supported by two or more randomized clinical trials (RCTs), or meta-analytic studies. *Promising to good* evidence reflects limited RCT support or uncontrolled pre-post improvement. *Mixed* evidence represents literature where contradictory evidence abounds; that is, patient improvement in active group treatment and control conditions is equivalent. If empirical examinations of existing protocols were not located we classified such as *Untested.* In short, this dimension classifies available evidence based on both the quality/rigor of the research design (i.e., experimental vs. pre-post) and extant findings (e.g., consistent support of group efficacy over studies vs. contradictory findings from two or more studies).

Outcome Findings: Our Present Knowledge

Table 5.1a reflects the crossing of the *how* and *what* dimensions and integrates findings from the last decade. In our previous chapter, we cited over 100 studies that tested the effectiveness of group treatment protocols. We have added over 250 new studies to update our findings, with changes reflected in Table 5.1a; the interested reader is referred to Burlingame, Strauss, and Joyce (2013) for citation information on the studies summarized below as well as more detail. Specifically, bold type denotes new findings, while plain type represents findings from our original chapter. Arrows in the table indicate a directional change from conclusions in our 2004 chapter, visually showing the progress that has been made in group research over the past decade. Fifteen disorders or populations (2 additions from 2004) had a sufficient number of studies to summarize general trends. We have come a long way since 2004 and are more confident in answering the question: Which treatment works for whom and under what conditions? The available evidence still suggests that the answer depends on population.

Very good to excellent evidence. In 2004, only two disorders using group as primary had very good to excellent support in the literature. The first, social phobia, was shown to be effectively treated with exposure, psychoeducational, and most notably, cognitive-behavioral group therapy (CBGT). The past decade has reinforced these findings with 28 additional outcome studies affirming CBGT's effects on social phobia symptoms as well as comorbid depression. Also, a recent meta-analysis (Powers, Sigmarsson, & Emmelkamp, 2008) that pooled a portion of these studies estimated the effects of group and individual treatment to be identical. In 2004, group treatment of bulimia nervosa (BN) was rated very good to excellent using both meta-analytic (e.g., Hartmann, Herzog, & Drinkmann, 1992) and rigorous individual studies (e.g., Wilfley et al., 1993). Since then, nine additional studies have added support to our previous conclusion, demonstrating that CBGT has consistent effects on BN symptoms, is equally effective compared with other treatment methods, and is also effective when elements of psychodynamic and psychoeducational models are included.

A second type of eating disorder, binge-eating disorder (BED), is a new diagnosis since our 2004 review, with group protocols tested over the past decade for this disorder receiving very good to excellent ratings. Thirteen studies compared CBGT to alternative approaches and found equivalent effects on binge-eating behaviors, BED-specific and general symptoms, self-esteem, and social functioning. Panic disorder had previously been found to have promising to good support with cognitive behavior as the most promising model. However, with 13 new studies reporting the efficacy of group treatment for panic disorder using exposure and response prevention (ERP; repackaged as CBGT), the level of support has increased to very good to excellent. Obsessive-compulsive disorder was also categorized as having promising to good support in 2004 with ERP as the dominant treatment. The last decade produced 6 RCTs and four pre-post studies that showed ERP and CBGT producing identical cognitive gains and outperforming wait-list controls. ERP proved more effective when differences in medication are controlled.

Table 5.1a Quality of Evidence From 1990s to the Present: Group Treatment Outcome Research X Patient Population

Use of Group Treatment	Very Good to Excellent	Promising to Good	Mixed to Untested
Group as primary	Social phobia **Panic disorder** **Obsessive-compulsive disorder** Bulimia nervosa **Eating disorders**	**Mood disorders** Panic disorder Obsessive-compulsive disorder	Mood disorders *Elders
Group as adjunct	SPMI—schizophrenia **Personality disorders** **Trauma-related disorders** Medical—cancer **Substance abuse**	*Medical—HIV Personality disorder—homogenous Sexual abuse victim **Pain/somatoform** **Inpatient**	*Domestic violence Substance-related disorders

NOTE: 2004 findings; 2012 additions/changes in bold.

*Information insufficient to update.

Very good evidence for the effectiveness of group as adjunct treatment was found for two challenging populations in our 2004 review. Schizophrenia was found to be successfully treated by social skills, psychoeducation, cognitive-information processing, and cognitive-behavioral groups with social skills groups being most effective. Twenty-seven new studies strengthen past conclusions of group efficacy and show that CBGT to be the dominant group method producing solid gains across a wide range of outcomes. Similarly, in 2004 we found excellent support in the literature for group treatment of cancer patients with psychoeducation, time-limited therapy, and support groups. Since 2004, 28 additional studies with more rigorous methods produced more conclusive findings, showing reliable improvements in emotional distress, coping, and improving life adjustment.

The most recent literature also supports three additional group as adjunct protocols as having very good to excellent evidence. Group protocols for personality disorders were previously categorized as having promising to good group treatment evidence but now have sufficient evidence to be considered very good to excellent. New studies primarily focused on Borderline Personality Disorder found cognitive-behavioral (CBT) and dialectical behavior therapy (DBT) to be most effective in successfully treating central problems of the disorder: suicidality, parasuicidality, depression, hopelessness, and hospitalization. Group protocols for trauma-related disorders in our last chapter were primarily focused on sexual abuse victims having promising to good evidence. Since then, research has flourished, providing evidence for four approaches. Support, process-oriented, psychodynamic, and integrated models all had varying degrees of promising evidence, while CBGT had strong evidence for effects on trauma symptoms and secondary outcomes. In 2004, substance-related disorders were categorized as having mixed results in studies comparing differential effectiveness of group versus individual treatment as well as traditional group versus 12-step studies. The last decade produced 16 studies, affording us more clarity and earning a very good to excellent rating. These studies found groups for substance abuse to show positive effects for both adolescents and adults, with minor differences in effectiveness between protocols.

Promising to good evidence. Group as a primary treatment of mood disorders had been classified as having mixed evidence in the literature in 2004 but currently has been found to have promising to good evidence. Major depressive disorder (MDD) was the focus of 10 new studies. The most convincing support found was for CBGT, though evidence for behavioral activation and eastern philosophy (e.g., Porter, Spates, & Smitham, 2004) was also found, each of which showed superiority over control conditions on measures of depression and depressive thinking. Seven new studies investigated the effectiveness of group treatment on bipolar disorder and found that psycho-educational groups (PEG) led to a reduced number of recurrences of manic/depressive episodes and hospitalizations. In the 2004 review, improvement of patients who attended placebo-attention groups equaled those in active treatment conditions. However, these mixed findings were not replicated in the last decade of research.

The HIV/AIDS population was the only adjunct group protocol classified as having promising to good evidence

in our 2004 chapter that remains unchanged. Though studies of efficacy of groups addressing preventative goals with a psychoeducational framework were promising, there is currently insufficient evidence to update these findings. However, two additional populations that were not addressed in our 2004 chapter have shown promising to good support in the adjunct group research over the past decade. Group protocols for patients suffering from varying types of pain and somatoform disorders received sufficient empirical attention to warrant inclusion. For example, group treatment of chronic pain has limited research relative to individual psychotherapy, but does show potential, while RCTs studying irritable bowel syndrome suggest that CBGT is effective in reducing pain and psychological symptoms, as well as increasing quality of life. Alternatively, research on distress and pain in cancer patients concluded that individual was more effective than group treatment. The final population in this category, inpatient groups, was also shown to have beneficial effects, with greatest improvements shown in patients with affective and anxiety disorders.

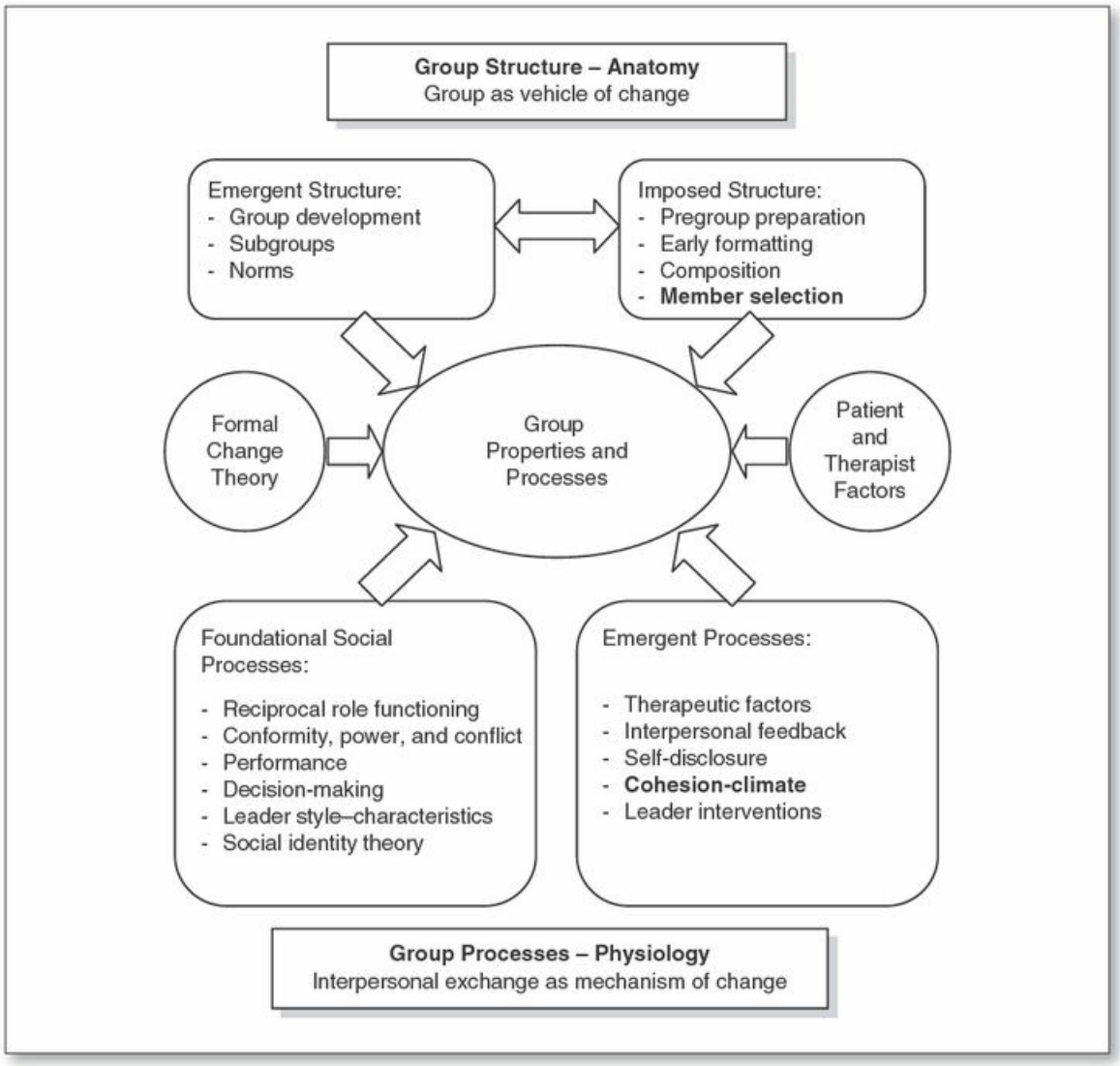
Both elderly populations and victims and perpetrators of domestic violence were categorized as being untested or having mixed results in our 2004 review and do not currently have sufficient evidence to be updated. Other areas that require additional research represent promising new developments in the field. For example, there are a plethora of studies in the literature that find group and individual treatment to be equally effective, but further research is needed to determine conclusions beyond general effects. Another interesting trend is the integration of competing approaches that previously stood alone. Similarly, clinicians note the reality and prevalence of diagnostically heterogeneous groups, but heretofore, research studies exclusively treat homogenous groups. Several studies, however, have addressed this issue by examining effects of mixed diagnosis groups with invariably positive results. Last, there is an increasing number of dismantling studies testing whether theorized treatment mechanisms actually explain change. Because findings were mixed, patient change is now a topic of study with sudden gains showing different patterns by disorder.

Process Findings: Our Recent Knowledge

We have argued elsewhere (Fuhriman & Burlingame, 1990) that the interactive interpersonal environment of group is a unique and powerful change mechanism in and of itself and that it predicts an independent portion of patient improvement beyond the theoretical orientation guiding the group leader. In our previous chapter, we discussed four change mechanisms: (1) pregroup preparation and early-group structure, (2) verbal interaction, (3) therapeutic relationship, and (4) therapeutic factors. We have recently expanded this four-fold conceptualization to integrate additional group dynamic properties suggested in both the empirical and theoretical group literature (Figure 5.1).

We labeled our revised model the "Anatomy and Physiology of Group Treatment" (Burlingame, Strauss, Borman, & Johnson, 2008; Burlingame et al., 2013) because it reflects structural aspects of small groups (i.e., anatomy) as well as distinct group processes (i.e., physiology). The model is based on Berne's (1966) analogy that knowledge of group dynamics (structure and process) for the leader is as essential as knowledge of anatomy and physiology for a physician. In this model, anatomy refers to the form of a group, and this form or structure is described as both *imposed* (the leader's actions that shape the group) and *emergent* (member actions that affect form). The physiology component captures additional interventions and processes that have been linked to member change. The intent of the model is to provide guidance regarding interventions, change mechanisms, and group processes that seems to be particularly salient from a clinical perspective but also have sufficient research to be considered evidence-based practice.

Figure 5.1 Evidenced-based Principles of Small Group Properties and Processes



A detailed explanation of each aspect of this model can be found elsewhere (Burlingame et al., 2008, 2013) and the research support for most of the anatomy and physiology components have remained stable over the past decade with notable exceptions (member selection screening tools and research is much improved); thus, previously offered conclusions from our 2004 chapter still hold (Table 5.1b). However, one process variable in Figure 5.1 that has received the considerable attention since our 2004 review is the therapeutic relationship, which is most often defined by measures of cohesion and group climate. The recent attention focused on group cohesion and climate can be understood by a familiar two-part debate that has existed for decades (Burlingame, Fuhriman, & Johnson, 2002). First, there is the mixed support for the therapeutic relationships' ability to predict member improvement and these mixed findings have led some to question its importance. Second, there is a lack of clarity in how to define the therapeutic relationship and this confusion produces conceptual ambiguity and more importantly does not provide group leaders with clear, action-oriented information to guide treatment. We address each point of the debate separately.

Table 5.1b Quality of Evidence: Empirical Support Associated With Select Group Processes

Use of Group Treatment	Very Good to Excellent	Promising to Good	Mixed to Untested
Group structure		Pregroup preparation Early group structure **Member selection**	Composition
Verbal interaction	Interpersonal feedback	Leader verbal style	Member self-disclosure
Therapeutic relationship	Alliance **Group climate** **Cohesion**	Group climate	Cohesion
Therapeutic factors		Differential patient value X setting	Dynamic interplay

NOTE: 2004 findings; 2012 additions/changes in bold.

Does the Therapeutic Relationship Predict Outcome in Group?

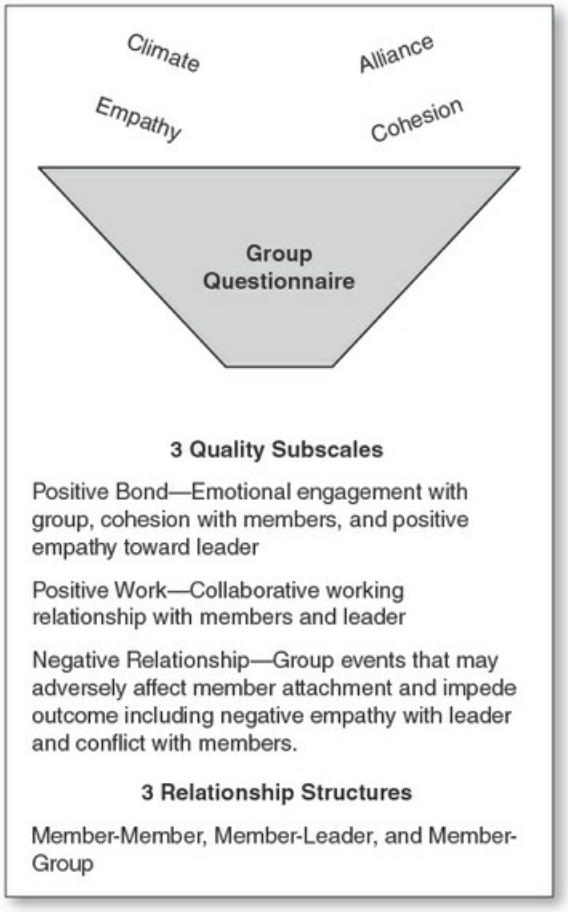
A point of debate for decades has been the degree to which cohesion and climate reliably predict treatment outcomes in group treatments offered across different clinical settings, diagnostic groups, and treatment orientations. Some studies have supported this link and others have not and these mixed findings have led some writers to question the universal value of the construct (Hornsey, Dwyer, Oei, & Dingle, 2009). However, a recent meta-analysis combined the findings from 40 studies that tested the cohesion-outcome relationship to determine if the mixed findings when examined as a whole could provide empirically based guidance to the group clinician (Burlingame, McClendon, & Alonso, 2011a, 2011b). The main finding of this meta-analysis was a significant positive relationship between cohesion and outcome (r = 0.25) confirming that when one has a sufficiently powered study, cohesion does predict patient improvement. Of equal import was the fact that the magnitude of this correlation was equivalent to correlations created by parallel meta-analyses in the individual therapy literature testing the therapeutic relationship-outcome link (Norcross, 2011). Thus, on an aggregate level it appears that we can empirically address the aforementioned debate and have empirical confidence that the therapeutic relationship predicts patient improvement in group at the same magnitude as in individual therapy.

Like most findings in the psychotherapy literature, the cohesion-outcome link is not a simple relationship. More specifically, there were significant interactions between five variables that moderated the size of the cohesion-outcome correlation. First, younger group member age was associated with a higher magnitude. Next, the theoretical orientation of the group leader affected the magnitude of the relationship, with interpersonal orientations having the highest cohesion-outcome relationship and cognitive-behavioral having the lowest. Nonetheless, the important empirical fact to note is that the cohesion-outcome link significantly predicted outcome for all theoretical orientations that had a sufficient number of studies to adequately test. The length and size of group was also related, with 12 or more sessions and 5–9 group members being associated with the highest correlation. Last, the use of interventions intended to enhance cohesion was significantly related to higher correlations. The take away message from 40 studies conducted over four decades representing a wide variety of settings, patient diagnoses, and theoretical orientations is that the therapeutic relationship matters and the strength to which it predicts patient improvement depends on patient (age), leader (orientation and interventions), and group (length and size) factors.

Can We Address the Confusion on how to Define the Therapeutic Relationship?

With the recent and compelling evidence that the therapeutic relationship predicts positive outcomes in group, it becomes important to effectively measure this relationship so that the leader can use this information to guide clinical practice. We have argued elsewhere (Burlingame & Beecher, 2008) that when we find good empirical predictors of patient improvement we should measure and use this information to guide our clinical practice (Strauss, Burlingame, & Bormann, 2008). However, we, along with others, have bemoaned the absence of a consensual definition for the therapeutic relationship, which has led to an unwieldy number of measures with no empirical understanding about how these measures relate to one another (Burlingame et al., 2002; Burlingame, Fuhriman, and Johnson, 2004; Hornsey et al., 2009). One solution to this plethora of measures is to convene an expert panel of group clinicians and researchers to arrive at a consensus recommendation about which measures to use. The American Group Psychotherapy Association and its German counterpart enacted this solution in the early 2000s convening an international panel of experts that produced a list of recommended measures (i.e., AGPA CORE–R battery) based on clinical and research criteria (Burlingame et al., 2006). The challenge with implementing this solution in daily practice was that a single measure was selected to assess cohesion, climate, alliance, and empathy since no single measure adequately captured the breadth of the therapeutic relationship construct. This, in turn, created a recommended process battery that was too large to be feasible in daily practice, even for clinicians interested in tracking groups (Beecher, 2008).

Figure 5.2 Creating the Group Questionnaire With Final Subscales



With this limitation in mind, a subset of researchers from the aforementioned AGPA expert panel created a multinational cooperation from the United States, Norway, Switzerland, and Germany. Their goal was to develop and refine a process measure that efficiently captured the independent information contained in the cohesion,

climate, alliance, and empathy measures recommended in the CORE–R battery. The result (Figure 5.2) was a 30-item instrument called the Group Questionnaire (GQ), which reduced the nine subscales in the four aforementioned measures to three latent quality variables (Burlingame, 2010). As depicted in Figure 5.2, the GQ assesses the quality of the therapeutic relationship with three latent variables (positive bond, positive work, and negative relationship) that are crossed with the three structural relationships found in group treatment (member-member, member-leader, and member-group). More importantly, the quality and structure dimensions of the GQ have received psychometric support from six studies conducted by the multinational research cooperation (Bakali, Baldwin, & Lorentzen, 2009; Bormann & Strauss, 2007; Bormann, Burlingame, & Strauss, 2011; Johnson, Burlingame, Olsen, Davies, & Gleave, 2005; Krogel 2012; Thayer, 2012) in four countries using groups from different settings, populations, and patient diagnoses (Table 5.2). These studies confirmed that the GQ factor structure was robust and created a normative sample of nearly 2600 members enabling one to interpret GQ scores across different group settings and populations (Table 5.2).

After replicating the psychometrics, the next task was to determine if the GQ provided useful information to the leader. In other words, why would a leader use a therapeutic relationship measure if they could detect the same information through clinical observation? Accordingly, Chapman and colleagues (2012) assessed leaders' ability to predict individual group members' ratings on the GQ by collecting repeat GQ administration on 20 groups led by 10 leaders in a university counseling center and state psychiatric hospital. The rationale for two divergent types of groups was to test a leader's ability to assess members' perceptions of the therapeutic relationship with highly and poorly functioning group members. These authors found group leaders to be poor judges of their clients' perspective on the therapeutic relationship. Only counseling center leaders were able to accurately predict member values on two GQ subscales (positive bond and positive work) but accuracy only emerged after 6 to 9 sessions of contact. Chapman et al. noted that this time lag may be too long to identify members that are at risk for premature dropout or poor outcomes and argued for the importance of directly assessing member perception on the therapeutic relationship and providing this feedback to group leaders.

Research Team	Clinical Setting	Members/Groups
Johnson et al., 2005	– 14 U.S. counseling centers – U.S. nonclinical process groups	326/81 336/30
Bormann & Strauss, 2007	– 15 psychiatric hospitals in Germany & Switzerland	453/67
Bakali et al., 2008	– 20-session psychodynamic – 80-session psychodynamic	145/18
Krogel, 2013—30-item GQ	– 2 U.S. counseling centers – U.S. nonclinical process groups – inpatient state hospital groups	207/na 160/na 118/na
Bormann et al., 2011—30-item GQ	– 9 psychiatric hospitals in Germany	424/63
Chapman et al., 2012—GQ-30	– 1 U.S. counseling center – Inpatient state hospital	135/20
Thayer, 2011—GQ-30	– 4 U.S. counseling centers – 1 CMHC	290/65
TOTALS	18 U.S. counseling centers; 61 nonclinical process, inpatient, outpatient, & state hospital	2594/344

Can We Provide Group Leaders with Useful Feedback on the Therapeutic Relationship?

The Consortium for Group Research and Practice (CGRP; https://fhssdev.byu.edu/cgrp/) at Brigham Young University has invested nearly a decade developing and testing different methods for delivering outcome and process feedback to group leaders. There is ample evidence from the individual literature that such feedback can improve patient outcomes; however, applications of systematic feedback interventions in group treatment are just beginning (Burlingame et al., 2013). Early CGRP efforts focused on AGPA's CORE–R battery measures (cf. Strauss et al., 2008) while more recent efforts have relied on computer-generated reports that use the GQ normative base (Table 5.2). More specifically, Krogel et al. (2013) found reliable differences in GQ subscale means for distinct clinical populations (e.g., college students report higher positive bond scores on average than patients in a psychiatric state hospital) necessitating feedback reports that calibrate GQ interpretation against different patient population norms. The most efficient method of providing feedback employs computerized administration, scoring, and interpretation, which is becoming more feasible and cost-effective given the number of clients who own smartphones; alternatives includes web-based administration or the use of inexpensive tablets. Our current protocol is to assess a client's perception of the therapeutic relationship directly after a session while the group interactions are fresh in their minds.

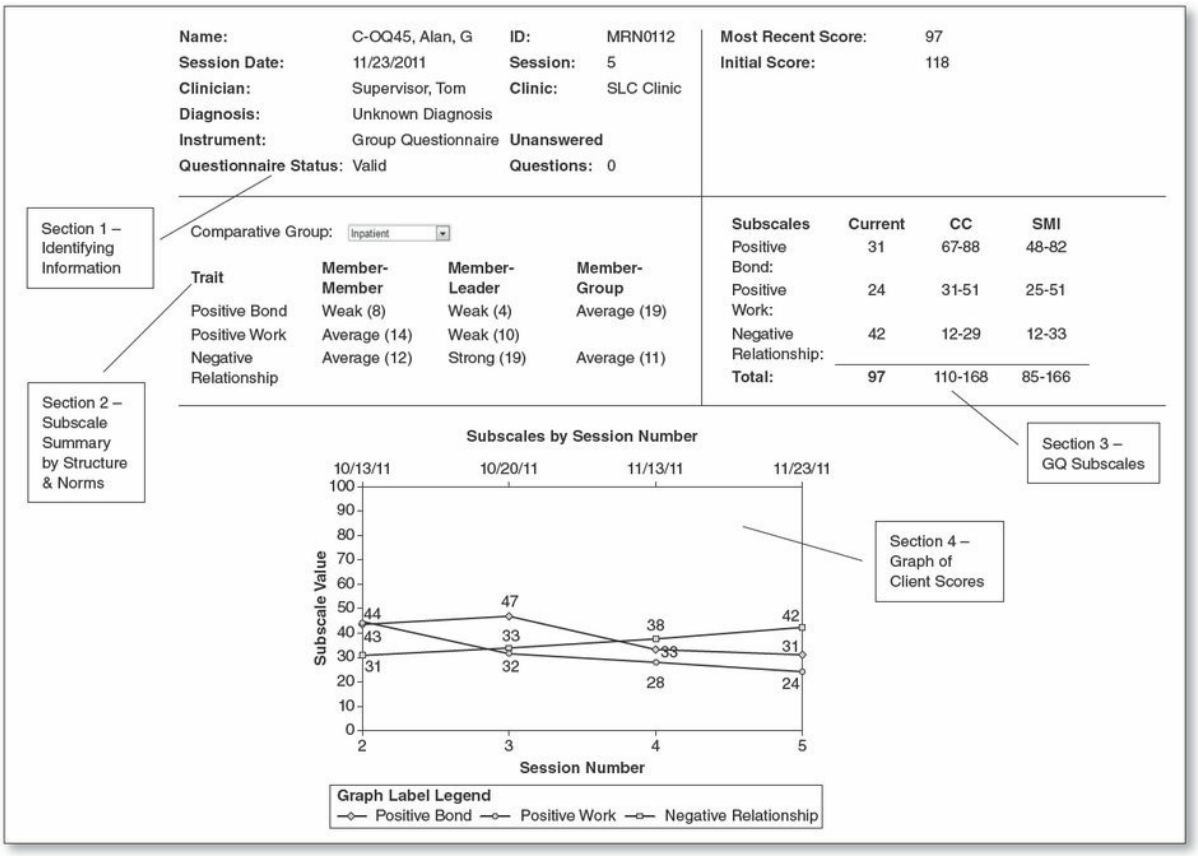
We have found that therapeutic relationship feedback is most useful to the therapist when it is both member- and group-specific. In the interest of space, we illustrate the former. Figure 5.3 is a computer-generated GQ feedback report for Alan, who is an inpatient state psychiatric patient in group treatment. The therapist is guided to Section 1 to confirm that they are looking at the correct client and that Alan completed a sufficient number of GQ questions to produce a valid report. Section 3 compares Alan's GQ Session 5 subscale scores using a 90% confidence interval created around means for two normative populations: counseling center (CC) and inpatient state psychiatric (SMI; serious mental illness). As can be seen in Section 3, all Alan's GQ subscales fall outside the confidence interval for both populations. Section 2 provides relationship-specific information for each subscale revealing that most of Alan's low GQ scores are because of a poor member-leader relationship. Indeed, the only low GQ score in Section 2 that is not leader-centered is member-member positive bond. Section 4 provides a longitudinal perspective on Alan's GQ scores that show a gradual decline over time; in fact, at Session 3 all his GQ subscales were average. The GQ report also provides item-specific alerts that provide actionable information that the leader can use to address low scores; for example, “The group leader is friendly and warm to me,” “The group leader and I respect each other.” Group-specific feedback summarizes all members reporting values outside the confidence interval and depicts longitudinal graphs by subscale.

Members of CGRP have now trained several hundred group therapists at AGPA annual meetings for the past decade and received feedback from several on its usefulness, especially when supported by software. The following are illustrative quotes from clinicians using GQ feedback:

> Therapist 1: Curtis had been pretty active with the group and had been quite involved. I looked at the scores of the group and thought there wasn't much there, but when I passed them out in group I noticed that bond and work were weak for Curtis. I asked Curtis if he could talk about that. He said he wasn't very connected to the group and was only there that day to tell them at the end of the session that he wasn't going to come anymore. By bringing it up at the beginning, he had the opportunity to talk about it. It ended up that he thought group members were being judgmental of him, but another member said he thought he'd been judging the others. It opened up a discussion about what had been happening underneath that I wouldn't have noticed without the feedback.
>
> Therapist 2: Yesterday I noted that most of the group members were reporting decreased bond and work and increased negative relationship. I was surprised by this. I knew there had been some tension in the previous session, but I didn't expect it to have such a dramatic impact on so many of the group members. I started the session by noting these changes on all three GQ subscales. This seemed to enable the group members to

jump right into a discussion of the previous session and what they wanted from each other. It seemed extremely helpful as a starting point for a discussion of feelings in the group that I'm not sure I would have been aware of otherwise.

Figure 5.3 GQ Clinician Report for Individual Member



Source: Sue Jenkins, CEO OQ Measures.

Source: Sue Jenkins, CEO OQ Measures.

Therapist 3: I had two clients who had previously been exposed to the GQ in a group that was not using the GQ. One of them stated to the group, “You know, in another group I was in, we used to fill out this thing after every group that asked us about how we felt about the group and stuff, and one of the questions asked about how you could trust the group, and I have to tell you I don't really feel like I can trust you guys right now.” The other client chimed in and said, “Yeah, I used to take that too, and I feel the same way.” It appears that the GQ gave words to experiences that group members had, allowing them to communicate their feelings to the group.

General Reflections

This broad perspective on outcome and process findings leads to three general observations with attendant recommendations. First, the group outcome literature is in a much better position than it was when in our last review. Efficacious protocols are evident for specific populations and for different applications of group (primary and adjunct). Moreover, the increased rigor of research in the past decade is without precedent in the group outcome literature. We are entering a new era where the evidence for the effectiveness of the group format has never been better, due primarily to the focus on tests of protocols for specific patient populations. It's a good time to be a group clinician because we have a burgeoning tool kit of evidence-based group protocols for most clinical settings. Thus, we see no excuse for group clinicians who do not guide their groups with an empirically supported intervention, even if one has to adapt a protocol to meet the unique characteristics of a clinical population. This advance ensures the best possible outcomes for our group members.

The second observation relates to the extant process literature in particular and the group dynamic literature in general. We provided a high-level overview of the evidence-based practices that should be guiding group leaders (i.e., Figure 5.1). Professional organizations such as the AGPA have developed practice guidelines based on this evidence (Bernard, Burlingame, Flores et al., 2007) and we believe that each group clinician should consider these evidence-based components as a preflight checklist, to be completed before leaders "take off" with their group members. In particular, the evidence for the therapeutic relationship (alliance, cohesion, empathy, and climate) with group members' improvement is no longer a matter of debate. This is one of the strongest areas of evidence in the group literature. In our last chapter, we issued "a clarion call for empirical effort that might clarify this conundrum of concepts" (Burlingame, Fuhriman, and Johnson, 2004, p. 57) associated with the therapeutic relationship. Over the past decade, the multinational collaboration took the best of existing measures of alliance, empathy, group cohesion, and climate to create the GQ providing one answer to our call. Other research cooperatives have produced alternatives (e.g., Therapeutic Factors Inventory, MacNair-Semands, Ogrodniczuk, & Joyce, 2010) but the bottom line from our perspective is that evidence-based group leaders can no longer leave this evidence-based component to chance.

Parallel advances in the general psychotherapy literature have created a compelling perspective for interpreting the positive developments for the therapeutic relationship in group treatment literature. We now know that the individual therapist accounts for as much client improvement as the empirically supported treatment protocol they are using (Baldwin & Imel, 2013). These findings are undoubtedly related to Wampold and colleagues' earlier conclusion that 9 times more variability in patient improvement is attributable to common factors across all treatments than the ingredients found in specific models of treatment (Hyun-nie & Wampold, 2001). When we cited this conclusion in our last chapter, we did not know how strongly the therapeutic relationship predicted outcome in group treatments. Given our current knowledge we believe it is imperative for group clinicians to take advantage of these findings in the same way that they use empirically supported treatments to guide their clinical practice. The growing use of outcome and process feedback systems in the individual literature must find their way into daily practice of small group treatment. These systems should prove more valuable to group leaders who are tracking multiple clients yet have less information than individual therapists.

Finally, we noted in our recent review (Burlingame et al., 2013) that the number of research teams that are studying mechanisms of change or process research has diminished over the past decade. Journal space that used to publish these studies is now devoted to an explosion of studies testing the efficacy and effectiveness of specific group protocols for specific patient populations. As we noted above, the latter is an important advance, but the reduction in overall research activity investigating mechanisms of change in the group literature is not a promising development. There is a negligible number of studies to update our empirical knowledge regarding process components we reviewed in our last chapter and those found in Figure 5.1. In short, the group dynamic literature must stay current with contemporary group treatments to ascertain if findings from past research generalize to newer group treatments. Without this, our group dynamic and process literature will shortly become out of date.

The group process and outcome literature has matured over the past decade. However, the oft cited counsel to

understand history to avoid repeating past mistakes seems to be a particularly apt warning for the group literature. If we do not heed past admonitions to conceptually and empirically focus on common and specific mechanisms of change we will be doomed to repeat past mistakes and be left with empirical support for efficacious group protocols with little-to-no understanding regarding the underlying change mechanisms.

Notes

1. This chapter is an update of our earlier chapter in this volume. In some cases, our text and conclusions remain the same while in other cases there is considerable change based on recent findings

2. We are aware of the active discussions regarding criteria for empirically supported treatments in the United States and evidence-based treatment in the United Kingdom and Germany. The unsettled nature of this debate led to our own criteria that reflect our clinical and empirical understanding of the literature. The more liberal criteria have shortcomings (e.g., category overlap, reliability) but as we have argued elsewhere (Fuhriman & Burlingame, 1994), we believe the empirical group literature lags behind the individual psychotherapy literature and thus believe a more generous stance is appropriate.

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Part II Best Practices of Group Counseling and Group Psychotherapy

Maria T. Riva

Best practice guidelines are drawn from research, theory, and leader expertise with the intent to guide group practitioners and researchers to the most effective ways to conduct and study groups. The following nine chapters address best practices in group counseling and group psychotherapy for a number of crucial topics. The first chapter in this section addresses guidelines for ethical and legal practices in group counseling and psychotherapy. Lynn Rapin reviews such fundamental elements of ethical practice as member screening, informed consent, and confidentiality for groups. Throughout the chapter, her rich examples identify ethical dilemmas regularly encountered by group leaders. Effective processing of critical events and activities is viewed as a key ingredient of effective group leadership and Donald Ward clearly articulates guidelines on how to effectively process the here-and-now dynamics that occur in group psychotherapy for the purpose of helping group members gain new perspectives on their behavior. The next two chapters are connected in that they address specific group leader skills. Often, group leaders need to select and use activities and exercises that will aid in their members' progress. Activities are not change agents in and of themselves but rather it is the careful selection and planning of these activities when targeted for a specific purpose in the group that promote this change. Amy Nitza reviews the literature and best practices on the selection, use, and group processing of structured activities when used in groups. Along with the choice and use of activities, all group leader skills have ethical implications. The fourth chapter by Melissa Luke discusses several effective group leader skills specifically targeted for three areas: the intrapersonal aspects of a group member, the interpersonal relationships between and among group members, and those that respond to the group as a whole. Excellent examples are used throughout these two chapters to illustrate best practices. Lawrence Shulman's chapter on the mutual aid process in groups follows next. A major tenet of group counseling and psychotherapy (as opposed to individual counseling) is that the interactions among group members can be just as powerful (some say even more so) than those between member and leader. In his chapter, Lawrence Shulman skillfully describes the mutual aid process and how it can create multiple helping relationships within a group. The next two chapters focus on training and supervision of group leaders. In the sixth chapter, Rex Stockton, Keith Morran, and Seok-Hwan Chang overview the research and best practices for training beginning group leaders. Although leader training is essential to the future of group counseling and psychotherapy, it has been one that has received little attention. The authors have highlighted the necessary components of successful training models and provide strong recommendations for future research. The supervision of group leaders has also been a neglected area in group counseling and psychotherapy training. Maria Riva underscores the importance of supervision, reviews the models of supervision of groups, and outlines recommendations for the future. The final two chapters focus on the best practices related to evidence-based practice and conducting research on group counseling and psychotherapy. In their chapter on assessment instruments used to measure group process, dynamics, group climate, and client outcomes, Sandro Sodano, Wendy Guyker, Janice DeLucia-Waack, Heather Cosgrove, David Altabef, and Brian Amos provide researchers and practitioners alike with a wealth of information on reliable and valid measures that can be used to assess group components. Trying to locate appropriate and available measures is often a stumbling block for those group leaders who want to assess whether their group is effective and for researchers attempting to locate measures that will accurately assess group process and outcome variables. This chapter, along with the final chapter by Joseph Miles and Jill Paquin on best practices in group counseling and psychotherapy research, articulate the critical need to study group process and outcome. Joseph Miles and Jill Paquin, as well as all the authors in this section, articulate well the need for collaboration between research and practice. They discuss the unique methodological considerations when studying groups and conclude with future directions for group counseling and psychotherapy research.

Chapter 6 Guidelines for Ethical and Legal Practice in Counseling and Psychotherapy Groups

Lynn S. Rapin

Key ethical issues cited in group literature since 1980 include member screening and orientation, voluntary and involuntary membership, group facilitator preparation and behaviors, protection of members, informed consent, confidentiality within groups, and dual relationships (Capuzzi & Muffett, 1980; Corey, Corey, & Callanan, 2003; Fallon, 2006; Lakin, 1994; Lasky & Riva, 2006; Paradise & Siegelwaks, 1982; Posthuma, 2002). Issues of multiculturalism and diversity (Corey et al., 2003; Posthuma, 2002) as well as the role of leader values (Corey et al., 2003) appear in more recent discussions of ethical behavior in groups. A special issue of the International Journal of Group Psychotherapy (2007) focused on ethical issues of group psychotherapists.

Cooper and Gottlieb observed in 2000 that the majority of psychology and counseling ethical decision-making models available at that time (e.g., Forester-Miller & Davis, 1996; Kitchener, 1984; Paradise & Siegelwaks, 1982) did not address the legal ramifications of ethical decision-making models. In some cases, an ethical decision may not be legal, and in other cases, a legal obligation may not seem ethical (Rapin, 2004). Careful attention to and clarification of both sets of expectations will increase the performance of ethical practice in counseling and psychotherapy groups. Newer ethical decision-making models incorporate legal conflicts and potential sources of guidance.

Numerous agency and employer issues can result in ethical conflicts, including independence in selection of group members, formats used for counseling and psychotherapy groups, ownership of group data, identified clients, and documentation requirements. Many of these concerns can be identified and modified in the planning process. Employers may put pressure on providers to keep groups filled for utilization purposes. In this instance, the needs of the group and its members may be in direct conflict with pressures to deliver billable units. The ethical practitioner has to be confident in providing sound rationale for selection or exclusion of participants.

In this chapter, I will review key elements of ethical practice in group counseling and psychotherapy and provide examples of their application through best practices. The chapter includes major sections of ethics documents and their restrictions on group practice, moral principles and values, ethical and legal decision-making models, and application of best practice guidelines.

Foundational Documents

Professional Ethical Codes and Groups

Because mental health ethics codes are general in nature, they apply to all areas of practice, including group psychotherapy and counseling within the given field (e.g., psychology, counseling, and social work). In a content analysis, Lakin (1994) reviewed the 1992 APA ethics code for its application to group and family therapies. His comments are still relevant to the most current code (APA, 2002, 2010). He made several general observations about the lack of applicability of the code to group therapy because of the more elaborate contexts in which ethical decisions are made in groups compared to individual treatment. Lakin pointed out that competence, a central issue in group practice, is an aspirational principle in the code, thus leaving open to group leaders' judgment their scope of group practice. The concept of informed consent is complicated by multiple layers of communication and participants' concerns about being accepted as members of the group. Lakin asserted that issues of mutual help and interdependency, assumed in the nature of counseling and therapy groups, could be both positive sources of therapeutic change and ethical risk. Group interactions cannot always be anticipated and controlled. Group cohesion and diversity present ethical challenges in groups because pressures on members and among members to conform to the therapeutic plan may be contradicted by outlying points of view or experience.

All major professional association ethics documents specify that legal limitations be imposed on group counseling and therapy activities. The American Psychological Association (APA) and American Counseling Association (ACA) documents serve here as important examples. In the APA *Ethical Principles of Psychologists and Code of Conduct* (2002, 2010), only three items directly address groups. Standard 10.03 states, "when psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality." Standard 7.02 concerns training programs and states in part, "Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content, including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service. … " Standard 7.05, *Mandatory Individual or Group Therapy*, states, "(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (b) Faculty who are or are likely to be responsible for evaluating student academic performance do not themselves provide that therapy."

In the ACA *Code of Ethics* (2005), group practice is addressed in three sections, including Counseling Relationship; Confidentiality, Privileged Communication and Privacy; and Supervision, Training and Teaching. Item A7 states, "When a counselor agrees to provide counseling services to two or more persons who have a relationship, the counselor clarifies at the outset which person or persons are clients and the nature of the relationships the counselor will have with each involved person. If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately." Regarding screening, item A8a states, "Counselors screen prospective group counseling/therapy participants. To the extent possible, counselors select members whose needs and goals are compatible with goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience." Protecting clients, item A8b states, "In a group setting, counselors take reasonable precautions to protect clients from physical, emotional, or psychological trauma." Regarding group work with couples and families, item B4b states, "In couples and family counseling, counselors clearly define who is considered 'the client' and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual's right to confidentiality and any obligation to preserve the confidentiality of information known." Addressing peer relationships, item F6e states, "Counselor educators make every effort to ensure that the rights of peers are not compromised when students or supervisees lead counseling groups or provide clinical supervision. Counselor educators take steps to ensure that students and supervisees understand they have the same ethical obligations as counselor educators, trainers, and supervisors."

Consistently in ethics documents is the requirement that group leaders inform members of roles and

responsibilities of group members and leader(s). In the area of providing protection for group members and students in training, group counselors, therapists, and supervisors/faculty have the responsibilities of defining group purposes; screening members for maximum gain and protection from physical, emotional, or psychological harm; and balancing individual and group needs.

Group Specialty Documents

Several group specialty associations provide guidance documents on group practice, but each organization adheres to the ethical principles of their parent association. Therefore, specialty documents are considered aspirational in nature. The documents suggest practice behaviors but none of the documents are legally enforceable. The Association for Specialists in Group Work (ASGW) provides guidance to group practitioners through aspirational "Best Practice Guidelines" (2007), "Multicultural and Social Justice Competence Principles for Group Workers" (2012), and "Professional Standards for the Training of Group Workers" (2000). The Association for the Advancement of Social Work with Groups (AASWG) published the "Standards for Social Work Practice with Groups" (2005) and AGPA supports group therapists via "Clinical Practice Guidelines for Group Psychotherapy" (Bernard et al., 2008) and published "Guidelines for Ethics" (2002) with its certification branch, the National Registry of Certified Group Psychotherapists (NRCGP). The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) is a counseling accrediting body that publishes training standards for counseling and its subspecialties, including group work. (See each of these documents in the online resources for this chapter.)

In her review of seven specialty documents, Rapin (2011) compared group association training standards documents across categories of target audience, competencies (core or advanced), group types, and required or recommended clock hours. Best practice documents were compared for audience, required or aspirational components, competency level, group types, and presentation. In training documents, there is some consistency in core components, but there is wide variation in the required number and nature of suggested training experiences across professional associations. Best practice documents had concurrence in several areas, including group phases, core and advanced skills, and in general areas of preparation, practice, and evaluation. Therefore, group counseling and psychotherapy colleagues who work in the same practice setting but who have different professional affiliations may demonstrate quite different levels of training and experience. Based on these documents, it cannot be assumed that fellow staff members have equal group training or experience. Staff with no professional association affiliations may have no group training.

Moral Principles and Values in Groups

Since the 1980s, there has been general agreement on five moral principles that guide the helping professions, including autonomy, nonmaleficence, beneficence, justice, and fidelity (Acuff et al., 1999; Forester-Miller & Davis, 1996; Kitchener, 1984). These principles have grounded ethical codes and decision-making models. Each principle is briefly described here.

Autonomy allows the individual freedom of choice and participation. Autonomy is also based on the assumption that the group member has the ability to make sound decisions about whether to enter, participate, and continue in group treatment. Ethics principles require that potential group members or student participants be provided information about the goals of the group; member and leader roles; and definition and limits of confidentiality so that they can make an informed decision (consent) about participation. Pressure to participate in a group session from both group members and leaders may complicate autonomy.

Nonmaleficence, the concept of doing no harm, involves both protection from intentional harm and refraining from actions that would risk harm both from group leaders and from members. Choices of activities, structuring and pacing of counseling and therapeutic events, levels of disclosure, modeling, and member selection represent major areas of group practice influenced by this moral principle.

Beneficence, the principle of doing good and providing benefits to others, reflects a proactive and harm prevention perspective. In contrast to nonmaleficence, beneficence focuses on actions that will enhance the lives of participants. Group facilitators must assess if group interventions are benefitting group members.

Justice reflects uniqueness and individuality in the treatment of others. Clear rationales need to be considered whenever an individual is treated uniquely. Issues of diversity, member experience, levels of participation, targeted group treatments, and homogeneity versus heterogeneity in group composition should be taken into consideration when placing group members in group and planning interventions.

Fidelity, referring to honor, faithfulness, and loyalty, requires trust in the therapeutic process and in those who execute it. Group leaders have a commitment to assist the group members throughout the stages of the group. Group interventions require a careful balance to preserve trust. Group facilitators can increase trust by modeling good group member behaviors and reinforcing those behaviors as group members demonstrate them. For example, the leader can reflect and summarize common experiences expressed by members with social anxiety, thereby assisting the members in understanding the similarities in their experiences and fostering a climate in which members can learn from each other.

Ethical/Legal Decision-Making Models

Based on moral principles, a number of ethical decision-making and problem-solving models exist to assist counselors and psychologists through ethical questions and dilemmas in broad areas of practice. While it is beyond the scope of this chapter to review each of these models in detail, it is relevant to provide an overview of them. No one decision-making tool is adequate to guarantee ethical practice. In combination with strong values, guidance from professional associations, licensing statutes, leadership skill development, and best practice, decision-making models can increase ethical depth.

Prior to 2000, a number of practice-based ethical decision-making models (Forester-Miller & Davis, 1996; Kitchener, 1984; Paradise & Siegelwaks, 1982) provided a sequential process for identifying and resolving ethical issues in practice situations. More recent decision-making models reflect legal considerations in addition to codes of ethics, values, and moral reasoning in ethical practice (Corey et al., 2003; Haas & Malouf, 2005; Koocher & Keith-Spiegel, 2008; Pope & Vasquez, 2010; Welfel, 2006). Mutual decision-making steps include

1. assessment of the problem situation and its contexts,
2. definition of the potential ethical conflict(s),
3. consultation and application of codes of ethics and relevant statutes,
4. generation of alternative responses to the situation,
5. assessment of the consequences of potential responses,
6. implementation of the selected course of action, and
7. evaluation of the final action taken.

Regarding item (c) above, resources are available to assist with legal conflicts. State laws and rules are published and are available from relevant websites; licensing boards manage compliance. States vary in their definitions of professionals governed by specific statutes. For example, the state of Ohio has a set of laws and rules governing the practice of counseling and social work and another set of laws and rules governing the conduct of psychologists and school psychologists. By contrast, the state of Indiana has a behavioral health and human services code governing social workers, marriage and family therapists, mental health, and addictions counselors and has another governing psychologists. Legislatures enact the laws in all states. Rules set the standards by which professional conduct is monitored. Case law documents situations in which specific laws have been tested in court (for example, malpractice actions). Resources on legal issues, including Bennett et al. (2006), Pope and Vasquez (2010), and Wheeler and Bertram (2012), assist practitioners in keeping abreast of changes in statutes.

When counselors and psychotherapists experience conflict between ethics and the law, they are advised (Hansen & Goldberg, 1999) to consult with colleagues; with state or provincial associations and boards; with statutes, case law, and employer policies; with ethics committees; or with attorneys who are familiar with psychology and counseling. APA, in its 2010 amendments to the 2002 *Ethical Principles of Psychologists and Code of Conduct* directly addressed potential conflicts between ethics and law with three specific changes to the document based on human rights conflicts. In previous language, if a conflict with law, regulations, or other governing legal authority was not resolved by commitment to the code of ethics and reasonable steps, psychologists could "adhere to the requirements of law, regulations, or other governing authority in keeping with basic principles of human rights." In revised language, the emphasis is on protecting human rights. Ethical Standard 1.02: Conflicts Between Ethics and Law, Regulations or Other Governing Legal Authority states, "If psychologists' ethical responsibilities conflict with law, regulations, or other governing authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights." Parallel language occurs with Ethical Standard 1.03: Conflicts between Ethics and Organizational Demands (APA, 2010, p. 493). This change in language reflects growing awareness of potential conflicts between an employer (for example, the military) and constituents served (for example, soldiers who work with military prisoners).

Applying Best Practice Guidelines to Ethical and Legal Issues in Counseling and Psychotherapy Groups

ASGW Best Practice Guidelines

The variety of settings and the potential complexities faced by counseling and psychotherapy group facilitators demand that group leaders understand the parameters of their work and the principles available to guide effective and ethical practice. The ASGW guidelines can provide structure to the planning, performing, and processing tasks required for effective and ethical practice in counseling and psychotherapy groups. Because the areas of responsibility for ethical practice are similar for psychologists, counselors, and social workers, the guidelines can provide a general source of assistance to professionals in each field. The ASGW document will serve as the general template for this discussion. The guidelines incorporate the use of ethics codes and standards of practice as integral elements. Further, the guidelines include many of the contextual issues cited in the literature.

In addition, Burlingame, Fuhriman, and Johnson (2001) outlined six empirically supported therapeutic principles that foster best practice in group treatment. These principles concentrate on the power of the group leader's behaviors in fostering cohesion and relationship building in groups. Leaders (a) conduct pregroup preparation to establish treatment expectations, define group rules, and instruct members in appropriate roles and skills needed for effective group participation and group cohesion; (b) establish clarity regarding group processes in early sessions, because higher levels of structure probably lead to higher levels of disclosure and cohesion; (c) model real-time observations, guide effective interpersonal feedback, and maintain a moderate relationship-building process; (d) consider the timing and delivery of feedback as they facilitate this relationship-building process; (e) serve as models to members in demonstrating the importance of managing their emotional presence; and (f) facilitate group members' emotional expression and the shared meaning derived from such expression.

Best Practice in Planning

Preparation can reduce, but not eliminate, the likelihood of some ethical concerns and legal issues. The *Best Practice Guidelines* can prompt thinking about potential choice points and provide opportunities for planned responses in anticipation of common dilemmas. The guidelines promote reflective examination of the values, moral dilemmas, and varieties of influence that underlie any choice point. Case examples demonstrate some of the myriad choice points. Each of the choice points is not independent but rather may reflect several ethical variables.

Professional Context and Regulatory Requirements

Group psychotherapists or counselors need to abide by the rules and practices of their employer. As well, they must be mindful of the laws governing the practice of their profession. For example, an experienced, licensed psychologist, counselor, or social worker in an agency setting is planning a counseling group for a specific emotional situation (for example, depression). In considering professional context and regulatory requirements, the staff member reviews the relevant code(s) of ethics and standards of practice and confirms how the professional code reflects the licensing laws and regulations in the practitioner's state. Furthermore, the facilitator consults any special agency requirements that govern counseling and therapy groups. As a setting that emphasizes short-term treatment, the agency has restrictions on the length of interventions. In this example, the agency guidelines permit a ten-session group but would not permit an ongoing depression group. Many managed care organizations mandate specific treatment guidelines for depression. In this example the agency requires that all members of the group take a depression screening inventory at the initial session and regular intervals until the conclusion of the group. Disclosure of any assessment data would be necessary for informed consent. If this agency uses insurance reimbursement or some subsidy for payment, there may be additional reporting requirements for a particular group. In some cases, shortening a group plan may meet agency requirements but not meet the treatment needs of its members. In this situation, the group facilitator would construct the plan to maintain both compliance with organization guidelines and to provide an ethically sound intervention. The leader may reduce the content to be covered in a structured group in order to limit the number of sessions. A sequence of groups could be designed to provide increasing exposure to skills. The leader could also engage in discussion with agency staff about the research supporting a particular group plan and potentially gain permission for the treatment.

In considering the options in record keeping, Knauss (2006) identified advantages and disadvantages of keeping individual records for each participant versus one group record. Individual records were seen as supporting the individual needs of members, providing protection from harm, and protecting confidentiality. One group record could provide perspective on the major issues in the group and general progress but risk confidentiality of individual member information. A group leader could both maintain individual progress records for each member while noting in a group record group gains only.

Voluntary/Involuntary Participation

Group facilitators employed in treatment units often work within a structure that requires group participation of all clients. Day treatment programs, for example, are composed of a series of required group counseling or group therapy sessions. Group leaders have an obligation to ensure that members understand what choices they have in participating and what consequences will occur if they refuse. It may be necessary for a group leader to discuss this issue with participants in addition to providing a written description of the ground rules for the group. If participation in therapeutic events (for example, singing aloud with others in music therapy) is documented in case notes, clients must know in advance that their behavior will be documented, because level of participation may directly influence length of treatment or other therapeutic events. The group leader's responsibility to protect members from harm reflects moral principles of nonmaleficence and beneficence as well as one of the three key areas specified in ethics codes pertaining to groups. The interdependence of moral principles, ethical decision-making, and sound training are repeatedly observable in best practices.

Scope of Practice

The group facilitator's scope of practice would determine whether a counseling group with a predominantly here-and-now orientation for individuals or a therapy group with a remedial focus and more severe or chronic maladjustment is most appropriate. Assuming that the group facilitator is adequately trained in both counseling and therapy groups, the specific type of group is chosen for the best fit for the agency's clients (ASGW, 2000; Wilson, Rapin, & Haley-Banez, 2004).

Burlingame, Kapetanovic, and Ross (2005) classified small group treatments in a three-factor cube, with variables being formal theory of change, patient population, and structural features. The cube serves as one functional system for understanding multiple group structures. Group leaders can employ the cube to define a particular group intervention or group program and can serve to define a group leader's scope of practice. Seven formal theories of change are described, including interpersonal, psychodynamic, cognitive-behavioral, nondirective, supportive, psychoeducational, and behavioral. Patient populations around which many groups are formed include mood disorders, anxiety disorders, heterogeneous composition, eating disorders, severe and persistent mental illness, medically ill, substance abuse, and personality disorders. Structural features of the cube include duration, frequency and number of sessions; setting; open, slow open, or closed membership; leadership training and number of leaders; group composition; group size; voluntary versus mandatory attendance; and prior or concurrent treatment.

In their review of empirically supported group treatments, Burlingame et al. (2005) concluded that they are similar in structure in spite of variation in theoretical orientation or patient population. “They are typically diagnosis- or problem-specific, homogeneous, time-limited, short-term, and manualized, with symptom reduction as their main goal. These managed care-friendly group treatments dominate contemporary group research” (p. 400).

It behooves group leaders to share preparation levels and to collaborate with more experienced peers when gaps occur. For example, a potential member may be excluded from participation because of a level of distress outside of the abilities of the leader and therefore beyond his or her scope of practice.

As part of ethical responsibility to group members and to the profession, group leaders initiate appropriate opportunities for consultation and training both within and outside of their work organizations (ACA, 2005). Scope of practice limits require that practitioners add new areas of practice or specialty only after obtaining appropriate training, supervision, and supervisory support. If a group leader is developing a new area of practice, she or he, the coleader and supervisors need to take steps to ensure that the developing leader performs competently and with harm prevention. Opportunities include learning experiences via course work, conferences or teleconferences, workshop attendance, professional presenting opportunities, continuing education via reading, among others.

Professional Disclosure and Informed Consent

Informed consent is viewed as a process variable during the course of the group, affected by individual member disclosures and opportunities for varied levels of participation. In providing initial information about the group, its goals, leader expectations, scope of practice, and ground rules, it would be wise for the leader to get written clarification from all members about whether they wish the leader to communicate any information and to whom. This type of permission is a reminder to both member and leader that protections are ongoing and that individual preferences about information sharing may be changed at any time during the life of the group.

Full oral or written disclosure aids informed consent. A professional disclosure statement can assist in a number of information areas related to training, group focus, and information about confidentiality and its limitations. The professional disclosure statement can serve as a discussion aid in introducing the leader and the nature of the group to potential members. Disclosure of the limits on confidentiality, described in more detail below, is essential to the protection of group members. Depending on credentials and place of employment, laws may require a

professional disclosure statement. For instance, the State of Ohio requires a written professional disclosure statement (Ohio Revised Code, Chapter 4757.12) for licensed counselors, social workers, and family therapists but not for psychologists. The elements include (a) name, title, business address, and phone number; (b) formal professional education, including institutions and dates attended and degrees received; (c) areas of competence and services provided; (d) fee schedule by type of service or hourly rate; and (e) a statement at the bottom of the disclosure that the information is a requirement followed by the name, address, and telephone number of the licensing board.

Group Member Screening

Group facilitators need to be competent at group member selection and screening. Knowledge of who might most benefit from a particular type of group and group format is central to ethical practice. Riva, Lippert, and Tackett (2000) found that the primary variable used by group leaders for selecting members was fit with the group theme. While this straightforward and frequently employed selection process matches a potential group member with a type of group (for example, depression), this does not take into account personality characteristics that might interfere with this individual benefitting from a group format. Potential members with therapeutic needs greater than those designed for the group may be harmed if they are not a good fit for the group. In reviewing 111 empirical group studies for client, leadership style, treatment, and methodological effects, Burlingame, Fuhriman, and Mosier (2003) found little significant difference among the variables. Wait-list control versus treatment comparisons demonstrated significance on three variables. Members who were in homogeneous, outpatient, and mixed-gender groups performed better than wait-list controls. Burlingame and colleagues did find significant pre- to post-treatment gains for active groups compared to wait-list groups, affirming the effectiveness of active group treatments. For the effective-treatments, most typical studies included a cognitive behavioral or behavioral orientation with high structure. They concluded “the acquisition of information and the practice of relevant behaviors are prerequisite to treatment gains” (p. 11).

While another chapter in this book covers group interventions with minors, it is important here to identify ethical issues in working with children. Ritchie and Huss (2000) and Hines and Fields (2002) discuss special considerations for recruitment and screening of minors to counseling groups. Ritchie and Huss suggest that it would be reasonable to screen first and then seek permission if the minor fits the screening criteria for the group, although the risk is that parents may not want their children assessed at all. Hines and Fields reflected that it might be frustrating to preselect minors for balanced counseling groups only to have permission later withheld by parents. This consideration depends on the setting of the counseling or therapy group. In a school setting, group facilitators would have access to potential members for prescreening and often have contact with potential group members and their parents over time. In a community setting, group leaders must take care to ensure compliance with state law. In some states, for example, in Ohio (Ohio Revised Code, Section 5122.04), on the request of a minor 14 years or older, a mental health provider may provide the lesser of six sessions or 30 days service without prior parental consent. Parents would not be notified without permission from the minor and compelling reason for disclosure based on substantial risk of harm to the minor or another. This is a case of potential conflict between legality and ethics because intervention directly with the minor may put the child at risk with his or her family. In addition, billing or submitting an insurance claim would put the confidentiality at risk because the parents would receive insurance confirmation.

Ritchie and Huss (2000) and Hines and Fields (2002) also discussed considering the options of individual or group interviews, prescreening interviews as part of a team staffing, and screening through written questionnaire and other technologies. Some group experts prefer individual interviews (Couch, 1995; Jacobs, Masson, & Harvill, 1998) to protect confidentiality of potential members and to provide information about the child's background and presenting concerns.

Group Member Preparation

Preparation occurs after members have been selected for possible fit for the group. Preparation for group assists potential members in understanding member roles and expectations for the experience and contributes to the

members' informed consent to participate. While confidentiality is discussed in the next section, it is important to note that issues of safety are central to member participation. To fully participate, members need to know that the group setting is safe for self-disclosure. Group leaders can suggest that members keep disclosures within the group, but they cannot guarantee it.

Legal Privilege and Confidentiality Limits in Groups

Many issues related to confidentiality and its limits in groups reflect harm prevention (nonmaleficence). Lasky and Riva (2006) observed that most individuals do not understand the difference between legal privilege and confidentiality. Further, Lasky and Riva concluded that many group leaders and their group members do not fully understand confidentiality and its limitations in groups. Legal privilege pertains to laws of evidence by defining a client's right to prohibit a therapist from disclosing confidential personal information in a court of law. The client, not the therapist, owns legal privilege; therefore, privilege exists even in group therapy (Tanford, 2001). Statutes that vary among states and provinces govern privileged communication. For information to be privileged, it must be intended as confidential and, in fact, be confidential. Personal disclosures as part of therapy or counseling are intended to be confidential unless there is some legal purpose and expectation that information may be used in a legal contest, for example, in a custody dispute or in a case where a client has pressed charges against the therapist (Tanford, 2001).

When a third party is involved in therapy or counseling (as with a group), the communication becomes subject to the multiple interactions that occur among the members (Anderson, 1996; Lasky & Riva, 2006). Personal information shared in group therapy risks numerous breaches of confidentiality. As stated in the ethics code section of the chapter, all major professional association documents specify legal limitations on group counseling and therapy activities. The specific limitations vary from one legal jurisdiction to another. While the client or group member owns confidentiality of their individual personal information, the group leader is ethically bound to protect that information, reflecting principles of justice, beneficence, and nonmaleficence. The leader is responsible for educating group members to the importance and advantages of keeping group counseling and psychotherapy information private. Doing so not only protects members from harm but also helps promote informed consent. Participation with other individuals in a group setting opens up the communications of all members to out-of-group contacts. While a group facilitator cannot disclose any information about members of the group, the leader is unable to guarantee that individuals in the group do not talk about their in-group experiences (Rapin, 2004). When group members breach confidentiality, the personal experiences, diagnoses, and histories of fellow group members may be revealed. Very innocent contacts can lead to a loss of confidentiality. For example, members of a group may encounter each other in public and introduce friends with reference to the group. Personal and/or diagnostic information may be revealed merely in saying a person is in the same group. Members may post notes about their group experiences online and put other members' identities and information at risk. A member may invite another member to be an Internet friend. Members may encounter each other and say hello. If either person has someone with them, that person may ask how the member knows the individual or join in small talk, which could make the counseling group known. Pepper (2004) commented about the increased risk of breaking confidentiality when members and leader live in a small community or when they work in an environment where they share multiple relationships and roles.

There are specific situations in which even the leader cannot guarantee confidentiality. As soon as treatment plans are written, insurance preauthorizations granted or insurance claims filed, confidentiality of group member information is out of the control of the group leader(s) and agency. Many clients do not realize that agreement to use insurance benefits comes with a waiver of confidentiality, verified when the client signs the claim form for insurance reimbursement. Managed care companies, insurance companies, and national data banks have access or potential access to client information. Furthermore, state statutes and codes of ethics identify situations in which the safety of group members or other individuals imposes limits on confidentiality. For example, in the ACA code (2005) confidentiality may be broken to protect a group member or identified third party from immediate harm or when legal requirements demand that information be revealed. When such a situation is likely, the group leader would seek consultation from informed sources. If a group member reveals a life-threatening, contagious disease and a third party might be at risk, the group leader is required to take the following steps: seek confirmation of the

diagnosis, assess the member's intent to share the information on their own, and the member's intent to engage in behaviors harmful to a third party. If information about a group member is subpoenaed, the counselor needs to secure written consent or try to limit any information supplied to protect the client.

The most well-intentioned group leader may feel confident in building trust within the group and foster a false sense of security about confidentiality with group members. For example, a group leader may enlist the promise from group members to not share information outside the group, thereby intending to enhance cohesion. Such a strategy may result in group members increasing their self-disclosure more than they would consider if they knew their information could be shared outside the group. Therefore, the group facilitator's efforts to inform group members about confidentiality can assist each member in making a personal determination about how much to reveal during the group. As the group progresses, many reviews of the limits of confidentiality may need to be conducted.

Best Practice in Performing

The performing phase of group work encompasses the intricate applications of self-knowledge, values, and ethical decision making to the dynamic interactions within group. Effective efforts at the planning stage provide theoretical and practical frameworks for the leader(s) and members to follow during the performing stage of group. While other chapters in this *Handbook* address specific techniques, process issues, and best practices in the performing stage of specific group counseling and therapy groups, it is important to highlight some ethical risks that occur when the group is at the working stage. The following best practices assist in risk reduction.

Leader Preparation

Strengths and weaknesses of the facilitators are monitored throughout the progress of the group in before-group planning meetings, after-group debriefing and supervision sessions, and in summary group evaluations. These preparation sessions are crucial to the effective performance stage and can be used to identify content for professional development of group skills. Timing, choice of technique, responses to group members, encouragement of participation, and distributed leadership between leaders and members are just a few examples of potential ethical decision points. For example, a group leader may assess that a particular group activity may be appropriate for a current session. In introducing the activity, the group leader may notice some verbal or nonverbal resistance to the activity. The power of the leader's therapeutic skill or developed relationship with the group may convince participation from an unwilling member. In some cases, providing a description of the activity and its benefits to members may be sufficient to proceed. In other cases, the ethical response may be to suspend the plan for the activity and to shift focus to the here-and-now moment. This is an opportunity for the leader to model observations about the immediate interaction and to support the members in their emotional expression.

No plan, however well developed, is likely to be implemented without significant modification. Group counseling and therapy leaders need to assess which parts of their initial plans can be implemented as designed, which parts need to be modified, or which parts need to be wholly redesigned or discarded. Most ethical transgressions occur because the clinician did not anticipate a problem. When choice points arise, it is helpful to assess how the facilitator feels about the situation, on what principles the facilitator is operating (for example, nonmaleficence), and how particular responses will affect individuals in the group. Challenges emerge as group members become better acquainted. Some members may appear more likeable than others and may prompt differential responses from other members. Other individuals in the group may have styles that provoke the group. Levels of self-disclosure, risk taking, and opportunities for out-of-group contact are but a few additional variables that may affect the leader's response to members. Consistent ethical vigilance of leader effects is never wasted.

Diversity and Multicultural Competence

Among the variables resulting in ethical dilemmas is lack of leader competence or sensitivity to cultural differences (Debiak, 2007; DeLucia-Waack & Donigian, 2004). It is important to communicate respect for the uniqueness of individuals (beneficence), their worth and potential while appreciating (fidelity, autonomy) the variety of cultural, social, psychological, and political contexts they may represent (ACA, 2005). ASGW (2012) introduced a document that incorporates multicultural and social justice principles to replace its previous diversity-competent principles. The principles encourage self-awareness and sensitivity to broad areas of race, ethnicity, socioeconomic class, age, gender identity and expression, sexual orientation, religion, and spirituality. The principles include active and intentional inclusion of discussion and norm setting to promote cultural acceptance essential to a culturally competent scope of practice. DeLucia-Waack and Donigian (2004) suggest that group counselors and psychologists can increase multicultural competence by demonstrating self-understanding and regard for the needs of group members served.

Best Practice in Group Processing

The events in counseling and psychotherapy groups can occur with such speed that it is impossible to respond to all activities during each group session. As one follows best practice, a general plan for within group, between group, and termination processing should be established prior to the start of the group. Once the group is under way, processing between facilitator and group and between coleaders is necessary to understand what has occurred, how the group leader(s) and members understand group events, how they monitor group progress, and how they modify the plan for subsequent sessions. These processing events protect members (autonomy, beneficence, and nonmaleficence) and leaders alike (fidelity). Scope of practice is enhanced when coleaders or leader-supervisor discuss ethical challenges and potential responses (Rapin & Conyne, 2006).

Evaluation

Reflective practice occurs as the group leader integrates the observations, ethical choice points, decisions made, and ultimate effects of the group plan and its components. This reoccurring pattern provides ample information for ongoing planning, improvement, and revision of the group plan. Learning can be documented, compared with other group results, used for revision of the counseling or therapy group, and can potentially add to the professional literature. Summative components such as overall member satisfaction with the counseling or therapy group, level of member involvement, and goal accomplishment can be measured. For example, instruments used in the selection process to identify potential clients or desired behaviors can be used in a schedule during the life of the group to measure pre- and postgroup gains. The importance of preplanning potential questions for measuring progress and gathering data along the way contributes to usable summative data. Experienced group leaders have many opportunities for enhancing legal and ethical group practice such as serving on planning teams to design or evaluate group offerings; by participating in training and supervision opportunities in agency, institution, community, or professional settings; and in contributing to the professional literature, group facilitators increase visibility of ethical practice.

Summary and Recommendations

A number of key components to support ethical leadership of counseling and therapy groups have been reviewed and applied in this chapter, including research on ethics, guiding moral principles, ethics codes and laws, and their application through ethical decision-making models and best practice guidelines. Informed behavior can improve ethical practice.

While there has been significant advancement in measuring ethical and unethical behavior in psychology and counseling in the last 20 years, there has been relatively little research on ethical practice in group work. Ethical issues in group practice have remained consistent over decades in spite of levels of training. Evidence-based group practice is growing, but it is concentrated on methods easiest to measure, for example, behavioral and cognitive-behavioral treatments with homogeneous, structured, time-limited groups. Further research is needed to understand which tools and behaviors provide the most gain in ethical practice and the best reduction in ethical mistakes.

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Chapter 7 Effective Processing in Groups

Donald E. Ward

The value of processing has been emphasized by major contributors to the field of group work. Processing in groups may "be defined as activity in which individuals and groups regularly examine and reflect on their behavior in order to extract meaning, integrate the resulting knowledge, and thereby improve functioning and outcome" (Ward & Litchy, 2004, p. 104). The work on processing has been strongly influenced by Lewin's original conceptualization and implementation of the experiential T-group (Lewin, 1951), Yalom's extensive explication of the fundamental two-tiered processing model (1970, 1975, 1995; Yalom & Leszcz, 2005), and Lieberman, Yalom, and Miles' 1973 study that identified the critical leadership functions of meaning attribution and caring as fundamental to change through group work. Cohen and Smith's three-dimensional, 27-cell model for conceptualizing and directing interventions (1976a, 1976b) has also had a major impact on the use of processing by clarifying a formal structure for understanding complex group dynamic processes. In addition to processing with individuals and relationships, Brown described the importance of processing at the group level as:

> *Group process commentary* is a complex group-level intervention that identifies what the group as a whole is emphasizing, ignoring or suppressing, doing or not doing. It is used to increase the group's awareness, and is the leader's responsibility. The perceptual shift from the individual and the ability to identify group themes and metaphors help the group to move, deepen the experiencing, and become more aware that individual behavior contributes to and is reflective of the group's needs and desires. (Brown, 2009, p. 12)

How do we proceed to describe processing in current group work practice? There are a plethora of theories of individual counseling and psychotherapy with some degree of evidence from research and clinical wisdom supportive of their effectiveness that describe and advocate the use of methods to help clients explore and identify meaning in their individual experience. This chapter will direct itself primarily toward within-session group processing that emphasizes helping individuals and groups examine their here-and-now experiences in the group in order to understand and revise the meaning they attribute to the experiences at the individual, interpersonal, and group-as-a-whole levels of group activity. Emphasis will also be given to leader processing of the individual, interpersonal, and group levels of group activity in order to better understand, evaluate, and plan facilitative interventions. The leadership function of meaning attribution identified and emphasized by Lieberman et al. (1973) and Yalom (1995) is central to processing, and the idea of processing as the central defining characteristic of the reflective practitioner as described by Conyne also captures the critical importance of group processing (Conyne, 1997, 1999; Rapin & Conyne, 2006). Other than in these cases of skills training and direct teaching and conditioning or in those instances where leaders continue to use an individual-counseling-in-a-group-context approach, processing among group leaders and members is ubiquitous in group work (Ward & Litchy, 2004).

Studies of Expert Best Practices in the Use of Processing

Meta-analyses of group work itself have yielded evidence that both group work in general (Burlingame, Fuhriman, & Mosier, 2003) and inpatient group work (Kosters, Burlingame, Nachtiga, & Strauss, 2006) show evidence of differential effectiveness over wait-list participants. Although the information gleaned from these studies continues to provide empirical evidence of group therapy efficacy, as with the majority of studies addressing group work, the role of processing is not directly addressed nor quantified. Therefore, it is not possible to know to what extent the findings supporting group therapy efficacy are because of processing or other variables. Results of investigations that more directly addressed the value and effectiveness of group processing on members and leaders will now be presented.

Earlier work supporting the strong effect of high levels of processing on individual and group outcome was described in Johnson, Johnson, Stanne, and Garibaldi's study of older teen academic achievement (1990) and by Yager, Johnson, Johnson, and Snider's study of the academic achievement of third graders (1986). Participants whose treatments included group processing performed significantly better on academic and performance outcome measures than students who worked together but without processing and than students who worked on their own. Studies by Coche, Dies, and Gottelman (1991) and Richardson and Piper (1986) have supported the research findings of Lieberman et al. (1973) emphasizing the critical importance of including an emphasis on the cognitive dimension of processing with affective and experiential dimensions. Participant learning in 12 experiential groups of 71 total members revealed that those receiving higher levels of meaning attribution through group processing from the group leaders showed larger gains than those who received primarily supportive caring with low levels of processing from their leaders.

Mangione, Forti, and Iacuzzi (2007) found that virtually all the seasoned therapists (275 AGPA members) they studied believed that preparation for and processing of termination is critical to positive group outcome. The findings of Augustyniak, Brooks, Rinaldo, Bogner, and Hodges (2009) showed that, contrary to the general opinion among cognitive-behavioral group workers, behavioral interventions without attention to cognitive understanding are sufficient for behavioral change, an emphasis on cognitive processing as well as on behavioral change is critical across all ages of school children. An illustration of attention to meaning and cognitive understanding for older elementary-age children in a group to reduce dysfunctional impulsive behavior and emphasize critical thinking and reflective responding might include the following leader statement:

Leader: I think each of you has now had an opportunity to respond to the imaginary situation. How do you think you did?

Abby: I think I did great. It was fun to be able act in a way that wouldn't end up getting me in trouble.

Evan: I didn't start very well, because I wanted to just jump in and tell the teacher off, but I stopped and stayed quiet until I could control myself.

Mekkiah: I think all of us did pretty well. I wish we good do this well all the time.

Leader: Very good. I am pleased that you all believe that you are learning a new tool to help you. What do you think is the key in using this tool after you stop first? What is it that stopping allows you to do before responding?

Stephon: I know that I remembered that I would end up having to miss recess every time I just yelled at the teacher.

Maria: I was able to think of a different way to ask the teacher to explain the rule to me so that I didn't get into trouble.

Leader: Good. I think that Stephon and Maria have hit it exactly right, don't you? Stopping and not responding immediately with your first strong emotional reaction allowed you to use your thinking to make good choices and improve your responses so that you do not wind up with negative consequences.

Bieling, McCabe, and Antony (2006) have written a book that describes and strongly advocates a process orientation including an emphasis on the use of processing in cognitive-behavioral group work in general. They describe a model that integrates the adapted protocol-based intervention delivery method to each individual group member characteristic of the most basic CBT group work with Yalom's seminal interpersonal process model (Yalom, 1995) and Burlingame, MacKenzie, and Strauss' small group process model that also incorporates the application of a formal change theory and the impact of leader, patient, and structural variables to bring about therapeutic outcomes in group treatment (2004). They provide description and examples of their process-oriented CBT model under headings such as "Emotional Processing in the Group Setting" (p. 31) and "Attending to Group Process Within a CBT Structure" (p. 32).

Okech, Rubel, and Kline conducted a number of studies using qualitative research methodology that identify the key features of expert group leaders and coleadership (Okech, 2008; Okech & Kline, 2005; Rubel & Kline, 2008). Rubel and Kline completed an intensive qualitative investigation of eight expert group leaders from which they were able to identify and describe the very strong emphasis expert group leaders place on a complex understanding and application of processing to maximize exploration, learning, and change in groups. They identified three major variables affecting expert group leadership: experiential influence, leadership resources, and leadership process. The leadership process variable is most applicable to this discussion, since it includes how the participants developed their understanding of group interaction and made decisions about interacting with the group. The authors emphasized the finding that these expert leaders engaged in and applied the information gleaned from their understanding in the here-and-now of the group experience using both prior knowledge and a great deal of professional intuition developed through experience. The experts then engaged the group and its members actively in the processing to help members identify, explore, extract meaning from, and plan improved functioning in their lives. It is important to note that the steps were not discrete; rather, they were woven intricately together and often overlapped or occurred simultaneously. For instance, a leader may observe that, after one member implied that he or she had some serious emotional issues that were overwhelming him or her in the first session of a counseling group, the group had not directly responded beyond minimal acknowledgment and had moved on to introductions by other members. Being cognizant of the fact that first-session strong affective disclosure would likely have been problematic, but also concerned that the member might become marginalized and their concerns unattended as the group progressed, an experienced leader might intervene in the following way:

Leader: It seems as if everyone has had a chance to introduce themselves and share their primary concerns and reasons for being here. It seems to me that the group feels more comfortable and ready to move on to work on our issues. However, I wonder if you realize that we seemed to avoid Kaitlin's statement last week about feeling overwhelmed? Perhaps it felt too early for the group to feel ready to deal with intensity last week. It seems to me, though, that we need to ask Kaitlin to tell us more about her situation in a way that we can understand where we are going in our attempt to support and help her.

Okech (2008) used qualitative research methodology to investigate the way in which the critical element of reflective practice, often used synonymously with processing, was prominent in group coleadership. She investigated the processing experiences in which coleaders engage in order to develop strong collaborative relationships. Her study identified many of the same characteristics that Rubel and Kline (2008) identified in their study of expert leaders. She defined the process in the following way: "Essentially, during coleader reflective practice, co-leaders simultaneously engage in intrapersonal and interpersonal processes, develop insights, which in turn inform their choices on how to engage with each other and group members to promote group member and group objectives" (p. 239), and she labeled this processing as reflexive practice, which had been described as central to skilled processing in professional group work by Conyne (1999). For example, if coleaders Missy and Louis decided through reflective practice on their own and in supervision that Annie, a group member, seemed to have considerable trouble with her mother and other female authority figures, during the next group meeting, Louis might intervene in the following way:

Louis: Annie, I noticed that, as the group has been giving Missy feedback that the caring and support she displays is very helpful to them, you seem to avoid involvement. I wonder if your reaction to Missy's caring is different from other group members and if you have experienced these feelings and reactions with other women in your

life?

Fall and Wejnert (2005) emphasized open processing between leaders in order for effective processing to be developed and facilitated in groups. They described a coleader developmental pattern of stages parallel to Tuckman and Jensen's 1977 model of group stage development. For example, Louis and Missy might at some time engage in coleader in-group processing:

Annie: Louis, I am feeling somewhat blocked now in my interaction with Missy. Is that what you see?

Louis: Yes, it seems as if you are being marginalized as you attempt to dialogue with her.

Annie: Does it appear that I am primarily responsible for the discordant interactions?

Louis: It does seem as if you are attempting to be congruent with your typical interactional style. Although I think that you and I have worked through our own issues of power and control with one another, it appears that these issues may be becoming central to your interaction with Missy. I wonder what Annie thinks about the situation.

It is clear that group processing is a complex variable that includes an array of leader skills requiring a great deal of leader cognitive complexity. Effective leaders must identify significant individual, interpersonal, and group events; understand and develop hypotheses about the meaning of these critical incidents; and then use this knowledge in order to select and organize microskills and more complex interventions in order to help members identify, explore, discover, and apply new meanings in their in-group and out-of-group interactions. Kivlighan and his colleagues (Kivlighan & Kivlighan, 2009; Kivlighan, Markin, Stahl, & Salahuddin, 2007; Kivlighan & Quigley, 1991) have conducted several studies over the years to investigate the differences between the knowledge structures of expert and novice group workers to determine whether or not experts display more complexity in their understanding of group processes. They used Multidimensional Scaling and Pathfinder Network Analyses (Schvaneveldt, 1990) in the three studies and found consistent differences between novice and expert leaders in the breadth and depth of their cognitive structures for observing, identifying, organizing information from, and directing their subsequent activity in the groups. They also found that members' use of knowledge structures expanded and became more complex and more similar to that of expert leaders with experience over time. Novice leaders focused only on dominant/submissive and high participation/low participation rates, whereas experienced therapists consistently included consideration of three dimensions: dominant/submissive, friendly/unfriendly, and supporting therapeutic work/hindering therapeutic work. A novice leader might state:

Novice Leader: Justin, you have been awfully quiet. Please share something about yourself with the group.

An experienced leader might frame his or her response in the following manner:

Experienced Leader: Justin, you seem like an interesting person, and I would like to know more about how the group and I can respond to support and work with you on your issues. Would you be willing to tell us something about yourself and help us know you better?

Hines, Stockton, and Morran (1995) studied differences in group leader cognitive processing. They identified 17 distinct thought categories leaders used to conceptualize client activity and found differences between novice and experienced therapists in the thought categories they use most frequently. Thought categories that positively correlated with group leadership experience included interpretation of group process, internal question regarding member, and interpretation of member. Leaders who had led more groups used these four categories, which clearly relate to group processing, more than those with less experience. In discussion of the findings, Hines et al. speculated that the kinds of cognitive processing needed by group leaders must be more complex than that of therapists working with individuals, since thought categories for understanding and leading exploration of interpersonal and group activities are necessary for group processing in addition to those needed for work with individuals. They also suggest that experienced leaders learn to automate fundamental thinking structures so that they may give more active attention to more complex aspects of interpersonal and group interactions. An example of an experienced leader's response reflecting the desired characteristics might be:

Experienced Leader: It seems to me that there might be some real value in our exploring the close bond between Georgia and Nicole that provides a clear example of cooperative interaction, but may also limit them in displaying individual differences and in connecting with others in the group. Would you be willing to examine this issue and explore what it means to each of you, your relationship, and our group?

Yalom's Primary Model

Yalom's (1970, 1975, 1995; Yalom & Leszcz, 2005) articulation of the two-tiered model of processing in interpersonally oriented groups remains the foundation of modern understanding, training, research, and application of processing in groups. The process of helping people explore, understand, and revise their perception and interpretation of their experience in the highly salient context of direct interpersonal interaction within the supportive atmosphere of a cohesive group can be profoundly effective (Ward & Litchy, 2004). When attention is directed toward applying and integrating new cognitive understanding in the immediacy of here-and-now behavior and feelings, members may engage in potent prime learning experiences. This process is facilitated by interaction with other members in the form of feedback and with a skilled facilitator combining the Lieberman et al. (1973) leadership functions of high levels of caring and meaning attribution with moderate levels of executive function and emotional stimulation.

Yalom's premise is that interpersonal learning and cohesiveness are the key factors affecting positive outcome in here-and-now, process-oriented group work. Helping members learn to focus on here-and-now activity and give feedback in the present is the active ingredient in processing. This type of activity can become a norm of the group, and both the leaders and members can engage in this first-tier processing. Ward and Litchy (2004) stated:

> The leader continually observes the relationship messages being communicated with the content of member verbal interaction, selects those that are most relevant to each member's therapeutic goals, and helps the members focus upon, understand, and integrate the learning into their everyday patterns of behavior. (p. 111)

For example, a leader might state:

Leader: Amy, I really appreciate how hard you have worked to increase your interactions in the group during the last two meetings after we suggested that you enter the process by showing interest through questions about things others talk about. I think you have seen how others have responded more positively to you and if that perception has helped you think about your ability to make friends. I wonder if you can make a plan to do the same in your life outside of the group, since it is one of the things that seems crucial to your goal of becoming more active socially and making more friends.

Yalom's four-step description of the evolution of this process with a specific client within the group is:

1. Here is what your behavior is like.
2. Here is how your behavior makes others feel.
3. Here is how your behavior influences the opinion others have of you.
4. Here is how your behavior influences your opinion of yourself (Yalom & Leszcz, 2005, pp. 180–181).

However, Yalom (Yalom & Leszcz, 2005) also proposes that, in order to accomplish meaningful and lasting change, the group must loop back on itself and explore, understand, and find meaning in the here-and-now experience, the second-tier of processing, which he labeled “process illumination” (p. 152). Yalom contends that that commentary on the process, especially at the group-as-a-whole level, should remain primarily the leader's responsibility in therapy groups in order to minimize potential negative competitive reactions often aroused in other members. This position is supported by a number of experts, including Chen and Rybak (2004) and Brown (2009).

Examples of first-tier process and then second-tier process commentary following Yalom's model might be:

Member: I don't believe that I am critical of others. I am very accepting.

Leader: Sharise, it seems as if you feel the need to defend yourself at this moment in the group. I wonder if you are

aware of that and what you are experiencing.

Member: Well, I just don't believe that I am critical of others, as Jerod suggests, and it makes me mad, so I feel as if I must speak up.

Leader: I understand, and that is consistent with how I thought you might perceive things. It might be important for you and the group to discuss the fact that, when someone describes an aspect of our group's activity that might have negative connotations, even if they did not specify that you were critical, you frequently respond in ways to deny any involvement.

The first leader comment focused on the immediate, here-and-now experience of the member, while the second related her behavior to that of group-level activity.

Some do not recognize Yalom's caveat that members can learn to engage in second-tier process commentary toward process illumination that is sometimes more meaningful and more accepted by other members than leader commentary. To accomplish this level of member processing, however, the leader must carefully encourage, nurture, and monitor the development of facilitative norms valuing member process commentary. The process of establishing a cohesive, collaborative group culture in which members join leaders to reflect on the thoughts, feelings, and behavior of themselves, other members, and the whole group is complex. Although the initiation, development, and implementation of member process commentary to augment leader commentary is ongoing and intuitive as well as systematic, important components of the process include the following:

1. Provide an appropriate level of initial structure to support the amount of initial member engagement and interpersonal risk taking required in an interactive process-oriented group.
2. Invite member spontaneous interaction and influence by communicating how a collaborative model in which members join with leaders to work on supporting, exploring, understanding, and communicating their reactions and understandings with one another will maximize the helping potential of the group and the degree of positive outcome achieved by each member.
3. Work to encourage member engagement at the interpersonal level and reflection on their internal experience, their interpersonal reactions, and the whole group process.
4. Model these processes.
5. Give specific instructions to help members understand and engage effectively in group process.

Group work is a complex, fast-moving, intense process of group interaction, systematically and intuitively identifying appropriate incidents to process, and engaging in processing, often with collaborative contributions from members in order to maximize group and individual member outcome. Especially for students learning group leadership, early career group workers, and those working with groups only on an occasional basis, a major challenge exists. Yalom's seminal work describing processing in groups and providing the rationale for its emphasis in order to enhance individual and group outcome is widely understood and accepted. How does one acquire the technical knowledge and skills and professional attitude and confidence necessary to apply Yalom's general model of processing effectively, efficiently, and systematically, other than only through repeated experience? How does the novice leader achieve this level of expertise with the process of processing?

As increasing attention was given to the explication of group dynamic theory, ASGW *Professional Standards for the Training Group Workers* (2000) and *Best Practices Guidelines* (Thomas & Pender, 2008) were developed and revised to advocate for the extensive use of between-session processing in effective professional group work. A number of scholar-practitioners proposed specific models to help students and inexperienced leaders move beyond intuition to more systematic learning in order to master the process of processing.

Perhaps the most complete explication of a model to guide the group leader's or both coleaders' engagement in the between-group processing function has been described by Conyne (1999) in his reflective practice guidelines. He elaborates on the between-sessions, deep-processing model in several books and articles (Conyne, 1999; Conyne, Wilson, & Ward, 1997; Rapin & Conyne, 2006). Combined with specific models describing the dimensions of the actual processing task itself, new and early-career group leaders can practice critical-incident processing in

classes, homework, journaling, and supervision sessions to learn and enhance here-and-now processing skills so critical to interactive, interpersonally focused group work described in the Yalom model (Yalom & Leszcz, 2005). However, a thorough description of both within-group and between-group processing models is beyond the limits of this chapter. Therefore, the focus here will be on within-session processing more closely reflecting Yalom's model that includes leader internal efforts to identify, consider, extract meaning from, and use the resulting information to act in the here-and-now moment of the group activity. Openly engaging in processing with a member, the interaction between a pair or small subset of members, or the whole group to consider, understand, and learn from their spontaneous interactive relationship activity is the essence of a process approach to group work. The ultimate goal is that the process becomes intuitive and normed so that the leader and members naturally use processing to help other members resolve issues and improve their lives.

Specific Structural Models that Reflect the Process of Processing

Early Processing Models

A number of models describing the process of processing are useful to students and practitioners. Among them are those developed by Cohen and Smith (1976a, 1976b), Conyne (1997, 1999), DeLucia-Waack (2002), Glass and Benshoff (1999), and Stockton, Morran, and Nitza (2000).

Newer Models

In her book on leading psychoeducational groups for children and adolescents, DeLucia-Waack (2006) included an extensive planning notes worksheet with sample processing questions that might be used in subsequent group sessions to focus on specific aspects of the member and group experience. For example, she lists the following questions to help the leader stimulate group processing of Cohen and Smith's three levels of conceptualization-intervention:

> Individual level to help members gain intrapersonal insight:
>
> "What have you learned about yourself?" "Were you surprised by your reaction to the activity?" "How did you feel disclosing the information about yourself?" and "How does that relate to your life outside of the group?"
>
> Interpersonal:
>
> "What did you learn about others?" "How will this learning affect your interactions with group members?" "What similarities did you notice between your responses and others' in the group?" "Differences?" "How will you apply this outside the group?"
>
> Group level:
>
> "What did you notice about how the group interacts?" "How will conducting this activity affect how we work together?" (p. 158)

Brown (2009) also provided information about using processing in groups, emphasizing group leader attention to Yalom's process commentary to illuminate interpersonal and group-level activity that affects members. She lists interpersonal themes, such as members' attempts to connect or dominate, and group themes, such as fear of engulfment or fear of exclusion. She also identifies seven primary leader process commentary tasks listed below (Brown, 2009, p. 166) with brief examples provided by the current author:

1. Assuming a present-centered focus. (Example: "Carrie, I wonder when you experienced the feelings you are describing you feel at home here in the group?")
2. Containing the group's anxiety, fears, rage, and other emotions without becoming overwhelmed. (Example: "We seem to have touched on some extremely powerful topics that have inhibited our natural interactions. I think that this would be a good time to talk about how we can work together to address very strong emotions that need to be explored in a meaningful way without overwhelming us.")
3. Understanding group dynamics. (Example: The leader notices members avoiding or minimizing differences.)
4. Using the expected behaviors for the stage of group as a guide for understanding what the group is experiencing when using process commentary. (Example: In previous example, the leader chooses not to draw the group's attention to the issue at this point, since avoiding differences is typical of group attempts to establish a safe climate and to establish initial bonding in the first stage of group development.)
5. Teaching members to assume a process orientation by learning to accept process illumination remarks. (Example: "For the first several meetings, we have ended by summarizing the highlights of the sessions. Today I would like to add some comments to our summary in order to begin to understand how the way in which we engage and interact can provide important information about our interactive styles and the effect they have on the issues we wish to address and change.")
6. Providing constructive feedback. (Example: "Mason, you have shown that you are willing to talk and interact in the group, which can help us during times when we may be unsure how to proceed. I wonder if you are also aware that sometimes you continue to hold the floor when other members begin to demonstrate their willingness to participate.")
7. Being judicious in the use of process commentary. (Example: While two members are addressing important meaning in their interaction, the leader notes that there are also group-level implications embedded in their interchange. However, the leader may choose to delay commentary on this level of the process to allow and facilitate the interpersonal processing of the two members.)

Jacobs, Masson, Harvill, and Schimmel (2012) provide an excellent update to the seminal work on the processing of group activities by Kees and Jacobs (1990). They again emphasize the necessity of processing group exercises

and include extensive new examples of processing comments leaders can use to enhance member learning. Examples include the following:

1. Leader: As you were listening to others' responses, what was triggered for you?
2. Leader: How did this reading get you to think about regarding how you are living? Are you living life as if it is a dress rehearsal?
3. Leader: I want you to think about the meaning of this exercise. All of you sculpted how you felt about this group, and not one person put themselves as open or toward the center of the group. What do you think this means?
4. Leader: That's interesting and something we can explore. Some of you felt comfortable outside of your space and others did not. Let's talk about how your experience just now relates to your life and not just to the exercise. (pp. 259–263)

Chen and Rybak (2004) describe an interpersonally-oriented process approach to group counseling and therapy and emphasize the value of helping the group and its members explore and extract meaning from the parallel process of within-group interpersonal and group-level patterns of behavior with member behavior in their everyday world. They address special attention to leader efforts to illuminate the meaning of behavior in relation to emerging interpersonal and group themes through the use of process illumination, as described by Yalom. They specifically describe and advocate the use of a major tactic they call the *hot-seat* method, in which the leader focuses on the behavior and feelings of one member in order to help that member and other group members to extract meaning and generalize the learning to their lives outside of the group. Chen and Rybak describe four steps in their hot-seat method:

1. The leader steps back and checks his or her own reactions to significant group events.
2. The leader monitors how the whole group and specific relationships and members reactively respond to instances in which specific members are enacting dysfunctional interpersonal patterns in the group.
3. The leader intervenes to invite and direct members to give feedback about their reactions to the member on the hot-seat.
4. The leader helps the members compare how other members in the group react to them with how people with whom they interact in their everyday worlds react to them.

They emphasize the increasing use of this strategy when the group has established a cohesive, collaborative working stage and provide lists of things to look for to use as topics as well as sample leader commentary. An example might be:

Leader: Jean, you have said that you felt as if everyone in the group judged you and abandoned you when you took the risk of discussing your history of abusing your younger siblings. Although this is very sensitive and difficult, openly examining and learning about ourselves by providing feedback and discussing the incident can be very helpful in the growth process. Are you willing to do that? Are the rest of you also willing?

As stated earlier, Conyne and his colleagues have produced a comprehensive model for use in planning and processing group work (Conyne, Crowell, & Newmeyer, 2008) in which a number of important group dynamic dimensions are identified and used to guide the practitioner to select techniques from their 19-page *Toolbox of Techniques.* The model itself is designed primarily as a between-sessions practice guide in order to assist leaders to choose appropriate interventions for application during the performing best practice work in the group itself. It provides a systematic methodology for early group leaders to learn to apply appropriate and effective within-group processing techniques with the group. Their model includes identification of best practice area (planning, performing, or processing), the group stage (beginning, middle, or end), the group type (psychoeducation, counseling, therapy, or task), focus (cognitive, affective, behavioral, or structural), level (individual, interpersonal, or group), and ecological concept (collaboration, context, interconnection, meaning making, social system, and sustainability). With training, supervised practice, and further experience, new and less experienced leaders may use the model naturally in the here-and-now of the group interaction to increase their effectiveness with within-group processing.

Three examples of within-session techniques that may be used at any of the four group types at any point, although especially useful in the end state, include leader statements such as: “What is happening now?” “What have you accomplished?” and “How will you apply what you have learned?” All are directed at meaning making and the latter also at sustainability, all at the cognitive focus, and the first at the group level while the latter two are directed at the individual level (see Conyne et al., 2008, p. 236). This model is the most comprehensive system to date to guide the three best practices and to address and engage in processing activities systematically.

ASGW Best Practices Processing Guidelines

The Association for Specialists in Group Work has published a set of best practices guidelines organized around the 3 P's of planning, performing, and processing. This demonstrates the emphasis ASGW places on the use of processing:

SECTION C: BEST PRACTICE IN GROUP PROCESSING

C.1. Processing Schedule

Group Workers process the workings of the group with themselves, group members, supervisors or other colleagues, as appropriate. This may include assessing progress on group and member goals, leader behaviors and techniques, group dynamics and interventions; developing understanding and acceptance of meaning. Processing may occur both within sessions and before and after each session, at time of termination, and later follow up, as appropriate.

C.2. Reflective Practice

Group Workers attend to opportunities to synthesize theory and practice and to incorporate learning outcomes into ongoing groups. Group Workers attend to session dynamics of members and their interactions and also attend to the relationship between session dynamics and leader values, cognition and affect.

C.3. Evaluation and Follow-Up

1. Group Workers evaluate process and outcomes. Results are used for ongoing program planning, improvement and revisions of current group and/or to contribute to professional research literature.
2. Group Workers conduct follow-up contact with group members, as appropriate, to assess outcomes or when requested by a group member(s). (Thomas & Pender, 2008, p. 117)

Conclusion

Processing in group work is one of the three dimensions of best group practices identified in the ASGW *Best Practices Guidelines* (Thomas & Pender, 2008) and *Professional Standards for the Training of Group Workers* (ASGW, 2000). In the specific sense, processing may occur within the group itself as the leader and members identify critical incidents, consider and track their development, extract meaning from the experiences, and use the learning to improve members' lives. Although this chapter has emphasized within-group processing, it can also occur between group sessions when leaders engage in this same process as part of the evaluation task in order to use the resultant information for group planning and later leader performance, the other two dimensions of the best practices. The emphasis in group work is on using the interpersonal nature of interactive groups at the interpersonal and group levels to engage members in collaborative exploration and meaning construction in order to enhance their personal learning processes.

More complex models for learning and mastering processing skills have been described in print in the last decade, elaborating on the seminal presentation by Yalom (1970; Yalom & Leszcz, 2005). Selected models have been described here with brief examples of application. Suggestions for learning activities to assist students, novices, and experienced group workers to learn and extend their processing knowledge and skills have also been described.

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Chapter 8 Selecting and Using Activities in Groups

Amy Nitza

The use of structured activities has become standard practice in many types of groups. Many books offer structured group "curricula" for specific types of themed groups; others consist of compilations of single activities that can be used with a variety of different types of groups and with different ages and populations. Yet activities in and of themselves are unlikely to promote change in groups. Dye suggested, "The actual experience of an activity rarely produces meaningful learning" (2009, p. 29). Rather, it is the carefully selected and planned use of an activity, targeted for a specific purpose within a specific group, and processed effectively that is likely to be useful in promoting change. This chapter will review the literature and suggest best practices related to the selection, use, and processing of structured activities in groups.

While much has been written about group activities, actual research evaluating their impact is more limited. What is currently known about the use of activities in groups has its origin in early studies of the role of structure, including the use of structured activities, in group development. The precise role of structure in groups is complex; however, results of these studies largely support the use of structure by group leaders. In general, groups in which leaders provided structure have been found to be more effective than groups in which less structure was provided (Dies, 1994). However, the relationship between structure and outcome does not appear to be linear. Lieberman, Yalom, and Miles (1973) concluded that the relationship between structure and outcome was a curvilinear one in which groups with very high and very low levels of structure were negatively associated with outcome.

Bednar, Melnick, and Kaul (1974) asserted that group leaders should utilize higher levels of structure in the early sessions of a group in order to decrease members' sense of responsibility for the group and therefore allow for a greater degree of risk taking. They posited that the increased risk taking promoted by initial structure results in increased cohesion, which in turn allows members to develop an increased sense of responsibility for the group. Structure should thus gradually be reduced as the group develops in order for members to take more responsibility for its functioning. In a further study of the relationship of structure to risk taking, Lee and Bednar (1977) found that highly structured groups were particularly beneficial in increasing desired group behaviors among members with low risk-taking dispositions. A comparison of high and low structure groups with incarcerated felons, defined as being a low risk-taking population in that setting, found that members of the high structure groups demonstrated significantly more improvement on several interpersonal measures as well as in long-term behavioral changes (Leak, 1980).

More recent studies have demonstrated that the role of structure is related to its impact on specific aspects of the content and process of groups. In an empirical investigation of the relationship between structure and group development, Stockton, Rohde, and Haughey (1992) demonstrated that structure could be used to enhance and facilitate development through the stages of a group. They found that matching the content of a structured activity to the developmental task of each stage helped move groups through the stages more consistently and with less cycling back through previous stages. Thus, structured activities that are targeted to the developmental stage of a group may be beneficial in facilitating group development.

Structured activities have also been effectively used to promote therapeutic factors and related group behaviors, which have been linked to positive group outcomes. In a recent meta-analysis exploring the role of cohesion in counseling and therapy groups for children and adults, Burlingame, McClendon, and Alonso (2011) identified structured exercises to facilitate emotional expression and feedback exchange as recommended therapist interventions for promoting the development of cohesion. Similarly, the therapeutic factor of interpersonal learning can be promoted through the exchange of feedback among group members (Yalom, 1995), and structured activities have been successfully used to increase the use of feedback. For example, Robison and Hardt (1992) found that a structured activity in which members discussed the potential negative consequences of exchanging corrective feedback, as well as how the group could avoid these negative consequences, increased the

amount of feedback exchanged. Rohde and Stockton (1992) found that the use of structured feedback activities related to members' individual goals was related to increased goal attainment. In this study, the feedback activity involved each member receiving both positive and corrective feedback (provided by either the leaders or group members) at the end of each session related to their progress during the session toward their individual goals for the group. In a review of the feedback literature, Morran, Stockton, Cline, and Teed (1998) recommended written exercises to promote the exchange of both positive and corrective feedback. They described an activity in which members were invited to write positive feedback to each other on index cards, and then to take turns delivering the feedback; this was followed by a second round in which corrective feedback was written down and exchanged.

The Role of Activities in Groups for Children and Adolescents

Structured activities perhaps play a more important role in child and adolescent groups than in groups with adults. Group therapy with children has its origin in activity groups, and structured activities continue to be a cornerstone of group work with this population, even with an increase in the use of verbal interactions as well (Leichtentritt & Shechtman, 1998).

Similar to studies of adult groups, it appears that structured activities in child and adolescent groups can be used effectively to promote member behaviors linked to therapeutic factors and positive outcomes. Findings from studies of therapeutic factors and verbal response modes in child and adolescent groups offer some important directions for the use of activities. Relationship-climate variables (including support, acceptance, and encouragement, as well as emotional experiencing and catharsis) have been identified as important therapeutic factors in groups with this population (Shechtman & Gluk, 2005). That is, children appear to benefit from the opportunity to share personal information and express emotions in a climate of care and support. Consistent with these findings, a study of children's verbal responses in groups identified self-disclosure as the most frequent type of member response (Leichtentritt & Shechtman, 1998). The use of structured activities (e.g., therapeutic games, art therapy, bibliotherapy, and drama) was one of the therapist interventions found to be most likely to produce self-disclosure responses from children.

Children have been shown to demonstrate a high frequency of self-disclosure even in the initial stage of groups (Leichtentritt & Shechtman, 1998; Shechtman, Hiradin, & Zina, 2003). In comparison to adult groups, children in these studies did not appear to have the same need to gradually establish safety and trust before actively engaging in the work of the group through self-disclosure (Shechtman, 2007). Thus, while the use of structured activities in the early stage of a group may be just as important with children and adolescents as with adults, it may serve a different function. Activities in the early stages of a group may best be used to provide appropriate structure to children's self-disclosure and shape desired norms for children's interactions throughout the group. Broadly stated, group activities with children and adolescents may therefore best be used as a part of an active leadership approach that uses a high level of structure over the life of the group in order to help children interact with each other in positive ways.

Recommendations for Selecting and Using Activities

Activities have been described as tools in the toolbox of a group leader (Trotzer, 2004), to be selected and used to advance the goals of a group or of individual members within a group. As with a carpenter's tools, they are devices to be selected and used as a means of accomplishing a bigger goal. Shechtman (2007) stated that effective group leadership requires "a creative leader whose tool chest is particularly rich in activities, and who is capable of employing methods and techniques skillfully and processing them effectively" (p. 55). The literature is full of activities that can become a part of a group leader's tool chest. Jacobs, Masson, and Harvill (2011) categorized group activities into 14 types that include the following:

1. Written exercises,
2. Movement exercises,
3. Dyads and triads,
4. Rounds,
5. Creative props exercises,
6. Arts and crafts exercises,
7. Fantasy exercises,
8. Common reading exercises,
9. Feedback exercises,
10. Trust exercises,
11. Experiential exercises,
12. Moral dilemma exercises,
13. Group-decision exercises, and
14. Touching exercises

Effective use of an activity requires carefully selecting the right tool to meet the needs of a particular group at a particular time. With the number and variety of activities available when planning a group, it would be easy for a leader to browse the literature, choose some interesting activities, and work them into a group plan. However, it is essential that the selection of activities be driven by, and consistent with, the theoretical and conceptual foundation of the group. Failure to do so can result in a group that becomes a series of activities that is directionless or takes a random "whack-a-mole" approach to dealing with issues. Relatedly, activities should not be used simply to fill time or because they seem like fun (DeLucia-Waack, 2006). Jacobs and Schimmel (2009) suggested that when deciding on an activity, the leader should be able to answer two important questions: (a) Why am I doing this particular activity at this particular time, and (b) What is it that I am hoping that the members, or the group as a whole, gain from participating in the activity? A round, for example, is an activity in which each member is asked to respond to a specific prompt or share their reactions to a specific event. Rounds can be used to accomplish many different goals within a group. Early in a group, rounds can be used to encourage members to share in a way that increases safety and cohesion. Members can be asked to share a word or phrase that describes how they relate to the topic of the group, or how they are feeling about being in the group. Doing so offers members a structure in which to begin to participate in the group and allows them to begin to identify with each other, which in turn promotes universality and cohesion. Later in a group, a round could be used to engage all group members in the work of a particular member. Members could be asked to share a word or phrase about how they are feeling in response to the work of the member or about a way in which they can relate to the work of a member. Shifting the focus to invite other members into the conversation promotes interpersonal learning and can also allow the original member to reflect more deeply on the work that they have done.

Trotzer (2004) offered a useful framework for considering the purposes of structured activities in which activities can be used to initiate, to facilitate, or to terminate. Activities used for initiating include those used to open a group or a session or to initiate a new direction, focus, or interaction within a session. Facilitative activities are those that are used to mobilize the group's resources to capitalize and build on, or expand an event that has occurred in the group. They are "intended to be catalytic, stimulating, and enhancing to group interaction" (Trotzer, p. 81). Facilitative activities might include those that are used to hold or deepen the focus on some

meaningful aspect of the work that is related to members' goals, highlight or focus on an important process issue in the group, or provide an opportunity for members to exchange feedback related to an important event in the group. For example, Gladding (2006) described an activity titled "Lines of Feelings" in which members express their feelings about an important event in the group by drawing lines on paper. As members share what they have drawn, processing questions can be geared to help members more fully explore and make meaning from their reactions to the event. Finally, activities can be used to terminate, including bringing closure to the group as a whole as well as to specific sessions.

Even when activities are based on a clear rationale driven by the needs of the group, they are unlikely to be beneficial if not sufficiently processed. It is the processing of an activity that allows members to reflect on and make meaning from the experience. While there are several definitions and models of processing, it can be defined as

> capitalizing on significant happenings in the here-and-now interactions of the group to help members reflect on the meaning of their experience; better understand their own thoughts, feelings and actions; and generalize what is learned to their life outside of the group. (Stockton, Morran, & Nitza, 2000, p. 345)

Processing can be done at different levels (i.e., intrapersonal, interpersonal, and group-as-a-whole) and for different purposes; the same activity can be used for different objectives depending on the way in which it is processed. Thus, having a clear rationale and plan for processing an activity is as important as having a rationale and plan for the activity itself. One group of activities that can be used for many different purposes are nonverbal movement activities in which members are asked to place themselves somewhere in the room in order to represent some characteristic, trait, or position on an issue. For example, members can be asked to place themselves on a continuum of traits such as from passive to aggressive, or from leader to follower. This type of activity can be processed differently to help members make meaning from it in different ways. Intrapersonally focused questions might include "What did you learn about yourself in this activity?" and "Did any of your responses reflect things you would like to change about yourself?" Interpersonally targeted processing might include questions such as "What similarities did you notice between yourself and others?" "What differences did you notice?" and "Based on these similarities and differences, who might you be able to learn something from related to your goals in the group?" Finally, at a group-as-a-whole level processing questions might include "What do members' responses tell us about how we might work together as a group?" or "How might this range of individual characteristics of members impact how we interact as a group?"

Type of Group

In addition to having a clear rationale and plan for processing, the successful use of an activity requires that it be tailored to match the type and stage of the group, as well as the characteristics of its members. Several considerations essential to this matching process will be discussed in this section. The Association for Specialists in Group Work (ASGW, 2000) defined four types of group work based on the purposes and intended goals of the groups. Activities are used to varying degrees and serve different functions in each type of group according to these differing goals. This section will focus on three of these types of groups: psychoeducational, counseling, and therapy.

Psychoeducational groups focus on prevention and utilize group-based educational and developmental strategies to promote the development of skills and coping strategies (ASGW, 2000). Psychoeducational groups place greater emphasis on learning through content versus process and may apply many learning strategies to introduce and teach new skills or practice and strengthen existing skills. As such, they may utilize activities more frequently than other types of groups. However, an overreliance on activities without sufficient attention to interpersonal interactions and group process can result in a group that is dependent on the leader and becomes a circle of people completing a series of exercises rather than a functioning group. In addition to activities specific to the theme of a group (such as anger management or stress reduction), activities that involve role-playing and rehearsing, problem solving and decision making, and promoting communication and relationship skills can be important components of psychoeducational groups. Additionally, while the emphasis of these groups is on skill development, the group format allows for the opportunity to capitalize on group dynamics as learning opportunities. Activities can be used to illuminate group process and help members make meaning from it, to heighten self-awareness, and to promote interpersonal learning and the exchange of feedback related to members' goals (DeLucia-Waack, 2006). For example, Jacobs et al. (2011) described a "most/least" feedback activity in which members share their reactions to each other by using "most" and "least" designations in response to questions by the leader. In an anger management group, this type of activity might be used to promote interpersonal learning and feedback exchange by having members respond to questions such as the following:

- Which member is the most similar to you in terms of how they currently deal with anger? Least similar?
- Which member do you feel you have the most to learn from?
- Which member do you see as having made the most progress in improving their anger management skills so far in the group?

Counseling groups "address personal and interpersonal problems of living and promote personal and interpersonal growth and development" (ASGW, 2000, p. 331). Counseling groups use the here-and-now process of a group to help people learn and grow within an interpersonal context. Therapy groups "address personal and interpersonal problems of living, remediate perceptual and cognitive distortions or repetitive patterns of dysfunctional behavior, and promote personal and interpersonal growth and development" (ASGW, 2000, p. 331). Therapy groups are also heavily process-oriented but focus more on remediation of problems that are more chronic or severe in nature.

Counseling and therapy groups with adults typically rely less on activities than psychoeducational groups, yet the judicious use of structured activities can play an important role in the development of these groups. It is generally recommended that such groups involve a higher level of structure earlier in the group in order to reduce anxiety and orient members to the group process. Activities can be used to offer structure and provide early experiences sharing here-and-now reactions as a way to set the stage for further process-oriented work (Johnson, 2009). The use of activities is then typically reduced during the middle or working phases as members learn to take more responsibility for the group, and much of the work has a here-and-now focus. Even in these middle phases, however, activities can be useful in deepening the work of a member or members (Jacobs et al., 2011), pursuing common themes among members, or otherwise facilitating "the exploration of material that emerges from the interactions within the group" (Corey, Corey, Callanan, & Russell, 1992, pp. 145–146). Finally, as in other types of groups, structured activities can be used effectively to facilitate the termination process as well.

Yalom (1995) described activities in therapy groups as accelerating devices that can speed up or circumvent some aspects of the group process. Particularly in brief therapy groups, they can be advantageous in helping the group move beyond difficult impasses. In a group that has experienced some tension followed by a notable period of silence, for example, he described the use of a round in which members are asked to briefly share what they had been thinking about saying but did not say during the silence. Yalom advised, however, that such activities should be employed with caution; in therapy groups, difficult impasses or moments of resistance are often important to the group process and as such are not something to be avoided or skipped over. Likewise, if a therapy group appears to be stuck in a period of low energy, he cautions against the use of an activity to infuse energy or generate affect, as doing so may be avoiding (or compounding) the underlying issues contributing to the lack of energy. Rather, he recommends exploring the lack of energy directly and considering what it means for the group and for individual members.

Group Stage

Activities can be used for a number of different purposes across the life of a group, but to be successful, they should be carefully matched to the developmental stage in which they are being used. Appropriate activities in the initial stage include those that orient members to the group experience and build sufficient trust and safety to allow them to begin to engage with the group. Activities can effectively be used to lower members' initial anxiety about the group and provide sufficient structure to allow them to function together effectively. To accomplish these goals, it is important that activities at this stage be of relatively low intensity and low risk while also offering opportunities for members to get to know each other and establish connections. Activities used in this stage are also good opportunities to begin to establish norms for interactions in the group and encourage desired member behaviors. Activities that provide some structure for members to begin the process of sharing and self-disclosure might include written activities such as sentence completion exercises in which the prompts range in risk from quite safe such as "If I were an animal, I would be a(n) _____," to those that offer a bit more risk and begin the process of focusing on the work of the group, such as "One thing I am hoping to get out of this group is _____."

During the middle stages of a group, as cohesion builds, members are increasingly willing to engage in the group process and work on the personal issues that brought them to the group. Activities during these stages can be of higher intensity and encourage a greater amount of risk taking. Activities can be used to encourage members to engage in self-exploration and gain increased self-understanding. As members actively work toward their goals, activities can also be used to challenge them to try out new ways of thinking, feeling, and behaving. Activities that promote opportunities for interpersonal learning through the exchange of feedback are particularly important during these stages as well. An example of an activity that promotes self-exploration as well as interpersonal learning is "Your Personal Board of Directors" (Jacobs, 2006), which asks group members to consider the people that influence them when they are making important decisions. The activity can be targeted to a specific type of decision related to the specific goals of a group or can be more broadly defined to include the major influences on their decision-making processes in general and can promote important group discussions related to family relationships, peer pressure, and other contextual issues surrounding behavior change.

As groups come to a close, key issues in the termination phase include consolidation of learning, the application of the group experience to members' lives outside the group, and bringing closure to the relationships developed in the group. Activities at this phase should return to a lower level of intensity and be used to facilitate reflection rather than provoking new experiences. Activities that help members identify what they learned and how they learned it are beneficial at this stage, as are activities that help members express what they have learned from each other and say goodbye. For example, an activity that encourages consolidation of learning involves asking members to compose a brief letter to themselves as they were at the beginning of the group, identifying cognitive, affective, or behavioral changes they have made during the group and discussing how they will maintain those changes now that the group has finished (see DeLucia-Waack, 2008). Alternatively, the group could work together to compose a letter to future group members sharing what they are likely to gain from the group and offering suggestions for how to get the most out of the experience. An activity that encourages members to share what they have learned from each other might involve some sort of visual representation of this learning. For example, members can take turns tossing a ball of yarn to another member while identifying what they have learned from that person. As each person tosses the ball, they can hang onto the loose piece of yarn, creating a visual "web" of connections (see Ramsey, 2008).

Member Characteristics

Beyond group-level factors, the specific characteristics of members in a group are important to the selection and use of activities. As described by Trotzer (2004), "Activities must be selected that are appropriate to the nature of each person, both from a commonality (how members are alike) and a diversity (how members are different and unique) perspective" (p. 78). Among other considerations, activities may need to be utilized differently in groups for children and adolescents. Culture is also a very important characteristic that is likely to impact how members respond to activities and should be carefully considered.

Children and Adolescents

Groups with children and adolescents are unique and require careful consideration of their developmental needs. When planning a group for this population, leaders should take into account the developmental characteristics of members, including attention span, cognitive abilities, and verbal skills, as well as the developmental tasks they face. Child and adolescent groups generally require greater structure and a more varied format than do adult groups, including more focused, specific, and multimodal interventions (DeLucia-Waack, 2006). Structured activities in particular may therefore play an even more important role in groups with this population.

As group members, children can be engaged and eager to participate and self-disclose. However, as described by Shechtman:

> Children typically do not choose to be in treatment, do not fully understand the therapeutic process, and do not possess the interpersonal skills needed to help themselves or someone else. Their attention span is limited, and their verbalization skills, particularly their ability to express emotions, are still under development. (2007, p. 55)

To benefit from groups, they may need help in channeling their enthusiasm into meaningful and therapeutic interactions. Children often self-disclose spontaneously but may need assistance doing so appropriately. Additionally, children do offer challenges and feedback to each other but often need assistance in doing so in a way that is constructive (Shechtman, 2007). Activities can be very important in facilitating therapeutic interactions among members and allowing them to help each other in the group process.

As a general rule, the younger the group members, the more structure and variety of activities are necessary throughout a group. Younger children naturally communicate and learn through play, and play activities can be important interventions. Nonverbal activities and activities that involve creative ways for children to express themselves have been recommended with this age group (DeLucia-Waack, 2006). Activities that utilize metaphors such as bibliotherapy and the use of props also have been recommended. Shechtman (2007) described the use of affective bibliotherapy, which allows children to identify with book characters and explore emotional experiences with less defensiveness or resistance than if they were asked to discuss them directly.

Groups are an excellent fit with the developmental transitions of adolescence (Akos, Hamm, Mack, & Dunaway, 2007). The important role of peer relationships and the interpersonal nature of many of their struggles make the group format particularly appropriate for this age group. However, adolescents may still experience anxiety and resistance about the group process, and structured activities can be used to help reduce anxiety and promote their active participation (Shechtman, 2004). Relatedly, while adolescents are more capable than younger children of engaging in and benefitting from direct verbal interaction in groups, they often need assistance getting started. Activities are very useful with this age group to initiate discussion or "as a framework within which to work on personal issues" (DeLucia-Waack, 2006, p. 22). Such activities can take the form of providing a stimulus for members to respond to, including stories, poems, or song lyrics. Alternatively, discussion prompts can be placed in a bucket or bowl in the center of the group and students can take turns pulling a prompt from the bucket and reading it aloud for discussion by the group. For example, in a high school group designed to promote

connections among students and prevent bullying, Horne and colleagues (Horne et al., 2012) utilized an activity called “Bucket True or False” in which prompts such as “Cliques are a pretty big problem at this school” and “Some kinds of kids deserve the bad treatment that they get” are placed in a bucket. Students take turns drawing the prompts out of the bucket and must state whether they believe the sentence to be true or false before discussing it further as a group.

Regardless of the specific topic of the group, activities can be used to enhance the developmental advantage of the group format with this age group by promoting opportunities for interpersonal learning. Additionally, cognitive reasoning, social perspective taking, and relationship skills are all important aspects of adolescent development that can be directly promoted in groups through the careful selection and use of activities.

Culture

Group activities should be selected with consideration of the cultural backgrounds of the group members. Cultural competence in selecting and using activities involves developing an awareness of how the impact of activities may be influenced by different cultural worldviews. It is incumbent on group leaders to consider the cultural assumptions embedded in any activity they select.

Many non-Western or non-European cultural groups operate from a collective worldview in which emphasis is on collective goals and the well-being of the group over the individual (Dwairy, 2002). The emphasis in collective cultures placed on harmony, cooperation, and putting the needs of the group over individual needs may serve as a barrier to members participating in some Western-based group processes. Many activities commonly used in groups tend to promote culturally bound behaviors that may be difficult or unnatural for members from non-Western cultures to perform (Shechtman, Goldberg, & Cariani, 2008). Such behaviors might include self-disclosure and open expression of emotion or internal experiences. Other examples include activities that encourage direct forms of communication such as challenge, confrontation, and the exchange of interpersonal feedback, as well as activities that work toward individual goals or the promotion of individuation and autonomy.

While it is essential for group leaders to consider the cultural implications of activities, this is not to say that activities that are inconsistent with the worldview of group members should be avoided completely. Kivlighan and Holmes (2004) wrote that “group members will benefit most from experiences that are dissimilar to their typical way of interacting or experiencing the world” (p. 33). This may include aspects of culture; Shechtman and Halevi (2006) and Nitza (2011) found that group members in non-Western cultures engaged in and valued behaviors such as self-reflection that tended to be culturally restricted in day to day interactions. To use activities that involve culturally inconsistent behaviors, however, it is important that the cultural implications be made explicit. Using activities or discussion to highlight group processes and norms, as well as the cultural backgrounds of group members, can set the stage for meaningful exploration.

Additionally, as recommended by DeLucia-Waack and Donigian (2003), group leaders should develop a range of group interventions that have been shown to be effective with different cultural groups, as well as an understanding of healing rituals in different cultures. Such activities can allow group members to express themselves and experience the value of the group in ways that are consistent with their worldview. For example, many cultures have very strong oral traditions in which stories, folklore and legends, myths, songs, and poems are used to store and communicate cultural information in addition to being used as a means of socialization (Chilisa, 2012). Stories, myths, or poems embedded in activities may allow members to explore important issues in a group in a culturally relevant way. Activities that incorporate traditional or indigenous healing methods may also be meaningful additions to groups for members from many cultures. Finally, using activities in which members can express themselves in their native language may be valuable.

Case Example

The author was involved in the development and facilitation of a new group model for adolescent girls in Botswana who are at risk of HIV infection (Nitza, Chilisa, & Makwinja-Morara, 2010). “In Botswana, as in other settings where gender inequality predated the arrival of HIV, lack of social, interpersonal, and economic power has directly impacted women's vulnerability to infection” (Nitza et al., 2010, p. 106). Therefore the groups, entitled *Mbizi*, were designed to address the oppressive gender role expectations and practices that are strong contextual influences on adolescent girls in the country and that put them at increased risk of HIV infection. The groups were psychoeducational in nature. The specific objectives were to assist members in examining cultural practices that influence their sexual decision making, developing skills and strategies for dealing with both cultural and personal barriers, and creating a supportive peer network for coping with challenges.

Several potentially appropriate activities from the existing group literature were identified but needed adaptation for use in the *Mbizi* groups. The adaptation of the goal setting activity “A Garden as a Metaphor for Change in Group” (DeLucia-Waack, 2008) for use in the group illustrates several important practices in the selection and use of activities. As described by DeLucia-Waack, this activity is intended for the initial stage of a group; the objectives are for members to explore their individual goals for the group as well as identify potential obstacles for change. This is done through the metaphor of planting a garden in which members identify:

- Flowers they want to plant: behaviors, skills, or thoughts they want to develop.
- Weeds they want to pull: behaviors, thoughts, or feelings they want to get rid of.
- Stones in their gardens: things that get in the way of change.

The activity was identified as a potentially good fit for the *Mbizi* groups because it is consistent with the oral traditions of the *Batswana* (the collective term for the people of Botswana) in which stories and metaphors are important aspects of communication. Nevertheless, to effectively utilize this activity with the *Mbizi* groups, several adaptations were deemed necessary. First, the metaphor of an individual planting a garden was changed to a story in which land passed down through generations is collectively cleared and planted for harvest. This adaptation invokes several aspects of their culture that are important among the Batswana, including the connection to one's ancestors through the inherited land and the connection to one's tribe through the collective celebration involved in clearing the land. The importance of land and farming to the Batswana also lends additional importance to the process of identifying the specific crops and vegetables to be planted, tools to be used in the planting, and removal of brush to ensure that the land is properly cleared for planting.

A second significant adaptation from the original activity was the stage of the group in which it was used. As noted above, the Garden metaphor is an individual goal-setting activity intended for use in the initial stage of a group. In the *Mbizi* groups, the activity was not utilized until the working stage. This adaptation was made in order to better fit not only the cultural context but also the needs of the specific population of adolescent girls and the specific topic of the group. First, in the collective culture of Botswana, individual goal setting in a group context is not a familiar idea. Therefore, it was decided that individual goal setting might be more beneficial after the group had begun to develop and norms had been shaped that allowed for individual expression, reflection, and goal setting. Second, one of the premises behind the design of the groups was that gender role expectations are largely unexplored influences on the lives of adolescent girls. Goal setting was therefore targeted after some time had been spent helping each girl explore these influences and reflect on their meaning or impact on her life.

As described above and highlighted in this example, selection and use of activities requires consideration of the specific type and stage of a group, as well as the specific characteristics of group members. In the case of the *Mbizi* groups in Botswana, while the general objectives and format of the original Garden activity were left intact, cultural adaptations and adjustments in the stage of group in which the activity allowed for its successful extension and application to a new population.

Ethical Considerations

Despite the value that activities can add to a group, they also have the potential to be misused. Several ethical issues and contraindications in the use of activities have been identified in the literature. Corey et al. (1992) discussed important ethical considerations in the use of all group techniques, including the use of activities. As with any other aspect of group leadership, leaders are obligated to work within their scope of competence when utilizing activities in groups. This includes "having training commensurate with the potential impact" (p. 29) of an activity and having the awareness and knowledge necessary to adapt an activity to the unique needs of a specific group. As with any aspect of group leadership, supervision is essential when implementing any activity for which a leader is not adequately trained.

The potential psychological risks of any activity should be considered. Activities that are done for the purpose of evoking emotion or conflict and physical activities, or those that involve physical touch, should be used with particular caution. Group members must have freedom from undue pressure in any activity, including but not limited to the right to decline to participate. For example, Mouladoudis (2006) described an activity in which physical touch is used in the form of placing their palms in each others' palms and holding that position for a few minutes. The goals of the activity are to promote connections and understanding among members, as well as to increase self-awareness. The use of this activity to achieve these goals should be carefully considered based on the particular population of the group, because it may be inappropriate for survivors of abuse or others for whom physical touch has been associated with boundary violations in the past. Additionally, the purpose and expectations of the activity should be explained ahead of time and group members should be given explicit permission to decline to participate. Finally, the processing of the activity should offer members the opportunity to express any discomfort they experienced.

Activities are contraindicated if their use serves as a means to avoid or work around issues that may be important to the group's development but difficult for the leader. This may include using activities to avoid exploration of conflict, content themes that may be uncomfortable for the leader, or awkward moments of silence or frustration (Yalom, 1995). For example, introducing an activity after one member angrily confronts another member, in order to deflect from the conflict or "change the subject" because the leader feels members are uncomfortable with the confrontation, may be contraindicated; doing so may take away an important opportunity for all members to learn more about how they handle conflict in their lives.

Finally, an overreliance on activities during times when a group is struggling with an issue may offer temporary relief but in the long term may foster dependence on the group leader or otherwise impede the group's progress. The conclusion by Corey et al. (1992) regarding the use of any group technique seems particularly applicable to the use of activities:

> In summary, one should be cautious about using techniques at all if they become substitutes for genuine exploration. In addition, when a technique is introduced, it should generally serve to highlight the cognitive, emotional, and behavioral materials present in the group and not to detract from it because of the leader's unease. (pp. 23–24)

Training in the Selection and Use of Activities

Preparation in the use of activities is an essential component of group work training. As students develop interest and confidence in group leadership they may be eager to try out interesting activities that they read about or participate in, yet activities should not be used without a clear rationale and careful planning. Thus, it is important that the effective and ethical selection and use of activities be integrated into the group training curriculum.

Fortunately, opportunities for teaching the effective selection and use of activities abound in a graduate training program. Any experiential learning activity used in a classroom is an opportunity to model and demonstrate skills in implementing and processing activities. Killacky and Hulse-Killacky (2004) described examples of teaching group competency skills, including the use of activities, throughout a graduate counselor education curriculum. Conceptualizing their classrooms as task groups, the authors used learning activities in nongroup courses, including a career development course to model the effective use of activities. Through the purposeful processing of career development activities, the authors were able to make explicit the important aspects of setting up, facilitating, and processing experiential activities in groups.

Of course, group courses offer similar opportunities to model the use of activities. Any activity used to teach group course content can also be used to teach the selection and use of activities. Riva and Korinek (2004) suggested discussing the choice of the activity, its purpose, and students' reactions to it. Potential discussion questions might include

- What was the purpose of this activity? Why do you think I chose to use this particular activity at this particular time?
- What did you learn about yourself or other people?
- What did this activity demonstrate or teach you about groups?
- How might you adapt this activity for use in the type of groups that you are most likely to lead?

Conclusion

Carefully selected and planned activities, used to facilitate specific objectives, can be valuable tools for promoting change in groups. To use them most effectively, leaders should have a clear rationale for the use of any activity and select an activity that is consistent with the theoretical foundation and type of group, the group's stage of development, and the specific characteristics of group members. Among others, the age and developmental characteristics of group members, as well as their cultural backgrounds and worldviews, are important considerations in selecting and adapting activities to meet their specific needs.

Activities abound in the group literature. As described by Trotzer (2004), "perusal of the literature might well result in a conclusion that use of structured activities in groups is rampant and dominates the group work field" (p. 87). Indeed, it appears that what is needed now is less emphasis on the development of new activities and greater emphasis on studies that can offer more detailed information to guide leaders in the selection and use of these activities. Recent calls for more process-outcome research in groups (Burlingame, Fuhriman, & Johnson, 2004; Shechtman, 2007) underscore the need for more empirical data to guide group leaders' decision making. Because activities are an important part of many types of groups, advances in such studies could help increase the knowledge base regarding what types of activities work best for what group members under what circumstances. This type of knowledge could help group leaders select and utilize activities in order to promote meaningful change for members.

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Chapter 9 Effective Group Leader Skills

Melissa Luke

This chapter integrates findings from recent empirical literature on group leader skills with that of past theory and research across different settings that provide group counseling. It begins by providing a broad definition of group leader skills, with an overview of the related literature. Forty years ago, Lieberman, Yalom, and Miles (1973) identified four categories of group leadership function (e.g., caring, meaning attribution, executive functioning, and emotional stimulation), which are discussed in relation to how group leader skills can be used to achieve these functions (Yalom, 1995; Yalom & Leszcz, 2005). After a discussion of the four categories, nine specific group leader skills are identified and presented as effective interventions across the intrapersonal, the interpersonal, and whole group level, in accordance with Group Systems Theory (Connors & Caple, 2005). Following a brief description of each intervention is a discussion of its support in the empirical and practice literature. Next, case examples are provided to illustrate the potential ways in which these interventions can be utilized in group counseling sessions. The chapter concludes with a summary and offers some suggestions for future research.

Regardless of whether the treatment modality is an individual or group setting, active listening, using minimal encouragers, reflecting, clarifying, paraphrasing, summarizing, and raising discrepancy have been identified as ubiquitous counseling skills (Morran, Stockton, & Whittingham, 2004). Greenberg (2003) described group skills as consisting of several factors, including, but not limited to, the level of leader activity, the ways in which the leader elicits group member engagement, and the means utilized to structure positive group interactions. While such skills are discussed in the group work literature (Page & Jencius, 2009; Toth, Stockton, & Erwin, 1998; Trotzer, 2006) as useful in building rapport and managing interactions (Corey & Corey, 2006), it has been argued that they are insufficient to promote personal awareness, interaction between group members, or facilitate whole group process (Page & Jencius, 2009; Rubel & Okech, 2006). Predicated based on the importance of group leadership functioning (Yalom & Leszcz, 2005) and the understanding that at any point, group leaders can intervene across the three group levels (e.g., intrapersonal, interpersonal, whole group). Schimmel and Jacobs (2011) explained how group leaders can use discrete skills in combination, across more elaborate group techniques, interventions, or intentionally introduced activities. As such, group skills are distinguished from individual counseling skills and other prescribed interventions because they stimulate interaction within and between group members, in addition to promoting therapeutic factors and whole group development. Thus, this chapter will focus on nine research supported group leader skills. Three of these can be intentionally employed to facilitate emotional stimulation and meaning attribution at the intrapersonal level. Another three can increase member interaction and caring at the interpersonal group level, and three others can assist in executive functioning, meaning attribution, and emotional stimulation at the whole group level.

Skills

Given the frequency with which group leader skills are discussed in the group literature, it would seem that their use should account for a large proportion of the variance in group process and outcome. Although there is a large overlap between the requisite set of group leader skills identified in the literature (Corey & Corey, 2006; Page & Jencius, 2009; Trotzer, 2006; Yalom & Leszcz, 2005), there is also a lack of operational clarity with respect to what constitutes a group leader skill (Ward, 2007) and further how these are, or are not, distinct from a group activity "strategy, technique or procedure" (ASGW, 2000, p. 13). Moreover, there is no agreement in the literature that any single group leadership skill is effective across all circumstances. Rather, it has been recognized that the appropriateness and effectiveness of group leadership skills can change over the course of the group's development (Tuckman & Jensen, 1997), varying with the goals of the different stages (DeLucia-Waack, 2006b). Corey and Corey (2006) purported that the effective group leadership is more than a summation of discrete skills and that the group leader is among the most important determinants of group outcome. Also suggesting that skills alone do not define the quality of group leadership, Riva, Wachtel, and Lasky (2004) concluded that effective group leadership involved group leaders who are "genuinely interested" (p. 39) in members as individuals and as a group.

Researchers have contended that there are many factors in need of consideration when evaluating group leader effectiveness. Rubel and Okech (2006) illustrated the importance of the intended level of the group system at which an intervention is targeted when evaluating its effectiveness. If a group leader intends an intervention for an individual, the assessment of the intervention should be done at that level. Similarly, it has been recognized that the appropriateness and effectiveness of leadership interventions can change over the course of the group's development (Tuckman & Jensen, 1977) and with member readiness (Schimmel & Jacobs, 2011). Illustrating this, Yalom (1995; Yalom & Leszcz, 2005) hypothesized that group members' perceptions of the effectiveness of interventions not only vary with the stage of group development but also change according to the nature of the group, as well as the individual group members' needs and preferences. Given the dynamic nature and cultural context of both individuals and groups (DeLucia-Waack & Donigian, 2004; Nitza, 2011; Riva et al., 2004), the effectiveness of any leadership intervention may depend more on the attentiveness, responsiveness, and flexibility of the group leader (Garcia, Lindgren, & Pintor, 2011), than on a specific skill used. Said another way, the group skill is inextricably linked to group leadership functions.

Categories of Leadership

Lieberman, Yalom, and Miles (1973) reported seminal findings from their comprehensive study that examined group leadership characteristics across various types of groups. This research used factor analysis to uncover four basic functions of group leadership, namely executive function, caring, emotional stimulation, and meaning-attribution. Though formulated four decades ago, this schema continues to be commonly used to organize categories of group leadership functions (DeLucia-Waack, 2006a). Executive functioning refers to how the leader establishes and maintains boundaries, often related to group rules, expectations, and norms. Group leaders' use of caring includes their concern for the well-being of group members and an investment in the effectiveness of the leadership skills and interventions used. Emotional stimulation refers to the group leaders' efforts to facilitate group members' expression of affect, values, and personal belief and attitudes. When describing meaning-attribution, Yalom and colleagues (Lieberman, et al., 1973) referenced the manner in which the group leader helps members develop understanding of not only themselves but also of one another in the group. Extending this, they discussed how meaning attribution also included helping group members gain insight about what happened inside the group related to that taking place elsewhere in their lives outside of the group. While these findings suggested that all four leadership categories were important for group functioning, high levels of caring and meaning attribution and moderate levels of executive function and emotional stimulation seemed more beneficial (Lieberman et al., 1973). In order not to treat skills as mutually exclusive components, a brief description of therapeutic alliance will help illustrate the importance of the relational context and group climate in which leadership skills can be most effective.

Therapeutic Alliance

The group treatment literature suggests that general mechanisms of change involving the group leader are operative in positive group treatment (Burlingame, Strauss, & Johnson, 2008; Chavez, Gutierrez, Ducaju, & Fraile, 2000). For example, the relationship between the group leader and members, frequently referred to as the therapeutic alliance, has been associated with advantageous group process and outcome across group treatment settings, as well as the group type (Bourgeois, Sabourin, & Wright, 1990; Gillaspy, Wright, Campbell, Stokes, & Adinoff, 2002). In a recent study of group psychotherapy with individuals with treatment-resistant auditory hallucinations, group members' perception of alliance at the sixth group session was significantly correlated with better attendance rates and therapists' perceptions of treatment compliance, as well as with overall insight at the end of group treatment (Johnson, Penn, Bauer, Meyer, & Evans, 2008). Numerous other studies have found that group leaders who exhibit warmth and caring (Burlingame, Fuhriman, & Johnson, 2002; Burlingame, MacKenzie, & Strauss, 2004), empathy and alliance building (Bourgeois et al., 1990; Johnson, Burlingame, Olsen, Davies, & Gleave, 2005; Marziali, Munroe-Blum, & McCreary, 1997), and had supportive relationships with group members (Burlingame et al., 2008; Dies, 1994), were more likely to have group members who made treatment gains. Related, a positive relationship has been found between the level of structure provided by the group leader, perhaps akin to executive functioning that Yalom and Leszcz (2005) discussed, and an increase in the subsequent involvement of group members (Dies, 1994; Schimmel & Jacobs, 2011; Stockton, Rhode, & Haughey, 1992). Interpersonal involvement between group members, particularly early in the group, in turn, appeared to facilitate the development of group cohesiveness (Johnson, 2010). The facilitation of Yalom's therapeutic factors (Yalom, 1995; Yalom & Leszcz, 2005) has become synonymous with effective group leadership. Group leaders recognize the importance of universality, altruism, hope, corrective experiences as well as the other identified therapeutic factors. It follows that much of what is known about the beneficial elements of group comes from studies that explored rapport building (Atkinson, Kim, & Caldwell, 1998) and the therapeutic factors (e.g., Kivlighan & Holmes, 2004; Nitza, 2011; Yalom & Leszcz, 2005). Various research reviews have cautioned that an effective group leader needs to balance the support and challenge provided (Page & Jencius, 2009; Riva et al., 2004). A group leadership style that was too passive (DeLucia-Waack, 2006a) or included excessively aggressive or ill-timed confrontation has been identified as leading to disengaged and contrary members (Schimmel & Jacobs, 2011), dissatisfied members (Dies, 1983, 1994), and was associated with potentially perilous treatment results (Yalom & Leszcz, 2005).

Group Systems Theory

In accordance with Group Systems Theory (Agazarian, 2001; Connors & Caple, 2005), at any point in development in any group, the leader has the option to intervene across the three levels of the group system, namely the intrapersonal, interpersonal, and group as a whole levels. Depending on the objective, the group leader can implement an intervention that targets any of the three levels. For example, the leader could focus on the internal thoughts, feelings, and experiences of an individual member (intrapersonal), address the interactions, communications, and dynamics between members (interpersonal), or respond to the development, dynamics, and experiences of the entire group (group as a whole). Some authors have suggested that intervention across all levels of the system is beneficial (Goodrich & Luke, 2011; Rubel & Okech, 2006), while others have cautioned that leader overreliance on any level compromises the effectiveness of the group (Donigian & Malnati, 1997; Kline, 2003). While there remains a need for future research into the effectiveness of group leadership skills and interventions across group system levels, the framework offers a useful means to conceptualize and discuss various group leadership skills and interventions.

Intrapersonal

Effective group leadership interventions within the intrapersonal level of the group are largely intended to promote group engagement and interaction by attending to and protecting the well-being of an individual group member (Smokowski, Rose, & Bacallo, 2001; Trotzer, 2006). Jacobs and Schimmel (2008) discussed effective means to work with the individual at this level within a group. Because interventions at the intrapersonal level early in the group development can positively influence the group functioning at other levels of the system at later stages, the group leader may employ more intrapersonal interventions at the initial phases of the group. For example, in their analysis of group members' weekly journals reflecting on their in-group experiences, Luke and Kiweewa (2010) found that group members attributed greater salience and meaning to the group leaders' intrapersonal interventions at the start of their group experience than they did in their later group sessions. Rubel and Okech (2006) suggested that although group leadership interventions at this level are unquestionably necessary, in practice they are often overused. Thus, it is recommended that group leaders employ reflective practice to monitor this and seek supervision to maximize their leadership efficacy (DeLucia-Waack & Fauth, 2004; DeLucia-Waack & Riva, 2010). Effective group leadership interventions at the intrapersonal level of the group can include supporting a group member, drawing out individual members, and blocking individual members when they are disruptive or damaging to the group process (Kline, 2003). Of importance is that unlike individual counseling wherein the counselor has sole responsibility to provide the client support, group counseling and psychotherapy contexts offers other group members the opportunity to provide some of the support and care to one another. Thus, the group leaders' interventions at this level can be viewed as a means to enable the confluence of structure and safety for this process to take place in the group.

Support

Early group research identified a lack of group leader support and protection as the most prominent factors influencing member dissatisfaction (Dies, 1983). More recently, Smokowski et al. (2001) conducted 87 interviews with people who had a negative experience in a therapeutic group, with 33 of these people ultimately identified as group casualties. Over three quarters of the members who identified themselves as casualties attributed their negative experience to lack of support and protection from the leader. As an effective group leadership intervention, support of the group member communicates the leader's attentiveness, demonstrates understanding, and can build safety as well as open communication (DeLucia-Waack, 2006a; Robson & Robson, 2008). Individual group member support can take a range of different forms, from normalizing the group member's experience and promoting a sense of safety to encouraging and reinforcing group participation. As group members all vary in terms of their readiness to reveal themselves and engage in the group, providing member support is especially useful when members are disclosing difficult information or attempting new behaviors in the group (Trotzer, 2006). The first example below illustrates how a group leader can reinforce member growth and encourage further development, while the second example highlights how a group leader can normalize group member experience and support the group member in considering something he had not anticipated yet.

Leader: Ashleigh, you've taken a big step today in talking to Sherman directly. This is a big moment for you as an individual, but also as a member of our group as we all move forward together.

Leader: Sampson, you seem relieved to have shared so much with the group. Maybe you were even a bit excited when your worst fears about that did not happen. At the same time, you might want to take some time here and think about what this sharing was like for you before you share more.

Drawing Out

Although not empirically examined in some time, drawing out group members has been linked to positive group outcomes (Dies, 1994) and is accepted as an important group leadership skill at the intrapersonal level. DeLucia-Waack (2006a) noted the importance of drawing out group members, particularly in the early stages of group

development, because it can assist in establishing group norms for shared participation. Further, Yalom (1995) described the relationship between increased sharing and interpersonal trust, group cohesion, and universality. Drawing out not only encourages a member to speak in the group but it also discourages intellectual distancing and behavioral silence, both known to impede group functioning (Page & Jencius, 2009). That said, the group leader needs to be careful when drawing out group members (Schimmel & Jacobs, 2011), because doing so without the group members' consent can be experienced as authoritative and coercive. Accordingly, many group leaders introduce the option for group members to pass when implementing this strategy, such that group members recognize that they always have the choice to not participate. Group leaders are advised to track and monitor the participation of group members and create a variety of opportunities for group members to participate, while still respecting the individual group member's autonomy to decide if and when that participation occurs. Although drawing out a member has been described as one of the most effective strategies to proactively balance group member participation (Trotzer, 2006), it may also be particularly useful as a corrective intervention when the group leader has noticed that participation has been uneven. Drawing out can be accomplished both indirectly and directly. Examples of indirectly drawing out a group member's participation include making eye contact with the identified member, pausing or using silence to motivate participation, and on occasion, even gesturing to a group member as a means of inviting his or her input. The examples below illustrate two ways in which a leader can directly draw out a group member by asking a member for his or her input and then encouraging all members to take a turn to share information.

Leader: It might be helpful to hear from the group about what has worked for them. Jasmine, would you like to start?

Jasmine: Well, I usually sit across from someone I feel more comfortable with. Like today, I picked this seat because I am facing Cyndi and when I get anxious, I can look to her for reassurance. This helps me participate.

Leader: Now that's a new strategy to me. I bet there are other things we could learn from each other. Let's go around the room and hear from everyone.

Blocking

Sometimes referred to as cutting off, this skill involves the leader stopping a member from talking. As an effective group leader intervention, blocking can be used to put an end to off topic discussion and refocus the group, quell storytelling and monopolizing by a group member, or to protect a group member by stopping an unproductive interpersonal interaction between members. Because group leaders can feel ambivalent about the social appropriateness of blocking (having been taught that it is rude to interrupt people), it is sometimes avoided (Corey & Corey, 2006). Blocking not only allows the group leader to fulfill the ethical obligation (American Counseling Association, 2005) to protect clients when necessary but it can also enable smooth transitions within the group and an adherence to time limits for the group (Schimmel & Jacobs, 2011). In the example below, the group leader demonstrates two different ways in which blocking can occur. Notice that the group leader is clear and firm in expressing the associated limits, but also combines other skills with the blocking intervention to affirm facilitative group dynamics and refocus members.

Johanna: So then I was like, "Yeah, I know exactly what you mean because she is always saying stupid things like that when I see her outside of group."

Leader: I'm going to stop you now Johanna. It's really helpful to hear from you, but using a negative label to describe Stephanie out of group doesn't practice the "here and now" talk, which is our goal. It also goes against our expectations for this being a safe space. (pause) Maybe it would be helpful to review the list of helpful/unhelpful behaviors that we created in an earlier session.

Stephanie: Nah, why should we do that. She knows the rules. She is just too stupid to follow them.

Leader: Whoa, Stephanie. (gesture with hand) It makes sense that you have feelings about the name calling, but even if you are embarrassed, mad, or something else, I can't allow you to attack Johanna either. I am confident

that we can all refocus and get back to the here and now activity we had started. Who remembers what we had agreed to practice in group?

Interpersonal

The interpersonal level of group interaction focuses on group members' relationships, interactions, and communications both with one another and the group leader (Kline, 2003). Kline suggested that the interpersonal level of group is the most useful but least utilized level of group interaction. Others have described interventions at this level as essential to facilitate growth and learning in group members (Yalom & Leszcz, 2005). A group leader may elect to intervene at this level when two or more group members are experiencing differences that are impacting not only their interactions and relationship but also interfering with the dynamics and development of the group as a whole (Rubel & Okech, 2006). Another example could be if the group leader thinks it important to identify aspects of vicarious learning taking place between group members (Goodrich & Luke, 2011). For example, a group leader may notice one group member adopting the language use of another as part of social modeling. The group leader can call attention to this, and invite the group members to speak to one another directly. In doing so, members have the opportunity to identify and process their reciprocal interpersonal influence with other group members.

O'Neill and Constantino (2008) recognized that interventions at the interpersonal level of group could link the intrapersonal and group as a whole levels. However, as all interpersonal interventions are aimed at a subsystem of the group, group leaders need to be careful to simultaneously monitor the actions and reactions of other group members to which the intervention was not aimed. This can be a challenge, particularly for new group leaders. Balancing one's focus on the content and process can be taxing for any group leader and the ability to fluidly move back and forth across these tasks can take time and practice to develop. Luke and Hackney (2007) observed that coleaders can share the responsibility when intervening at the interpersonal level. When one group leader is focused on one interpersonal subsystem, the other can monitor, and intervene if necessary, with the remaining members of the group. Effective interpersonal interventions include modeling, linking, and feedback.

Modeling

In accordance with social learning theory (Bandura, 1976), group leaders can encourage the skills, attitudes, and characteristics that are desired within group (Trotzer, 2006) through modeling. Group leaders use modeling to act out and demonstrate personal qualities (i.e., attentiveness, respect, care) or specific behaviors (i.e., use of "I" statements) they wish to engender in group members (DeLucia-Waack, 2006a). Studies showed that prosocial intrapersonal dispositions and interpersonal behaviors exhibited by a group leader led to an increased demonstration of these same behaviors by group members (Barlow, Hansen, Fuhriman, & Finley, 1982; Dies, 1994). Further, Schimmel and Jacobs (2011) noted that when dealing with involuntary or negative members, it may be especially necessary for the group leader to actively use modeling, since relying on other group members for this purpose may be counterproductive. Similarly, it has been suggested that modeling is indispensable in psychoeducational and skill-building groups (Furr & Barret, 2000), given the experiential learning. Others have pointed out that unplanned opportunities for modeling also arise in group, wherein a leader can capitalize on the opening to employ a skill, or coleaders can model an interpersonal exchange (Luke & Hackney, 2007; Riva et al., 2004). In the following example, the group leader models a nondefensive response to interpersonal feedback. Although the verbal exchange is between the leader and a single group member, modeling is also an ancillary interaction between the leader and other members of the group.

Tristan: I'm pretty upset with you for telling Anna that she was wrong just then. I mean I wouldn't like it if you said that to me.

Leader: I appreciate you letting me know how you feel about my interaction with Anna. I get how my saying that I "didn't see things the same way" she did might have sounded like I thought there was a right or wrong. Your willingness to deal with this with me directly gives me a chance to clarify things with Anna, and it also helps me recognize how you or someone else in the group might hear something like that from me in the future.

In other instances, a leader might model a specific skill as a means of teaching it, while also facilitating members' comfort with and ability to use the skill in a future group. For example:

Leader: Let's recognize Claude's impact on each of us and our group. I'd like us all to go around the room and offer one "metaphoric" gift to Claude as we say goodbye. So this will be both personal and symbolic, and what you choose to "give" Claude will say something about how he has impacted you. I will start so you can see one way this can happen. Claude, as you move to a new state, I would like to give you (gestures toward Claude with hands cupped) a baseball because I keep thinking about the time when you compared our work in this group to your experiences playing on a baseball team.

Linking

A group leader can implement linking as a means to connect members to one another and promote interpersonal bonding, as well as build cohesion and trust in the beginning stages of a group. Use of linking at later stages of group development can increase group member interaction, instill hope, as well as build universality (DeLucia-Waack, 2006a). Corey and Corey (2006) noted that the use of this leadership intervention requires insightfulness, as the leader needs to find creative ways to relate what "one person is doing or saying to the concerns of another person" (p. 37). A group leader can accomplish this indirectly by observing aloud a common experience across members or articulating a unifying theme grounding two or more in group behaviors (Yalom, 1995; Yalom & Leszcz, 2005). Another more active means of linking ensues when the group leader facilitates an interaction between group members in the here and now (Dies, 1983). The group literature supports the relationship between the direct linking of members and not only the developmental process of the group but also the direction it takes (Page & Jencius, 2009). Accordingly, linking can be a direct intrapersonal intervention between members, while also less directly influencing the development of the group as a whole. It is possible that the group experiences the leader's "link" as a sort of validation that a particular topic is worthy of his or her comments and the groups' focus. In the first example that follows, the group leader links the input of two group members and then creates an

opportunity for the remaining group members to contribute.

Guillermo: When I came home last night, my daughter was screaming, my wife looked upset, and all I wanted to do was unwind after my tough day. It made me think about how much easier it would have been if I stopped at the bar like I used to do.

Adam: Hearing you say that makes me want a drink, man!

Leader: So Guillermo and Adam both talked about feeling triggered, though it seems for different reasons. Has anyone else felt triggered this week and wants to share how they respond at those times?

Illustrating a more active linking, the leader in the next example invites one group member to address another in the here and now.

Sylvia: I know what John means when he says it is hard to know what to do. I remember when my mother died. I had no idea where to start.

Leader: Sylvia, it sounds like you are relating to what John said. Can you talk directly to John about this?

Feedback

Stockton and Morran (1982) indicated that it is the group leader's responsibility to provide the structure so that group members can engage in feedback with one another. Although Yalom (1995) contended that there was an optimal level of structure involved in effective feedback delivery, others have illustrated the necessity of group leaders to teach group members through modeling or direct teaching how to give and receive feedback (Furr & Barret, 2000; Toth et al., 1998). As group members may equate the term feedback with evaluation or corrective feedback received elsewhere, the group leader should take care to identify both the definition and purpose of feedback from that of criticism. One way this can be accomplished is to forgo the use of the term *feedback* entirely, and instead invite group members to offer their concrete observations. To prompt group members' observations, the leader can ask questions such as "What did you see right then?", "What did you hear her say?", and "What were your thoughts or feelings when he did that?"

Underscoring the importance of the context of feedback, Davies, Burlingame, Johnson, Barlow, and Gleave (2008) conducted an experimental study in a university counseling center that assessed the impact of a feedback intervention directed at group members and leaders. The findings noted that there was minimal impact between the intervention and either group therapeutic factors or member treatment outcome. It is possible that the experimental design of this study introduced a confounding variable related to the timing of the intervention, thereby possibly showing less potency of feedback than expected from theory and earlier research. Yet when members endorsed high levels of conflict in the group, there was a negative effect between the feedback intervention and treatment outcome. Thus, the group leader may wish to monitor group climate and assess the levels of both interpersonal safety and conflict in the group prior to introducing a feedback intervention. Another option may be to structure the feedback intervention by asking members to complete out loud the following prompt, before offering feedback of their own, "I am saying this because …" In the example below, the group leader's feedback to an individual group member can be simultaneously seen as a direct intervention to one member related to its content and an indirect intervention to the remaining group, because it serves as a process model for how they may provide feedback to each other in the future.

Leader: Shayla, I noticed while I was just talking, you looked off and started to fiddle with the chair. I was wondering if you were having a reaction to me, what I was saying, or if something totally unrelated was going on.

Group as a Whole

A group leader can utilize group as a whole level interventions to address material that is impacting norm setting, group development, and overall group dynamics (Rubel & Okech, 2006). Luke and Kiweewa (2010) investigated the experiences of 14 counselors-in-training who participated in an experiential group as part of their training. Group member participants identified nine different group as a whole factors that were involved in critical incidents that influenced their experience (e.g., structure, group norms, group content, environment, sitting arrangement, composition, group purpose, goals, ambience, and continuity). A group leader deciding to intervene at this level can address these aspects of group and as a consequence, promote therapeutic factors and facilitate group development (Garcia, Lindgren, & Pintor, 2011; Goodrich & Luke, 2011). As such, whole group interventions can be a powerful means to increase group learning (Garcia et al., 2011), but Kline (2003) observed that if they are overused, they can lead to the group becoming disengaged or perceiving the leader as authoritative. Thus, group leaders are advised to attend to when and how they are utilizing whole group interventions, and to consider eliciting group member feedback about how these interventions are experienced. Effective whole group interventions include reframing, self-disclosure, and processing.

Reframing

Reframing has been described as a form of reauthoring that is jointly constructed within the communication between two or more parties (Gordon & Luke, 2013). Within a group counseling context, reframing occurs when the group leader supports and affirms one aspect of the group while also offering a new perspective or interpretation of the group's behavior (Corey & Corey, 2006). A key aspect of reframing as an effective group leadership intervention involves a tentative introduction of the new perspective. The group leader joins with the group through a validating statement and follows this with an invitation to consider another possible interpretation. Group leader interpretation has been shown to help members make sense of and integrate group experiences and further invest in the group (Dies, 1983, 1994). For example, Schimmel and Jacobs (2011) described how group leader explanations of the ways in which involuntary members might benefit from a group can be helpful when group members are unable to discern these on their own. Moreover, delivering an interpretation within reframing can lower the level of defensiveness and personalization in a group. Trotzer (2006) noted that it can be useful in refocusing the group interactions from the intrapersonal and interpersonal to the group as a whole. At the same time, although group members may be reluctant to offer a discrepant view or speak up against the shared group opinion on their own (Burgh & Yorshansky, 2011), recent studies in teacher education have demonstrated that when group leaders model reframing interventions, it increases reframing among group members (Gillies & Haynes, 2011; Oliveira, Tinoca, & Pereira, 2011). The three examples below illustrate, respectively, the way in which reframing can affirm and challenge the group, how a group leader can use reframing to introduce an external frame of reference to make sense of group process, and the way in which reframing may assist group members in meaning attribution.

Leader: It is really encouraging to see the ways in which the group has rallied around Meg in her time of need. Yet I also wonder if the group is getting something else out of this. Could it be possible that by keeping the focus on Meg's vulnerability, the group is protected from having to acknowledge its own?

Leader: I see your point, Ming, the group has shifted the topic several times. But I wonder if the group is showing how scary it is to jump into a single topic after all the challenges that took place last week.

Leader: On one hand, it sounds like Jose and Mark have each suggested that there's a disagreement about our group's goals. Yet the fact that both have openly talked about this with the group reminds me that in addition to our content goals, there are also process goals. Seems like although we're unsure of our destination or the content, the group might have some agreement about how we'll travel—or the process we'll use. When else might this kind of thinking—about *where* you are headed, and *how* you're going to get there— apply to your life, especially outside of group?

Self-disclosure

Sometimes deemed as leader transparency, self-disclosure involves the group leader revealing personal, here and now reactions to the group events. Self-disclosure not only displays leader genuineness, authenticity; the immediacy involved can also reveal aspects of the person of the group leader. Linehan and O'Toole (1982) noted that group leader self-disclosure may promote therapeutic factors and increase openness among group members. Leaders are ill advised to use self-disclosure solely for this purpose. Yalom (1995) warned the group leader to be selective with self-disclosure and to weigh the possibility of leader credibility against any potential benefits for interpersonal learning in the group. As a group as a whole intervention, leader self-disclosure may increase similar self-disclosure among group members. In a study by Tschuschke and Green (2002), group members indicated that when a group leader revealed personal information or feelings, it contributed positively to their group experience, permitting them to learn about self, others, and the group. In the example below, the group leader illustrates how self-disclosure can serve as an opportunity for whole group learning.

Leader: As we sit here in silence, I am blown away by the bravery of this group. I sense that others are as well. I wonder how often we talk about this openly.

Processing

Both planned activities and unplanned events within a group can be processed, because neither of them by themselves are necessarily enough to promote growth (Yalom, 1995). Because there is almost always more taking place within a group than can be consciously tracked, absorbed, or integrated at any one time, it is necessary for the group leader to strategically utilize processing as an effective group as a whole intervention. Processing refers to a group discussion of thoughts, feelings, and experiences related to here and now occurrences in the group. As such, group leaders use processing to assist group members in reflecting on their experience and then translating "the concrete to the abstract" (Bridbord, 2006, p. 16). Stockton, Morran, & Nitza, (2000) described the group as a whole level intervention of processing as "capitalizing on significant happenings in the here-and-now of the group to help the group members reflect on the meaning of their experience; better understand their own thoughts, feelings, actions, and generalize what is learned to their life outside the group" (p. 345). Though there are numerous models of processing and a wide range of ways in which a group leader utilizes this intervention effectively, Trotzer (2006) suggested that it is an often overlooked intervention. Although the types of processing interventions likely fluctuate over the development of the group (Bridboard, 2006), collectively they have been associated with therapeutic factors and can minimize the effects of negative dynamics on group development (Oliveira et al., 2011). In the following example, the group leader uses processing to stimulate the group's reflection on what occurred, as well as to catalyze group members' meaning making.

Leader: We have spent the past half hour or so working really hard to challenge an unproductive group norm. As this happened, what was going on inside each of you?

Olga: For me, it was really scary at first, I didn't know what you meant when you said we were just sharing surface stuff, but then Natasha helped me begin to see the difference between our "story telling" and really listening and talking to each other.

Leader: It seems like your experience of discomfort was somehow related to growth, or at least increased understanding. Let's talk more about how something similar might happen other times, either in group or elsewhere in our lives.

Jay: I guess it's sort of like when I get together with my extended family at the holidays, part of me wants to let them know what's been going on for me all year, but it's awkward too and because of that, I just fill the awkwardness with superficial discussion.

Leader: Sounds like you've recognized how the story telling can take up space and prevents you from accomplishing goals not only in our group but also in your family, Jay.

Conclusion

Group leaders can find additional information elsewhere in the group literature about how the type, setting, and development of the group can influence what constitutes effective group leadership interventions (Furr & Barret, 2000; Garcia et al., 2011; Toth et al., 1998). The nine group leadership interventions discussed in this chapter offer group leaders a range of possible interventions to accomplish the primary tasks of group leadership across the three levels of the group system. Not every leadership function is addressed through these interventions. For example, screening group members, conducting a role induction into the group, and planning group sessions are all essential responsibilities of the group leader. However, for the purposes of this chapter, these leadership functions and responsibilities were selected because the group work training literature (Corey & Corey, 2006; Page & Jencius, 2009; Trotzer, 2006; Yalom & Leszcz, 2005) concurs that they represent the core skills needed to effectively intervene across the intrapersonal, interpersonal, and group as a whole levels of the group.

As was previously noted, there are countless additional group leadership interventions that may also be employed in tandem with the nine identified skills to serve positive purposes in the group. Although each leadership intervention has been presented as a discrete skill, it is expected that in practice there will be overlap across interventions. In fact, this is evident in many of the case examples, where the group leader utilized more than a single intervention. Similar to Stenack and Dye's (1983) work in supervision, future research may wish to examine how group members respond differentially, depending on which of the nine different group leadership skills are used. Another important leadership consideration is the increasing use of computer technology to support group work (Oliveira et al., 2011). While there is empirical support for many aspects of group leadership, the effectiveness of any leadership intervention will depend on the synergy between the context, the leader, and the group members themselves. That said, there is no question that group leadership skills are an essential element of effective group leadership and that they need to be facilitated with care. Group leaders should attend to the ways in which they implement leadership skills across the intrapersonal, interpersonal, and group as a whole levels, as these serve different group leadership functions.

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Chapter 10 Unleashing the Healing Power of the Group: The Mutual Aid Process

Lawrence Shulman

Whenever a group of people are assembled with a purpose, an entity is created called the group-as-a-whole. The organism, which is more than the sum of its parts, has the potential to become a mutual aid support system for any type of psychoeducational, counseling, or psychotherapy group, in any setting, developed for any specific group purpose, and designed for any member population. Mutual aid can also be a force in evidenced-based group models, for example, cognitive-behavioral, solution-focused, or motivational interviewing. Members of the group have the power to help each other in ways that the group leader cannot. But this mutual aid process may not happen by itself. It is the role of the group leader to help the group members to help each other. This is what this chapter is about. What do the core mutual aid processes look like and how does the group leader help make it happen?

Literature Review

The mutual aid group practice model was defined in a seminal article by Schwartz (1961) as follows:

> The group is an enterprise in mutual aid, an alliance of individuals who need each other, in varying degrees, to work on certain common problems. The important fact is that this is a helping system in which the group members need each other as well as the leader. This need to use each other, to create not one but many helping relationships, is a vital ingredient of the group process and constitutes a common need over and above the specific tasks for which the group was formed. (p. 18)

As in all counseling sessions, first sessions, or contracting sessions, are important in order to provide a structure that frees the group to work. Corey (2008) stresses the importance of the first meeting as follows:

> The initial stage of a group is a time of orientation and exploration: determining the structure of the group, getting acquainted, and exploring the members' expectations. During this phase, members learn how the group functions, define their own goals, clarify their expectations, and look for their place in the group. … This phase is generally characterized by a certain degree of anxiety and insecurity about the structure of the group. (p. 77)

All these dynamics are similar to the ones experienced in the beginning of any new helping relationship. The major difference in the group setting involves the presence of other group members. While the client's primary concern in the first session is the group leader, questions about fellow members follow closely behind. As the group session proceeds many questions will arise: Who are these other people? Do they have the same problems as I do? Do they seem sympathetic and supportive? and, How can other people help me if they have the same problems I have?

Delucia-Waack (2006) points out that providing specific information about what will happen in the group sessions and the role of the leader will help reduce group members' anxiety. Their anxiety will also be reduced by participating in the screening interviews and the first session. Disclosing about their situation and finding that others have similar situations and/or reasons for being in the group is particularly helpful in alleviating initial anxiety related to group participation (pp. 95–97).

Recent research in the group psychotherapy field has been paying increased attention to the concept of the group-as-a-whole and exploring group development issues and their impact on outcomes. While the concept of the *therapeutic alliance* between a therapist and patient has been found to have a positive impact on outcomes, alliance to the group-as-a-whole has not been as widely studied. Lindgren, Barber, and Sandahl (2008) have argued that

> in treatment formats in which the group process is predicted to be a curative factor, it is counterintuitive to emphasize only the relationship between an individual patient and therapists. (p. 164)

In their own pilot study of patients diagnosed with burnout-related depression who received short-term psychodynamic group psychotherapy they found an association between patient report of group alliance (using the group version of the California Psychotherapy Alliance Scales) and two of their three outcome measures.

> Alliance to the group-as-a-whole explained 50% to 55% of variance in change of global symptoms and anxiety after control of initial symptom level and group membership and 22% of the variance in change of depression. (p. 173)

In another study of group therapeutic alliance and cohesion, Joyce, Piper, and Ogrodniczuk (2007) examined the impact of each on outcomes in short-term group therapy.

> In the group context, then, treatment benefit may be facilitated by the patient's relationship with the therapist (alliance), the patient's sense of cohesion with the other patients, the patients' experience of cohesion to the group as a whole, or some combination of these relationships. In this study, our aims were to explore, first, how global measures of the alliance and cohesion may overlap and, second, how they may jointly influence group therapy outcome. (p. 270)

To pursue these aims, the researchers used measures of cohesion that assessed the quality of the patient's relationship to the group-as-a-whole (commitment) and the quality of the relationships with the therapist and other members (compatibility), from the perspective of each group member and the group leader (p. 273). Patients were matched on two personality variables and then randomly assigned to either an interpretative or a supportive group therapy and each group was assigned a therapist. Of the 107 patients who completed the 12 sessions (32 attended less than 8 and were considered dropouts), a relatively equal number were in each group. The two groups were equally successful in achieving a number of positive outcomes, including, for example, reduction of grief symptoms. The authors reported, among others, the following significant outcomes:

- The therapist's view of the alliance was moderately associated with the patient's rating of commitment to the group and to the other members' rating of the patient's compatibility.
- The patient-rated alliance was directly associated with improvement on all three outcome factors: general symptoms, grief symptoms, and target objectives/life satisfaction.
- The group alliance variables were more consistently associated with outcomes than cohesion variables.

While both studies report important limitations, nevertheless they mark an interesting venture into operationalizing key concepts such as group alliance, compatibility, commitment, cohesions, and so forth and their impact on each other and on outcomes. As this research continues it will add to our understanding of this entity called the group-as-a-whole. It should also offer insights into the mechanisms of change in group practice.

Integrating Evidence-Based Practices (EBP) and the Mutual Aid Model

Although this chapter describes an approach to group practice that emphasizes mutual aid, the underlying assumptions about human behavior in general and groups in particular are congruent with most other models. For example, the most widely used models of evidence-based practice start from a strengths perspective. Most of the models believe that individuals have the capacity to change how they think, change their emotions, and change how they act. They also believe that changes in any of these elements, thoughts, feelings, or actions impacts the others.

Motivational Interviewing (MI)

While most of the development and research on MI has applied to individual treatment, efforts have been made to translate the model into a group treatment modality. Central to the MI group model is the concept of stages of change in which group members move from a "precontemplation" stage to "contemplation" and "action" with the ability to recycle back based upon success of their efforts. The mutual aid model uses the concept of phases of work in which the group members need to be engaged in early sessions at identifying common concerns as they perceive them. The core concept in mutual aid of "starting where the members are" rather than starting where the group leader thinks the members "should be" is consistent with MI strategies. For example, in a mandated group for men arrested for driving while intoxicated, where most of the group members are in a precontemplation stage, the group leader would not challenge the usual denial, but instead, explore how the arrest and having to attend the group is experienced by the men.

MI believes in the member's potential to change and, as with the mutual aid model, a strengths perspective is attributed to each member and the group-as-a-whole. The beginning phase of a mutual aid group is all about engaging the members as active participants and internal leaders in the process.

Van Horn (2002), describing a pilot-tested motivational interviewing group for dually diagnosed inpatients points out that

> Motivational interviewing shows promise for engaging clients with dual psychiatric and psychoactive substance use diagnoses in treatment. While initially developed as an individual treatment approach, key motivations enhancement principles may be applied to structured group interventions to facilitate its introduction to inpatient dual-diagnosis treatment. (p. 1)

Researchers have proposed adaptations of the MI model to group practice in the substance abuse field suggesting the development of a "core motivational group" as part of a treatment program (Ingersoll, Wagner, & Gharib, 2007). This framework uses topics such as the stages of change, decisional balance exploring the pros and cons of changing and staying the same, supporting self-efficacy by exploring strengths, planning for change, and so on in the group modality with a combination of presentation and group discussion and group support.

In a study of the impact of the use of a group-based motivational enhancement program prior to standard treatment the authors report that the 73 clients who attended the motivation group, compared to the 94 that did not, had significantly more positive outcomes (Lincourt, Kuettel, & Bombardier, 2002). When controlling for diagnosis, employment, and age, those in the motivational group had a higher rate of attendance to the overall program as well as treatment completion.

Finally, a randomized-controlled study was conducted with 161 alcohol-dependent inpatients who received three individual counseling sessions on their ward in addition to detoxification treatment and 161 inpatients who received 2 weeks of inpatient treatment and four outpatient group sessions in addition to detoxification. Both interventions followed the principles and strategies of motivational interviewing (John, Veltrup, Driessen, Wetterling, & Dilling, 2003). The researchers found that group treatment resulted in a higher rate of participation in self-help groups at the six month after treatment point but this difference disappeared after 12 months. There was no difference in the abstinence rate between the two groups.

Solution-Focused Practice (SFP)

Another model of practice with elements that fit nicely in the mutual aid model is solution-focused practice or solution-focused brief therapy in group. Both models start with a strengths perspective and focus on the group member's perspective of what needs to change. In addition, both have an existential view of change suggesting that, for example, that by acting "strong" one is strong. Each one would explore what specific, even small steps,

the group members can take to change their lives.

Corey (2008) points to the underlying positive orientation as a key concept:

> Solution-focused brief therapy is grounded on the optimistic assumption that people are resilient, resourceful, and competent and have the ability to construct solutions that can change their lives … Clients are believed to be competent regardless of the shape they are in when entering therapy, and the role of the counselor is to help clients recognize the resources they already possess. Solution-focused therapists engage in conversations with their clients about what is going well, future possibilities and what will likely lead to a sense of accomplishment. (p. 424)

This is also central to the mutual aid model in which the strength for change is emphasized both for the group-as-a-whole and for each member. The central idea that the source of support and help is going to come from the group, rather than from a group leader, emphasizes this similarity. Rather than providing what often resembles individual counseling in a group session, the mutual aid group leader always turns to the group members to respond to an individual's concerns and problems. This process leads to a strengthening of the group alliance, which was described earlier in this chapter as a strong influence on the retention of members and the success of the group.

In one example in a mutual aid support group developed in a program for students suspended from school for violence or weapons or drug possession (Shulman, 2011), group members were asked to identify what factors they believed helped them go as long as they did between suspensions—a common solution-focused technique—rather than only discussing the causes of the current suspension. Other group members were encouraged, through the mutual aid process, to share with an individual what sources of support they had found helpful.

In an AIDS/Recovery group led by this author, members shared what had helped them maintain their recovery in the past rather than only focusing on the triggers that led to their current relapse. They were also encouraged by the group leader to help each member recognize their strengths rather than be preoccupied with what they perceived as their weaknesses. Group members regularly reminded each other of the phrase from their AA group experiences that “relapse was a part of recovery.”

Since the mutual aid model emphasizes “getting help” by “giving help,” each group member was better able to be less self-judgmental and to identify their own strengths as they were able to see them in others. The concept of getting help by giving help is sometimes referred to as the connection between “altruism” and “self-interest” (Flynn & Black, 2011). While they were examining the connection between the two in terms of the importance of counselors meeting their own needs in order to meet the needs of others, this connection can be applied to mutual aid support groups. The closest we come to empirical support for the concept is research conducted on self-help groups in which participation, which involves providing support for others, is associated with positive outcomes.

In a review of research on the effectiveness of self-help mutual aid groups, Kyrouz, Humphreys, and Loomis (2002) found that most self-help groups have found important benefits of participation. Studies are cited on mutual aid groups in a number of treatment areas, including support groups dealing with addictions, bereavement, cancer, caregivers, chronic illness, diabetes, aging, mental health, and weight loss. This review focused on pure self-help groups that were not led by professional group leaders, however, the specific mutual aid process and outcomes are similar.

Cognitive-Behavioral Treatment (CBT)

Concepts drawn from the CBT model are also easily integrated into the mutual aid group work approach. For example, in a recent review of the literature on the effectiveness of cognitive-behavioral and supportive-expressive group therapy, Boutin (2007) reviewed 20 studies that examined the extent to which cognitive-behavioral therapy (CBT), supportive-expressive group therapy (SEGT), or a combination of these two treatments impact women

with breast cancer. Most studies (80%) used randomized assignment to the treatment or control groups. Studies also differed on the stage of the cancer and the ages of the women as well as the treatment options: SEGT, CBT, or a combination of the two.

Outcomes varied for different studies and different designs, however, key findings across studies included less mood disturbance, no survival rate difference, less depression, higher self-esteem, increased vigor and "fighting spirit," less affect suppression, decreased anxiety, less pain and suffering, and so forth. Addressing the findings across studies Boutin (2007) states:

> Despite evidence for success across all of the treatments, the pattern of results from the CBT, SEGT, and combination of CBT and SEGT studies are imbalanced. More repeated positive outcomes from studies implementing an experimental design were found for the SEGT treatments than for CBT as well as than the combination of CBT and SEGT treatments. Furthermore, studies with less experimental control were identified that support the outcomes of the more rigorous SEGT studies, but no supportive evidence was identified that support the outcomes of the more rigorous CBT or combination of CBT and SEGT studies. (p. 279)

Boutin identifies limitations in both the review and in individual studies, however, the author does suggest that group treatment using different modalities, particularly supportive-expressive group therapy, appears to have a positive impact on a number of important variables. A central process in the mutual aid model, as illustrated in the sections that follow, is the powerful impact of a member receiving emotional support from other members. This is also the core helping dynamic in supportive-expressive group therapy (SEGT).

The Mutual Aid Processes with Illustrations from Practice

There are core (or constant) dynamics and skills that cut across all group practice as well as variant elements that are introduced by such factors as the following: group structure (e.g., psychoeducational, counseling, psychotherapy, play therapy); population (e.g., children, young adults, the elderly); problem (e.g., school violence, illness, parenting issues, mental health concerns); setting (e.g., community mental health center, school, hospital, corrections institution, private practice); and level of authority (e.g., voluntary, mandatory or semivoluntary groups). The section will identify a number of mutual aid processes with examples from a range of groups in an effort to illustrate the constant as well as the variant elements of mutual aid group practice.[1] The processes include:

- Sharing Data
- Discussing a Taboo Area
- The All-in-the-Same-Boat Phenomenon
- Mutual Support
- Mutual Demand
- Individual Problem Solving
- Rehearsal
- The Strength-in-Numbers Phenomenon

Sharing Data

One of the simplest and yet most important ways in which group members can help each other is through the sharing of relevant data. Members of the group have had different life experiences, through which they have accumulated knowledge, views, values, and so forth that can help others in the group. For example, in a married couples' group I led a number of years ago one of the couples was in their late sixties. As other group members who are in their fifties, forties, thirties, and twenties described their experiences and problems, this couple was often able to share an insight, which came from being able to view these crises from the perspective of time. In the group, we created a form of the extended family in which one generation passed on its life experiences to the next. In one session, as the youngest couple listened to the struggles shared by each of the other four, many related to the stage of the life cycle each of these couples were in, the young husband Ron said, "Do you mean Gwen and I are going to have to go through all of this?" The 69-year-old Lill responded, "You will, Ron, but at least you will have this group to help you."

In another group I led of persons with AIDS who were in early recovery from substance abuse specific information about the recovery process and coping with AIDS and its treatment was shared on a regular basis. For example, one group member told another, "This is the start of your second year in recovery— the feelings year—so don't be surprised about all of the pain you are feeling because you don't have the drinking and drugging to cover it up."

In the example that follows, group members provided tips on how to increase one member's chances for acceptance into a special housing program for people with AIDS. My job as group leader was to help connect the group to the member to facilitate this form of mutual aid.

> I pointed out that, earlier, Theresa had mentioned her interest in getting into this independent living facility. I wondered if we might help her just by addressing that issue, as well. She told us she was concerned about putting an application in because she didn't think she had established enough credibility in her single-room occupancy housing. At this point, Jake and Tania started suggesting strategies and ideas about how to approach the living facility.
>
> Tania (a transgendered member) pointed out that the building—if you looked at it—was supposed to be for people with AIDS, but it was essentially for gay men. She said she was the only woman in the whole building. She said to Theresa: "If worse came to worst, you could always tell them it's discrimination, and that'll get their attention." She said, "That's how I got in." They continued to talk with Theresa about ways she could demonstrate her responsibility, things that she had done, her commitment to recovery, the fact that she wanted to leave the place she currently lived in. She took it all in, thanked them for their advice, and said she was going to apply.

Discussing a Taboo Area

Each group member brings to the group the *norms* of behavior and the *societal taboos* that exist in our larger culture. For example, one norm of group behavior may be to avoid discussion in an area of societal taboo. In the beginning phase of work, the group recreates in this microsociety this general "culture". Direct talk about such subjects as authority, dependency (on people and/or substances), death and dying, and sex may be experienced as taboo. One of the tasks of the group leader is to help the group members develop new norms so that the group can be more effective. This is referred to as helping the group to develop a *culture for work.*

As the work proceeds and the level of comfort in the group increases individual members may emerge as an internal leader. If we consider the group leader, as a person invested with the authority of the setting, then the internal leader is a group member who derives their authority from the group. Different internal leaders may take the lead around different issues because of their personal life experiences or their sense of urgency for addressing the topic. They take the first risk that leads the group into a difficult area. By being first, the member allows the more fearful and reluctant members to watch as the taboo is violated. As they experience positive work, they are given permission to enter the formerly taboo area.

In my AIDS/Recovery group, one member spoke about her own abusive past history and how she had escaped her family and turned to the streets and "to every kind of drug and drink you could imagine." She went on to describe her experiences prostituting in order to raise money for drugs and how she was not proud of herself or what she did. She said, "While I was on the street I was with many men but I was really with no man." These revelations opened the door for other members to share their own sexual experiences, often degrading and exploitive, as they went on "coke dates" to raise money for drugs. The ability to discuss their emotions in a supportive, nonjudgmental environment appeared to have a cathartic effect, creating a culture in which other taboo issues were discussed, such as their own illnesses, their rejection by friends and family, painful losses of people close to them, and their own fears of debilitation and death associated with AIDS.

These taboos can also impact children's groups where the internal leader may use a more indirect method of raising an issue. The following example involves a group for 10- and 11-year-old children who had lost a close family member. They were referred to the group because of behavior problems in school and elsewhere that signaled their difficulty coping with the death. The group members called themselves the "Lost and Found Group," since they had lost someone close but had found each other (Vastola, Nierenberg, & Graham, 1994). The authors describe how Mark, at the start of a group session following one in which members had begun to open up and discuss their losses, sends a mixed message using paper and pen. He repeatedly writes "Bob," the name of his grandfather who had recently died.

Carl: Mark, your grandfather died?

Mark: I don't want any damn body talking about my grandfather or I'll kick their butt.

Leader: You sound pretty angry.

Mark: I'm not angry. I just don't want anybody talking about my grandfather.

Leader: It's very difficult.

Mark: It's not difficult. I just don't want anybody saying that he died. (His anger is escalating.)

Gloria: Nobody wants to talk about nobody dying.

Dick: Yes, we don't want to talk about that.

Leader: How come?

Gloria: That's why he (Mark) is running around. You can't force him if he doesn't want to.

Leader: Are you saying that perhaps that's what makes you run around—so you won't have to talk about something upsetting?

Mark: Nope.

Leader: Maybe you feel it's too hard to talk about.

Mark: No, it's not hard for me to talk about anything … but that reminds you, and you could be dreaming.

Carl: Yup, you dream for about a week when you talk about your mother, then it takes about five days to try to get over it, but it comes back again and it stops and it comes back again. … Nightmares, I hate. I hate talking about my mother. (p. 87)

Through his behavior, Mark has demonstrated his difficulty in dealing with the loss. The group members move to his defense, because this is their problem as well. The group leader's persistence sends a message to Mark (and the group) that she will not back off from this difficult issue. As she explores Mark's resistance by acknowledging the difficulty and asking what makes it hard to talk about his loss, the members begin to open up. It is interesting how often asking reluctant group members to discuss what makes it hard to address an issue actually leads to their addressing the issue. One can often interpret resistance as the group member or members saying to the group leader: “We need some help because this is a painful area.”

In a recent and poignant example, a group leader of an after-school program located in a community dominated by a military base asked the members to stand up if their mothers or fathers served in the military. Almost all the children stood. One boy still sitting asked: “My father was in the military but he died in Afghanistan. Am I supposed to stand up?” When viewed as an indirect yet powerful communication it's possible to understand the question as a child's way of raising the issue of grief over a lost parent. This would be a sensitive and somewhat taboo subject of discussion. The child who raised it could be seen as an internal leader raising a concern that must also be on the minds of the other children whose parents were still fighting, had just returned from serving, or were preparing to leave for another tour of duty.

The All-in-the-Same-Boat Phenomenon

After the group enters a formerly taboo area, the members listen to the feelings of the others and often discover emotions of their own that they were unaware of, feelings that may have been having a powerful effect on their lives. They also discover the reassuring fact that they are not alone in their feelings, that group members are "all in the same boat." Knowing that others share your concerns and feelings somehow makes them less frightening and easier to deal with. When one discovers that one is not alone in feeling overwhelmed by a problem, or worried about one's sexual adequacy, or wondering who one is and where one comes from (e.g., a foster teenager), or experiencing rejection because of "the virus" (AIDS), one is often better able to mobilize oneself to deal with the problem productively.

Discovering that feelings are shared by other members of the group can often help release a group member from their power. Guilt over "evil" thoughts and feelings can be lessened and self-destructive cycles broken when one discovers they are normal and shared by others. For example, a parent of a child with a physical or mental disability who hears that other parents may also feel that their child's condition represents "God's punishment" may be better able to cope with their guilt. This can be one of the most powerful forces for change resulting from the mutual aid process. There is not the same impact when a leader tries to reassure the group member that the same feelings are shared by others. Hearing them articulated by others in the group sessions makes a unique impression.

Many group members, particularly those belonging to oppressed and vulnerable populations, may internalize the negative definitions assigned to them by the larger society. Thus, battered women, survivors of sexual abuse, persons of color, the mentally ill, or people with AIDS may assume the blame for their troubles and see their difficulties as a product of their own personal shortcomings.

In group where common experiences of oppression are shared, it becomes easier for group members to recognize that a source of their problems in living may be external to themselves. Early in the women's movement, this process was exemplified in the *consciousness-raising groups* designed to help women become more aware of gender stereotyping and oppression issues that affected their lives. The anger against the oppression—anger that often lurks just beneath the outward signs of depression, submission, and apathy—can be released and converted into positive energy for dealing with personal as well as social issues.

This central concept in the mutual aid model, the "all-in-the-same-boat" process, is similar to the concept of *resonance*, which is one of the three constructs found in "relational theory" developed and researched at the Stone Center in Wellesley, Massachusetts. The center is dedicated to studying the unique issues in the development of women and methods for working effectively with them. The center has built on the early work of Jean Baker Miller whose publication entitled *Toward a New Psychology of Women* (Miller, 1987; Miller & Stiver, 1993) laid the groundwork for the relational model often referred to as "self-in-relation" theory.

The concept of *resonance* suggested by Fedele (1994) is described as "a resounding; an echoing; the capacity to respond that, in its most sophisticated form, is empathy" (p. 7). She suggests that resonance manifests itself in group work in two ways:

> The first is the ability of one member to simply resonate with another's experience in the group and experience some vicarious relief because of that resonance. The member need not discuss the issue in the group, but the experience moves her that much closer to knowing and sharing her own truth without necessarily responding or articulating it. Another way resonance manifests itself in a group involves the ability of members to resonate with each other's issues and thereby recall or reconnect with their own issues. (p. 14)

Mutual Support

When the group culture supports the open expression of feelings, group members' capacity to empathize with each other is evident. Empathy was an important element in many of the curative factors described by Yalom (1995) and Yalom and Leszcz (2005) in group work. These factors are imparting of information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential learning. Yalom and Leszcz suggest that "if it is the group members who, in their interaction, set into motion the many therapeutic factors, then it is the group therapist's task to create a group culture conducive to effective group interaction" (pp. 120–121).

With the group leader setting the tone through expression of personal feelings and understanding of others, each member is able to observe the powerful effect of empathy. Since group members share some common concerns, they are often able to understand each other's feelings in a deeper way than the leader. This expression of empathy is an important healing agent for both the group member who receives it and the one who offers it. As group members understand the thoughts and feelings of the others, without judging them harshly, they begin to accept their own thoughts and feelings in new ways. For a member struggling with a specific concern, the acceptance and caring of the group can be a source of support during a difficult time.

I have just used the expression "the acceptance and caring of the group." The important element here is the group, the entity that is created when people are brought together. This entity, which I have called the group-as-a-whole, involves more than just the simple sum of the parts (members). For example, support in the mutual aid group often has a quality that is different from support received in interaction with a single empathic person. It is more than just a quantitative difference of more people equaling more empathy. At crucial moments in a group one can sense a general tone or atmosphere, displayed through words, expressions, or physical posture, that conveys the caring of the "group" for the individual. One can almost sense it "in the air." This seems to have a special meaning and importance to the individual group member.

In the following example of support, also from my AIDS/Recovery group, the group member who is reluctant to confront her boyfriend for fear of losing him asks the transgendered member how she looks. I sense the underlying question related to the impact of having AIDS and I tried to articulate Theresa's feelings:

> Once again, Theresa asked Tania how she looked. She said, "You're a woman. I know, as a woman, you will be honest with me and just tell me what you think. Do you think I look okay?" Tania seemed confused and said, "Well, sure, you look wonderful." I said, "I wonder if Theresa is really asking, 'Am I pretty enough? Am I attractive enough? If my boyfriend leaves me, can I find someone else who could love me even though I have AIDS?'" She said, "That's it," and came close to tears. She said, "I'm so afraid, if I lose him, I won't find anyone else." She said, "I know I could have guys, and I know I could have sex, and I like the sex. I sure missed it during the time I was in prison, but can another guy love me?"
>
> The group members tried to reassure her that she was a wonderful person, and Tania said, "It's not what you look like on the outside, it's what you're like on the inside." And she said, "And you honey—you've really got it where it counts."

In another example one member in a DWI (Driving While Intoxicated) group finally revealed his trigger for his drinking was the memory of having driven his car while drunk, crashing, and the resultant death of his wife. The group leader described how all the men leaned forward toward him, physically and verbally supporting him as he struggled with his loss while also experiencing the feelings associated with their own losses due to their drinking.

Mutual Demand

Also central to this group work practice framework is the concept of the helping relationship consisting of elements of both support and demand, synthesized in unique, personal ways. In the group counseling context, mutual aid is provided through expectation as well as through caring. One illustration is the way group members confront each other. For example, in my couples' group, two male members were able to challenge a third who was maintaining that the source of the problem was his wife, that she was the identified "patient," and he was coming to group merely to "help her out." Both of the confronting group members had taken the same position at our first session and had slowly modified their views. They had lowered their defenses and accepted the idea that the problem was a "couple" problem. This demand on the third member had a different quality coming from group members, rather than the group leader.

As the group culture develops, it can include expectations that members risk their real thoughts and ideas, listen to each other and set their own concerns aside at times to help another, and so on. These expectations help develop a productive "culture for work." Another group expectation can be that the members will work on their concerns. At moments when group members feel overwhelmed and hopeless, this expectation may help them take a next step. The group cares enough about them not to let them give up. I have witnessed group members take some difficult action, such as confronting a boss or dealing more effectively with a close relative. When the action was discussed the following week, they indicated that one of the factors that had pushed them to make the move and take a risk was the thought of returning to the group and admitting that they hadn't acted.

In my AIDS/Recovery group, members often used their insights and understanding about the recovery process, gained through participation in 12-step groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), to confront each other when their behaviors threatened their recovery. In one example, a group member who had just spent two weeks in a detoxification program after relapsing into cocaine use described how hard it was for him not to "hang around" the pool hall where all his friends were. He described how he wavered each day, wondering if he could connect up with them and not relapse again. One of the other members, using an analogy obviously known by the others through their AA and NA experiences, said, "You know, John, if you hang around a barbershop long enough" (pause) and the group, in a chorus, replied, "you are going to get a haircut!" The group members all laughed, and John replied, "I know, I know, you're right, I would definitely be risking my recovery."

Mutual demand, integrated with mutual support, can be a powerful force for change. While the literature contains references to "facilitative confrontation" on the part of group leaders with group members and group members with each other, empirical support for this integrated response is lacking. There is support, however, particularly in the substance abuse treatment field, that confrontation by itself can be counterproductive.

Individual Problem Solving

A mutual aid group can be a place where an individual can bring a problem and ask for assistance. For example, in one group in a community mental health counseling center, a young mother discussed the strained relationship between herself and her mother. Her mother lived nearby and was constantly calling and asking to come over. The group member had been extremely depressed and was going through periods where she neglected her work at home (dishes piling up in the sink, not cleaning the house, forgetting to prepare a meal, and so on). Each time her mother came over, she felt, because of her mother's actions, that she was being reprimanded for being a poor housekeeper and a poor mother to her young children. The group member presented the issue, at first indirectly and later with much feeling and tears. The other members reached out to offer support and understanding. They were able to use their own experiences to share similar feelings. The older members of the group were able to provide a different perspective on the mother's actions. They could identify with her mother's feelings, and they pointed out how uncertain she might feel about how to help her daughter. It became clear that the group member's perceptions were often distorted by her own feelings of inadequacy and her harsh judgments of herself.

It is important to note that as the group members offered help to the individual with the problem, they were also helping themselves. Each group member could make associations to a similar concern. All of them could see how easily the communications between mother and daughter were going astray. As they tried to help the group member clarify her own feelings, understand her mother's reactions in new ways, and see how the mutual stereotypes were interfering with the ability to communicate real feelings, the other group members could relate these ideas to their own close relationships. This is one of the important ways in which giving help in a mutual aid group is a form of self-help. It is always easier to see the problem in someone else's relationships than in your own.

This mutual aid process challenges the false dichotomy often posed between meeting the needs of the individual or the needs of the group, that is, the feeling by group leaders that they must choose between attending to the individual with a specific problem or attending to the group. This false dichotomy can lead to doing individual counseling in the group or ignoring individual issues for fear of losing the group. If the group leader sees his or her job as helping individuals reach out to the group and helping the group members to respond then there is no need to choose between the one and the many. The group leader can be with both at the same time.

Rehearsal

Another way in which a mutual aid group can help is by providing a forum in which members can try out ideas or skills. In a sense, the group becomes a safe place to risk new ways of communicating and to practice actions the group member feels may be hard to do. To continue with the previous example of the young mother concerned about her mother's regular visits, as the session neared the end, the group leader, detecting some ambivalence, pointed out that the group member seemed hesitant about taking up the issue with her mother. The following excerpt starts with the group member's response.

Rose: I'm not sure I can talk with my mother about this. What would I say?

Leader: That's a good question. How about trying it out right here? I'll pretend to be your mother calling to ask to see you. You can practice how you would respond, and the group can give some ideas about how it sounds. Does that sound all right?

Rose: (She stopped crying now and was sitting straight up in her chair with a slight smile on her face.) OK. You call me and tell me you want to have lunch with me and that I should keep the kids home from school so you can see them.

Leader: (Role-playing.) Hello, Rose, this is Mom.

Rose: Hi, Mom. How are you and Dad feeling?

Leader: Not so good. You know, Dad gets upset easily, and he has been feeling lousy. (The group member had indicated that her mother often used her father's health to try to make her feel guilty.)

Rose: That's it! That's what she would say to make me feel guilty. (The group members are laughing at this point.)

The discussion picked up, with the group members agreeing about how easy it is for others to make them feel guilty. Rose tried to practice some ways to get past the communication block and reported the following week that she had talked with her mother about how it made her feel when her mother tried to do things for her (e.g., wash the dishes when she came over), and her mother had responded by describing how she never really knew what to do when she came over—should she help out or not? Rose felt it cleared the air, even though other issues and feelings were not discussed.

The interesting thing about the role-playing device as a form of rehearsal is that it often reveals the underlying ambivalence and resistance that the group member feels but has not expressed in the discussion. The rehearsal not only offers the group member a chance to practice, it also reveals to the group, the leader, and the group member some of the feelings that need to be dealt with if the group member is to succeed in his or her efforts.

In my AIDS/Recovery group, at one point the group member who had raised boyfriend problems used the group to consider how to approach him with her concerns. One member helped by role-playing how Theresa could handle the conversation:

> We returned to Theresa, and I said, “Is the question really, Theresa, that you're afraid that he might not stay with you—that, if you actually confront him on this issue of the other women, that he might leave you?” She agreed that it was her concern. At this point, I wondered if it might help Theresa to figure out what she might say to her boyfriend. Theresa said that would be helpful because she didn't know when and how to say it. Then she laughed and said, “Maybe I should say it in bed.” Tania said, “Oh no. Don't say it before sex and don't say it after sex.” And I added, “And don't say it during sex.” Everyone laughed at this point, and Tania, a professional stand-up comedian sitting on a couch, did an imitation of having a conversation with Theresa's boyfriend, while pumping up and down as if she were in bed having sex with him.

> Tania then quietly said, “You have to find a quiet time, not a time when you're in the middle of a fight, and you have to just put out your feelings.” I asked Tania if she could show Theresa how she could do that. She started to speak as if she were talking to Theresa's boyfriend. I role-played the boyfriend, and said, “Oh, but Theresa you're just insecure, aren't you?” Tania did a very good job of not letting me put her off and, instead, putting the issue right where it was—whether I (role-playing Theresa) was prepared to make a commitment or if I was too insecure.

Ambivalence and fear often underlies our clients’ inability to take a difficult step. In the earlier example in the previous section, the young woman was not really sure if she wanted to speak with her mother, even though she expressed disappointment at her mother not wanting to spend time alone with her. In Theresa's situation, ambivalence about confronting her boyfriend about their relationship was related to not being sure she wants to hear his answer. This, in turn, is connected to the purpose of the group, the impact of having AIDS on their lives.

The Strength-in-Numbers Phenomenon

Sometimes it is easier to do things as a group than it would be as an individual. In one example, a group of female survivors of sexual abuse attended a “Take Back the Night” march. The “strength-in-numbers” phenomenon worked to decrease their feelings of isolation and individual risk involved, which encouraged the group members to make demands for their rights to feel safe. An individual's fears and ambivalence can be overcome by participation in a group effort as his or her own courage is strengthened by the courage of others. In this group, the march coincided with the ending and transition phase of the group. In the session following the march, the group leaders shared their own feelings:

> As the group processed how the march had felt for them, Jane and I shared how powerful it had felt for us to see them there, marching, chanting, and singing. We also shared that it was hard for us to see them and know that the group was ending. The group was special for us, and it would be hard to let it go. (Shulman, 2011, p. 272)

In the next session a member, Martha, empowered by the march and the group support reported that she was finally able to confront her father. She was the last member of the group to disclose the details of her abuse in the session before the march. Her father had not only sexually abused her himself but had taken her to bars to sell her to patrons for sex. She had been forced to dance on the barroom tables. In early sessions of this group, she had been the member who acted as “gate keeper” by acting out, dancing on tables in the group room, when other group members shared details of their abusive childhoods. The group leaders reported on this session after the march:

> Martha told the group that she had confronted her father with the abuse since the last group. We were all amazed, because this had been a goal that Martha had not hoped to attain for several months, if not years, in the future. Her abuse had been very sadistic, and her father had continued to hold incredible power over her when he was able to have contact with her. She had been with Linda before he called and described “just feeling very powerful and safe. I was able to see Linda and my roommate right there, and I could hold the whole group right in my mind and feel you supporting me and helping me to be safe. I've never felt anything like that before. And he was weak! He was the one who seemed powerless.”
>
> Martha had burned a picture of her father after the call as a way of exorcizing his control over her, and she had brought the ashes to group. Later, the group gathered and flushed the ashes down the toilet. Both leaders credited Martha's incredible and rapid growth and related it to the ending and how she had taken control of how she wanted to accomplish her goals and approach the end of group. The group gave Martha feedback and discussed how it felt to be part of her sense of safety. (Shulman, 2011, p. 253)

Conclusion

Mutual aid, as a group process, can be used as a core element of most counseling groups whatever the setting, group type or population. It can also be integrated into more formal evidence-based practice models that operate on similar underlying values and beliefs. Central to the examples shared in this chapter has been the idea that members of any group have the potential to be helpful to each other. For this to take place the group leader needs to believe in this concept and develop the skills and interventions required to help group members help each other. An important first step is to believe and to act as if the group belongs to the members and not to the group leader.

Note

1. For a more complete discussion of the mutual aid processes see Shulman, 2011.

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Chapter 11 An Overview of Current Research and Best Practices for Training Beginning Group Leaders

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The origin of formal group counseling and psychotherapy is often traced to 1905 when Joseph Pratt, a physician, utilized a group or "class" format to assist patients with tuberculosis (Gazda, Ginter, & Horne, 2001). Throughout the remainder of the 20th century, groups emerged as an increasingly popular mode of intervention in psychotherapy and counseling settings. Today, group methods are popular across a wide variety of settings to assist clients who present with a diverse range of goals and concerns (Corey, 2012). Thus, training models need to provide for this diversity. Group counseling is generally considered to be a treatment mode that is equal in effectiveness to individual counseling (Barlow, Burlingame, & Fuhriman, 2000; Kivlighan, Coleman, & Anderson, 2000; Piper, Ogrodniczuk, Joyce, & Weideman, 2011). The effectiveness of group counseling, combined with its economical advantages, make it an increasingly important treatment format in this age of managed care and third party payments (Greene, 2000).

Training programs in group counseling and therapy need to provide leader trainees with a solid understanding of group stages, group dynamics, and leader interventions that move group members toward meaningful interactions and subsequent personal growth. Successful training programs must enable trainees to gain a thorough understanding of group processes, how these processes relate to outcomes, and how the leader may intervene to influence group dynamics. The importance of a research base to provide guidance for leadership training cannot be overemphasized. The purpose of this chapter is to review the training models, research related to group leadership, and best practices related to training beginning group leaders.

Models for Leader Training

Standards and general guidelines for the training of group leaders have been developed by organizations such as the Association for Specialists in Group Work (ASGW, 2000) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009). Within the training standards of ASGW, basic competencies have been explicated that include both core group competencies and advanced group competencies (Conyne et al., 1992; Conyne, Wilson, Kline, Morran, & Ward, 1993). These standards suggest that knowledge and skill development should proceed from basic group work proficiency toward expertise required for specialty groups. They also recommend that training experiences focus on three areas: knowledge competencies, skill competencies, and clinical experience competencies.

Process Models

The training of group leaders has typically been conceptualized across three domains, including group process, skill acquisition, and a combination of the two (Robison, Jones, & Berglund, 1996). The following sections will discuss training models within each of these three domains. It should be noted, however, that these categories are somewhat artificial since training approaches seldom, if ever, fit exclusively into either the process or skill acquisition domain. Thus we have attempted to categorize models according to the training mode that appears to be most emphasized. With few exceptions, training programs employ, at least to some extent, an integration of process and skill acquisition experiences for trainees.

The group process model of training emphasizes the importance of trainees initially gaining a firm understanding of group stages and dynamics. This viewpoint is represented in the work of Yalom and his colleagues (Lieberman, Yalom, & Miles, 1973; Yalom & Leszcz, 2005). Their process orientation asserts that specific therapeutic elements have been found to have a positive impact on outcome, thus students should first understand what occurs in groups and subsequently learn what to do as a group leader.

While Yalom and Leszcz (2005) noted the importance of didactic and methodological readings, what he emphasizes in leadership training is for the neophyte to have an opportunity to serve, in effect, an apprenticeship with more experienced clinicians. He also recommends post-session meetings to give feedback, providing trainees with a group member experience, and teaching trainees to maintain a here-and-now, interactional focus. His specific recommendations include didactic training; observation of experienced group clinicians; close supervision of the trainee's initial group leadership or coleadership experience; training group experience; and personal therapy to develop better recognition of countertransference responses, personal distortions, and blind spots.

DeLucia, Bowman, and Bowman (1989) supported the notion of having trainees participate as group members in their early training. They contended that the transfer of knowledge from supervised group experiences can enhance the identification of process-level issues (e.g., cohesion obstacles, subgrouping, avoiding corrective feedback exchange) in the group by the trainees. By clarifying these process issues, a trainee's self-confidence and intervention skills are increased.

Corey and Corey (2008) highlighted the importance of focusing group leader training/supervision on three domains that include thinking, feeling, and behaving. They begin their instruction with an experiential theme-oriented class (Corey, 2001). At each stage of the group process, the leader may focus on the thinking, feeling, and behaving of group members, while utilizing an existential approach that consists of individual choice and responsibility. Finally, they conclude by describing the importance of fostering cohesion and trust in the group, as well as client readiness, when choosing interventions (e.g., linking, confronting, supporting, blocking).

Skill Acquisition Models

Skill acquisition approaches emphasize the importance of acquiring intervention behaviors that are specific to group counseling. The student is taught selected interventions as they pertain to member behavior and interpersonal issues that are occurring in the group. Skill-based approaches have been successfully used to prepare counselors in individual psychotherapy since the 1960s (Baker, Daniels, & Greeley, 1990; Ivey, 1994). Supporters of this approach within the group leader training area include Jacobs, Masson, and Harvill (2009) who adopted Ivey's microcounseling approach to training leaders. First, students observe the skill to be learned, through videotape or live interaction, and then practice the skill (e.g., protecting, drawing out, leader modeling).

Smaby, Maddux, Torres-Rivera, and Zimmick (1999) outlined a training approach called the Skilled Group Counseling Training Model (SGCTM). This model focuses on systematically teaching group counselors both low-level (e.g., attending, questioning, reflecting) and high-level skills (e.g., leader self-disclosure, immediacy, confrontation). Particular attention is given to teaching decision-making and contracting skills for taking action. Instruction methods include viewing videotaped group sessions, instructor demonstrations, leadership practice in training groups, performance feedback, and guided practice on skills not performed or not performed adequately. Therefore, students who experience this 36-hour training sequence are taught how to apply general techniques in a group format through the practice of both basic and higher level counseling skills. A comparison study by Smaby et al. (1999) revealed that 68 counselors-in-training, who completed the SGCTM instruction, demonstrated significant gains in skill acquisition and performed significantly higher than 15 trainees from a conventional group counseling class.

Jacobs et al. (2009), Toth, Stockton, and Erwin (1998), and Toth and Stockton (1996) propose leader training that involves students in brief small group experiences. These small group experiences differ from role-playing in that students do not have scripted scenarios to discuss but instead engage in nonthreatening interaction that begins to activate the dynamic group process. Experiences such as these provide students with the security of a laboratory environment while giving them an interpersonal experience that simulates a real group session. Experiences such as these may help prepare students for later skill acquisition (Toth et al., 1998).

Conyne and his colleagues (Conyne & Bemak, 2004; Conyne & Cook, 2004) proposed an ecological perspective for group work and the training of group leaders. They view groups as complex, living, open, and interactive social systems wherein the group influences and is influenced by the broader social context. Conyne and Bemak outlined leader functions/tasks and training guidelines for planning, performing, and processing ecological-centered groups. They stressed that group work trainees must be “encouraged to deeply understand context and its role in relation to the group as a whole, each group session that occurs, and to a member's experience within the group” (p. 16). For example, in planning and conducting a group, the leader should carefully consider the needs, culture, and values of the prospective members.

Integrated Models

As noted earlier, programs differ primarily in terms of the degree to which they focus on group processes or trainee acquisition of specific skills. Some theorists have stressed a need to combine process and skill-based approaches into a single integrated theoretically driven training model (Stockton, 1992, 2009). This speaks to the importance of utilizing a combination of approaches in the training of group leaders.

Caffaro (2001) describes an integrated development sequence for group therapy, which begins with an initial nine weeks of dyadic instruction as well as a "learning group" experience. Students progress into another nine-week segment that is an in-class process group with the instructor providing consultation. This approach outlines the importance of developing a basic understanding about the group as well as the importance of participating in an experiential component in training.

Stockton (1992, 2009), in his integrated training model, proposed that instruction and training for group leaders should focus on three related dimensions: (a) Perceiving, (b) Selecting, and (c) Risking. In developing this model, Stockton attempted to combine process and skill acquisition approaches and to incorporate best practices as suggested by research and expert opinion. In the following paragraphs, Stockton's original model is reviewed and expanded.

Though presented as separate training steps, an important caveat to the Perceiving, Selecting, and Risking (PSR) model is the understanding that this process in actuality is nonlinear and overlapping. The components are viewed as instructional targets that must be attended to within each didactic or experiential training activity. The processes of helping trainees learn to effectively perceive group dynamics, select appropriate interventions, and develop the courage to actually intervene in a group situation, for example, are recycled over and over as the trainee progresses toward new or more advanced skills.

The Stockton (1992, 2009) PSR model assumes that group leaders begin with a basic understanding of individual counseling and related knowledge areas that are typically taught in counselor education programs. The importance of then building conceptual maps on top of these basic competencies and prior experiences is crucial. Although students may be eager to learn techniques, a sound grasp of schemas to understand groups and group dynamics is also important. Therefore, exploring, through didactic and other means, group dynamics, therapeutic factors, and other core principles that underlie all groups is essential.

The next step is to address techniques and microskills that are specific group interventions. These should include skills such as promoting member-to-member feedback, processing group events, protecting members when needed, and promoting the generalization of new member understandings and behaviors to life outside the group. This component involves the presentation of specific skills, instructor/supervisor modeling of the skill (videotaped training tapes are very useful at this point), trainee skill practice, performance feedback, and recycling of the process until an acceptable level of skill is attained. Microskill training initially focuses on basic group skills (linking, drawing out, protecting) and in later training stages focuses on more advanced skills (leader promotion of therapeutic factors such as cohesion and meaning attribution). Along with the teaching of microskills, it is also important to reintegrate theory to allow the techniques to rest on a solid foundation allowing for later appropriate and purposeful intervention selection. Without this integration of the two, choice of technique becomes problematic and leaders end up making arbitrary choices in selecting interventions. Thus, theory helps inform the conceptual foundation, which allows leaders to select appropriate interventions.

An important thing to understand about beginning group leaders is that with this kind of learning comes accompanying anxiety. Dreyfus and Dreyfus (1986) highlighted the fact that in mastering any area, individuals go through several stages of cognitive and emotional development each of which has its own process. Part of the process of mastering group leadership skills is the increase in self-efficacy and resultant reduction of anxiety in those who have reached a point in training and experience where they can appropriately risk themselves to select and attempt interventions.

The idea of leading a group is a very intimidating one for most neophytes. Instructors should be aware of this normal level of anxiety. To meet this need, students are provided the opportunity to experience group membership and to discuss and practice specific leader intervention skills (microskills that were previously learned and practiced) within the safety of small student groups. Additionally, since several groups may be occurring, trainees are able to observe other groups. These small groups are used to engage students in discussing their apprehensions about being a group leader while also providing experience as a group member. This experience allows trainees to experience group dynamics as an observer, a member, and a leader/coleader; provides additional practice on group leader microskills; and provides a format for helping trainees deal with their anxiety.

Another key component of this training model is the supervised leadership experience that involves the student actually leading or coleading a group. This experience typically occurs in an advanced group course or as part of a practicum experience and includes observation by a supervisor who provides immediate feedback on completion of each session. In addition to proving feedback on trainee skill applications, supervisors are also encouraged to share their own thoughts with trainees concerning such things as critical incidents in the group just before or at the time of the intervention, their hypotheses about underlying issues affecting the group, possible plans to consider in moving the group forward, and similar thought processes. Such cognitive modeling provides the trainee with examples of how more experienced leaders might process and make sense of group dynamics and, in turn, aids the trainee in developing more complex and flexible cognitive maps to guide their own leadership efforts.

Stockton and Toth (1996) emphasized that trainees' ability to perceive group dynamics, select appropriate interventions, and risk-taking interventions are inextricably intertwined in both practice and training. For example, as trainees read and discuss the elements of group process they can also be exposed to a wide range of leader interventions that are designed to influence group development. Such knowledge in turn can increase trainees' confidence that they can effectively lead a group. Similarly, classroom groups can offer an opportunity for trainees to discuss their anxieties about leading a group as well as help them crystallize the understanding of group processes that were acquired through reading and discussion.

Supervision Models

Models for guiding the supervision of group leader trainee experiences have also been developed (Riva, 2014; see Chapter 12 for more detailed information about the supervision of group counseling trainees). Granello and Underfer-Babalis (2004) called for intentional efforts to develop the cognitive complexity of group counseling supervisees. They link cognitive complexity to such counselor skills as developing clinical hypotheses, increased flexibility in counseling methods, and more meaningful client conceptualizations. Granello and Underfer-Babalis presented a supervision model based on *Bloom's Taxonomy of Educational Objectives* that provides guidance for developing leader cognitive complexity across the various group stages through the use of intentional supervisor-provided structure, intervention, questioning, and modeling. This model seeks to move supervisees from lower levels (knowledge, comprehension) to higher levels (analysis, synthesis, evaluation) of understanding concerning group dynamics and leadership; for example, to move a supervisee from simply recognizing resistance in the group to actually formulating a plan or exercise to help work through the resistance. They report that their own use of the model has proved useful but caution that research will be needed to test the generalizability of the model.

Rubel and Okech (2006) described their Supervision of Group Work Model (SGW) based on the discrimination model of Bernard (1979) and adapted to the multilevel group environment issues that need to be addressed by group work supervisors. The 3 x 3 x 3 model provides a structure for supervision that includes supervisor roles (teacher, counselor, consultant), supervision foci (personalization skills, conceptualization skills, intervention), and interaction levels (individual, interpersonal, group-as-a-system). This model provides a conceptual template for group supervision along with descriptions of the knowledge and skills required of the competent group work supervisor. The authors call for research to assess the effectiveness of this supervision model.

In addition to the training models and supervision approaches discussed above, there are a variety of other potentially useful suggestions that emerge from the literature. Some of these include layering the teaching of group skills over three years of training (Barlow, 2004), the use of activity- or adventure-based group experiences (Connelly, Carns, & Carns, 2005), and the use of writing exercises such as journaling whereby the trainee focuses on the specifics of group dynamics (Brown, 2010).

Research on Group Leadership

In 1980, Stockton noted that while growth in the group work literature had been impressive, literature on the training of group leaders was not extensive. In his review, he concluded that most of the literature concerning the supervision of group leaders was anecdotal and focused on global concepts. Happily, there has been considerable progress in this area; however, there is still much to be done.

Not surprisingly, there are a variety of approaches to research. It is beyond the boundaries of this chapter to hold an extended discussion on methodology (Stockton & Morran [2010] discuss research methodology for group work in more detail). However, it is important to note that researchers have most frequently utilized experimental and quasi-experimental designs, which attempt to control for extraneous variables when researching outcomes of deliberate interventions. Thus if it can be demonstrated statistically that the intervention has had an effect, conclusions can then be drawn and generalizations (with appropriate caveats) made.

Because of the complexity of doing inquiry in the social sciences, it is important for researchers to use a wide variety of approaches to capture "truth"; however, researchers have to keep in mind Polkinghorne's (1983) comments that "knowledge is understood to be the best understanding that we have been able to produce thus far, not a statement of what is ultimately real" (p. 2).

Leadership Style

In an early study, Powdermaker and Frank (1953) concluded that the ability of group leaders to face attack from group members without being defensive was the key factor in distinguishing episodes that were successful from those that were judged to be unsuccessful. This was the first research to support the common belief that group leaders must be able to assume a nondefensive stance when confrontation occurs in the group.

A later, but still early, systematic study of group leadership by Lieberman et al. (1973) identified four styles of leadership, including executive function, emotional stimulation, caring, and meaning attribution. According to Lieberman et al. (1973), the most effective leadership style consists of leaders "who are moderate in Stimulation, high in Caring, utilize Meaning-Attribution, and are moderate in expression of Executive Functions" (p. 240). Meaning attribution emerged as an especially important aspect of this research, a dimension that has also been strongly supported by other studies (e.g., Shechtman & Toren, 2009). This leadership style highlights the importance of a cognitive element within group counseling. By attending to this element, leaders and members are able to make sense of what is occurring in the group and to consider implications for members both within and outside the group setting. Furthermore, this study demonstrated that there are qualities of leadership that are detrimental to the group as well as qualities that are beneficial. Less effective leaders in the Lieberman et al. (1973) study were "very low or very high in Stimulation, low in Caring, do [did] very little Meaning-Attribution, and displayed too little or too much Executive behavior" (p. 240).

In two comprehensive reviews, Dies (1983, 1994) highlighted the results of studies that make evident the importance of a positive therapist-client relationship. He cited investigations that addressed open-ended or "nonmanualized" leadership approaches that correlated with process-outcome variables. Included in this are important aspects of the therapeutic change process, including providing a context or framework that is meaningful for clients, having the proper amount of structure in the therapeutic sessions as it relates to group member's clinical problems, and ensuring a safe climate for change. These leadership styles can promote the therapeutic conditions for productive member interactions and lead to positive treatment outcomes.

Burlingame and Fuhriman (2002; Burlingame, Fuhriman, & Johnson, 2004) also noted the importance of the therapeutic relationship, stressing its complexity. They include the therapist, group members, and members' interactions as well as in-therapy feelings, attitudes, and behaviors. They suggest that the therapeutic relationship includes the alliance or bond, which can be facilitated through therapeutic interventions, and therapeutic factors such as processes that contribute to overall clinical change. Although this is one of the more recent major contributions in the area of group work, other researchers in the field have also commented on the role of the leader in group counseling.

Based on a long career as a researcher as well as clinician, Yalom and Leszcz (2005) provided a clear description of the group leader's purpose in therapy. He described an effective leader as one that allows group members to interact with each other, thereby acknowledging the importance of naturally occurring therapeutic forces. Thus, the leader's role is to aid the group in the maximization of these therapeutic forces through the utilization of specific interventions and techniques at appropriate times during the course of the group. Dies (1983), after reviewing a large body of research literature, similarly concluded that while the role of the leader is important, it is the interaction among group members that has the most impact on individual change. Therefore, a critical task of the leader is to encourage and facilitate meaningful member interaction. Dies (1994) outlined a summary of leadership and group research that sheds light on the fact that certain therapeutic elements, such as the need for leaders to provide a climate for change, to define treatment goals, and to recognize the impact of client behaviors, all provide some answers as to what is occurring therapeutically in the group.

Group Cohesion

Group cohesion is an important foundational element to a successful group experience. Once it is established, leaders may then be able to develop other therapeutic factors that require more member risk taking, including catharsis and insight-oriented elements. Also, group cohesion and the working alliance seem to be closely related elements of therapeutic change within groups. Kivlighan et al. (2000) discussed the research on leadership styles and concluded that less controlling leaders tended to have more cohesive groups. One caveat to this finding is the myriad of variables and therapeutic elements that contribute to an overall successful group. Any one element contributes to a partial understanding but does not describe the entire picture.

Feedback Exchange

An additional skill that is important for the group leader to be able to facilitate and manage is interpersonal feedback. Feedback that occurs between members of a group is essential for both group development and the interpersonal growth of the members. The self-reflection and insight that is promoted through feedback exchange allows members to better understand themselves and what is necessary for personal growth and behavior change (Davies, Burlingame, & Layne, 2006; Morran, Stockton, Cline, & Teed, 1998). Thus, a comprehensive training program will need to include specific instruction and practice to enable leaders to effectively give feedback and to promote effective member-to-member feedback exchange.

Feedback occurs when both members and leaders share, with each other, their personal reactions and insights about one another (e.g., pointing out a tendency to belittle one's own accomplishments or pointing out a tendency to always agree with the leader). Morran et al. (1998) reviewed a series of studies on feedback exchange and concluded that in early sessions positive feedback should be emphasized, with a balancing of both corrective and positive occurring in later sessions. When feedback is delivered, a positive-corrective or positive-corrective-positive sequence of delivery is recommended. These exchanges should focus on observable and specific behaviors, while considering the readiness and openness of the receiver. Group leaders should also model feedback exchange to group members, as they encourage them to engage in the process. The process of feedback exchange affords members the opportunity to view their behavior from new perspectives and to make meaningful behavior change in the context of the group, thereby hopefully promoting the transfer of this interpersonal insight into everyday life. Group leaders should therefore be knowledgeable about the role of feedback exchange as a potentially therapeutic factor if done properly.

Feedback exchange in training groups is also a key component of leader training. Coleman, Kivlighan, and Roehlke (2009) reported the findings of two related studies that were conducted to develop a taxonomy of the types of feedback given by peers and instructors in group supervision. Their results identified two first-order clusters (task/technical and personal/relationship feedback) and four second-order clusters (task, technical, support, and affective feedback). They concluded that peers were more likely to provide feedback on the technical aspects of leader performance than on the leader's personal qualities and trainee leaders found positive feedback to be the most acceptable. They recommend that supervisors be aware of the reluctance of peers to provide personal/relationship- focused feedback and work to counter this tendency. They also hypothesize that trainees will be more open to all types of feedback when there is intentional inclusion of positive feedback.

Group Leader Cognitive Skills

In recent years, research has increasingly focused on group leader trainees' cognitions and knowledge structures. Hines, Stockton, and Morran (1995) conducted a study that examined the cognitions of novice and expert group leaders. After viewing several video vignettes, leader cognitions were recorded and sorted into 17 thought categories. It was found that two of the cognitively complex categories, group process and internal questioning regarding member interpretation, accounted for 56% of the variance in leader experience level. In a later study, Stockton, Morran, and Clark (2004) used stimulated recall to collect and assess the intentions of 34 group leaders in relation to their therapy group interventions. Multidimensional scaling revealed four intentions clusters, including promoting insight/change, planning and guiding, attending, and assessing growth. It was hypothesized that the four intensions clusters relate to recurring functions whereby leaders attend to what is happening with individuals and the group as a whole. Careful attending allows the leader to accurately assess group dynamics and member functioning, which in turn aids in the development of meaningful plans for guiding and focusing the group. Leaders can then act on their plans to facilitate member insight and change.

In a series of related studies, Kivlighan and his associates (Kivlighan & Kivlighan, 2009; Kivlighan, Markin, Stahl, & Salahuddin, 2007) compared changes in the knowledge structures of group leader trainees and their convergence with the knowledge structures of experienced group leaders between early and late group phases. The training protocol included providing trainees with immediate access to experienced group leaders with live modeling of leader techniques, live feedback on trainees' performance, and real-time access to experienced group therapists' conceptualizations of group dynamics and processes. From these two studies, Kivlighan and Kivlighan concluded that training focused on developing knowledge structures helps novice group counselors acquire, over a relatively short time period, a more complex and hierarchical view of group leader interventions that is similar to that of experienced leaders. In a follow-up study, Kivlighan and Kivlighan (2010) found that the development of such knowledge structures (e.g., more complex, hierarchical, and circular thinking patterns) in trainees was associated with increased group member satisfaction.

Best Practices

In the process of determining best practices for the training of group leaders, it is important to consider existing training models and the related research base. As was noted earlier, significant gaps still exist concerning our knowledge of the best methods for training both beginning and advanced group leaders. However, the training models and research findings reviewed in this chapter do suggest a number of elements and activities that should be considered in designing a group leader training approach. However, it is important to remember that novice leaders are not "empty vessels," who simply need to absorb knowledge and experiences. Before developing a curriculum for leadership, instructors should pay attention to general principles of learning as well as the emotional aspects (anxiety) associated with acquiring new knowledge.

Even though theorists sometimes differ on which aspects of training are most significant, there is still a high degree of convergence on what are considered to be the basic training components for group counselors; these include (a) theoretical and practical knowledge through the presentation of didactic material, (b) opportunities to observe groups in action and to learn and practice specific group skills before actually leading a group, (c) participation in a personal growth group experience to promote personal development and to provide trainees with the opportunity to observe group development from a members' perspective, and (d) practice in leading or coleading a group under close supervision (Stockton & Toth, 1996).

Research findings and expert opinion also suggest a number of trainee experiences that should precede or be embedded within the four basic training components outlined above. Before group leader training begins, trainees should be well grounded in the theories and basic skills of individual counseling. Specific measures should be taken to help trainees address and cope with the normal anxiety that comes with leading a group. Group microskills should be studied, modeled, and practiced with a gradual progression from basic skills to more advanced skills. Finally, in addition to performance feedback, supervisors should share with trainees, on an ongoing basis, their cognitions related to critical events in the group, alternative hypotheses about underlying dynamics, possible action plans for activating therapeutic forces, and related thinking processes. This type of expert cognitive modeling is likely to be very helpful as trainees attempt to develop their own cognitive maps for effectively intervening in the group process.

Stockton's (1992, 2009) PSR model, outlined in some detail earlier in this chapter, represents an attempt to combine research findings and expert opinion into a single integrated training model. While there is general agreement about the necessary components for group leader instruction, there are differences in emphasis. At this point in time, we simply don't have answers to the proper sequencing of (didactic) information and experiential learning. Clearly, leaders benefit by having comprehensive knowledge about what goes on in groups, thereby allowing them to make appropriate interventions. Some of this will be gained through didactic means, and some will be gained through practice whether it is simulated or in an actual group.

In addition to preparing knowledgeable and skilled group leaders, training programs must also incorporate training in multicultural diversity and social justice issues. Additionally, training programs must deal with dual relationship concerns as they provide supervision for trainees' group experiences. These issues are addressed in the sections below.

Training in Multicultural Diversity and Social Justice

There is an increasing emphasis on issues of diversity, competency, social justice, and cultural responsiveness in the training and supervision of group leaders (e.g., Brown, 2009, 2010; Fernando & Herlihy, 2010; Ibrahim, 2010; Okech & Rubel, 2007; Paisley, Bailey, Hayes, McMahon, & Grimmett, 2010). Bemak and Chung (2004) stressed the importance of training "aware, competent and highly skilled multicultural group counselors at the graduate level" (p. 32). Seventeen specific recommendations for teaching multicultural group counseling are provided and include, for example, infusing Multicultural Counseling Competencies and Standards into training, understanding racial identity development of group members, and understanding how to adapt group theory and technique to a particular culture.

While these are laudatory goals, as Brown (2010) has noted, the research base regarding the efficacy of these methods has not been explored in depth. This makes it difficult to decide how to utilize these worthy goals to ensure good practice. Nevertheless it is important to develop cultural awareness and sensitivity in counseling procedures, including group work. As MacNair-Semands (2007) noted, as group psychotherapists become more sensitive to potential or actual ethical challenges in their practices, they must process information with the depth and complexity necessary to respond with integrity and skill.

Ethical Dilemmas in Experiential Groups

There are a number of issues that confront those who supervise experiential group training. A frequently discussed issue is the problem of dual relationships when a supervisor of an experiential group has the responsibility of evaluating the trainee (Anderson, Gariglietti, & Price, 1998; Gumaer & Martin, 1990; Lloyd, 1990; Merta & Sisson, 1991; Merta, Wolfgang, & McNeil, 1993).

The current ASGW "Professional Standards for Training of Group Workers" (2000) require that "Core training shall include a minimum of 10 clock hours (20 clock hours recommended), observation of and participation in a group experience as a group member and/or as a group leader." Consistent with CACREP standards for accreditation, the supervised experience provides the student with direct experiences as a participant in a small group, and may be met either in the basic course in group theory and practice or in a specially conducted small group designed for the purpose of meeting this standard (CACREP, 2009, Section II, Standard G.6.e). In arranging for and conducting this group experience, care must be taken by program faculty to ensure that the ACA ethical standard for dual relationships and ASGW standards for best practice are observed.

Shumaker, Ortiz, and Brenninkmeyer (2011) surveyed 82 instructors of master's-level group counseling and psychotherapy training courses in order to determine current training practices and student outcomes. Their results suggested that 90% of such training programs utilize experiential groups as part of training; there is an increased appreciation of the potential for dual-role dilemmas and negative student experiences to occur; and there was a relatively modest frequency of problematic student real-world outcomes reported. Results also indicated that about a third of the training programs relied on instructors to teach both the didactic and experiential portions of the course while in almost half of the programs someone other than the instructor conducted the experiential portion of the course. They also concluded that, in comparison to past survey results, training programs appear to be more aware of pertinent ethical issues and to provide more safeguards for student group members.

There is always a fine line between providing for experiential activities and safeguarding against learning information that may be used in an evaluative capacity. In commenting on this, Lloyd (1990) stated "if participating in counseling demonstrations, group activities and supervision experiences (which include some elements of counseling) are the best training methods available, should the student be denied this opportunity because of the possibility of a dual relationship ethical violation?" (p. 86). Of course, at this time, there is little research as to precisely which training methods are most effective. Ethical guidelines as they apply to this issue are, without doubt, extremely complex. This type of training has similarities with the role of counselor educator as a clinical supervisor whether in individual or group counselor training. Both roles require constant monitoring of boundaries, dual-relationships, and maneuvering through the fine distinctions that may become blurred. It is critically important that those in a position of power (by definition supervisors) understand that they have special ethical obligations to adhere to so that training opportunities will be ethical and efficacious.

The ACA standards (2005), particularly Standard F.7.b on self-growth experiences, state that "Evaluative components of experiential training experiences explicitly delineate predetermined academic standards that are separate and do not depend on the student's level of self-disclosure." There are a variety of opinions on this controversial topic. For example, Goodrich (2008) addressed the issues surrounding the group course instructor also serving as group facilitator for students' experiential groups. He concludes that the literature challenges the assumption that such dual relationships must be inherently bad and asserts that such relationships can offer benefits to students' personal and professional development by "allowing them to work through ethical concerns, and serve as exercise in critical thinking" (p. 233). However, it remains true that students are well aware that they can be judged and potentially eliminated from the program based (at least in part) on how they interact in the group situation if the professor observes their experiential group activities.

Some of the dilemmas in this situation can be resolved. Forrester-Miller and Duncan (1990) suggested four possible solutions. First, there is the possibility of using students who are post-master's as supervisors (the implication here is that these students would not be in a power position). Second, the instructor may use a system

in which the students make observations about the group process they have taken part in and uses numbers as identification on the written assignment. Third, instructors require trainees to participate in a counseling group run by a group leader external to the training program. Fourth, they suggest utilizing role-plays.

Merta et al. (1993) offered alternatives, including simulated exercises, having a self-directed group, and having a leader observe but not lead a group. Instructors may also choose to utilize group leadership training videos where, after viewing, students can actively participate in discussions. The first author of this chapter often focuses on specific vignettes after the students have had the chance to view an entire videotape. There are a number of group leader training videotapes available. ASGW has sponsored several of these. Videotapes can be purchased through the American Counseling Association or commercial publishers. It is most important that students do have numerous opportunities to interact with others regarding the various roles that are present in actual counseling groups. This may be achieved through small group simulations, class discussions and other didactic materials. What is important is that students feel comfortable with themselves and in their interactions with others. Group experiences can enhance this and should be encouraged in a variety of ways.

Conclusion

Those designing group training curriculum are also faced with limitations, including resources, time, and others, which vary by program. It is important for instructors to realize that effective group leadership will not be taught in a one semester course. However, having a single course can provide very effective group leader instruction, depending on how the rest of the curriculum is constructed and sequenced and what other opportunities are presented to the beginning leader. Depending on the resources, both human and material instruction can address a variety of approaches that will help ensure that best practices are incorporated into leadership training. Further research may well reveal an "ideal" group leader curriculum; however, the vagaries of real-world constraints will always impinge on any design and continue the need for reflexive and adaptive planning. The concept of multiple means to achieve the same end is an important concept.

Although this chapter has focused on training beginners in group leadership skills, there is also clearly a need for a focus on how to move from beginner status to intermediate and advanced levels of practice. These training experiences should allow for the chance to develop specialized skills, techniques and theory bases that allow the trainee to both deepen and broaden their skill base. For example, developing support groups for adolescents or addictions groups requires integration of specialized skill and knowledge bases to overlay onto preexisting conceptual schemas.

Therefore, to develop and work toward expert status, trainees should also be moved toward a model where they have opportunities for informed, reflective practice. The need for supervisory feedback to help integrate new knowledge bases with underlying conceptual bases is arguably the most important piece of the process of moving to expert status. Without this reflection and questioning, group leaders run the risk of falling into conceptual and cognitive ruts that result in inflexible and unresponsive practice. Without opportunities to learn from emotional and cognitive responses to new situations and ways to integrate previous schemas, the dangers of stagnation are clear.

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Chapter 12 Supervision of Group Leaders

Maria T. Riva

Supervision of group counseling is an essential component of training group leaders as well as overseeing the quality of care for those members who participate in counseling groups. Surprisingly, supervision of groups has received only a small amount of attention in either research or theory. The research body on supervision of groups is reminiscent of how previously group counseling literature was about 20 years behind the individual counseling literature. Group psychotherapy research has made impressive strides in catching up to the research on individual psychotherapy with evidence that now suggests many positive group outcomes for specific types of problems and at times, that group therapy is more effective or as effective as individual therapy (see Burlingame, Whitcomb, & Woodland, 2014). There has been more attention to supervision of individual therapy in general and on group supervision of individual therapy more specifically. Both of these areas offer some guidance to supervisors who are responsible for assuring that group leaders are providing beneficial treatment to their group members. Although the theory and research literature on supervision of group leaders is in its infancy, positive strides have been made with the outlining of competencies for entry-level group leaders. Recently, Barlow (2012) outlined group adaptations to the general competencies being used for the field of professional psychology and underscored additional competencies that are specific for group treatment. With the increased usage of counseling groups, it is essential that we are training effective and ethical group facilitators. Many group leaders have limited (or no) training in group leadership, and with the large number of new counseling professionals entering the field who will very likely be required to conduct counseling groups, competent and ethical supervisors are also necessary.

This chapter underscores the importance of supervision for leaders of therapeutic groups. It begins by defining terms that are often confused in the group therapy and supervision literature. The next section discusses the recent focus on competencies for entry level group therapists. The chapter then highlights briefly the literature on supervision of individual therapists, touching on important areas such as the supervisory relationship, the relationship between supervision and improved client outcomes, and the benefits of cognitive complexity for supervisees. The next section describes the limited research on the supervision of group leaders and the complexities of group counseling that impact the potential focus of supervision including the format and theme of the group, the support given by the supervisor, the high anxiety levels of early group leaders, parallel process, and countertransference. The following section addresses the models of supervision of groups with a brief overview of the theories related to supervision of individual therapists and discusses related literature on supervision in a group format that generally addressed supervisees' individual clients (i.e., group supervision) and supervision with a supervisee who has individual clients (i.e., individual supervision). The chapter concludes with recommendations for future research on supervision of group leaders.

Clarifying Terms

In this chapter, group counseling, group therapy, group psychotherapy, and group work are used synonymously. The terms group facilitators, group leaders, group counselors, group therapists, and group workers are also used interchangeably. When referring to the supervision of groups, the literature often incorrectly described it as group supervision. In this chapter, supervision of groups relates to supervision of group leaders. This may occur with a supervisor who is providing supervision with coleaders of a group (sometimes called triadic supervision), with an individual group leader, or in a group format with group leaders (group supervision of group leaders). Group supervision is defined as supervision within a group context with therapists who see individual clients. All of these types of supervision are discussed later in the chapter.

Group Work Competencies and the Need for Supervision

Yalom and Leszcz (2005) viewed the supervised clinical experience as the "sine qua non in the education of the group therapist" (p. 548). The importance of supervision for group work cannot be disputed given the complexities in conducting group therapy that are beyond those of individual therapy. Added to the intricate nature of group leadership is the concern that although group treatment is being used more frequently across all types of therapeutic settings, master's programs in counseling typically require one basic course in group counseling while doctoral programs frequently have no required course. The current model of training typically places a large focus on individual therapy skills, which of course is important. Yet individual therapy skills do not easily translate to group therapy and, without training specifically in group dynamics, group process, and other ingredients specific to groups (i.e., confidentiality, group goals, etc.), many practitioners do not have the prerequisite skills to effectively facilitate a therapy group (see Stockton, Morran, & Chang's chapter in this *Handbook*). With so many groups being conducted in the field and so few resources going to training group leaders at the graduate level, it seems essential to provide oversight and skill development to group facilitators through supervision specifically on their groups. In order to provide effective supervision, it is necessary to understand what skills and knowledge are needed to help support the effectiveness of the group leaders. Supervising group leaders, then, requires a deep understanding of both supervision and of group treatment (Riva, 2011).

One problem that parallels the limited graduate training available in group counseling is the total lack of information on how often supervision of groups is actually offered and how it is practiced. From my observations of supervisory practice, "most group leaders receive little supervision on their group-counseling facilitation. It is also typical that if supervision of groups is provided, the primary focus is on problematic clients and not on the group dynamics. Similarly, if the counseling group has coleaders, minimal time is spent during the supervision session on the coleader relationship" (Riva, 2011, p. 370).

In a recent article, Barlow (2012) outlined the developing role of competencies in psychology practice in general and individual psychotherapy practice more specifically. Competencies are subdivided into knowledge based and those that are applied. Barlow discussed the need to adapt these competencies to group psychotherapy and to develop additional competencies that are unique to group psychotherapy. One of the competencies for entry level psychologists is the knowledge needed for training and supervision of group leaders. Examples of *knowledge-based competencies* that entry-level group psychologists should have when doing training and supervision are information related to the development of moving students from novice to experienced group leaders and knowledge about how to match supervisory strategies with the level of skill and/or development of the trainee or supervisee.

Stoltenberg and others (e.g., Stoltenberg, McNeil, & Delworth, 1998) provided a context for supervisors to assess the level of their supervisee in order to match supervisory methods with supervisee skill and developmental level, yet no similar description has been delineated for group facilitators. It is highly likely and probably often the norm that someone could have a very high level of skill and development in individual therapy but have a low level in areas required to lead a group. For example, group leaders need to attend to several people with varying verbal and nonverbal cues. It is unlikely that training in individual psychotherapy will prepare new group leaders to track the multitude of reactions that rapidly occur in the group process. Barlow summarized some of the expected skills in the applied competency area of training and supervision for entry-level group psychologists. For example, they should be able to provide training to others in norm setting, stages of group psychotherapy, and be able to actively participate in the supervisory process of observing actual group sessions, along with using other methods such as video and audiotapes, transcripts, and role-plays to observe the supervisee facilitating a group. Group psychologists should be competent in helping group trainees understand and implement interventions that are directed to both content and process. Legal and ethical considerations in group work are essential competency areas that need to be highlighted here as they pose complex dilemmas that are different from those in individual therapy (see Rapin, 2014).

Even prior to the competency movement in professional psychology, the Association for Specialists in Group

Work (ASGW) developed the developed the "Best Practices Guidelines for Group Work," which was revised in 2007. The document specifically stipulates knowledge and skills for group leaders. In a 1983 document and the 1990 updated version, ASGW promoted professional standards for the training of group workers. The 1983 ASGW Training Standards established nine knowledge competencies, seventeen skill competencies, and a stated amount of hours for various aspects of supervised clinical experience in group counseling. The 1990 revision built on the earlier core competencies to describe specialty competencies.

Both of these competency models for group leaders hold that counselors leading groups can develop over time from novice to those more experienced, that skill development is ongoing, and that supervision plays a large and important role in this growth. The ASGW training document, for example, outlined expectations for group leaders such as "Group workers remain current and increase knowledge and skill competencies through activities such as continuing education, professional supervision, and participation in personal and professional development activities" (ASGW, 2007, p. 4). They also acknowledged that group leaders are expected to "seek consultation and/or supervision regarding ethical concerns that interfere with effective functioning as a group leader" (p. 4). All of the current best practice guidelines are based on clinical knowledge and practice from experienced group leaders and from literature in the group field. Research on the topic remains quite limited (DeLucia-Waack & Fauth, 2004; Rubel & Okech, 2009). Core competencies for group workers are a prime area for future research and could address, for example, the supervisory relationship over time, or the best strategies to increase skill level in early group leaders.

Supervision of Individual Therapy Applied to Group Therapy

Supervision of individual counseling offers some direction to the supervision of group counseling in several important areas, including the role of supervision and responsibilities and ethical considerations of supervisors. Bernard and Goodyear (2009) stated that supervision "provides a means to impart necessary skills, to socialize novices into the particular profession's values and ethics, to protect clients, and finally to monitor supervisees' readiness to be admitted into the profession" (p. 3). Falender et al. (2004) noted that supervision is seen as one of the most important components in training individual psychotherapists and necessary to establishing competencies. A commonly used definition of supervision is "an intervention provided by a more senior member of a profession to a more junior member of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession" (Bernard & Goodyear, 2009, p. 7).

There is considerable agreement in the literature that being a good therapist is a critical but not sufficient ingredient in being a competent and ethical supervisor. Similarly, being an effective group therapist will not result in competency in supervising group psychotherapy. Supervision is now a regular component of doctoral programs in professional psychology and there is awareness by many licensure organizations that developing supervisory competence requires specialized training and experience.

The Supervisory Relationship

The purpose of supervision is two-fold: to foster the professional development of the supervisee and to ensure the welfare of the clients (Bernard & Goodyear, 2009). Of course, these two foci are not mutually exclusive and are interconnected. A positive alliance between the supervisor and the supervisee who is seeing individual clients is vital and has strong research support (e.g., Ramos-Sanchez et al., 2002). In fact, building an alliance between the supervisee and supervisor is *the* task of early supervisory sessions (e.g., Nelson, Gray, Friedlander, Ladany, & Walker, 2001). A strong supervisory relationship allows the process of supervision to begin and the supervisee to better hear corrective feedback that is an essential aspect of supervision. Supervisors often need to provide sensitive information to their supervisee about the need for increased skill in some areas, impasses between the supervisee and a client, "and the supervisee's personality characteristics that may prevent counseling interventions from succeeding" (Riva, 2011, p. 372). Yet Hoffman, Hill, Holmes, and Freitas (2005) found that corrective feedback was not easy for supervisors to give to their supervisees. It appears that formative feedback (addressing gaps in skill level such as needing practice on time management in a group) seems considerably easier for supervisors than is summative feedback, which says more about how the supervisee is doing (Bernard & Goodyear, 2009), such as when the supervisor needs to address a supervisee's high level of anxiety that interferes with group facilitation. Trust is the critical element of a strong supervisory relationship. As can be imagined, even with a strong supervisor-supervisee alliance and a supervisor who has carefully developed a trusting relationship, these conversations can be tricky with a supervisee who has some real counseling skill deficits. Trust evolves across time in the supervisory relationship from an accumulation of what might seem like small and also larger supervisory behaviors and responses. Supervisors can begin the process by being on time for supervision, providing a safe environment for discussing both successes and failures, offering a balanced approach of positive messages and corrective feedback, showing respect even when delivering difficult messages, and appreciating the power differential that accompanies supervision. Since supervisors are more advanced than their supervisees and have not been a novice counselor for many years, it is often easy for supervisors to forget what it was like to be highly anxious, struggle with confidence, and be intimidated by many aspects of the counseling process. Supervisors who can communicate to their supervisees that these behaviors are normal will go a long way to ease apprehension and build trust.

The Relationship Between Supervision and Client Outcomes. It is expected that supervision increases supervisee skill and then would impact client outcomes although the relationship between supervision and client outcomes has rarely been measured systematically. In a review that spanned two decades (1981–1997), Freitas (2002) found only 10 studies that looked at whether clinical supervision resulted in improved client outcomes. Each of these studies had several methodological limitations. More recently, Bambling, King, Raue, Schweitzer, and Lambert (2006) compared supervised and unsupervised therapists on several variables including level of depression yet found no differences between the two groups of therapists and both groups showed positive client outcomes. Callahan, Almstom, Swift, Borja, and Heath (2009) found that supervision was moderately positively related to client outcomes when looking at archival data for 76 discharged clients. Results showed that 16% of the variability in outcome was accounted for by supervision after taking into account the clients' beginning severity level and therapist characteristics. The main purpose for conducting supervision is to provide effective care for clients and it is vital for the field that this avenue of research increases and begins to identify specific supervisory variables that relate directly to increased client outcomes. At this point, no research has looked at the supervision of group leaders and relationship to positive gains for the group members.

Cognitive Complexity of the Supervisee. A key component in supervision appears to be the cognitive complexity of the supervisee. Current research suggests that supervisees who have higher levels of cognitive complexity are more satisfied with supervision and have more positive working alliances with their supervisors (Ramos-Sanchez et al., 2002). High cognitive complexity allows inexperienced counselors to deal better with the intricate aspects of the counseling process. Taking this a step further, cognitive complexity would seem to be even more important in supervising group leaders due to the multilevels that are the norm in facilitating a group. Group leadership requires the ability to see the "forest for the trees," to see themes emerge without getting bogged down in all of the content that occurs in a group. Kivlighan and Kivlighan (2009) found that early group trainees' knowledge

structures were linear and simplistic compared to their more experienced counterparts. Supervision then may need to look to ways to increase the cognitive complexity of supervisees.

One model that addresses supervision of group counseling specifically by Granello and Underfer-Babalis (2004) matches the characteristics of Bloom's *Taxonomy of Educational Objectives* (i.e., knowledge, comprehension, application, analysis, synthesis, and evaluation) with the developmental stage of the group trainee in order to increase cognitive complexity. For example, in the earliest level, Knowledge, supervision might concentrate on learning the meaning of terms that are used in the counseling profession. When supervisees are able to move to the Synthesis level, supervision would focus on integrating different skills or information from multiple disciplines. Although there is no research on methods to increase cognitive complexity for group supervisees, supervisors who match the techniques used with the skill level of the supervisee would intuitively have a better chance of increasing the complexity of how they think about the counseling process. It may make sense, for instance, for beginning group leaders to start with leading highly structured groups. Once their confidence and skill level increases and their anxiety decreases, it seems reasonable that they could tolerate a less structured group counseling experience.

Supervision of Group Leaders

Group leadership requires a multidimensional focus that centers on dynamics that occur between member to member, member to leader, and for the group as a whole. Group leaders need to understand and respond to limitless situations that are beyond the scope of individual therapy. Some of these complexities surround such considerations as group selection, norm setting, breeches of confidentiality, responding to group members who monopolize or verbally attack another member, developing group cohesion, developing trust across membership, and the termination stage of the group, just for starters.

Supervision should play a vital role in the education and training of group leaders. The ASGW underscored in its *Professional Standards for the Training of Group Workers* (2000) specific requirements for the education, training, and supervision of group facilitators. These standards address the assessment of leader skills and interventions, the development of the counseling group within and across sessions, and the positive gains of the group members. These *Professional Standards* (1983) along with the ASGW *Best Practice Guidelines* (2007) provide core and specialist training expectations for different types of groups (e.g., psychoeducational, counseling) and at various points in the group process (i.e., planning, performing, and processing). These documents can serve as guidelines for supervisors who supervise group leaders.

Type of Group

Supervisors will need to know information about specific types of groups that require leaders to vary, for example, in their decisions about the amount of structure and group process that they use. As an example, the ASGW outlined four general types of groups: task, psychoeducational, counseling, and psychotherapy (Conyne, Wilson, & Ward, 1997). Psychoeducational groups typically are skill based, brief (e.g., six sessions), and closed to new members after the initial session. Effective leaders are those who are skillful at managing time, are able to redirect the focus of the session when appropriate, provide considerable structure to the group, and are competent at helping members set clear, specific, and concrete goals (e.g., parent training group). Counseling groups are geared toward the improvement of interpersonal relationships and the intrapersonal growth of members (e.g., groups for dealing with a trauma). Psychotherapy groups generally address more severe problems, and the format is often longer term and possibly open-ended (e.g., groups for persons with obsessive compulsive behaviors). "Counseling and psychotherapy groups require group leaders who use the dynamics of the group as learning opportunities for the members and who can deal with conflict that occurs more often in these types of less structured groups" (Riva, 2011, p. 373).

Supervisor Support

Consistent with the literature on supervision for individual therapists, the supervisor's behaviors are crucial to developing a strong supervisory alliance. One major element in a strong supervisory relationship is support by the supervisor. Supervisees who were satisfied with their supervisory relationship felt supported by their supervisors and saw them as empathic. Conversely, those trainees that were dissatisfied with their supervisors felt unheard, criticized, and saw supervision as unhelpful (Leszcz & Murphy, 1994). In interviews with supervisors of group leader trainees, Okech (2009) found that supervisors saw support as one element that was related to the supervisee's progress as a group leader.

Competence to Work with Diverse Group Members

One of the strengths of group counseling is that group members can interact with persons from different backgrounds, cultures, sexual orientations, and those who have diverse views on such areas as religion and politics. This is an asset when group members are working on interpersonal relationships or when, for instance, they are working on being more tolerant, or less judgmental. With a multicultural and diverse group membership, members can address their biases, begin to understand the roadblocks in their relationships, or learn to appreciate their own diverse views and gain confidence in expressing their own views assertively and with respect. Supervision is thought to play a major role in the development of diversity-competent group leaders (Okech & Rubel, 2007). Understanding the need for group leaders who can respond effectively to diverse group members, the ASGW (1998) provided the "Principles for Diversity-Competent Group Workers," a guiding document that states:

> Issues of diversity affect all aspects of group work. This includes but is not limited to: training diversity-competent group workers; conducting research that will add to the literature on group work with diverse populations; understanding how diversity affects group process and dynamics; and assisting group facilitators in various settings to increase their awareness, knowledge, and skill as they relate to facilitating groups with diverse memberships. (p. 7)

This document highlights the expectation that group facilitators should be competent in responding to diverse group members and directs supervisors to oversee that group leaders are competent at encouraging and addressing diversity that is broadly defined. The document underscores the need for honoring differences. For example, it states that "diversity competent group workers demonstrate movement from being unaware to being increasingly aware and sensitive to their own race, ethnic and cultural heritage, gender, socioeconomic status (SES), sexual orientation, abilities, and religion and spiritual beliefs and to valuing and respecting differences" (ASGW, 1998, p. 7). In order for the supervisory process to aid group workers along this continuum, the supervisor needs to be diversity competent as well.

Supervisee Anxiety

Twenty years ago, Leszcz and Murphy (1994) described group therapists as fearing that they would lose control, look incompetent, and feel bombarded by the vast amount of information that occurs within a counseling group. It is not surprising that research has found that beginning group leaders feel overwhelmed and have negative emotional responses in their initial experiences in leading a group (Murphy, Leszcz, Collings, & Salvendy, 1996). Being a group leader for the first time can be a very intimidating experience for novice group leaders and leaders-in-training (Stockton et al., 2014). It is vital for supervisors to be sensitive to, acknowledge, and normalize the high anxiety experienced by early group leaders and allow them to express their feelings and concerns in a supportive and safe supervisory atmosphere.

Parallel Process and Countertransference. These two terms, *parallel process* and *countertransference*, originally derived from psychoanalytic theory are often addressed in supervision. Friedlander, Siegel, and Brenock (1989) described parallel process as unfolding when "supervisees unconsciously present themselves to their supervisors as their clients have presented to them" (p. 149). Some authors view parallel process as more common during times of stress and conflict (e.g., Etgar, 1996). Supervisors can encourage their supervisee to understand and address the parallel process that has been transferred from the group counseling process into the supervisory relationship. A common example and noted many times by this author is when a supervisee has a group member who is experiencing a critical situation such as being evicted from his apartment. The group member is frantic with worry and expresses these concerns in the counseling group. While discussing the group member in supervision, the supervisee talks in an urgent manner looking to the supervisor for an immediate solution. The supervisee's behavior mirrors that of the group member. If the supervisee is able to process this parallel process during supervision, the group leader will be able to be more effective at addressing the client's anxiety in the following group sessions. The group leader might say to the group member at the next session, "When you get so concerned, you begin to talk very fast and it makes it harder for you to think clearly. How about you slow down and we can help you look at your options."

Corey and Corey (2002) and Yalom and Leszcz (2005) talk about countertransference as the group facilitator's irrational response toward a group member that is generated from the group leader's unresolved personal issues. Countertransference reactions are often provoked by early childhood concerns such as those responses to authority, anger, control, etc. (e.g., Delucia-Waack & Fauth, 2004; Halpern, 1989). In order for the supervisor to manage countertransference effectively, a strong supervisory relationship is needed. Several authors have suggested that identifying and exploring countertransference within a supportive supervisory relationship is the best avenue for addressing this phenomenon (Kleinberg, 1999; Murphy et al., 1996). As an example, a supervisee states several time in supervision that "I do not like to be told what to do." When a group member says to this leader, "you need to help us more," the group leader becomes defensive and angry. The supervisor suspects that this response is really about the supervisee's difficulty with authority. The supervisor asks whether the supervisee has had this reaction before and explores why this statement by the group member resulted in this strong response.

Another way that countertransference can play out in the supervisory relationship is in the supervisor's response to the supervisee. Ladany, Constantine, Miller, Erickson, and Muse-Burke (2000) described it as "a complex and inevitable process that involves unconscious and exaggerated reactions stemming from a supervisory interaction customarily related to the supervisor's unresolved personal issues or internal conflicts" (p. 102). Given the potential for countertransference to occur for supervisees with several group members participating in the group therapy, supervisors will need to be aware of this phenomenon and also notice when it happens in their own responses to their supervisees.

Theoretical Models of Supervision

Theories or models of supervision help to provide an organizational system for large amounts of data as well as providing direction on how to conceptualize the interactions that occur in supervision and the supervisory relationship. Bernard and Goodyear (2009) discussed several models of supervision including three broad categories: psychotherapy, developmental, and social models. The developmental and the social role models were designed specifically with supervision in mind, although several theoretical orientations under the psychotherapy model are regularly used in supervision (e.g., psychoanalytic, cognitive-behavioral). Supervision generally incorporates several aspects of each of these models. Presently, no model addresses the complexities involved in supervision of groups. For an overview of the models of supervision, see Bernard and Goodyear (2009).

Models Specific to Supervision of Groups

Some models and methods commonly used for supervision of individual psychotherapy are relevant for supervision of groups. Yet as Barlow discussed with regard to group psychotherapy competencies, supervision of groups does pose several unique aspects that are not addressed in the individual psychotherapy models of supervision. Almost 15 years ago, Kleinberg (1999) pointed out that little attention has spotlighted supervision of group leaders specifically. This description continues to be the status of the literature in this area. The following section provides information on four often used methods of supervision of group leaders. These models differ as to who is included in the supervision sessions. One model occurs when supervision takes place with one group leader. For many groups, there are coleaders that could result in the supervisor meeting with the coleaders together. Another commonly used method of training and supervising group leaders is what Leszcz and Murphy (1994) defined as *dyadic supervision.* This occurs when the supervisor coleads a counseling group with the supervisee. A fourth option is for a supervisor to meet with several group leaders in a group format known as "group supervision of group leaders." Each of these four supervisory methods is described in the following sections.

Supervision with a Group Leader or Coleaders

The process of supervision entails many different functions. Bowman and DeLucia (1993) suggested that supervision has three main areas of attention: client (or group as a whole) conceptualization, skill development, and attention to intrapersonal and interpersonal responses by the group leader that would obstruct his or her ability to lead an effective group. Case conceptualization typically is a presentation by the supervisee that includes a description of the group and the group members, the theme, group format, the group dynamics includes the content of the group material, the dynamics of the group, and so forth. With an understanding of the group and the group process, the supervisor can aid the supervisee in gaining the requisite skills needed to facilitate a counseling group. There are many challenges for an early trainee, including how much structure to provide to the group, how to redirect a group member or the group when it veers off topic, how to sit with silences, setting clear norms and goals, responding to hostility in the group, and so forth. One skill area that seems guaranteed to be a focus for supervision is to help supervisees gain confidence in their ability to lead. The use of role play is an excellent way to practice new skills and allows the supervisee opportunities to make mistakes without it impacting the actual group members. Along with skill development, supervision should address the strengths and weaknesses of group leaders. The third component addresses the countless interactions and reactions that the supervisee will have in conducting a group. It is easier, of course, to respond to the strengths of a supervisee, yet supervisors also need to address those skill deficits and personality characteristics that will interfere with competent group leadership.

Coleadership of a group presents an additional dynamic in supervision even if the supervisor is meeting individually with the leaders. Several authors have suggested that the development of the coleader relationship parallels that of the therapy group (Dugo & Beck, 1997; Wheelan, 1997). This hypothesis has not been tested, yet intuitively it seems reasonable that coleaders who are unable to resolve conflict might stymie conflict from occurring in their counseling group. Another example could be that group coleaders who compete for control with each other might have a group that mirrors this behavior. Yalom and Leszcz (2005) stated “how the co-therapy goes, so will the group” (p. 446). Coleaders need to be able to count on each other, be open with each other, and acknowledge each other's strengths (Yalom & Leszcz, 2005). The supervisor can encourage the coleadership team to make time to prepare for the group, review group sessions, and discuss the relationship between them. If a group coleader is unable to discuss her or his disagreements about how the session went, it may be that the counseling group will not be able to move to a very deep level.

Supervisor/Supervisee Leading a Group Together

Leszcz and Murphy (1994) defined dyadic supervision as the "apprenticeship model in which a more experienced group leader co-leads with an inexperienced trainee" (p. 99). This model is used frequently when training a counselor to work in groups and it has strengths and weaknesses. The advantage is that supervisors can directly observe the supervisee's skills at leading a group. If the alliance between the supervisor and supervisee is built on support and trust, the supervisor can encourage the supervisee to actively participate in the leadership role. More often from the author's experience, group supervisees *observe* their supervisor leading the group and say very little during the group sessions. It is an effective supervisor who can expect the supervisee to begin to assertively take responsibility for some portion of the group facilitation. The supervisor will also help the supervisee manage anxiety that is often present when leading a group for the first time. This anxiety no doubt is even higher due to the evaluative component present when leading a group with one's supervisor.

The potential weakness of this model relates to ethical concerns surrounding dual relationships. A strong supervisory alliance may benefit the coleadership relationship, yet it can also complicate it if the supervisor is not a competent group leader. If the supervisory relationship outside of the group leadership process is not based on support and trust, it is doubtful that this coleadership training model will be a positive one.

Group Supervision of Group Leaders

In an introduction to a Special Issue on group supervision of group psychotherapy, Bernard (1999) stated that "though I know of no empirical data about how frequently group psychotherapy is supervised in a group format, I have the unmistakable impression that it is relatively rare" (p. 153). Currently, we still do not know how common this practice is or how it is practiced. In this model, the supervisor meets with several group leaders-in-training to discuss their counseling groups. This type of supervision can mirror an actual group in that it can offer in vivo experiences of group dynamics (Moss, 2008). Newman and Lovell (1993) stated that this format is an "excellent forum for obtaining feedback, encouraging healthy leadership relationships, enhancing group facilitation skills, and fostering counselor-in-training self-awareness" (p. 22). Most of the research on group supervision with groups uses anecdotal interviews with leaders or a case study of one supervision group of group counseling (e.g., Christensen & Kline, 2001; Linton, 2003). This is an area ripe for research.

Group supervision that has a membership of supervisees who are seeing individual clients (and not those in group counseling) is a growing body of research that shares some of the same dynamics found in group supervision of group leaders. Both of these types of supervision involve a group process which can be an advantage over supervision with one supervisee. In discussing group supervision of individual psychotherapy (and is also true for group supervision of groups), Riva and Cornish (1995, 2008) suggested that advantages are that supervisees can learn vicariously, learn from multiple perspectives, practice hearing and accepting feedback from their peers nondefensively, and give clear and beneficial feedback to their peers.

In interviews with supervisees participating in group supervision, Bogo, Globerman, and Sussman (2004) noted several components to effective group supervision including group supervisors were available, they provided a clear educational purpose for group supervision, they developed a safe environment and utilized adequate structure that included both content and process, there was enough time to share information and learn from others, there was a balance between the needs of the group and those of individuals, and group supervisors were skilled at addressing the group process.

Research also has underscored some potentially negative characteristics of group supervision. Enyedy et al. (2003) described events that could prove to be obstacles to an effective learning environment in group supervision. From their interviews with supervisees, five negative components were identified that included problems between group members, those between members and the supervisor, anxiety of the supervisee, logistical constraints, and ineffective management of time.

In a rare study of multicultural events in group supervision, Kaduvettoor et al. (2009) found that "increased multicultural learning and extra-group multicultural events positively related to supervisees' multicultural competence whereas multicultural conflicts with supervisor, misapplication of multicultural theory, and the absence of multicultural events negatively related to supervisee multicultural competence" (p. 786). This study clearly points to the need for the group supervisor to be multiculturally competent and help increase multicultural competence in the supervisees.

Smith, Riva, and Erickson Cornish (2012) looked at ethical considerations in group supervision. A sample of supervisees and a sample of unmatched group supervisors were asked about multiple relationships, confidentiality, and norm setting in group supervision. For many potential dilemmas that might occur in group supervision, such as sexual relationships between group members or between a member and the leader, both samples stated that these rarely or never happened. More often, group supervisees responded that they did not have some of the information that they needed, to know how to proceed in the group supervision process. Group supervisees regularly responded that supervisors did not tell them about the privacy of the material that they share in group, the purpose for group supervision, and how shared information would be used in their evaluation.

An area that was concerning was that supervisees stated that group supervisors regularly came late to supervision or cancelled the supervision group entirely. The supervisors responded more often that they covered this information in the group supervision and that they rarely cancelled or came late to supervision. It is important to underscore

that these two samples were not matched yet group supervision, like with all groups, has a risk of ethical violations. This was the first survey to look directly at the views of supervisors and supervisees on ethics in group supervision. The focus was not on group supervision of group counseling which would add yet an additional layer of ethical complexity. Studies that point to helpful and hindering factors, potential ethical dilemmas that can occur in group supervision, and those that suggest specific and unique types of learning that can result in this type of supervision can provide some guidance for group supervision of group counseling.

Future Research Directions

With the increase in the use of group counseling for mental health facilities, it is a prime time to begin to focus on supervision of groups. One of the most critical areas for supervision in general is for research studies to begin to look at the relationship between supervision and *client* outcomes and not just supervisee outcomes. Callahan et al. (2009) stated that "crosstabulation of supervisors by client outcome categories (i.e., recovered, reliably improved, no reliable change, deteriorated) indicated that supervisors are significantly related to client outcomes, generating a moderate effect" (p. 72). Much more research is necessary.

Another topic for future study is the supervision of group leaders/coleaders. Understanding more about which coleadership behaviors and styles are most beneficial to group members and how best to supervise coleaders are areas that have received little focus. Increasing the competence of group leaders is one of the essential features of supervision. Helping to develop early group leaders into confident and skillful group leaders is a topic for future investigation. Some studies have described more complex thinking of experienced group leaders compared to their novice counterparts (Hines, Stockton, & Morran, 1995; Kivlighan & Quigley, 1991). This trajectory toward "expert" is really unexplored. Of course, experience is necessary; yet understanding how to increase cognitive complexity in group leaders would be an asset for the field.

There has been some discussion of ethical and legal considerations specifically related to group counseling (ASGW, 2000; Lasky & Riva, 2006; Rapin, 2014), although little has been written about the ethical dilemmas related to supervision of groups. It is unclear how familiar supervisors are with the legal and ethical guidelines of their state and their professional organizations and competent they are to train supervisees to address ethical dilemmas or to respond when ethical and legal guidelines contradict each other. Group counseling poses many complex and thorny considerations concerning the limits to confidentiality (Lasky & Riva, 2006), informed consent, voluntary participation, multiple and dual roles, removing a member from the group, and working with minors in a group. For supervisors not to have a deep understanding of ethical and legal issues puts both group members and group supervisees at risk.

Conclusion

This chapter underscores the need for additional attention to supervision of groups from both a clinical and research standpoint. The practice of group counseling is growing rapidly and it is critical that there are competent and ethical group leaders. With the increased emphasis of group treatment in mental health and hospital settings and the need for leaders of those groups, it is troubling to think that many of these leaders will have no specific training in how to lead a therapeutic group. Although one can learn a great deal from the research and practice of individual therapy and supervision of individual therapists, many aspects are not transferable to group counseling or supervision of groups. One component of developing quality group leadership is through supervision of these group leaders. Supervision of groups can be conducted in several formats including a supervisor with one group leader, with coleaders, or in a group with several leaders. Whatever the method, it is now the time for a commitment to the training and supervision of group leaders who can influence positive outcomes for their group members. Research in all aspects of supervision of groups is needed from skill development, ethical dilemmas, and development of group leaders from novice to competent experts.

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Chapter 13 Measures of Group Process, Dynamics, Climate, Behavior, and Outcome: A Review

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The question is no longer "Is group therapy effective?" but instead "What makes groups effective?" "Sufficient empirical evidence exists to conclude that group is an effective modality" (Burlingame, 2010, p. 1). The focus in group research and practice has expanded to include interventions and processes that create change. Thus, assessment measures related to group are being developed to measure these mechanisms of change that Yalom and Leszcz (2005) call "therapeutic factors." Leading group theorists have long hypothesized that process variables such as group climate, dynamics, and therapeutic factors contribute to change in behavior, regardless of type of group or specific problem. More reliable and valid outcome measures still exist than group process instruments. However, more effort and research has been focused on the development of group measures with demonstrated reliability and validity.

In this chapter we review measures related to group process, dynamics, interventions, therapeutic factors, and leadership behaviors. The focus will be on reliable and valid measures. To be included in this chapter, a measure must (a) assess process or outcome related to group dynamics or efficacy; (b) have at least a moderate level of reliability, and construct validity; and (c) have been used in three or more published research studies on groups published in the last 5 years. A brief description of the measure and subscales is included with a table that provides reliability and validity information. Measures that appear promising are also noted.

Screening and Selection Instruments

Screening measures assess attitudes toward groups and/or interpersonal behavior that may affect group members' ability to benefit from psychoeducational, counseling, and therapy groups.

The Group Therapy Survey– Revised

The *Group Therapy Survey* (GTS; Slocum, 1987) was revised by Carter, Mitchell, and Krautheim (GTS-R 2001) by replacing the words *group therapy* with *group counseling*. Items are rated from 1 (*strongly agree*) to 5 (*strongly disagree*) and are reverse scored with higher scores associated with pro-group beliefs. A principal components analysis to the 25 revised items with college students presenting for counseling indicated the 20 items were reducible to three dimensions, *Efficacy, Myths*, and *Vulnerability*. As shown in Table 13.1, the mean scores suggested neutral to positive attitudes toward group counseling by the students and adequate internal consistency for the new subscales.

The Group Counseling Survey

Despite initial support of the GTS–R, several methodological issues were identified that might undermine internal validity: (a) dimension labels may not accurately represent the constructs being assessed, and (b) the same item appears to have been administered twice with each item reported to load on different dimensions. To address these validity issues, Sodano, Guyker, DeLucia-Waack, and Amos (2013) examined the factor structure of the 19 unique GTS–R items in samples of undergraduate students and graduate counselor trainees. The same three dimensions of the GTS–R were replicated in the EFA but only after poorly performing items were removed from the first dimension (Efficacy) and the third dimension (Vulnerability). The item set was reduced to 15, resulting in improvements to the internal consistency estimates and item-total correlations to these dimensions across the samples (see Table 13.1). The fit of the two versions of the scale to the three-factor model was assessed by CFA, with the 15-item scale fitting the model significantly better than the earlier 19-item version in the graduate trainee sample. Group expert ratings of the final items to dimension contents were then examined empirically. Across samples, Dimension 1 is more accurately characterized as *Therapeutic Factors* (than Efficacy), while Dimension 2 as *Misconceptions* (than Myths). To minimize confusion between the two scale versions, the refined 15-item scale is now referred to as the *Group Counseling Survey* (GCS). Support for the convergent validity of the GCS was shown in a significant medium-sized negative correlation between the *Vulnerability* subscale and global interpersonal distress across samples. Further, previous counseling experience had a significant medium-sized correlation to the myths subscale in a subsample of (n = 44) counselors in training (Sodano et al., 2013).

Group Readiness Questionnaire

The *Group Readiness Questionnaire* (GRQ; Burlingame et al., 2012; Cox et al., 2004) is a screening questionnaire to assess clients' expectancies regarding group therapy outcomes and positive and negative interpersonal characteristics. It is a 19-item measure rated from 1 (*never*) to 5 (*almost always*). The GRQ has been shown to exhibit factorial validity across several studies and settings (Burlingame et al.; see Table 13.1). The GRQ's clinical utility is to help identify foci for pregroup interviews (i.e., see norms and cutoff scores in Burlingame et al.) or to "triage" potential participants who might need minimal, typical, or extensive pregroup preparation (e.g., those with higher scores on the GRQ are likely associated with a greater need for pregroup intervention).

The Inventory of Interpersonal Problems–Circumplex–Item Response Theory

The *Inventory of Interpersonal Problems– Circumplex–Item Response Theory* (IIP–C–IRT; Sodano & Tracey, 2011) is a brief 32-item self-report measure of interpersonal problems that has been recently begun to be used as a screening measure recently with groups. (Its use as an outcome measure will be discussed later.) The Inventory of Interpersonal Problems–Circumplex (IIP–C 64; Horowitz, Alden, Wiggins, & Pincus, 2000) is a well-established measure of interpersonal problems based on Interpersonal theory (Sullivan, 1953) and the Interpersonal Circumplex (IPC; Wiggins, 1982). There are two categories of items for all IIP–C versions, behaviors that are either *difficult for an individual to engage in* or *are difficult for an individual to restrain.* All items are rated from 0 (*not at all*) to 4 (*extremely*) on how distressing the particular interpersonal problem has been for a respondent. Continuous scores are calculated for the 8 (i.e., octant) subscale levels; these scores can also be aggregated into the two underlying dimensions of interpersonal problems, *Control* and *Affiliation.* The dimensional scores can also be utilized to differentiate interpersonal problem profiles categorically based on their locations on the IPC, which can provide a direct connection between assessment, interpersonal theory, and intervention. Profile scoring identifies the predominant interpersonal problem type (e.g., hostile-submissive) while also providing a continuously scored index of its intensity. Higher intensity of the specific problem type can signal a lack of flexibility (i.e., rigidity) of an interpersonal style. In addition, a global interpersonal distress score can also be calculated by averaging across all items. This total score is the most frequently reported IIP score for psychotherapy research in general.

Scale Authors (date)	Sample Type, N (age) Sample Characteristics	Subscales Label (# items)	Central Tendency *M (SD)*	Reliability α (test re-test r)	Validity		
					Internal / Structural	Convergent / Discriminant (*rs*)	Convergent / Discriminant (*rs*)
GTS-R							
Carter et al. (2001)	ucc, $N = 212$, (M_{age} 20, *R* 17–50) ncug, $N = 93^b$ (M_{age} 23)	Efficacy (7) Myths (6) Vulnerability (7)	3.36[a] (0.49) 3.69[a] (0.57) 3.43[a] (0.49)	0.78 (0.65[b]) 0.77 (0.76[b]) 0.75 (0.80[b])	PCA: 3 dimensions		
Marmarosh et al. (2009)	Op[+]: $n = 63$, ncug[+] $n = 28$; $N = 91$ (68% f)	Efficacy (7) Myths (6) Vulnerability (7)	24.87[a] (4.62) 14.44[a] (3.91) 22.14[a] (3.85)			ECRS: Avoidant (ns) (ns) (– 0.24*)	ECRS: Anxious (ns) (ns) (ns)
GCS							
Sodano et al. (2013)	ncug, N = 187 (M_{age} = 21.3, SD 2.4), (62%f) (wea 64%, Aas 8%, Aaf 10%, Hsp 7%, O 3%, U 8%)	Therapeutic Factors (4) Misconceptions (6) Vulnerability (5)	1.75[a] (0.67) 1.95[a] (0.62) 2.59[a] (0.78)	0.82 0.76 0.77	PAF: 3 dimensions	IIP-C-IRT ns ns (– 0.31***)	
	cit, N = 172, (M_{age} = 24.7, SD 4.1), (79% f) (wea 67%, Aas 6%, Aaf 9%, Hsp 4%, Na 1%, O 2%, U 12%)	Therapeutic Factors (4) Misconceptions (6) Vulnerability (5)	1.73[a] (0.62) 1.81[a] (0.58) 2.62[a] (0.80)	0.81 0.70 0.78	CFA: 3 dimensions	IIP-C-IRT ns ns (– 0.40***)	Prev. couns. ns (0.30*) ns
IIP–C–IRT Sodano & Tracey (2011)	ncug[+] non-group (all samples) $N_1 = 1000$, (62%f). $N_2 = 981$, ($n_2 = 641$ f) $N_3 = 36$	Octant subscales (4): PA, BC, DE, FG, HI, JK, LM, & NO. Dimensional subscales (24) for Dominance & Affiliation, & Total Score (32)		Octant M_{1a} = 0.72, range = 0.62–0.80 Octant M_{3a} = 0.74, range 0.62–0.81 females; 0.73, range 0.63–0.80 males. (Octant M_{3y} = 0.71[b], range 0.64–0.76)	Good fit to the circular order model, equivalent across gender.	IIP–C 64 octant M_{2y} = 0.92 females, M_{2y} = 0.92 males	
Sodano et al. (2013)	ncug (see sample info. under GCS) cit (see GCS info.)	Global Interpersonal Distress Global Interpersonal Distress	0.92[a] (0.43) 0.94[a] (0.40)	0.88 0.88		(see GCS info) (see GCS info)	
GRQ							
Layne et al. (2001)	adolescents N = 80	Expectancy; Nonparticipation; Domineering; Group Deviance; Open-participation			PCA: 5 dimensions		
Cox et al. (2004)	ucc (N = 288)	Expectancy; Participation; Demeanor			PCA: 3 dimensions		
Loeffler et al. (2007)	Ip(G) N = 264	Expectancy; Participation; Demeanor			CFA: 3 dimensions		
Cox (2004)	ucc (N = 294)	Expectancy; Participation; Demeanor			PCA: 3 dimensions		
Baker (2010)	ucc	Expectancy; Participation; Demeanor			CFA: 3 dimensions		

GTS-R = Group Therapy Survey–Revised (Carter, Mitchell, & Krautheim, 2001); ECRS = Experiences in Close Relationship Scale (Brennan et al., 1998); IIP–C 64 = Inventory of Interpersonal Problems–Circumplex (64-item version). IIP-C-IRT = Inventory of Interpersonal Problems -Circumplex -Item Response Theory (Sodano & Tracey, 2011); GCS = Group Counseling Survey (Sodano, Guyker, DeLucia-Waack, & Amos, 2013); ECRS = Experiences in Close Relationship Scale (Brennan et al., 1998); IIP -C 64 = Inventory of Interpersonal Problems -Circumplex (64-item version) (Horowitz, Alden, Wiggins, & Pincus, 2000).

Note 1: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted. [a]1 week test re-test interval, [b]2 week test re-test interval, [c]1 month test re-test interval. *$r = p < 0.05$, ** $r = p < 0.01$, ***$r = p < 0.001$, NS = NS at 0.05

Note 2: ucc = university counseling centers; op = outpatient mental health centers; ip = inpatient treatment; ncug = nonclinical undergraduate sample; cit = counselors in training

Note 3: [a] = before group

Note 4: CFA = Confirmatory Factor Analysis; PAF = Principal Axis Factor Analysis; PCA = Principal Components Analysis.

Note 5: f = Female; Aaf = African American; Aas = Asian/Asian American; mr = multiracial; Hsp = Hispanic/Latino; wea = White European Americans; EaI = East Indian; NA = Native American; O = Other; G = German; U = unreported

Note 6: sa = substance abuse; ed = eating disorders

Note 7: *Age not provided

GTS-R= Group Therapy Survey-Revised (Carter, Mitchell, & Krautheim, 2001); ECRS= Experiences in Close Relationship Scale (Brennan et al., 1998); IIP-C 64 = Inventory of Interpersonal Problems-Circumplex (64-item version). IIP-C-IRT = Inventory of Interpersonal Problems - Circumplex -Item Response Theory (Sodano & Tracey, 2011); GCS = Group Counseling Survey (Sodano, Guyker, DeLucia-Waack, & Amos, 2013); ECRS = Experiences in Close Relationship Scale (Brennan et al., 1998); IIP -C 64 = Inventory of Interpersonal Problems - Circumplex (64-item version) (Horowitz, Alden, Wiggins, & Pincus, 2000).
Note 1: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted.

a1 week test re-test interval,

b2 week test re-test interval,

c1 month test re-test interval.

* $r = p < 0.05$,

** $r = p < 0.01$,

*** $r = p < 0.001$, NS = NS at 0.05
Note 2: ucc = university counseling centers; op = outpatient mental health centers; ip = inpatient treatment; ncug = nonclinical undergraduate sample; cit = counselors in training
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Note 6: sa = substance abuse; ed = eating disorders
Note 7: [+]Age not provided

The IIP–C–IRT (Sodano & Tracey, 2011; see Table 13.1) was shown to fit the circular order model well and also be invariant across gender. Initial validation efforts have shown that the IIP–C–IRT possesses several key advantages, including increased precision in the assessment of interpersonal problems. The IIP– C–IRT can be utilized in screening clients prior to group therapy. Traditionally used in individual psychotherapy outcome studies, recently total scores on IIPs have been used in group studies (e.g., Lorentzen & Hoglend, 2008; Tasca, Illing, Ogrodniczuk, & Joyce, 2009). Longer treatment time has been indicated for higher levels of interpersonal distress (Lorentzen & Hoglend, 2008), thus highlighting global interpersonal distress levels as an inclusion criteria in general. However, those clients with higher interpersonal distress levels are likely to be better served by longer running groups.

Interpersonal theory also makes predictions based on different interpersonal styles through the principle of complementarity, which describes the cyclical nature of interaction behaviors (e.g., Carson, 1983). There is a tendency to evoke the opposite behavior along the Control Dimension (e.g., dominance pulls for submission) and the same behavior along the Affiliation Dimension (e.g., hostile pulls for hostile). Rapport building, conflict negotiation, and termination for successful therapy dyads has been shown to be a function of complementarity (see for a review Tracey, 2002). Therefore, it seems important for the group leader(s) to consider type and intensity of the interpersonal problem profiles of potential group members in selection along with the leader's (leaders') own comfort and skill with managing the pulls associated with each profile relative to those of other potential group members. One of the hallmarks of the IIP–C–IRT is the diagnostic information provided by specific profile scores, which may suggest inclusion/exclusion of group members as well as treatment goals within group. Although the global interpersonal distress (i.e., mean total IIP) score is clearly an important group selection and outcome assessment, more research is needed in order to realize the full advantages that the specific application of IIP–C–IRT can offer assessment in group therapy contexts.

Assessment of Group Climate

Measures of group climate and environment have been used extensively with counseling and psychotherapy groups. These measures have been used to assess group stage as well as predict positive group member outcome.

Group Climate Questionnaire– Short

The *Group Climate Questionnaire–Short* (GCQ–S; MacKenzie, 1983, 1990) measures three dimensions: *Engaging* (cohesion, self-disclosure, and willingness to confront), *Avoiding* (conformity, superficiality, and denial of responsibility), and *Conflict* (friction, distrust, and mutual withdrawal). Originally, the GCQ consisted of 32 items and 8 subscales but was shortened to be administered after every session (MacKenzie, 1990). The GCQ–S consists of 12 items rated from 0 (*not at all*) to 6 (*extremely*) and can be completed by both group leaders and members. "In more successful groups, clients perceived the climate as more engaging and characterized by more conflict and anxiety and less avoiding" (Kivilighan & Angelone, 1992, p. 469).

MacKenzie (1983) suggested that the GCQ–S assesses the developmental stage of the group and/or identifies members who view their group so differently that they end up being a scapegoat. The GCQ–S is one of the most widely used measures of group climate and has been tested in a variety of settings: residential treatment facilities (Bonsaksen, Lerdal, Borge, Sexton, & Hoffart, 2011), university counseling centers (Davies, Burlingame, Johnson, Gleave, & Barlow, 2008), training groups in Botswana (Nitza, 2011), and Israel (Harel, Shechtman, & Cutrona, 2011; see Table 13.2). The GCQ–S, and specifically *Engagement*, has been shown to improve with group treatment (Burlingame, MacKenzie, & Strauss, 2004) and sensitive to change over four sessions (Kivlighan, London, & Miles, 2012). Very interestingly, Chapman et al. (2012) found no significant relationship between group leader and member assessment of group climate.

In the past, the *Group Environment Scale* (GES; Moos, 1986) has been utilized. However, a literature search for the past 10 years does not indicate its usage in published studies. Wilson et al. (2008), however, reported promising findings with a shorter version (*Intervention GES*; 25 items).

Therapeutic Factors in Group

Altruism, catharsis, cohesiveness, corrective recapitulation of the primary family group, development of socializing techniques, existential factors, imitative behavior, imparting information, instillation of hope, interpersonal learning input (feedback), interpersonal learning output (new behavior), and universality are the twelve therapeutic factors (Yalom & Leszcz, 2005) suggested to be the mechanisms that promote change in group members. Kivlighan and Holmes (2004) reported four clusters of groups based on differential ratings of the most important therapeutic factors rated: *affective insight groups, affective support groups, cognitive support groups*, and *cognitive insight groups.* In this volume, Kivlighan and Kivlighan (2014) extending their work suggested collapsing the 12 factors into four therapeutic factor domains. They then concluded that no additional ranking studies are needed; new research should examine "the relationship between therapeutic factors, other group processes, and outcome." Measures of therapeutic factors differ in what they assess, as does the presence of or helpfulness of a therapeutic factor to a particular group member during a specific group session.

Scale Author(s)	Sample Type; N; $M_{age}(SD)$ or M_{dn} Population Characteristics	Subscales Label (# Items)	Central Tendency *M(SD)*	Reliability Internal Consistency, (Test re-test r)	Validity Structural	Validity Convergent / Discriminant (rs)
GCQ–S						
Kivlighan et al. (2012)	*Choices*[1] program N = 176 (89f); M_{age} =*15.05* (0.97) 32 Groups (37% Aaf; 48% wea; 15% O)	Engagement (5); Avoidance (3); Conflict (4)	3.40(0.70)[wg] 3.08(0.53)[wg] 1.96(0.89)[wg]	0.86 0.75 0.79		
Bonsaken et al. (2011)	Ip (social phobia) N = 80 M_{age}: *37.5* (11.4) 10 groups RCT RIPT	Engagement (5); Avoidance (3); Conflict (4)	 1.98 (0.75)[gm] 2.11 (0.60)[gm]	0.76 0.60 0.77	PCA: 3 dimensions	-
Joyce et al. (2011)	ucc, op, ph N = 380 (267f) M_{age} = *36.28 (13.6)* 51 Groups; (5% Aaf; 2.8% Aas; 1.7% mr; 1.4% Hsp; 1.1% EaI; 1.4% O)	Engagement (5) Avoidance (3) Conflict (4)		0.74 (0.41[a]) 0.40 (0.18[a]) 0.74 (0.49[a])	CFA: 4 dimensions	TFI-19 Hope (0.51[***]) Express (0.68[***]) Impact (0.61[***]) Learning (0.60[***]) Hope NS Hope (– 0.14[*])

Note 1: [1] = *Choices* is a group therapy program for at-risk youth experiencing problems such as alcohol abuse, physical abuse, and school suspension

Note 2: RCT = cognitive group therapy; RIPT = interpersonal group therapy

Note 3: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted. [a]1 week test re-test interval. *$r = p < 0.05$, ** $r = p < 0.01$, ***$r = p < 0.001$, NS = NS at 0.05

Note 4: TFI-19 = Therapeutic Factors Inventory–19 (Joyce et al., 2011); GCS–S= Group Climate Scale–Short (MacKenzie, 1983)

Note 5: ucc = university counseling centers; op = outpatient mental health centers; ph = partial hospitalization programs

Note 6: [wg] = aggregate scores at end of study; [gm] = grand mean of total scale scores

Note 7: CFA = Confirmatory Factor Analysis; PCA = Principal Components Analysis

Note 8: Aaf = African American; Aas = Asian/Asian American; mr = multiracial; Hsp = Hispanic/Latino; EaI = East Indian; O = Other

Note 1: [1] = *Choices* is a group therapy program for at-risk youth experiencing problems such as alcohol abuse, physical abuse, and school

suspension
Note 2: RCT = cognitive group therapy; RIPT = interpersonal group therapy
Note 3: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted.

a1 week test re-test interval.

*$r = p < 0.05$,

** $r = p < 0.01$,

***$r = p < 0.001$, NS = NS at 0.05
Note 4: TFI-19 = Therapeutic Factors Inventory–19 (Joyce et al., 2011); GCS–S= Group Climate Scale–Short (MacKenzie, 1983)
Note 5: ucc = university counseling centers; op = outpatient mental health centers; ph = partial hospitalization programs
Note 6: ^{ag} = aggregate scores at end of study; ^{gm} = grand mean of total scale scores
Note 7: CFA = Confirmatory Factor Analysis; PCA = Principal Components Analysis
Note 8: Aaf = African American; Aas = Asian/Asian American; mr = multiracial; Hsp = Hispanic/Latino; EaI = East Indian; O = Other

The Therapeutic Factors Inventory–19

The *Therapeutic Factors Inventory–19* (TFI–19; Joyce, McNair-Semands, Tasca, & Ogrodniczuk, 2011) assesses group members' perceptions of which therapeutic factor(s) are present in a particular group session. The original TFI (McNair-Semands & Lese, 2000) was 99 items, reduced to 44 (TFI–S; McNair-Semands, Ogrodniczuk, & Joyce, 2010), and now 19. The items are rated from 1 (*strongly disagree*) to 7 (*strongly agree*) for four subscales: *Social Learning, Instillation of Hope, Secure Emotional Expression*, and *Awareness of Relational Impact.* McNair-Semands et al. suggested that all four subscales were sensitive to change between sessions (see Table 13.3).

Critical Incidents Questionnaire

The *Critical Incidents Questionnaire* (CIQ; Kivlighan & Goldfine, 1991) asks group members to respond to "Of the events that occurred in this session, which one do you feel was the most important for you personally? Describe the event: What actually took place, the group members involved, and your own reaction. Why was it so important to you" (Kivlighan, 2011, p. 150). This information has typically been rated using two coding systems: Bloch and Crouch's (1985) *Therapeutic Factors* and *Group Counseling Helpful Impact Scale* (GCHIS; Kivlighan, Multon, & Brossart, 1996).

The GCHIS is a 28-item scale that combines adaptive items from three different rating systems: Elliott's (1985) taxonomy of helpful impacts, Mahrer and Nadler's (1986) good moments system, and Bloch and Crouch's (1985) therapeutic factors rating system. The rating scale is a 0 (*not all*) to 4 (*very much*) for four dimensions: *Emotional Awareness-Insight; Relationship-Climate; Other-Focus Versus Self-Focus*; and *Problem Definition-Change*.

Coding the CIQ using Bloch's therapeutic factors has been used most recently to examine differences in perceptions of group members within the same group as a predictor of group satisfaction (Kivlighan, 2011), therapeutic factors in Sweat Therapy with college students (Colmant, Eason, Winterowd, Jacobs, & Cashel, 2005), experiential training groups in Botswana (Nitza, 2011), groups in an alternative middle school (Horrocks & DeLucia-Waack, 2003), and adult inpatient verbal and art therapy groups (Shechtman & Perl-Dekel, 2000). Ratings using GCHIS examined differences in therapeutic factors perceived by university counseling center clients in individual and group counseling (Holmes & Kivlighan, 2000), groups with Israeli children (Shechtman & Gluk, 2005), and parents (Danino & Shechtman, 2012).

Assessment of Group Leadership Behavior and Skills

It has been noted that the assessment of group leadership is one of the most neglected areas in research on groups (Chapman, Baker, Porter, Thayer, & Burlingame, 2010). It appears that based on a literature search, this continues to be true. Only the *Group Psychotherapy Intervention Rating Scale* (GPIRS; Sternberg & Trijsburg, 2005) has been identified as a promising measure. The GPIRS is an observer-rated scale with three dimensions shown to the have strongest empirical relationship with cohesion (Burlingame, Fuhriman, & Johnson, 2002): *Group Structuring* (7 items), *Verbal Interaction* (21 items), and *Creating and Maintaining a Therapeutic Environment* (20 items). Each item is rated on clarity (rated *poor* to *excellent*) and quantity of the intervention. Chapman et al. (2010) provides evidence that the three dimensions are correlated with measures of group climate and process. Each subscale of GPIRS corresponds with a subscale of the *Group Questionnaire* (described later; *Group Structuring* & *Positive Working Relationship*; *Verbal Interaction* & *Positive Bond; Creating and Maintaining a Therapeutic Emotional Climate* & *Both Positive Bond and Negative Relationship*). Most interestingly, Chapman et al. (2012) reported no significant relationship between leader and observer ratings on all three dimensions.

Alliance Measures

The relationship, or alliance, between group members and between group leader and members has been shown to influence treatment outcome. Recently, measures to assess the different aspects of alliance within group have begun to be developed.

The California Psychotherapy Alliance Scale for Group–Short

The *California Psychotherapy Alliance Scale for Group–Short* (CALPAS–G; Gaston & Marmar, 1993) measures therapeutic alliance in groups. The CALPAS– G is 12 items (originally 24 items; Lindgren, Barber, & Sandahl, 2008) rated from 1 (*not at all*) to 7 (*very much so*). Higher scores indicate a higher level of perceived therapeutic alliance. It is a parallel scale to the CALPAS– P, which has been widely used within individual therapy settings (Gaston & Marmar, 1993). The CALPAS–G consists of four subscales: *Patient Commitment* (group member's attitude toward therapy, including affection, trust, and commitment); *Patient Working Capacity* (member's ability to work actively and purposefully during treatment); *Working Strategy Consensus* (agreement between group member and leader how therapy should best proceed); and *Member Understanding and Involvement* (assesses member's involvement in group, including empathic understanding and active participation). The CALPAS–G has been shown to be sensitive over time (Tasca, Balfour, Ritchie, & Bissada, 2007) and weekly sensitivity (Tasca et al., 2010; see Table 13.4). An Italian version has been adapted (Prestano, Lo Coco, Gullo, & Lo Verso, 2008) and used (Lo Coco, Gullo, & Kivlighan, 2012). The total score has been found to predict outcome (Crowe & Grenyer, 2008; Tasca & Lampard, 2012).

Scale Author(s)	Sample Type; N; M_{age} (SD) or M_{dn}	Subscales Label (# Items)	Central Tendency M (SD)	Reliability Internal Consistency, (Test re-test r)	Validity		
					Structural	Convergent (*rs*)	Discriminant (*rs*)
TFI-19							
Joyce et al. (2011)	ucc, op, ph N = 380 (267f); M_{age} = 36.28 (13.6) 51 groups (5% Aaf; 2.8% Aas; 1.7% mr; 1.4% Hsp; 1.1% EaI; 1.4% O)	Social Learning(3) Instillation of Hope(4) Secure Emotional Expression(7) Awareness of Relational Impact(5)	3.35(0.8)[4] 4.34(1.14)[4] 2.93(0.66)[4] 3.2(0.77)[4]	0.66, (0.53[a]) 0.90, (0.72[a]) 0.85, (0.73[a]) 0.79, (0.66[a])	CFA: 4 dimensions	GCS-S[4] Engaged (0.60***) Engaged (0.51***) Engaged (0.68***) & Conflict (– 0.23***) Engaged (0.61***)	PRF & IIP28[4] PRF-SD (– 0.16**) PRF-SD (NS) PRF:SD (0.26***) & IIP28: Ambivalence (– 0.14*) PRF:SD (–0.17**)

Note 1: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted. [a]1 week test re-test interval. *$r = p < 0.05$, ** $r = p < 0.01$, ***$r = p < 0.001$, NS = NS at 0.05

Note 2: TFI–19 = Therapeutic Factors Inventory–19; GCS–S = Group Climate Scale–Short; PRF = Personality Research Form; SD = Social Desirability Scale

Note 3: ucc = university counseling centers; op = outpatient mental health centers; ph = partial hospitalization programs

Note 4: [4]= Session 4

Note 5: CFA = Confirmatory Factor Analysis

Note 6: Aaf = African American; Aas = Asian/Asian American; mr = multiracial; Hsp = Hispanic/Latino; EaI = East Indian; O = Other

Note 1: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted.

a1 week test re-test interval.

*$r = p < 0.05$,

** $r = p < 0.01$,

***$r = p < 0.001$, NS = NS at 0.05

Note 2: TFI–19 = Therapeutic Factors Inventory–19; GCS–S = Group Climate Scale–Short; PRF = Personality Research Form; SD = Social Desirability Scale

Note 3: ucc = university counseling centers; op = outpatient mental health centers; ph = partial hospitalization programs
Note 4: ^{4}= Session 4
Note 5: CFA = Confirmatory Factor Analysis
Note 6: Aaf = African American; Aas = Asian/Asian American; mr = multiracial; Hsp = Hispanic/Latino; EaI = East Indian; O = Other

The Group Questionnaire

The *Group Questionnaire* (GQ; Burlingame, 2010) assesses the quality of the therapeutic relationship in groups, specifically climate, cohesion, empathy, and alliance. Items from the GCQ–S (MacKenzie, 1983), *Cohesion* subscale of the TFI (McNair-Semands & Lese, 2000), and *Working Alliance Inventory* (Horvath & Greenberg, 1989) were combined and then factor analyzed to create this new measure (see Table 13.4). Research with different populations has supported the three-factor structure (*Positive Bonding Relationship, Positive Working Relationship*, and *Negative Relationship*) across three structural dimensions (member-leader, member-member, and member-group; Bakali, Baldwin, & Lorentzen, 2009; Chapman et al., 2012; Johnson, Burlingame, Olsen, Davies, & Gleave, 2005; Krogel et al., in press).

The GQ is currently a 30-item (began as 60; then 40) self-report measure with three factors. Items are rated from 1 (*not true at all*) to 7 (*very true*) (Krogel et al., in press). The factor structure of the measure has been supported using inpatient, outpatient, and nonclinical groups in the United States, Switzerland, and Germany (Burlingame, Whitcomb, & Woodland, 2014). Data from Krogel et al.'s study of three populations (inpatient, counseling center, and nonclinical groups) offers population-specific norms to create feedback sheets allowing group leaders to compare member scores with relevant normative group scores.

Ratings of In-Session Group Behavior

Some of the oldest instruments used to analyze and assess therapeutic groups are those that rate in-session group leader and member behavior based on videotapes, audiotapes, or a transcript of actual group sessions have not been used recently in three or more published studies in the last 5 years. The *Interactional Process Analysis* (Bales, 1950), while in the past had been used to examine psychoeducational and counseling groups, has been used more recently in task and work groups (e.g., Kelly & Spoor, 2007; Nam, Lyons, Hwang, & Kim, 2009).

Research examining the group dynamics of online support groups has begun to use a social behavioral code originally developed with couples (Cutrona & Suhr, 1992), which includes 32 individual behavioral ratings within eight main categories of Emotional Support, Information Support, Esteem Support, Network Support, Tangible Assistance, Tension Reduction, Attentiveness, and Negative Behavior.

Scale Author(s)	Sample Type; N; M_{age} (SD) or M_{dn}	Subscales Label (# Items)	Central Tendency M, SD	Reliability Internal Consistency (Test retest r)	Validity Structural	Validity Convergent / Discriminant (rs)
CALPAS-G						
Lo Coco et al. (2012)	Op (anx, ed) N = 32[1](26f); M_{age} = 23.4 (3.8) 5 groups	Total Score	5.16 (0.91) [gm]	0.80		
Tasca & Lampard (2012)	Op (ed) N = 238f[C] M = 26.11 (8.58)	Total Score	4.91 (0.85)[1] 5.15 (0.7) [4] 5.23 (0.79) [8] 5.28 (0.78) [9]			
Tasca et al. (2010)	Ph (ed) N = 229[C]	Total Score	4.91 (0.84) [0] 5.12 (0.75) [1] 5.18 (0.74) [4] 5.28 (0.77) [8] 5.36 (0.75) [12]			
Tasca et al. (2007)	Op (ed) N = 65f[C] M = 43.9 (10.5) 10 groups GCBT GPIP	Total Score	5.48 (0.4)[gm] 5.27 (0.69)[1] 5.33 (0.79)[4] 5.50 (0.94 [8] 5.61 (0.86)[12] 5.91 (0.79)[16]	0.88 [t]		GCQ-S *Engaged (0.36*)*
GQ						
Chapman et al. (2012)	Ucc; n = 33 4 groups M = 23 Ip N = 31 6 groups M = 39	Positive Bond (13) Positive Work (8) Negative Relationship (9) Positive Bond (13) Positive Work (8) Negative Relationship (9)	5.74 (0.79)[gm] 5.13 (1.08) [gm] 2.12 (.84) [gm] 4.73 (1.26) [gm] 4.73 (1.72) [gm] 2.49 (1.28) [gm]	0.79 0.85 0.86		

Note 1: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted. [a]1 week test retest interval, [b]2 week test retest interval, [c]1 month test retest interval. *$r = p < 0.05$, ** $r = p < 0.01$, ***$r = p < 0.001$, NS = NS at 0.05

Note 2: TFI-19 = Therapeutic Factors Inventory-19; GCS-S = Group Climate Scale-Short; PRF = Personality Research Form, SD = Social Desirability Scale IIP 28–Personality Disorder Scales; BDI = Beck's Depression Inventory

Note 3: ucc = university counseling centers; op = outpatient mental health centers; ph = partial hospitalization programs; ip = inpatient treatment; ncug = nonclinical undergraduate sample; nc = nonclinical sample; ncg= nonclinical graduate students; cit = counselors in training

Note 4: [0] = before group; [1] = Session 1; [4] = Session 4; [8] = Session 8; [12] = Session 12; [16] = Session 16; [gm] = grand mean summed over all group sessions

Note 5: CFA = Confirmatory Factor Analysis

Note 6: Aaf = African American; Aas = Asian/Asian American; mr = multiracial; Hsp = Hispanic/Latino; EaI = East Indian; O = Other

Note 7: [t] = total for whole scale

Note 8: Anx = anxiety disorder diagnosis; ed = eating disorder diagnosis; dep = depression diagnosis; GCBT = group cognitive-behavioral therapy; GPIP = group psychodynamic interpersonal psychotherapy

Note 9: All samples are American unless noted otherwise; [I] = Italian (and Italian version); [C] = Canada

Note 1: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted.

a1 week test retest interval,

b2 week test retest interval,

c1 month test retest interval.

*$r = p < 0.05$,

** $r = p < 0.01$,

***$r = p < 0.001$, NS = NS at 0.05

Note 2: TFI-19 = Therapeutic Factors Inventory-19; GCS-S = Group Climate Scale-Short; PRF = Personality Research Form, SD = Social Desirability Scale IIP 28–Personality Disorder Scales; BDI = Beck's Depression Inventory

Note 3: ucc = university counseling centers; op = outpatient mental health centers; ph = partial hospitalization programs; ip = inpatient treatment; ncug = nonclinical undergraduate sample; nc = nonclinical sample; ncg= nonclinical graduate students; cit = counselors in training

Note 4: ^{0} = before group; ^{1} = Session 1; ^{4} = Session 4; ^{8} = Session 8; ^{12} = Session 12; ^{16} = Session 16; ^{gm} = grand mean summed over all group sessions *Note 5*: CFA = Confirmatory Factor Analysis

Note 6: Aaf = African American; Aas = Asian/Asian American; mr = multiracial; Hsp = Hispanic/Latino; EaI = East Indian; O = Other *Note 7*: ^{t} = total for whole scale

Note 8: Anx = anxiety disorder diagnosis; ed = eating disorder diagnosis; dep = depression diagnosis; GCBT = group cognitive-behavioral therapy; GPIP = group psychodynamic interpersonal psychotherapy

Note 9: All samples are American unless noted otherwise; ^{I} = Italian (and Italian version); = Canada

Outcome Measures

The Outcome Questionnaire–45

The *Outcome Questionnaire–45* (OQ–45; Lambert et al., 1996) is a 45-item self-report instrument with a five-point Likert-type scale used to measure outcome and/or track progress throughout therapy. While it has been primarily used in individual therapy, recently it has been used as an outcome measure in groups (Chapman et al., 2012; Davies et al., 2008; Gillaspy et al., 2002; Lo Coco et al., 2012). The subscales of the OQ–45 are *Interpersonal Relations, Subjective Distress*, and *Social Role Performance*, with a total score that represents general distress and item-level indicators to assess for risk of harm and substance abuse. The cutoff score for American sample is 64 (66 for Italian sample; Lo Coco et al., 2012), with reliable change by 4 points or more (Chapman et al., 2012). The OQ–45 has good internal consistency and test-retest reliability for the overall score in general (Lambert & Hawkins, 2004; see Table 13.5) and with an Italian version (Lo Coco et al., 2008).

With respect to external validity, several studies have shown significant differences in total scores of patient and community samples and for clinical samples varying in levels of pathology (e.g., Umphress, Lambert, Smart, & Barlow, 1997). As a measure of psychotherapy progress, the OQ-45 has shown sensitivity to change weekly (Vermeersch, Lambert, & Burlingame, 2000; Vermeersch et al., 2004). Support has been less consistently found for the convergent and discriminant validity of the OQ–45 subscales relative to the total score (e.g., Doerfler, Addis, & Moran, 2002); thus, some degree of caution remains warranted for using the subscale scores. Studies employing the OQ –45, particularly with groups, have utilized the total score. Alliance scores were predictive of OQ-45 total distress in inpatient substance abuse treatment groups (Gillaspy et al., 2002).

The Inventory of Interpersonal Problems–Circumplex–Item Response Theory

The *Inventory of Interpersonal Problems– Circumplex–Item Response Theory* (IIP–C–IRT; Sodano & Tracey, 2011) is a brief 32-item self-report measure of interpersonal problems (its use as a screening measure was discussed earlier). The total score is the most frequently reported IIP score for psychotherapy research in general and more recently with group (e.g., Lorentzen & Hoglend, 2008; Tasca et al., 2009). As an example, Lorentzen and Hoglend (2008) utilized IIP–64 total score as an outcome and showed that severity of pathology (e.g., depression) and interpersonal distress may require a longer duration of treatment in order to show improvement in interpersonal functioning.

Conclusion

It is important that studies evaluate the effectiveness of group interventions utilizing instruments that are reliable and valid. It is also important that there is some uniformity and consensus about what instruments are used so that some comparisons can be made across studies. Important strides have been made particularly with the American Group Psychotherapy Association supporting the development of the Core Battery and advocating for its use in both group research and practice.

Further research is needed to establish reliability and validity for group measures across settings, cultures, and countries. Burlingame (2010) applauds the development of international cooperation between several complex group research programs as evidence that the group field is moving toward evidence-based practice. Such collaborations are essential and hopefully will continue to contribute significantly.

Some measures are designed to be used from multiple perspectives. It appears that the perspective of the rater (or assessor) is important and must be considered when choosing a measure. Most interesting is the finding by Chapman et al. (2010) that ratings by observer and leader using the GQ did not correlate significantly, suggesting important differences in perspective. Thus, what a leader perceives is happening is different than an independent observer with implications for supervision. Perhaps these differences are what need to be assessed for clinical usefulness. If a group member varies significantly from the perceptions of other group members or the leader, then perhaps that group member will become a scapegoat. Assessing this early may help establish a relationship with that group member that keeps them in group. Group measures are most useful when they help advance the field of group theory and also inform group practice.

Scale Author(s)	Sample Type; N; Age *M, SD or R*	Subscales Label (# Items)	Central Tendency *M (SD)*	Reliability α (Test retest r)	Validity	
					Structural	Convergent / Discriminant (*r*s)
OQ–45						
Bludworth et al. (2011)	Ucc; N = 1,100; *M* 23, *R* 18 – 59 59% Female; 90% WE, 5% Hsp, 2% PI, 1% A, 1% NA, < 1% Aaf, 1.5% Other	Symptom Distress (25); Interpersonal Relations (11); Social Role (9); Total Score (45)			CFA = 3 – 1 Bi-level factor model	
Gillaspy et al. (2002)	VA ip sub Total N = 49; *M* 45.41, *SD* 8.49 55% African American, 41% Caucasian, 4% Hispanic; *M* # grp sessions = 7.9, *SD* = 1.3	Baseline at 4th session Total Score[4] 30-day follow-up Total Score	79.70 (27.01) 57.48 (23.56)	0.94 0.94		BDI–II 0.79** InDUC 0.45** GTAS *ns* GAS-C – 0.33* BDI–II 0.68** InDUC *ns* GTAS – 0.38** GAS-C – 0.28*
Lo Cocco et al. (2012)	Op N = 32; M_{age} 23.4, *SD* 3.8 from 5 groups	Total Score[gm] (Avg'd from multiple administrations, avg. 9.30 times per patient, SD = 2.45)	66.70 (22.20)	0.82		
IIP–C 64[+]						
Lorentzen & Hoglend (2008)	op, N = 69, M_{age} = 36; F = 54%	Total (64)	1.50[o] (0.52)	0.92		
Tasca et al. (2008)	op, binge eating sample 1: N = 75	Total (64)	Sample#: pre/post/6mos S_1: 1.48[o] (0.51)/1.26			
IIP-C 64[+] Tasca et al. (Continued)	op, grief sample 2: N = 60; op, supportive sample 3: N = 83		(0.57)/1.23 (0.57); S_2: 1.52[o] (0.53)/1.49 (0.66)/1.27 (0.72); S_3: 1.53[o] (0.54)/1.37 (0.55)/1.24 (0.59)			

Note 1: OQ-45 = Outcome Questionnaire-45 (Lambert et al., 1996). BDI–II = Beck Depression Inventory–II (Beck, Steer, & Brown, 1996). In DUC = Inventory of Drug Use Consequences (Miller, Tonigan, & Longabaugh, 1995). GTAS = Group Therapy Alliance Scale (Pinsof & Catherall, 1986). GAS–C = Group Atmosphere Scale–Cohesion (Gillaspy et al., 2002; Silbergeld et al., 1975). IIP–C 64 = Inventory of Interpersonal Problems–Circumplex 64 (Horowitz et al., 2000).

Note 2: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted. [a]1 week test retest interval, [b]2 week test retest interval, [c]1 month test retest interval. *$r = p < 0.05$, ** $r = p < 0.01$, ***$r = p < 0.001$, NS = NS at 0.05

Note 3: ucc = university counseling centers; op = outpatient mental health centers; ip = inpatient treatment

Note 4: [gm] = grand mean summed over all group sessions

Note 5: CFA = Confirmatory Factor Analysis

Note 6: Aaf = African American; Aas = Asian/Asian American; EaI = East Indian; Hsp = Hispanic/Latino; mr = multiracial; NA = Native-American; O = Other; PI = Pacific Islander; WE = White-European

Note 7: Sub = Substance abuse treatment

Note 8: [+]Ethnicity not provided. IIP–C 64 = Inventory of Interpersonal Problems–Circumplex (64-item version)

Note 1: OQ-45 = Outcome Questionnaire-45 (Lambert et al., 1996). BDI–II = Beck Depression Inventory–II (Beck, Steer, & Brown, 1996). In DUC = Inventory of Drug Use Consequences (Miller, Tonigan, & Longabaugh, 1995). GTAS = Group Therapy Alliance Scale (Pinsof & Catherall, 1986). GAS–C = Group Atmosphere Scale–Cohesion (Gillaspy et al., 2002; Silbergeld et al., 1975). IIP–C 64 = Inventory of Interpersonal Problems–Circumplex 64 (Horowitz et al., 2000).
Note 2: Internal consistency estimated by Cronbach's Alpha, unless otherwise noted.

a1 week test retest interval,

b2 week test retest interval,

c1 month test retest interval.

$^{*}r = p < 0.05$,

$^{**}\ r = p < 0.01$,

$^{***}r = p < 0.001$, NS = NS at 0.05
Note 3: ucc = university counseling centers; op = outpatient mental health centers; ip = inpatient treatment
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Note 7: Sub = Substance abuse treatment
Note 8: $^{+}$Ethnicity not provided. IIP–C 64 = Inventory of Interpersonal Problems–Circumplex (64-item version)

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Chapter 14 Best Practices in Group Counseling and Psychotherapy Research

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Group counseling has a "dual nature" that includes both research and practice (Barlow, Burlingame, & Fuhriman, 2000). Following from the scientist-practitioner tradition, the practice of group counseling should be based on rigorous research in order to ensure that group members benefit from, and are not harmed by, treatment. In return, group research should be useful and accessible to practitioners and be informed by the actual practice of group counseling. And, while a growing body of research shows that group counseling is effective across many settings, populations, and problems (see Barlow, 2011, for a discussion of meta-analyses on the effectiveness of group counseling), additional research is needed to better understand the mechanisms involved in changes in group counseling that lead to successful (or unsuccessful) group experiences (e.g., Kivlighan, Miles, & Paquin, 2011).

Interestingly, the complex group dynamics that make group counseling both an engaging and effective treatment, also present unique conceptual and methodological issues for group researchers and the practitioners who use this research to inform their group work. Group theorists, researchers, and practitioners have long pondered "the subsystems of group [counseling], made up of multiple interactive parts: client, therapist(s), and the group as a whole, asking, 'Is this a singular, cumulative, or collective phenomenon?'" (Barlow et al., 2000, p. 117).

Barlow's question also reflects the nested nature of small group data, as individual group members are nested within groups. This means, for example, that a researcher interested in group counseling attendance may examine qualities of an individual group member (e.g., interpersonal style and expectations about treatment; e.g., MacNair-Semands, 2002), the qualities of the group as a whole (e.g., the level of cohesion in the group; e.g., Roback & Smith, 1987), or the interaction of individual and group level factors (e.g., the individual group member's commitment to the group and the group's absence norm; Kivlighan, Kivlighan, & Cole, 2012). Further complicating group research is the fact that group development occurs over time, often across multiple sessions, adding yet another level of nesting. So the group researcher interested in group counseling attendance may also choose to examine qualities of specific sessions that contribute to attendance in following sessions (e.g., Paquin, Miles, & Kivlighan, 2011).

Finally, data from individuals within the same group are likely to be more similar or dissimilar than data from members of different groups (e.g., Kenny, Mannetti, Pierro, Livi, & Kashy, 2002). In other words, group data are nonindependent, thus violating one of the basic assumptions of many statistical tests of significance. Thus, to return to the example of the researcher interested in group counseling attendance, she may also choose to consider whether individual group members' session attendance is predicted by the behaviors of the other group members, in addition to their own previous behaviors (e.g., intimate behaviors; Paquin et al., 2011). (The nonindependence of group data and considerations for research design and data analysis are also discussed in detail below.)

These complexities of group counseling often mean that traditional research designs and data analytic techniques used in research on individual counseling may not be appropriate for use in research on group counseling, as they do not take all these issues into account. In addition, these complexities also have important implications for group practitioners. Burlingame and Beecher (2008), for example, stated that, in order to be an "evidence-based" group practitioner, one needs to be mindful of "all five sources of influence" found in the group counseling empirical literature that explain group member improvement: patient characteristics, structural factors, leader characteristics, formal change theories, and small group processes (p. 1201). Therefore, in this chapter, we attempt to address some of these complexities in order to help group researchers conduct rigorous, methodologically sound research on group counseling; and to help practitioners to be informed and critical consumers of group research. We begin with a discussion of the relationship between group research and practice and discuss unique

methodological considerations and best practices in group research. We conclude with a discussion of future directions for group counseling research.

The Relationship between Research and Practice

A survey of members of the Canadian Group Psychotherapy Association membership reflects a gap between group counseling researchers and practitioners of group counseling (Ogrodniczuk, Piper, Joyce, Lau, & Sochting, 2010). Specifically, while all respondents expressed a belief that group psychotherapy research can enhance a group psychotherapist's effectiveness, only about half reported being at least moderately familiar with group psychotherapy research. In addition, more than three quarters reported that they wished that they were more familiar with this body of research. These findings may be because of perceptions that the current research does not capture the complexity of groups, that it is not representative of actual clinical practice, and that data collection in "real-life" groups distorts or disrupts the therapy.

Recently, there have been calls to "bridge the gap" between group researchers and practitioners of group counseling (Lau, Ogrodniczuk, Joyce, & Sochting, 2010; Stockton & Morran, 2010). For example, Lau et al. (2010) advocated for the development of practice-research networks to facilitate group psychotherapy research in real-life settings to enhance the external validity of group research and help group practitioners access empirically determined benchmarks on which to evaluate their practice. Lau et al. (2010) also suggested that the use of the American Group Psychotherapy Association's (AGPA) CORE-R Battery (Burlingame et al., 2006) by both researchers and practitioners could facilitate collaborations. In addition to practice-research networks, Stockton and Morran (2010) also suggested that group research teams include group clinicians to maximize the relevance and accessibility of group research to group practitioners.

Despite these creative solutions to addressing the group counseling research-practice divide, more work is necessary. For example, Klein (2008) pointed out that, despite its psychometric properties and clinical utility, AGPA membership has been slow to adopt the CORE-R Battery. Klein (2008) also suggested that there may be many reasons for the continued divide between group counseling research and practice, such as a lack of familiarity with evidence-based practice and/or with group research, and a sense among clinicians that extant group counseling research is not targeted to their practice.

Methodological Considerations and Best Practices in Group Research

Perhaps another reason for the group practitioner-researcher divide is the inherent difficulty in conducting rigorous research on such complex phenomena. Client characteristics, structural factors, leader characteristics, formal change theories, and small group processes have all been found to explain group member improvement (Burlingame & Beecher, 2008). Zaccaro, Cracraft, and Marks (2006) highlighted that a main difference between studying individual phenomena and group phenomena is the "presence of interpersonal dynamics that characterize the latter" (p. 227). They went on to note, "conducting careful group research, therefore, requires a consideration of these dynamics not only in the conceptualization of group phenomena but also in the design of studies, the collection of data from the group as a whole as well as from individual members, and the analysis of such data" (p. 227). Ultimately, they recommended that the methods selected for group research should be guided by the primary purpose of the researcher. For example, we believe group counseling is best conceptualized as a dynamic process whereby members are mutually influencing one another rather than as many individual counseling sessions that happen to be occurring in the same place, at the same time, with the same counselor(s). The former conceptualization gives rise to all kinds of interesting research questions that are at the heart of group counseling and requires researchers to choose measures that get at both individual and group-level phenomenan. For example, researchers may be interested to know whether an individual's in-session behavior in one session will predict her behavior in the following session *and* whether the in-session behaviors of the other group members will predict her behavior (e.g., Miles, Paquin, & Kivlighan, 2011; Paquin, et al., 2011). The Actor-Partner Interdependence Model (APIM; Kenny et al., 2002) is one tool for modeling this mutual influence and interdependence. In a recent study, Paquin, Kivlighan, and Drogosz (2013) tested a simple yet unstudied question using a similar framework described here, to determine if symptom improvement of other group members in a group will predict improvement for an individual group member.

While the complexity of group research and its multiple, interacting components has been acknowledged throughout the history of group work (Barlow et al., 2000), much of the research on group counseling that has been conducted has not taken into account these complex dynamics (Miles, et al., 2011; Paquin, et al., 2011). In this section, we highlight some of the important methodological considerations necessary in group research design, including selection of a group research setting and participants, and measurement of group processes over time. For a full discussion of research design with groups (not specific to counseling), we refer the reader to Zaccaro, et al., (2006); for a full discussion on research in counseling (not specific to groups), we refer the reader to Heppner, Wampold, and Kivlighan (2008); for a discussion with expanded breadth specific to group counseling research design, we refer the reader to Stockton and Morran (2011). We then discuss important considerations for the analysis of group data, including the need to address the nested nature and nonindependence of group data. Throughout this section, we highlight best practices for addressing these methodological considerations in group counseling research.

Group Research Design Considerations

The study of group processes in counseling groups poses unique challenges to researchers. For example, client needs and the availability of resources and services often make it difficult to study counseling groups using experimental designs in which individuals are randomly assigned to treatment and control conditions. In addition, while a researcher may be able to control for some variables (e.g., group size, presenting problem, or therapist level of training), it is difficult to control for other variables, such as group member relationships outside of the group, or time spent engaged in additional treatment (e.g., individual counseling). Because of (and despite) these concerns, group counseling research commonly utilizes intact groups occurring in their natural setting, highlighting again the need for collaboration between group researchers and group practitioners (Lau et al., 2010; Stockton & Morran, 2010). Below we make some recommendations for handling two of the most common challenges in group counseling research design: selecting participants and collecting and analyzing data over time.

Participant Selection

Considerations related to the selection of group participants will vary depending on the research design, setting of the study, and the type of research questions one is interested in exploring. One important consideration is the number of participants and the number of groups that a group researcher needs in order to detect relationships among variables of interest (Zaccaro et al., 2006). To illustrate, a group researcher seeking to understand group cohesion in an unstudied or understudied group type or population may choose a case study design (n = 1). For example, Prestano, Lo Coco, Gullo, and Lo Verso (2008) used a case study design to provide a preliminary examination of process variables (e.g., group climate) in group psychoanalytic therapy for eating disorders. The case study approach allows the researcher to holistically explore how a construct (in the case of this example, group cohesion) operates in a new context (in this example, an understudied group or population) in order to begin to be able to generate and test hypotheses. It is important to note, however, that while case studies may serve to maximize internal validity, there is less external validity than there is in larger studies of multiple groups.

In a different scenario, group researchers seeking to elucidate relationships among group cohesion and group member outcomes (e.g., symptom change) will likely require more groups and group members for their study. This is because the degrees of freedom in a study are based on the highest level (or largest unit) of analysis (unless the effect is fixed). So if a group researcher does not have enough groups and/or group members in her or his study, there will not be enough degrees of freedom to conduct appropriate analyses and to make generalizable claims about the data. We refer readers to Spybrook et al. (2009) for a detailed discussion on sample size and power in multilevel research (and software that may be used to calculate these). However, it is most important to note here that the realities of group research (e.g., the feasibility of conducting research with a large number of group members), often dictate the number of sessions, group members, and groups that group counseling researchers include in their studies.

Furthermore, in considering the number of group members and groups necessary, a group researcher should consider the level (i.e., session-level versus member-level versus the group level) at which the research question rests. For example, a study in which the research question rests at the session-level (e.g., "What is it about this session that predicts group member attendance in the next session?"; Paquin et al., 2011), data must be gathered at each session, over the life of a group. Thus, the N (and the degrees of freedom) will be based on the number of group members multiplied by the number of sessions (e.g., the N in a session-level analysis with 10 group members over 10 sessions would be 100). In contrast, in a study aimed at comparing the relative efficacy of one group treatment to another, the research question lies at the group level (e.g., "What is it about these groups that predicts more of [fill in the blank] change, when compared with these other types of groups?"). For example, in a study comparing a trauma-focused group intervention with a present-centered group intervention for survivors of childhood sexual abuse (Classen et al., 2011), the authors randomly assigned participants and included baseline and outcome data from seven groups in each of the two treatment conditions, plus a wait-list control group; each group consisted of eight participants (7 groups x 3 conditions x 8 members each = 168 participants). This study required more participants (and groups) in order to achieve enough degrees of freedom for any test of the means to achieve stability (although group means, as opposed to individual means, have been found to be relatively more stable; Zaccaro et al., 2006). Because research questions differ, best practices in participant selection should be guided by the research question.

Data Collection over Time

In addition to the question of *who* will be included in the research, group researchers need to consider *when* (e.g., at one point in time, pre- and postgroup, or repeated observations over the life of the group) and *how* (e.g., self-report measures, observational methods) they will examine group phenomena. With regard to the question of when, pre- and postgroup measures are useful for examining group outcomes but miss the session-to-session group processes that relate to these outcomes. For example, the amount of intimate behaviors (e.g., making self-disclosures, providing feedback; Shadish, 1986) within an individual session has been found to relate to group member absence (Paquin et al., 2011). Specifically, Paquin et al. found that when an individual group member enacted the most or the least intimate behaviors within a session and when the other group members enacted a low level of intimate behaviors in a session, the individual group member was more likely to be absent from the following session. In this study, collecting data only at the individual level would have missed significant, session-

level processes connected to being absent from group sessions. Session-level data of this kind can also provide practitioners with an ongoing source of evaluative data and can allow for interventions that prevent absence in real time (e.g., if a group leader notices that a group member has been unusually high in disclosure relative to the other members, the leader may choose to process this with the group and encourage this member to return next session). Therefore, studies of group counseling may be strengthened by examining group process over time using repeated measures, to account for the nesting of sessions within group members (Kivlighan, Coleman, & Anderson, 2000; Zaccaro et al., 2006). Repeated measurements throughout the life of the group allow researchers to examine how group processes may mediate the relationships between group inputs and group outcomes (Zaccaro, et al., 2006). Several data analytic techniques are available that appropriately handle repeated measurements of group data (e.g., growth curve analysis, multilevel latent growth curve analysis). Here we discuss one of the most widely used techniques in group counseling research: growth curve analysis.

Growth Curve Analysis

One technique for analyzing these repeated measures data is growth curve analysis, a form of hierarchical linear modeling (HLM) that allows researchers to examine change over time (e.g., Luke, 2004; Raudenbush & Bryk, 2002; Singer & Willett, 2003). For example, Miles and Kivlighan (2008) used growth curve analysis to examine the development of the group climate (engaged, avoiding, and conflict, as assessed with the Group Climate Questionnaire–Short Form; MacKenzie, 1983) over time in intergroup dialogue groups and whether the coleaders of these groups developed more similar conceptualizations of their groups over time. To do this, they ran separate growth curve analyses for each of the dependent variables (engaged, avoiding, conflict, and similarity in coleader conceptualizations of their group members) using HLM. Using a two-level model in which group sessions (i.e., Level 1) were nested within groups (i.e., Level 2), they modeled change over time (i.e., within groups), as well as between groups. They found that, over seven weeks, engagement increased significantly and avoiding decreased significantly. However, there was no significant change in conflict or similarity in coleaders' conceptualizations of their group members over time. For a full discussion of growth curve analysis, the reader is referred to Luke (2004), Raudenbush and Bryk (2002), and Singer and Willett (2003).

An additional question that group counseling researchers must consider is how they will collect their data. For example, they need to determine whether they will use self-report methods (e.g., asking a group leader to pass out a paper and pencil survey to group members after each session) versus observational methods (e.g., having a process observer in a group session or having research team members watch videos of group sessions). As with any research, group counseling research is subject to monomethod biases (Heppner et al., 2008). So rather than relying solely on group member self-reports of group process and outcome variables, group researchers should consider additional sources of data (e.g., observational methods).

Given the complex, dynamic, and often fleeting nature of counseling groups, audio or videotaping group sessions for later transcription and coding may be particularly useful (Zaccaro et al., 2006). While videotaping presents its own set of ethical and logistical concerns, particularly with sensitive populations (e.g., trauma survivors, children, or adolescents) or in underresourced mental health settings, some researchers have had success in videotaping sessions among even vulnerable populations (Nickerson & Coleman, 2006) and have thus created an invaluable (yet sensitive) data archive.

The Nested Nature of Group Data

In a symposium at the 2011 Annual Convention of the American Psychological Association, Division 49, the Society of Group Psychotherapy and Group Counseling on "best practices in group research," a panel of group researchers addressed some of the pitfalls that weaken conclusions in group therapy research. Problems associated with the inappropriate analysis of nested, interdependent data (or "intragroup dependency") were highlighted as some of the major pitfalls (Burlingame, 2011; Paquin & Kivlighan, 2011). Group counseling researchers have traditionally analyzed small group data by looking only at individual group member effects. For example, a researcher might ask, "How does Colin's behavior in his counseling group predict Colin's perceptions of his group?" However, group data exist on multiple, nested levels (i.e., the session level, the level of the individual

group member, and the group level). Looking only at how Colin's behavior affects Colin's perceptions misses much of the richness that makes group work both effective and engaging. Therefore, it is important for researchers to consider the level(s) at which they will examine their group phenomena. For instance, researchers may be interested in examining phenomena at the session level (i.e., a between-sessions design; "What was it about this particular session that related to Colin's perceptions of the group?"), the level of the individual group member (i.e., a between-persons design; "What is it about Colin's personality that relates to his perceptions of the group?"), or the group level (i.e., a between-groups design; "What is it about the group that Colin is in that relates to Colin's perceptions of his group?").

Generally, group research has examined group phenomena at one of these levels but rarely attends to multiple levels of data (Paquin et al., 2011). This is problematic because the nested nature of group data means that variance may be accounted for at any one or more of these levels. So even if a researcher's question is at the session level, for example, it is still important to examine the individual group member and group levels.

Multilevel Models

In order to account for the multilevel, nested nature of group data, researchers need to use data analytic tools that account for these levels. As discussed above, with regard to the analysis of repeated measures over time, hierarchical linear modeling is one data analytic tool that accounts for the multiple, nested levels of data inherent to group research and also allows for the partitioning of the variance among these levels (Raudenbush & Bryk, 2002). This way, researchers can separately examine the variance that is attributable to the sessions, individual group members, *and* the group. For example, in HLM, the variance attributable to the group can be assessed by examining the intraclass correlation coefficient (Burlingame, 2011). This metric, ranging from 0 to 1.0, is a measure of "groupiness"; it tells the researcher to what extent the variable of interest is a group-level variable.

A study by Kivlighan (2011) highlights the importance of addressing the nested, multiple-level nature of group data. Previous research on therapeutic factors typically has examined perceptions of these factors at the level of the group as a whole (Kivlighan, 2011; Kivlighan et al., 2011). In contrast, Kivlighan was the first to examine relative variance in perceptions of therapeutic factors at the session, individual group member, *and* group levels. Following each of 28 sessions, Kivlighan asked participants in six growth groups to complete a critical incident form (i.e., responding to questions about what was the most important event to that person in the most recent session and why it was important) and session evaluation questionnaires. He then coded the critical incidents using the classification of therapeutic factors developed by Bloch, Reibstein, Crouch, Holroyd, and Themen (1979). This classification system includes 10 therapeutic factors, including catharsis, self-disclosure, learning from interpersonal actions, universality, acceptance, altruism, guidance, self-understanding, vicarious learning, and hope. Kivlighan then ran 10 separate completely unconditional models in HLM (one for each of the 10 therapeutic factors) in order to partition the variance. He found that, on average, about 95% of the variance in group members' perceptions of therapeutic factors was at the session level, about 4% of the variance was at the level of the individual group member, and only about 1% of the variance was at the level of the group. Kivlighan concluded that if researchers continue to examine therapeutic factors at the group level only, they will likely miss the most important source of variance—the session. Rather than asking, "What is it about this group, compared to other groups, which accounts for change in group counseling?" researchers might consider asking, "What is it about this session that accounts for change in group counseling?" Before leaving this section, we should note that the social relations model (Marcus, 1998; Warner, Kenny, & Soto, 1979) and the actor-partner interdependence model (Cook & Kenny, 2005; Kenny et al., 2002) also account for the nested nature of group data. These models will be discussed in the section that follows regarding the nonindependence of group data.

The Nonindependence of Group Data

In addition to their nested, multiple-level nature, group data are also nonindependent. The nonindependence of group data "means that persons who are in the same group are more similar (or dissimilar) to one another than are persons who are members of different groups" (Kenny et al., 2002, p. 126). Much of the existing research on groups has not taken into account the nonindependence of the data (Kivlighan et al., 2000; Miles et al., 2011;

Paquin et al., 2011). For example, in a review of group treatment studies of panic disorder, obsessive-compulsive disorder, and breast cancer, only one study out of the 56 reviewed controlled for data nonindependence (Burlingame, 2011). This is problematic because traditional methods of data analysis (e.g., ANOVA, regression) assume independence of observations, and group data violate this assumption. Violation of this assumption distorts the estimate of error variance, invalidating the standard errors, *p* values, confidence intervals, and most effect sizes and may lead to increased Type I or Type II errors and decreases in power (Kenny et al., 2002).

Failure to account for the nonindependence in the data also may mean that an individual's scores are potentially confounded with the rest of the group's scores. For example, if a group researcher is interested in the mean level of some behavior in the group on Julie's perceptions of the group, and Julie's score is included in the calculation of the group mean, it is unclear the extent to which any observed relationship with Julie's perception of the group is attributable to the group and to what extent any observed relationship is because of Julie's own behavior.

As described above, one measure of nonindependence is the intraclass correlation coefficient. When the observations for a variable are equal for all members of a group and the group means differ between groups, the intraclass correlation coefficient will be at its highest, 1.0, indicating a high level of "groupiness" is associated with that variable. When observations for a variable differ among group members, but group means are similar, the intra-class correlation coefficient will be lower.

Baldwin, Murray, and Shaddish (2005) pointed out that the problem of nonindependence in group data has far-reaching implications in the current context of managed care. To further illustrate how nonindependence presents a problem in empirical research on group counseling and psychotherapy, Baldwin et al. (2005) conducted a meta-analysis of all 33 studies of "group-administered treatment" identified in 1998 as "empirically supported treatments" by a Task Force of the American Psychological Association's Division 12 (p. 924). They reported that none of the 33 studies included mention of the nonindependence of group data nor reported intraclass correlation coefficients. In addition, when they applied a correction to the analyses in these studies to account for the nonindependence of the data, they found that only about 12%–68% of the effects in the 33 studies that had been reported as significant actually were significant. Ignoring the nonindependence of the group data, and not including a group term in the analyses, resulted in increased Type I error; the researchers of the original studies detected a treatment effect that may have been attributable to the group itself, not the treatment.

Nonindependence in group data can come from many sources, including nonrandom assignment to groups (*compositional effect*), the fact that members of a group coexist within the same environment (*common fate*), and the impact that members of a group have on one another (*mutual influence*). It is often impossible for a group researcher to control for all these sources of nonindependence. Fortunately, there are several techniques for addressing the nonindependence of group data. Here, we discuss two: the social relations model (e.g., Marcus, 1998; Warner et al., 1979) and the actor-partner interdependence model (e.g., Cook & Kenny, 2005; Kenny et al., 2002).

Social relations model

The social relations model (SRM; e.g., Marcus, 1998; Warner et al., 1979) is one method for examining interpersonal behaviors and perceptions in groups that group researchers have begun using to handle the issue of nonindependence in group data. In addition to its ability to handle nonindependence, SRM also has several other advantages (Markin & Kivlighan, 2008), including that it accounts for group-level variance and can analyze data across different levels that exist in group research (i.e., session, group member, and group).

The SRM was initially developed to deal with round robin data (Marcus, 1998; Warner et al., 1979). In a round robin research design, "all possible pairs of subjects from some set of subjects interact … For each person paired with every other person, an observation is made of some social behavior" (Warner et al., 1979, p. 1742). Counseling and psychotherapy groups can easily provide these data. For example, a round robin design might be utilized to examine patterns of feedback between group members (i.e., which group members are providing and/or receiving feedback from which other group members; Marcus, 2006). Kenny's (1993, as cited in Marcus, 1998)

SOREMO program can be used to analyze round robin data in the SRM.

The SRM for examining interpersonal behavior consists of the actor effect, the partner effect, the relationship effect, the constant (group effect), and error (Marcus, 1998, 2006). When examining interpersonal perceptions, the terminology is somewhat different, though the model itself is identical (Marcus, 1998). In this case, rather than actor and partner effects, we would refer to perceiver and target effects. For example, returning to Marcus' (2006) suggestion that the social relations model may be useful for examining group feedback patterns, let's say Pat provides feedback to Julie in a group session. Using the SRM, we could examine the perceiver effect (i.e., the typical feedback that Pat gives to all others), the target effect (i.e., the typical feedback received by Julie from all others), the relationship effect (i.e., feedback that is characterized by Pat's unique relationship to Julie), and the constant group effect (i.e., the typical feedback given in this particular group). Marcus pointed out that high levels of variance accounted for by the target effect imply consensus within the group (in the case of our example, this would imply that Julie receives similar feedback from all members of the group; there is consensus with regard to the type of feedback given to Julie). Similarly, Mallinckrodt and Chen (2004) have suggested that perceiver effects can be used to examine transference configurations in group counseling (see below).

The SRM has not often been utilized by researchers (Kivlighan et al., 2000; Marcus, 1998; Markin & Kivlighan, 2008), however it has many potential applications for group counseling and psychotherapy research. For example, Mallinckrodt and Chen (2004) used the SRM to examine transference in group psychotherapy. They suggested that, because perceiver variance reflects "idiosyncratic differences between the ratings given by one group member and the aggregate ratings of other members for the same target person" (p. 214), it could be used as a proxy indicator for transference distortions. Mallinckrodt and Chen examined perceiver variance in round robin data on the dimensions of control and affiliation dimensions of Kiesler's (1987, as cited in Mallinckrodt & Chen, 2004) interpersonal circumplex, as well as pretest data on parental bonds and attachment styles in interpersonal growth groups. They found perceiver variance (i.e., transference distortion) was significantly related to certain negative memories of parental bonds and attachment styles. So, for example, a group member who rated her or his parents high on overprotection was also likely to perceive hostility from other group members that the rest of the group members did not perceive.

Markin (2009) also advocates for the use of the SRM in the examination of transference in group psychotherapy, and she has used the social relations model in her own studies of transference and the social microcosm hypothesis (Markin & Kivlighan, 2008). Specifically, Markin and Kivlighan collected data on central relationship themes (CRTs) in group members' romantic relationships (i.e., their wish or need from their partner; their perception of how their partner will respond to this need; and how they, themselves, respond to this perception), and round robin data in which each group member rated every other group member on CRTs, as they perceived them in the group. Markin and Kivlighan found that perceiver variance accounted for a significant amount of variance in CRTs and accounted for much more variance than target variance. This suggests that individual differences related to transference, rather than something about the situation or their fellow group members, drive the perceptions that group members have of their fellow group members' CRTs.

In addition to examining transference with the SRM, Markin and Kivlighan (2008) examined the social microcosm hypothesis, which suggests that group members perceive others in the group in a manner consistent with their interpersonal problems (e.g., Yalom & Leszcz, 2005). As a result of these perceptions, group members enact maladaptive relationship patterns in the group, have the opportunity to receive feedback, and try out new, more adaptive behaviors in the context of the group. In order to empirically examine the development of social microcosm in group psychotherapy, Markin and Kivlighan examined the correlations between perceiver variance in CRTs in psychotherapy groups and CRT data on group members' romantic relationships outside of groups. Inconsistent with the social microcosm theory, none of the correlations were significant. Based on these studies, it is clear that the social relations model not only handles the nested nature and nonindependence of group data but that it also holds promise for future group counseling research.

Actor-Partner Interdependence Model

The actor-partner interdependence model (APIM) is an adaptation of multilevel modeling that can also be used for studying reciprocal social relationships, and that accounts for nonindependence in group data (Kenny et al., 2002). Furthermore, the APIM permits longitudinal study of group processes as it can be used to analyze multiple data points over time (Cook & Snyder, 2005). This model was initially developed for examining dyadic data (e.g., Cook & Kenny, 2005; Kenny, 1996) and was "created to combine the results from a between-within analysis into a more conceptually meaningful solution" (Kenny et al., 2002, p. 131).

When applied to group research, the *actor effect* refers to the degree to which an individual group member's own level of an independent variable relates to her or his own outcome, or dependent variable. The *partner effect*, then, refers to the effect of the group's level of an independent variable on the individual group member's outcome, or dependent variable. As articulated by Kenny et al. (2002), however, the partner effect is calculated as the mean for the rest of the group members, not including the focal individual. This calculation allows for separate examination of actor and partner effects, without one confounding the other.

The study described above examining the relationship between intimate behaviors and absences by Paquin et al. (2011) provides an example of the use of the APIM in interpersonal growth groups for trainees in a graduate counseling program. Specifically, Paquin et al. hypothesized that when an individual group member has made herself or himself vulnerable in a group by engaging in either the most or the least intimate behaviors in a session (i.e., the actor effects), then she or he would be more likely to be absent in the next session. In addition, they hypothesized that a low level of intimate behaviors by the *other* group members (i.e., the partner effect, calculated as the mean amount of intimate behaviors by the other group members, excluding the amount of intimate behaviors engaged in by the focal individual) would reflect low cohesion in a group session and would also be related to a decreased likelihood that a group member would attend the following session. Consistent with their hypotheses, Paquin, Miles, and Kivlighan found significant actor effects such that when an individual group member engaged in the most or the least number of intimate behaviors in a session, relative to the other members of their group, they were at an increased likelihood to be absent in the next session. They interpreted this finding to be consistent with the literature that suggests being a group session "outlier" is likely to result in increased absences and an increased likelihood of dropping out for the deviant group member (e.g., Yalom & Leszcz, 2005). In addition, they found significant partner effects such that a low level of intimate behaviors by the other group members in a session was related to an increased likelihood that an individual group member would be absent in the following session. They suggested that this finding highlights the importance of the group context for continued investment in the group. This finding also highlights the importance of examining both actor (individual) and partner (the other members of the individual's group) effects in group counseling research.

Miles et al. (2011) also used the APIM to examine group and partner effects on an individual group member's amount of intimate behaviors in a session. Specifically, they were interested in the relationship between the amount of intimate behaviors that an individual group member engaged in during a session and the amount of intimate behaviors engaged in during the following session (i.e., the actor effect). They were also interested in the relationship between the intimate behaviors of the other group members and the intimate behaviors of the individual group member (i.e., the partner effect). They suggested, however, that the partner effect should consist of two components: amount (i.e., mean level) and consistency (i.e., standard deviation) of intimate behaviors of the other group members. That is, they hypothesized that it was not just the amount of intimate behaviors enacted by the other group members in a session that mattered but also the consistency of those behaviors across group members (versus, for example, only one group member engaging in a lot of intimate behaviors, thus inflating the group mean). They found a significant actor effect, such that the previous amount of intimate behaviors of an individual group member related to the future intimate behaviors of that group member. In addition, they found a significant interaction effect between the two components of the partner effect, such that when the consistency with which the other group members engaged in intimate behaviors was low (i.e., when the standard deviation was high), there was a significant, negative relationship between the amount of intimate behaviors of the other group members and the amount of intimate behaviors of the individual group member. However, when the consistency with which the other group members engaged in intimate behaviors was high, the relationship between the amount of intimate behaviors of the rest of the group and the intimate behaviors of the individual group member was not significant. This study expands on the APIM, suggesting that it is not just the level of a

behavior (i.e., mean) of the rest of the group members that matters but also the (in)consistency with which the group members are engaging in that behavior (i.e., the standard deviation).

Missing Data

A final consideration in group research that we would like to highlight is how to handle an incomplete data set. Missing data typically occurs when there are nonresponses to items on a measure, attrition in the case of longitudinal studies, or group member absence from a particular group session. Missing data can affect statistical inferences and can bias study results, therefore it is important to consider the meaning of the "missingness" of data from a study (Schlomer, Bauman, & Card, 2010). For instance, what percentage of the total data set contains missing data? Is the missing data missing at random or is there a pattern? Which statistical tools are better suited to address various amounts and types of missing data? These and other questions will help the researcher determine how to address the issue of having an incomplete data set.

Researchers are encouraged to report missing data in both the text and tables of a manuscript (Bauman, 2011). Expectation maximization, multiple imputation, and full information maximum likelihood are three recommended strategies for estimating the missing values, available as part of (or easily interphased with) most statistical packages (Bauman, 2011). For a detailed discussion on how to address missing data in groups, we refer the reader to Schlomer et al. (2010).

Future Directions for Group Counseling and Psychotherapy Research

Given the complex nature of group counseling, group researchers have an important role to play in helping us understand the processes and outcomes of group work, ultimately leading to the most therapeutic experiences possible for group members. It is also clear, however, that for this research to be useful to group practitioners, it must be both accessible and relevant to their actual group work. For this reason, we echo the call for increased collaborations between group researchers and group practitioners given by Lau et al. (2010) and Stockton and Morran (2010) in order to bridge the gap between group researchers and group practitioners. Group practitioners have identified a desire for additional research connecting group process to outcome, on group leadership issues, cost-effectiveness of group counseling, member selection, long-term group therapy, and group treatments for individuals with personality disorders (Ogrodniczuk et al., 2010). They have also expressed a desire for additional qualitative studies, including case studies. These are all potentially fruitful avenues for future group counseling research. We also offer additional suggestions for more specific areas of need in group research.

Translational Research

Tashiro and Mortensen (2006) highlighted the utility of *translational research*, which applies "basic science findings to the prevention and treatment of illness" (p. 960), to better understand the mechanisms that underlie successful interventions. We believe that this is a potentially useful avenue for group counseling researchers as well. Counseling and psychotherapy groups are but one (albeit highly specialized) type of small group, involving a range of social interactions (e.g., providing feedback) and cognitive and emotional processes (e.g., interpersonal learning, catharsis). Therefore, it is instructive for group researchers to continue to incorporate "basic science," theory, and methodology from other areas of psychology, such as cognitive, social, and industrial-organizational psychologies, who also study these processes.

To some extent, this integration between basic and applied group research from across disciplines of psychology is occurring. For example, Kivlighan and Miles (2007) conducted a content analysis of the manuscripts published during the first five years of publication of the journal *Group Dynamics: Theory, Research, and Practice*, using cluster analysis. They found that these manuscripts could be categorized into six "clusters." They labeled these clusters (in order of decreasing frequency): cohesion and group identification, attributions and perceptions in groups, leadership and performance in groups, power and relationships among group members, knowledge and cognitive process in groups, and group psychotherapy. Kivlighan and Miles pointed out that the majority of the studies on group counseling were not actually in the group psychotherapy cluster. Thus, they concluded that the journal has allowed for an integration of small group research from the various subdisciplines of psychology that study small groups. That is, it appears that group counseling researchers have integrated, to some extent, with others who study group phenomena. Barlow (2011) echoed this conclusion and highlighted the possibilities for continued "alliances" (p. 213) between group counseling researchers and researchers in other domains of psychology. These continued collaborations with other areas of psychology have the potential to provide group counseling researchers with novel group theory and research methods that will further the state of group counseling research.

For example, Miles and Kivlighan (2008) borrowed the concept of team cognition from industrial-organizational psychology and applied to the coleadership of group interventions. Research on team cognition in industrial-organizational psychology typically finds that the degree of overlap in cognitions (e.g., "mental models") among members of a team or group is related to team effectiveness (e.g., Bonito, 2004; Espevik, Johnsen, Eid, & Thayer, 2006; Mathieu, Heffner, Goodwin, Salas, & Cannon-Bowers, 2000; Waller, Gupta, & Giambatista, 2004). Similarly, Miles and Kivlighan examined the relationship between similarity in coleaders' cognitions about their group members and group members' perceptions of the group climate in intergroup dialogue groups, a group intervention specifically aimed at issues related to diversity and social justice. They found that similarity in coleaders' cognitions about their group members was, in fact, related to increased perceptions of engagement and decreased perceptions of avoidance in the groups over time. Miles and Kivlighan concluded that similarity in cognitions about their group members allowed group coleaders to work together on similar goals for each group

member, and the group as a whole, and this was experienced by group members through the development of a productive group climate. Future research might look at the similarity in the cognitions of group members or the similarity in cognitions of group members and group coleaders and their relationship on group climate (or other group process and outcomes).

Group Coleadership

Another specific area in which additional research is needed pertains to group coleadership. Though coleadership of group counseling is a common practice (e.g., DeLucia-Waack, 2006; Yalom & Leszcz, 2005), relatively little research exists on the processes involved in group coleadership or the relationship between these processes and group member outcomes (Fall & Menendez, 2002; Luke & Hackney, 2007). Roller and Nelson (1993) pointed this out twenty years ago, stating that "Psychotherapists … have been keenly interested in the relationships that their patients form with others, but [they] have been curiously reluctant to focus their attention on the relationships they themselves form with colleagues as they treat patients in the practice of cotherapy" (p. 304). This is interesting, given that group leadership is one of the major content themes identified across subdisciplines concerned with small group research (Kivlighan & Miles, 2007).

In one attempt to address this gap in the literature on group coleadership, Miles and Kivlighan (2010) proposed and tested a coleadership, team cognition-team diversity model. Based on the findings of Miles and Kivlighan (2008) that similarity in coleaders' cognitions about their groups was related to the development of a productive group climate, they hypothesized that similarity in coleaders' cognitions about their group members may be beneficial in terms of group process and outcomes. At the same time, however, based on the literature on team diversity, they hypothesized that differences in coleader behavior would also be beneficial in terms of group process and outcomes. Miles and Kivlighan found partial support for this model. Specifically, they found that dissimilarity in coleader behavior was related to decreases in conflict over time. However, they also found that reductions in avoidance were greater over time when coleaders were perceived as more similar in their behaviors. Clearly, the issue of coleader similarity and dissimilarity is a complex one, and additional research is warranted to determine optimal levels of affective, cognitive, and behavioral similarity in coleader pairs.

Multicultural Group Counseling

A final area of need within group counseling research is multicultural group counseling. While a recent PsycINFO search for keywords "group counseling," "group therapy," or "group psychotherapy" yields over 15,500 results, the addition of keywords "multicultural," "diversity," "diverse," or "social justice" yields just 79 results. This suggests a strong need for research on multicultural issues within group counseling, given the professional ethical codes and guidelines of professional organizations such as the American Psychological Association (2002) and the American Counseling Association (2005) that require practitioners to deliver competent multicultural treatments and the assumption that all groups are, to some extent, multicultural in nature (Chen, Thombs, & Costa, 2003).

In their chapter on affirmative counseling for gay men, Chen, Stracuzzi, and Ruckdeschel (2004) referred to Yalom's concept of the "counseling group as a social microcosm"—that is, that it represents a "miniaturized presentation of each member's social universe" (p. 402). Members of marginalized groups are often exquisitely aware of their environment and their fringe-position within these environments given their lack of power and status. Given this, a meaningful conceptualization of group members' "social microcosm" and their experience interfacing with mental health treatment (in this case, participating in group therapy) requires a contextual (as well as clinical) examination and one in which the tools outlined above are particularly well suited. However, the majority of extant group counseling (and counseling, in general) theory and practice have been developed from a Eurocentric, masculinist, and heteronormative perspective; therefore, additional research on multiculturally competent group counseling, and on addressing the needs of diverse populations, is paramount (Rivera, Garrett, & Crutchfield, 2004). Chen et al. (2003) highlighted the importance of intercultural dialogues such as those in group counseling, given the real, ongoing impacts of social inequality on the lives of group members. However, group counseling research has yet to empirically examine the use of this type of intergroup dialogue in group counseling. Researchers might, for example, qualitatively explore the experiences of racially and ethnically diverse

group members within the same group, as the group dialogues about the impacts of privilege and oppression on their lives. Chen et al. (2003) also highlight the importance of developing an understanding of culture on group processes, such as self-disclosure and providing feedback, and their relationship to group processes and outcomes. These are just a few of the many concepts related to multiculturalism, diversity, and social justice that are ripe for exploration in future group counseling research.

Conclusion

Barlow et al. (2000) discussed the "dual nature" of group counseling, highlighting the importance of both group research and group practice. It is clear, however, that a gap remains between group research and group practice and that continued development of collaborations between group researchers and practitioners is necessary (Lau et al. 2010; Stockton & Morran, 2010). As any group therapist can attest, the factors that make group counseling and psychotherapy so rich and rewarding are the very things that make it difficult to study. However, rigorous group research is crucial, as it informs our understanding of effective and ethical group practice. The nonindependence of group data, the nested nature of group data, missing data, and the longitudinal nature of counseling and psychotherapy groups necessitate special methodological considerations, not usually necessary in research on individual interventions. Therefore, thoughtful attention to study design, participant selection, and tools for analyzing group data are key. In addition, both group researchers and group practitioners must be informed and critical producers and consumers of group counseling research. Research must be relevant and accessible to group practitioners and driven by questions derived from the actual practice of group counseling. Specific needs lie in the areas of group coleadership and multicultural group counseling, and group researchers may also draw on a wealth of psychological research on other social processes and/or different types of small groups, beyond counseling to conceptualize previously unrecognized or poorly understood group therapy phenomena.

Given the emphasis on group counseling as the "treatment modality of the future" (Yalom & Leszcz, 2005, p. xiv), it is imperative that it be based upon the most rigorous research available (Burlingame & Beecher, 2008). While conducting group research can be arduous and complex, a continued scientific exploration of simply what it means when clients and therapists find themselves to be a part of a group that is working well can and should be our most fundamental guiding question.

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Part III Introduction to Multicultural and Diverse Counseling and Psychotherapy Groups

Janice L. DeLucia-Waack

Much has changed in the field of multicultural counseling, and specifically, multicultural groups in the last ten years. The definition of multicultural has become broader and more inclusive. Yalom and Leszcz (2005) emphasized the importance of heterogeneity in helping group members consider problems (and solutions) from multiple perspectives. Thus, embracing heterogeneity and using it to facilitate group dynamics is a positive step. Anderson (2007) offered this:

> Multicultural group work is a helping process that includes screening, assessing, and diagnosing dynamics of group social systems, members, and leadership for the purpose of establishing goals, outcomes, processes, and interventions that are informed by multicultural counseling knowledge, skills, and abilities. It is a process of planning, implementing, and evaluating group work strategies from a sociocultural context of human variability, group, and individual identity, worldviews, statuses, power, and other salient demographic factors to facilitate human and organizational development. The goal of multicultural group work is to promote human development and to enhance interpersonal relationships, promote task achievement, and prevent or identify and remediate mental, emotional or behavioral disorders or associated distress that interfere with mental health, and to lessen the risk of distress, disability, or loss of human dignity, autonomy, and freedom. (pp. 225–226)

Diversity and multicultural issues are inherent in groups. Interactions, and individual interpretations of such interactions, vary based on ethnicity, culture, religion, gender, sexual orientation, and age. Effective groups help members understand themselves and others as individuals within the context of their culture. Multicultural counseling competencies suggest that group leaders choose interventions and methods of change based on the interplay between individuals and their worldviews. Traditional group work is based on Eurocentric values, beliefs, and assumptions about counseling, specifically individualism, independence, competitiveness, and achievement (Taha, Mahfouz, & Arafa, 2008; Toseland, Jones, & Gellis, 2004). The lead chapter in this section by Michael D'Andrea takes on the challenge of how worldviews, the overarching Eurocentric view of counseling, and individual racial/cultural identity development, create a complex dynamic that can hinder and help group progress.

In addition, Constantine, Hage, Kindaichi, and Bryant (2007) proposed that social justice competencies be infused into the training of all group leaders. Current professional standards are beginning to reflect this emphasis with the newly revised Association for Specialists in Group Work retitling their standards "Association for Specialists in Group Work: Multicultural and Social Justice Competence Principles for Group Workers (2012)." New to this edition, the final article in this section by Anneliese Singh and Carmen Salazar highlights the importance of social justice in all groups and suggests strategies and group interventions for social justice.

Each of the remaining chapters in this section focus on specific multicultural and diverse groups to help group leaders understand the key issues and themes in these groups based on current research and practice and suggest best practices for groups with these populations. Diversity competent group leaders possess "attitudes and beliefs, knowledge and skills to facilitate a group process where diversity and culture are not only acknowledged, understood, and valued but also mobilized for the collaborative productivity of the group and the therapeutic benefits of its members" (Merchant, 2006, p. 323). Each culture has its own set of beliefs about healing, loyalty, honor, and family that influence counseling and group work. It is imperative that group leaders examine their beliefs about how people learn, change, and grow from both a cultural and theoretical orientation perspective, then begin to think about how people from other cultures may view the group process and interactions. In addition, "practice principles for cultural competence must be built on an empirical foundation as we gather data

from and about diverse ethnic and racial groups" (Garvin, Gutiérrez, & Galinksy, 2004, p. 6). Then research must systematically evaluate and help tailor culturally sensitive group treatments. Each chapter in this section is unique but all have incorporated current research and practice. Sharon Horne and colleagues make a unique contribution in their chapter working with gay, lesbian, bisexual, transgender, queer, and questioning (GLBTQQ) group members by clearly outlining the planning process and its importance around confidentiality, disclosure, and creating cohesion. Sam Steen, in his chapter on African Americans, comments on the dearth of research on groups for this population, then focuses on barriers that prevent the use of group counseling, and ends with suggestions on how to incorporate cultural values into group work. Stephanie Ellis and her colleagues tackle the tall task of addressing how to lead effective groups with persons with disabilities (a very broad perspective) beginning with physical and special accommodations and then discussing in detail specific types of groups based on goals and disabilities. Rita Chi-Ying Chung and Fred Bemak emphasize the importance of intragroup and intergroup differences when working with Asian group members, providing specific guidelines for both homogeneous and heterogeneous groups. In another new chapter, Tammi Vacha-Haase describes the issues inherent in working with those in their later years and describes specific groups and research supporting these group interventions. Edil Torres-Rivera and colleagues continue to explore the issues that may arise when leading groups with Latinos/as, specifically cultural values that may help and hinder the group process, and suggest a Liberation Psychology approach to lead groups with this population. Paula McWhirter and Rockey Robbins begin their chapter with descriptions of Native American traditional healing methods (and their congruence) with group counseling, leading into suggestions to address barriers for Native Americans to joining and participating in groups.

I thoroughly enjoyed reading these chapters. I learned a lot as well as was forced to examine my personal worldview, my assumptions about how groups work and different populations, and what works for whom. Hope you are challenged as well!

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Chapter 15 Understanding Racial/Cultural Identity Development Theories to Promote Effective Multicultural Group Counseling

Michael D'Andrea

The United States is undergoing an unprecedented transformation in its demographic makeup (U.S. Census Bureau, 2010), shifting from a historically White, western-European, English-speaking majority to a diverse mix of non-White, non-western European, and non-English-speaking persons. This demographic transformation demands mental health practitioners to acquire new competencies to work effectively, respectfully, and ethically with persons from diverse racial/cultural groups (Lewis, Lewis, Daniels, & D'Andrea, 2011).

The Association for Multicultural Counseling and Development and the Association for Specialists in Group Work have led the counseling field by developing *Multicultural Counseling Competencies* (Sue, Arredondo, & McDavis, 1992) and *Multicultural and Social Justice Competence Principles for Group Workers* (ASGW, 2012). The ASGW *Principles for Diversity-Competent Group Workers* (2012) state that "issues of diversity affect group process and dynamics, group facilitation, training, and research" (p. 1). These guidelines suggest that culturally competent group leaders choose interventions and methods of change based on their understanding of the interplay between individuals and their worldviews (DeLucia-Waack, 2011).

Being knowledgeable of between-group differences that exist among culturally and racially different clients is not enough. It is equally important to understand the within-group differences manifested among individuals from the same cultural-racial background (D'Andrea & Daniels, 2012). Culturally competent group counselors are knowledgeable of the impact of worldview differences, racism, racial stereotyping, discrimination, and cultural oppression on the psychological development of White persons and Persons-of-Color (POC) (D'Andrea & Daniels, 2010). Although White people are often oblivious to the above stated factors, these stressors routinely undermine the psychological health and personal well-being of millions of people in our society (Ivey, D'Andrea, & Ivey, 2012; Rollock & Gorden, 2000). Sue and Sue (2008) noted that these stressors lead many culturally and racially diverse persons to (a) adopt a White, Euro-American worldview, (b) disavow the reality of their own racial-cultural background, and (c) internalize negative aspects of racism and White superiority that continue in both explicit and more subtle ways in our society. Using these factors as important considerations, Sue and Sue (2008) describe their Racial-Cultural Identity Development (RCID) Theory.

Racial-Cultural Identity Development Theory (RCID)

RCID is "a conceptual framework to aid therapists in understanding their racially and culturally different clients' attitudes and behaviors that are exhibited in four corresponding attitudes and beliefs." These different attitudes and beliefs are reflected in distinguishing constructions and reactions culturally and racially diverse people have of "(a) themselves, (b) other members of the same minority group, (c) persons from other minority groups, and (d) individuals in the dominant racial-cultural group in the United States" (Sue & Sue, 2008, p. 242).

With this backdrop in mind, it is distressing to note the dearth of writing and research focused on RCID and the implications of this model for group counseling. The RCID of both group members and leaders impacts views of self, views of members of their own racial group and other groups, and interpersonal interactions that mark multicultural group counseling situations. Thus, it is essential to understand how RCID may impact group members' readiness and willingness to participate in groups, their goals and interactions in multicultural groups, and the types of group facilitation strategies that foster positive multicultural group counseling outcomes.

This chapter is designed to serve three goals. First, it briefly introduces the different stages of RCID and statuses of White racial identity development (WRID). Second, it explores the impact of group leaders and members, who are operating at different racial/cultural identity development stages and statuses in multicultural groups. Third, recommendations for specific group facilitation skills and interventions are discussed as they relate to multicultural group interventions.

Stages of Racial/Cultural Identity Development

Sue and Sue (2008) described the RCID framework in 5 stages: *Conformist, Dissonance, Resistance and Immersion, Introspection*, and *Integrative Awareness.* A brief description of these developmental stages, typical behaviors, and suggestions for group leaders follows. For a more detailed description, see D'Andrea (2004).

The Conformist Stage

At the *Conformist Stage* (CS), people develop an externalized self-identity (Helms, 1984, 1990). As a result, individuals (a) internalize negative attitudes and beliefs about their own cultural-racial background, (b) construct and project a host of negative thoughts and feelings toward other members in their racial-cultural group, and (c) idealize the dominant cultural-racial group in the United States (Sue & Sue, 2008). The internalization of negative and self-depreciating attitudes is carried over to other members of a person's own racial-cultural group. CS individuals also avoid thinking about sociopolitical factors and manifest a set of attitudes that reflect one's belief in the superiority of White cultural, social, and institutional values and standards.

Sue and Sue (2008) describe several implications for counseling. This includes the recognition that clients at this stage generally prefer White counselors and group leaders. It also leads to an understanding why Clients-of-Color are frequently reluctant and resistant to engage in discussions that focus on how clients' problems may be linked to cultural/racial injustices. Given the psychological disposition manifested by CS Clients-of-Color, they are more likely to resonate with and benefit from traditional group counseling interventions. This includes but is not limited to group interventions that are aimed at fostering clients' personal strengths, skills, and well-being, such as groups that foster problem-solving skills, effective decision-making competencies, and improved interpersonal communication skills (D'Andrea & Daniels, 1996, 2001). Being knowledgeable of the psychological disposition that characterizes clients operating primarily from the conformist stage, culturally competent group practitioners understand why White group counselors are likely to be more accepted and effective than Counselors-of-Color.

The Dissonance Stage

The *Dissonance Stage (DS)* is characterized by a heightened sense of confusion about one's racial-cultural identity. Societal pressure to accept the notion that "White is best" conflicts with a growing awareness that racism and oppression occurs. Persons exhibit both depreciating and appreciating attitudes and beliefs toward themselves and other members of their racial-cultural group. They also begin to question negative and stereotypic racial-cultural views perpetuated by the dominant group (Sue & Sue, 2008). Individuals are motivated by and interested in group discussions on cultural-racial topics and concerns.

Sue and Sue (2008) suggested that DS clients may be willing to work with group Counselors-of-Color, although there may still be some preference for White group counselors. These group members will often be receptive to explore the personal meaning of cultural and racial issues; however, they are likely to exhibit confusion and personal frustration due to their mixed ways of thinking and feeling about their own racial identity (D'Andrea & Daniels, 1996).

The behavioral and emotional reactions people exhibit at the dissonance stage are tied to the cognitive confusion one experiences. Consequently, group counselors are encouraged to use cognitive-behavioral strategies that are intentionally designed to help Clients-of-Color think in new and more complex ways about their racial identity.

Hays and her colleagues outline a number of empirically supported cognitive-behavioral interventions that have been found to be effective in multicultural group settings (Hays, 2009; Hays & Iwamasa, 2010). These CBT group intervention strategies are recommended for use with Clients-of-Color who are primarily operating from the dissonance stage. This is so because clients at the dissonance stage can be assisted in realizing new dimensions of their own empowerment and mental health by learning to control their thinking in ways that foster clarity about their racial/cultural identity, increase their personal sense of self-worth, and acquire a deepened respect for the collective well-being of other people in their cultural/racial group (Hays, 2009).

The Resistance and Immersion Stage

The *Resistance and Immersion Stage (RIS)* is marked by two themes: "the idealization of the group of color and the denigration of Whites" (Helms, 2003, p. 47). White social, cultural, and institutional standards are viewed as having no validity or benefit for the resistance and immersion individual or their racial-cultural group. A heightened sense of acceptance for themselves as racial-cultural beings with emphasis on learning about their heritage also occurs. Members of the dominant group (or those POC who support it) are viewed as oppressors responsible for the unfair and unwarranted treatment that continues to be inflicted on People-of-Color. Thus, RIS individuals are generally suspicious and distrustful of anyone who is seen as part of the dominant group.

Group members operating from this stage will predictably exhibit resistance, hostility, and anger toward White counselors and racially different counselors and group members, who are perceived as being supportive of the dominant cultural-racial group. Therefore, it is important to assess clients' RCID and WRID during the prescreening group counseling process to consider the impact that resistance and immersion clients may have on other group members operating at the same and different identity development stages/statuses (D'Andrea, 2012). This recommendation is made to avoid unproductive interpersonal interactions that are likely to occur when resistance and immersion stage clients express conflict with counselors and clients operating at different stages.

Group counselors can assess clients' RCID and WRID during pregroup screening interviews by asking specific evaluation questions to gain insights:

- How would you describe yourself?
- What do you think of the racial conditions in our society?
- Who are some of the people who are role models for you?
- To what degree do you think a person's racial or cultural background affects her or his development and mental health?
- How do you feel about participating in groups that are comprised of people who have different views of racial and cultural issues than yourself?

In addition, group leaders might utilize a standardized instrument that measures a person's racial identity development. The Cross Racial Identity Scale (Cross & Vandiver, 2001) provides a valid and reliable measure of individuals' development in this area.

Group counselors are encouraged to implement nontraditional group counseling strategies when working with clients, who are primarily operating from the RIS. This includes innovative learning and development groups that are grounded in community service and social justice activities, which build on the strengths and passions of resistance and immersion stage clients. Among the group goals that can be achieved when implemented such service projects is the fostering of a greater sense of community with others and more complex thinking about oneself and society.

The following guidelines promote an increased understanding of some of the basic requirements necessary to implement the above stated group concepts effectively. The first group meeting is designed to have

1. the group members introduce themselves and explain why they are in the group;
2. the group leader proceeds to explain the purpose of the group (which is to stimulate the "learning and development" of all participants, including the group leader), discuss the issue of confidentiality, and explain that this nontraditional group is based on the principle of self-determination;
3. the group members are encouraged to work together in the first session to establish goals they wish to achieve by participating in the group meetings and community services-social justice activities aimed at stimulating the group's collective learning and development;
4. the group leader should indicate that it is likely to take a number of meetings to build trust with one another and agree to specific group goals and activities;
5. the group leader would do well to volunteer to facilitate the initial group discussions until the group has

agreed to the goals and community services-social justice activities that all the members agree to work together in implementing;

6. the group leader emphasizes the importance of having all the group members make a commitment to participate in the group's *process meetings* that are convened at the completion of the various community services and social justice activities;
7. the group leader suggests that s/he can serve as the facilitator to assist the members in working through disagreements and conflicts during group meetings; and
8. having the group facilitator be responsible for overseeing an evaluation of the strengths and weaknesses of the group at the end of this intervention (D'Andrea, 2012).

Some of the general challenges counselors are likely to encounter in groups with members operating from the RIS include (a) frequent passionate expression of individual group members' views about racial and cultural injustices that negatively impact members in marginalized groups; (b) intense anger that is often expressed by many resistant and immersion stage clients about the unfair treatment they commonly encounter as a result of being subjected to racial/cultural injustices; and (c) excited group discussions when clients' exercise their self-determination rights in proposing specific goals for the group (D'Andrea, 2012).

The Introspection Stage

Cross (1995) suggested that, as individuals work through the strong and emotionally charged attitudes, beliefs, feelings, and behaviors at the RIS, they experience a growing discontent with the rigid ways of thinking and feeling that characterize the RIS. Individuals entering the introspection stage are motivated to balance a sense of responsibility and allegiance to one's own racial-cultural group with notions of personal independence and autonomy. An increasing uneasiness with the racial/ethnocentrism of the RIS often leads introspection stage persons to reach out to members of other minority groups to learn about their experiences of stereotyping, discrimination, and oppression. They may also exhibit a concern about the ways that they have unfairly generalized negative attitudes to members of the dominant racial-cultural group in society (Sue & Sue, 2008).

In contrast to persons operating at the RIS, introspective stage individuals demonstrate a greater willingness to balance feelings of trust and distrust based on their direct observations of the ways dominant group persons exhibit sensitivity, respect, and understanding of various racial-cultural issues. Introspective stage persons will also be open to work with counselors from different ethnic groups and willing to listen to others who have different beliefs and experiences than their own.

Group counselors would do well to demonstrate the sort of sensitivity, understanding, and empathy about racial injustices that come from more than book learning. Counselors in groups comprised of persons operating from this stage are likely to gain greater respect by discussing how they have participated in the struggle for racial justice and describe the negative experiences and stressful challenges they experienced in doing so (D'Andrea, 2012).

Among the different counseling theories that are useful to implement in group settings that include persons in transition to the introspection stage are cognitive-behavioral theories, particularly, Ellis's (1999) Rational Emotion Behavioral theory (REBT). REBT is designed to assist clients in examining how inaccurate and irrational beliefs negatively impact one's emotional health and often result in ineffective and self-defeating behaviors. D'Andrea (2012) notes that when used in culturally competent ways, REBT is effective in helping clients make the transition to the introspection stage.

The Integrative Awareness Stage

At the Integrative Awareness Stage (IAS), individuals experience an inner sense of personal security that is linked to their ability to appreciate unique aspects of all racial-cultural groups. Furthermore, individuals operating from this stage develop a more positive self-image, sense of self-worth, and personal confidence (Sue & Sue, 2008). They also commonly report experiencing a genuine sense of connection with and respect for other members of the same cultural-racial group. They do so without an unequivocal acceptance of the values, beliefs, and actions manifested by persons operating from different racial/cultural identity stages.

Integrative awareness stage clients communicate empathic understanding for other group members coupled with an increasing awareness of the worth and uniqueness of each group member (Sue & Sue, 2008). They also commonly demonstrate genuine respect for those persons in the dominant racial/cultural group, who express concern about and work to eliminate oppressive conditions that have a negative impact on people in devalued and marginalized groups.

Integrative awareness group members possess greater psychological resources as a result of acquiring increased understanding of the systemic nature of racism and cultural oppression as serious and complex social pathologies that adversely affect all persons, including White persons (D'Andrea, 2012). Preferences for group therapists "are not based on race but on those who can share, understand, and accept their worldviews" (Sue & Sue, 2008, p. 257).

Among the group strategies that could be used to stimulate the development of the various characteristics described above include the following:

- Lead discussion groups in local high schools that focus on various multicultural-social justice issues;
- Help develop and implement preventive psychoeducational groups to foster the physical, psychological, and spiritual health and well-being of at-risk youths in various community human service agencies; and
- Train paraprofessional counselors who can volunteer to work with racially and culturally diverse families in need of support to more effectively cope with the unique life stresses that families in marginalized and oppressed groups routinely experience in their lives (D'Andrea, 2012).

Helms's Theory of White Racial Identity Development (WRID)

Since the vast majority of counselors in the United States are Caucasians (D'Andrea & Daniels, 2001), it is essential to understand how their racial identity development affects their counseling orientation and group interventions. Helms (1995, 2003) asserted that, while White counselors have traditionally directed their attention to non-White RCID issues, they have generally failed to consider the impact of their own racial background, history, and conditioning in the work they do as mental health practitioners. She also argues that all Whites (regardless of their socioeconomic status) have greater privilege and power than persons in other marginalized and devalued racial groups. For this reason, it is important for White group workers to understand racial privilege to become culturally competent practitioners.

As a result of being conditioned to accept this culturally biased, dominant, and oppressive worldview as the normal way of thinking, feeling, and behaving, many White persons are generally not encouraged or motivated to reflect on their own racial identity development. More specifically, many are not encouraged or motivated to reflect the ways that their racial position in society impacts their constructions of themselves, other White people, persons in culturally and racially-diverse groups, and the different forms of injustice that are perpetuated by the dominant racial group. This cultural conditioning has traditionally resulted in the development of group counseling theories and interventions that are based on Eurocentric values, beliefs, and assumptions about counseling (DeLucia-Waack, 2011).

Helms (2003) described White racial identity development (WRID) as a process that is characterized by six psychological statuses: *Contact, Disintegration, Reintegration, Pseudoindependence, Immersion/Emersion*, and *Autonomy.* White persons move from avoiding or denying the sociopolitical implications that race has on their own and others' development (Contact) to a much more complex psychological disposition that is marked by a greater degree of accuracy, comprehensiveness, respectfulness, and understanding of the ways that racial factors influence human development (Autonomy status). The increased level of cognitive complexity that occurs as individuals move toward a more mature White identity development status is a major factor that leads White people to achieve a more humanistic and nonracist identity (Autonomy). D'Andrea (2004) developed a table that provides an overview of key characteristics, typical statements, and implications for group counseling with clients operating at each status of Helms' WRID theory. (See Online References for Table.)

The Contact Status

White individuals at the Contact status appear satisfied with the racial status quo, oblivious to contemporary forms of racism, and unconscious of their unintentional participation and complicity in perpetuating this pervasive social pathology (D'Andrea & Daniels, 2010). Unfortunate group dynamics can result in groups comprised of a majority of White clients operating from the contact status with only one or two Clients-of-Color. In these situations, Clients-of-Color may discuss specific experiences they have personally encountered that reflect racial/cultural stereotyping, discrimination, and injustice by White persons only to be met with indifference by contact stage White group members and counselors.

It is important for group members to discuss such experiences in multicultural group counseling settings. However, when these discussions are initiated by Clients-of-Color, White group members operating at this status are likely to have negative reactions; they may say "I am tired of hearing how bad White people are" or "I really don't think we need to talk about this sort of racial stuff in this group." They may show body language that communicates disinterest and/or frustration (D'Andrea, 2012).

The predictability of such dynamics occurring highlights why it is important for group leaders to openly explain, in the first group meeting, that one of the rules of multicultural groups is for all group members to be mindful of remaining respectful of the different life experiences that each member shares with the group. As the process of multicultural group counseling unfolds, culturally competent group counselors do not wait for Clients-of-Color to take the risk in discussing negative experiences they have encountered. Instead, these counselors skillfully use modifications of the following statements to introduce the issue of negative racial experiences among group members:

> I want to make a couple of comments about obvious differences in this group. There are six men in this group and they all come from White backgrounds. And we have two African American men here as well as one Latino member. I know that our racial background and experiences affect how we think, feel, and act. I also know that many people do not like to discuss racial or cultural issues. I am going to guess that all of us have had at least one negative experience as a result of our racial or cultural background. If any group member feels that it might be useful to share what is commonly thought to be a taboo topic—I hope we can all be respectful and thoughtful of what that group member has to say so that we can learn from and help one another with this and any other issues that are presented for discussion in our group.

D'Andrea (2012) has raised questions about the appropriateness of White group counselors operating at the contact status to be leaders of multicultural groups. However, given the reality of the unprecedented changes in the demography of the United States, group counselors are increasingly likely to find themselves responsible for leading multicultural/multiracial groups (D'Andrea & Daniels, 2001). This reality underscores the need for group counselors to

1. make a commitment to participate in professional development activities that contribute to the lifelong process of becoming culturally competent counselors (Sue, Arredondo, & McDavis, 1992);
2. become knowledgeable of the implications of the RCID and WRID theories for group counseling; and
3. consider how the recommendations stated in this chapter might be useful in promoting positive outcomes for all clients participating in multicultural group counseling settings.

Disintegration Status

White persons experience a heightened sense of disorientation and anxiety as a result of becoming aware of racial dilemmas that force a person to choose between one's racial group loyalty and racial justice. Persons primarily operating from this status are stymied and confused by such racial dilemmas (Helms, 2003). An example of the disintegration status was expressed by one White client who stated the following in a multicultural group counseling meeting:

> I am really confused and frustrated by this discussion of racial problems that some of the group members say they have experienced. On one hand, Thomas (an African American group member) talks about how badly he has been treated by White people. On the other hand, Gary has just explained how he feels he has experienced "reverse racism" when a Black applicant who was not as qualified as Gary was hired ahead of him for an important job that Gary wanted. I really don't know who is right and who is wrong in these situations. But I do know that this talk is very confusing and frustrating to me.

White counselors and group members, who are primarily operating from the disintegration status, may be unable to address issues of racial diversity and injustice, which will predictably draw the ire of many Clients-of-Color while gaining respect by some individuals operating from the integrative awareness stage. A prudent question when thinking about the disintegration status of the WRID theory is: Is it a good idea to have White counselors primarily operating at the disintegration status leading multicultural groups?

From the perspective of the author of this chapter, the answer to the above question is an emphatic "No!" White group counselors operating from the disintegrative status by definition do not possess the awareness, knowledge, and skills that are necessary to operate as culturally competent practitioners (D'Andrea, 2012; Sue et al., 1992). Not being culturally competent predictably results in inappropriate, ineffective, and disrespectful practices in multicultural counseling situations (D'Andrea, 2012).

Reintegration Status

White persons demonstrate a reidealization of their racial group and express denigration and intolerance for other groups when operating from the reintegrative status of Helms's theoretical framework. Among the similarities that exist between group counselors operating at the contact, disintegration, and reintegration statuses is their lack of cultural competence and lack of understanding of the complex impact of racial and cultural factors on human development.

Group counselors operating at the reintegration status are often not able to effectively and ethically address the interests and needs of many racially and culturally diverse group members. Consequently, for White group counselors operating at the reintegration status, this may mean that they need to be limited to working in groups that are only comprised of White clients.

This recommendation is made because reintegration status group counselors' psychological orientation, lack of awareness of their own racial biases, limited knowledge of the complexity of racial factors on Clients-of-Color, and restricted skills to effectively address the complex psychosocial dynamics that predictably occur in multicultural groups may result in negative outcomes in multicultural groups counseling situations. More specifically, such professional deficiencies place these White counselors at risk for unintentionally harming Clients-of-Color in multicultural group settings (D'Andrea, 2012).

Pseudoindependence Status

White persons manifest an intellectualized commitment to one's own racial group and deceptive tolerance of other groups. This is manifested when persons operating from the pseudoindependence status make life decisions that are aimed at “helping” other racial groups. For example, pseudoindependence status group counselors have been noted to “help” Clients-of-Color demonstrate the importance of being respectful of all opinions expressed by White clients in group settings. Unfortunately, these counselors do so without also acknowledging the importance of the counselor's role in ensuring that Clients-of-Color will not be subjected to undo duress by White clients operating from the reintegration or the pseudoindependence statuses.

The lack of empathy for persons subjected to racism and cultural oppression as well as an egocentric disposition that are commonly manifested by White group counselors operating at the pseudoindependence status are likely to alienate Clients-of-Color at the dissonance, resistance and immersion, introspection, and to a lesser degree the integrative awareness stages of RCID. For instance, when pseudoindependence status group counselors and/or clients talk about White people being increasingly subjected to “reverse racism” without communicating understanding and empathy for the pervasive forms of racial injustice that continue to adversely affect millions of People-of-Color in the United States, such intellectualizations will predictably result in negative reactions by many clients operating from the dissonance, resistance and immersion, introspection, and integrative awareness stages of RCID.

Immersion/Emersion Status

This developmental status is marked by a search for a greater understanding of the personal meaning of racism and cultural oppression as well as the ways that one benefits from being a part of the dominant racial-cultural group in society. Life choices may include activism for racial justice. This includes initiating and facilitating discussions about clients' personal experiences with and understanding of racism and other forms of cultural oppression. White group counselors and members operating at this status are likely to be more positively seen by persons in the dissonance, resistance and immersion, introspection, and integrative awareness stages of RCID but will predictably experience resistance and negativity from many persons at the CS of the RCID model and contact status of WRID.

Group counselors operating at the immersion/emersion status have acquired a greater level of multicultural counseling competence as a result of

1. becoming more aware of the ways that their own cultural conditioning impacts their constructions of the world, themselves, and persons in different racial groups;
2. being more knowledgeable about the history, worldviews, values, and lifestyles of people in diverse racial groups as well as well as the different ways People-of-Color construct meaning of mental health and appropriate helping interventions; and
3. acquiring a broad range of skills that result in more effective group counseling outcomes among persons in diverse racial groups (D'Andrea, 2012; Sue et al., 1992).

Autonomy Status

Persons functioning primarily at this status demonstrate an informed and positive commitment to ameliorate various forms of racism and cultural oppression. In multicultural group counseling situations, this disposition leads some White counselors to appropriately self-disclose some ways that they work to eradicate forms of racism and cultural oppression. White persons also demonstrate a genuine willingness to relinquish the privileges of racism that accompany being a member of the dominant cultural-racial group. Consequently, when engaged in discussions about racial issues in multicultural groups, White persons operating from the autonomy status will:

1. express views that are more complex than those voiced by contact status White clients;
2. reflect greater understanding of the complexity of racial dynamics in our society than disintegration status White clients;
3. communicate greater empathy to POC who are routinely subjected to various forms of racism and cultural oppression than reintegration status group members; and
4. exhibit a balanced understanding and commitment to other White persons as well as POC, all of whom are adversely impacted by the pervasive forms of racial injustice and cultural oppression that continue to be perpetuated in our society (D'Andrea, 2012).

As a result of demonstrating the above stated capacities, autonomy status White group counselors and clients can play important roles in fostering the racial/cultural identity development of other persons. Autonomy status individuals do so by stimulating more complex thinking and empathic understanding about racial and cultural issues as a result of their group interactions with immersion/emersion status and introspection stage group leaders and members. Autonomy status White persons are also likely to find a sense of shared psychological camaraderie with other members of the group operating at the integrative awareness stage of the RCID model and some White persons at the immersion/emersion status of the WRID framework.

On the other hand, White group counselors and clients operating from the autonomy status are likely to be met with negative reactions from persons at the conformity and the resistance and immersion stages. It is also likely that they would encounter resistance from other White clients and counselors whose racial identity development mirrors the characteristics of the contact and reintegration statuses of Helms's WRID theory (D'Andrea, 2012).

Culturally competent group counselors recognize that White clients operating from the autonomy status would benefit from a pregroup screening interview in which culturally competent group counselors summarize Helms's WRID model and describe the characteristics associated with the different statuses. The group counselor could proceed with this discussion by:

1. asking what the autonomy status individual thinks about this model;
2. discussing why the group counselor has observed the autonomy status client to be potentially operating from this developmental perspective;
3. exploring with this client how s/he thinks other group members might react to her/his views of the impact that racial-cultural injustices have on people's lives; and
4. collaborate with the autonomy status White client to see what responses are likely to help or hinder the multicultural group counseling process.

Using Racial-Cultural Interactional Patterns to Understand Multicultural Group Interactions and Suggestions for Practice

When working in group counseling settings that include persons from culturally and racially diverse backgrounds, counselors are likely to notice some group interactions that help build a sense of group trust and cohesiveness while other interactions have a negative effect on the participants. Multicultural group counseling sessions are commonly affected by four distinct racial-cultural interactions: *parallel, progressive, regressive*, and *crossed interactions* (Helms, 1995).

Parallel Interactions

Parallel interactions are created by two or more group members who are operating from similar RCID or WRID stages/statuses. The following group interaction between two clients operating from the CS of the WRID model is an example of a parallel interaction:

> CS Client #1: You know I am very tired and frustrated when people talk about how a person's race or cultural background gives them special entitlements.
>
> CS Client #2: I couldn't agree with you more, Tammy. There is so much talk in our society about how a person's racial group is harmful because different racial people think they can't get a job because of racism or that they are always treated unfairly because of their cultural background. For myself, I only see one race … *the human race.* (D'Andrea, 2012)

Because parallel interactions acknowledge agreement and promote harmony with the racial-cultural views that are expressed by persons at similar stages/statuses, they help increase the sense of trust and support these group members experience. However, rather than allowing such overly simplistic and inaccurate views such as the ones presented above to sit unaddressed, the culturally competent group counselor could make an effort to stimulate more complex thinking about racial and cultural issues. The non-confrontational nature of the following statement is a good example of a skill a culturally competent group leader might use in response to the parallel interactions similar to the ones noted above.

Group counselor: Those are interesting and important comments made by the two of you. What do other members of our group think about these comments?

After the group members have developed a greater level of trust for one another, a culturally competent counselor may decide to use a more confrontational skill in addressing similar parallel interactions. One way of doing this is noted below.

Group counselor: I am glad that the two of you are exercising one of the agreements we made at the beginning of this group, which is for all of us to feel free to express our honest thoughts and feelings about any issue that is discussed in our group meetings. I also want to express additional thoughts I have about your comments and then ask a question.

As I watch the nonverbal messages some of the people in this group have to your comments, I think your comments are stimulating frustration and maybe even some anger with other group members. I do not think you are intentionally trying to do that and perhaps do not consider how your comments affect some of our group members including myself. I am particularly concerned that the non-verbal reactions I am picking up from Justin [an African American client operating at the resistance and immersion stage of the RCID model]. Justin, what are your reactions to these comments especially the view that there is only one race … the human race?

Progressive Interactions

Helms (1995) notes that *progressive interactions* occur when group members express views about racial-cultural issues that reflect more complex thinking than those manifested by other group members functioning from less developed stages and statuses. Progressive interactions have the potential to foster positive connections among persons who participate in multicultural groups. The following are examples of progressive interactions in a multicultural group counseling situation:

Thomas, a dissonance stage group member: I have a lot of confusion about being a Black man in this society. This confusion plays a big part in the depression I am experiencing and one of the main reasons why I joined this group to get help.

Ashid, a resistance and immersion stage client: So exactly what are you confused about?

Thomas: Well, I joined the marines to fight in Iraq because I believed that it is my responsibility to protect our freedoms here in the United States. But while I was in the marines and after I returned back home I had interactions with people who really had negative views of African Americans. Some of the White officers, who gave orders, clearly discriminated by showing favoritism to other White guys and having Black guys do the least popular jobs to do on our base, such as cleaning the latrine and mopping the cafeteria and things like that. Then once I got back here, I started noticing things I just did not see when I was younger. I have been stopped by the police when I was driving my car several times since returning for no reason and then have been stopped by cops as part of this new policy the police have about stopping suspicious people walking the streets. This has happened several times since I have been back and ordered to provide identification until I was not thought to really be a suspicious guy and they let me go.

When I talked to my friends about these things they said, "hey man … where have you been … these things have been going on forever … you just now experiencing them"… I feel like I have been oblivious to these kinds of discrimination and feel stupid … or maybe I just ran into a couple of bad apples with the police department.

Ashid: Look, man … I am angry to hear all that and am going to really try to control my anger to say this … As a Black man I can tell you that what you have experienced are things Black people experience all the time in their lives. It is a good thing you are waking up to that fact. If I were you I would live up to the fact that you can't trust any White people and find ways to work against the sort of racism you talked about with other brothers in our community. Don't lose the anger you feel when the cops stop you … channel that anger by working to deal with the racism that is harming all Black people. Just hearing you talk about this really pisses me off.

Thomas: That makes a lot of sense. Roger [an integrative awareness stage African American group member], you are working with that group of brothers at your church that has been getting a lot of attention in dealing with racism … what do you think?

Roger, an integrative awareness stage client: Well, first, I respect Ashid's comments and the way he deals with racism in our community. I agree with him that racism continues to be a huge problem in our society and African American people would do well to work with people in other racial groups experiencing the same problems with racism.

Thomas, I agree that what you have experienced in Iraq and when you returned home are part of the racial problems in our society. I know from my own personal experiences that this can be very confusing … and we can do nothing about it or work with other people to deal with this problem.

I have a little different take on White people than Ashid. As you know, I work at the university and many of the White people there talk about the problem of racism and say they are against it. But I can honestly say that I know of only two White professors that are working in the community to deal with this problem. So like Ashid, I am not completely trusting of White people, but once I see a White person genuinely involved in dealing with racism,

I feel more trusting to them.

I want to invite you to come to one of the meetings our church group has to deal with this problem. I am certain you will find the folks there supportive and it might be helpful with your confusion and depression.

The interactions that are reflected in the comments made by Thomas, Ashid, and Roger as members of a multicultural counseling group reflect progressive interactions. Thomas began this interaction by describing his confusion as a Black man who is dealing with psychological challenges associated with the dissonance stage of the RCID model. Ashid, the African American client operating at the RIS, responded to Thomas in ways that helped clarify some of Thomas's confusion. Roger's comments effectively acknowledged his respect for Ashid's position as well as his differences with Ashid's absolute condemnation of all White people. In doing so, Roger helped validate most of Ashid's comments as well as expanding on the discussion of racism and finally offered Thomas a way to reduce his confusion and depression that, in part, come from Thomas's experiences in Iraq and when he returned to the United States from his deployment.

The interactions described above come from group members. A relevant question is: How would you respond to these interactions if you were the group counselor in this helping process? The following section describes the reaction of a White group counselor operating at the contact status, which resulted in regressive interactions.

Regressive Interactions

In sharp contrast to the sort of progressive interactions described above are *regressive interactions.* Helms describes regressive interactions when group counselors and/or members express views about racial-cultural issues that are indicative of a less complex understanding of racial-cultural issues. William, a counselor facilitating the multicultural counseling group in which Thomas, Ashid, and Roger are members, appears to be operating from the contact status of the WRID. What follows is an example of how William's responses to the above stated progressive interactions represent a regressive interaction.

William, the White group counselor primarily operating from the contact status of the WRID: Ok, I want to say something about the comments that the three of you have made. I think we could continue to discuss the problem of racism and the different ways African Americans and White people make sense of this complex problem.

On the other hand, we can look at the positive ways African Americans and White people can work together in different ways that promote good feelings and respect for one another. This is called operating from a "strength-based approach to counseling." So I wonder if we can take some time to discuss some of the many strengths people in our community are demonstrating by working together in general regardless of what race they come from and not limit the discussion to the problem of racism? To be honest with all of you, some other people in this group have told me that they feel Ashid is trying to be intimidating and bullying in the way he talks about racism and White people and I don't think that should continue.

The group fell into an uncomfortable silence after William expressed these points. Thomas's and Roger's body language suggested disappointment and resignation by the way William inappropriately tried to shift the focus from racism. Ashid's body language indicated that he was very tense and perhaps frustrated or even angry about the comments made by this White group counselor.

Before describing how Ashid's verbal response to William represents what Helms refers to as a *crossed racial-cultural interaction*, it would be useful for you to pause and reflect on the following question: If you were the other counselor in this group meeting, how would you respond to the comments made by William in response to the issues that were discussed earlier by Thomas, Ashid, and Roger?

Crossed Racial-Cultural Interactions

Crossed racial-cultural interactions occur when group counselors and members exhibit attitudes and beliefs about racial-cultural issues that are directly opposed to one another. Crossed racial-cultural interactions are likely to occur in group counseling settings that are comprised of White counselors primarily operating at the contact status of WRID and a number of Clients-of-Color operating at the Resistance and Immersion stage of RCID.

When these interactions are allowed to persist in group counseling settings, they predictably result in antagonistic relationships. The failure of group counselors to effectively address crossed interactions can seriously undermine the overall cohesiveness and effectiveness of racially heterogeneous groups (Helms, 1995).

The following reaction that Ashid (the African American client operating at the resistance and immersion stage) had to William (the White counselor operating at the contact status of the WRID model) represents one of the ways that crossed racial-cultural interactions occur in multicultural counseling groups:

Ashid's response to William: Hey wait a minute. You can't just change the important discussion that Thomas, Roger, and I started about White racism. I am not going to let another White person try to dominate me by shutting me down and say I am “intimidating” and “bullying.” It seems that there are a lot of times that White people will use those words when Black people try to be direct and honest about White racism. That is what we call being defensive and not allowing a long overdue honest discussion about racism to take place. If this is the way this group is going to run, I don't want any part of it.

As noted above, crossed racial-cultural interactions can have a very detrimental impact on multicultural counseling groups and the individuals in them. Group counselors are encouraged to be prepared to effectively deal with these group interactions when they occur and more importantly, to try to prevent such interactions from occurring.

Conclusion

The issues that are presented in this chapter only scratch the surface in dealing with the complex challenges counselors face when working in multicultural group settings. Nonetheless, it is my hope that you will:

1. feel that your overall awareness of the complexity of running multicultural groups is enhanced, and
2. be more sensitive and mindful of the between-group and within-group differences that group members are likely to exhibit in these kinds of group counseling situations as a result of reflecting on the information presented in this chapter.

If this occurs, you will have taken one more step in acquiring the awareness and knowledge competencies necessary to meet the challenges of living and working in a culturally and racially diverse 21st century society.

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Chapter 16 Group Therapy with Native People

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Introduction

Nearly five million Native American and Alaska Natives represent hundreds of diverse and distinct tribes, many with unique customs, traditions, and languages (U.S. Bureau of the Census, 2009). There are more than 250 distinct tribal languages spoken and almost one third (29%) of Native People report speaking a language other than English in the home (U.S. Bureau of the Census, 2009). Despite numerous differences within tribal healing and spiritual practices, many Native Peoples share a common epistemological worldview. Similarities in fundamental cultural and spiritual beliefs profoundly outweigh intertribal differences (Robbins, Hill, & McWhirter, 2008). Virtually all traditional Native Americans base spiritual principles and philosophies in a relational context (Robbins et al., 2008), including relationships beyond the nuclear family and proximal friendships. The concept of relational harmony with elements in the natural world is considered fundamental as is the recognition of persons who have moved onto the spirit world. Spiritual prayer and ritual emphasize harmonious relations with rocks, plants, animals, wind, and people to honor the Creator. Human beings have a responsibility to contribute to balance in the relationship of all things (Garrett & Herring, 2001).

Throughout the chapter, we explore the nature of group work and its connection with Native spirituality, tradition, and culture. We begin by examining common traditional healing methods and describing barriers Native Americans may face in joining and utilizing therapy groups. Next, we consider comparisons with healing in the context of group therapy methods. Finally, utilizing the "Association for Specialists in Group Work Best Practice Guidelines" (2007) and the "Multicultural and Social Justice Competence Principles for Group Workers" (2012) as overarching frameworks, we provide recommendations for culturally grounded group therapy work with Native Americans.

Group Work with the Native American Culture

Group therapy resonates with ancient spiritual, communal, and healing practices that traditionally strive to create a personal, relational, environmental, and spiritual connection (Garrett, Garrett, & Brotherton, 2001; Hunter & Sawyer, 2006). Ancient ceremonial practices underscore and promote spiritual and social relatedness while facilitating awareness of the interconnectedness of all things. The individual exists only in relationship to others (Robbins et al., 2008). Consequently, healing ceremonies involve participation in circular group dancing, the ingestion of medicines in the presence of others, singing ancient songs of healing with others, or joining together to design, create, and construct a community building or monument.

Similar to group therapy, shared experiences are used as a means of individual healing and occur only in the context of relationship with others. Common healing practices among Native People, including the *vision quest*, the *Native sacred circle*, and the *sweat lodge ceremony*, involve ritualistic ceremony similar to therapeutic group work. Each will be discussed below in relationship to modern group therapy.

The vision quest. One of the most poignant examples of healing within a relational, spiritual, and social context involves the traditional *vision quest*, an ancient ritual (Moondance, 2004). Typically first experienced as a coming of age ceremony, vision quests are commonly held at several points in life when greater understanding and meaning are desired. With knowledge and support from family, friends, and community, an individual retreats to seclusion within nature and sits in a sacred circle for a specified number of days based on individual tribal tradition. A vision quest in the Lakota tradition may last two to four days but may last as long as a month among Native Indians of other traditions. Through depriving oneself of food, water, sleep, and shelter, the individual who engages in a vision quest is seeking spiritual guidance in the form of a prayerful auditory or visual message, or *vision* for oneself, the people, and the earth (Sue & Sue, 2008). The quester returns to share visions and process meaning in a group format. Similar to group therapy, secrecy, confidentiality, and cohesion among group members is critical to understanding and healing during this time. To indiscriminately reveal a vision to individuals outside of this group sharing is believed to dilute its power for the individual and for those who hold it as sacred. Those uninvolved in the ceremony may hold inaccurate or superficial interpretations of the vision; the images must be integrated as part of the group ritual. Only after four days may the quester share his vision with others. Even the vision quest, a deeply spiritual adventure that focuses on self-purification and understanding, requires support from others in the form of continuous prayer and emotional encouragement (Moondance, 2004). The connection between spiritual healing and social support is clear throughout the vision quest experience, from preparation through celebration.

This communal involvement reflects several of Yalom's group therapeutic factors (Yalom & Leszcz, 2005). Universality (relating to problems similar to others and knowing one is not alone) and altruism (helping and supporting others) are reflected in around-the-clock tending to the fire while offering supportive prayer. These factors are further expressed prior to the quest when community members are involved in many purification ceremonies to aid in spiritual preparation of the quester. These are also seen through supportive emotional and physical preparation with the quester and in celebration on the quester's return. Interpersonal learning (understanding oneself through group interactions) and unconditional acceptance (knowing and embracing uniqueness in self and others) are fundamental following the quest in which spiritual experiences are shared. The importance of group membership within the ceremony reflects Yalom's cohesion (experiencing warmth, comfort, and shared value expressed within group) given the importance placed on the confidential nature of group process in discussion of the spiritual experience.

The Native sacred circle. The Native sacred circle is a traditional form of ceremonial expression using a group format (Lewis, Duran, & Woodis, 1999). Elements of the Native sacred circle ritual are used in every important meeting with traditional Native Americans. The ritual is described later in this text, as part of the group activity *Soul Wound II.* This spiritual ritual involves mutual listening and respect, processes fundamental to group therapy among facilitators and members (Yalom & Leszcz, 2005). Similar to group work, group members participating in the Native sacred circle are encouraged to engage in honest expression of thoughts and feelings, verbally and

nonverbally. Through this catharsis, members release emotional tensions, thought to engender spiritual healing. The therapeutic factor of *imparting information* is evident when group members learn from elders within the group regarding traditional ways to perceive and handle members' concerns.

The sweat lodge ceremony. During the sweat lodge ceremony, purification of body, mind, and soul are achieved through a communal, spiritual, sweat experience (Sue & Sue, 2008). The ceremony is typically conducted for those undergoing any form of life transformation or healing (Garrett et al., 2011). Leaders create a dwelling in preparation for the ceremony that allows placement of rocks in the center of the lodge. Participants enter the low level dwelling, often through an entrance so low that they must enter on their hands and knees, signaling respect to Earth, nature, and the spirits. Encircled by participants, the rocks are heated to allow the release of the oldest Earth-dwelling spirits. Much like the group therapy process, the presence of the group is considered a necessary condition for healing and transformation during the ceremony (Garrett et al.). Similar to that which is stressed in therapeutic group processing (Yalom & Leszcz, 2005), leaders listen intently to participants. Participants are encouraged to hear each other through spoken prayer. Tribally specific ceremonial content includes meditative spiritual chant and silent prayers of gratitude followed by communal prayer and discussion. Similarly, in group therapy, it is the shared experience with others that provides the conditions necessary for healing (Yalom & Leszcz, 2005). In fact, Colmant and Merta (1999) examined therapeutic factors in the context of the Native sweat lodge ceremony within a residential treatment center for Navajo males. Catharsis, universality, imitative behavior, and interpersonal learning were identified as the most evident therapeutic factors. The authors concluded that when group facilitators are immersed in the cultural context, Native spiritual healing practices could be effectively integrated into group psychotherapy practices.

Barriers Native Americans May Face in Joining and Utilizing Groups

Experienced and Internalized Oppression

Native Americans experience unique barriers to joining and utilizing groups. Perhaps the most profound are a consequence of internalized oppression. Native Americans have experienced profound personal losses of familial, cultural, legal, and religious traditions, beliefs, and practices (Mental Health America of San Diego County [MHA], 2009) and remain the longest standing victims of social justice abuses in the United States (Turner & Pope, 2009).

Native People continue to be oppressed by the ongoing cumulative impact of colonization and face cultural devaluation, racial discrimination, economic exploitation, and social stereotyping (McWhirter et al., 2010). As a result of historical and continued European colonization, Native Peoples express higher distrust of institutions, including clinical and counseling agencies and the therapists associated with them (Robbins et al., 2008).

Unrecognized Cultural Perspectives of Health and Well-Being

Different beliefs regarding sickness and healing offered by many mental health professionals further impact American Indians' trust in the care. Native People may view sickness as a result of a lack of harmony in one's life and in one's relations (Robbins, Asetoyer, Nelson, Stillen, & Tall Bear, 2010) or as a consequence of engaging in tribally taboo behaviors or the result of interacting with ghosts or spirits (Sue & Sue, 2008). Many may fear that their views will not be respected by people who have been trained in the context of western beliefs influenced by the medical model (Duran, 2006).

Culturally Insensitive Application of Traditional Group Techniques

The emphasis on trust and honest, open communication within a therapeutic group setting—often the basis of traditional group interactions—may serve as barriers to Native American participation in group therapy participation. The confessional nature of many groups, such as AA, has been experienced by some Natives as an overly public setting (Robbins et al., 2010).

It may be considered inappropriate by some Native Americans to disclose issues traditionally revealed and resolved among family only (Thomson-Fuller & Minkler, 2005).

Engaging openly in groups comprised of non-family members (or involvement in groups consisting of nontribal or crosstribal participants) may be viewed by some Native Americans as a betrayal of familial or cultural tradition (Thomson-Fuller & Minkler, 2005).

Logistical and Practical Considerations

In addition to these profound sociocultural barriers, many Native Americans experience logistical and practical barriers to group therapy, including limited access to quality mental health care. Geographic distances and financial costs result in difficulty retaining experienced mental health professionals in many Native communities, which may insidiously perpetuate lack of trust in therapy. Newly graduated therapists unfamiliar with Native ways are often recruited to serve Native communities in order to repay federal student loans, yet these new therapists typically are unable to support themselves with the salary offered (MHA, 2009). The result is a pattern of limited guidance among agency leadership and high therapist turn over. Furthermore, culturally targeted group therapy programs typically exist only in areas where there are concentrated numbers of Native Americans, such as on reservations, tribal homelands, and in some urban areas. Taken together, these realities compromise continuity of care and perpetuate reduced trust with mental health service providers.

Addressing Barriers through Best Practices

To foster trust, it is crucial that group facilitators honor the traditions that Native Americans bring with them to counseling in the context of their own mental health traditions. It is crucial that group facilitators work to avoid imposing their own cultural values onto their Native clients. Studies involving counselor attractiveness suggest that Native Americans prefer counselors who seek to understand and honor their ways rather than in having a specifically Native American counselor (Robbins & Harrist, 2004). Certainly, it is crucial for Euro-American counselors to be aware that traditional Native Americans may not prefer direct eye contact and may desire longer silences between comments (Robbins & Harrist, 2004). Group work practice embedded in understanding, sensitivity, and respect through the best practices outlined below are fundamental to address these barriers and ultimately to provide culturally relevant healing experiences.

Recommendations for Best Practices in Group Work with Native Americans

An effective group therapist engages in counseling strategies and techniques that resonate with Native Indian tradition and custom in their work with Native People. Recommendations presented below address common issues faced by group therapists working in a Native American cultural context and include integration of cultural practices, leadership style, and group dynamics. These elements are organized according to "ASGW Best Practice Guidelines" (2007) three primary functions of group leadership: planning, performing, and processing. Suggestions are also guided by ASGW's "Multicultural and Social Justice Competence Principles for Group Workers" (2012) to provide a framework for culturally sensitive group work with Native clients.

Planning

Specific tasks involved in culturally competent planning require thoughtful consideration of all activities conducted in preparation for the group experience.

Needs Assessment

The initial needs assessment includes determining the purpose and type of group to be offered and identifying its leaders and members. We recommend forming single-session pilot group(s) designed to identify group format, timing, setting, therapeutic themes to be addressed, and leadership characteristics. Pilot group members should include important tribal members and individuals that represent potential group members. In one example, a needs assessment was conducted to determine group themes relevant to urban American Indian women across tribal acculturation and affiliation. Self-exploration and education, aging, body image, work, friendship, love commitment, and nurturance/motherhood were among the themes addressed (McWhirter et al., 2010).

Intertribal, Intratribal, and Mixed Group Membership

When planning a group, the culturally grounded group facilitator is acutely aware of the differences in a group experience based on participants' tribal and acculturative experiences (Trimble & Gonzalez, 2008). Many tribal communities are no longer intact, particularly in urban areas (Robbins, Hill, & McWhiter, 2008). Consequently, intertribal connections are commonly forged to stage important cultural events: pow wows, stomp dances. Many Native Americans experience meaningful interactions across tribal affiliation. In working in these contexts, the culturally sensitive group therapist is aware that an overemphasis on tribal differences is considered by some to be an unintended aspect of colonialism (Duran, 2006). New developments in counseling and therapy with Native Peoples promote unity within and across tribes. This inclusive effort further recognizes that, in fact, all peoples may have some personal ancestral lineage with an indigenous people, thus emphasizing a fundamental interconnectedness among all peoples (Duran, 2006). Care should be taken to deliberately select for participation based on acculturation and tribal membership. Furthermore, within Native communities, these issues frequently will intersect with determining the type of group to be offered: intertribal, mixed, and intratribal.

Intertribal

In communities inclusive of intertribal affiliation, facilitators may wish to offer groups with a focus on intercultural learning. These groups are designed to increase cultural understanding and improved relationships across tribes. Groups with members of differing tribal affiliation include a focus on respect for universal interconnectedness that exists across tribes. *Through the Diamond Threshold* (Robbins et al., 2010) is a full group curriculum with activities and suggestions for implementation in intertribal and mixed groups.

Mixed

Groups that include members across tribal affiliation may also involve a mix of tribal membership and dominate culture members and can produce positive mutual outcomes. Such groups are helpful to address a variety of therapy and support group options for urban agency clients. The goal of these groups centers on increasing unity and building mutual support and understanding. In one such mixed group, an Indian tribal participant stated to the authors: "We were never in many groups with white people and we felt and experienced white people who were for once not in power. It was good." This member witnessed non-Natives express appreciation for Native ways. The result was a greater expression of acceptance of non-Natives living within their community. Non-American participants indicated that even though they had lived in American Indian communities, they had been excluded from Native healing and spiritual ceremonies. In the therapy group, they were allowed to participate in many culturally expressive conversations, resulting in feelings of community integration in an appropriate setting. This allowed non-Native members to connect and understand more fully. *Project Eagle* (Robbins, Tonemah, &

Robbins, 2004) is a psychoeducational group therapy curriculum recommended for intertribal and mixed Native American families.

In conducting *intertribal* and *mixed* groups, leaders should clearly identify the inclusive nature of group membership, particularly when forming content-focused groups. For example, a facilitator working within urban populations among Native Americans who have created trusted intertribal connections may choose to initiate a content-focused group on domestic violence or trauma related to abuse, based on community need (Garrick, 2006; McWhirter et al., 2010; Robbins et al., 2010). Given the sensitive nature of these topics, group therapists should inform potential members that they might be discussing sensitive issues with members of other tribal affiliations or members of the dominant culture and determine individual comfort level prior to participation. Care should be taken to balance membership according to majority versus minority cultural background, and/or across tribal affiliation. In particular, members from the dominant culture should be carefully screened to include individuals interpersonally open to intercultural group experiences. Sensitive prescreening may help ensure that group cohesion is not impeded by resistance to an authentically diverse experience (McWhirter et al., 2010; Robbins et al., 2004).

During careful preparation, a group therapist should solicit information regarding basic tribal customs and traditions. Specifically, learn whether the tribe is patriarchal or matriarchal and how this plays itself out in participant's interactions and in situations involving leadership and prayer. If songs are utilized in session, the counselor needs to know that some songs need to be approved by appropriate tribal persons. When counselors travel to tribal areas, it is crucial to ask about proper protocol that should be observed before beginning each session. Groups should include tribally specific traditional stories for psychoeducational group activities and processing. Honoring differences by modifying how activities and procedures are conducted communicates a respect for tribal uniqueness (McWhirter et al., 2010; Robbins et al., 2004).

Intratribal

The importance for group therapists to respect individual tribal uniqueness cannot be overstated when offering tribal (culture) specific groups within tribal lands involving only members of a specific, individual tribe. For example, working with Navajo tribal members on reservation land requires knowledge and respect for the group members' traditional values and ways. Care should be taken to match cultural, tribal, and clan identity of participants. Group leadership, membership, preparation, and intervention should be culturally relevant and tribally specific. The group should be created by, for, and with tribally identified individuals or groups.

The following example, experienced by the second author, illustrates this: "Though I am from a woodland tribe, I often facilitate marathon group therapy groups (comprised of several day-long sessions) with both Plains and Southwest Natives. The first time I worked with a Plains tribe years ago, I prayed in my tribal language at the beginning, ordered pizza for lunch, and ended the day with what my tribe calls a 'walk dance.' At the end of the first day, I asked the group about their perception of the day. They expressed surprise about how Native elements could be used in group therapy but then explained that they wanted to use their own tribal traditions when we returned. During the next session, a Plain's medicine person prayed, we had a traditional Plain's Indian meal for lunch, a Plain's traditional story was shared, and we ended the day with a Plain's song. Trust, tribal integrity, and self-esteem were nurtured."

Becoming a Culturally Competent Facilitator

Matching facilitator and group member ethnicity may be particularly difficult in work with Native Americans. This is because of both the great diversity across tribal cultures and the low number of group therapists with Native American ethnicity. As a result, it may be important to encourage and train group leaders from a wide variety of ethnic and cultural backgrounds to work with specific Native American tribal groups (Bemak & Chung, 2011; McWhirter et al., 2010; Merchant, 2009). Group leaders need to have a deep understanding of members' sociocultural history in the context of the members' current life experiences (Merchant, 2009). Potential counselors must increase their knowledge of sociocultural history and their sensitivity to Native American

concerns. Individual counselors' knowledge of tribal/cultural issues, sincerity, authenticity and openness to working with Native Americans is critical. Counselors interested in work with this population should work to hone their basic therapeutic and group facilitation abilities. Further, it is recommended that group counselors attend tribal/cultural sensitivity trainings and immerse themselves in tribal activities before engaging in therapy with Native Americans. Group counselors should attend tribal dances and social gatherings, such as the weekly tribal meals for elders. Counselors should consider devoting group session time to engage in culturally meaningful experiences, such as asking group members how their experiences in school, business, churches, and clubs are different because they are Native.

Group therapists also must be cognizant of diversity within tribes. Even in *intracultural* groups where all group members belong to one tribe, acculturation varies widely. Robbins et al. (2010) categorized Native Americans according to cognitive, emotional, spiritual, and social acculturative domains as *traditionalists* (speak their language and participate in their ceremonies), *assimilationists* (adopted mainstream ways and rejected traditionalist ways), *biculturalists* (move fluidly through both traditional and mainstream spaces), and *marginalists* (do not fit into either traditionalist or mainstream spaces). These researchers argue that acculturative level may vary according to domain. As such, individuals may be traditionalists spiritually yet assimilationists socially. Conflicts in groups often revolve around these differences, both within individuals and among group members. One powerful group activity requests members classify themselves using the acculturative categories within each domain. This activity is recommended in initial group sessions to encourage inclusion and can be effective in all group types (intertribal, intratribal, and mixed). This increases self- and member awareness and provides the language for dealing with acculturative conflicts that inevitably emerge during later stages of group work (Robbins et al., 2004).

In addition, group leaders need to be aware of underlying cultural tensions and differences in communication styles in order to skillfully negotiate differences or cultural conflicts as they emerge (Merchant, 2009). Group members, both of differing tribes and with shared tribal affiliation, express different levels of acculturation and may need to discuss this in establishing group trust. A skilled facilitator provides ample opportunity to honestly address these issues rather than pretending that no differences exist (Herring, 1999). This important step is often necessary to facilitate cohesion, encouraging trust, inclusion, and authentic expression within the group.

In planning for any group, it is important that counselors address external relationships as a part of the group selection process. Once discussed, members frequently decide to participate; on rare occasions, a potential group member might ask to be moved to another group. Group leaders also need to objectively work through any conflicts that may occur. For example, within one eastern Oklahoma tribe, two families have experienced a long-standing feud. As a result, members of one family experience difficulty working with members of the other.

The group activities presented at the end of this chapter may be used in a variety of contexts. When used to assist in the training of group leaders interested in working with Native Americans, the brief immersion experience in the activity allows participants to experience briefly the marginalization and mistreatment Native Americans encounter. The activity also effectively increases awareness when used in *intertribal* and *mixed* groups and validates experiences of significant loss and subsequent resilience when used in *intratribal* groups.

Performing

Performing in groups includes consideration of both micro (i.e., group process and individual needs) and macro (i.e., systemic, cultural, political and historical context) level issues (ASGW, 2007). In the section below, we discuss performing in the context of Native American group therapy, providing examples and specific suggestions for intervention.

Establishing Group Norms

When establishing group norms, leaders should pay particular attention that initial greetings and checking-in procedures honor traditional ways. A gentle handshake is considered the proper greeting among many traditional Native People. A firm, hard, strong handshake is interpreted within mainstream American society as a sign of confidence, connectedness, and enthusiasm; among many traditional Native People, it is interpreted as an aggressive show of power and may even be considered an insult (Garrett, 2004). In much the same way, direct and prolonged eye contact may be interpreted as aggressive or hostile. Deference expressed through a lowering of the eye demonstrates respect and facilitates trustworthiness (Sue & Sue, 2008). Furthermore, silence during initial moments when two people meet allows each to experience the "presence" of the other person (Duran, 2006). Allowing for silence at the beginning of a session provides members an opportunity to recognize and experience each other and transition into the therapeutic process.

Native Americans often speak of being together in a *good way.* Traditional Native groups often began by drumming or singing a traditional song. In addition, some groups may begin with *smudging*, a ritualistic, spatial cleansing involving the burning of sage, cedar, or sweet grass. Therapy and counseling groups with Native clients may consider entering every meeting using some of these rituals. If done sensitively even groups with non-Native clients might benefit from such opening rituals. Each entering participant would walk to the front of the room where the designated smudger will gently fan the participant with cedar smoke, offering a ceremonial reception to the entering participant. The participant may receive this as a cleansing required to be a part of the group. This may be signified by the receptive gesture, motioning of both arms upward and outward, then toward the self, bathing oneself in the smoke. Other participants honor the new participant in silence. Members would then begin group work with the use of the talking stick, as described in the *sacred circle* ritual described in the earlier section on Group Work with the Native American Culture.

During initial sessions, facilitators are advised to address internalized oppression, a consequence of colonialism. *Externalization* (Robbins et al., 2010) is one technique for helping participants gain a better understanding of their inner core of beliefs. Participants are asked to describe their important values. Then, they are encouraged to engage in a discussion, referred to as *archeological work*, to discover how they came to possess these values. Members write the values on a card and place it on a table in front of them. For instance, one person might indicate that they value punctuality. Other participants may ask about events when the member either exhibited this quality or not. The group therapist then asks how this value corresponds to their Native values. Often, participants find that they have not considered the values' congruence with Native Indian ways or how a value manifests itself differently when in Indian country (Robbins & Harrist, 2004). Within the context of intercultural groups, however, the discussion is intensified. Sometimes Native Americans feel guilt or shame for having unconsciously adopted values associated with dominant society while Euro-Americans sometimes acknowledge their cultural advantages within dominant society. During group processing of this activity, group facilitators are encouraged to remain objective, supportive, and patient. The activity *Soul Wound I* (described later) provides a context for group facilitators to effectively process these issues.

Demonstrating "Neutral" but Active Leadership Style

Multicultural group leaders must avoid aligning with members who share similar political beliefs or cultural values (Merchant, 2009). Instead, facilitators are encouraged to offer multiple perspectives, particularly important with

Native Americans of different levels of acculturation and tribal affiliation. A directive leadership style approach is recommended as a way to meet many Native clients' initial cultural expectations (Garrett et al., 2001; Trimble & Gonzalez, 2008). For example, many Native Americans are hesitant about allowing themselves to become vulnerable because of a long history of broken promises and abuse (Robbins & Harrist, 2004). To alleviate the anxiety that group members may feel during the initial stages of group therapy, a directive group leader may enumerate not only the rules of confidentiality and so forth but also directly address issues such as fears revolving around self-disclosure of feelings. An honest and forthcoming leader can create norms that contribute to creating a safe environment for expressing feelings.

With this approach, the therapy process mimics obtaining advice from Elders (Trimble & Gonzalez, 2008). To balance this directive style, facilitators should be encouraged to engage in democratic group decision making whenever possible. For example, a directive facilitator would ensure opportunities for each group member to give voice and contribute to collective group decision making.

Facilitators who do not share the cultural background of group members need to be particularly careful to avoid inadvertently imposing their values on members. One example of this occurred in a group supervised by the authors in which a female European American facilitator began the group by stating the name of the first activity: *the wagon wheel.* One Native woman participant said that the wagon wheel represented *the White way.* Instead of honoring and processing this member's experience with the use of the term wagon wheel, the leader became overly directive, insisting on completing the activity. In giving directions as part of the activity, the facilitator instructed the members to turn to their left in order to accept a message. Another member indicated: "I can't turn that way." When questioned, one of the men indicated: "The Comanche don't move in that direction." The facilitator continued on, attempting to push past what she viewed as initial group resistance. She stated: "It's just an activity." The group member also continued: "I won't do this. That goes against the flow of life for us; the way it is set up." As this example illustrates, facilitators need to guide from within the culture, honoring multiple perspectives.

Attending to the Interplay of Culture and Communication

In all interactions with Native People, consideration should be given to "respect" as viewed in the traditional way. This involves being culturally attentive, deferential, and responsive (Jackson & Turner, 2004), and is necessary to establish trustworthiness of both the group leader and the therapeutic process. Respect can be demonstrated in multiple ways and may be expressed toward oneself, group members, known community members, and the natural and spiritual world. These signs of respect engender trustworthiness and may take on several forms, depending on the needs of individual group members.

Respect for others may be evident to group members when engaging in common facilitator skills (e.g., linking) and in working to help clients develop close, cooperative relationships with each other while establishing cohesion. Leaders encourage sharing from traditional Native American perspectives, including members' experience, descriptions, knowledge, skills, or feelings. Respect is commonly discussed in relation to interactions with elders. A group therapist should be aware that any significantly older person in a group should receive deference. In group facilitation, this can be problematic. For example, the group facilitator must take care about interrupting elders, even when they have spoken for a disproportionate amount of time. In one group, one elder spoke for almost an entire hour and half session. Unlike other Native American meetings that might last for many hours, counseling group sessions do not. The skillful leader must gently acknowledge the great wisdoms the elders have, while also offering others a chance to speak. Helping members understand the nature of group therapy and sensitive norm development in the initial sessions can be very helpful. Group leaders may directly acknowledge hierarchies based on life experience and age as these outward recognitions are fundamental cultural expressions of respect. Use of the talking stick in the Soul Wound II activity described at the end of this chapter is an effective way to norm respect.

Another way of expressing respect within the group is to offer a brief pause before and after comments. This is common among traditional Native Americans and can be normatively integrated into groups. Hurried reactive responses are deemed disrespectful.

Humor may be used to facilitate comfort with the group process, given Native Americans often get to know each other through teasing and laughing together. The use of humor as a therapeutic technique has largely been understated in the literature, particularly in work with Native People (Garrick, 2006). Among other uses, humor has assisted trauma survivors in mitigating the intensity of their traumatic stress reactions (Garrick, 2006). This may explain its effectiveness with Native Peoples in coping with the effects of historical trauma (discussed below). Specifically, humor is a coping skill that allows group members to appreciate the significance of a difficult or traumatic event without minimizing its impact. It can empower group members by providing an experience in which they recognize their own ability to cope and thrive in their environment following a difficult life change or traumatic experience (Garrick, 2006). Leaders can utilize humor as a linking technique. Members without shared experiences can relate to the expression of humor and demonstrate acceptance unobtrusively, in return, through the common expression of laughter.

Group leaders unfamiliar with Native humor typically find themselves pulled in by the contagious belly laughter and the sometimes confusing content of the jokes. At one group session, one of the members teased another about his “Indian car”; bailing wire was holding the passenger car door closed. He added that he was going to tease him about it but he saw the car was backed into the parking place and he thought: “Maybe this guy is a *hoyoka*.“ (Hoyokas are powerful medicine people, associated with thunder, who do many things in reverse or backward.) “I sure didn't want to be struck with lightning.”

This joke was spoken slowly, with long pauses and lots of *ayes* and laughter. One of the group leaders stated later that he had never laughed harder in his life, even though he didn't understand the joke at all. He added: “Indians laugh with their stomachs not their throats.” Nothing connects people, especially most Native People, more than laughter.

Group leaders working with Native Americans also need to consider how Native People view hospitality. Sharing food at some point during the group experience is congruent with Native traditions of hospitality (Harper, 2011). Hospitality can be an expression of the core belief of connectedness, as articulated in the Lakota, *mitakuye o'yasin* (i.e., all my relations; Harper, 2011). Preparing and experiencing a meal is ritualized in many Native healing ceremonies. Following the sweat lodge ceremony, for example, sweat lodge group participants bring home-grown or homemade food. The giving of food following a meaningful therapeutic group experience resonates with healing in the traditional way and provides an opportunity to express gratitude and reciprocity for the presence of each group member.

Historically, many tribal leaders were the materially poorest members of their tribe because they gave almost everything they had to others. At today's powwows, one can witness frequent “giveaways,” where a person who receives an honor for something will give away many gifts, such as traditional blankets. Sharing is a way many Native Americans experience a distinct difference between themselves and members of the dominant culture. For example, the Choctaw word for Euro-Americans is the same word for “greed.” One group activity involves participants’ drawing names from a hat and a “give-away” is conducted. The session is always filled with great emotional disclosure and bonding. This can be used early to demystify the group process and to facilitate group norms, including reflective disclosure, turn-taking, and cohesion. To conduct this as a group activity, have group members sit in a circle. The presenter of the gift walks to the center of the circle and calls the name of the gift receiver, shakes his or her hand, offers the person an encouraging remark, and then gives the gift to him or her. The receiver acknowledges kindness with a thank you in his tribal language or in English. The group does not look at the give-away but acknowledges it with a preestablished gesture or word, such as “good” in a tribal language or in English. After all have made their exchanges, a discussion follows regarding how participants felt during the ceremony and about the meaning and the significance of giving.

Using Culturally Appropriate Formative and Summative Evaluations

Group facilitators should consider group closure in a culturally appropriate context. Avoid the use of the term “termination” as this is viewed in an historical reality of exploitation and subsequent profound loss (Duran, 2006). Indeed, many individuals and even whole tribes have “terminated”: a fact not lost on Native People. Group work

allows members to connect to others: their healing traditions, nature, and spirit world. This connectedness is congruent with Native worldview. Group leaders should emphasize going forward to face new challenges once the group comes to a close. In most Native American communities, courage and bravery are highly valued and frequently associated with moving toward new challenges and tasks (Robbins et al., 2010).

Processing

Incorporating Traditional and Spiritual Healing

Perhaps the most profound recent development in counseling Native People involves contextualizing healing from the Westernized psychological idea to the Native traditional spiritual concept of healing (Duran, 2006). In group work with Native People, self-understanding includes an exploration of underlying spiritual motivations that, while not always inconsistent, goes beyond Western psychological conceptualization.

According to Duran (2006), healing is a spiritual undertaking, represented in the Greek root of psyche, meaning "the soul." Intervention necessitates a therapeutic integration of traditional spirituality. Colonization has deeply affected the human soul, inflicting *spiritual injuries* or *soul wounds* accounting for rampant distress among contemporary Native communities. The concept also has relevance and application to non-Native clients. The practice of mental health diagnosis fails to recognize the historical source of traumatic dysfunction in Native lives. As a result, imposing Westernized diagnoses is pathologizing and as such, might be considered an act of continued contemporary colonization (Duran, 2006).

In spiritualizing the healing process, problems are reframed in spiritual terms and in an historical context. This instills a new consciousness among group members and allows them to externalize behavioral problems. For example, alcoholism and drug addiction are viewed as engaging in "bad medicine" involving bargaining with malevolent spirits, engendering unforeseeable consequences to all interconnected with the client. Effective intervention consists first of recognizing the power of unseen spirits and its inevitable consequences for self and loved ones. This shift in conceptualization from alcoholism as a mental health disorder to a condition of spiritual distress allows group discussion that incorporates traditional spiritual healing. As a spiritual condition, alcoholism requires bargaining with "the Spirit of Alcohol" (Duran, 2006). The alcohol spirit provides an immediate need (relief, laughter, sleep) to those who use it; but in return, it demands spirit energy either from the user or perhaps from a member of their family. The shift simultaneously honors the client's traditional way, while empowering clients to recognize personal power to engage in unhealthy behaviors (Duran, 2006).

This approach can be effectively integrated into group work. Facilitators are poised to move from psychologizing to spiritualizing in the context of group therapy by introducing elders and Native healers into therapy and incorporating many of the spiritual rituals described in this chapter and elsewhere (McWhirter et al., 2010).

Chapter Summary

In sum, we hope you come away from this chapter with a deep understanding that the therapeutic effectiveness of any group work for Native Peoples must be conducted with great sensitivity for participant dignity and tribal rights and with conscience awareness of a history of exploitation, resultant trauma, and subsequent historical trauma. We hope the perspectives and examples provided in this chapter contribute to profoundly meaningful, culturally grounded, and truly healing group therapy experiences.

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Chapter 17 Group Counseling for African Americans: Research and Practice Considerations

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African Americans are one of the largest minority groups in the United States, growing by 15% from 2000 to 2010 (faster than the total U.S. population growth rate; U.S. Census Bureau, 2011). Like other racial groups, African Americans may need mental health services; however, they are less likely to receive services. Only 25% of all African Americans dealing with mental disorders received treatment, whereas nearly 40% of Caucasians struggling with mental health issues sought and received counseling and/or psychotherapy services (Wells, Klap, Koike, & Sherbourne, 2001). This is not surprising given that in general People of Color are less likely to seek counseling (Davidson, Yakushka, & Sanford-Martens, 2004).

The limited use of counseling services is critical in light of other more controversial challenges faced by many African Americans. Racism affects everyone in significant and different ways (Singh, Merchant, Skudrzyk, & Ingene, 2012). For Blacks, racism has been found to produce negative psychological and emotional effects (Pieterse, Todd, Neville, & Carter, 2012) and been linked to increased anxiety and depression (Chao, Mallinckrodt, & Wei, 2012).

To be effective in recruiting and providing services, group leaders must be willing to examine internal characteristics (e.g., interpersonal struggles, mental health issues, racial, ethnic, and cultural identity development) as well as external characteristics (e.g., racism, socioeconomic status, systemic barriers) for Black members (Jones, Brazel, Peskind, Morelli, & Raskind, 2000). If African American group members are provided the opportunity to explore sensitive issues in group, they may experience curative factors such as catharsis, interpersonal development, universality, and the development of a social microcosm (Yalom & Leszcz, 2005). To illustrate, Blacks have historically faced environmental, societal, health, educational, and economic barriers due in part to skin color. In a group session, leaders might begin with an activity where the group members identify physical similarities and differences among the group members. The group leader could delve a bit deeper into a discussion on phenotypical characteristics (e.g., skin complexion, hair texture) and the positives and negatives that are stereotypically associated with each (Mitchell, 2000), such as nappy or kinky hair and darker skin complexion being viewed less favorably than soft or straight hair and lighter skin. This discussion creates the environment for Blacks to explore how African Americans respond to being a part of their group membership. Doing so will offer participants the chance to experience new perspectives offered by other members during discussions and self-reflections. These perspectives may also be affirming for the group members who may have doubts about their own original thoughts. These fresh perspectives will also provide a sense of normalization for the group members because they are able to hear some of their own struggles in the disclosures of their peers. Facilitating group counseling interventions with African American participants will take a balancing act that includes addressing any presenting needs of the group members while also considering the broader factors that impact how these challenges manifest inside and outside of the group.

This chapter discusses research findings as they influence group counseling interventions for African Americans, barriers to and cultural factors impacting utilization of group counseling, and presents a group counseling model for African Americans based on the emerging literature. The purpose of this chapter is to provide group workers with a culturally relevant resource to lead groups with African American clients. (Note: the terms *Blacks* and *African Americans* are used interchangeably.)

Research Findings Relevant to African Americans, Counseling, and Groups

The counseling literature on Blacks is dismal with a number of studies presenting Black clients from a deficit perspective (Harper, Terry, & Twiggs, 2009). Harper et al. (2009) described nearly 20 individual and group counseling studies with statements of the major findings offering bleak and depressing statistics. This focus of the interventions was to change problems rather than emphasize strength-based approaches: achievement deficits, overrepresentation in special education, suicide, homicide, HIV/AIDS, police violence, unemployment, domestic violence, fatherless households, identity issues, and false imprisonment.

Another major concern with the counseling literature for Blacks is that the participants in the studies are typically from either working-class or low-income backgrounds (Shin et al., 2010). The few exceptions are studies with Black college students or when Black clients are part of a composite racial and/or ethnic minority group. These limitations question the feasibility of developing group counseling interventions for a wide range of member compositions, including those that are intercultural (i.e., between various racial and ethnic groups) or intracultural (i.e., within racial or ethnic group membership; Merchant, 2006). For example, the group interventions based on SES would vary significantly. Groups for African American students from low-income backgrounds would focus on career development and postsecondary education since research shows that students from low-income backgrounds are less likely to engage in career development activities and receive less guidance from home and school in regard to career and college planning (Hoffman, 2007). This may be less relevant for persons from higher socioeconomic levels where college and career development may already be a natural part of conversation. This research that inadequately addresses the needs of Blacks likely impacts group interventions and may negatively impact public policy (Harper et al., 2009). It is commonly accepted that groups can be a microcosm of the larger society, but the narrowly focused perspective about Blacks with worldviews of abandonment, hopelessness, or skepticism of authority figures may perpetuate negative generalizations for group leaders facilitating interventions with African Americans (Harper et al., 2009).

A 25-year content analysis of group work articles published between 1982 and 2007 was published recently. Only 41 empirical articles have included racial minority groups as participants during this study. Of these 41 studies, only seven had African American clients (Stark-Rose, Livingston-Sacin, Merchant, & Finley, 2012). It is not clear whether there is just a lack of actual group interventions facilitated with Black clients, limited published studies for this population, or a combination of these (Stark-Rose et al., 2012). In addition, less than 3% of the students of color used university counseling services. Of those students of color, only 3% were African American (Davidson et al., 2004), emphasizing Blacks may avoid or be hesitant to participate in counseling.

Barriers to Counseling and Groups for African Americans

African Americans are less likely to seek help for their mental health concerns from a counseling center (Snowden & Pingitore, 2002), perhaps based on the belief that counselors may be culturally insensitive (Mitchell, 2000). Another explanation may be that many African Americans do not self-disclose in a public or counseling setting (Madison-Colmore & Moore, 2002). This is logical in that many Blacks historically have been forbidden from exercising many freedoms, such as the freedom of speech, access to education, and equal rights in society. In a group session, this is important to consider in the event that any of the Black group members are reluctant to express their true perspectives for the fear of being judged or discriminated against by others. Furthermore, African Americans typically seek out advice from family, friends, or their pastors (Aten, Topping, Denney, & Hosey, 2011). With this in mind, the group leader can explore the thoughts and feelings associated with committing to a group counseling intervention, such as religious and spiritual issues. In general, group leaders need to be aware of the values, heritage, cultural images, and background of African American clients and incorporate them into their counseling with this client population. When working with some African Americans, it is also important to pay attention to counselor-client racial match and the incorporation of the principles of Black psychology (Smith & Wermeling, 2007).

African American clients have also been misdiagnosed because the interventions used may have relied too heavily on traditional counseling theories (Fusick & Charkow Bordeau, 2004). These therapies are not culturally relevant and increase the chances of cultural misunderstandings, which have been linked to premature termination for Black clients (Knox, Burkard, Suzuki, & Ponterotto, 2003). For example, during the early stages of group when it is important to develop cohesion, it is critical that the group leader highlights tangible outcomes the client may work toward in group. The therapeutic alliance can be established by helping African American clients explore more culture-specific issues that may not have been explored previously. Other ways to increase the comfort levels of the group members would be for the group leader to be open to acknowledging the clients' worldviews and attending to clients' reports of racism (Fuertes, Mueller, Chauhan, Walker, & Ladany, 2002). Establishing a good therapeutic alliance is vital in group counseling with Blacks in that it makes the sharing easier in a group setting.

Cultural Values to be Considered When Leading Groups with African Americans

In this section, spirituality, family considerations, and communal worldview are explored as cultural values that may affect how African Americans experience group counseling. Spirituality as a value must be considered when conducting groups with African Americans. Blacks traditionally have had a strong sense of belief in a Supreme Being (Pack-Brown & Fleming, 2004) and this may impact how they see life and the interactions that they have with others. For many Blacks, spirituality is synonymous with the church and African American culture. Group leaders must respect African American clients' spiritual beliefs and values, because they affect worldview, psychosocial functioning, and expressions of distress (Washington & Moxley, 2001). All Blacks are not churchgoers or Christians, but generally speaking, spirituality is heavily relied on when making decisions.

In some cases, it might be useful to use prayer as a method of fostering engagement in the change process, particularly for people who may be reluctant to involve themselves in a group treatment experience or who have not had any prior experience with groups. African American clients may be more familiar with group prayer than group therapy. It is important to note that as a group leader, one way in which to know whether or not African American clients would be open to prayer would be to simply ask. It is well understood that when facilitating group sessions with any clients, making an assumption without asking directly might end in less favorable outcomes. The vignette presented below illustrates the drawbacks of making an assumption that all Blacks would be open or interested in integrating spirituality into their group experience.

> Thomas, an African American man, is leading the first group counseling session with eight adult members who were invited to participate in group for those who have experienced loss (e.g., family member, job, marriage). All the participants identify as Black, Biracial, and/or Multiracial. Thomas decided to begin the session by inviting the pastor from his church to come and open the group in prayer. Following the prayer, the pastor left. Thomas noticed that some of the group members became visibly uncomfortable when meeting the pastor and during the prayer while others actively participated. Recognizing that he acted from his own worldview, Thomas facilitated a discussion for the members to explore what just occurred. One member expressed appreciation for the presence of the pastor and stated that he felt more comfortable about the group as a result. Another responded by expressing her discomfort with the situation. She stated that she felt Thomas overstepped his bounds by assuming everyone in the group prayed. She said that she was now very uncomfortable and did not know if she would return to the group next week. This conversation continued with other members expressing both positive and negative feelings regarding the opening of the session. Thomas self-disclosed that he may have made a mistake in asking his pastor to open the session in prayer and apologized for the supposition that all the group members would feel the same way. He suggested that each group member share something about how they deal with loss that would be incorporated into future group sessions.

Exploring spirituality with African American clients may help foster a group environment in which members can freely express themselves and their spiritual beliefs and their personal narratives (Washington & Moxley, 2001). It is important to also be aware and ready to explicitly explore God, or a belief in a higher power (Pack-Brown & Fleming, 2004) as it relates to what happens in group and group members' presenting issues. For those who integrate spirituality into their daily lives, it could enhance the counseling process by increasing group cohesion and reducing depression (Miller et al., 2012). If a Black client mentions their faith, then a group leader may be able to ask about how it impacts their presenting issue—positively and negatively—perhaps suggesting other issues to address or possible solutions.

The importance of family also should not be overlooked. Family dynamics (e.g., parental influences, sibling issues, extended family suggestions) are sources of information that many Black clients must examine when making their own personal decisions. Typically, African Americans are cognizant of how their family would view them

attending the counseling sessions in the first place. One way to address this issue with African American clients during the recruitment or in group sessions is to allow members to discuss their feelings when asked about their families' reactions regarding their participation in groups. Black group members may also be worried about how their families might react to them discussing some of their struggles that could be perceived as private matters. Group members also need to be provided the opportunity in the group to process their feelings about the worries they might have in this matter. The group leader can facilitate discussions that allow group members to share how they anticipate their family and friends will react to the counseling process. By sharing these concerns, members will be able to work together and develop ways to address others' opinions of their choice to receive counseling. Further, acknowledging these dynamics by asking for members to share individuals in their lives who they turn to for help could normalize Black clients' fear of participating in groups and also identify support and sources of information and advice needed for future discussions in group. Helping Black clients talk about their perceptions and feelings related to disclosing personal issues would be an appropriate strategy to address these issues (Moore & Madison-Colmore, 2005).

Next, another value common to African Americans is communalism. Communalism is a collective responsibility of individuals to his or her group. In other words, African Americans have a strong sense of collectivism that may be reflected in relationships that extend beyond the immediate family and into the broader community (Wiggins Frame, Braun Williams, & Green, 1999). For example, often Blacks identify more easily with other Black people. This comfort may stem from sharing a similar racial or ethnic group membership and can be readily seen in a group when the African American members are collectively expressing and dialoging about personal struggles. Therefore, the group leader must consider both the relationship between group member and leader(s) and the interaction among the group members. A group leader's ability to facilitate cohesion will in turn enhance the potential therapeutic benefits of the group experience. One thing a group leader can do to increase group cohesion is offer self-disclosures. The group leader can also express personal observations about how the group members are interacting with each other. For example, in a group session where there is some racial and ethnic diversity, the group leader may notice that many of the Black group members sit near each other and/or readily identify with other Blacks but may also be reluctant to sit near someone who is not African American or be reticent to engage in the group process when non-Black members are sharing. The group leader can point this out, not necessarily as a problem but rather as an opportunity to talk about what might be playing out in the group. By adopting some activities such as randomly arranging the seating among group members might lead to a discussion about how it feels to sit with someone that is different from them racially or ethnically.

Culturally Competent Group Leader Training

Group leaders must be willing to explore difficult and sensitive topics with diverse members. However, current group counseling training, preparation, and practice traditionally have been deficient in providing group counselors strategies to work effectively with African American clients (Burnes & Ross, 2010). What currently is lacking is an understanding of the impact of oppression and privilege on the group process. Moreover, improper group training and preparation may increase the likelihood of cultural misunderstandings, frustrations, and other barriers that may emerge between counselor and clients (Pack-Brown, Thomas, & Seymour, 2008). Group counseling training must make a more concerted effort at teaching preservice counselors how to broach issues related to race, ethnicity, and culture (Day-Vines et al., 2007). African American group participants are more likely to feel comfortable expressing themselves fully, if given the opportunity to broach issues related to race, ethnicity, and culture and thus, may lead to better treatment outcomes (Chao et al., 2012).

The ASGW *Multicultural and Social Justice Competence Principles for Group Workers* (Singh et al., 2012) are useful as a framework to conceptualize group work interventions with African American clients. This revised document provides definitions for multiculturalism, diversity, social justice, social privilege, oppression, and taking action. Principles under the following three domains are described: (1) awareness of self and group members, (2) strategies and skills, and (3) social justice advocacy. The impact of multiculturalism and social justice on group process and dynamics, group and individual outcomes, facilitation, training, and research are discussed in-depth.

Culturally Appropriate Strategies for Leading Groups with African Americans

Included in this section are strategies that have been recognized to increase not only the awareness of culturally adept group workers but also their competence in facilitating groups with a wide variety of racially and ethnically diverse clients. First, *consulting* with individuals from backgrounds that are culturally matched is appropriate and useful when serving specific populations (Steen, 2009). In the case for African Americans, one might pursue an elder from the community who may be from a similar socioeconomic, religious, or cultural background to provide a context in which to draw from while trying to plan and facilitate appropriate counseling interventions. Questions, such as "How common is depression for the Black community?" or "How is the social and economic outlook for African Americans in your view?" can be asked of the cultural informant. Answers to these and other questions could be helpful in gaining a more accurate perception of a Black client's experience. Group leaders can take this relevant information and approach the groups using a strength-based orientation or counseling approaches that build on the assets of African Americans instead of counseling approaches that are likely to focus on psychopathology, mental disorders, and therapeutic remediation.

Another strategy includes *immersing oneself* in relevant cultural experiences as a way to gain a greater appreciation and deeper understanding of some groups members' life experiences. An obvious gathering place for African Americans would be religious congregations and visiting a predominantly Black church may provide a sense of this population's spiritual experiences. Another manner in which the group leader could more intimately discover the experiences of African Americans would be to spend some time, say a few days, in a Black community as a visitor (Moore & Madison-Colmore, 2005). The goal would be to develop a greater and more personal understanding of issues some Blacks may face. These meetings may be informal and consist of short interactions or more in-depth interactions if the group leader is able to find people who would be willing to share their experiences being Black. If a practitioner stretches oneself to go into communities that may be unfamiliar to them but similar to their group members, they stand a greater chance of discovering and addressing the most relevant issues.

When appropriate, group workers should *partake in specialized training and development* (Moore & Madison-Colmore, 2005). In this case, group workers can participate in specialized language training in African American English (AAE) to appreciate the distinctive linguistic traditions of AAE speakers and to understand that AAE provides its speakers with a distinct form of self-expression, identity, and belonging (Day-Vines et al., 2007). For example, currently, there is a K–8 charter school in Los Angeles that uses Black English (e.g., African American English) as the basis for a language arts curriculum (Zeal Harris, personal communication, October 5, 2012). In this program, students are taught traditional English while being allowed to integrate their natural language into their class participation, assignments, and homework. This type of training could help preservice counselors understand the subtle nuances of language and communication for clients from diverse backgrounds, especially African Americans who have unique communication forms. For example, some Blacks have been known to speak in a loud voice, even if they are not angry (Bireda, 2010). Thus, if members are engaged in a loud discussion, they may not be angry with one another. Also, sometimes African Americans communicate simultaneously. It does not mean that Black group members are attempting to be rude, but that they are actively engaged in the current discussion (Day-Vines et al., 2007). Group leaders who take the time to learn these and other factors associated with AAE stand a greater chance of becoming more culturally competent when offering group counseling interventions for Blacks.

Group workers can attend specialized seminars and conferences that may feature African Americans (e.g., National Association for Multicultural Education) that might help provide a better understanding of issues they may face. Another strategy is to search the literature. Practitioners can read a seminal work written by W.E.B. Du Bois entitled *The Souls of Black Folk* (Du Bois, 1903), or Beverly Daniel Tatum's publication entitled *Why Are All the Black Kids Sitting Together in the Cafeteria? and Other Conversations About Race* (Tatum, 2003). These pieces, written a century apart, offer critical discourse on similar issues such as racism and racial identity. Group leaders can use this information to gain a fuller understanding of the various experiences of Blacks.

Knowledge, Open Communication, Faith, Family, and Empowerment (KOFFE): A Group Counseling Model for African Americans

The *Knowledge of the African American experience, Open and honest communication, Faith and spirituality, Family exploration, and Empowerment* (KOFFE) is a group counseling model for African Americans created by the first author, Sam Steen. The acronym is a reminder of the topics that should be explored in groups for African Americans. The intent is to provide a framework that allows adjustment along the way. These topics chosen have emerged from some of the group counseling literature specifically targeting African Americans in homogenous groups as opposed to those that are racially and/or ethnically mixed (Bemak, Chung, & Siroskey-Sabdo, 2005; Madison-Colmore & Moore, 2002; Moore & Madison-Colmore, 2005; Steen, 2009). For instance, when planning for a group with African American clients, group workers can prepare by gaining a *knowledge* related to historical or current political movements. This cultural understanding will provide a better understanding of African Americans' unique experience (Moore & Madison-Colmore, 2005).

Open and honest communication (Jones et al., 2000) must be explored to establish a supportive environment. A supportive environment can be fostered by exploring confidentiality and its limits as well as allowing ample opportunity for group members to share their hesitations about participating in the group intervention. Once a supportive environment is created, the group leader can model honest, direct, and intentional communication. For example, the group leader can state the importance of group member's willingness to engage in self-disclosure that is conducive to drawing connections among the group members, while also demonstrating the unique experiences of the individuals. In the beginning stage of a group, the group leader may facilitate an ice-breaker activity for members to get to know each other. During this activity, group members will have opportunities to share their personal experience and things that make them unique individuals. Sharing these things will create opportunities for group members to make connections with each other and recognize commonalities that exist between them. It may be difficult for some Black group members to self-disclose. However, all group members may or may not share similar experiences but providing the opportunity for them to verbalize any concerns they have openly and honestly among strangers while not being criticized or judged will lead to greater group cohesion. Once one member discloses his or her concerns about sharing, this likely will enhance the group members' ability to connect because simply sharing this concern might expose that this is a common issue for many of the group members.

Faith and spirituality and a belief in a Higher Power is common within the African American community (Washington & Moxley, 2001). As a result, exploring a Black client's spirituality and how it may play a role in their presenting issues will provide a fuller understanding of the daily experiences of Blacks. For example, a young African American woman interested in pursuing romantic relationships may not consider engaging in sexual intercourse until she is married. The young woman may make this decision solely on her belief that it would be improper to engage in sexual relationships (even if consensual) outside of marriage. This information is vital if offering support to someone whose spiritual background may contradict popular opinion. Spirituality may impact every aspect of life such as where to live, occupational choices, and how to raise children (Wiggins Frame et al., 1999). In the situation mentioned above, an effective group leader would be open-minded while helping explore what it is like to be making a personal choice that is considered contradictory to popular opinion. Furthermore, the group leader can draw other members in by allowing them to share their impressions and similar experiences.

It is not uncommon for Blacks in group to identify *Family* as an important part of their experience (Bemak et al., 2005). Therefore, the group leader working with African American clients may want to facilitate a discussion on defining family as well as the role their family and extended family may play in their lives. The purpose of this is to ask group members to express and explore their personal narratives about their family. The group may also present as the reenactment of a family with the facilitators serving as parents, aunts, or uncles, and the other members as siblings, and so forth; this reenacted family in group can be useful to provide a forum to discuss and resolve difficult emotional experiences (Yalom & Leszcz, 2005). The purpose is to have the chance for an increased awareness about relationships group members have with others outside of the group, with the hope of a closeness developing between the participants and facilitators (Bemak et al., 2005).

Empowerment is essential to groups with African Americans, defined as developing a sense of belonging, strength, and the skills to gain control over one's life (White & Rayle, 2007). Group leaders must understand the impact of systemic institutionalized oppression as a primary cause for many of the psychosocial difficulties experienced by Blacks (Bemak et al., 2005). Further, it is imperative that group workers help their African American clients refrain from seeing themselves as solely responsible for the issues they may be facing. Culturally relevant bibliotherapy (i.e., books about Blacks and/or written by Black authors; Day-Vines et al., 2007) would be useful to help Black clients not see themselves as victims. At the same time, group leaders also must refrain from seeing African American clients from a perspective of insufficiency and promote an awareness of the oppressive forces in their lives to help them become fully capable and equipped to transform the environments in which they live. The group leader can foster empowerment by helping the group members discuss and come up with viable solutions to confront injustices that may be regularly encountered by group members (Ratts & Hutchins, 2009). For example, in a group intervention that is being attended by African American former juvenile offenders, the group leader suggested members share their thoughts about racism and/or discrimination and any impact this may have on their ability to find employment. The goal of this discussion was to counteract the negative feelings of isolation and loneliness that Black clients may experience when trying to find employment with a criminal record.

Goals

The goals of the KOFFE group include exploration of these factors when considering interventions and goals in homogenous African American groups. Additional goals will be contingent on the purpose of the group, which can be derived from the presenting issues of the group members. For instance, if one is running a group for Black women who are experiencing depression, then in addition to facilitating group discussions about depression and the struggles associated with this disorder, all topics listed above should be intentionally explored to contextualized the presenting issue, therefore establishing a more culturally congruent group counseling intervention (Jones, 2008). In this case, exploring the meaning of depression within the context of the group members' family of origin (e.g., how family members view this disease, family history) is necessary. Furthermore, considering how the women feel about God could also be important in treating their depression.

Group Leadership Strategies

It is important to note that there is a dearth of literature specifically examining counselors implementing group counseling interventions with African Americans adults, although the information presented for children and adolescents is more readily available (see Bailey & Bradbury-Bailey, 2007; Bemak et al., 2005; Steen, 2011). These examples of groups for African American children and adolescents inform the manner in which each of the group counseling sessions can be structured. The KOFFE group counseling model has built on prior research. In particular, one culturally relevant group counseling model for African American youngsters is especially useful (Steen, 2009) and is described based on phases rather than sessions. These phases are (1) Assessment, (2) Review, (3) Acquaintance, (4) Challenge, (5) Empowerment, and (6) Support.

The group's phases are presented sequentially with the assessment phase occurring prior to the beginning of the life of the group and all the rest of them occurring as the group progresses. However, the other phases do not necessarily occur in a certain order. The phases of the group unfold based on the unique makeup of the group members, leader(s), presenting issues, and other factors that influence the group.

During the assessment phase, the group leader collects and uses any relevant data gathered or gleaned from the media, health files, or individual screening meetings prior to the group's commencement to select and screen group members and develop a tentative agenda (e.g., purpose and focus of sessions, group goals and objectives, and duration of intervention). For example, a counselor interested in running a group for Blacks interested in career exploration may use the assessment phase to meet with the group members individually, community members, or with cultural brokers to identify either potential members or other specific data that may be useful when working with potential members of a group. Once a list of potential group members is identified, the group leader would interview and screen potential group members to determine those who would benefit. By assessing the individual needs of potential group members and considering the goals of the group, leaders can determine which individuals will be best fit to participate. Specifically, this phase can be used to develop information about some areas that the counselors can consider when serving this clientele. It is important to note that gathering data from cultural informants or other appropriate community members acting as group consultants can be done periodically throughout the life of the group and feedback that emerges from the group can also be shared with these parties when appropriate after asking the group members for their permission.

The group actually starts with the review phase. During this phase, the group leader reviews information pertaining to the group with group members such as the group expectations, individual and/or group goals, and group norms once created. The review phase usually takes place in the first few sessions but similar information can be discussed as often as needed in the remaining sessions. In this case, group expectations such as whether or not to allow family members to come to the session or whether or not to include prayer as part of the groups could be reviewed.

In the acquaintance phase, which occurs during the first few sessions, the group leaders help the Black group members become familiar with each other, as well as the group leader(s), leadership style(s), and group process. During this phase, the group leader will also use appropriate self-disclosure that will help shed light on them as participants in the group as well as their leadership style. This is particularly necessary for African American clients to feel comfortable and without such engagement in cohesion-building activities, the chances of Black clients even returning for additional sessions is slim (Utsey, Howard, & Williams, 2003). For example, a few group members want to begin each session of group with prayer. The group leader may want to explain their comfort level with prayer. In the event the group leader does not attend church or is uncomfortable with spirituality, this may become even more important to self-disclose. This revelation about prayer will give the group members the opportunity to express how they feel about this and as a result the group leaders and members will at least become more acquainted. Furthermore, the group leader can help the members negotiate how to integrate prayer in session despite the group leaders' comfort levels.

During the challenge phase, the group leader gently encourages members to explore any inconsistencies between

what they may verbally share in the group and their individual goals described in their screening interviews. For instance, the counselor may have become aware from the data gathered at the onset of the group that one of the members is interested in exploring how to more effectively communicate with coworkers who are from racially different backgrounds. The group leader uses the information from the data collected during the assessment phase to inspire clients to explore when, where, and how often these limited successful attempts at communicating with coworkers occurs and to solicit input from this particular member, as well as others, as to how to counteract this unproductive behavior. This phase is useful in directly addressing the problem areas or presenting concerns for the group members. For instance, in the situation mentioned above, the group leader could facilitate a discussion regarding communication with coworkers that would involve all group members, not just the member who had a concern regarding this topic. By initiating this discussion, the group leader can open the floor for members to share their own struggles and successes when communicating with others that are racially or ethnically different from them in the workplace.

In the empowerment phase, the group leaders teach information and skills to overcome difficulties. For instance, for the earlier example, the group leader might challenge the group to explore strategies to assist the group member in more appropriately and successfully communicating to their colleagues that may be racially or ethnically different from themselves. In this case, counselors could empower the group member by providing information on appropriate communication with racially different coworkers and other adults. In groups with African American clients, it is important for group leaders to encourage group members to explore strategies in a collaborative way and to offer each other ideas that could empower the individual to handle their specific concerns.

This phase also presents an opportunity for people with certain expertise to be invited to give a guest lecture or presentation. For example, if African American clients were interested in gaining more information about applying for college when making second career choices—or more specifically on financing college— admissions officers or financial aid specialists from a local community college or university that may have some experience working with Blacks could be invited to provide specific information that might be useful and beyond the scope of the group leader's role.

Finally, the support phase brings closure to a group. For example, the counselor should facilitate a discussion about group members' initial goals established early in the group, how their goals may have changed, and whether they have accomplished their goals. They should also encourage clients to give each other feedback about areas of growth observed in one another.

This phase can also be used by the counselor to help Black group members identify supports and resources within and external to the group to help them continue striving to accomplish their goals. The counselor could lead African American clients in discovering resources available within the group (e.g., personal acceptance, enhanced self-esteem), and within their family and community (e.g., prayer partners, community programs). Group leaders can brainstorm with group members how they may draw on these resources for support as they work toward their goals and as the group terminates. A discussion of external resources during group sessions and at the conclusion of the group can help increase long-term positive results for group members (Steen & Bemak, 2008).

It is imperative that the pre- and post-intervention measures are culturally appropriate. One assessment tool that can be used with a diverse population is the Multi-Ethnic Identity Measure (MEIM) (Phinney, 1992). Although this scale was not normed on an entire African American sample, it is a reliable measure that captures identity development, which may be influenced by factors that will be explored in a group for Black clients. Finally, as the group comes to a close, the counselor should help Black group members celebrate their accomplishments. This can be done formerly by hosting a ceremony or informally by simply sharing a meal and reflecting on all the things that have emerged during the group experience (Bemak et al., 2005).

In sum, the KOFFE group counseling model, as it currently stands, could be used tentatively to develop group interventions that are appropriate for working with African American clients. The model is innovative in that it offers some contextual considerations such as exploring important topics that will augment the presenting issues such as, knowledge of the African American experience, open and honest communication, faith and spirituality,

family, and empowerment. Furthermore, this model suggests collaborating with cultural informants and community members by exploring concerns of the African Americans in their communities and connecting group members to internal and external assets as the group terminates.

Future Directions

Salient evidence-based research is needed to determine the feasibility and appropriateness of group interventions. Group workers must conduct needs assessment, discussions with cultural brokers, and review the necessary research to determine if/when homogeneous groups is the right type of group work to facilitate. The KOFFE group counseling model for African Americans is one that we hope will inform future research and practice.

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Chapter 18 Group Counseling with Asians

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Asian Americans are one of the fastest growing ethnic groups in the United States (U.S. Census, 2010). Asians comprised 5.6% (17.3 million) of the total U.S. population. It is projected that by 2050, they will comprise 9% (40.6 million) of the population, increasing the likelihood that counselors will encounter more Asian clients (U.S. Census, 2010). Since Asian Americans come from collectivistic family and group orientated cultures, group counseling can be an effective intervention. However, for group workers to be effective with Asians, it is important to be aware and understand the characteristics of this diverse population. The chapter will begin with a brief overview of the Asian population that includes cultural values and worldviews and then discuss the challenges in group work with Asians, followed by suggestions for effectively implementing group work with this population.

Who are Asian Americans?

The Asian American population is a diverse ethnic group that consists of over 43 different groups throughout the Asian region (Chung & Bemak, 2007). The term *Asians* in the Census 2010 refers to people having origins in the Far East, Southeast Asia, or the Indian subcontinent, including places such as Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippines, Thailand, and Vietnam. The category is not limited to nationalities but includes ethnic groups as well, such as the Hmong (Chung & Bemak, 2007). The main groups within the Asian category are Chinese, Japanese, Korean, Filipinos, Vietnamese, Cambodians, Laotians, and South Asians. Asian immigrants account for 8.9 million or 26% of the foreign-born population in the United States (Capps & Passel, 2004). Failure to recognize the unique inter- and intragroup differences could cause group members to prematurely terminate counseling.

Intergroup Differences and Conflict

For group workers to fully understand Asian clients, they must be aware of the unique historical and sociopolitical backgrounds of the various Asian groups. For example, the Chinese were the first Asian group to migrate to the United States in the 1800s working in the gold mines and railroads, often confronted with discriminatory and racist migration restrictions and policies (Takaki, 1989). In the late 1800s, Japanese Americans migrated primarily to Hawaii to work as cheap laborers on sugar plantations. Their experiences differed from other Asian groups due to the internment of Japanese Americans during World War II, resulting in intergenerational trauma that was passed down from generation to generation (Mio, Nagata, Tsai, & Tewari, 2007). In comparison, Southeast Asian refugees from Vietnam, Cambodia, and Laos entered the United States in 1975 after the fall of Saigon and the end of the Vietnam War. With approximately 1.5 million Southeast Asian refugees entering the United States, this group became the fastest growing ethnic group in the United States. Due to the atrocities encountered during the Vietnam War, Southeast Asian refugees experienced serious mental health and psychosocial adjustment challenges in the United States (Chung & Bemak, 2006). The different historical and sociopolitical experiences have been passed down from generation to generation and therefore, may still impact Asian Americans today.

It is essential that group counselors are aware of potential intergroup conflict between Asian groups and subsequent challenges in working with groups that are comprised of different Asian groups. For example, school personnel approached the first author to ask for advice about a teacher who was having difficulty with Chinese and Japanese students in her class. There were group projects that were randomly assigned to various students. The teacher could not understand why a group of Chinese and Japanese students would refuse to work together despite no overt conflicts in the class. If one understood the sociopolitical and historical background between China and Japan, this would not be surprising. During World War II, the Japanese attacked and plundered China leaving a long-standing tension between the two groups resulting in an intergenerational impact. Other historical sociopolitical examples include the strained relationship that can at times occur between Chinese and Vietnamese, or Koreans and Japanese, or between Chinese who come from mainland China and those that come from Taiwan. Again the tension in these relationships originates in historical and/or current sociopolitical situations between the countries. Simply placing Asians together does not display cultural sensitivity and eliminate cultural differences but instead may create potential conflict that affects group dynamics. Group counselors need to be mindful of potential sociopolitical and historical issues occurring between and within Asian cultures. One way to be aware and understand these issues is familiarize oneself with the history of these countries and to be current on sociopolitical events through the different news media outlets (e.g., CNN, BBC).

Intragroup Differences

It is also important for group counselors to acknowledge differences within groups. For example, Southeast Asian refugees are often discussed as a cohesive group. Although members of this group share similar experiences due to the Vietnam War and as refugees, they also have different and unique premigration experiences, which impact their postmigration adjustment process (Chung & Bemak, 2007). For example, the first wave of refugees from Vietnam arrived soon after the Vietnam War while the second wave arrived five years later and experienced more traumatic events during the escape process. Hence, refugees from the second and subsequent waves experienced more serious mental health and adjustment challenges than their first-wave counterparts (Chung & Bemak, 2006).

There are also gender differences in acculturation that must be taken into consideration. Immigrant women in general acculturate faster than men (Chun, Organista, & Marin, 2003). This is related to the changing family role as women are forced to work outside the home for economic reasons while gaining exposure to Western views that promote greater gender equality. Simultaneously men may experience downward socioeconomic mobility due to not finding a job or being underemployed while women experience upward mobility as they financially contribute to the household and break free of traditional cultural gender roles (Chung & Bemak, 2006). However, refugee women, due to their premigration traumatic encounters (such as loss of spouse and experiences of multiple rapes and sexual abuse), typically experience more psychological distress (Chung & Bemak, 2006).

Group workers must also acknowledge differences in one's identification with their country of origin due to the historical and sociopolitical background. For example, group counselors may assume group members are from People's Republic of China (mainland China) when they are in fact from the Republic of China (Taiwan). The differences between foreign-born and U.S.-born Asians are also important. Asian clients may become highly offended if group counselors make the assumption that they are foreign born given the accompanying stereotype that they may have a low degree of acculturation or English proficiency.

Asian Cultural Values and Worldviews and Attitudes toward Group

Collectivistic versus Individualistic

Collectivistic cultures regard group, community, and family as more important than the individual (Chung & Bemak, 2012). Life decisions such as vocation, where to live, utilization of free time, and so forth, are made considering the impact on family and friends and based on interdependence and one's relationships within the social matrix rather than made as independent decisions. Therefore, group counseling is consistent with the focus on collective goals and needs of the group. This is in contrast to the U.S. individualistic culture that focuses on independence, competitiveness, personal goals, maintaining a strong individual identity, and greater acceptance of confrontation and emotional expression. In collectivistic cultures, the aim is to maintain harmony (Chang, Chang, & Chu, 2007). Maintaining harmony necessitates that individuals do not outwardly display independent behavior or expressions of emotions that might disrupt familial harmony. Members of collectivistic cultures are more likely to describe themselves in social and collective terms compared with individualistic members who describe themselves independent from others using a variety of abstract terms (Draguns, 2008). Subsequently, in group counseling Asian group members may use the term *we* rather than *I* when referring to oneself and may find it challenging to outwardly express their feelings. It is important for group counselors working with Asian groups to understand these cultural dimensions and facilitate safety in expressing deeply rooted feelings within a culturally appropriate context where social relationships take precedence over individual needs and wants. Facilitators' comments that acknowledge the interrelationship between oneself and others would be important, such as, "I realize it is important for you to consider others and I am wondering how you also fit into that situation?"

Hierarchical Family Structure

Asian families are generally patriarchal with a hierarchical family structure that has prescribed roles based on age and gender. Males and particularly the oldest son have dominant roles. Filial piety is a major cultural value and refers to the responsibility, obligation, and duty that children have for their parents. Parents are expected to be taken care of by their children in their old age. Older age for Asians is a sign of status and symbolizes honor, authority, respect, wisdom, and custodians of the cultural heritage (Iwamasa & Sorocco, 2007). It is important that group counselors realize that they may be challenged by Asian group members who are older than them or that group members may find it more important to serve their parents' needs rather than meet their own personal needs. Group counselors must readily acknowledge these cultural norms within the group when they manifest within the group dynamics, directly acknowledging to group members that their respect for parents or elders is completely understood and that their parents or elders are also important.

Loss of Face

Crucial in working with Asians is the finding that Asians are more likely to be highly sensitive to refutation and shame and have stronger self-regulation when compared to White Americans (Yamaguchi, Kuhlman, & Sugimori, 1995). Loss of face for Asians occurs when one fails to fulfill one's social role and upsets interpersonal harmony. Loss of face is similar to shame and involves public exposure for a transgression (Hall & Eap, 2007). If one loses face it is felt not only by the individual but by the entire family and community to which the individual belongs. The shame extends to possible loss of support and the threat of ostracism from one's family and community resulting in shaping social norms and group conformity. Shame is often used to threaten others and influence and shape personal, family, and community behaviors (Chang et al., 2007). Subsequently Asians have developed intricate and very subtle ways of communicating with each other as a means of allowing all involved parties to maintain face. It is therefore important for group therapists to consider “saving face” when doing group work. For example, if there was a situation where a family member became drunk in public, embarrassing the entire family, the group counselor could not address this problem directly in group but instead might generally talk about family relationships and impact of behaviors by other family members on the group members. Another example can be seen in group counseling based in a school, where the group facilitator would not directly point out that an Asian member is failing in a course, since the student's behavior may be perceived as relating to the quality of upbringing by the parents, but instead would discuss these issues indirectly by talking about assignments, study habits, and homework.

Acculturation and Racial Identity

Although Asians at different levels of acculturation can benefit from group counseling, it is important that group facilitators are familiar with acculturation issues and assess group member's acculturation levels. Acculturation refers to the process and the degree to which individuals adopt mainstream society's values and behaviors (Berry, 1980). It is important to be aware that acculturation is a complex and multidimensional procedure that requires negotiation between the Asian and the U.S. cultures to work out how to balance and integrate the two cultures. Acculturation differs among Asian Americans depending on whether they are foreign born or U.S. born, as well as the number of generations that they have resided in the United States. Those who are born in the United States are more acculturated than those who were born outside of the United States, coupled with the fact that the more generations one's family is in the United States the greater the level of acculturation. The assumption is that each generation becomes more Americanized, losing some of one's Asian cultural roots (Kim, 2007). Where the Asian client resides will reveal information about acculturation. For example, if the Asian client lived a majority of her life in an ethnic enclave—that is, in Chinatown—regardless of the number of generations in the United States, she may be less acculturated due to being constantly surrounded within her cultural heritage. Those who are highly acculturated tend to have more positive attitudes toward seeking Western professional psychological help and group counseling (Kim, 2007). Group facilitators must discuss honestly and openly within the group about the intergroup acculturation differences and the values group members carry as a result of their acculturation levels. These issues can be explored by asking questions such as, “I wonder what some of the differences and similarities we share in our group as we reflect on how our own cultural values relate to mainstream values in the United States?”

For example, a homogeneous group may consist of all Chinese clients. The group leader should ascertain if group members are foreign born versus American born and/or how they ethnically identify themselves. Do they characterize themselves as Chinese or Chinese American? These acculturative differences are essential to understand when working with what may appear to be a homogeneous group. Those who have just arrived in the country may still hold strong traditional Chinese values compared to those who may be foreign born but have lived most of their lives in the United States. Thus, an all-Chinese group may be comprised of individuals who identify themselves as American, Chinese American, Taiwanese, Malaysian Chinese, Hong Kong Chinese, or as being from mainland China, each with different levels of acculturation and perceptions about their Chinese peers in the group, resulting in profound differences and potential tensions and conflicts among group members despite similar Chinese backgrounds. Similar to other immigrant groups, Asians undergo a significant psychological struggle in the acculturation process with both internal and external pressures from family and community to either acculturate or to maintain traditional values (Kim, 2007). Studies have suggested that Asians who have high levels of acculturation are more open to group counseling than their counterparts with low or no levels of acculturation (Kim, 2007). Group leaders can assess the level of acculturation and adapt their leadership styles by asking a series of questions, such as how they identify themselves, whether they speak English as a second language, if they speak an Asian language and, if so, how often, are most of their friends Asian, and so forth.

Another important concept for group counselors is racial identity theory, which provides an understanding of the developmental process of coping with societal racism and developing a healthy self-concept within a racial heterogeneous society (Helms, 1995). Awareness of racial/ethnic identity is critical in working with multiethnic groups and addressing issues of positive interethnic group relations. Group leaders must attend to differences with group members and serve as role models in the exploration and acceptance of ethnic and cultural differences. Modeling openness to cultural and ethnic differences helps groups understand how to examine cultural differences and prevents the group from experiencing racial or cultural polarization. For example, an Asian member may be in the immersion/emersion status and therefore may value everything that is Asian, while denigrating other cultures. It is critical that group counselors understand the Asian member's racial identity status and work within that framework to help that person come to terms with their resentment and anger toward other cultures. In this case, it would be important for the group counselor to explicitly acknowledge the Asian group member's cultural values while simultaneously facilitating a group discussion about each member's values toward other cultures by asking, “How do group members feel toward other cultural values?” Another example can be seen when Asian members

may be in the dissonance status where they are ambivalent and confused about their racial and sociocultural group identity. Although they no longer see themselves fitting in with their peers from other races or ethnicities, they are not fully comfortable with their Asianness. In this case, the group counselor needs to be supportive of the Asian group members as they begin to explore their Asian culture and ask them directly about their discomfort with being Asian.

Therefore, it is essential that group counselors assess the racial identity and acculturation levels of individual Asian members by evaluating how one presents themselves in terms of race and identity. This is important in avoiding the mistake of assuming that all Asian group members are at the same level of acculturation and racial identity. For example, Asian group members may identify themselves as Asian, Asian American, or American. Their identification will give group counselors an indication of their racial identity and level of acculturation.

Help Seeking Behavior

A key concept in Asian cultures is self-reliance and self-restraint resulting in the perspective that those who seek outside help are weak and dependent (Sue & Sue, 2008). Asians tend to remain quiet regarding their personal problems or turn to family members for help. Mental health problems may be viewed as genetic disorders, which have implications for past and future generations in one's family. Because Asians often do not share their emotions or problems, distress is frequently somaticized, causing a predilection for discussing academic and career-related issues rather than personal problems (Leong & Gupta, 2007) or underutilization of mainstream counseling services.

Guidelines for Best Practice in Group Work with Asians

Culturally Appropriate Group Goals

Given that Asians are from a collectivistic culture, groups may be a good fit for this population. However, to be effective with this population it is important for group counselors to examine the group goals, techniques, and interventions from a multicultural perspective. For example, Corey (2008) noted the goals of group counseling as "increasing awareness and self-knowledge; developing a sense of one's unique identity; increasing self-direction, interdependence, and responsibility toward oneself and others; learning how to express one's emotions in a healthy, constructive way and becoming aware of one's choices" (pp. 5–6). These goals are based on traditional Western group counseling emphasizing verbalization, confrontation of internal and interpersonal conflict, individuation, and autonomy, all of which may cause anxiety and confusion for Asian clients (Sue & Sue, 2008). More appropriate goals for Asian group members may be increasing awareness and self-knowledge within the context of family and community, developing one's unique identity within the framework of family and community, increasing self-direction as it impacts others, healthy interdependence, responsibility toward others and the relationship to oneself within this social context, and understanding and how the expression of personal needs, emotions, and choices impacts one's family and community.

Group Leadership Skills

One foundation of group counseling is to establish trust and openness in order to create safety for individual members to explore feelings and thoughts (Corey, 2008). Asian culture emphasizes humility and modesty so that openly expressing feelings and drawing attention to oneself contradicts cultural values and creates anxiety. Moreover, many Asian Americans are uncomfortable with direct types of communication, challenge, confrontation, interruption, and assertiveness (Sue & Sue, 2008). Thus, group skills and interventions need to be reformulated when working with Asian clients. Many Asian group members remain quiet and withdrawn, even when language proficiency is not an issue. They may be too polite to participate, avoid self-disclosure with polite nods or smiles, or attempt to focus on the trivial as a way of participating without violating cultural norms. Group members and leaders may become frustrated by the failure of initial attempts to engage Asian members or Asian members may be perceived as sitting pleasantly through session after session, hiding frustration and perhaps anger about feeling alienated from the group. It is essential that group counselors gently question group members about how their cultural values may impact their participation in group and establish norms that accept greater self-disclosure.

For example, if an Asian group member establishes a pattern of sitting quietly, the counselor may kindly ask the group member if they would mind sharing how the experience of being in the group is for them. Although norms in the Asian culture are to remain quiet, there may be situations where alternatively the Asian member may become extraordinarily verbose, talking superficially with little reference to the therapeutic work of the group. Such members may be viewed as monopolizing, unsophisticated, and obstructionistic in attempts to avoid delving into deeper issues. Instead of patiently listening, the group leader may attempt to set limits with such clients by pointing out their behavior, redirecting or restructuring their comments, or gently interpreting the meaning of their behavior or comments with statements such as, “Talking about this sounds very difficult for you.” A group leader's intervention should focus on this type of culturally sensitive intervention aimed at appropriately addressing this behavior within the context of the group by raising the issue of avoidance. Furthermore, group counselors must be aware of Asian clients who appear to be overly pessimistic, which may be a cultural phenomena rather than negativity or pathology (Chang, 2002). In such instances, it is helpful to facilitate group discussion regarding the cultural underpinnings for pessimism and the need for balancing negative outlooks with positivity, asking questions such as, “I wonder why it is that there seems to be such a negative perspective and what part our own cultural backgrounds contribute to this perspective?”

The Model Minority: Myth and Racism

Asian Americans, similar to other ethnic and racial groups in the United States, encounter racism and difficulties despite the *Model Minority* media image that portrays Asians as an ethnic group who works hard, is high achieving, and is successful with few psychological problems (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008). The *Model Minority* stereotypes place extreme pressure on Asians in that it is an overgeneralization that all Asian Americans are successful in all aspects of their lives, discounting those who may be struggling (Suzuki, 2002). For example, if an Asian student is struggling with school work she may quietly withdraw while being perceived by the teacher, school psychologist, or school counselor as a student fitting the model minority stereotype. More insidious is that the stereotype has been used to pit the success of Asians against their African and Latina/o American counterparts who are perceived as not as successful. Group workers need to be aware that Asians are constantly seen as perpetual foreigners who are constantly asked where they are *really* from, even though they may be fourth generation Asian Americans (Chung et al., 2008). Contributing to the prejudice is the aftermath of 9/11 and the ethnic profiling of South Asian communities as potential terrorists, due to media coverage and generalizations that *all* terrorists look similar to South Asians (Mio et al., 2007). The racism Asians encounter creates mistrust of mainstream society and impacts their views of help-seeking behavior and their experiences in group counseling. To address this in group, the facilitator could directly ask, "How do you experience the mistrust that we are discussing? How do you manage that mistrust? How would you deal with this in group?"

The Mysterious Member Syndrome

Given these group dynamics, group leaders must understand the mysterious member syndrome. This happens in groups when Asian members may increasingly feel alienated and out of place by being misperceived and stigmatized with stereotypes such as the “obedient Asian woman,” the “Kung Fu expert,” or the “brilliant mathematician,” leading to withdrawal and silence. Being unable to understand or interpret the quiet Asian group member may foster generalized frustration with non-Asian members that could turn into displaced anger. Given the Asian's courteous, nonconfrontive demeanor compounded by the “mysterious member syndrome,” Asian members may become scapegoats. If the group leader is unaware and ignores these dynamics, it may result in negative group experiences for Asian clients and a continuation of perceptions of Asian members as helpless, unemotional, dysfunctional, mysterious, and unreachable. Once again, a culturally sensitive assessment for the context of the behavior and a culturally appropriate intervention illuminating cultural differences, styles, and tolerance within the group setting are recommended.

Unconscious Racism in Group Dynamics

Although issues of power in relationships will manifest in all groups, it may become more prominent in multiethnic groups given the status of each ethnic group within the larger society with themes of in-group versus out-group, majority versus minority, using the *Model Minority* concept as a marker of success for other ethnic groups, and the struggle for inclusion. Members' attitudes and behavior toward each other reflect race relations in the United States and may consist of stereotyping, scapegoating, displacement, intellectualizing, intolerance of differences, and ultimately polarization of the group along cultural and racial lines (Mio et al., 2007). Division of group members along ethnic/racial lines may result in unconscious racism. Examples could be the use of overt or covert racial jokes, stereotypes, mimicking the Asian members' accent, speaking and overprotecting Asian members, bullying Asian members through inaccurate interpretations, attributing nonexistent thoughts and feelings to Asian members, and/or alienating Asian members from the rest of group. It is crucial that group leaders honestly identify these issues directly within the group to help raise self-awareness, asking group members specifically about these issues with questions such as, "What was your experience when that joke was just made about the Chinese accent?"

Suggestions for Effective Implementation of Group Work with Asian Americans

When are Homogenous Groups Most Effective?

Studies have found Asian Americans who have lower levels of acculturation and racial identity prefer to be in all Asian groups and benefit more from homogeneous groups and the comfort of other similar-looking group members (Chen & Han, 2008; Liu, Tsong, & Hayashino, 2008; Singh & Hays, 2008). Even though it is erroneous to assume that for Asians a homogeneous group will eliminate conflict and cultural biases, an all-Asian group for Asians with lower levels of acculturation may provide a good starting point in the healing process. As mentioned above, problems can arise in placing different Asian groups together given the longstanding sociopolitical history of these groups. Due to the heterogeneity within Asian cultures, it is important for group counselors to initially acknowledge inter- and intragroup differences that may have bearing on group dynamics. In the early stages of Asian groups the group counselor may include a psychoeducational component focusing on historical and sociopolitical differences, which can then evolve into the facilitation of a discussion and exploration of intergroup relations that explore topics such as inter- and intragroup differences, historical and sociopolitical issues of Asians represented in the group, information regarding migration, generation and acculturation levels, racial identity, and reports of racism and discrimination against Asian populations.

Group workers should be aware that Asian homogeneous groups with mixed genders could also be problematic. Some traditional Asian cultures are male dominant where men do most of the talking and women only speak when given permission by the men. Given that women may defer to men, it may be more effective for group counselors in group counseling to divide men and women into two separate groups to promote female participation in both psychotherapy and psychoeducational groups (Leong, Chang, & Lee, 2007). Respect for age is also a factor influencing homogeneous Asian group interactions. Similar to gender, older members tend to have greater authority than younger members and often talk more and dominate the activities. Although studies have found that homogeneous counseling groups are effective with Asians, group counselors should not discount placing Asian members in heterogeneous racial/ethnic mixed groups. However, in doing so the group workers must be culturally responsive and address any racial-ethnic and gender dynamics that may occur as discussed above by directly introducing these issues with questions such as, “You seem to speak to the female members of the group differently than the other males. Are you aware of this?” or “What is it like in our group to be such a diverse group with three Asians, three African Americans, two Latina/os, and two White members? How, if at all, does this affect each of you and our group?”

Consideration of the Structure and Format of the Group

It is important for group leaders at the beginning of the first group session to acknowledge the different ethnic and cultural backgrounds of themselves and group members (Day-Vines et al., 2007). For example, group members may introduce themselves identifying three characteristics that they value about their ethnicity and culture and share those with other group members. By acknowledging ethnic and cultural differences, group leaders and members validate the unique life experience arising from the interplay between the ethnic client's cultural heritage and the challenges as a person of color living in White majority society. This step must be taken to prevent the group from treating ethnic and cultural differences as irrelevant and therefore avoid talking about sensitive race issues. However, group counselors must take care not to rely on Asian clients or other clients of color to answer all questions regarding their culture or make them the spokespeople for their entire ethnic group. By treating Asian American clients as cultural representatives by asking them to speak for their entire race devalues their own unique life experiences. To encourage group cohesiveness and exploration of ethnic differences, group leaders may focus on the universality of personal problems and emotional reactions to these problems, such as reactions to loss, separation, and family conflict. Working with Asian group members to explore and reflect on the role of their cultural values and the influence on their behavior through this type of probing and discussion is important in the therapeutic process. For example, a group counselor may ask the Asian group member, “I sense you are quiet right now. What is happening for you being so quiet?”

Considerations for Culturally Responsive Interventions within the Group

Group leaders must maintain a clear balance when working with Asian clients between not being overprotective or overly confrontational. If one is too protective of an Asian client, there can be a reactivation of group members' stereotypes of Asian clients as being quiet, helpless, fragile, and inarticulate. This behavior may encourage other group members to stereotype the Asian group member and ignore, devalue, or treat them in a similar overprotective manner. Excessive confrontation can result when the group leader is unable to draw the client into the group or foster any meaningful participation, resulting in the group member becoming anxious and frustrated. At times, group leaders who may think they are culturally responsive to Asian clients may be patronizing. For example, a group counselor who continually tells the group that it is acceptable for the Asian member to remain silent because she comes from a reserved culture may be overly protective and patronizing.

Although seeking collective help is an aspect of Asian culture, specific group counseling techniques, as discussed previously, are foreign to Asian clients. It is important for group leaders to discuss the goals and the process of group counseling, clarifying expectations for participation and membership, and openly identifying aspects of group process that may be in conflict with cultural values. This helps eliminate potential problems and dynamics arising from misunderstandings and establishes a set of group norms that is by and large constant with the varying cultural and ethnic backgrounds and personal expectations of the group. The role of the group leader is to educate group members about the purpose of the group, expected behavior, and the nature of members' relationships to the group leader and other group members. This type of education and norm setting is best addressed in the first group session and may be periodically revisited and explored as the therapeutic process evolves.

Racial/Ethnic Identity of Group Leaders

It is important for group leaders to be aware of their own and their group members' racial/ethnic identity and how racial/ethnic identity affects the group dynamics and process. Group leaders must undergo an in-depth analysis of their own racial/ethnic identity, honestly examining personal prejudices, stereotypes, biases, and privilege. This calls for an assessment of their own socialization and conditioning with regard to other racial or ethnic groups, including prejudice, biases, and stereotypes they hold of that group (see Helms, 1995). It is important the group counselor, whether Asian or from another racial or ethnic group, is aware of, understands, acknowledges, and accepts issues of racism, discrimination, and oppression, and the concept of White privilege. For example, a Chinese group leader may have stereotypes about other Asian cultural groups that may interfere with their interaction with the group members. If Asian group leaders are from the same cultural group as their group members they need to be aware of their own biases toward the different acculturation and racial identity of their Asian group members. To be effective group leaders, regardless of their race or ethnicity, one must be able to identify stages of racial identity and the relationship to themselves and group members (Helms, 1995). This requires that group leaders be able to identify and be aware of countertransference issues (Bemak & Epp, 2002). For example, female group leaders may face problems with Asian men who come from a male dominated culture, requiring that they deal with their own feelings and views of sexism. In turn, Asian men may be conflicted and uncomfortable with having a woman in a leadership position. If these issues are not understood and addressed, group interaction may be inhibited. Furthermore, group leaders must also be aware of their own political countertransference (Chung et al., 2008). For example, given the media coverage of terrorism and terrorist profiling after the events of 9/11, group leaders may feel uncomfortable with South Asian group members and may subconsciously or consciously associate these members as potential terrorists.

Considerations for the Role of Group Leader

Since Asian clients may perceive the group leader as an authority figure, an expert, an adviser, a teacher, an information giver, and a problem solver, to be effective with Asian group members may require role modification of the group leader. This perception is not necessarily negative. Instead, it represents the group leader as an expert with credibility, solid professional qualification, and/or leadership qualities such as maturity, sophistication, calmness, insight, knowledge, wisdom, and the skill to provide clients with direction and guidance. These values cannot be ignored in group dynamics. It may be difficult for Asian clients to relate to the group leader as a facilitator of the group process rather than as an authority figure who will behave in a parental fashion. Given the qualities attributed to the group leader, their openness may enable clients to accept their own imperfections and may relate to the fact that Asian clients were frequently more comfortable disclosing personal information in groups as opposed to individual counseling (Hall & Eap, 2007).

Being seen as an expert helps the group leader employ and integrate psychoeducational strategies within groups, which may be highly beneficial to Asian group members. In psychoeducational groups, the group leader's role as teacher and information giver is clearly defined and in line with Asian cultural norms. In group counseling, the roles of both group leader and member may be more ambiguous without clear definition, causing Asian members having to define their role to a greater degree. This may require greater structure with more directness rather than a passive leadership role. Open-ended questions can be used; however, the group leader may find that in many situations Asian clients expect straightforward statements from the group leader. Asian clients may feel anxiety due to the vagueness of many open-ended questions.

Asian clients may feel inhibited expressing feelings and emotions even during later stages in the group process. Helping Asian clients' gain a sense of acceptance and security within a nonthreatening and safe group environment is critical since the group would be considered a public setting. It is thus essential to let Asian clients know that it is acceptable to explore personal feelings, both positive and negative. A norm for this level of openness must be clearly established during the first session. Consistent with self-disclosure is establishing confidentiality, which must also be presented and discussed in the first session. Confidentiality is important in reducing Asian members' fear that their personal stories might someday be exposed outside the group and essential for every member to understand their personal obligation to protect all other group members' right of privacy as a way to achieve a safe environment. The formation of mutually supportive and respectful atmosphere is a critical task of the group leader in working with Asian group members.

Even if a safe environment is created, Asian members may still be constrained about openly sharing within the group. To assist Asian members to feel more comfortable, group leaders may disclose personal information to model and facilitate openness. This should be done intentionally throughout the group meetings to reinforce the norm of openness and assist clients to learn how to be respectful about others' feelings as well as express their own feelings. A byproduct of personal sharing by the group leader is fostering the Asian client's confidence and trust in the group leader. However, a word of caution is necessary: If group counselors self-disclose, they must do so with authenticity. By self-disclosing, they are fostering both achieved and ascribed credibility and thus avoiding premature termination and dropout (Sue & Zane, 1987). *Ascribed credibility* is credibility counselors have due to their status as a counselor, whereas *achieved credibility* is determined by the counselor's cultural responsiveness. A group counselor may have ascribed credibility; however, Asian clients may drop out of group if group counselors do not demonstrate achieved credibility.

When working with Asian clients there must be a fine balance regarding self-disclosure. If the Asian group member feels pressure that he or she has to tell some family or personal stories, anxiety can accumulate and the sense of withdrawal may intensify or even prevail. It is essential to set a tone that helps each Asian member understand that although they are encouraged to share personal feelings and thoughts, it is not a requirement. This cultivates a safe and trustful environment so that Asian members' psychological needs and interests to share and communicate arise naturally. However, group leaders must also be mindful of the resistant Asian client who may use culture as an excuse not to disclose or to participate. Group leaders must therefore have an in-depth

knowledge of Asian culture and skills to determine whether the lack of participation is cultural or individual.

Conclusion

In summary, group leaders must acknowledge that many goals and techniques used with groups are based on Western values and may be inappropriate or have no value to Asian group members. Furthermore, it is erroneous for group leaders to assume that Asians will not benefit from group counseling and psychotherapy due to their difficulties with self-disclosure. Asian members will personally share given the "right" environment. To be effective with Asian clients, group leaders must not only have the multicultural competencies to work with this population but also understand the impact of culture on their clients. They must have skills and be creative in using, modifying, and altering traditional group skills and techniques to be effective with this population. To truly understand the complexities of the Asian American population, group leaders must assess Asian community resources as a context for group work. Since group is viewed as a public setting for Asian clients and therefore has the potential for Asian members to be inhibited in expressing themselves, it is critical that group leaders not only create a safe environment but also model self-disclosure. Group leaders who truly understand Asian culture and have the multicultural competencies required to work with ethnic groups will be able to create a safe environment for every member's personal growth and facilitate effective groups.

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Chapter 19 Psychoeducational and Counseling Groups with Latinos/as

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Latinos/as are now the largest ethnic minority in the United States (U.S. Census Bureau, 2010). Data from the U.S. Census Bureau indicated that between 2000 and 2010 there were 50.5 million Latino/as in the United States —16% of the total U.S. population. Furthermore, Latinos/as in the military have increased drastically from 11.2% in 2006 to 48% in 2010 (Department of Defense, 2010). The demographic projections suggest in 2025 Latinos/as will be the largest ethnic minority group in the United States. Changes in the demographic composition have intensified the demand and need for counseling services for Latinos/as that are culturally and linguistically competent.

The mental health field has begun to focus on Latinos/as and counseling and psychotherapy, with a substantial number of publications (more than 500) focusing on this topic. Only four articles focus on group therapy with Latinos/as with empirical data supporting group efficacy still limited. However, understanding of a Latino/a worldview as it impacts counseling, particularly as it relates to groups, can no longer be ignored (Torres-Rivera, 2004). Recent studies in this area have focused on behavioral techniques and psychopathology (Stacciarini, O'Keeffe, & Mathews, 2007) without consideration of the needs and basic cultural beliefs and worldviews of ethnic populations. The application of Euro-American models of counseling and group work perpetuate the intrapsychic model of treatment, which focuses on the client's individual developmental and organizational deficits without considering other variables that might impact overall client's functioning (Organista, 2007).

Furthermore, when examining social, racial, and political factors, Latinos/as are a diverse group. Therefore, it is vital that mental health professionals understand the experiences, cognitions, and behaviors of Latinos/as from a multicultural perspective as an alternative to the one-size-fits-all approach to group counseling and therapy (Organista, 2007; Torres-Rivera, 2004). This chapter provides suggestions for group leaders working with Latinos/as with a particular emphasis in worldviews/cultural issues, commonalities, and also intragroup differences for Latinoa populations. Additionally, suggestions for group leader preparation, effective group leadership behavior, and interventions are provided in particular using the principles of liberatory psychology.

In this chapter, the authors will use the term *Latino/a* rather than the term *Hispanic*, as Latino/a is an inclusive term used by individuals of Latin/Hispanic descent to empower themselves in political arenas, humanities, and literature (Bermúdez, Kirkpatrick, Hecker, & Torres-Robles, 2010; Organista, 2007; Suarez, Marcelo, & Mariela, 2008).

Based on the latest statistics (U.S. Census Bureau, 2010), this chapter focuses on the three largest Latinoa groups: (a) people of Mexican descent or Mexicans (63%), (b) Puerto Ricans (9%), and (c) Cubans (3%). The strongest commonalities that exist among Latinos/as in the United States are (a) the use of the Spanish language and (b) Catholicism (68% are Catholic with 25% being Protestant, mainly Pentecostals) (Pew Forum on Religion & Public Life, 2007).

Issues to Consider When Facilitating Group Work with Latino/A Populations: Attitudes, Values, and Beliefs

Cultural dynamics, issues, and topics of discussion that may influence willingness to be in a group and participation among Latino/a group members include time, money, relationships, friendship, intimacy, love, sexuality, parenting, commitment and responsibility, center of focus, communication and negotiation, thought, logic, decision making, power, rules, product and process, and morality (Garcia-Preto, 2008; Montero, 2009; Organista, 2007; Torres-Rivera, 2004). The following section provides some descriptions and examples of how Latinoas define and understand these concepts from a broad cultural perspective with suggestions for group leaders.

Time. For the majority of Latinos/as, time is not absolute or concrete. For many, it means being present when they are needed. On the other hand, the majority culture in the United States believes that the numbers on the clock are existent, emphasizing the importance of being "on time" (Schaef, 1992; Torres-Rivera, Phan, Maddux, Wilbur, & Arredondo, 2006). Also in contrast with the Latino/a perspective of time is the American middle-class value of "future" as the most important aspect of time rather than the present or past, while Latinos/as stress the past as the primary worldview of time (Torres-Rivera, 2004).

Group leaders who do not have an understanding of how Latinos/as view time may label them as irresponsible or unmotivated if they are late or absent from group sessions. Furthermore, if a group leader ends the group session without allowing the Latinoa group member to feel "complete" or "done," it could lead to early termination and/or emotional withdrawal from the group because it invalidates clients' experiences. For example, the senior writer of this chapter is conducting a group focusing on men's issues with Mexican immigrant farm workers that starts at 7:00 p.m.; however, it is not uncommon that the group members show up about an hour later, and the most productive sessions have been when everyone showed up late.

The issue of time could be a sensitive issue for group leaders working in settings where time constraints are present. At the same time, the group leader needs to be aware of the group members' worldviews and their concept of time. A good way to address this issue is for the group leader to acknowledge the importance of being on time without been judgmental and allowing room for expecting what is not expected. School settings may be different because the group leader will get all students at the same time. In such settings, the issue most likely would be how to quickly get the group started since socialization is very common among Latinos/as. Therefore, group leaders should be proactive in terms of getting the group focused on the task ahead of them. Having clear goals and agendas is helpful, but groups are more successful where there is room for accommodating members' needs and not having a prescribed agenda.

Intimacy and Love

Latinos/as (men in particular) approach emotional intimacy via sexual and physical avenues. The area of intimacy may be more gender-specific than cultural. For instance, many Latino males establish a relationship with a woman assuming that the relationship will lead to sexual intercourse (Torres-Rivera, 2004), which may be similar to many dominant-culture male beliefs (Schaef, 1992). Latino males also have the tendency to assume that they will have complete control of the relationship (somewhat similar with the dominant-culture male beliefs) but for Latino males, this is not a matter of choice. Folklore dictates some behaviors for men and women that are related to their gender, such as *machismo* and *marianismo* (Garcia-Preto, 2008; Torres-Rivera, Wilbur, Roberts-Wilbur, & Phan, 1999). Group leaders should be aware of how these dynamics might play out in the context of the group and avoid being judgmental, particularly because *machismo* or *marianismo* often is seen as a negative behavioral trait. When issues like this arise in the group, it is an excellent opportunity for leaders to explore the meaning of these behavioral expressions from the members' point of view to avoid members feeling invalidated, judged, or misinterpreted. Lack of awareness on these issues could result in members not returning to the group.

Group leaders should also be aware that intimacy is also approached at an emotional level (and may not be a conscious process for many Latinoa clients); it is during periods of intense pain when these feelings are more present (Bourgois, 2003; Torres-Rivera, 2004), meaning that Latinos/as are not prone to disclose intimate/private matters in public, even if there are more Latino/as in the group. Thus, it is recommended that group leaders create a safe environment for group members free of preset ideas and biases.

Latinos/as consider the expression of intense emotions and feelings private and only can be shared with family. Thus, it is imperative for the group leader to become a *compadre* or *comadre* (coparent) to the Latino/a client, meaning that self-disclosure will only be facilitated if the group leader is able to develop a trusting relationship with the group members. For Latino/a members, the group leader becomes a *comadre* or *compadre* when a certain level of rapport and trust is built. A good first step is for the group leader to be open-minded, flexible, and willing to step out of their comfort zone. In moments of intense emotional disclosure, Latinos/as need to feel respected, validated, and comforted, not judged because of their "intensity" of their emotional reactions.

Group leaders also need to follow a nondirective but firm approach to reach respect and trust and overcome this behavior. For example, when asking questions, the facilitator may want to ask differently using herself or himself as an example and redirecting the question to the client: "I have felt the same way before. How is this experience different for you?" In addition, discussing the client's family is also highly recommended. An example might be asking the group members: "Tell me about your family" or "How did your family members deal with this type of situation?"

Latinos/as often express intense doubt, confusion, and questioning regarding the existence and meaning of love (Torres-Rivera, 2004). Despite the fact that romanticism and the idealization of love are common among Latinoas (Garcia-Preto, 2008) and love, intimacy, and relationships with the opposite sex are important within the Latinoa culture (Torres-Rivera, Phan, Wilbur, & Maddux, 2001), when Latinos/as find themselves in an unfamiliar culture, they often develop doubts and a distorted sense of what it means to love and to be loved or to be romantic. They find themselves trying to justify their worldviews, which are somewhat different than the perceptions of the majority culture. For example, Latinoas might express feelings of being misunderstood and lonely even in the face of acceptance and recognition. Therefore, group leaders need to consider that validation and constant reaffirmation is a necessary technique that, while at times overwhelming, it is extremely effective as well. Moreover, these beliefs about love and romanticism may differ with the majority culture, which often believes that love can be "defined" and proven by doing specific things, such as remembering anniversaries and giving presents (Schaef, 1992). Thus, many Latinoas may experience incongruity and confusion about the meaning of love and relationships. Therefore, group leaders may need to realize that such confusion and doubt (i.e., in group might be played out as members being perceived as insensitive or not caring enough) are a result of cultural differences and not a lack of commitment to significant people or to relationships in Latinos/as' lives.

Logic and Data Processing

Latinos/as usually process information from an emotionally oriented perspective, which may include mistrust of people and society (Torres-Rivera et al., 1999). This reaction is usually associated with the experiences of Latinos/as in this country (i.e., oppression, discrimination, marginalization) in that they will approach people carefully and cautiously. Thus the group leader will need to prove herself or himself to the member before she or he can begin to trust the group leader. Therefore, it may not be uncommon for Latinos/as to express a great deal of dissonance with regard to their own beliefs and behaviors, divided between self and social identity issues (Torres-Rivera, 2004). This could manifest itself in members contradicting themselves and sometimes making statements, one after the other, that directly contradict each other. An example of such contradictions is when a group member has just expressed fear of dying and a second later, tells the group that he or she is not afraid of dying. Thus, group leaders might want to assist Latinos/as to be less emotionally involved with their attitudes and values during the early stage of the group by developing a cognitive discussion of the topic and their exploration of different perceptions, influences, beliefs, and conflicts. For example, by using a theme that is concrete such as work or how they spend their free time followed by other less emotional issues until trust and safety can be reached before getting into more emotional issues.

The dominant culture values logical and linear thinking to provide people security and predictability (Torres-Rivera, Wilbur, & Roberts-Wilbur, 1998). For Latinos/as, on the other hand, security often stems from and depends on their ability to stay alive (survival). Group leaders who are unaware of this particular characteristic may impose logical, linear, and security-based thinking onto Latinos/as and deny their realities of survival in a hostile and chaotic world. Consequently, group leaders must be careful not to impose a linear worldview onto Latinos/as by assuming everything follows a similar or a one-size-fits-all pattern (i.e., assuming we all go through difficult times and we all have the opportunity to thrive and succeed). In some cases, the group member does not have the resources to be able to do so.

Responsibility

Latinos/as customarily approach responsibility by trusting those around them, by doing what they need to do, and by making decisions based on collateral influence. Most often, decision making will be delegated to the person or persons that Latinos/as believe possess more experience and intelligence to deal with the matter at hand. On the other hand, the majority culture generally blames others for failures or ineffective decision making by means of established “accountability” procedures (Schaef, 1992). Taking this into consideration in the group setting, group leaders working with Latinos/as need to understand that trust and collateral influence are part of Latino/a culture and neglecting these fundamental aspects of responsibility and decision making may create unnecessary distance between the group leaders and members. A good example of how to do this is by the group leader assigning small tasks to those members that appear to have the natural ability to lead, such as arranging the group room before the group session and/or to develop small quasisocial events like bringing snacks or water for the sessions. Since group leaders are perceived as the “experts,” most group members will rely on them when making important decisions about the group. However, as previously mentioned, group leaders should be aware of “innate leaders” within the group and allow opportunities for collaborative decision making.

Morality

Morality is defined as the quality of being that should be in agreement with standards of what is good or right behavior. For the majority culture, morality is more often viewed as a public issue that is frequently mandated and controlled through legislation. For the majority of Latinos/as, morality is viewed as a private matter (Torres-Rivera et al., 1999) that is only discussed within the family circle. Therefore, it is necessary to discuss how Latinos/as view morality because issues discussed in counseling and psychotherapy are viewed as moral issues. For example, talking about familial problems or relationships are issues that are moral in nature, thus, only discussed with family members in the intimacy of the home.

Rules

Latinos/as perceive rules as a tool of control, to limit others' and one's own behavior (Angelique, 2008; Hooks, 2003). The majority culture tends to view rules, order, and power as necessary to control the negative and destructive influences in society to protect and preserve the American middle-class "way of life" (Schaef, 1992); without rules and order, there is chaos. Among many Latinos/as, however, chaos is not necessarily negative but sometimes a new beginning or an opportunity. This opportunity manifests more so in the group setting with Latinos/as as creative risk; that is, group leaders can use the rule of respect as the guiding rule rather than striving for control.

For Latinos/as, responsibility and rules are probably critical when working in a group setting. Because group leaders, in particular those who belong to the dominant culture, are often seen as authority figures (rather than *compadres*) representing the rules of the system, Latinos/as will most likely view the process as oppressive and freedom limiting. Therefore, group work with this population requires the establishment of relationships from a more humanistic, less authoritarian position to prevent such self-defeating perceptions. Because Latinos/as operate within a collectivistic framework, rules should be developed in consensus and taking into consideration the goals that group members feel more comfortable addressing. The group leader's responsibility is to facilitate the process and identify each member's unique contributions to the group, not to control the process or impose his or her own values and beliefs to the group members. Creativity among group members is fostered when group leaders are supportive and the flexible-group process is fluid; therefore, change rather than keeping the status quo should be the goal.

Communication and Negotiation

Latinos/as use their language in a genuine attempt to understand others and to get closer rather than to control or dominate the communication (Zentella, 2009). For example, if a group member or leader is controlling or dominating the dynamics, it would not be atypical for a Latino/a group member to withdraw from the interaction. The Latino/a group member may even use an abstraction or metaphor to tell a story that may or may not be directly related to the focus of the current discussion in order to highlight that they are in need of some attention from the group. Therefore, the group leader should restructure the dynamics and redirect the group energy to that particular group member and using the concept of *peleita monga* block the member dominating the group without actually confronting the dominating member. Group leaders should be aware that in a collectivistic culture everyone works for the benefit of the entire group. When one person is dominating the discussion, that does not allow for conversation, collaboration, and exchange of ideas. Thus, if group members perceive their voices don't matter they lose interest in the group.

This could lead to further misunderstanding as the leader may define the Latino/a members' desire and attempt to understand as negative, when in reality what Latino/a members expect from communication is greater understanding and connection instead of control, negotiation, or prediction (Organista, 2007). Group leaders should feel comfortable not only addressing these issues when they arise but also be willing to listen and make necessary adjustments. This would mean for the group leader to open dialogue, listen to concerns, and negotiate with group members what is the best course of action in order to keep the group moving forward.

Leadership

Being in control and having answers to all problems is characteristic of how the majority culture defines leadership; how expertise and competence are measured is based on status, credentials, and economic possessions (Schaef, 1992; Torres-Rivera et al., 1998). For Latinos/as, leadership involves egalitarian relationships with importance placed in responding to people equally and with respect (Torres-Rivera, 2004). A group leader who does not acknowledge this difference may be imposing his or her values onto Latino/a group members and by doing so may be perpetuating existing variance in perceptions of leadership (Kanel, 2008). Group leaders should have a heightened sense of awareness when working with Latinos/as. This includes addressing cultural and linguistic differences at the beginning of the group and finding a common ground were both leaders and members

feel comfortable, validated, and respected. Taking an egalitarian approach is important since Latinos/as operate within a collectivistic framework. Thus, leadership is exerted when the group leader is comfortable sharing some of the decision making and members feel included and regarded as important.

Being Bilingual and/or Bicultural

Bilingualism is as important as and at times even more essential than being bicultural (Organista, 2007). It is critical that mental health professionals who work with Latinos/as in groups have knowledge of the language in order to facilitate connections with Latinos/as whose primary language at home was and/or is Spanish. In other words, if the Latino/a clients are recent immigrants, second- or third-generation immigrants living in Latino barrios, their earlier experiences as well as their most traumatic moments have been associated with the Spanish language (Ainslie, 2009; Falicov, 2009; Zentella, 2009). Therefore, the ability to assess those emotions and/or feelings decreases dramatically when the intervention is conducted in a language other than Spanish. Group leaders should be aware of group composition, including linguistic abilities and acculturation status of all group members; this should be made during the screening phase. Because being culturally and linguistically competent is a prerequisite for success, not only is it important to be able to communicate in Spanish but also to understand the cultural nuances and significance of language in the context of the group. If the group composition is all monolingual Spanish speakers, the group leader should be a Spanish speaker. If the group is able to communicate in English, the group leader can be an English speaker but must be aware and respectful of the role of native language and expressions as important elements of sharing experiences/emotions in groups.

Thus, the use of language is improved dramatically when used within the cultural bounds of the specific Latinoa culture (Mexicans, Puerto Ricans, Cubans, etc.), such as *dichos* or *refranes* (proverbs) during the counseling intervention. For example, a group leader will be seen as a friend by greeting the group with "*y la familia como está*?" meaning "How is the family doing?" Other examples of openings or "backdoor" interventions, such as "*No se puede tapar el cielo con la mano*," meaning that a person cannot cover the sky with their hand, can be used when a group member is in denial and does not want to see the reality of his or her problem(s); "*lo que no mata engorda*," meaning that what does not kill you makes you stronger, can be used when a group member needs motivation to move forward despite the obstacle in front of him or her. The important part of this is not to be *pedante* and be humble as what these clients are looking for is understanding and acceptance and not clichés and/or catch phrases. This particular humility on the part of the group leader will allow her or him to become a *compadre* or *comadre.*

Community Involvement and Familial Ties

For most Latinos/as, the primary source of self-definition and self-esteem, as well as the structure and support for the individual, is the family (Falicov, 2009); thus, group leaders need to establish trust and gain the Latino/a clients' loyalty, as if they were a *compadre/comadre* (coparent). Group leaders who do not recognize this important variable during group sessions with Latino/a clients are perceived as violating the client's right for human dignity and privacy. In addition, families should be included when dealing with Latino/a clients, implying that group leaders are working with a significant number of people (Falicov, 2009). This is known as *familismo* and is accomplished through a series of steps that lead to accepting the group leaders in a sense, as a member of the "Latino family."

To become a member of the family, group leaders should invest time in participating in community activities such as *quinceañeras* (when a young girl celebrates entering into her womanhood), weddings, and other religious/community celebrations. *Respeto* is perhaps one of the most important elements of Latino culture. Counselors working with Latino/a clients need to be knowledgeable about cultural matters without being seen as a *pedante*, which means pretentiously displaying how much book knowledge they have. This is a difficult balance to achieve but a necessary ingredient if *respeto* is to be fully accomplished (Torres-Rivera, 2004). The key issue here is to validate the role of family in conceptualizing and addressing issues (obviously the more acculturated the person is, the less emphasis is on family but still very prominent in our culture).

Pregroup Planning

Group Size

Some Latinos/as have the tendency to speak all at the same time. Therefore, by limiting the number of interactions, group leaders will be able to maximize their intervention effectiveness. It is our experience that 10 group members with a cofacilitator is an optimal number of Latinos/as in one group.

However, it is also important to note that due to the structured nature of psychoeducational groups, the number of members could be higher (11–12); because of the level of intimacy and emotional disclosure involved in counseling groups, keeping the number of members to a maximum of 10 is very important to ensure the effectiveness of the interventions.

Resistance

With Latinos/as, group resistance is a sign of progress and not necessarily a sign of "lack of progress" because resistance may be manifested in the form of honest expression of feelings and hostility toward the group leader(s) at a later stage of the group development. In fact, resistance is an important ingredient of change. This resistance is no different than when working with other populations; however, given that Latinas/os are more apt to be more expressive, this might be seen as aggressive.

Resistance may be encountered prior to or at the beginning of group if group members think that the group is "therapeutic," because many Latinos/as believe that "therapy" is only for "crazy" people. Therefore, sometimes to minimize that resistance, the use of words such as "counseling" or "group" might assist group leaders in dealing with that type of resistance. However, this type of resistance is more common in counseling groups than in psychoeducational groups. Last, while food is often used in group settings to increase familiarity among group members, it might not be a good idea while working with Latinos/as, as using food will take away some of the formality of the counseling process.

Leader Culture-Specific Knowledge and Self-Knowledge

A group leader's *mental set* refers to attitudes, values, beliefs, perceptions, opinions, and ideas that a person brings to the group, as well as their biases, prejudices, and expectations about the group, group leaders, and other group members. In the Latino/a mental set, the group leader is expected to (a) know how to modify his or her technique to reflect the cultural differences of the client, (b) know how to deal with difficulties during the group process/dynamics due to cultural differences between the client and the group leader, and (c) understand how culturally different people conceptualize and solve their problems that are bound in cultural patterns. For example, a group leader who has been trained without a culture-specific component that addresses self-awareness may not be able to distinguish between a Latino/a client who is quiet because he or she needs an invitation from the leader from someone who is resistant. Thus, it will be important to invite the client to speak on at least three occasions during the session. Another issue that is usually misunderstood is the communication patterns where clients are seen as too aggressive rather than just passionate or energetic toward the subject. Therefore, it will be of great help to group leaders to be familiar with the work of Santiago-Rivera, Arredondo, and Gallardo-Cooper (2002), Organista (2007), and Villarruel et al. (2009).

Preparation of Members

The effectiveness of the preparation of Latino/a group members to function in group depends on the ability of the group leader(s) to deal with the variables of *personalismo* (by conveying egalitarian approach), *familismo* by using the *compadrazgo* (is the act of being a *compadre*), *marianismo* (by knowing how this particular characteristic plays into religion and *machismo* when working with Latinas), *machismo* (similar to *marianismo*, although this characteristic can be overstated in the United States), *dignidad* (again refers to attitudes, values, and beliefs, particularly to aspects such as responsibility, decision making, gender-specific topics, etc.), and r*espeto* (similar to *dignidad*, this particular variable is tied to responsibility, morality, rules, leadership, and gender-specific roles).

Personalismo. Group leaders should convey an environment of mutual respect and collaboration. Although their job is to move the group forward, group leaders should also encourage group members to express themselves and in doing so, group leaders should avoid judgment or stereotypical beliefs.

Familismo. Family plays a central role in the lives of Latino/a clients. An effective group leader is able to acknowledge the centrality of family when addressing issues in a group and the role family plays in the healing of group members. Also because Latinos/as are collectivistic once the group evolves, the group eventually becomes also *familia.* So group leaders need to be comfortable assuming that role.

Marianismo and Machismo. Marianismo and machismo are tied to gender roles and how Latinoa males and females are expected to behave in matters of spirituality, interpersonal relations, and outlook on life. Because such values contradict those of the mainstream culture, group leaders should be able to understand the cultural context of these gender roles and not jump into judging or assuming psychopathology of members who display these behaviors.

Dignidad and Respeto. These values refer to how Latino/as relate to others and expect to be treated in social situations.

Pregroup Screening and Selection Criteria. In the preselection process group leader should consider that while a number of commonalities have been mentioned earlier, not all Latino/a populations are similar in every aspect. Thus, issues such as acculturation levels, language proficiency, gender differences, age, and the group goal are just a few of the variables that are important to consider in this preselection process.

Interventions

The use of specific techniques, such as effective listening, analyzing, and responding from a multicultural perspective, creates a group environment that minimizes conflict and resistance and facilitates communication, interpersonal and intrapersonal connections that are healthy for collective people like Latina/o populations (Torres-Rivera et al., 1999).

Listening

In a group setting, Latino/a clients need to tell their stories, accounts, and life events in order to be heard and understood. Listening to the specific events of the group members' lives and validating those experiences will result in congruency between their beliefs, behaviors, and experiences. This was addressed earlier as allowing people to tell their stories and keeping a balance between the clients airtime and preventing monopolization.

Understanding and Responding

In order to truly understand a group member's story and then respond, a leader must be able to analyze the situation on the basis of what is presented. For the case of Latina/o clients, this analysis should be done in terms of power and oppression (Angelique, 2008). Thus, a group leader may respond that one of the group member's beliefs seem to be in conflict with those of the dominant culture, which provides them a cognitive framework for a better understanding of how and why they were traumatized by the immigration experience. This realization helps them view their divergent beliefs as normal rather than "crazy" when compared to the normative beliefs of the majority culture.

This intervention not only assists Latinos/as in separating their disparate beliefs from those of the majority but also helps them accept their beliefs as part of their reality rather than attempting to deny, distort, or delete them. This separation and acceptance of their minority beliefs results in less emotionality, stress, and self-defeating behavior and an increased ability to perform normative tasks and behaviors in the dominant culture. For example, in the group with Mexican immigrant farm workers, issues of isolation and loneliness are common complaints. In the group, they questioned their manhood for feeling homesick and lonely. A group leader could help the group members by explaining the collective nature of the Mexican population and the individualistic nature of the U.S. society and how their feelings were a normal reaction to the change. These premises are very similar to most Latinos/as in different settings like college students and/or military and agency settings.

Using Liberation Psychology as a Basis for Groups with Latinos/as

A book entitled *Writings for Liberation Psychology* (Aron & Corne, 1996) popularized the works of the Jesuit priest Ignacio Martín-Baró, which coined the term "Liberation Psychology" to explain his approach to psychology. Martín-Baró refers to liberation psychology as a psychology that has to begin with a new horizon, a new epistemology, and a new praxis. The new horizon must be the historical reality from which it departs and about which it reflects. The new epistemology is hope oriented; its horizon is the future of a people in the process of becoming the subject of its own history. The new praxis is to aid in the process of realizing *peoplehood* through its *defetishization* of reality. These practical bases dictate the following three urgent tasks: (1) the recovering of the historical memory, (2) de-ideologizing everyday experience and social reality, and (3) utilizing the virtues of people.

Concientization is the main goal of liberation psychology, which is the awakening of the critical consciousness of the person/group. Without creating critical concientization, transformation and action are not possible outcomes of the liberation psychology process. According to Martín-Baró (1998), concientization is the knowing or not knowing of self through the world and through other people; it is when knowledge comes first through experience and practice before entering the cognitive domain.

Furthermore, concientization is a developmental process by which the client moves toward critical concientization. This process is different from raising consciousness, as raising consciousness may involve transmission of preselected knowledge, leading to "banking" of prepackaged consciousness rather than helping the client to create their own. Concientization means breaking through prevailing ideologies to reach new levels of awareness—specifically, awareness of oppression. This awareness involves moving from being an instrument of others' will to becoming a self-determining person. Hence, the process of concientization involves identifying contradictions in experience through dialogue and becoming part of the process of changing the world (Montero, 2009).

Montero (2009) provided a series of 10 conditions, or principles, each adapted to group settings. According to Montero, the main goal is to trigger a problematization to initiate critical evaluation and movement toward responsible change (reflection –> action –> reflection followed by action –> reflection –> action). A concept originally coined by Freire (2000), "[p] roblematization sensitizes, denaturalizes, and establishes the concrete and affective bases necessary to motivate changes thus inducing concrete transforming actions" (Montero, 2009, p. 80). Montero's (2009) model proposes the following conditions (an example of a possible beginning of this process is presented at the end of the conditions):

1. *Listening.* To discover and accept the condition of the group members and the dynamics of the group.
2. *Dialogue.* Group members and counselor(s) must be willing to engage in critical dialogue or the clients will be separated from the interventions that eventually will be imposed on them. In other words, constant dialogue with group members will foster the idea of counseling as a democratic process geared toward growth and development.
3. *Using the language of equals.* It is essential that group counselors' dialogue is egalitarian and does not have an academic or superior tone that can be adopted when working with underprivileged clients (see Watkins & Shulman, 2008). In other words, the use of academic language perpetuates the idea of oppression, minimizing the ideal of being equal in the relationship. Once again, the idea is to foster awareness, concientization, an empowerment; the group members need to feel they are experts in their own matters and that they have the power to change their oppressive circumstances.
4. *Communication.* Reinforcing the principles of dialogue and participation, group counselor(s) can inspire the possibility for curiosity, creativity, humor, and emotion in the group by allowing the space for dissenting, discussion, and asking while conversing. In other words, verbal exchange and open communication, in a common language, is critical to this process.
5. *Humility and respect.* Together, counselor(s) and group members develop, create, and nurture mutual respect, honoring differences and not assuming knowledge of the other. In other words, the working stage is reinforced via an egalitarian approach to treatment that validates, respects, and honors what each group

member brings to the process.

6. *Critique.* From the beginning, all in the group need to understand that critique is germane to the process and is not destructive; rather, it is essential in the de-ideologization process, which is core to liberation and action. Critique is not fabricated by external agents; rather, it is the outcome of the questioning and reflective dialogue between the counselor(s) and group members.
7. *Silence.* As consciousness occurs from reflection and the denaturalization of oppression, silence is to be honored among all in the group for this process to evolve. In other words, silence is a necessary component of the group process and should not be seen as a sign of withdrawal or resistance.
8. *Concreteness.* The problematization process is always situation specific to everyday, real-life experiences of the clients and is not based on isolated incidents or the imposition of preexisting Western values.
9. *Reflexivity.* The problematization process is reflexive in nature, as the main function is to create a critical examination of the situation and its underlying assumptions. In other words, awareness and concientization stems from a constant self-reflection of our action and how those might not only impact the individual but the collective as well.
10. *Possibility of consciousness.* "Possibility" implies the creation of more choices, both of thought and action, beyond the limited situation that existed before the problematization process was introduced to the client.

With these conditions in mind, the authors suggest that problematization may begin by asking questions that invoke doubt about the explanations of everyday life experiences. After members have listened to others and shared their story, the group leader(s) may ask a series of questions such as the following:

1. What did I learn from the group today?
2. What did I teach others in group today?
3. How are we oppressed by society and others?
4. How do we oppress each other?
5. How do we allow ourselves to be oppressed?

The first question will help clients enter into dialogue and reflection. The second question will help them understand that they have something to offer and to contribute even in their condition. The third question will enable group members to reidentify their daily struggles without housing collectively. Questions four and five will challenge the assumptions of powerlessness and will create awareness of group members' role in the system in situations specific ways. With the help of other group members, each member may explore the ways in which they internalize biases, thereby limiting themselves and restricting the potential of others. In all, this process will lead the Latinoa client to behavioral change.

Conclusions

The change in demographics of the United States highlights that Latinos/as are increasing in numbers and needs, meaning that it is highly probable that group leaders in any system will encounter Latino/a clients. However, many Latinos/as still struggle to understand how discrimination and immigration have impacted and changed them. Such issues need to be better investigated, understood, and treated from the perspective of the Latino experience, as well as the Latino cultural perspective. Therefore, as group leaders, we must continue to increase awareness of our own attitudes, values, and beliefs, in addition to our awareness of those who suffer oppression in our country (Suárez-Orozco & Páez, 2009).

When working with Latinos/as or any minority group, it is important to understand our personal biases, stereotypes, and assumptions and how those may undermine our effectiveness as group leaders. Many of these assumptions and biases are based on a Universalist focus that does not address differences in experiences and beliefs or the effects of oppression (McGoldrick & Hardy, 2008; Montero & Sonn, 2009). Such biases, stereotypes, and assumptions may unintentionally lead group workers to misdiagnosis and inequality in treatment. There also is a need for more societal awareness about discrimination in general and Latino/a clients in particular.

Due to the collectivistic nature of the Latino/a population, group work appears to be a good fit and a cultural relevant practice. However, there is still a lack of evidence-based group models that could guide effective service when delivering treatment for this population. Case conceptualization, regionalisms, living in the border towns, ethnic identity, language issues, and acculturation issues need to be further studied and addressed.

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Chapter 20 Group Work with Gay, Lesbian, Bisexual, Transgender, Queer, and Questioning Clients

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Since 2004, 13 states and the District of Columbia have legalized marriage for same-sex couples, with 16 states and the District of Columbia enacting varying degrees of protection that include gender identity and expression. While a great step forward for gay, lesbian, bisexual, transgender, queer, and questioning (GLBTQQ) individuals, there are also negative consequences of this increased exposure (Rostosky, Riggle, Horne, & Miller, 2009). Given that the world is rapidly changing with respect to GLBTQQ issues, counseling approaches for GLBTQQ clients, including group work, are needed (Cochran, 2001).

Groups for GLBTQQ are available in metropolitan areas and university counseling centers (Wright & McKinley, 2011), high schools (Goodrich & Luke, 2011), and medical settings providing HIV/AIDS and breast cancer support groups (Feldman, Torino, & Swift, 2011; Fobair et al., 2002). Most recently, gay and lesbian parenting and family planning groups are being offered as well as groups for transgender individuals (Maguen, Shipherd, & Harris, 2005; Svensson, Cura, & Burr, 2011). Group research reflects the increasing complexity of GLBTQQ lives, such as group therapy for those seeking political asylum (Reading & Rubin, 2011), Internet groups with queer youth (Jacobson & Donatone, 2009), and the use of positive aspects of GLBTQQ identity and community to support GLBTQQ individuals (Page, 2009).

Group work is beneficial to GLBTQQ individuals in a number of ways. Given the isolation that many GLBTQQ people experience due to stigma surrounding their minority sexual and/or gender identities, groups can highlight the universality of experience (Yalom & Leszcz, 2005). Because many GLBTQQ individuals experience interpersonal challenges with families of origin and friends during the process of integrating a sexual or gender minority identity, groups also can provide acceptance and hope for members. They also provide an opportunity to observe and imitate other members' skills and strategies for integrating sexual and gender identities and disclosing them to significant others. Finally, groups for GLBTQQ individuals allow for interpersonal learning about GLBTQQ concerns such as self-disclosure practices, GLBTQQ community norms, or community engagement (DeBord & Perez, 2000). This chapter highlights issues for group planning, performing and processing with GLBTQQ groups and members. A complete case example is available in the supplemental materials online.

Best Practice in Planning for Glbtqq Groups and Members

Professional Context, Regulatory Requirements, and Scope of Practice

In addition to the ASGW Professional Standards and Best Practice Guidelines (ASGW, 2000; Thomas & Pender, 2008) and relevant ethical codes (e.g., ACA, 2005; APA, 2002), group facilitators working with GLBTQQ clients should be aware of specific guidelines (ALGBTC, 2009, 2012; APA, 2000, 2008), which identify major practice issues: heterosexist attitudes and behaviors, family and work challenges, diversity within GLBTQQ communities, and limitations in research and training. These guidelines are grounded in the scientific literature and offer important recommendations for ethical and informed approaches to working with GLBTQQ clients.

Self- and Ecological Assessment

Group leaders should examine their own biases and assumptions regarding sexual and gender orientation prior to working with this population. They need to reflect on messages they learned about homosexuality growing up and any stereotypes or myths they may believe (e.g., GLBTQQ individuals can't maintain long-term committed relationships, GLBTQQ people are unfit to parent). GLBTQQ facilitators should reflect on their own possible internalized heterosexism or transphobia when working with GLBTQQ groups, especially when working with unfamiliar groups (e.g., a lesbian therapist conducting a transgender support group).

Group workers should be aware of unique concerns for GLBTQQ individuals so they do not minimize or dismiss salient concerns such as those related to the experience of heterosexism (APA, 2000). At the same time, leaders should be aware that some differences are developmental (e.g., coming out) and avoid exaggerating sexual orientation differences. For example, same-sex and other-sex relationships have been found to be more alike than different (Kurdek, 2004).

Group facilitators should also be aware of their own developmental processes, whether heterosexual or GLBTQQ identified (Goodrich & Luke, 2011). Chojnacki and Gelberg (1995) described a parallel process of coming out for heterosexual group leaders who are allies to GLBTQQ individuals and GLBTQQ individuals themselves. The process encompasses an initial stage of confusion for counselors who are just becoming aware of the oppression that GLBTQQ individuals experience and who privately support GLBTQQ work. A second stage is characterized by fear and anxiety about becoming GLBTQQ allies; allies then often increase their activism and advocacy on the part of the GLBTQQ community. Next, they feel pride concerning their roles as advocates while experiencing increased alienation from colleagues and family. And, finally, allies often feel a sense of professional and personal integration as their values become more congruent with the relationships and activities they engage in as advocates.

When group workers lead their GLBTQQ group, it will be important to seek out a coleader or supervisor with GLBTQQ group experience. If they are grappling with the initial confusion stage, it will be important to explore how their struggle may impact the group and identify steps to reduce this impact such as allowing the coleader to facilitate content that is unfamiliar and to process confusing dynamics after the group session concludes. Group leaders need to seek support from peer facilitators in processing their reactions if they are early in their awareness of GLBTQQ concerns. Heterosexual group leaders comfortably communicating their awareness of the privilege they hold can help build trust. For instance, in facilitating a discussion of the benefits and challenges of same-sex marriage, a heterosexual facilitator may acknowledge her own legal and social privilege in accessing federal benefits related to marriage, while creating safety for members to process their own views of the issue.

Group leaders need to conduct a thorough ecological assessment prior to beginning a GLBTQQ group. Exposure to anti-GLBT legislation and public initiatives creates psychological burdens for GLBTQQ individuals and their families of origin (e.g., Rostosky et al., 2009). Verbal and physical harassment, as well as highly publicized hate crimes, can lead many clients to feelings of insecurity or fear related to the disclosure of their sexual or gender orientation. In fact, PTSD symptoms are not uncommon among GLBTQQ individuals (Reading & Rubin, 2011). In addition, it is important to assess professional training, attitudes, and support of leaders and the agency toward the group, as well as community needs (Thomas & Pender, 2008).

Program Development and Evaluation

It is important for facilitators to identify the type of group from the outset, put in writing the purpose and aims of the group, and to determine meeting schedule, fees, and leadership. Some GLBTQQ groups work best with weekly themes, either leader or member generated. These groups often consist of members exploring coming out, such as adolescents or university students. In our experience, members usually welcome structure as long as the group is flexible to emerging concerns that should take precedence over weekly themes (e.g., the concerns of a young lesbian woman who is kicked out of her home when her sexual identity is revealed to her family should be prioritized over a weekly theme such as dating). Weekly themes also can increase participation by group members by exploring topics relevant to GLBTQQ individuals that may be rare in other contexts, such as hate crimes and safe same-sex behaviors.

Task, psychoeducational, counseling, and psychotherapy groups vary by their respective goals. An example of a task group would be a GLBTQQ advocacy group organizing in support of the passage of a local nondiscrimination policy, while a common psychoeducational group might be a group for young gay and bisexual men who are at risk for contracting HIV. Coming out groups for GLBTQQ individuals who are just beginning to integrate their minority sexual or gender identity is an example of a counseling group. These groups focus on mental health issues that are disabling (e.g., comorbidity of substance use and a mental health disorder).

Although these types of groups differ in their respective goals, these aims may overlap at times. For example, in an HIV prevention psychoeducational group that is providing information on safe-sex procedures, a member may want to discuss the loss of a partner who leaves the relationship due to conflicting feelings about his sexual identity (a discussion more typically found in a counseling group). Likewise, during a counseling group, if a member were to share lack of knowledge concerning safe-sex practices, leaders could share safe-sex information congruent with a psychoeducational approach.

Member composition may also vary in GLBTQQ groups: mixed groups of men, women, queer and transgender individuals; homogeneous gender groups; and mixed orientation groups (Perez, DeBord, & Brock, 1999). The purpose of the group should determine gender and sexual orientation makeup. For adolescents and college students, mixed gender groups are often beneficial as they highlight universal concerns of GLBTQQ experience and help increase support networks at a developmental stage that can be characterized by anxiety and vulnerability. Other groups that serve one particular group within the population (e.g., men of color managing sexual and racial stigma, lesbian and gay parents) typically benefit from limiting group members to individuals whose particular needs are shared with the group. For example, separate transgender groups are often offered for male-to-female transgender individuals in contrast to female-to-male given differences in experiences in living as the other gender, hormone therapy, and social and familial relationships (Maguen et al., 2005).

For mixed groups of heterosexual and GLBTQQ clients, group leaders should explore in advance whether potential GLBTQQ clients are comfortable self-disclosing their sexual orientations or gender identities within the group. Similarly, group leaders should inquire of potential heterosexual members their comfort level with diversity and GLBTQQ identities. Facilitators should be aware of the potential for heterosexism, homophobia, or transphobia and be prepared to process comments and ensure safety. The inclusion of these members requires that facilitators create a safe environment for the GLBTQQ individual(s). Therefore, individuals whose biases would be overly disruptive or irreconcilable should not be placed in these groups. When GLBTQQ members are included in a group with non-GLBTQQ members, helping members build on universal aspects of their experiences is vital for the benefits of mixed sexual identity groups (Krentz & Arthur, 2001). Indeed, acquaintanceships with GLBTQQ individuals can be one of the most effective ways to counter heterosexism (Mohr & Sedlacek, 2000) and reduce negative attitudes. Group work to reduce stigma and isolation with gay men with mixed GLBT groups has been successful (e.g., Nel, Rich, & Joubert, 2007).

Resources and Professional Disclosure Statement

Advertisements should state that the group is affirmative toward GLBTQQ individuals. Despite the practice

guidelines of different helping organizations (e.g., ALGBTC, 2012; APA, 2000, 2008) that explicitly reject therapies that aim to convert same-sex identified individuals to heterosexual identities (conversion and reparative therapies), these therapies are found throughout the United States. Indeed, many GLBTQQ individuals report experiencing maltreatment seeking mental health treatment (Israel, Gorcheva, Burnes, & Walther, 2008; Levitt & Ippolito, 2013). The advertisement should also describe the theme of the group (e.g., transgender support group, safe-sex psychoeducational group). The Online Resources for this chapter includes a flyer and a related case example.

Group and Member Preparation

For GLBTQQ groups, there is nothing more important than establishing and maintaining confidentiality. For GLBTQQ individuals in many locations, disclosure of a minority sexual or gender identity puts them at risk for losing their jobs, upsetting family relations, and other severe consequences. Facilitators should not assume that all members of groups have the same respect and level of concern about confidentiality. Members who have come out or who are not facing as much threat around coming out may not comprehend the fear and concern of others. Relevant questions to be asked in the prescreening interview include: "Have you had any challenges related to your sexual orientation or gender identity that you have experienced recently?" and "What are some things you have learned about yourself related to your sexual orientation or gender identity that you would want to share in a group?" Some group members may believe that "outing" members who are closeted would be beneficial to their psychological adjustment—a practice that could be extremely damaging. In addition, advances in technology have made confidentiality even more challenging to secure. Confidentiality needs to be discussed in light of new technology (e.g., no texting or picture messaging that might show others who are in the group, clarifying policy around Facebook friending group members).

Professional Development and Group Leader Preparation

Leaders of GLBTQQ groups should expect to disclose their own sexual and gender identities during the initial screening interview. By doing so, leaders enhance trust and model openness. GLBTQQ leaders should disclose in a way that also affirms within-group differences (e.g., generational differences in labeling and experiences as well as individual differences). For example, many GLB individuals born before 1970 are comfortable identifying as gay or lesbian, and younger generations are more comfortable with identifying as queer or genderqueer. If leaders are heterosexual, an initial disclosure in combination with a description of the development of their interest in and support of GLBTQQ issues or identity as an ally helps avoid suspicion and build group cohesion (Goodrich & Luke, 2011). In addition, acknowledgment of the limitations imposed by heterosexism for all individuals such as social sanctions about same-sex intimacy and gender oppression can increase universality and cohesion (e.g., social sanctions that prevent men from engaging in close relationships with other men).

Best Practice in Performing with GLBTQQ Groups

Group Leader Competencies and Group Plan Adaptation

There is great diversity within GLBTQQ populations in the ways people understand and describe their sexual and gender identities. Stage models of sexual identity development (for a review, see Bilodeau & Renn, 2005) describe processes of GLBTQQ identity acceptance, synthesis with other identities, and increasing GLBTQQ group affiliation and can help leaders understand and normalize differences among members. While some group members may be quick to label themselves, others may be reluctant to label themselves at all. These models should be used as heuristics and should not blind facilitators to the idiosyncratic processes of identity development. If group leaders assume a coherent GLBTQQ identity is already formed prior to beginning a group, they may exclude those members who are most in need of supportive exploration, such as those who are unsure or ambivalent about their identities. Group leaders also may encounter members who object to categorizing themselves within a sexual or gender identity label (Cadwell, 2009), which may reduce a sense of universality and could create power differentials among members. To allow group members freedom to explore and shape their own identities, leaders may wish to overtly encourage members to take their time in coming to sexual or gender identities congruent with their self-identities and acknowledge that identities can be fluid (not fixed from a young age but somewhat variable over time; Diamond, 2008).

Best Practice regarding Diversity within the GLBTQQ Population

Group facilitators approach their work with attention to within-group differences. With GLBTQQ groups, this includes sensitivity to the intersections of these identities with racial, ethnic, gender, religious, disability, regional, and other cultural characteristics. DeLucia-Waack (1996) decried the myth that groups are ever homogeneous, given the numerous ways group members can differ. In the following section, we discuss issues specific to different types of intersectionality. Leaders of any type of group, however, may wish to make available contact information for organizations that provide resources and support for diverse communities within the GLBTQQ community.

GLBTQQ Youth Issues

Peer support or gay-straight alliance groups are typically psychoeducational and focused on support; they allow GLBTQQ youth visibility and safety in the environment in which they often report feeling most unsafe: school (Heck, Flentje, & Cochran, 2011; Walls, Kane, & Wisnesky, 2010). Typically, one or two GLBTQQ-affirming adults serve as facilitators or faculty sponsors for the groups, comprised of both GLBTQQ youth and their heterosexual allies. The Gay Lesbian Straight Education Network provides information on these groups (www.glsen.org). Training and supervision of school counselors conducting group work with GLBTQQ youth has become more common (e.g., Goodrich & Luke, 2011) as well as open-ended group formats for adolescents (Turner, 2011).

In addition to the same developmental concerns that all adolescents face, GLBTQQ adolescents' lives can be more complicated (Rosario, Schrimshaw, & Hunter, 2011). Much research has documented elevated rates of depression and anxiety in GLBTQQ youth (D'Augelli, 2002), high risk for substance abuse (Marshal, Friedman, Stall, & Thompson, 2009), rejection by family members (Ryan, Huebner, Diaz, & Sanchez, 2009), homelessness and HIV-positive status (Coker, Austin, & Schuster, 2010), and suicide attempts (Haas et al., 2011). For youth in particular, it can be important to respect the process of negotiating labels. Increasingly they are electing for fluidity within self-identity and shunning traditional GLBT labels (Jacobson & Donatone, 2009). Hollander (2000) stressed the importance of supporting "questioning" youth by not superimposing rigid developmental models on their growth and providing them with school support programs that build alliances among youth regardless of sexual identity or orientation. Modeling comfort with GLBTQQ issues and identities is important, because youth may be seeking clues about reactions to them in their future lives as adults. In addition, planning a group for GLBTQQ youth requires research into the state laws about parental consent and providing counseling to youth.

Age

Research suggests that gay men may link self-worth to chronological age more so than lesbians or heterosexual individuals and that such self-estimations lead to *accelerated aging*, the process of defining of oneself as old earlier than one's chronological age (Brown, 2009). Facilitators can counter and discourage statements that suggest ageism. As older GLBTQQ individuals become more visible in public life, this tendency toward accelerated aging may decrease. Senior GLBTQQ individuals may feel hesitant about using resources that are not clearly GLBTQQ-friendly, especially after coming of age in eras that may have been more heterosexist (Hughes, 2009). The influence of political and historical conditions affect identify formation across generations and use of services (Kimmel, Rose, & David, 2006). Many senior GLBTQQ individuals grew up during a time of very limited openness about sexual orientation and may experience discomfort in participating in activities labeled GLBTQQ. It may also be challenging for those senior GLBTQQ individuals to ensure legal safeguards for medical care, long-term partner care, and death and dying issues if they are not accustomed to discussing sexual or gender orientation with health care and legal professionals. Groups can be a place where senior GLBTQQ members can share their concerns and forge new connections with others (Drumm, 2004).

Race and Ethnicity

Therapists who understand how oppression shapes minority clients' identities and who possess multicultural counseling competencies will be better prepared to guide group members to integrate their GLBTQQ identities with their racial and ethnic identities. The decision to disclose sexual or gender identity to racial group members may be more threatening for GLBTQQ people of color, as they may risk rejection, in addition to other forms of discrimination from both ethnic minority and mainstream GLBTQQ communities.

GLBTQQ members who are racial or ethnic minorities may experience microaggressions related to either their ethnic minority identities or sexual or gender identities (Balsam, Molina, Beadnell, Simoni, & Walters, 2011), as well as conflict between their ethnic and sexual identities and feelings of marginalization within one or both communities (Harper, Jernewall, & Zea, 2004). Raising the topic of multiple oppressions gives members permission to share experiences of racism/ethnocentrism as it complicates heterosexism and explicates cultural differences within the group. GLBTQQ group members of color may also share with White/European group members their strategies for managing oppression and, thus, contribute to the group's resources and broaden group members' perspectives on oppression beyond sexual and gender identities.

Spirituality and Religion

While some GLBTQQ individuals report conflict over their faith and sexual identity, research suggests that identifying with an affirmative faith group, however, is related to greater spiritual and psychological well-being (Lease, Horne, & Noffsinger-Frazier, 2005). Many GLBTQQ individuals often reconcile their spirituality and sexual orientations (Horne & Noffsinger-Frazier, 2003; Lease et al., 2005). It has been found that gay men are quicker to come out when they have integrated their spiritual beliefs with their sexual identities (Wagner, Serafini, Rabkin, Remien, & Williams, 1994). In group contexts, group members may wish to share how their faith beliefs change as they adopt an affirmative sexual or gender identity. The group process can help members become aware of a broader set of options available to them within their religious or spiritual communities (Horne & Noffsinger-Frazier, 2003).

Class

There is very little research available on class and sexual and gender orientation (Barón & Cramer, 2000) or on class and group work (for exceptions, see Blackwell, 2002; Storck, 2002). GLBTQQ groups often are provided through university counseling centers, and thus, clients with lower socioeconomic status (SES) and education may not have access to these services or may not feel comfortable attending groups in these settings. Group leaders should be aware that GLBTQQ groups with different SES statuses may have different cultural characteristics. For instance, "butch-femme" identities historically have been associated with lower SES communities (Faderman, 1991), although this trend may be changing (Levitt & Horne, 2002). Rural lower income GLBTQQ individuals may have fewer resources at their disposal, and the costs (e.g., transportation) for accessing services in nearby cities may be prohibitive. Also, transgender people have been found to have fewer resources because of employment discrimination and health care costs associated with transitioning (Rosser, Oakes, Bokting, & Miner, 2007). Sliding-scale or no-fee rates may be necessary to optimize accessibility for these populations.

Disability

For GLBTQQ individuals with disabilities, it may be difficult to access resources and information to support their sexual or gender identities (Harley, Novak, Gassaway, & Savage, 2002). The emphasis in many GLBTQQ communities on sexual self-acceptance and respect for diversity may offer support to sexual minorities with disabilities (Ketz & Horne, 2003). Likewise, group facilitators should promote an atmosphere that encourages members with disabilities to communicate their sexual and social needs (Noonan & Gomez, 2011).

Bisexual and Transgender Identities

Bisexual individuals often face double marginalization within heterosexual society because of their same-sex

attractions and marginalization within GL communities because of the misconceptions that bisexuals should commit to a gay or lesbian identity or that bisexuality itself is not a "genuine" orientation (Firestein, 2007). Thus, groups can be important sources of community for bisexual individuals (Griffin, 2009). To ensure safety in group contexts, bisexual clients will need to be assured of group inclusivity and support of all bisexual relationships, whether they are involved with same-sex or other-sex partners (Firestein, 1999).

Transgender individuals may find it difficult to use GLB resources because they are in need of support for gender identity issues rather than concerns related to sexual orientation (dickey & Loewy, 2010; Maguen et al., 2005). They may identify as heterosexual or they may identify as gay, lesbian, or bisexual but feel unsure whether a group would affirm their gender identity. Facilitators should be aware of the many different identities that are subsumed by the broad rubric *transgender.* For instance, many cities have transitioning female-to-male (FtM) groups, but a masculine-appearing lesbian who identifies as butch or who does not wish to transition may feel misplaced in such a group and might require other alternatives to explore her gender identity (e.g., Levitt & Bigler, 2003). Also, there may be fewer FtM transitioning groups in comparison to male-to-female. Additionally, some transgender individuals believe that undergoing sex-reassignment surgery and hormone treatments to change their bodies is central to achieving congruence between one's sense of gender and one's body (and might wish to do this to different extents), but others may have no interest or may lack the resources to engage in medical intervention. Transgender and bisexual people have been found to share experiences of alienation and invisibility in the LGB community (Cashore & Tuason, 2009) and so group leaders will want to be careful to be inclusive and aware of these issues.

HIV-Positive Groups

Although HIV (human immunodeficiency virus) and AIDS (acquired immune deficiency syndrome) are found among individuals of any sexual orientation and gender, this virus has caused particular devastation within the male gay and bisexual community (Prejean et al., 2011). Different types of group interventions have been developed specifically for this population, including support, psychoeducation, prevention, and behavioral medicine (e.g., Berger, Ferrans, & Lashley, 2001).

The stigma facing individuals with HIV/AIDS remains a formidable obstacle for individuals seeking diagnosis and treatment. Berger et al. (2001) suggested that HIV/AIDS stigma is made up of four components: personalized stigma, concerns about disclosure, self-image, and concern with public attitudes toward HIV individuals. Issues relating to stigma will be useful to explore as individuals work to retain or develop a positive sense of GLBTQQ selves.

Because of this stigma, support groups for HIV/AIDS differ from groups for other health issues. Although there have been many promising developments in the treatment of HIV and AIDS, and life expectancy has been extended considerably, there still is no cure for the virus, and individuals struggle with existential as well as social issues (de Ridder, 1999). The opportunity to come together with others who share similar struggles with the virus can be empowering, educational, and may lead to activism. Supportive therapy can be effective not only for individuals with HIV/AIDS but also for those mourning the loss of individuals who died with complications from AIDS (e.g., de Ridder, 1999).

There are many psychoeducational group formats that have been developed to prevent HIV/AIDS within specific populations. Telephone groups have targeted closeted men (e.g., Roffman, Downey, Beadnell, & Gordon, 1997), and hip-hop groups have been created for African American adolescents (e.g., Stephens, Braithwaite, & Taylor, 1998). Groups have also targeted sexually compulsive men having difficulty implementing safety precautions in their sexual practices (e.g., Baum & Fishman, 1994) or psychoeducation support groups for gay men (Blye, 1999). Choi et al. (1996) identified four main goals of HIV/AIDS prevention group work: the development of self-identity and social support, safe-sex education, eroticization, and negotiation of safe sex. Research indicates that these groups do appear to promote safer sex practices and greater awareness of risk (e.g., Sorenson, London, & Morales, 1991). Cognitive-behavioral group interventions for HIV groups have been developed as well (Lee, Cohen, Hadley, & Goodwin, 1999; Roffman et al., 1997).

It may be most efficacious to form groups that are exclusive in terms of the stage of illness, risk behaviors, and gender of members (see Perez, 1996; Siebert & Dorfman, 1995). At initial awareness of HIV/AIDS, individuals are working on integrating this illness into their other identities. Initially, group members will need to bolster one another's sense of hope, which may be difficult if confronted with other members with more advanced stages of AIDS. Similarly, it may be difficult for members who have later stage AIDS and are negotiating physical and treatment stressors to have a sense of group cohesion with members who are asymptomatic. With the increasingly popular use of the Internet as a therapeutic tool, online groups may be another possible solution for clients with HIV/AIDS (Bar-Lev, 2008). The Internet also has been used successfully as an outreach tool to reach and retain high-risk HIV/AIDS clients (Feldacker, Torrone, Triplette, Smith, & Leone, 2011).

Ethical Surveillance

GLBTQQ groups pose particular ethical surveillance concerns, particularly confidentiality, because of the lack of protection for GLBTQQ individuals against employment discrimination, denial of custody of children, refusal of adoption, and limiting access to housing. In addition to overt discrimination, GLBTQQ individuals are at risk for losing social support of family members, friends, or religious affiliations if their sexual or gender identity is made known (Ryan et al., 2009). Even in a community where there may be ample supports and GLBTQQ-affirmative policies, individuals may be vulnerable to subtle discrimination, such as poor access to health care and service, should their GLBTQQ status become public or if they are visibly GLBTQQ (Hiestand, Horne, & Levitt, 2008). The likelihood of interaction outside of a group is generally quite high, given the small size of GLBTQQ communities; thus, group members need to decide if limits to outside-group contact are a realistic or desired goal. These rules should be clearly established, and consensus reached.

Best Practice in Group Processing with GLBTQQ Groups

Reflective Practice, Evaluation, Consultation, and Follow-Up

It is helpful for group leaders to allot time to process the working of a group between themselves and the group members. Structuring an ongoing evaluation of the group process can allow leaders to continue to adjust the group goals and functioning in synchrony with its member's needs (Thomas & Pender, 2008). In a GLBTQQ group, goals might change as individuals become more comfortable with one another, with their own identities, or as tasks become resolved— depending on the focus of the group work (Medeiros, Seehaus, Elliott, & Melany, 2004).

Group workers assess the process and outcome of the group and conduct an evaluation with group members once the group is concluded if appropriate (Thomas & Pender, 2008). Evaluations can help GLBTQQ clients notice the progress they have made in their goals and set new goals. Finally, group workers support the development of the field by providing consultation and training to organizations and community agencies. This work can be especially needed with this population as many organizations, such as schools or business, may be unsure how to create safe environments for GLBTQQ employees or students.

Conclusion

Group counselors must be prepared to deal with unique issues and concerns that operate in tandem with the oppression that many GLBTQQ individuals experience. Because GLBTQQ individuals are usually not raised within a context of GLBTQQ family, they may have internalized heterosexist prejudices without buffers or role models from family and community. Because of the many differences between GLBTQQ individuals' cultures, stages of identity development and goals, group leaders will need to form, shape, and conduct groups with an eye to revealing the biases within the culture at large and within group members themselves. By allowing for the discussion of oppression at multiple levels and valuing the differences between group members, group facilitators can allow members to shape identities that are congruent with their experiences and to become resilient in the face of the future obstacles they may face.

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Chapter 21 Group Counseling Services for Persons with Disabilities

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Americans with disabilities are a large and diverse population. The Centers for Disease Control (CDC, 2005) noted that 21.8% of adult Americans have a disability, approximately 47.5 million people. Unfortunately, people with disabilities often report lower life satisfaction, with 34% much less likely to say that they are very satisfied with life in general than people without disabilities (61%; Kessler Foundation, 2010). Most pertinent is the finding that people with disabilities are almost twice as likely to go without needed health care (19% vs. 10%) or mental health care (7% vs. 3%; Kessler Foundation, 2010).

Over the past four decades, the education, treatment, and opportunities for individuals with disabilities have increased substantially (Yell, Katisyannnis, & Hazelkorn, 2007). Yet academic, occupational, and psychological outcomes for people with disabilities continue to be significantly lower than their peers without disabilities (Kessler Foundation, 2010). Therefore, it is critical for professionals to become active stakeholders in supporting individuals with disabilities. This chapter will address how group therapy can be an especially useful treatment modality for people with disabilities as a primary or adjunct treatment.

Americans with Disabilities Act

Briefly, the laws and social history of the governmental regulations regarding treatment of and accommodations for persons with disabilities in the United States began with vocational rehabilitation for disabled veterans after World War II (Matchette, 1995). Over time, the original legislation was expanded to offer more services to people with a wider range of disabilities (Olkin, 1999). In 1964, the Civil Rights Act laid the groundwork for antidiscrimination and the concept of integration, which would later impact persons with disabilities. In 1973, the Rehabilitation Act was passed, which was the first act to address equal access for and prohibition of discrimination against persons with physical disabilities. Over the next two decades, amendments to the Rehabilitation Act broadened the definitions of disabilities and rights/services provided to people with disabilities (Olkin, 1999). In 1990, the Americans with Disabilities Act (ADA) recognized the large number of Americans with disabilities, acknowledged that they are marginalized, and guaranteed the rights of persons with disabilities to equal access and nondiscriminatory behavior in employment, government, and other services with a focus on inclusion, integration, accommodation, and accessibility (Department of Justice [DOJ], 2009). This makes the relative paucity of available services and outcome research for psychological treatment for individuals with disabilities, including group therapy, worthy of attention.

Definition of Disability

There are multiple definitions of disability, which vary in breadth, specificity, and intention. For the purposes of this chapter, we will use the definition provided by the ADA, which specifies that a disability is a condition which is recognizable by its outcomes. The ADA defines a disability as

> a physical or mental impairment that substantially limits one or more major life activities … [which include] caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working … [and] major bodily functions (Sec. 12102; DOJ, 2009).

While the ADA definition will serve as the foundation for this chapter, it is worth noting that younger people with disabilities are most often identified and/or served by the educational system, which has a much more detailed definition, focused on provision of educational services as provided by The Individuals with Disabilities Education Improvement Act of 2004 (IDEIA, 2004; National Dissemination Center for Children with Disabilities, 2012).

Though not stated explicitly in the ADA definition, the authors would like to make a few distinctions in the working definition for this chapter. First, the definition of disability easily lends itself to a division between *physical disabilities* (i.e., those that primarily affect performing manual tasks, walking, standing, etc.; e.g., loss of limb, chronic respiratory illness) and *cognitive (or intellectual) disabilities* (i.e., those that primarily affect learning, reading, thinking, etc.; e.g., learning disorders, traumatic brain injury). Another important distinction made in the culture of disability is that of *visible disabilities* (i.e., those that are easily recognized such as by wheelchair use) and *invisible disabilities* (i.e., those that other people would not know about if they are not told by the person with the disability). Many mental health conditions may qualify as a disability using the ADA's criteria (e.g., Major Depressive Disorder); however, a full discussion of group therapy for the full range of mental health disorders is beyond the scope of this chapter. (See related chapters in this volume.)

Providing Group Services to Persons with Disabilities

Group counseling is a highly varied set of treatments and techniques, with the potential to help people across the physical and mental ability spectrum in a way that is individualized to their unique needs. *Psychoeducational groups*, which are usually based around a certain theme, often help members in terms of skill building or life transitions (Corey, 2012). For people with disabilities, psychoeducational groups might be developed based on setting; for example, a rehabilitation facility may offer a group with a focus on understanding limitations of mobility, a university may offer a group for adult students to learn how to navigate the accommodations system in a college setting, or an elementary school might offer a program on bullying. *Support groups* offer understanding, universality, and increased coping and are especially helpful for members who believe there is a substantial stigma associated with their conditions (Davison, Pennebaker, & Dickerson, 2000). People with physical and mental disabilities are at high risk for experiencing stigmatization and discrimination (e.g., Scheid, 2005), so the support of a group may be especially useful to provide social supports and destigmatization of individuals who have similar disabilities and experiences. *Group counseling and/or psychotherapy* can be used as a treatment for mental health disorders that qualify as disabilities but also provide benefits, including increasing connectedness with others, increasing self-direction and self-acceptance, promoting healthy development and decision making, offering hope, increasing resilience, fostering social support, and encouraging positive change (Corey, 2012).

Therapeutic Factors

Nondirective psychotherapy or support groups may offer people with disabilities a unique experience with substantial benefits beyond what individual therapy and/or medical treatments can provide. Of the therapeutic factors commonly associated with group counseling (Yalom & Leszcz, 2005), some are especially relevant to counseling people with disabilities. Perhaps the most important is *cohesiveness*; the bonding, peer acceptance, emotional intimacy, and experience of being valued that occurs during group therapy work is often missing from the lives of people with disabilities because of limited access to quality social support and the influence of prejudice or sense of being different from others. *Instillation of hope* is another beneficial component of group work; seeing the progress of others (e.g., gains in physical functioning, coping skills, and emotion regulation) can empower members to make their own changes as well as reduce feelings of hopelessness, depressive symptoms, and anxiety about change. People with disabilities may also make special gains as a result of *imparting information*; because this group represents a particular minority with particular needs (perhaps even more so in a group tailored to specific types of disability), other members of the disability community may have the most practical, relevant information to share with each other.

For people with physical disabilities, especially central is *universality*; the acceptance and validation of shared experiences is vital to development of identity as a person with a disability. This is of such benefit because of the intense stigma and victimization experienced by people with (especially visible) physical disabilities. *Altruism* is especially important because people with disabilities are subjected at times to being "over-helped" and feeling as if they are a burden to others. They less often have the chance to see themselves as helpers; group therapy allows members to have the experience of genuinely impacting others' lives for their good.

For those with cognitive disabilities, *development of socializing techniques* may be of particular value. People with autism spectrum disorders, learning disorders, developmental disability, and other cognitive deficits face substantial challenges in developing age-appropriate social skills. It may be impossible for them to develop these skills in "mainstream" environments, which tend to dismiss or ostracize rather than encourage learning. Similarly, *imitative behavior* allows group members to model not only the group leader but other members as they make gains in interpersonal skills, supportive behaviors, and self-acceptance.

Group Intervention with Individuals with Physical Disabilities

Research on group interventions for individuals with specific physical disabilities such as visual, hearing, speech, and orthopedic impairments is virtually nonexistent. This is likely because the responsibility for assessment, diagnosis, and treatment typically falls to a health professional in the medical, occupational therapy, and/or vocational rehabilitation fields. However, mental health practitioners have an important role in addressing individuals' coping with their disabilities, developing disability-congruent identities, and helping engage social support and other resources for maintaining mental health.

Process and Support Groups

Issues that are common sources of distress for people with physical disabilities fall into health-related, financial, social, and intrapersonal categories. Each of these topics may be the focus of a group or simply content in an unstructured group; group leaders who desire to work with this population should be familiar with these concerns. While this is a brief overview, other sources cover these areas in rich detail (e.g., Livneh & Antonak, 2005; Olkin, 1999).

Health-related

Group leaders must consider that people with disabilities have health concerns that impact their lives to varying degrees, from minimal influence to being the most prominent day-to-day concern (Kessler Foundation, 2010), and should elicit this information from members rather than making assumptions. Leaders need to be familiar with the major symptomology and/or functional limitations of the members they are working with but encourage members to be the experts in describing how the disability influences their living. For example, only *after* a member has disclosed a particular disability, the group leader may follow up with a question such as, "How does this impact your daily living?" or "How would you like to bring this into the group experience?" In a group format, different members will likely be at different places along this continuum and efforts must be made to honor each individual's circumstances while building a sense of shared identity and community. This means taking a phenomenological stance in valuing each member's disclosures while discouraging competitiveness by giving members equal time and attention regardless of varying levels of severity. Other concerns that group leaders should be aware of include possible progressive decline in functionality, appearance and body image concerns, access to health care, managing the medical and insurance systems, and possibly end-of-life issues.

People with disabilities, especially those who see progressive decline or who experience the onset of disability after childhood, may be grieving several losses (e.g., loss of function, loss of autonomy, loss of a body part). Drench (2003) describes how to use various grief models in understanding and treating physical disabilities. She encourages care providers to consider the type of loss (e.g., sudden vs. gradual, anticipated vs. uncertain, temporary vs. permanent) and to allow for a grieving process before focusing strongly on coping strategies. One model she suggests adapting to disability-related losses is Worden's (2002) Tasks-of-Mourning model, which enumerates four main tasks: accepting the reality of the loss, experiencing the pain associated with grief, adjusting to new physical or emotional situations created by the loss, and progressing with life. This model may be useful in a group counseling situation because it allows for any of the tasks to be in-progress at any time rather than stipulating a linear progression. In a group setting, members would likely be working on different tasks at different times and, through imitative behavior and instillation of hope, the group members could help each other progress.

Financial

People with disabilities are about twice as likely to be unemployed, to live in poverty as those without disabilities, and are more likely to accumulate debt (Kessler Foundation, 2010). Of primary concern to many people with disabilities are career issues, such as the need for vocational rehabilitation or job change as a result of disability. Discrimination in employment (an issue for 43% of people with disabilities; Kessler Foundation, 2010) and uncertainty about rights in the workplace are also common themes. Care must be taken by group leaders to be sensitive to financial hardship, both as a possible issue to be addressed therapeutically but also in a practical sense (i.e., though group is a cost-effective strategy, are there ways to decrease the financial burden of services, e.g., through the use of pro bono or sliding scale work?).

Social

Perhaps the largest social concern for people with physical disabilities is stigma. This group has traditionally experienced chronic stigmatization and prejudice from peers, family, and the media as well as systematic

institutional victimization from all aspects of society, including the medical profession, the educational system, and the workforce (Gibson, 2006). Even counselors experience and express discomfort (i.e., reluctance, fear, and hostility) in working with people with physical disabilities (Thomas, Curtis, & Shippen, 2010). Group leaders *must* address these issues before and during group through self-examination and supervision/consultation further avoid harming group members. However, any type of group counseling discussed herein could be utilized to reduce the experience of stigma and create a culture of shared understanding in a way that individual therapy and medical/rehabilitative services cannot simply because of the potential for universality and building cohesion.

Stereotypes of people with disabilities that group leaders need to be aware of may include the following: people with disabilities are less than fully human; disabilities are problems or abnormalities that need to be cured or corrected; disabilities are contagious; successes are necessarily great triumphs over adversity; disabilities allow people to demonstrate extraordinary virtues (e.g., courage, perseverance); people without disabilities are obligated to sacrifice continually in providing care for people with disabilities; people with disabilities are necessarily depressed or angry about their conditions; people with disabilities are dangerous to themselves, others, and/or society (Block, 2011). It is important to note that people with disabilities are not immune to holding stereotypes about others with disabilities (Olkin, 1999). In a group setting, encouraging talk about stereotypes may provide a way for members to connect deeply and build cohesion, but it may be divisive if some members have not experienced or recognized prejudice or if they express hostility or fear and this is not processed. This may be achieved through awareness-building exercises, psychoeducation, gentle confrontation, and positive, equal-status contact in the context of open, respectful group communication.

Additional social concerns that are common to people with physical disabilities may be related to gender and sexuality (Olkin, 1999). Traditional gender roles may be challenged when a person has a physical disability. For example, men may struggle to integrate their disability identity with the conventional masculine identity emphasizing strength, control, virility, and/or fitness (Rapala & Manderson, 2005). Similarly, women with disabilities may experience a struggle in the increased cultural expectation of being childlike, helpless, and/or weak as they are members of two (or more) minority groups. An additional misconception about people with disabilities is that they are asexual, either not desiring sex or incapable of sexual activity, and there are cultural pressures related to dating, romance, and sexuality that are not often talked about. Similarly, many people hold strong negative attitudes about the appropriateness of people with disabilities fulfilling roles as parents—for example, they should not risk passing on genetically related disabilities or they are not capable of properly caring for their children. One of the gifts of group therapy in particular is *universality* (Yalom & Leszcz, 2005), which in part comes from the freedom to discuss topics (such as gender issues and sexuality) that are taboo or about which members feel shame, embarrassment, or fear (Yalom & Leszcz, 2005). Group leaders themselves need to be comfortable with and knowledgeable about these issues before starting group; then, they can demonstrate the acceptability of these topics by initiating the conversation, encouraging participation, and speaking matter-of-factly.

Intrapersonal

As with other dimensions of culture, identity development is an important intrapersonal task. Gibson (2006) proposes a model with three stages: passive awareness (marked by dismissal of disability and attention avoidance), realization (marked by self-hatred, anger, and highly concerned with others' perceptions), and acceptance (marked by self-acceptance, integration of disability, involvement in able-bodied world, and advocacy). As some of the main functions of group counseling are to address life transitions, personal growth, and development (Corey, 2012), it is an ideal setting to explore one's identity development. Even if it is not a content focus of group counseling, group leaders should attend to members' identity development and incorporate that into their conceptualizations and treatment plans. Leaders may accomplish this by attending to identity development during group screening, ensuring that the group has a blend of stages represented so that members have the opportunity to learn from each other. Also, group leaders should be ready to normalize reactions common to any stage during the group process and be watchful for members' progress. If one or a few group members show no progress or are far outside the range of development common to the rest of the group, the leader may consider supplemental individual therapy for these members.

Also of particular interest is the concept of *autonomy.* People with physical disabilities are especially likely to be perceived as being dependent, helpless, or incompetent (Wang & Dovidio, 2011). There may be a struggle between the need for accommodation and the stigmatized view of self that discourages help-seeking and fosters a sense of dependence. Wang and Dovidio (2011) suggest that resilience can be improved for people with disability by advancing members' self-esteem, by calling attention to their other valuable roles (apart from being a person with a disability), and through advocacy related to perception by people without disabilities. Group therapy could be an excellent milieu for this, as both the group leader and fellow group members could encourage and demonstrate the development of autonomy and resilience.

Cognitive/Behavioral and Psychoeducational Groups

A highly structured approach, cognitive-behavior group therapy (CBGT) emphasizes active introspection, behavior modification, and skills training (White & Freeman, 2000). Common methods in CBGT include challenging maladaptive thoughts, building self-awareness, monitoring mood, arousal, behavior, problem solving, relaxation, and relapse prevention (White & Freeman, 2000). Because it is structured, time-limited, and has strong efficacy data, it is one of the most widespread kinds of groups, especially in schools and special populations (Corey, 2012).

Because a substantial proportion of the physical disabilities faced by Americans are compounded by lifestyle factors (e.g., respiratory problems, back pain, blood pressure; CDC, 2005), group counseling can be beneficial by offering social support for behavioral health interventions and compliance with their health-related behaviors. CBGT interventions can increase adherence to physical activity plans. Rejeski et al. (2003) found that CBGT increased frequency of weekly exercise and health-related quality of life in older adults with cardiovascular disease or risk-factors. The groups focused on building self-regulation skills such as identifying motivations for behavioral change (e.g., avoiding increased disability), setting appropriate and attainable goals (e.g., increased physical activity), self-monitoring of behaviors, and dealing with relapse or failure to meet goals. CBGT was added to the controls' group exercise and education treatments (although total staff contact time was the same between groups) and resulted in significant improvements in adherence to exercise programs as well as overall fitness.

Chronic pain management is another area in which people with physical disabilities often require assistance and cognitive-behavioral group strategies are fairly common and several treatment manuals exist (e.g., Thorn, 2004) for this issue. The basic cognitive work in these groups follows a standard pattern: build awareness of members' primary appraisal of their pain as a stressor, identify their perceived ability to cope, review their cognitive coping strategies, and examine/change cognitive distortions that prevent effective coping (e.g., catastrophizing, all-or-nothing thinking; Thorn & Kuhajda, 2006). Behavioral techniques commonly incorporated are relaxation training, stress management, and reducing avoidance behavior (e.g., of appropriate physical activity; Samwel, Kraaimaat, Crul, van Dongen, & Evers, 2009). Samwel et al. showed that after 10 weeks of cognitive-behavioral group therapy, members with medically untreatable pain had significantly decreased pain intensity and reduced functional disability. Group work is especially useful in this context because it promotes a sense of belonging and understanding among members and allows for modeling of effective coping and relevant discussion and generalization (Thorn & Kuhajda, 2006).

Practical Considerations

There are some important practical considerations that group leaders should be aware of when working with people with various physical disabilities. First, leaders should consider the needs of the members of the group, especially needs associated with invisible disabilities. For example, it may be easy to remember to use a first floor meeting room when group members use wheelchairs; however, this is also a reasonable accommodation to make for people with disabilities such as cardiovascular or respiratory conditions. Second, group leaders need to take all aspects of the setting into account (e.g., when working with members with hearing impairments, meeting in a small enough group and room that lip-reading is possible) and carefully monitor their own behavior (e.g., addressing each member by name rather than using nonverbal gestures when working with members with visual impairment). Also, group norms need to be co-created with special regard to the varying levels of ability of the members, whether all members have similar disabilities or not. This can be done during the early stages of group, by encouraging every participant to be active in establishing the group norms/rules. There are several resources for appropriate etiquette for working with people with various disabilities (e.g., Federal Communications Commission, 2003; National Center on Workforce and Disability, 2008). As always, group leaders should be knowledgeable about the group they plan to work with and regularly ask group members for feedback.

Second, consider that emotional disturbances are commonly comorbid with physical disabilities; depression and anxiety are especially common (Thorn & Kahujda, 2006) and may be viewed as expectable reactions to the initial diagnosis of a disability, the chronic experience of discrimination, or the challenges of adapting to a new setting or identity status. Further, suicidal ideation and actions increase in the presence of physical disabilities, especially when there are marked decreases in physical functioning (American Psychiatric Association, 2003). Leaders should conduct a thorough group screening, including a diagnostic assessment and mental status exam to give a baseline of members' emotional functioning. Depending on the group composition (i.e., the level of other members' emotional distress), group type (i.e., a process or psychotherapy group is more amenable to emotional disturbance than a psychoeducational, strictly behavioral, or support group), and leader comfort, some individuals may not be appropriate for group, or may require supplemental individual services (certainly the case for actively suicidal clients).

Group Intervention with People with Cognitive Disabilities

The research on group interventions for individuals with cognitive disabilities (e.g., learning disabilities, autism spectrum disorders, developmental delay, and dementia) is much more substantial, probably because these are diagnoses more typically made by mental health practitioners rather than medical professionals. On the other hand, the literature regarding the day-to-day experiencing of these conditions as part of the disability culture is much less, possibly because many are invisible disabilities.

Process and Support Groups

Issues that are common sources of distress for people with cognitive disabilities may also be delineated into categories: educational/occupational, social, and intrapersonal. Again, these topics may inform the focus of the group in terms of content, or they may just be important as a backdrop to understanding the group process. In addition to the struggles discussed in the physical disabilities section (e.g., poverty, stigma, identity development), people with intellectual disabilities may have additional or different areas of concern.

Educational/Occupational

Young people with intellectual disabilities are often first diagnosed and served in the education system. IDEIA (2004) requires that students with disabilities have an individualized education plan that includes assessment of their academic and functional performance, goals, educational needs, and the services that will be provided. IDEIA maintains an emphasis on balancing the least restrictive environment for students with providing a continuum of individualized services to help students have a meaningful education experience (Rose, Allison, & Simpson, 2012). Content for groups with these students may range from processing initial assessment results, to navigating the education environment, to the struggles with peer acceptance in mainstream classes, and more (Ridgeway, Price, Simpson, & Rose, 2012; Simpson, Rose, & Bakken, 2013). Group leaders should be familiar with these processes, especially if working with children with disabilities or their parents/caregivers.

Despite efforts to maximize accommodations and movement through the educational system, people with disabilities attain lower levels of education than those without. Seventeen percent of people with disabilities have not completed high school (compared to 11% of people without disabilities); 81% have not graduated from college (compared to 73%; Kessler Foundation, 2010). In addition, adults with disabilities are much less likely to describe themselves as working either full or part time (21% vs. 59%; Kessler Foundation, 2010). Many employers still exclude persons with intellectual disabilities from the workplace because of persistent but unfounded stereotypes (e.g., higher absenteeism, higher insurance costs) or because they lack information and perceived efficacy to make accommodations, though resources are available to help employers with these issues (U.S. Equal Employment Opportunity Commission, 2011). In addition to other general benefits of group, imparting information may be the most effective tool in this area as people with disabilities who have navigated the educational system and workforce may be able to share important, practical information and support with those who have not (e.g., what assessments are necessary, trusted evaluators or lawyers in the area, shared experiences with disclosing disabilities to employers). This may be a leader-initiated part of a support or psychoeducational group, or it may happen informally as group members simply share with one another.

Social

In general, people with disabilities have less social interaction than those without (Kessler Foundation, 2010). Specifically, people with intellectual disabilities have smaller social networks than people with physical disabilities and have few relationships with nondisabled people (Lippold & Burns, 2009). Even despite involvement in social activities, social support among people with cognitive disabilities is low. Group therapy may be a profoundly different and positive experience, with its focus on cohesion, universality, and interpersonal learning.

Also, many intellectual disabilities (e.g., autism, developmental delay) can impact the development of age-appropriate social skills. In a recent review, Stephens, Jain, and Kim (2010) suggested that extant literature supports the use of group counseling to increase social skills through behavioral modeling in a comfortable and trusting environment. Groups can facilitate learning, practicing, and validating social skills (Rose et al., 2012) especially when they are proactively structured using behavioral models demonstrating and reinforcing positive social skills. This creates an environment in which people with disabilities feel like vital members of the group and observe and practice social skills among their same-aged peer group (Rose et al., 2012). For example, Terpstra and Tamura (2008) outline effective social interaction strategies employed within inclusive environment, including

sensitivity training for peers without disabilities, teaching specific social initiation strategies, and peer imitation training. Overall, the goal of social skills training is to allow the individual to be successfully integrated alongside his/her same-aged peer group.

Intrapersonal

One important struggle that people with cognitive disabilities (and other invisible disabilities) may experience as more potent than those with visible, physical disabilities (who may experience more public stigma) is *self-stigma*, which is an internalization of negative stereotypes often coupled with low self-esteem and self-efficacy. However, Corrigan, Larson, and Rusch (2009) noted some people with self-stigma are empowered to achievement and advocacy. They suggest that building awareness of discrimination and dispelling myths (e.g., psychoeducation), fostering positive group identification (e.g., through cohesion and universality), and encouraging alternate understandings of self-worth (e.g., through interpersonal learning) can raise self-esteem and promote empowerment.

Cognitive-Behavioral and Psychoeducational Groups

Cognitive-behavioral group therapy (CBGT) may be a useful approach across the continua of age, disability severity, and settings because it can be modified to fit the needs of the members. For example, CBGT for children may have an emphasis on behavioral and skills training; a similar group for high-functioning adults would be more focused on introspection and self-monitoring. Corey (2012) suggests that CBGT is well suited for many diverse populations because it is quite straightforward, not overly focused on emotions, and highly demystified. Of course, good communication skills, cognitive aptitude, ability to identify emotions, and ability to understand the CBT model improve outcomes (Hatton, 2002).

CBGT has also been shown to be effective in reducing interpersonal sensitivity, obsessive compulsivity, depression, anxiety, and global distress in individuals with intellectual disabilities (Ghafoori, Ratanasiripong, & Holladay, 2010). This study used CBGT over nine sessions focused on building rapport and management of depression, anger, and anxiety. The group facilitators included numerous interventions, including role play, writing exercises, cognitive restructuring, relaxation training, the antecedent-belief-consequence model, and more tailored strategies. It may be that a cognitive-behavioral approach is useful because it allows members to supply all the data for the therapeutic work and the collaborative stance encourages full participation, which makes it very individualized, even in a group setting. Group members can determine not only group norms but possibly group content (as in the Ghafoori et al., 2010, study) and supply feedback to group leaders about desired or preferred activities.

Designed for adolescents with comorbid emotional, behavioral, social, and intellectual deficits, Social Competence Group Training is a highly structured, behavioral skills training program that addresses social problem solving, social reciprocity, adaptive social behaviors, and social anxiety (Nestler & Goldbeck, 2011). Group tasks included didactic learning, modeling by group leaders, role plays, self-talk, and monitoring of thoughts, feelings, and behaviors. These interventions, focused on assertiveness, anger control, emotion management, and learning conversation rules, led to significant gains in overall social competence and social problem solving (Nestler & Goldbeck, 2011).

Dialectical Behavior Therapy (DBT) is a variant of traditional cognitive-behavior therapy that focuses on mindful awareness, interpersonal effectiveness, emotion regulation, and distress tolerance (Linehan, 1993). Sakdalan, Shaw, and Collier (2010) found that a DBT skills program decreased risk behavior, increased coping skills, and increased global functioning in people with intellectual disabilities. These positive changes were seen over the course of 13 weeks and as a result of the stand-alone skills program (i.e., in the absence of the individual sessions and between-session contact that is typical of DBT work with clients with personality disorders).

Practical Considerations

For persons with intellectual disabilities, level of communication skills (delay or lack of speech/inability to initiate or maintain communication), tactile defensiveness, sensitivity to sensory inputs or outputs, deficits in social skills, maturity level, preference for being alone, and self-stimulatory behavior may be present in varying degrees and each may impact group process. Because each cognitive disability exists on a continuum, group leaders must remember that characteristics may vary in intensity and may be displayed differently among individuals with the same diagnosis (Boutot & Tincani, 2009). This issue may be most readily managed with thorough prescreening for group inclusion to ensure that group members have some similarity in skills rather than trying to accommodate substantial individual differences once a group has already begun. A mental status exam included in the screening may be sufficient for assessing appropriateness for a particular group, depending on group type or composition (i.e., there is no preferred level of skills necessarily).

Some points of etiquette for working with people with cognitive disabilities include appropriate communication; leaders should speak to adults with cognitive disabilities as adults (not as children) and they should direct communication to the member (not to a caregiver or assistant; National Center on Workforce and Disability [NCWD], 2008). Group leaders may also choose to have materials available in different formats (e.g., written, oral, video) so that members may choose to work with materials in their areas of strength (Olkin, 1999). It is also important to use the correct, current, and least stigmatizing language. At the time of this writing, the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* is in its fourth edition and uses terminology including “mental retardation” and “dementia” (2000), but changes in diagnostic labels are forthcoming, perhaps to include such terminology as “intellectual disability” and “major neurocognitive disorder” (APA, 2012). As always, group leaders must avoid stereotyping and respect individual differences (NCWD, 2008).

Visible versus Invisible Disabilities

Visible physical disabilities are those that are readily observed by others, such as impairments in vision, hearing, or mobility (e.g., scoliosis, loss of limb, wheelchair use). Visible cognitive disabilities may include those that have concurrent physical expressions (e.g., cerebral palsy). That these conditions are quickly identified by others may lead to increased access to accommodations but leaves individuals more vulnerable to open prejudice as well. Groups that include these individuals will need to have leaders who are cognizant of the day-to-day experiences of people with visible, physical disabilities especially in terms of public stigma.

Five of the top ten most common physical disabilities (arthritis, heart problems, lung/respiratory problems, diabetes, and stroke) are often invisible and represent 37.4% of all reported disabilities in U.S. adults (CDC, 2005). Further, most of the cognitive impairments (e.g., ADHD, learning disabilities) and virtually all the emotional/mental health disabilities (e.g., depression, bipolar disorder) are invisible. Particular concerns for this group are the reduced access to resources and accommodations coupled with a peculiar type of prejudice that comes from "not looking disabled" (Invisible Disabilities Association [IDA], 2011). Other stereotypes include people being lazy, succumbing to moral failure, or choosing not to follow doctors' recommendations. Sometimes, people with invisible disabilities fall into a culturally created category of "not being disabled *enough*," which cultivates a bicultural identity in which people feel ostracized from both able-bodied and disability-centered realms (IDA).

General Guidelines for Group Practice

Though people with disabilities constitute a very large and very diverse group, there are some basic guidelines that should underscore all group counseling for people with disabilities.

Leader Functions/Characteristics

Start with the Person

It is important for the group leader to be knowledgeable about both the content the group is expected to cover as well as the individual members and the expected member issues. However, understanding and honoring the group members as individuals is paramount to group success; group leaders must accept members as the experts on their own experiences. This is especially true when leaders without disabilities are leading groups for persons with disabilities. A humanistic (i.e., phenomenological) foundation may be useful in gaining an accurate awareness of members' experiences with accessibility, discrimination, and the like.

Regard Disability as a Cultural Dimension

Disability can be considered a dimension of culture; as with all multiculturally competent counseling, group leaders must possess the appropriate awareness, knowledge, and skills to work with their target populations. Especially important is that group leaders become aware of and address any biases, anxieties, or other emotional reactions they may have regarding working with people with disabilities. Additionally, leaders should not assume that a member's disability status is their most salient dimension of diversity, even if the person is attending a group targeting disability issues.

Attend to Identity Development

A group of individuals with disabilities will certainly have members at different points in their journey of disability identity development. Care should be taken to recognize members' individual level of disability integration and to ensure that group material and processes are appropriate for all members.

Accommodate and Destigmatize

Group leaders should be aware of and use the current accepted etiquette and language that is preferred by the particular group(s) with whom they work. Group setting, composition, content, norms, and processes should be modified to best meet the needs of the particular group. In all contacts with group members, group leaders should work to reduce the culture of "ableism," whether from the group leader or other group members.

Group Function/Characteristics

Cultivate Belonging

Group leaders should maximize the group therapeutic factors of cohesion and universality by actively working to promote shared understanding and the development of sense of community in the group.

Modify for Level of Ability

Modifications of traditional group models may include accommodations for physical or cognitive disability. These may be changes in group size, setting, norms, communication styles, goals, content, processes, or strategies. When modifying, use the specific members' needs as guidelines and solicit feedback from members as the group progresses regarding possible changes that could make group more effective or comfortable.

Explore Options

While cognitive-behavioral/psychoeducation groups have the most empirical support, group leaders may consider the benefits of alternative approaches—psychodynamic or humanistic group therapy, creative therapies, movement therapies, and others have all been described as effective for certain groups of people with disabilities.

Conclusion

Best practices for supplying services to people with disabilities have to include approaches that satisfy the breadth and depth of this cultural group. The wide range of disabilities (e.g., physical, emotional, intellectual) and their sequelae (e.g., from chronic pain to social skills deficits) calls for a sizeable palette of potential interventions that cross the spectrum of medical, educational, vocational, and mental health venues. The depth of the influence of disabilities (e.g., level of severity, multiple comorbidities, extensive life impact) also requires intensive treatment strategies so the implementation of several tiers of available treatments are necessary to really provide the best services. Because such a comprehensive approach is necessarily time and resource intensive, efficacious treatments that are cost-effective have an important place in the treatment for persons with disabilities. Group counseling can then be a highly valuable piece of holistic treatment for this population.

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Chapter 22 Group Work with Those in Later Life

Tammi Vacha-Haase

There is no denying the increase in the number of older adults. Estimates indicate that in the year 2050, there will be more than 86 million Americans over the age of 65 (U.S. Census Bureau, 2010). Changes in the racial and ethnic compositions of these older Americans are forecasted, with much of the growth in the older population being Hispanic (U.S. Census Bureau, 2010).

Although the majority of older adults enjoy an overall positive mood and emotional well-being, one out of five will experience some type of psychological disorder (American Psychological Association, 2003). For those living in a long-term care (LTC) setting during their later years, estimates are much higher with almost 80% suffering from some form of mental disorder (Conn, Hermann, Kaye, Rewilak, & Schogt, 2007). The most common psychological difficulties include mood disorders and anxiety (American Association of Geriatric Psychiatry, 2008). Other areas of concern include alcohol and substance abuse (Fingerhood, 2000), insomnia (Lichstein & Moirin, 2000), and persistent pain (Krein, Heisler, Piette, Butchart, & Kerr, 2007).

Meta-analytic reviews recognize group interventions as an effective modality for treating those over the age of 65 (Burlingame, Fuhriman, & Mosier, 2003; Payne & Marcus, 2008). Benefits include belonging and affiliation, validation of experiences, ventilation, meaningful roles, personal insight, information, problem solving, and social support (Toseland & Rizzo, 2008). Because older individuals often experience isolation and loneliness, group-based work provides social interaction (Potter, Atix, & Chen, 2006). In addition, listening to older peers may help normalize later life struggles, facilitate expression of otherwise difficult feelings, and provide opportunities to support others (Agronin, 2009).

This chapter begins with a discussion of age-relevant groups highlighting areas such as cognitive decline, caregiving, bereavement, and prevention needs. Challenges for older adults suffering from later-life depression and mental illness are addressed with specific group interventions offered. Following best practice guidelines (Association for Specialists in Group Work, 2008), attention is given to planning for groups with older adults, followed by practical recommendations for working with older group members and outcome assessment. The chapter concludes with a look to the future, noting the need for continued theory development and empirical advancement in group work with older adults.

Types of Groups with Older Adults

Group work with older adults tends to fall into the general categories of counseling, therapy, and psychoeducational. Group intervention can take many approaches, including life review or reminiscence (Stinson, 2011), psychodynamic (Schwartz & Schwartzberg, 2011), interpersonal (Scocco, DeLeo, & Frank, 2002), and cognitive behavioral (DeVries & Coon, 2002). Groups with older adults often vary with respect to type of population, disease or diagnoses, setting, approach, and goals.

Cognitive Decline and Dementia Treatment Groups

One predominant area for group counseling is for those with dementia. Deemed the next epidemic, dementia is one of the most disabling and burdensome health conditions, and increasingly present with a growing older population. Group work has been found to be an effective intervention, because social stimulation and interaction is important for older adults with a diagnosis of dementia given that even small amounts of consistent social contact can have lasting effects on overall well-being (Hampson, 2009).

Groups might be offered to reduce functional disability and negative emotions or to provide comprehensive group intervention for memory-based challenges (Hoogenhout, de Groot, & Jolles, 2010). Examples include cognitive-behavior treatment for those diagnosed with mild cognitive impairment (Banningh, Kessels, Rikkert, Geleijns-Lanting, & Kraaimaat, 2008) and group reminiscence therapy for older adults diagnosed with mild to severe dementia (Wang, 2007). Other group approaches to those with cognitive impairment include validation therapy with the goal of supporting old memories that may represent issues needing to be resolved; reality orientation, which focuses on current aspects of the "here-and-now" by emphasizing the time, day, month, year, situation, and weather; and life review that allows group members to talk about developmental times in their life.

In a group reminiscence treatment for those over age 65 with a diagnosis of mild to moderate dementia, a nine-session group, each lasting 60 minutes, format was utilized, asking group members to share memories from their past (Nawate, Kaneko, Hanaoka, & Okamura, 2008). After the first introduction session focusing on the value of reflecting on and sharing past memories, sessions included memories about their hometown, school, marriage, and travel.

In a ten-week group for older adults diagnosed with dementia (Cheston, Jones, & Gilliard, 2003), group members were asked to discuss "what it's like when your memory isn't as good as it used to be" (p. 453). The group leaders focused on the emotional impact of the group members' experiences, with attention on the here-and-now, allowing for exploration of feelings related to "forgetfulness." A more in-depth discussion of this form of group therapy is provided in Cheston and Jones (2000).

Hoogenhout (2010) and her colleagues developed a comprehensive group intervention for older adults with cognitive complaints. In an attempt to reduce negative emotional reactions to their declining cognitive functioning, this group approach embodied a strong educational component, meeting twice a week for four consecutive weeks. The authors described the group intervention in detail, incorporating (1) a psychoeducational component about aging and cognitions (e.g., differences between normal age-related cognitive change and dementia, influence of lifestyle on cognition); (2) focus on compensatory behavior (e.g., use of mnemonics, anticipating environmental demands, reliance on others); and (3) group discussion relating each topic to the generalization and application in daily life.

Groups for the Caregiver

Dementia does not only affect the older adult but friends, family, and loved ones. According to recent estimates, 65.7 million Americans serve as family caregivers for an ill or disabled relative (National Alliance for Caregiving, 2009), with many experiencing a significant negative impact on their own well-being (Elliott, Burgio, & DeCoster, 2010). Group intervention has also proved to be beneficial for this population. One example is a therapeutic group focusing on anger and depression management for women caregivers of a relative diagnosed with dementia (Coon, Thompson, Steffen, Sorocco, & Gallagher-Thompson, 2003). Overall goals for groups like this include a psychoeducational aspect about dementia (e.g., types of dementia, common changes in behaviors) and management of behaviors (e.g., communication style, use of community resources). Additional goals include helping caregivers to make decisions, solve problems, increase coping skills, and improve self-care.

In a highly structured five-session intervention (Hosaka & Sugiyama, 2003), the focus was on relaxation training, with alternation of psychoeducation and group discussion. Group members learned about the general concept of stress, identified specific stressors in their own lives, and were taught progressive relaxation techniques.

Groups Focusing on Aging, Death, and Grief

Those in their later years often experience the need for groups focusing on aging, death, and dying (Cañete, Stormont, & Ezquerro, 2000; Davis-Berman, 2004), bereavement (Cohen, 2000), and complicated grief (Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001). Although death is not unique to older adults, loss of loved ones may occur more frequently for this population. Curative factors in these types of groups with older adults include instillation of hope, acceptance, decrease in social isolation, support, and education (Cohen, 2000). For older adults, increased loneliness can be a significant factor following the death of a loved one, and the group can provide needed support and socialization. The group can also allow the older member to grieve and recognize the significance of the loss, combating the belief that because the individual is in his or her later years it should be easier to accept the death.

For those older adults who have powerful emotions from the past, whether it be from someone who has died or otherwise, Ingersoll-Dayton, Campbell, and Ha (2009) designed an eight-week forgiveness group. The first two sessions focused on exploring anger toward the offender, the third on making a commitment to forgiveness, and Sessions 4 and 5 geared toward developing compassion. The final three sessions focused on letting go of feelings of hurt and resentment, while moving toward forgiveness. The authors provide a detailed description of questions to begin group sessions, including "What are your reasons for wanting to forgive?" and "What did you learn from being hurt?" In this group, members were asked to write in a journal each week about their forgiveness process, based on weekly journal assignments, such as "How will you know when you have genuinely forgiven?" Another group intervention focused on decreasing feelings of powerlessness that accompany life changes by helping group members to feel a sense of competence in their daily functioning with increased insight related to adaptation to loss and implementation of coping and preventive strategies (Bonhote, Romano-Egan, & Cornwell, 1999).

Later-Life Depression Groups

Group intervention has been found to be effective in treating later-life depression (Fiske, Wetherell, & Gatz, 2009; Krishna et al., 2011). In general, group approaches to decreasing depression with older adults focus on education (e.g., warning signs, importance of treatment), mood and cognitions (e.g., memories, thoughts), and overall physical well-being (e.g., exercise, diet, sleep).

Wilkinson (2009) and his colleagues developed and tested a brief group cognitive-behavior treatment manual to reduce depression in older adults. Group sessions included understanding basic principles of cognitions and behaviors, linking activities with mood, monitoring thoughts, and identifying techniques to address daily stressors. For example, group members were asked to differentiate their thoughts from their feelings, identify unhelpful thoughts, and learn behavioral approaches to challenging negative thinking.

In another example of group therapy to focus on the reduction of depression (Rokke, Timhave, & Zeljko, 2000), intervention included (1) self-management, where focus was given to the relationship between mood and members' activities and thoughts, such as members monitoring their pleasant activities and mood on a daily basis, and setting realistic goals for individually identified personal problems; and (2) education and support, where members learned about depression, risk factors, and common treatments, followed by discussion of how this might relate to them.

Husaini and his colleagues (2004) found that a 12-session group approach was effective in reducing symptoms reported on the Geriatric Depression Scale (GDS-15), especially for Caucasian women 55–77 who reported at least a moderate level of depression. In the group program designed to reduce depression symptoms in an older population, groups of 6–12 members met twice a week for two hours over a six-week span. Six weekly group modules were selected based on empirical evidence supporting reduction of depression for those in their later years. Topics focused on increased awareness of health and cognitive changes, stress management, both positive and negative memories across the life span, and exploration of unrealistic expectations of self and others. Husaini and his colleagues (2004) included an overview of the session activities for the group program, as well as recommendations for training group leaders, such as the value of goal setting, communication patterns, and cultural sensitivity.

Mental Health-Focused Groups

A variety of groups can be offered to support older adults who suffer from a serious mental illness. Kelly (2004) provided a detailed description highlighting the value of peer support, recommending that group leaders focus on increasing intimacy within the group through helping group members connect with one another. He also suggested empowering older group members by allowing them to make decisions about the group topics to be discussed.

In a dynamically oriented psychotherapy group (Evans, Chisholm, & Walshe, 2001), the goal was to explore factors that increased the group members' symptoms of mental illness and continued dependency. Focus was given to taking personal responsibility for recognizing symptoms and pursuing treatment. Ageism was discussed, both for the group leaders (e.g., they were surprised at the group members' ability to change their behaviors) as well as several group members, who initially refused to participate because everyone in the group was "so old."

Patterson et al. (2003) suggested a group intervention for older adults with schizophrenia and other chronic psychoses focusing on improving daily living skills. The intervention included six domains, including medication management, social skills, communication skills, organization and planning, transportation, and financial management. For example, when focusing on medication management, the importance of tracking medication and the value of using a pillbox was explored, followed by each group member developing a chart to assist them with daily tracking of their medication. A common theme in all the interventions was the recognition of the vulnerability of this population, because they have a mental illness as well as being in later life.

Goals for a group with older adults diagnosed with bipolar disorder (Nguyen, Truong, Feit, Marquett, & Reiser, 2007) included teaching group members to monitor their mood, with increased awareness of change; identifying ways to stabilizing mood; improving treatment adherence; and development of individualized coping plans. The authors noted the value of having a psychoeducational component to teach about the illness and to develop coping skills to manage symptoms (e.g., controlling overstimulation, cognitive restructuring). For older adults who heard voices, Lee and her colleagues (Lee, Hannan, van den Bosch, Williams, & Mouratoglou, 2002) noted the importance of providing a safe and accepting environment and assisting group members in learning new coping skills for dealing with auditory hallucinations. The most valuable aspect for older adult group members was the recognition that there were others who also heard voices, which helped decrease feelings of isolation and to increase confidence (Lee et al., 2002).

Prevention Groups

Preventative groups are increasingly being used to support physical and mental health in older adults to improve overall quality of life. The purpose is to provide group members with knowledge and skills to avoid harmful situations, while enhancing members' strengths (Conyne & Harpine, 2010). Prevention groups have been utilized with older adults for pain reduction, anxiety control, and development of social skills. One example of a useful prevention group intervention is a cognitive-behavioral group focusing on psychosocial factors to prevent falls (Zijlstra et al., 2011). Sessions were aimed at increasing group members' realistic views of falling, increasing awareness of fall risks, and increasing safe activities and behaviors. For example, group members identified their thoughts related to the fear of falling and then recognized the unhelpful thoughts and their effects on feelings and behaviors. In another session, group members learned about misconceptions regarding physical exercise for older adults, identified their own barriers for becoming more active, created a list of how to overcome these barriers, and then practiced simple physical exercises. The authors provide a detailed outline of the topics explored over the eight weeks, including exploring thoughts and concerns about falling and practicing safe behaviors.

Another useful preventive model is a smoking cessation group for older adults (Thomas, Supiano, Chasco, McGowan, & Beer, 2009), focusing on social support, education, and skill-building strategies. The program utilized a three-part model, asking group members to think about physical addiction, psychological or learned behaviors, and social factors that maintain smoking behaviors. Great care was given to resolving issues of isolation and loneliness for the older adults because this was often a significant factor. Physical limitations of the older adult must be taken into account when devising a plan for behaviors that replace smoking.

Best Practices: Planning

In preparation for group work with older adults, leaders need to understand the aging group member in relationship to cohort, ethnic-racial background, and aging-related changes. Clinical skills and practical considerations such as group compositions and reducing barriers for older members are also important while planning for the group.

Understanding the Older Group Member

Those over the age of 65 are a heterogeneous population (Stoller & Gibson, 2000), with differences spanning race/ethnicity, socioeconomic status, sexual orientation, religious preference, and geographic location. Based on their cohort group, historic, social, religious, and economic factors have influenced their lives and set the stage for social and familial norms. For example, those over the age of 85 experienced World War II, the popularization of owning a television, and crooners like Frank Sinatra in comparison to the Baby Boomers (65–74 years old) who came to age during the Vietnam War, spaceflights to the moon, and The Beatles. Ethnic minority older adults have each lived years with unique racial and societal views. For example, given the general exclusion from much of the movement's leadership and policies, a woman of color may have quite a different perception of the advent of feminism and the women's liberation movement compared to her White female peer (Enns, 2004).

Culture may impact how older adult group members treat one another, how they experience an illness, or their willingness to participate in a group format. For example, Arab Americans are typically thought to have unique family support, and thus it may mistakenly be assumed that an older Arab American group member's needs are taken care of by his family (Ajrouch, 2007). A Latinoa member of the group may be more comfortable with a larger number of members, and view the group as “a family” related to a high value for collectivism and the notion of *familismo* (Lee & Ayon, 2005). In a group focusing on relaxation, an Asian American member may tend to describe her symptoms of anxiety through somatic-focused complaints such as headaches and digestive issues. Another group member may express a desire to keep “difficulties” within the family, and continue to be hesitant in sharing with the other group members. A group member who is Native American may identify a belief in pursuing alternative options such as meeting with a spiritual healer in addition to attending group counseling.

Each older group member can best be understood through a multifaceted lens of intersecting identities (Vacha-Haase, Hill, & Bermingham, 2012). For example, the group worker might consider a “multifarious jeopardy” hypothesis (Vacha-Haase, Donaldson, & Foster, in press) that includes intersection of not only race-ethnicity and age but additionally gender and cohort. That is, older women and men of color face what might be considered a multidimensional phenomenon because they integrate gender role messages with cultural values and continuing experiences with racism at the same time they are experience the aging process.

Age-Relevant Changes

Aging across the life span brings with it positive aspects, such as increased cognitive complexity, enhanced emotional regulation, and development of expertise through experiences with work, family, and society. Group counseling with older adults can capitalize on the positives as members bring maturity and years of experience to the topics discussed.

However, group workers will also need to be sensitive to the age-related challenges. Those in their later years may experience a declining health status with increased disability and mortality with considerable variation across physical, cognitive, and emotional levels of functioning. Although aging is not equivalent to poor physical health, older adults are more likely to suffer chronic medical conditions that have significant impact on psychological well-being (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009). This is increasingly true with advancing age, as more than 85% of persons over 80 have at least one chronic health condition and 62% with more than one (Anderson & Horvath, 2004). Common afflictions include arthritis, diabetes, osteoporosis, and high blood pressure. Although the majority of older adults will not experience cognitive impairment, one out of five will suffer from dementia (Plassman et al., 2007), a progressive disease including memory impairment and multiple cognitive deficits that interfere with day-to-day activities.

Living Arrangements

Older adults may be living independently in their own homes, with family members, in senior living, or in institutions. The older group members who are in hospitals or LTC facilities will often be experiencing higher rates of physical illness, pain, comorbidity, disability, and cognitive deficits (Meeks & Tennyson, 2003). They may also report negative effects from the environment (Choia, Ransom, & Wyllie, 2008), such as loss of independence, lack of privacy, increased dependence on others, and issues revolving staff. Types of groups to help adjust to change for those who have recently moved and to provide psychoeducation about illness, medication maintenance, and compliance with treatment are helpful. Molinari (2003) provides an in-depth discussion of groups with older adults in LTC facilities, highlighting the need for group leaders to be directive, flexible, and supportive, noting the group process may be at a slower pace, and that sensory deficits and physical challenges are common.

Clinical Skills

The older adult's overall comfort level with the group process may require an adjustment in establishing rapport and setting group norms. Some older adults will be unfamiliar with a group format and find the group process to be unknown and disconcerting, if not outright distressful, causing them to present as hesitant, cautious, or even suspicious. Depending on the circumstances, some older adults may be frightened, embarrassed, or anxious regarding their participation in the group. General clinical skills for working with older adults are summarized in books authored by Blando (2011), Knight (2004), and Duffy (1999). Skills for group work with older adults are further explored in Wilson and Rice (2011), Drown (2008), and Toseland and Rizzo (2004).

Interdisciplinary Collaboration

Interaction with other disciplines is prominent when working with older adults (Geriatrics Interdisciplinary Advisory Group, 2006). Group workers may need to often consult with other professionals involved in the older adult's care, such as a physician, nurse, social worker, occupational therapist, or family member.

Practical Considerations

Groups with older adults should tend to be on the smaller side, usually no more than five to seven members. Group workers must be sensitive to the challenges experienced by older group members, with focus given to adaptations for their group plan. For example, older group members may require an environment that is conducive in regard to lighting, temperature, seating, and acoustics. When needed, group workers must be willing to make changes in their service delivery, such as rapport-building techniques and altered informed consent procedures. For example, larger font and easy-to-read typeface are recommended for written materials. Additional attention is needed regarding flexibility in making the arrangements for the group, such as time of day, availability of transportation, or accessibility of location. Although it depends on the type or population of the group, for example caregivers compared to those adjusting to retirement, group workers should be prepared for members missing groups due to obligations, conflicting appointments with health care providers, and medical issues that arise.

Group Composition

Group leaders must be mindful of group composition. For example, within the older adult population is a large variation of cognitive functioning, from normal decline due to aging to significant decline due to dementia. Thus, caution should be taken to ensure members are cognitively similar; that is, a group should consist of those who possess similar levels of memory functioning and thought processes. Group workers can assess this informally through a general intake or more formally through using brief screening measures such as the Mini-Mental Status Exam (MMSE; Folstein, Folstein, & McHugh, 1975) or St. Louis University Mental Status (SLUMS; Morley, 2006).

Reducing Barriers

Group workers must also recognize age-related challenges that often can bring about barriers that older adults face in comparison to younger group members. For example, when compared to younger adults, older members have a higher attrition in group therapy (Krishna et al., 2011), possibly due to practical barriers (Toseland & Rizzo, 2008), such as declining health, poor mobility or lack of transportation, and/or financial resources. Recommendations include offering educational group interventions, increasing liaisons with community providers, going to the client in the community (e.g., Senior Centers) to enhance visibility for the groups being offered, and increasing comfort level and ease of access for older group members. Men in particular are more likely to withdraw from participation during mid-group (de Medeiros, Harris-Trovato, Bradley, Gaines, & Parrish, 2007), possibly due to traditional male attitudes or fear of stigma (Vacha-Haase, Wester, & Christianson, 2010).

Recognizing Own Views on Aging

It will be important for group leaders to be aware of their own judgments or stereotypes about older adults. Ageism, the prejudice toward, stereotyping of, and/or discrimination against people simply because they are perceived or defined as "old" (International Longevity Center, 2006), is one of the most commonly experienced form of bias (Bousfield & Hutchison, 2010). Older adults not only face the gender and racial-ethnic stereotypes they have negotiated during their lives but face the added age stereotypes that come with being older in a youth-driven society, that is, a mixed "warm but incompetent" stereotype where older adults are viewed as being socially warm and accessible but no longer useful to society (Cuddy, Norton, & Fiske, 2005). Thus, group workers must be sensitive to their own life experiences and the potential for ageism during group intervention with older adults.

Business Practice

Group workers who utilize third-party payment for providing services to older adults should recognize the importance of regulatory compliance, specifically the importance of Centers for Medicare and Medicaid Services (CMS) policies, and the central requirement for *medical necessity* (Vacha-Haase, 2011). That is, CMS requires that all compensated services be "expected to improve the health status or function of the patient" with documentation supporting the intervention was "reasonable and necessary" and thus, medically necessary.

Best Practices: Performing

At the core of effectively working with older adults in groups is a strong foundation of basic clinical skills, with modifications to meet the unique complexity of needs in the later life client (Knight et al., 2009). Group workers will most likely need to be more directive at times, because the older members may not be experienced in the group process or might be more comfortable with a clear structure to the group. Older adults may look to the group workers as the "experts," waiting for them to set the agenda. At times, interactions between older group members may be somewhat informal, with a "conversational" or a "storytelling" quality.

If hearing is a challenge for any of the group members, the leaders may want to speak slightly lower, louder, and slower, remembering that maintaining eye contact is vital. During the group, the group worker may need to repeat what a group member said so that all group members are able to know what was shared. Throughout the meeting, group workers should be aware of a member's possible lowered stamina, fatigue, or pain issues. Groups may need to be scheduled for shorter time periods, allow for breaks, or even end early.

Communication

Initially, older adults should be addressed by their last name, such as “Mrs. Smith” or “Mr. Garcia.” Attention to vocabulary will be important, because older group members may not use words such as “depression” or “anxiety” but instead note they are “feeling blue,” “not felt like myself lately,” or “been down in the dumps.” More anxious group members may state they have “felt more on edge lately” or experienced a “hard time relaxing.” Use of terminology by group members will not be determined only by age but also education level, cohort, religious preference, culture, and geographical surroundings.

Group workers will also want to be aware of their own communication style to guard against “elder speak,” such as speaking too loud or slowly to an older adult who does not have a hearing impairment or using a term of endearment such as “sweetie,” “honey,” or “dear,” which may be experienced as an insult (Collins, 2008). One resource offering further guidance communicating with older adults is “Talking With Your Older Patient: A Clinician's Handbook” (National Institute of Aging, 2009).

Sensory impairments, such as vision and hearing problems, need to be accounted for in communication. Sensitivity to cultural norms may arise through body language (e.g., eye contact) and interpretations of hand gestures. A conservative approach is recommended if the racial or ethnic background of the older group member is unknown or unclear (National Institute of Aging, 2009).

Best Practices: Processing

Group workers should ensure relevant, culturally sensitive, and scientifically sound evaluation and follow-up to the groups they conduct with older adults. Unfortunately, assessment with older adults can often be challenging given the limited number of assessment instruments that were developed specifically for this population. In addition, care must be taken even when using measurements that include norms for those over 65 years of age because it is important for outcome measures to be appropriate in regard to content, length, level of complexity of instructions and format. Further difficulty in assessment with older adults stems from the heterogeneity of the population, as well as the rates of comorbidity of cognitive, physical, emotional, and functional aspects. Thus, expertise in the basics of assessment must be relied on, but with an additional skill set incorporated such as the inclusion of knowledge regarding the aging process. Additional information is available for implementing assessment procedures (Vacha-Haase, in press) and group outcomes measures (Vacha-Haase, Balhan, Brescian, Martin, & Fitzpatrick, 2009).

Future Directions

Although progress has been made, much more is needed in empirical advancements in group counseling with those over the age of 65, because older adults should be included in ongoing practice, theory development, and research on groups. Unfortunately, the majority of current group research does not include groups with older adults. In the studies that do focus on those in later life, a need for more rigorous empirical investigation exists, with the utilization of both quantitative and qualitative methods (Molinari, 2003). Larger sample sizes, clarity of criteria for participation, and more thoroughly developed rationale for implementation of particular interventions will help move the area forward. With the additional development and implementation of outcome measures (Vacha-Haase et al., 2009), clinically based empirical investigation focusing on evidence-based groups with older adults will help answer the many questions that continue in the literature.

From an applied standpoint, it would be advantageous for a prevention-based outlook to evolve for group counseling with older adults, because the need for a preventive approach with an older adult population is undeniable. An empirical review to identify critical gaps in clinical preventive areas (Centers for Disease Control, 2011) identified both smoking cessation (Maciosek et al., 2006) and counseling interventions to promote sustained weight loss for obese adults (U.S. Preventive Services Task Force, 2009). Another area, unique to older adults, is that of fall prevention. Thus, prevention groups may be the way of the future as, "The purpose of prevention groups is to enhance members' strengths and competencies, while providing members with knowledge and skills to avoid harmful situations or mental health problems" (Conyne & Harpine, 2010, p. 194).

Conclusion

Mental health needs for older adults have remained consistently unmet (Palinkas et al., 2007). Thus, with the increasing demands, as well as the mounting evidence of efficacy, group work with older adults is an emerging area of practice.

Group members in their later years bring years of experience, as well as unique traits from years of living. Age and culturally appropriate solutions that address both prevention and treatment represent the best strategies for addressing the challenges facing the growing older adult population, with group counseling offering a powerful intervention.

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Chapter 23 Using Groups to Facilitate Social Justice Change: Addressing Issues of Privilege and Oppression

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There has been much discussion about the roots of social justice in counseling (Crethar, Torres Rivera, & Nash, 2008; Goodman et al., 2004). This "return" to our values of social justice change and advocacy in counseling has extended to the practice of group work, leading to examination of group interventions with a different lens. Social justice is a critically important aspect of group work, because group leaders and members each have intersections of identities related to privilege and oppression. Just as scholars have asserted all groups are multicultural in nature (DeLucia-Waack & Donigian, 2004), all groups are microcosms of the social inequities that exist within society at large (Singh & Salazar, 2010a; Smith & Shin, 2008). Attending to social justice issues within group work is "collaborative in nature, emphasizing empowerment, self-determination, advocacy, and change" (Singh & Salazar, 2010a, p. 98).

There are many types of groups leaders may facilitate—from task groups and psychoeducation groups to psychotherapy groups—and social justice concerns are evident in all group work. Group leaders' efforts to facilitate members' sense of belonging, ownership in the group process, and collaborative work toward individual and collective goals are rich with opportunities to nurture members' empowerment to enact personal change in their own lives. Social justice group work brings added dimensions of awareness, understanding, and potential for social change. As leaders help members increase their ability to understand their individual and shared experiences of privilege and oppression and begin framing these experiences as systemic problems, members feel more empowered to change and become advocates for themselves and perhaps become agents of change for others. Building on a foundation of multicultural competence, social justice-minded group leaders put into practice the social justice principles of equity, access, participation, and harmony described by Crethar et al. (2008) when planning, performing, and processing groups. As leaders help members increase their awareness and critical consciousness, they are mindful of group members' needs and the context in which the group takes place. They are further mindful that empowerment is a process of discovery and change that occurs within and among group members. Empowerment is not the leader's to bestow.

We have organized the chapter into five major sections: (a) concepts of privilege and oppression in social justice group work, (b) history of social justice interventions in group work, (c) guiding principles for multicultural and social justice competence, (d) social justice group work strategies, and (e) examples of social justice groups. The chapter ends with a vignette illustrating social justice-minded group leadership in action.

Understanding Social Justice and Group Work 101: Privilege and Oppression

To fully understand social justice and group work, it is important to expand on the constructs of *privilege* and *oppression* (Burnes & Ross, 2010; Smith & Shin, 2008). Social justice group work acknowledges that the ideal of meritocracy prevalent in U.S. society—if you work hard success will automatically follow—is a myth (McCoy & Major, 2007). In contrast, a social justice perspective acknowledges that there are systems of privilege and oppression that mold and shape opportunities for individuals, groups, and communities (Singh & Salazar, 2010a; Smith & Shin, 2008). *Privilege* refers to the unearned advantages individuals possess based on their identities associated with dominant groups (e.g., White, straight, owning-class, able-bodied; Bell, 2010). *Oppression* refers to inequitable, unjust, and discriminatory treatment of those whose identities are assigned less access to advantages, such as people of color; women; lesbian, gay, bisexual, transgender, queer people questioning (LGBTQQ); people living with disabilities; and people who are poor or working class (Bell, 2010). (See Table 23.1: Dimensions of Identities and Related Systems of Oppression.)

Often, social justice practice emphasizes oppression and its effects more than privilege (Israel, 2012). One reason is that privilege is hard to define, understand, notice, and identify. The Task Force of the American Psychological Association Division 17 (Counseling Psychology) on *Exploring Privilege* was charged with defining privilege; they concluded, "*Privilege* is comprised of unearned advantages that are conferred on individuals based on membership in a dominant group or assumed membership." Privilege has the following characteristics: (a) it "reflects, reifies and supports dominant power structures"; (b) it is "supported structurally and systemically, including an investment in maintaining a lack of consciousness about the benefits and costs resulting from that privilege"; and (c) it is "enacted through societal structures, systems, and daily interactions" (Israel, 2012, p. 166). Further, "a single individual may experience intersecting privileges and oppressions which may reflect differential receipt of benefits" (Toporek et al., 2011, p. 2).

Dimension	Privilege	Oppression	System
Race/Ethnicity	White	People of Color	Racism
Sexual Orientation	Straight	LGBTQQ	Heterosexism
Gender	Man Cisgender	Women Transgender	Sexism
Migration	Citizen	Immigrant	Nationalism
Social Class	Owning class Middle class	Poor Working class	Classism
Ability	Able-bodied	Mental disability Physical disability	Ableism
Age	Adults	Young people Older people	Adultism Ageism
Religion	Christianity	Muslim, Buddhist, Jewish, Pagan	Religious

Although a helpful beginning place to explore social justice is with privilege, group leaders must also understand the construct of oppression as it manifests in interpersonal interactions and intrapersonal belief systems (Smith & Shin, 2008). For instance, systems of oppression operate through individuals—and therefore, also are evident in interpersonal relationships. Feminists have historically used the phrase "the personal is political" (Worrell & Remer, 2003, p. 48) to identify the impact systems of oppression have on the lives of individuals. An important skill for group leaders is the ability to identify the impact of oppression on individual members. Furthermore,

group leaders should develop awareness of the impact of oppressive systems in their own lives in order to best support members in doing the same. Oppression resulting from forces outside the individual can also become internalized (Bailey, Chung, Williams, Singh, & Terrell, 2011). Therefore, group leaders must be able to identify and process within a group how members internalize oppression experiences. To do so, leaders must first engage in self-reflection on their own identities, the degree to which they have internalized oppressive messages, and the effects on their sense of personal and professional self-hood. For instance, a queer Latina would explore how she has internalized messages of sexism, heterosexism, and racism and then seek to understand how these internalized messages influence her group leadership and ability to identify and process group members' internalized oppression.

There has been a growing body of research in recent years examining the impact of various forms of oppression on well-being, including links between racism and various physical illnesses (Brondolo, Brady ver Halen, Pencille, Beatty, & Contrada, 2009), poverty and access to mental health services (Hernandez, Montana, & Clarke, 2010), heterosexism and internalized homophobia (Weber, 2008), and sexism and career outcomes for women (Coogan & Chen, 2007). Therefore, the value of social justice group work becomes more evident in light of current disparities in mental and physical health (Smith & Shin, 2008). Because the goals of group practice include developing a sense of universality among group members (Rubel & Ratts, 2011; Yalom & Leszcz, 2005) and providing a site for individual change (Burnes & Ross, 2010), there are multiple opportunities for group leaders to validate members' experience of oppression and help members identify advocacy strategies to increase their access to needed resources (Singh & Salazar, 2010b). For instance, group leaders can infuse a social justice approach into their leadership no matter the type of group they are facilitating (e.g., task, psychoeducation, counseling, psychotherapy) by understanding how privilege and oppression experiences shape the lives of members and leaders, as well as group dynamics. However, leaders can also seek to develop groups in which the overall purpose is to explore issues of diversity, multiculturalism, and social justice more directly through engaging in "difficult dialogues" or "courageous conversations" (Singh & Salazar, 2010b).

History of Social Justice within Group Work

The term *social justice* may be relatively new in group work, but the values underlying social justice practice are not. The major tenets of social justice—attention to inequities, advocacy, and empowerment strategies for members of historically marginalized and oppressed populations—are woven throughout group work's history (Singh & Salazar, 2010a).

Many people are familiar with Jane Addams' work at Hull House helping people develop life skills to not only access basic resources for living but also find community in one another. Considered the founding mother of social work, Addams' feminism and political-mindedness informed and infused her work. Her group work focused on the social justice issues of poverty, homelessness, public stigma related to chronic illness (e.g., tuberculosis), and advocacy in order to promote positive social change. She strategically identified the resources (political and otherwise) and the systems (e.g., churches, government agencies) she needed to support her work (Jane Addams Hull House Association, 2011).

Historically, group work has been a powerful catalyst for the enactment of positive social change, in modalities ranging from psychoeducation groups (Pope, 2009) and consciousness-raising groups (Worrell & Remer, 2003) to community organizing (Alinksy, 1971). Therefore, we have rich examples of what this work "looks like." Similarly, when one thinks of common knowledge about Rosa Parks, it is typically her famous refusal to move to the back of the bus when requested to do so by a White man (National Association for the Advancement of Colored People, 2011). However, a closer look at what actually happened that day reveals Parks' action to be a strategic part of her training within a more progressive arm of the civil rights movement—where many civil disobedience actions were planned within a group setting (Kohl & Edelman, 2005). One can also look to the consciousness-raising groups of the women's liberation movement, where women and men would gather separately and together to identify the impacts of sexism on their lives (Worrell & Remer, 2003). In addition, transgender people of color were at the center of the Stonewall Riots of 1969, which is acknowledged to begin the U. S. gay liberation movement; however, this same group is often discriminated against today within the larger gay, lesbian, and bisexual movement (Carter, 2004).

Much of the scholarship on group work history focuses on group modalities used since the 1920s, with major emphasis on White, Western, and male theorists and practitioners. Therefore, social justice-minded group leaders must become "archaeologists" to discover the many influences on and uses of group work beyond these contexts. In addition, the history that is traditionally discussed as the roots of our profession should be questioned and examined for the missing voices, typically those of historically marginalized groups. Many lessons can be learned if group leaders seek answers to the following questions about any group they are planning: (a) What are the social justice roots of this issue, concern, or group modality? (b) What information do I have or do I lack about its history? (c) What are the multicultural considerations regarding its history? (d) How do my personal cultural identities and experiences with multiculturalism and social justice influence the historical knowledge I have and the knowledge I lack?

To illustrate, Anna, a novice middle school counselor, noticed the high number of African American boys in her school with multiple discipline referrals for disruptive behaviors and negative attitudes. Enthusiastic about group work, she planned an anger management group and was surprised and discouraged when several parents called to express displeasure at receiving a permission letter for a group for "African American boys with aggressive behavior." After talking with several colleagues about what happened, Anna began to realize that as a White woman with little multicultural training, she might not fully understand the multicultural and social justice issues surrounding anger in African American boys. After doing some "homework" on the issues, she learns that African American boys are often overrepresented in discipline referrals. Anna further discovers she must be alert to stereotypes about "angry Black males," more knowledgeable about possible misinterpretation of body language and tone of voice, and the effects of discrimination on African American boys' anger and hostile views of relationships (Simons et al., 2006). She finds research and other materials (e.g., Chambers & McCready, 2011; Franklin & Pack-Brown, 2001) that will help her rename and redesign her group intervention, moving from a

problem-based approach to an empowerment perspective that is sensitive to historical and current factors that impact the lives of African American boys.

Social Justice and Group Work: Guiding Principles for the Field

In 1999, the Association for Specialists in Group Work (ASGW) published the *Principles for Diversity-Competent Group Workers* that detailed the competencies necessary for "understanding how issues of diversity affect all aspects of group work" (p. 7). The document was a significant step toward integrating much of the multicultural group work scholarship and the emphasis on cultural competence within counseling overall. ASGW's endorsement of the diversity principles signaled the organization's recognition of multiculturalism as a key component of group work and that "issues of diversity affect group process and dynamics, group facilitation, training, and research. As an organization, we recognize that racism, classism, sexism, heterosexism, ableism, and so forth, affect everyone" (p. 7).

Despite recognition of the effects of oppressive systems, the document's focus was primarily on multicultural competence. In light of increasing attention to social justice competence that has taken place in the profession in recent years, ASGW's diversity principles have been revised. The revised document, the *ASGW Principles for Group Workers Seeking Multicultural and Social Justice Competence* (2012; see www.asgw.org), reflects revisions in five primary areas. First, a more specific privilege and oppression framework is used to reflect the rich literature on social justice advocacy that has appeared since the original document was created (e.g., Constantine, Hage, Kindaichi, & Bryant, 2007; Crethar et al., 2008; Hage & Kenny, 2009; Singh & Salazar, 2010b; Vera & Speight, 2007). This framework helps clarify, explain, and strengthen the overall position of the relationship between multiculturalism and social justice within group work competence. Second, the revised document expands intervention strategies for group leaders. It focuses on the influence of both multicultural and social justice issues with regard to areas such as the role of group leaders and members, group dynamics, group screening, planning, and interventions. Third, the authors revised the document with an awareness of how it might be used in tandem with other American Counseling Association (ACA) competency documents, the ACA *Competencies for Addressing Spiritual and Religious Issues in Counseling* (2009a), the ACA *Competencies for Counseling Transgender Clients* (2009b), and the ACA *Advocacy Competencies* (Lewis, Arnold, House, & Toporek, 2002).

Fourth, the original document was commendable for recognizing a range of identities; however, some of the language and terms used were in need of updating (e.g., "transgendered" versus "transgender" and use of the word "tolerance" rather than "acceptance" with regard to interactions with diverse cultural groups). Finally, the new document includes case studies describing a group leader seeking to expand multicultural and social justice competence to showcase how the competencies might be used in action. In addition to having familiarity with the multicultural and social justice competencies within this document, group leaders can develop strategies to implement these competencies within their work, as discussed below.

Six Strategies for Social Justice Group Work

Singh and Salazar (2010b) analyzed 20 social justice group work articles, revealing six strategies for social justice group work that exemplify what group leaders are doing today to engage in social justice change and provide a source of inspiration for future group work. We discuss each of these strategies below and integrate best practices in group work within the description of each strategy.

The Use of Group Work for "Courageous Conversations" on Social Justice Issues

Integral to developing social justice competence is the ability to initiate discussions about multicultural and social justice concerns. Sometimes referred to as "difficult dialogues" (e.g., Sue, Lin, Torino, Capodilupo, & Rivera, 2009), group explorations of difference and diversity can be or should be reframed as "courageous conversations" (e.g., Singleton & Linton, 2006). The difficulty of these group engagements is because of the intense emotions they engender; consequently, full engagement requires courage by both leaders and members.

Because issues of social justice are present and affect group dynamics in a variety of settings and types of groups—from workplaces to schools and counseling agencies—group leaders must develop the critical skills of planning, performing, and processing "courageous conversations" in groups in these settings. For instance, group leaders are often brought in to workplaces as "outside consultants" to facilitate conversations about how issues of diversity, multiculturalism, and social justice shape interpersonal relationships. It is important that leaders plan for more than one session for these types of groups so that group leaders have the time and resources to fully engage members in a deeper exploration within these courageous conversations. Another example is a professional growth group for counseling trainees in which the focus of the group is supporting trainees as they explore their interpersonal and intrapersonal belief systems related to privilege and oppression. This type of group can also be facilitated so that trainees understand how their experiences in the professional growth group might mirror some of the awareness and skills they will need to develop when leading similar groups. A final example is group leaders' engagement with community organizations to help identify, process, and address issues related to diversity, multiculturalism, and social justice that are influencing their service delivery and relationships with one another.

Skilled group leaders already possess abilities Sue et al. (2009) identified as necessary to facilitate difficult dialogues: knowledge of group dynamics and the ability to (a) distinguish content versus process, (b) help members actively listen to and hear one another, and (c) acknowledge and validate members' feelings as well as their own. Along with these essential skills, group leaders need to enhance their critical consciousness—that is, their awareness of sociocultural dynamics of power and privilege. Friere (1971) called this process *conscientization*—the ability to understand the forces systems of oppression exert on individuals' lives and the ability to seek justice based on this understanding and awareness. Such awareness enables leaders to address oppressive dynamics as they appear in their groups and facilitate collaborative relationships, enhancing growth and learning across differences. For instance, some questions to translate social justice awareness into performing and processing of groups include the following: How does my own level of cultural identity development affect my ability to hear and respond to the experiences of group members? What topics (e.g., racism, sexism, homophobia, ageism) do I tend to avoid, and why? How do I overcome my reluctance and fear to engage in these topics? What have been my successes as well as failures in facilitating courageous conversations, what contributed to each, and what might I do differently next time?

The Centrality of Multicultural Competence

Multicultural counseling competency is implied as a given strategy in the work of social justice– minded group leaders, regardless of group topic, because issues of social justice, privilege, and oppression are attached to multicultural identities, values, and belief systems (Singh & Salazar, 2010b). Social justice scholars have described the interplay between multicultural competency and social justice (Rubel & Ratts, 2011; Singh & Salazar, 2010b). Group workers cannot develop the awareness, knowledge, and skills needed to work with a specific cultural group without a simultaneous understanding of the specific social justice issues of equity and access to resources related to cultural identities (e.g., Crethar et al., 2008; Ratts, 2011). Ibrahim's (2010) model of intentional planning to teach strategies to examine culture and privilege in group work and Paisley, Bailey, Hayes, McMahon, and Grimmett's (2010) model for enhancing school counseling trainees' commitment to social justice are illustrations of the intersection of both. Others emphasize the need for group leader cultural competency when addressing social injustices with specific populations, by using a culturally grounded counseling style and culturally relevant symbols (McWhirter et al., 2010) or being sensitive to the importance of language of origin in facilitating a climate conducive to group members' empowerment (Nitza, Chilisa, & Makwinja-Morara, 2010).

Attempts to enact social justice empowerment and advocacy strategies without grounding in multicultural competency have the potential to reinforce the status quo and do inadvertent harm. Therefore, it behooves group leaders to view social justice and multicultural competency as intertwined processes of learning and practice. When planning group interventions, culturally competent social justice–minded group leaders ensure the goals, objectives, member screening, and evaluation of the group (ASGW, 2000) are grounded in acknowledgments and reflection on the relevant multicultural and social justice issues for the group at hand.

The Interplay between Content and Process

Much of the scholarship on social justice– minded group work focuses on the group leader strategy of intentionally planning and leading groups to address specific social justice issues. Singh and Salazar (2010b) found that although the content of these topic groups varied (e.g., groups with students of color, undocumented students, indigenous people of the United States, transgender people, and international group work), the processes leaders used to plan and conduct the groups and facilitate member empowerment are similar. Strategies include (a) collaboration with group members to identify social justice–oriented group goals, (b) identification and validation of the impact of privilege and oppression on members' lives, and (c) facilitation of member explorations about the access they need to important resources in order to actualize their potential. Conversely, some (e.g., Burnes & Ross, 2010; Newton, 2010; Ratts, Anthony, & Santos, 2010) have developed models for incorporation of social justice consciousness into group practice. Three important strategies from these models follow.

Increasing Leader Ability to Discuss and Integrate Social Justice Group Work into Traditional Group Work

Ratts et al. (2010) provided leaders with a conceptual model for understanding the degree to which social justice is actualized in groups and for transforming their traditional group work into a socially just framework. The authors' *Dimensions of Social Justice Model* contains five dimensions that describe the group's experience of social justice concerns: (a) naiveté, (b) multicultural integration, (c) liberatory critical consciousness, (d) empowerment, and (e) social justice advocacy. Utilizing this model helps leaders infuse social justice consciousness and action according to the developmental needs and readiness of both group leader(s) and members by planning interventions that facilitate growth through the model's stages.

Increasing Leader Awareness of Social Class and Classism to Enable Leaders to Address These Forces with Members

Newton (2010) encouraged group leaders to explore their own class-related values and worldviews and their own social class identity, with particular attention to how they have internalized classism. Such exploration takes place during training and supervision, as well as informal dialogues with family members and friends. Increased awareness enables leaders to attend to the impact of social class on leader-member relationships and on group dynamics (e.g., subgouping, member marginalization, group conflict). Newton recommended Liu, Soleck, Hopps, Dunston, and Pickett's (2004) Modern Classism Theory (MCT) and Social Class Worldview Model (SCWM) as frameworks to help group leaders assess the impact of social class on group dynamics and plan and implement interventions.

Developing Leader Awareness of and Ability to Address Oppression and Marginalization Occurring in Groups

Burnes and Ross (2010) identified specific strategies for recognizing and addressing oppressive dynamics in groups. First, group leaders need to intentionally strive for diversity of group membership and avoid having token members of a marginalized community. Second, leaders should use prescreening sessions and the first few sessions of group to assess the group's ability to handle discussions of oppression before they process issues of social justice. Third, it is important for leaders to facilitate consciousness raising and create awareness of social justice in group members. Leaders can accomplish this goal by processing issues of oppression as they occur during group through the use of structured activities to facilitate dialogue about issues of privilege and oppression.

The Influence of Privilege and Oppression

An important strategy for developing social justice competence is to explore how privilege and oppression affect the types of groups offered, group settings, group stages, leader's and members' roles, and evaluation methods. In any group, leaders and members affect and influence each other yet power and privilege are often left unaddressed. In social justice–minded group work, leaders take steps to (a) not only reflect on the interaction of their own positions of power and privilege with that of the group members, but also (b) overtly address the dynamics of power and privilege in group among group members and between members and leader (Singh & Salazar, 2010b). Such reflection and action can be accomplished in a variety of ways, such as sharing power with group members (e.g., collaborating with members in choosing topics to decrease members' feelings of marginality and invisibility in their lives outside group) and asking specific questions of themselves and group members that highlight power dynamics (e.g., How did the interaction that just occurred marginalize some of the group members, and in what ways? What can we do differently?). In addition, leaders work to understand group members' needs with regard to the injustices they face and their efforts toward empowerment rather than viewing members' needs through the lens of their own agendas and notions. For instance, if leaders share a cultural identity with members (e.g., race/ethnicity), the leader cannot assume that members experience the world as they do.

Experiential activities carefully chosen, conducted, and processed (ASGW, 2000) with attention to group composition and members' readiness can be powerful vehicles for bringing awareness of privilege and oppression into the immediacy of group interaction. Further, they help facilitate group members' identification with each other across differences. Examples of group activities that do this include *Learning From the Margin: Power Line Exercise* (Comstock, 2006) and *Level Playing Field* (Jackson, 2009).

The Effects on Power Dynamics within and outside Groups

As group members develop their critical consciousness and are more able to understand their individual experiences as systemic problems, the potential increases for power dynamics to shift not only within the group but outside the group as well. Therefore, a critical social justice skill is to understand how this potential for change ranges from individual empowerment and self-advocacy—as in Coker, Meyer, Smith, and Price's (2010) groups for mothers experiencing homelessness—to systemic intervention at the community or school level and as in Shin et al.'s (2010) transformative groups for youth of color in urban schools. Moving even further into systemic intervention, group processes can be applied on a large scale—as in Malott et al.'s (2010) national-level advocacy project to address social injustices and generate change. An essential strategy for group leaders is to recognize group members' empowerment needs from the perspectives of group members themselves and to facilitate changes most suited to those needs.

The Use of the Action Continuum as a Guide for Intervention

Because social justice is so strongly linked to action (Singh & Salazar, 2010b), before initiating action, group leaders must identify the readiness of individuals and contexts (e.g., schools, agencies, communities) to address social inequities and engage in social justice change. Adams, Bell, and Griffin's (2007) action continuum helps group leaders strategize as they plan and implement social justice interventions. The eight-point continuum spans *actions against inclusion and social justice* at one end to *actions supporting diversity and social justice* at the other. Each point describes a stage of individual and collective response to injustices that characterizes communities and organizations, as well as individuals within these contexts (e.g., actively participating in discrimination, denying and ignoring injustices, initiating change and preventing injustices). Group leaders can use these points to assess which type(s) of groups might be most effective, given the context in which they work. For example, leaders working in settings that ignore, deny, or minimize discrimination or injustices could create informal as well as formal opportunities to facilitate courageous conversations. Such conversations could validate the anger and frustration experienced by members of marginalized groups, increase awareness, and promote intergroup dialogue.

Each of the eight points on the continuum also provides opportunities for leader self-assessment. Leaders consider questions such as (a) what prevents them from taking action; (b) what is the nature of their fears and how realistic are they; (c) what support do they need, and from whom, for challenging their biases and fears; and (d) what knowledge and skills do they need and how will they gain them? Leaders can use the continuum to assess their readiness to work *collaboratively* with group members and communities in ways that are culturally sensitive and mutually empowering.

Social Justice–Minded Group Practice for Specific Populations

The group work literature includes social justice group practice put into action with a variety of populations. Below are brief examples drawn from groups for survivors of trauma and for members of specific cultural groups.

Groups for Survivors of Trauma

Social justice–minded group interventions for survivors of trauma include, but are not limited to, empowerment groups for survivors of intimate partner violence (IVP; Chronister & Davidson, 2010), adults experiencing homelessness (Brubaker, Garrett, Torres Rivera, & Tate, 2010; Coker et al., 2010), and long-term unemployed adults (Bhat, 2010). For example, Chronister and Davidson found that in their program designed to enhance the critical consciousness of women IVP survivors, as group members' critical consciousness increased they became more able to enact change in their lives. The authors outlined six group processes to promote critical consciousness: (a) *collaborative dialogue* that recognizes the value of the women's skills and experiences; (b) *group identification* to foster a cohesive, safe, and supportive environment; (c) *posing problems* with the goal of collaboration among leader and members to facilitate critical thinking about problems and possible solutions; (d) *identifying contradictions*—that is, naming inconsistencies between a woman's perceptions and the reality of her actual experience; (e) *power analysis*, in which group members examine how power is distributed and used in a given situation (e.g., in their families, in their interactions with social service agencies, in the work place); and (f) *critical self-reflection*, in which the women increase their awareness of personal experience of privilege, power, strengths, weaknesses, and biases.

Another example is Coker et al.'s (2010) work with young mothers experiencing homelessness, a population that sometimes overlaps with the one described above. In planning and conducting personal growth groups with these women, the authors were guided by the four social justice principles of equity, access, participation, and harmony. Their goal was to create a therapeutic environment in which the women could explore their lives, identify personal goals, and develop strategies for improving life for themselves and their children. Coker et al. outlines recommendations for group leaders. First, pay attention to the perceived power differential between residents and group facilitators as residents may view group leaders as outsiders and/or part of the "system." Such perceptions may affect trust and safety, limiting willingness to self-disclose and explore concerns. Recommendations include visiting or volunteering at the shelter ahead of time to allow residents opportunities to develop a measure of trust, and providing community service in other environments homeless women might frequent, such as churches and food banks, to increase counselors' visibility as potential resources.

Culture-Specific Groups

Social justice group work is a powerful vehicle for facilitating empowerment and advocacy for members of specific cultural groups experiencing marginalization. Examples include Nitza et al.'s (2010) psychoeducational group for empowerment and HIV/AIDS prevention for adolescent girls in Botswana, McWhirter et al.'s (2010) culturally grounded therapy group for urban American Indian women, Dickey and Loewy's (2010) group work with transgender clients, and Delgado-Romero and Wu's (2010) "conversation" group for Asian international students in counseling programs. Each illustrates the interplay between cultural sensitivity and social justice empowerment and advocacy. For example, the goals of Nitza et al.'s group were heightening the girls' awareness of restrictive social norms and expectations and helping them develop efficacy and skills to combat the barriers they face. Strategies included culturally congruent activities, such as deconstructing and "rewriting" messages found in traditional Batswana myths, song lyrics, and proverbs that are disempowering to women.

Social Justice–Minded Group Leadership in Action

Opportunities arise in any group to implement social justice–minded group leadership, not only in those with an intentional social justice focus. The following vignette illustrates considerations for social justice group work put into action in a personal growth group:

> Shiloh, the group leader, is White, heterosexual, and identifies as a woman. She has been a licensed professional counselor for eight years. The group members are three White women (Amy, Christa, Michelle), two African American women (Keisha, Tonya), and one mixed heritage African American and Mexican American woman (Laurie). In the third week, Shiloh notices that only the three White women are sharing stories about their struggles to find their "voice" in their personal and professional lives. She also notices the slightly puzzled looks on the faces of the three women of color as they silently listen. Reflecting on these observations, Shiloh realizes that considerations of cultural identity, racism, and sexism could all be at play. She recognizes the potential for the women of color to become silenced and their experiences marginalized if the discussion continues to focus only on the White women's experiences. She sees the opportunity to facilitate a courageous conversation and does a quick self-assessment. She asks herself how ready she feels to start the dialogue (scared and unsure of herself but willing to try). She also asks herself what holds her back (fear that the White women will see her as needlessly bringing up race; fear that the women of color will view her, a White woman, as patronizing if she calls attention to their silence).
>
> Despite her fears, Shiloh intervenes before the opportunity is missed. She takes the first step in facilitating a courageous conversation by bringing her observations to the group's attention: "I have noticed it is Amy, Christa, and Michelle, all White women, who have shared their frustration at not having a voice and their struggles to find their voice and speak it. I am curious whether it is the same situation for the women of color in this group." Keisha, one of the African American women, speaks up: "I've *never* had to *find* my voice. From the time I was a little girl, my mother told me I had to speak up for myself because I could never be sure anyone else would do it for me." Laurie says her Latina grandmother and her African American aunt told her the same thing. Tonya chimes in, saying when she does speak her mind, especially at work, she is often "criticized for being angry, intimidating, or just too loud. It's that angry Black woman image that's used against us." Keisha and Laurie agree.
>
> Shiloh now sees an opportunity to open up the dialogue further so the women can learn from each other and recognize that both sides of the picture are "reality." She asks the White women about their reactions to Keisha, Tonya, and Laurie's stories. Christa, Michelle, and Amy share that they had not thought about how women of color might have such a different experience of "voice" and speaking their mind than they do, as White women. Shiloh then follows up, exploring with the group each of these questions: "How do we want to explore issues of race and other identities in this group? How do experiences of our racial/ethnic identity affect our interpersonal relationships in general? How do these experiences affect what group members share and do not share about their lives?" As the group members respond to the questions, Shiloh judges the readiness of the members to engage in genuine dialogue about race, power, and privilege and intervenes as needed. For example, when she notices the White women are struggling a bit, she discloses some of her own experiences as a White woman as a way to model this type of exploration for the group.

As you think about the above vignette, consider the following questions:

1. What is your general reaction to Shiloh's intervention? What would you do if you were leading this group? How similar or different would it be from what Shiloh chose to do?
2. If the discussion was not about race/ethnicity but was instead centered on identities such as sexual orientation, social class, or ability, how might Shiloh address these identities within the group?

Conclusion

In this chapter, we have discussed the central relevance of social justice values and action in group work. As U.S. society and the world continue to change, there will be increasing need for culturally competent group leaders who are prepared to assess the specific kinds of groups needed to address social justice issues and to take action with culturally relevant social justice– minded group practice.

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Part IV Introduction to Counseling and Psychotherapy Groups in Special Settings

Janice L. DeLucia-Waack

While group practice can be viewed as a specialty, it is also quite diverse in its focus. Group goals, population, diversity, and age all impact the specific approach and interventions used. In addition, the setting in which the group is offered greatly impacts the makeup of the group. Our intent in this section, "Counseling and Psychotherapy Groups in Special Settings," is to highlight settings that groups typically occur in and provide guidelines for best practices based on the unique structure, climate, and parameters of each setting. Groups are being increasingly utilized in many settings as a counseling modality due to both recognition of their efficacy and also cost-effectiveness.

The lead chapter is this section integrates science and practice so that practice informs science and science informs practice. Macgowan and Hanbidge describe a model to advance our knowledge of groups by suggesting a framework in which to pose practice-based questions and then how to use empirical data to answer these questions. Their model is described in an easily understandable way with eloquent examples. From a group practitioner perspective, Macgowan and Hanbidge provide guidelines on how to locate, evaluate, and incorporate current group research into future groups to answer questions that arise from leading (or preparing for) a specific group with a specific population in a specific setting. Following that chapter, the rest of the chapters provide a reference point to begin to examine current research and practice within individual settings. Falco and Bauman review current research on groups in the schools, focusing their recommendations on psychoeducational and counseling groups as the most utilized types of groups in schools. They highlight legal and ethical challenges unique to schools (and working with minors) and offer suggestions for evaluating groups in schools (important now because school personnel are increasingly being asked to be accountable and provide outcome data). Next, Whittingham advocates a systemic perspective in his chapter on groups in university counseling centers, emphasizing the importance of a group coordinator and exploring common problems that may occur (and offering solutions) such as "failure to launch" groups. He also details pregroup interventions, including inclusion/exclusion criteria and screening interviews that are critical to helping potential group members join and participate fully in groups. Rath, Bertisch, and Elliott provide up-to-date research and suggestions for best practices for groups in behavioral health settings, including psychoeducational, support, and psychotherapy groups. They discuss groups for those living with and/or impacted by HIV/AIDS, chronic pain management, spinal cord injury, acquired brain injury rehabilitation, and limb loss. Rath et al. also suggest interventions in an effort to reach out to underserved groups, including the use of technology. Les Greene and his colleagues at the VA Connecticut Healthcare System and Yale University Department of Psychiatry take on the challenge on providing guidelines for groups in the VA setting at a time when these services are increasingly being offered. Group interventions for PTSD have been shown to be effective and cognitive-behavioral group therapy in particular is an often-used treatment approach with veterans.

Chapter 24 Advancing Evidence-Based Group Work in Community Mental Health Settings: Methods, Challenges, and Opportunities

Mark J. Macgowan
Alice Schmidt Hanbidge

The integration of research into practice has been a long-standing concern in group work. The most recent manifestation of the desire to integrate the best available research into clinical settings is evidence-based practice (EBP). Although there is now much literature on the dissemination and implementation of EBPs in community settings, only recently has the process and content of EBP for group work been articulated. Pollio (2002) defined evidence-based group work (EBGW) as "the conscientious and judicious use of evidence in current best practice" (p. 57). Macgowan (2006, 2008), building on Pollio's work, outlined a multistage process model of EBGW. In recent years, there have been special issues of scholarly journals dedicated to EBP in group work (Burlingame & Beecher, 2008; Klein, 2008; Pollio & Macgowan, 2010).

Group work has increasingly been utilized in community settings, including mental health centers, community agencies, and health maintenance organizations (CMHS). However, EBP has not been widely implemented in CMHS (Mullen & Bacon, 2004). This chapter describes the different perspectives on EBP in groups and discusses a process model (EBGW) for integrating the best available evidence into group work in CMHS. To illustrate the principles in practice, a case example is included showing how EBGW could be implemented in a community setting. Challenges and barriers to advancing EBGW in CMHS are presented with suggestions for overcoming them.

Perspectives on Evidence-Based Practice in Groups in Community Settings

The term *evidence-based practice* is rooted in medicine's effort to provide the best medical care to patients (Straus, Richardson, Glasziou, & Haynes, 2005). Today there are many terms representing EBP, which can be organized into three types: empirically supported group interventions; evidence-supported group processes, techniques, and guidelines; and EBGW, which critically incorporates the other two areas. This section reviews these three areas and notes how they connect with group work in CMHS.

Empirically Supported Group Interventions

Empirically supported group interventions (ESGIs) have been shown to be efficacious for specific diagnostic groups (often using the *DSM-IV*) through randomized clinical trials (RCTs), meta-analyses, or through consensus of experts based on a critical review of the best research evidence. The term *intervention* is used broadly to include preventive interventions designed to prevent problems for at-risk populations. Some of the problem areas include alcohol and other drug (AOD) use, anxiety disorders, depression, schizophrenia, and co-occurring AOD with other disorders. A meta-analysis on the efficacy of group treatment for a wide range of diagnoses (e.g., depression, anxiety, eating disorders, personality disorder) reported a large pretreatment/posttreatment effect size of 0.71 from 111 studies (Burlingame, Fuhriman, & Mosier, 2003). The review noted that participants in group treatments were better off than 72% of those in untreated, wait-list control groups (effect size = 0.58).

Persons with serious mental illnesses (SMI) such as bipolar disorder, severe depression, or schizophrenia have impaired social functioning with prolonged disability and/or are in need of intensive treatment (Garvin, 2011). A review of thirteen studies reported that group rather than individual Cognitive-Behavioral Therapy (CBT) was a more effective modality for early psychosis (Saksa, Cohen, Srihari, & Woods, 2009). The researchers speculated that group work allows group member concerns to be more effectively integrated with CBT principles so that, for example, a member learns new ways to manage a personal problem by hearing how another member handled a similar concern.

Table 24.1 provides a summary of selected systematic reviews published in the past ten years, across a range of *DSM-IV* diagnoses often assigned to persons seeking services in CMHS. As indicated, group work is an effective modality, particularly for anxiety, depression, and eating disorders. Co-occurring SMI and AOD are commonly presented challenges in CMHS. Treatment seems to be effective in reducing AOD use, with some effects on mood disorders (Table 24.1). There are many types of groups that may be offered to persons with co-occurring disorders, including CBT, which focuses on the thought processes related to AOD use, motivational interviewing (MI), which enhances a desire for change and often combined with CBT, and specific group therapies such as "double trouble," which are intended to strengthen coping and interpersonal skills to stop AOD use (Cleary, Hunt, Matheson, & Walter, 2009). Given the prevalence of co-occurring disorders in the community, there is strong need for more RCTs with improvements in mental illness outcomes.

In addition to professionally led groups, self-help groups have an important place in community mental health. There is promising evidence that such groups can help persons with chronic mental illness, depression/anxiety, and bereavement (Pistrang, Barker, & Humphreys, 2010). A review of interventions for persons with co-occurring disorders (Mueser, Drake, Sigmon, & Brunette, 2005) noted that self-help groups were valuable if they included elements to address both AOD problems and psychiatric symptoms (e.g., dual recovery, double trouble groups).

Evidence-Supported Group Processes, Techniques, and Guidelines

Group workers in CMHS should also become aware of evidence-supported group processes, techniques, and guidelines endorsed through rigorous research and/or expert consensus. Two examples in this area include cohesion and practice standards.

Cohesion

One important area explored in the literature is the evidence-based psychotherapy relationship (Norcross & Lambert, 2011). Cohesion is "the therapeutic relationship in group psychotherapy emerging from the aggregate of member-leader, member-member, and member-group relationships" (Burlingame, Fuhriman, & Johnson, 2001, p. 373). A recent meta-analysis of 40 studies (n = 3323) reported that cohesion was significantly associated (r = 0.25) with reductions in symptom distress or improvements in interpersonal functioning across different settings and diagnoses (Burlingame, McClendon, & Alonso, 2011). Factors associated with cohesion include the following: (a) Cohesion is most strongly associated with client improvement in groups using an interpersonal, psychodynamic, or cognitive-behavioral orientation; (b) Group leaders who facilitate member interaction, regardless of theoretical orientation, have higher cohesion-outcome links than groups that focused less on process; (c) Cohesion is related to outcome regardless of length but is strongest when a group has over 12 sessions and includes five to nine members; and (d) it contributes to outcomes regardless of inpatient and outpatient and diagnostic classifications (Burlingame, McClendon et al., 2011).

Problem Area/ Population	Sample | Theories/Models	Findings
***DSM-IV-TR* Axis I: Alcohol and Other Drug (AOD) Problems**		
Adolescents (Engle & Macgowan, 2009)	13 GTs for adolescents reviewed (*N*=1751); mostly males, W, non-H/L, with a few including at least 30% H/L or AA. | CBT, CBT/MET hybrid, social learning, two types of PS, STG, IT, 12-step, AGT	10 GTs reported statistically sig reductions in AOD use (those that did not were supportive therapy group, DHP, AGT). Of 10 with positive outcomes, 2 were "possibly efficacious" by also outperforming comparison conditions on AOD use at 7 & 10-month F/U
Adults (Weiss et al., 2004)	24 studies (*n*=4075) comparing group work to other conditions; mostly adults (22 studies). Gender/race/ethnicity: NS | CBT, psychodynamic, social skills training, supportive GT, interactional	Study supported value of GT. Three specific findings: no difference in outcomes between GT & INDT; no evidence of one type of GT superior to another; supplemental GT can improve "usual treatment"
Family members affected by AOD use (Templeton, Velleman, & Russell, 2010)	34 studies, of which 5 group-based, in NA. 4 involved only family members w/o alcohol user, which included partners of heavy drinkers (*n*=194, almost all female); adult children of alcoholics (*n*=138); children ages 9–13 (*n*=271); race mostly W. One additional study included alcoholics & spouses (n=33 couples); race mostly W | GT, coping skills training, 12-step facilitation, mutual help group, group preventive intervention	All group interventions reported positive findings across a range of outcomes
Anxiety/Phobia		
Anxiety (Burlingame et al., 2003)	10 RCTs and quasi-experimental studies. | CBT, BT, psychodynamic, eclectic. Sample: NS	Sig ES: AVG of 0.84 for PR/T to P/T anxiety disorder studies compared with 4 wait-list studies of overall average of 0.20 ES
Social phobia, adult women (McEvoy, 2007)	*N*=153, 39% women; Race/ethnicity: NS | CBGT	Strong positive findings for community-based CBGT. CBGT compared well to individual CBT. CBGT effective within community mental health clinics, recommended as first-line treatment, time & cost-effective
Autism Spectrum Disorder		
(Reichow, Steiner, & Volkmar, 2012)	5 RCTs; N=196; 172 males, 24 females, ages 6–17; U.S. participants; race/ethnicity: NS; average to above-average intelligence | SS groups	Some evidence SS groups improved social competence (ES = 0.47) & quality of friendships (ES = 0.41). Decreases in loneliness (ES = 0.66) but no effect on child or parent depression
Depression		
General review (Burlingame et al., 2003)	25 RCTs & quasi-experiments (sample characteristics & theory/treatment, NS); 12% of studies conducted in outpatient mental health organizations | CBGT, BT, psychodynamic, eclectic	Statistically sig improvements in depression from PR/T to P/T, AVG ES = 1.10
Adolescents (Brunwasser, Gillham, & Kim, 2009)	17 controlled studies (N = 2498); Adolescent boys & girls; race/ethnicity: NS | PRP (type of CBGT)	Sig reductions in depression at P/T & F/U compared with no intervention group (ES range 0.11 to 0.21). PRP no more effective than active control treatment that does not target cognitive factors
Women, low income (Levy & O'Hara, 2010)	11 RCTs, 5 group-based in U.S. (*N* = 266); low SES women, some pregnant or postnatal; mixed race/ethnicity, W, H/L, AA | CBT, BT, IGT, PS	Generally positive: 2 studies using CBT or BT reported AVG ES of 1.30 over controls. 2 studies reporting participant impressions/other indicators noted improvements after GT, though in one study no difference when compared with TAU GT. Third study no differences on depression but GT had better postpartum adjustment compared with control
Eating Disorders		
General review (Burlingame et al., 2003)	12 RCTs and quasi-experimental studies on eating disorders; Demographics: NS | CBT, BT, psychodynamic, eclectic	Large ES (1.38) for PR/T to P/T in contrast to 7 wait-list studies with ES = 0.00
Binge eating (Vocks et al., 2010)	23 RCTs (*N* = 864); 90% female, AVG age 43.5 years; Race/ ethnicity: NR | CBGT	Large ESs for CBGT addressing disturbed eating patterns, antecedents, & associated symptoms. CBGT recommended as first treatment for binge eating
Schizophrenia/ Thought Disorders		
Schizophrenia (Lockwood, Page, & Conroy-Hiller, 2004)	13 RCT or quasi-experimental NA studies (*N* = 549); male and female ages range 28–57; race/ethnicity: NS | CBGT, IBT, Modular skills training, CST, PS	Generally positive. Longer term GT or modular skills training can be effective at improving overall symptoms. Intensive CBGT & supportive counseling reduced # of psychiatric symptoms in those with short duration & less symptoms of illness. CST effective at improving goal attainment. GT effective at decreasing social anxiety & improving social interaction. IBT not effective at improving social functioning. Modular skills training effective at medication compliance but not group PS training
Thought disorders (Burlingame et al., 2003)	4 thought disorder RCTs and quasi-experimental studies; Demographics: NS | CBGT, BT, psychodynamic, eclectic	Some support for improvements for thought disorders from pretest to posttest with AVG ES = 0.64
Caregivers of persons with psychotic disorders (Chien & Norman, 2009)	3 experimental designs, 12 U.S. studies and 13 other areas of world; 19 quasi-experiments, non-experiments or qualitative studies (Western countries); mostly women (75%) and W (67%) | Mutual support groups	Supported the short-term sig positive effects (up to 1 year) of professional-facilitated or family-led mutual support groups
Stress		
(Burlingame et al., 2003)	7 stress RCT & quasi-experimental studies | CBGT, BT, psychodynamic, eclectic	ES = 0.50 compared with 5 wait-list studies with AVG ES = 0.12
(de Vibe, Bjørndal, Tipton, Hammerstrøm, & Kowalski, 2012)	26 RCTs; (*N* = 1456); age 18+; Studies from Norway, Sweden, Germany, Switzerland, Holland & U.S.; Race/ ethnicity: NS | MBSR	P/T moderate ES = 0.56 for stress/distress. Intervention appeared to improve personal development, including empathy, coping, sense of coherence, & enhancing mindfulness
***DSM IV-TR* Axis II: Personality Disorders**		
Borderline & avoidant personality disorder/ (Matusiewicz, Hopwood, Banducci, & Lejuez, 2010)	16 RCTs for DBT treatment for BPD compared to TAU (*N* = 564 adults); race/ethnicity: NS. 2 studies CBGT for AVPD (*N* = 90) | CBGT, DBT, SFT, STEPPS.	Considerable support for DBT group treatment for BPD across various symptoms, including suicidal behavior. Efficacy of short term CBGT for AVPD, anxiety, depression & overall social functioning
Obsessive-compulsive disorder (Jonsson & Hougaard, 2009)	13 quantitative studies (*N* = 549); 63% females, AVG age 36.4 years; Race/ ethnicity: NS | CBT, ERP	PR/T to P/T AVG = 1.18 & a between-group ES = 1.12, overall weighted mean = 1.18. CBGT or ERP is an effective treatment for OCD
Co-Occurring Disorders: Axis I & II		
AOD & internalizing, youth (Bender, Springer, & Kim, 2006)	7 studies of 6 RCTs; 2 studies of 3 GTs (*N* = 120); adolescents, mostly male (~66%), 90% W | CBGT, IGT, PS	"Moderate" to "large" effect size reductions from PR/T to P/T in internalizing disorders & AOD outcomes (all theories), maintained 15 months after treatment
AOD & SMI, adults (Cleary et al., 2009)	54 studies; 5 used group exclusively, of these 1 RCT, 4 non-experimental (*N* = 316); Additional 5 included GT with other components (*N* = 242); Adults; Gender & race/ethnicity: NS | Integrated group therapy, staged group therapy; MI+CBT	Of the 5 using group alone, the RCT increased retention but no differences between groups on AOD or mental status outcomes. The 4 non-experiments had some reductions in some AOD use & psychopathology, fewer hospitalizations, & increased retention at long-term F/U. However, results not uniform across non-experiments & designs weak. The additional 5 studies using group alone or with other modalities, had positive results
AOD & SMI, adults (Drake, O'Neal, & Wallach, 2008)	45 controlled studies, 8 group-based (*N* = 601); Adults. Gender/race: NS | Education, peer support, & tools to manage AOD & mental illness (often combined) mostly including CBT	7/8 group studies had positive results for AOD & non-mental health outcomes. For mental health outcomes 2/6 studies had positive outcomes. No negative outcomes

AA = African American; AGT = Adolescent group therapy; AOD = Alcohol and other drug use; AVG = Average; AVPD = Avoidant personality disorder; BDI = Beck depression inventory; BE = Binge eating; BPD = Borderline personality disorder; BT = Behavioral therapy; CBGT = Cognitive-behavioral group therapy; CBT = Cognitive-behavioral therapy; CI = Confidence interval; CST = Coping skills training; DBT = Dialectical behavior therapy; DHP = Drugs haem psychoeducation; ERP = Exposure and response prevention; ES = Effect size; F/U = Follow-up; GT = Group therapy; H/L = Hispanic/Latino/a; IBT = Interactional behavioral training; IGT = Interpersonal group therapy; INDT = Individual therapy; IT = Interactional therapy; MBSR = Mindfulness based stress reduction; MBT = Mentalization-based therapy; MET = Motivational Enhancement Therapy; NA = North America; NS = Not specified; OCD = Obsessive Compulsive disorder; PRP = Penn resiliency program; PR/T = Pretest; PS = Psychoeducation, P/T = Posttest; PTSD = Post traumatic stress disorder; RCT = Random controlled trial; SES = Socioeconomic status; SFT = Schema Focused Therapy; Sig = Significant; SMI = Serious mental illness; SS = Social skills; STEPPS = Systems Training for Emotional Predictability and Problem Solving; STG = Supportive therapy group; TAU = Treatment as usual; W = White.

AA = African American; AGT = Adolescent group therapy; AOD = Alcohol and other drug use; AVG = Average; AVPD = Avoidant personality disorder; BDI = Beck depression inventory; BE = Binge eating; BPD = Borderline personality disorder; BT = Behavioral therapy; CBGT = Cognitive-behavioral group therapy; CBT = Cognitive-behavioral therapy; CI = Confidence interval; CST = Coping skills training; DBT = Dialectical behavior therapy; DHP = Drugs harm psychoeducation; ERP = Exposure and response prevention; ES = Effect size; F/U = Follow-up; GT = Group therapy; H/L = Hispanic/Latino/a; IBT = Interactional behavioral training; IGT = Interpersonal group therapy; INDT = Individual therapy; IT = Interactional therapy; MBSR = Mindfulness based stress reduction; MBT = Mentalization-based therapy; MET = Motivational Enhancement Therapy; NA = North America; NS = Not specified; OCD = Obsessive Compulsive disorder; PRP = Penn resiliency program; PR/T = Pretest; PS = Psychoeducation; P/T = Posttest; PTSD = Post traumatic stress disorder; RCT = Random controlled trial; SES = Socioeconomic status; SFT = Schema Focused Therapy; Sig = Significant; SMI = Serious mental illness; SS = Social skills; STEPPS = Systems Training for Emotional Predictability and Problem Solving; STG = Supportive therapy group; TAU = Treatment as usual; W = White.

To build cohesion, specific methods have been suggested. Burlingame and colleagues (2001) identified six principles for building cohesion, across structure, interaction and emotional climate:

> (a) conduct pre-group preparation to establish treatment expectations, define group rules, and instruct members in appropriate roles and skills needed for effective group participation and group cohesion; (b) 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; (c) model real-time observations, guiding effective interpersonal feedback, and maintain a moderate level of control and affiliation; (d) time the delivery of feedback based on the developmental stage of the group and the readiness of members; (e) effectively manage his or her own emotional presence in the service of others, which affects relationships with individuals in the group and as they vicariously see the workers' manner of relating with others; and (f), facilitate group members' emotional expression, the responsiveness of others. (p. 375)

Based on the three important areas related to cohesion (structure, interaction and emotional climate), the Group Psychotherapy Intervention Rating Scale (GPIRS; Chapman, Baker, Porter, Thayer, & Burlingame, 2010) was developed, which can be used by group workers to monitor the clarity of their cohesion-building strategies.

Practice Standards and Guidelines

Group workers in CMHS should also be aware of group work standards and practice guidelines, which have been developed by panels of experts to promote appropriate and effective practices. These standards and guidelines are rooted in professional values and codes of ethics of the respective professional organizations that developed them, such as the American Counseling Association and Professional Social Work Associations in the U.S. and Canada (ACA, 2005; CASW, 2005; NASW, 2008). The International Association for the Advancement of Social Work with Groups (formerly the Association for the Advancement of Social Work with Groups, AASWG, 2006) and the Association for Specialists in Group Work (ASGW, 2000, 2007) have their own set of practice and training standards. There are measures that have been developed to assess group workers' perceived importance of—and ability to perform—the AASWG and ASGW standards (Macgowan, 2012; Wilson & Newmeyer, 2008). Clinical practice guidelines have been developed by the American Group Psychotherapy Association (AGPA, 2007) and others have offered ways to utilize them in practice (Leszcz & Kobos, 2008).

A document that has had support from a consensus of group work experts from AGPA is the CORE–R Battery (Burlingame et al., 2006). The CORE–R Battery contains materials on pregroup member preparation and a selection of measures for screening members, assessing group processes, and outcomes. According to the different standards and guidelines, it is important to include both process and outcome evaluations in group work. For example, the AGPA guidelines (among the others) recommend selecting clients for group work. One tool that could be used for the screening of group members for group psychotherapy is the Group Selection Questionnaire (GSQ; Burlingame, Cox, Davies, Layne, & Gleave, 2011), endorsed in the CORE-R Battery. The GSQ may be used to evaluate client expectancies for group work, which "may identify clients that could be 'at risk' for premature dropout, allowing more effective preparation of the client prior to group participation" (Burlingame, Cox et al., 2011, p. 71). The CORE-R Battery and the AGPA guidelines also recommend assessing group processes such as group climate and cohesion, to assess the functioning of the group and for workers to take

action.

The ASGW has developed multicultural and social justice competence principles for group workers (ASGW, 2012). The principles fall into the following three main areas: (1) awareness of self and group members; (2) use of strategies and skills that reflect multicultural and social justice advocacy competence in group planning, performing, and processing; and (3) social justice advocacy. In working with increasingly culturally diverse populations, it is essential for group workers in CMHS to become familiar with these guidelines.

Evidence-Based Group Work (Process Model)

The third type of EBP is a process model, which incorporates ESGIs, evidence-based group processes and guidelines, or other relevant and appropriate evidence with the highest possible rigor. This model is fitting for practice in CMHS and underlies EBGW, which is defined as "a process of the judicious and skillful application in group work of the best evidence, based on research merit, impact, and applicability, using evaluation to ensure desired results are achieved" (Macgowan, 2008, p. 3). Each of the elements in this definition will be briefly discussed.

Evidence refers to "unobserved as well as observed phenomena if the former reflects signs or indications that support, substantiate, or prove their existence, accuracy, or truth" (Cournoyer, 2004, p. 3). Evidence may be research- or authority-based. Research-based evidence may be derived from quantitative or qualitative research but can also derive from systematic study of one's own practice. Authority-based evidence is all other evidence, such as "the opinions of others, pronouncements of 'authorities,' unchecked intuition, anecdotal experience, and popularity (the authority of the crowd)" (Gambrill, 1999, p. 7). Research and authority-based evidence may be weak or strong, and must be evaluated. *Best available evidence* is determined by an assessment of the evidence's research merit (rigor), impact, and applicability to the group situation, described below.

The EBGW model has four stages in which group workers (a) formulate an answerable question derived from the practice context; (b) search for evidence; (c) undertake a critical review of the evidence to identify the best available evidence; and (d) apply the evidence with judgment, skill, and concern for relevance and appropriateness for the group, utilizing evaluation to determine if desired outcomes are achieved (adapted from Berg, 2000; Straus et al., 2005). This process model provides the framework into which the other two parts of EBP fit. For a complete discussion about this process model, see Macgowan (2008).

Stage One: Begin with a Practice Question

A member-relevant, answerable, practice question (MAP) related to the group service is identified. Examples of MAP questions might be, "What is the briefest yet most effective group intervention for reducing depression among Latinas?" and "How can I increase cohesion among my group members?" Once the question is formulated and refined (detailed in Macgowan, 2008), then it is suitable for a search.

Stage Two: Search for Evidence

The second stage is to undertake a search for evidence, expanding beyond one's convenient evidence (e.g., one's own experience or one's own possibly outdated library) and to systematically collect and appraise evidence. Searches should focus on research-based evidence rather than authoritative-based evidence. Macgowan (2008) details how and where to look for research. The website (www.EBGW.org) includes links to free sources of systematic reviews and other scholarly literature, terms to aid in the search for group-based literature, and links to the table of contents of nine major peer-reviewed group work journals, where users may subscribe to table of contents alerts of the latest group literature.

Stage Three: Critically Review to Identify "Best Available" Evidence

The third stage involves a critical review of the evidence, yielding the best available evidence. The evidence (e.g., article, book, material) must be evaluated for its rigor, impact, and applicability.

First, workers evaluate the *rigor* (research merit) of the evidence. Studies high in rigor minimize bias. In intervention research, the preference is for research evidence, which increases the confidence that the intervention was specifically responsible for beneficial effects, as opposed to evidence that is authority-based. The degree of confidence that an intervention or action will produce a desired outcome may be assessed using a "'hierarchy of evidence,' with each level yielding a higher comfort level of certainty, from the most basic level of anecdotal or

word-of-mouth testimonials to the highest level of scientific study, the controlled clinical trial with random assignment of subjects" (Hyde, Falls, Morris, & Schoenwald, 2003, p. 5). However, both sets of evidence, whether authority or research-based, should be evaluated for rigor.

Second, group workers also evaluate the *impact* of the evidence; that is, how significant (i.e., statistically and clinically) and in what direction are the findings. Ideally, there should be clinically meaningful change. For example, a study (Petry, Martin, & Simcic, 2005) using token reinforcement to improve attendance and abstinence rates gave strong evidence for both statistically significant and meaningful change. The researchers noted that the number of group sessions attended was "correlated with cocaine abstinence, and each group session attended during treatment was associated with a 17% increase in the probability of reduced cocaine use 12 weeks after the study" (Petry et al., 2005, p. 358). Group interventions that have been replicated with the highest rigor and impact typically become labeled ESGIs, such as CBGT for social anxiety (Table 24.1).

In the *applicability* stage, group workers evaluate the evidence's relevance and appropriateness for their own groups for "clinical utility" or "clinical applicability." To evaluate applicability, the fit of the material with the clinical situation in three areas is assessed: agency setting (e.g., will the agency support the practice?), group worker (e.g., is the group worker qualified to do it?), and group members (e.g., does the material fit with group member values and preferences?). In particular, there is a growing literature on the importance of racial and cultural factors in the role of interventions and on client preferences in treatment (e.g., Chen, Kakkad, & Balzano, 2008; Swift, Callahan, & Vollmer, 2011). There are concerns about whether interventions developed and tested with dominant cultures are congruent with the values and worldviews of racial and ethnic minority groups. If the material is not consistent with group member values, or if group members are not going to support the intervention, it should not be applied. For example, the literature on youth violence prevention in Latino communities has noted the importance of attending to cultural values such as the central role of family (*familismo*), religiosity (*religiosidad*), and interpersonal relationships (*personalismo*; Mirabal-Colón & Vélez, 2006). Latino participants in studies have reported that they prefer a warm and expressive therapeutic relationship (reflecting *personalismo*) rather than a sterile, distant one (Mulvaney-Day, Earl, Diaz-Linhart, & Alegría, 2010). Group interventions that ignore these cultural values are not likely to be as successful as ones that do.

The three areas of rigor, impact, and applicability map well onto the nine "ideal features" of a mental health intervention in community settings described by Bond, Drake, and Becker (2010): (a) demonstrate effectiveness through rigorous research studies, (b) few side effects, (c) positive long-term outcomes, (d) well-defined for replication by the group worker, (e) reflect client goals and preferences for service, (f) consistent with societal goals, (g) reasonable costs, (h) relatively easy to implement, and (i) adaptable to diverse communities and client.

To evaluate rigor, impact, and applicability of evidence, group workers use a set of guides designed for group work. Developed from research and designed to be as brief as possible, Macgowan (2008) includes guidelines for evaluating quantitative studies, qualitative research, authorities, literature reviews (systematic and nonsystematic), multiple studies/reports, and measures. After assessing rigor, impact, and applicability, a decision must be made whether to apply or abandon the evidence. Conceivably, the best available evidence may not be the most rigorous or impactful but may be the most applicable. In some cases, the material may need to be abandoned, perhaps because the practitioner lacks the training to implement a specialized intervention, or the material is ill suited for the group members (see Macgowan, 2008, for examples).

Stage Four: Apply (Replicate, Adapt) the Evidence and Evaluate

This stage involves application of the evidence, which may involve replication or adaptation, and to evaluate if desired outcomes are achieved. As applied to EBGW, *implementation* is the integration of the best available evidence into group work. As a general guide, group workers should maintain the integrity of the original intervention/technique. Substantial research suggests that fidelity to interventions significantly increases favorable outcomes and a loss of fidelity reduces program effectiveness (e.g., Elliott & Mihalic, 2004; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002). However, group leaders serving minority communities may be faced with the situation of finding an intervention that has high *rigor* and *impact*, but it is not *applicable* as the

study involved a different population group. La Roche and Christopher (2008) noted that *no* empirically supported treatment has met all the criteria set forth by the APA Task Force for treatment efficacy (American Psychological Association, 2006) for *any* minority group. In these cases, the material may need to be adapted.

There is a growing consensus that interventions adapted or tailored for race and ethnicity are advantageous (Benish, Quintana, & Wampold, 2011; Chen et al., 2008), although the finding with adolescents is inconclusive (Huey & Polo, 2008). An ESGI may be adapted by simply changing surface structures, such as language (e.g., translating materials) or ethnicity or race of role models, but deep structure elements that deal with salience of the entire intervention approach should be considered. Deep structure reflects an understanding of "cultural, social, psychologic, environmental, and historical factors influence health behaviors differently across racial/ethnic populations" (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000, pp. 274–275). For example, this would involve asking group members about their perceptions of their concerns, the helping process, and the group leader. Attending to, and showing respect for, clients' worldviews and perspectives about their concerns and the helping process improves satisfaction with treatment and client outcomes (Benish et al., 2011) and is consistent with culturally competent group work (Chen et al., 2008; Comstock, Duffey, & St. George, 2002; also see Section III of this book). For guidance in the adaptation, group workers should consult with a colleague, supervisor, and a prospective member (or an advisory group of prospective members) from the race or ethnic group for which the intervention is going to be applied. There are examples in the literature of effective cultural adaptation of both CBT and interpersonal psychotherapy for groups with Latino depressed youth (Rosselló, Bernal, & Rivera-Medina, 2008) and group interventions for depressed, low-income Latinas (Le, Zmuda, Perry, & Muñoz, 2010) and African American women (Kohn, Oden, Muñoz, Robinson, & Leavitt, 2002). When adapting the group model, the essential elements of the intervention should be retained, while at the same time adding cultural elements to maximize effects. However, group workers should be aware of the risk of "how much adaptation can occur before the practice no longer becomes 'evidence-based' but rather becomes 'lost in translation'" (Palinkas & Soydan, 2012, p. 86). Thus, group workers should carefully examine the treatment manual or guidelines to determine if the authors identified the "essential elements." If these are not retained in an adaptation, the original intervention is not being used and has become "lost in translation." Instead, a highly adapted (if not novel) intervention has been developed, with dubious efficacy.

Once the intervention is applied, the group worker evaluates the effects of the action to determine whether the desired results are achieved using conventional methods for the evaluation of practice. Application and evaluation are not separate endeavors but are intertwined in a circular and iterative process. Thus, the process does not end with knowing whether the strategy "worked" but continues with a systematic, critical process of improving practice based on the ongoing results of the application in practice and evaluation.

In summary, the process model of EBGW flexibly and critically incorporates ESGIs and evidence-supported group processes, techniques, and guidelines. A case example provides applications of some of the principles outlined, followed by strategies for advancing EBGW in community settings.

Case Example

Rosa Gutiérrez is a newly hired group worker at a community mental health center (CMHC) in a large metropolitan area. She recently graduated with a masters degree in social work and had brief previous experience working at another CMHC. She is fully bilingual and considers herself a bicultural Latina, the population mostly served by the CMHC. Rosa was asked to lead a group for Latinas diagnosed with depression and without medical insurance. To fulfill her mandate, Rosa felt she needed to get a better idea about the best available evidence to provide services that were culturally responsive to depressed Latina groups. Her supervisors limited knowledge about evidence-based practices caused Rosa some initial concern; however, she recommended Rosa speak with a field instructor who had access to relevant, summarized literature located in peer-reviewed journals. At a team meeting, Rosa advocated for and was supported by the organization in the development of a new EBGW intervention. A Spanish-speaking bilingual staff member named Maria, who was knowledgeable about EBP, volunteered to cofacilitate the Latina depression group with Rosa.

To begin the EBGW process, Rosa formulated a MAP question: In establishing a culturally relevant group for Latinas, what relatively brief (10-12 sessions) group intervention will best reduce depression? Next, evidence was collected from the literature about whether there was an effective group approach for low-income Latinas or if a mainstream option would need to be adapted. Group treatments for depression, primarily using CBT and interpersonal therapy, had been rated as "well-established" for adolescent and adults (Johnson, 2008; Levy & O'Hara, 2010, cf. Table 1). Other culturally appropriate material literature (Muñoz, Ippen, Rao, Le, & Dwyer, 2000; Muñoz & Miranda, 1986) was identified without the need for substantial modifications. Rosa and Maria critically appraised the evidence for its rigor, impact, and applicability and then applied the evidence to address Rosa's MAP question. They related the three areas of rigor, impact, and applicability to Bond's (2010) nine "ideal features" of a mental health intervention and decided to implement the CBGT model as it was developed specifically for low-income Latinos/as. They utilized the twelve-week model, which included the core elements of the intervention but not the extra four-week module related to health issues as it was not deemed relevant (Muñoz & Miranda, 1986). The manual was available electronically in Spanish and English (Muñoz et al., 2000). Rosa and Maria also included discussion about challenges in the acculturation process, which may contribute to depressive symptoms (Levy & O'Hara, 2010), group content that recognized acculturation as a bidirectional process, and acculturation issues related to gender (e.g., mother and child challenges, financial stressors). Group sessions would also include information about accessing no-cost community resources.

In terms of process, Rosa and Maria reviewed the AGPA (2007) and AASWG (2006) practice standards and the ASGW (2012) multicultural and social justice competence principles to prepare and implement the intervention. Specifically, ethnically and linguistically matched therapists offering the group in client-preferred languages is important and improves outcomes (Smith, Rodríguez, & Bernal, 2011). It is also important to explicitly emphasize the cultural values of the clients throughout group sessions (Griner & Smith, 2006). Rosa would also selectively disclose personal information to enhance a personalized professional relationship with group members to build the therapeutic alliance, reflecting personalismo, or valuing the personal connection in relationships. In addition, they would monitor how the group received the material.

To secure referrals, Rosa shared information with the local hospital's family health clinic noting that transportation vouchers would be offered (Stacciarini, O'Keeffe, & Mathews, 2007). The Group Selection Questionnaire (Burlingame, Cox et al, 2011) was administered to select group members. Additionally, to maximize cohesion, the maximum number of group members would be nine. Group orientation sessions were arranged so prospective group members could meet Rosa and Maria over coffee and pastries, with specific information shared about the group (AGPA, 2007). They discussed handouts (in Spanish) that oriented group members to the group experience. For an outcome measure, the Patient Health Questionnaire (PHQ-9) (available in English and Spanish) was used to measure both depression symptoms and their severity (Martin et al., 2006). The PHQ-9 was selected because it is brief, easy to administer, and free of charge (http://steppingup.washington.edu/keys/documents/phq-9.pdf). Depression scores would be measured every couple of weeks and charted over time. In addition, group members would complete a brief evaluation of each session, which asked to rate on a scale from 1 (not at all) to 5 (very highly satisfied), "How satisfied were you with today's session?" (in Spanish) and to comment if they wished. These ratings were reviewed weekly. To assess cohesion, the GPIRS was used (Chapman et al, 2010).

At the end of the group sessions, Rosa and Maria reviewed both the outcomes and process of the group. Reflecting on the MAP question, the main purpose of the group was to reduce depression. She and Maria reviewed the depression progress chart, member satisfaction scores, and ratings from the GPIRS to determine group effectiveness and cohesion. Process and outcome results were communicated with the agency team to determine the implications for offering another Latina depression group.

Advancing EBGW in Community Settings

EBGW is essential for advancing effective practices in CMHS. However, there are both challenges and areas of opportunities for implementing the best available evidence in CMHS. Some of the areas of opportunity include professional (practice, education, research) and organizational described next.

Professional Factors

Practice

Professional group work organizations require its members to integrate best evidence into practice. Group workers who are members of AASWG and ASGW should utilize measurement tools to determine how much they value, and are able to practice, those standards (Macgowan, 2012; Wilson & Newmeyer, 2008). AGPA (2007) has done an important service by clearly identifying the evidentiary support of group work practices and has contributed a series of articles on using the practice guidelines (e.g., Bernard et al., 2008; Leszcz & Kobos, 2008). There are also measures to evaluate practitioner knowledge, attitudes, and use of the EBP process: the Evidence-Based Practice Process Assessment Scale (for students, Rubin & Parrish, 2010) or the Evidence-Based Practice Process Assessment Scale—Short Version (for experienced practitioners, Parrish & Rubin, 2011b). Although these measures are not directly related to group work, they may be used to indicate readiness to do EBGW.

Education

When the research evidence is not there or is contradictory, group workers must decide what is best. Practitioners need help to develop knowledge and skills to formulate, access, and integrate the best evidence into practice. Training in EBP has been done successfully (Parrish & Rubin, 2011a), which has focused on a range of indicators such as participants' knowledge and attitudes about the EBP process and their involvement in EBP. A website is available for training in EBP (http://www.ebbp.org/) and Macgowan (2008) suggests a workshop model on EBGW. McCloskey (2011) suggests web-based booster sessions while Lopez, Osterberg, Jensen-Doss, and Rae (2010) advocate that ongoing supervision helps maintain effects. On-the-job coaching after training offers the largest gains in learning (Sholomskas et al., 2005).

Research

Good research evidence is a foundation of EBGW, and more high quality studies are needed to guide practice. Group work is generally effective, but much more research is needed concerning different problem areas and populations, especially involving racial and ethnic minority groups (Griner & Smith, 2006; La Roche & Christopher, 2008).

Organizational Factors

To advance EBGW in CMHS, there needs to be a favorable organizational culture. One of the major complaints to doing EBP is that it takes too much time (Baker, Stephens, & Hitchcock, 2010; Edmond, Megivern, Williams, Rochman, & Howard, 2006). Administrators must grant time for practitioners to adequately engage in EBGW, allocating staff for particular functions related to EBGW. For example, group workers could identify important clinical questions to be answered with particular staff designated to engage in the search and critical review of the evidence. Another team of practitioners could determine how to best apply the evidence.

To more effectively advance EBGW, organizations may partner with a university. Reciprocal, agency-academic partnerships can help overcome organizational challenges (Bellamy, Bledsoe, Mullen, Fang, & Manuel, 2008; Fouché & Lunt, 2009; Kazdin, 2008). One idea is to establish within the organization a knowledge-sharing team ("link officers," Austin, Dal Santo, & Lee, 2012), which can both serve as a liaison with the university about emerging practice questions that need answers, and help group workers apply the best available evidence in practice. Alternatively, group workers could seek out institutes or centers for EBP that have generated local research that can be useful for EBGW (Regehr, Stern, & Shlonsky, 2007). Practitioners might also approach the local chapter of their group work organization to form collaborative practice-research networks of practitioners and faculty (Borkovec, 2004).

Summary and Conclusion

With its emphasis on applying the best available evidence into practice, EBGW is a necessity for advancing EBGW in CMHS. This chapter has described a process model, which incorporates ESGIs and effective group processes, techniques, and guidelines. The model is designed for group workers to find, critically assess, and integrate into practice the best available evidence, using evaluation to ensure desired effects are obtained. A case example illustrated how the principles are applied in CMHS. Yet there are challenges in doing EBGW in the community. Ideas for meeting these challenges were offered, requiring changes in training and in how organizations function to support EBGW. The recommended changes are expected to increase the likelihood of successful advancement of EBGW in community settings.

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Chapter 25 Group Work in Schools

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Groups are an effective way to teach skills to a wide range of students with diverse needs. Group interventions are not only a way to serve more students with limited time but because of the importance of peers to children and adolescents are a developmentally appropriate approach. Although groups in schools are similar to those with children in other settings, there are aspects, both dynamic and logistic, that are unique to the school environment.

In many graduate programs, there is a single required course in group counseling (Akos, Goodenough, & Milsom, 2004), and the focus in those courses is often on conducting groups with adults that do not prepare trainees to conduct groups with children and adolescents (Riva & Haub, 2004). In addition, Steen, Bauman, and Smith (2008) found that only 28% of the sample of 802 school counselors observed groups with children or adolescents as part of their training. School counseling graduates report feeling unprepared to lead groups in schools (DeLucia-Waack, 2000; Riva & Haub, 2004; Steen et al., 2008). In this chapter, we provide essential information about conducting groups in schools.

We use the term "counselor" inclusively to refer to professionals working in schools and providing counseling services, including groups. Providers of these services include social workers, psychologists, and school counselors (Lindsey & White, 2009). Agresta (2004) surveyed members of the three professional groups' national associations: social workers spent an average of 10.28% of their time providing group counseling, school psychologists 2.55%, and school counselors 7.98%. Members of all three professions indicated they would like to spend more of their time on this service. The American School Counselor Association (2012) recommends that school counselors spend anywhere from 15% to 45% of their time providing direct services to students. With high student-to-counselor ratios in many schools, reliance on individual counseling for responsive services is not always feasible. Group counseling interventions have demonstrated improvement in important student outcomes related to personal/social development (Hagborg, 1993; Utay & Lampe, 1995), career development (Hatfield & Falco, 2010; Whiston, Brecheisen, & Stephens, 2003), and academic development (Brigman & Campbell, 2003; Steen & Bemak, 2008). Borders and Drury (1992) in their seminal review of 30 years of school counseling outcome research concluded group interventions have a positive effect on students' achievement, behavior, and attitudes. In their review of 56 outcome studies, Hoag and Burlingame (1997) found group counseling had an overall positive effect on child and adolescent participants for a variety of issues, although groups in clinical settings were found to be more effective than groups in school settings. Results of a meta-analysis (Prout & Prout, 1998) suggested that cognitive-behavioral group interventions focused on specific issues were most efficacious. Gerrity and DeLucia-Waack (2007) examined the most frequently utilized group interventions in schools, including eating disorders, bullying and anger management, sexual abuse prevention, pregnancy prevention, and social competence, and concluded that research generally supports the efficacy of group treatments in school settings. More research is needed to better understand the types of group interventions that are most effective for each issue and for different populations.

Types of Groups in the Schools

Of the four types of groups described by ASGW (2000), counseling and psychoeducational groups are the most frequently utilized in school settings (Gerrity & Delucia-Waack, 2007). Group psychotherapy is generally beyond the scope of practice in schools and is more likely to take place in a clinical setting. Therefore, this chapter will emphasize task, psychoeducational, and counseling groups within the school setting.

Task Groups

Task groups are formed to work toward a specific goal; the focus is on accomplishing the goal rather than on individual needs of group members. The purpose of the group is specific and clear; task groups are generally time limited and end when the task is completed. Examples of task groups facilitated by the counselor and comprised of students include planning a community service project (e.g., a food drive or adopt-a-highway) or creating a new school club (e.g., art club or book club) or organization (student government or Family Career and Community Leaders of America [FCCLA]). Task groups provide opportunities for synergy of ideas, interdependence, cooperation, and sometimes altruism in ways that working individually to meet a common goal might not (Corey, Corey, & Corey, 2010; Southern, Erford, Vernon, & Davis-Gage, 2010). Additionally, task groups might be comprised of faculty, staff, or other adults involved in the educational process, such as student support teams, 504 planning groups, or Faculty Family Organization (FFO) groups.

Task group leaders should identify the group goals, generate group membership and guidelines, establish a structure for meetings, and facilitate both the process and the content of the group (Corey et al., 2010; DeLucia-Waack & Nitza, 2010). Van Velsor (2009) proposed a model for using task groups in collaboration with classroom teachers to help students develop social and emotional skills while engaging in an academically oriented task. Learning interpersonal skills for working in a team is enhanced when students are applying the skills in an authentic, versus simulated, context. While the teacher manages the task progress, the counselor helps students handle feelings, negotiate differences of opinion, and communicate effectively.

ASGW *Professional Standards for the Training of Group Workers* (2000) emphasizes "application of principles of normal human development and functioning through group based educational, developmental, and systemic strategies applied in the context of here-and-now interaction that promote efficient and effective accomplishment of group tasks among people who are gathered to accomplish group task goals." Thus, leaders help members feel connected to and part of the group and help them understand that each member has a unique contribution to make toward the group goal, whether it be specialized information, creative strategies, or process-focused skills such as alleviating tension, encouraging others, or inviting quiet members to contribute.

Psychoeducational Groups

Because it is impossible for counselors in a school setting to address the needs of all students individually, classroom guidance and psychoeducational groups are critical. Psychoeducational groups are more structured than counseling groups and are focused on specific issues and behavioral goals (Bryan, Steen, & Day-Vines, 2010; Corey et al., 2010). Common psychoeducational groups include communication and social skills groups (e.g., friendship groups, career/educational decision making, and study skills). These groups help students develop decision-making skills, and behavioral and affective skills necessary for expressing emotions appropriately. Brigman and Campbell's (2003) "Student Success Skills" is designed to improve participating students' academic and social skills, and Steen's (2009) "Achieving Success Everyday" model is designed to enhance students' personal-social development while helping them improve academic behaviors.

For psychoeducational groups, the counselor should select the topic and activities prior to implementing the group, devise a format for each session, and formulate specific processing questions for each activity. Many excellent references are available to assist the counselor in preparing a group (e.g., DeLucia-Waack, 2006; Foss, Green, Wolfe-Stiltner, & DeLucia-Waack, 2008). Brigman and Goodman (2008), Greenberg, (2002), DeMarco (2001), and Erford (2010) provide general information in addition to specific group plans. Minardi (2008) provides 50 exercises that can be incorporated into a variety of groups, and Guerra (2009) provides a manual for conducting cognitive-behavioral groups.

Psychoeducational groups provide opportunities for students to learn new information and skills, make connections to previous knowledge, and make personal meaning of the information presented (Bryan et al., 2010). Skills frequently taught in these groups include problem solving and decision making, handling relationships, managing stress, asking for help, and expressing feelings appropriately. The following model (Conyne, 2003, cited in DeLucia-Waack, 2006) is useful for teaching skills in the group context. Note that skill learning would typically occur over several sessions. First, the leader presents the skill, both describing and demonstrating. Members then practice the skill in pairs or subgroups. Two members may practice while a third observes; those roles rotate so that each member gets a chance to practice and observe. Then observers give feedback to members on what they did well and what they need to improve. Leader and members then discuss how they would use the skill outside the group in their daily lives. Skills are then practiced again in session, and members are encouraged to use the skill between sessions and report back to the group. The group then processes the experience of learning, practicing, and using the skill.

Counselors who lead psychoeducational groups should teach content and attend to group process for a meaningful and substantive group experience (Bryan et al., 2010). While imparting information is a major goal of the group, it is critical to link members so they see that others share their concerns, to encourage shy members to participate, to invite members to talk about how the information will apply to them, and to guide members to acknowledge the value of other members' ideas. Processing that occurs in psychoeducational groups helps members understand and make meaning of the content and information presented (Bryan et al., 2010). Processing involves asking members to reflect on the experience they have had, share their reflections, feelings, and reactions with the other members, connect their experience with those of other members, and translate the experience to their lives outside the group (Bridbord & Nitza, 2008). To be effective, questions should elicit thoughtful reflection, be empathic, and focus on the important themes, deepening that focus as appropriate (Bridbord & Nitza).

Counseling Groups

Group counseling provides a structure for students to give and receive feedback with peers, practice new skills in a safe place, and an opportunity for students to talk and express feelings with others who may share common experiences. Counseling groups are designed to help students work on interpersonal problems and to promote positive behavior and emotional development related to those problems. Although they are often problem oriented, counseling groups can also be preventive and growth oriented. Counseling groups can have multiple benefits for children and adolescents, such as improving interpersonal skills, obtaining support from others, and increasing their understanding of self and others (Southern et al., 2010).

Several groups are always needed in schools because of the inevitability of these situations and the fact that for many students, the situations may present challenges that interfere with the student's functioning in school. One such group is grief or bereavement groups (Goodman & Brigman, 2001). Students may be faced with the death of peers, parents, teachers, grandparents, and/or pets, and these experiences may exceed the coping resources of children. Goals for school bereavement groups include normalizing the grieving process, helping students understand their emotional responses to their loss, demonstrating that they are not alone, and developing positive coping strategies. Samide and Stockton (2002) provided an excellent guide for grief groups in elementary schools; Finn (2003) described a model that incorporates art into a bereavement group, and Hilliard (2007) discussed the outcomes of a music therapy group for bereaved elementary students. Huss and Richie (1999) evaluated a support group for middle school students who had lost a parent and concluded the groups benefitted members.

The second type of group is a support group for children of divorce. Children whose parents are divorced or separated may experience stress, anxiety, loneliness, and loss of stability (Amato, 2000). Group counseling can be a practical, efficient, and effective treatment because it provides a mechanism for students to talk aloud about feelings and experiences that may assist in reducing some of the negative emotions associated with divorce. The group context normalizes the divorce experience and provides support to children who need it (Pedro-Carroll, 2005). In an important review, Yauman (1991) highlighted the value of school-based group work for children of divorce, pointed out the importance of developmental factors, showed the value of parental and teacher involvement, and indicated how group counseling can incorporate a discussion of a new family constellation. For guides to groups for elementary and middle school groups on divorce, Morganett's books (1990, 1994) are quite helpful. Erford (2010) has an excellent plan for a divorce group suitable for middle school, and Goodman and Brigman (2001) have a group plan for divorce/changing family groups for high school students.

Best Practices for Group Work in Schools

Groups in schools exhibit the stages of typical group development (initial, transition, working, final; Corey, Corey, Callanan, & Russell, 2003). However, in a school setting, certain issues are inherently different from groups in other settings and must be addressed from a different perspective. What follows are suggestions to maximize group effectiveness in schools.

Membership

It is important to select students whose needs are congruent with the focus of the planned group. For example, in grief groups, not all students who qualify will want to or need to be in a group. After receiving referrals, the school counselor must meet with the student to determine whether the group is appropriate at this time. It is generally advisable to postpone group membership until the initial shock of the loss has subsided, but the needs of each student, and their fit within the group, must be considered. A student who is coping well with the loss might not want to join a group that might revisit the pain. Likewise, in a group to support students with substance abuse problems, some students do not acknowledge that their use is a problem, and would not fit well in a group of students who are committed to sobriety. Counselors facilitating groups should bear in mind that not every student will benefit from every group and that, often, voluntary participation tends to maximize the benefits of the group for all members (Geroski & Kraus, 2010). Informed consent and assent are essential to the screening process and will be discussed in more depth later in the chapter. Sample forms can be found in Goodman and Brigman (2001), DeLucia-Waack (2006), and Smead (1995), among others.

Developmental issues such as age and maturity also play a role in group membership in a school setting. Group counselors need to select members and structure groups according to students' cognitive abilities and developmental stage. VanVelsor (2004) noted that preschool children have limited abilities to express themselves verbally, and typically are quite egocentric. A group setting may provoke anxiety for this age group, so it is important for the facilitator to structure the group to diminish that anxiety. She pointed out that groups for preschoolers are likely to use principles and practices from play therapy. Elementary school students, although they are better equipped to communicate than the preschool group, still tend to express themselves, particularly about emotional states, in nonverbal ways. However, they are beginning to understand others' perspectives. Facilitators need to be attentive to nonverbal communication, provide structure, and encourage empathy (Van Velsor, 2004).

Adolescents are much more verbal and focused on their peers. This makes groups a very fitting milieu for this developmental stage. Less structure is needed for this level. Facilitators should have an appropriate exercise planned but should defer to the immediate needs of members. A beginning check-in round will often reveal issues members want to work on; the exercise should be put aside in that case. Facilitators need to be alert to the potential for too early and intimate self-disclosure, while being poised to draw out the less open members. Counselors may have to cut off the overly revealing member, perhaps saying "I'm glad you are willing to share, but at this point, I want us all to get to know each other a bit better, so I'm going to ask you to save this until a bit later." At the same time, you may need to encourage more reserved members, often with a prompt such as "Tell us a bit more about that," or "We'd like to hear a little more from you so everyone can get to know you." Adolescents also may react negatively to authority, so leaders have to be able to be careful about the tone and style of leadership used. An authoritarian style is usually counter-productive in a group; telling members they will be removed from the group for misbehavior deprives the member of feedback from the group about the effect of his or her behavior on others. Generally, older students will be better able to process more complex emotions than younger students. This will affect the type of group that is most appropriate for students at various grade levels.

Selecting group members within a narrow age-range is preferable and grade level is a practical method for doing so (Berg, Landreth, & Fall, 2006). However, there may be times when it is beneficial to have cross-grade membership. When the focus of the group is specific and there are few eligible students (as in grief groups or groups for children with Type 1 diabetes) inviting members who span several grades would allow a group to form, whereas restricting the group to one or two grades might not provide sufficient members. The counselor must evaluate the cognitive and social skills of potential members when there will be a range of ages to ensure that the developmental differences will not preclude meaningful interaction. Counselors will also need to tailor their vocabulary in developmentally appropriate ways in order to maximize the engagement of the group members (Geroski & Kraus, 2010).

Recommendations for the number of group members vary. For younger (elementary aged) children, the number

of members should probably not exceed six (Berg et al., 2006), and for adolescents (middle or high school aged) the number of members should not exceed 12 (Jacobs, Masson, Harville, & Schimmel, 2011). Group sessions should run for 20–30 minutes with children in preschool and kindergarten, 30–40 minutes with children in first through 3rd grade, and 40–75 minutes for students in 4th grade and above (DeLucia-Waack, 2006). Experts disagree about whether groups should be segregated by gender (Gladding, 2008), although that is less an issue with younger children than it is with adolescents. Unless the topic of the group is gender specific (e.g., sex education), mixed gender groups provide opportunities for young people to learn to communicate openly and honestly with all peers.

Diversity is another important consideration when selecting members for group counseling in a school setting. Even when issues of race, class, and status are not explicit topics of a particular group, they are always present (Corey et al., 2003; Jacobs et al., 2011). Counselors need to be alert to potential challenges that a diverse group might experience, and deliberately broach these topics so members know that the group is a safe place to talk about differences. Groups will be influenced by the varying communication styles, languages, sexual orientations, abilities, ethnicities/races, beliefs, behaviors, and perceptions of its members (Holcomb-McCoy & Moore-Thomas, 2010). Group counselors need to be intentional about selecting members so that each has a place and an opportunity for growth within the group (Geroski & Kraus, 2010). Some schools are more diverse than others; this will affect the counselor's ability to compose a group that is based on common needs, is well balanced in terms of verbal facility and experience with the group topic, and is also diverse. If a potential member is going to be the only one of a particular status (e.g., race/ethnicity) in the group, this should be discussed in the screening interview so that the member is not surprised at the initial meeting. The interview should also focus on the commonalities the member has with others, and invite the member to feel free to contribute his or her unique perspective to the group.

Another major difference when conducting groups in schools is the relationship the counselor has with all students. Because the counselor is known to all students through a variety of activities in classrooms, it may be easier to establish a trusting relationship with group members. However, it is critical to clarify how the group leader role differs from other roles that the counselor has in the school. In an introduction, the counselor should inform the group that, although members know him or her from classroom lessons and possibly from individual meetings, *in this group* the role is to help students learn from each other, learn about themselves, and learn and practice new skills. That means the group is *everyone's* group, not just the counselor's, and everyone has something valuable to contribute.

Ethical and Legal Considerations

Proper screening is essential for group counseling in a school setting. It might appear that because the school counselor knows most students, this step is not necessary. On the contrary, the school counselor should screen potential members to ensure the appropriateness of the students for a particular group and to do what is in the best interest of the other students in the group (Linde, Erford, Hays, & Wilson, 2010). If a student discloses a particularly severe issue during the screening interview, including the student in a group may lead to inordinate time spent on this member. Asking such a student about expectations for the group can give the counselor a sense of whether the student expects the group to solve his or her problems, and whether the student appears to have sufficient empathy for others. Individual counseling is a better fit for a student with low empathy for others and serious challenges in life. Students who are extremely shy, but say they can benefit from the group by just listening, are likely to be confronted by the group at some point because it will appear that they have a lower investment in the group. In order not to put such students at risk, it is advisable to alert them that one of the expectations of the group is that everyone participate at some minimum level, and ask if they are willing to do so, even if it is not easy for them. It is also helpful to ask what they need from the group to feel comfortable to share, and invite them to talk about this early in the group. It is important that students understand their rights as group members, the purpose of the group, the goals and expectations of the group, the limits of confidentiality, and that their participation is voluntary. These aspects of consent are in accordance with the school counselors' ethical standards (ASCA, 2012) and best practices for group work as determined by the Association for Specialists in Group Work (ASGW, 2000). The ASCA ethical standards (2012, Section A.6.b) state that professional school counselors "recognize that best practice is to notify the parents/guardians of children participating in small groups."

Regardless of whether or not school policy requires consent, it is always prudent to obtain parental permission and student agreement prior to the beginning of a group. In many cases, sending a note home with the child giving information about the group and requesting permission will be sufficient, but counselors may encounter language or literacy difficulties that preclude this method. It is important to collaborate with other staff who can be of assistance with translating or reading information to parents. If parents do not respond to written requests, a phone call or home visit, with the child's knowledge and consent, might be helpful. Similarly, privacy is also important for helping avoid unnecessarily disclosing confidential information or identifying students who are seeking counseling. Finding a location that will preserve student privacy is an important step and necessary for the success of the group, such as the counselor's office if it is large enough (with a sign on the door to dissuade interruptions), or a conference room or empty classroom if they are the only available spots.

During recruitment and screening, group counselors should be careful not to inadvertently label participants (e.g., "Children of Alcoholics"). Ritchie and Norris Huss (2000) offered the following to maintain privacy during the recruitment process: (a) do not give the group a name that implies a label or diagnosis, (b) advertise groups, but allow potential members to make an appointment to discuss their participation at their own discretion, and (c) provide teachers and other school professionals, who may refer students for participation in a counseling group, with a checklist of obser vable behaviors without identifying those behaviors as characteristics associated with a particular label.

Confidentiality is necessary to build trust and communication between the counselor and members and among members. Confidentiality has a unique set of challenges for groups in schools. Ideally, confidentiality and its limits should be discussed with members during the screening process so students are aware that, just as with individual counseling, there are limits to confidentiality in certain circumstances (such as harm to self or others). Students must also be aware that, in groups, confidentiality cannot be absolutely guaranteed because there will be multiple students present during each session. Still, the school counselor has an ethical obligation to try to uphold confidentiality (see section A.7.d of the ASGW *Best Practice Guidelines*), which can be facilitated during the initial stages of a group by helping students establish trust and understand the importance of not disclosing outside of the group what has been shared. School counselors should remind students to honor confidentiality even after the group has ended.

In schools, students in a group are likely to know each other and have a history of interactions prior to the initiation of the group, and those relationships will continue after the group concludes. This means that risks of self-disclosure may be greater in a school group because of the ongoing relationship with other members. In addition, the risks for breach of confidentiality are higher because other members have ongoing contact with students who know other members. Children in school groups also have contact with each other between groups, which may affect their willingness to participate, their level of self-disclosure, and the degree of comfort they experience in the group. Their outside interactions are likely to have a significant impact on their interactions in the group. The group counselor should inquire about relationships with other potential members during the screening process and try to avoid placing close friends or those with a history of negative interactions in the same group. This minimizes the amount of group time and energy that would go toward addressing these relationship issues within the group. In addition, the leader should include a group rule regarding bringing outside interaction to the attention of the group, and carefully explain why this is necessary to avoid subgrouping.

Counselors in schools interact with a variety of adults who may have an interest in the children in a group, and who may apply pressure on the group leader to report on group interactions. For example, a teacher may refer a student to group because he or she seems sad and distracted in class. That teacher may believe that knowing details about the student's situation will enable her to be more responsive to classroom needs, and request information from counselors. It is important the counselors maintain collegial relationships with other educators, and must be understanding of their needs while still respecting children's confidentiality. Sometimes a counselor might ask a child, in front of the group, if something shared in group would be helpful for the teacher to know, and if the student agrees, ask what she thinks is the best way to tell the teacher. That sends a message to all members that the leaders will not share information without students' permission, except in cases that have been described during informed consent. Dealing with parental inquiries is similar to that in other settings, but balancing the needs of administrators to be informed of important issues with the counselor's professional responsibility for confidentiality can be challenging. Counselors conducting groups need to be very clear about what they are required to report, but also they should be strong advocates for professional discretion. If they work in a setting where they are required to report certain types of disclosures to the school administrator, this must be included in informed consent.

Dual relationships between the school counselor and group members and relationships among group members pose unique ethical challenges. In school settings, the school counselor may have several significant relationships with one or more members of a particular group, and it is not uncommon for group members to see each other often outside of the group. ASCA ethical guidelines state that school counselors should avoid dual relationships that "might impair his/her objectivity and increase the risk of harm to the student" (2012, Section A.4.a), but dual relationships may not always be avoidable, nor are dual relationships between the counselor and student(s) necessarily harmful or unethical. To minimize any potential negative consequences of dual relationships, group 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 (American Group Psychotherapy Association, 2007). Group counselors working in schools must be careful to keep information learned in other circumstances (e.g., in individual counseling) from being inadvertently divulged in the group setting. Knowledge of relationships among members can be used judiciously in forming groups that avoid increasing the likelihood of subgrouping.

Counselors doing group work in a school setting must also attend to issues related to the Family Educational Rights and Privacy Act of 1974 (FERPA). FERPA grants the legal right to access education records to parents and legal guardians of students under the age of 18. In some instances, counseling notes kept during group sessions may be considered educational records, and counselors should be cognizant of the type of information they choose to include in any notes in order to prevent any future ethical or legal problems that might arise (Linde et al., 2010).

Evaluating Groups in Schools

Accountability is a major emphasis in education today. Professionals in education settings must demonstrate that their efforts contribute to the academic success of students. It is particularly difficult—and especially important—to evaluate the effects of non-academic activities. Those facilitating groups in the schools need to show that they do two things: (1) make a difference in the well-being of students, and (2) improve academic achievement. Item one can and should be done locally, not just for gathering data to show stakeholders that the group is accomplishing what it set out to do but also for the benefit of the facilitator. The group leader engages in the evaluation process to continually improve future groups. Item two requires larger scale research over a longer period of time than is feasible for school employees.

Trotzer (2006) suggested a framework for evaluating groups; two elements must be considered in deciding whether a group was effective: *process* and *outcome.* Process is the dynamics and interactions among participants in the group; outcome is the change in members with respect to the goals of the group. When evaluating process, data about how the leader's interaction style, methods, and leadership affected group progress and also how members' attitudes, characteristics, and behavior in the group affected their own and others' growth is collected. Methods vary for examining process. If one has a nonintrusive setting for inviting a colleague to observe the group (with members' permission), the observer may be able to offer comments about dynamics obser ved. Also, some form of session evaluation is often completed by members. Depending on the age of the participants, those will vary from simple graphics of faces that members can mark to show their reactions to more detailed checklists that can be quite specific. It is important to collect these evaluations immediately after a group session so that the members can comment accurately on the session and the group leader can consider the comments to plan future sessions.

An ideal way of evaluating group process is to view video recordings and reflect on the process. This method is widely used in professional training but rarely in practice. Practitioners may not need to view every tape in its entirety, but viewing recordings of difficult sessions or interactions may help the leader notice elements and dynamics that she missed in session. Video recording is optimal but nonverbal information often provides invaluable information. Finding an unobtrusive way to record is important and it should be done routinely so that it is not a novel practice for a particular session. There are a number of evaluation forms that are available to assist the facilitator in reviewing the tapes. Of course the counselor must inform the members of the purpose of the recording and be clear about how confidentiality will be ensured and when recordings will be destroyed. Although interaction matrices exist by which the facilitator can document exchanges among members throughout the session, it is not realistic to complete such a detailed document for most purposes. Matrices can also be used pre- and postgroup to detect changes in group members on relevant characteristics and behaviors. For example, a grid with all member names along one axis and characteristics, such as nervous, empathic, hostile, warm, and so forth, along the other provides a rating for each member by each other member. These can be tallied at the first and last meetings and change scores calculated. These types of matrices provide a numerical way to evaluate process elements (Dwivedi & Mymin, 1993). It is crucial to attend to these aspects of evaluation. Hastily constructed forms, in which members record what they liked or did not like about the group, are biased data, especially when the members of the group have a positive feeling toward the counselor. Thus, finding measures that provide specific items about the process aspects of group are necessary. The critical incidents questionnaire is useful with students who are able to express themselves in writing. This procedure involves asking members to talk about the most significant even in the group for them, and explaining why that event/interaction was so significant (Kivlighan & Goldfine, 1991). These can be done for each session but are more often used at intervals or at the end of the life of a group. Typically, this questionnaire is used to identify which therapeutic factors are operating at a given time in the life of a group. Shechtman and Perl-Dekel (2008) used this measure and reported 80% inter-rater agreement before discussion. For the purposes of monitoring group process, users would code the responses into the therapeutic factors (see original article for listing of factors). Evaluating outcomes depends on the goal of the group. The question to be addressed in such an evaluation is, "How did the group experience help members make changes to meet the goals and purpose of the group?" Obviously, it is necessary to have clear goals, both for the group as a whole and for individual members, in order to engage in this process. As with process

evaluation, there are existing measures that can be found to assess change in group members. Pre- and posttests can be very useful in documenting change. Such measures usually are based on symptoms or behaviors and yield a score or profile that is quantitative, and that can be compared at different time points. It is also especially important in the school setting not to rely solely on student self-report but to obtain reports from teachers and parents as well. This triangulation helps the facilitator determine whether changes generalize to settings outside the group as well as within it. Follow-up evaluations add information about the stability of changes; group counselors are advised to make follow-up evaluations standard practice.

It is likely that much of the data obtained in the evaluation process will reveal positive process and outcomes from group counseling. If not, the data may help pinpoint what components or dynamics were influential. For example, was the group of sufficient duration? Was the amount of structure helpful, or did it hinder the emergence of potentially important themes? Did the group affect different members in different ways? What could account for the difference? How could the screening process be improved to select the members most likely to benefit from the experience? The group facilitator who engages in this process is doing what is needed to improve a program while also gathering evidence of effectiveness.

Final Thoughts

Group work has been a component of school counseling programs for many decades (Berg et al., 2006) and is one efficient and effective method for delivery of counseling services within a comprehensive school counseling program (ASCA, 2012). Additionally, within the current context of public education where school counselors are under increasing pressure to demonstrate their impact on student outcomes, group counseling interventions are a compelling way for school counselors to establish themselves as essential contributors to improved personal/social and academic outcomes for students.

The importance of group work in a school setting cannot be overemphasized. School counselors may be discouraged by the apparent lack of time or support for implementing group-based interventions. However, thoughtful planning that includes collaboration and a "team-building" approach can alleviate administrator and teacher concerns and embed group interventions into the academic mission (Wilson, 2010). Effective communication is essential; school counselors should strive to communicate the intent of their group interventions in the most transparent way possible to foster collaborative relationships (Geroski & Kraus, 2010). In addition to gaining schoolwide support, school counselors are encouraged to find creative ways to build time into the regular school day for conducting groups, such as during lunch or homeroom. When specific study hours or advisory periods are built into the schedule, teachers might be more flexible. Other options include groups immediately before or after the school day or rotating the times and days of the week when a particular group meets. In addition, school counselors might use technology to convene groups of students after the school day ends.

Perhaps the best way to advocate for group interventions is to establish their relevance. Geroski and Kraus (2010) suggest that in planning group interventions, school counselors must ask themselves: Does this group assist its members in maximizing their chances for success in school? Applying this question to each planned group intervention gives school counselors a concrete strategy for articulating a compelling rationale for their group interventions. Communicating the answer to this question to the various stakeholders can generate support for a group counseling program.

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Chapter 26 Group Work in Colleges and University Counseling Centers

Martyn Whittingham

Groups have consistently been a part of University Counseling Centers (UCCs) standard practice for over 50 years (Slocum-McEneaney & Gross, 2009). A survey in the 1970s indicated over 60% of groups were adequacy enhancing, took a developmental-preventative focus, and emphasized personal growth (Conyne, Lamb, & Strand, 1975) with that trend continuing in the 1990s (Golden, Corazzini, & Grady, 1993). The 2000s were characterized by a large number of time-limited, process and/or topic groups and a significant number of process-oriented psychotherapy groups (Kincade & Kalodner, 2004).

Most recently, tremendous external pressure on universities to reduce costs and increase enrollment have resulted in greater client demand for mental health services, often leading to increased wait lists. Accompanying this rise in demand has been an increase in severity of presenting-client concerns, with severe pathology, comorbidity, Axis I and II, and a need for ongoing care becoming an increasing feature of this population (Rudd, 2004; Wolgast et al., 2005). There are many possible reasons for this increase in severity. Some suggest that students with visible and invisible disabilities, including mental illness, are more likely to pursue a college education because of the increasing availability of pharmacological and other supportive interventions (Slocum-McEneaney & Gross, 2009), while others more controversially suggest that the current "Millennial" generation (Howe & Strauss, 2000) may be less able to cope with the stressors of college than previous cohorts (Twenge, 2007). In addition to increases in demand and severity, the college population is also becoming increasingly ethnically and racially diverse (Pew Research Center, 2010). In 2007, freshman enrollment of Hispanics rose by 15%, of African Americans by 8%, and of Asians by 6%, compared to an increase of only 3% by Whites.

However, despite the changing demographics of college students, the most common presenting problems at UCCs still lie in familiar and expected domains. The top three complaints dealt with at UCCs (sometimes comorbidly occurring) remain anxiety (40%), depression (38%), and relationship problems (36.3%; Barr, Rando, Krylowicz, & Reetz, 2011). Therefore, many centers may best be characterized as dealing with the same issues as they always have but in greater numbers, with more diversity, and with an increasingly severe population being added to their center caseload.

Burlingame, MacKenzie, and Strauss's (2004) review supported group therapy as effective with many mental health problems. On aggregate, group was found to be as effective as individual therapy and also displayed a reliable effect when used as either sole treatment or adjunct to other treatments, such as individual, family, and psychopharmacological intervention (Burlingame & Beecher, 2008).There is also clear consensus that groups meet the developmental needs of the college population (DeLucia-Waack, 2009; Drum & Knott, 2009). College is a period marked by many life transitions and challenges. These include formation of new friendships and romantic relationships, exposure to people from different backgrounds and belief systems, dealing with oppression, self-regulation, and struggling with personal identity. Moreover, many students lack skills in emotional regulation, managing conflict, and have difficulty developing social support systems. In many cases, this is compounded by inexperience with significant life events or intimate relationships and poor insight into their own contributions to dysfunctional interpersonal patterns (DeLucia-Waack, 2009; Johnson, 2009). Moreover, Lotkowski, Robbins, and Noeth (2004) found that social support and social involvement are key to retention and graduation, and this is a particularly important factor for marginalized students, who face unique developmental issues, such as negotiating their identity, managing the coming out process, and dealing with overt discrimination and prejudice (Eason, 2009; Johnson, 2009).

Despite the potential for groups to address students' mental health needs, improve retention, and provide support for those traditionally underserved, groups continue to be underutilized. In a recent AUCCCD Director's Survey (Barr et al., & Reetz, 2011), only 287 of the 362 UCC's reported offering group therapy at all, and only 33% of

those offering groups reported increasing utilization of group therapy. This chapter will outline how planning, best practices, and understanding cutting-edge issues related to group work in UCCs can aid in this mission. In particular, significant attention will be paid to planning, coordinating, and evaluating group programs to meet the specific needs of university students.

Best Practices in Groups in UCCs

Failure to launch and *failure to thrive* are common issues in UCC groups. *Failure to launch* takes place when groups never begin, while *failure to thrive* occurs when they begin but quickly collapse. Both can be caused by a wide variety of factors, but problems often begin before the first group has even started. Factors leading to failure to launch and thrive will now be explored in more detail and best practices solutions offered.

Appointment of a Group Coordinator

Developing a group coordinator is an important first step for many UCCs since it allows a greater focus on the reasons for success and failure of a group program (AGPA, 2007). Responsibilities for a group coordinator are to (1) assess and increase commitment to groups; (2) track patterns of group referrals; (3) develop clear inclusion and exclusion criteria; (4) liaison with higher administration to advocate for groups; (5) develop training and supervision programs related to group; (6) generate in-house training opportunities related to group therapy; (7) stay abreast of the latest developments and research in group; and (8) formalize assessment of group process and outcomes (AGPA, 2007; Whittingham & Frick, 2010). Group coordinators can benefit from wider contact with their peers via professional groups and listervs for group coordinators (e.g., groupsinscc@lists.fsu.edu).

Group coordinators face a number of challenges when building a thriving group program. These include insufficient referrals, lack of adequate group screening, and inconsistent therapist allegiance, enthusiasm, and training (Parcover, Dunton, Gehlert, & Mitchell, 2006). Group coordinators must begin by understanding where the specific issue for their UCC occurs. While external factors (e.g., time of year or scheduling problems) may sometimes lead to these breakdowns in treatment delivery, a rigorous collection of data can also pinpoint internal factors (Whittingham & Frick, 2010).

Failure to launch is often caused by lack of referrals. If therapists believe (as clients may) that group is second-rate treatment, they are unlikely to make referrals or may quickly capitulate to offering individual counseling in the face of client initial resistance (Parcover et al., 2006). This can be the result of group leaders' uneasiness with groups (Marmarosh, 2009) or worries about feeling vulnerable and incompetent (Hahn, 2009). Therapists can also have had limited or ineffective group training and are unclear themselves how groups are beneficial. Group coordinators must help the entire UCC staff understand and articulate the benefits of group. Orientation to the research on group efficacy for UCCs along with in-house workshops or on issues such as referral, screening, and running groups can also aid in this mission (Whittingham & Frick, 2010). Further, a philosophical shift to the idea of "why not group?" that invites therapists to assume most clients are suitable for at least one type of group unless exclusion criteria are met is needed (Parcover et al., 2006). Both failure to launch and failure to thrive have multiple causes and solutions; however, extra attention paid to pregroup variables can offset many later problems.

Pregroup Preparation

As Johnson (2009) states, “Perhaps the most significant aspect of any group is preparing potential members for the group experience” (p. 515). College students often hold negative beliefs about group therapy (Parcover et al., 2006). However, research has underscored that preparation of members increases cohesion, understanding of members’ role, satisfaction, comfort with the experience, and decreases attrition (Burlingame, Fuhriman, & Johnson, 2001). Corey (2004) suggested pregroup preparation is particularly important for students from diverse backgrounds who may have less exposure to group therapy.

Pregroup preparation can begin prior to any contact with the group leader. It can include use of website information (e.g., http://www.cmhc.utexas.edu/g_qanda.html or http://www.wright-counseling.com/Group.html); brochures (e.g., http://www.virginia.edu/studenthealth/documents/CAPS%20Group%20Therapy%20brochure%20web.pdf); moving picture frames in waiting rooms with group-relevant information; video (e.g., Campinha-Bacote, Whittingham, Rando, Moss, & Sluder, 2010); and/or connected social media content such as YouTube videos (e.g., Campinha-Bacote, 2012). The use of social media in particular is an important means to reach this generation of tech-savvy students. The CORE–R Battery (AGPA, 2006) also provides excellent handouts for clients to understand the group process, dispel myths, and promote the benefits of group work (Burlingame et al., 2006).

Group Screening Interviews

Individual interviews with potential group members are essential to begin to establish a working alliance and decide about group fit (Kincade & Kalodner, 2004). Even for psychoeducational groups, screening can be important in preventing dropout and promoting member growth (DeLucia-Waack, 2009). A scheduled face-to-face meeting that includes a sufficient amount of time to discuss the benefits of groups and allow the potential group member to ask questions is essential. Carter, Mitchell, and Krautheim (2001) found that spending 1 to 5 minutes with a potential group member predicted 33% of the clients who intended to follow with group counseling, whereas 6 to 10 minutes spent in discussion resulted in an increase in intent to follow through of 70% (Parcover et al., 2006).

Inclusion/Exclusion Criteria

Selecting members who will be successful in group is key in avoiding both failure to launch and failure to thrive (Piper, 2008). Yalom and Leszcz (2005) suggested that what is an exclusion criterion for one group can be an inclusion criterion for another. Broad criteria for inclusion should incorporate a rationale for how the mechanism of change within each group relates to the etiology of a client's presenting problem. For example, an interpersonal process group might have inclusion criteria that seeks clients whose presenting problem (e.g., depression) is caused by some underlying interpersonal problem (e.g., difficulty in forming and keeping relationships leading to isolation and loneliness). Information to referral sources should be clear about what constitutes a good referral and examples should be presented outlining the differences between an appropriate referral and one better suited for other groups or interventions. For example, someone who is struggling with their sexual identity as a primary concern might be better suited to a GLBTQ group than a general depression group.

Exclusion criteria are anything that prevents clients from benefitting from a specific group (Yalom & Leszcz, 2005). Active suicidality, logistical difficulties (such as only being able to attend every other session), low motivation, and severe current crises might impact group members' participation. For each group offered, consideration should take place on what the focus of the group is and factors that might interfere with work being done. For example, if a group is designed to stimulate insight, then factors that might block insight, such as rigidly externalizing, having low ego strength, and being in the midst of severe crisis, might all suggest referral to a different type of group (Yalom & Leszcz, 2005).

Development of a Therapeutic Alliance

Creation of a strong working alliance between group leader and member must be developed as part of pregroup preparation (AGPA, 2007) as it influences both premature termination and outcome (Abouguendia, Joyce, Piper & Ogrodniczuk, 2004; Marmarosh & Kivlighan, 2012). Horvath and Greenberg (1989) suggested three aspects —bond, task agreement, and goal agreement— to be addressed in screening and preparation. A predominately warm and somewhat dominant therapist presence has been shown to increase the leader-member bond, with warmth the more important dimension (Hersoug, Hoglend, Monsen, & Havik, 2001), suggesting that group leaders conduct their own group screenings to begin to develop the therapeutic alliance as soon as possible. Once selected for a group, members should be helped to identify at least one other group member with whom to connect (DeLucia-Waack, 2009) so cohesion with group members develops.

Goal agreement is also critical. For example, Parcover et al. (2006) emphasized for process groups, group members must understand how their presenting problem might be underpinned by interpersonal issues. The group leader begins by asking about the presenting problem and taking an interpersonal inventory (Yalom & Leszcz, 2005). As relationship themes become clear (e.g., difficulty in repairing conflicts or trouble developing intimacy), group goals can be identified to target these issues. Goals should be achievable from the client's perspective, linked to the mechanisms of change within the group, and time limited. Skillful formulation of goals often entails working through considerable resistance. This is particularly important in mandated groups (e.g., anger management) or

groups where clients are struggling with internalized oppression (e.g., GLBTQ or Students with Disabilities groups).

Task agreement for group is crucial (AGPA, 2007) and involves presentation of information about expectations of attendance, confidentiality, and timing (day, time of day, and length of sessions) for group members to truly make an informed decision about group participation. Anxiety can be decreased by asking about concerns about joining a group and then validating and reframing them. Clients should be apprised of behaviors expected in group. For a process group, giving and receiving feedback using "I" statements to share reactions and listening to other group members' issues are important tasks. Leaders should also acknowledge that growth is an anxiety-provoking experience and to coach clients to recognize signs of anxiety as an opportunity to move toward change.

Screening Instruments

Assessment tools can provide invaluable information to assess appropriateness for group (Jensen et al., 2012; Krogel, Beecher, Presnell, Burlingame, & Simonsen, 2009). The CORE–R Battery (Burlingame et al., 2006) is a collection of measures to aid in group member selection and outcome assessment. The Group Readiness Questionnaire (Burlingame, Davies et al., 2010) assesses underlying factors predictive of difficulty in group participation (Krogel et al., 2009), such as members who might have an unsuccessful group experience or low motivation. Care should be taken with both instruments to allow them to inform clinical judgment and not supplant it (Burlingame, Beecher, MacNair-Semands, & Bowman, 2010). However, by identifying key factors predictive of dropout, leaders may be able to focus group screening around those issues thus increasing the likelihood of successful referral.

Process tracking can also be useful both as a means to augment choice of intervention and also as a "trouble shooting" device. For example, the Group Climate Questionnaire (GCQ–S; MacKenzie, 1983), the Group Questionnaire (Krogel et al., 2013), and Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) allow group leaders to assess the ongoing health of the group by tracking evidence-based constructs such as cohesion and goal and task agreement (AGPA, 2007). This can allow group leaders to augment their clinical judgment with self-report evidence regarding the socioemotional health of both individual members and the group as a whole. Thus group leaders might better anticipate potential dropouts, thereby reducing attrition of individual members, as well as preventing the group from becoming demoralized and failing to thrive. Finally, by utilizing group outcome measures, such as the Outcome Questionnaire (Lambert et al., 1996) and IIP–32 (Horowitz, Alden, Wiggins, & Pincus, 2000), group leaders can track outcomes and better understand client progress.

Confidentiality is essential to any group but has new challenges to current college students with the advent of new media and social networking (Aronson & Hurster, 2011). The Millennial Generation, born between 1982 and 2004, are considered significantly less private in their communications and having fewer boundaries in their interactions than previous generations (Zur, 2011). Social media (e.g., Facebook, other social networking sites, texting, and tweeting) are a normal, everyday part of social life (Pew Research Center, 2010). Group members may think nothing of looking each other up online, connecting to each other and their therapists through social networks via "friend requests," taking photos of each other and rapidly posting them (in some cases covertly), and even texting each other during sessions (Aronson & Hurster, 2011). Without clear verbal and written guidelines around these ethical concerns, group members may inadvertently expose each other to significant breaches in confidentiality due to a very different set of assumptions about privacy (Sheppard, 2011). Group leaders should clearly outline their ethical guidelines in writing on social networking and confidentiality as part of their informed consent process as is routine clinical practice with this population. Current resources outlining these areas in more general terms (Alessi & Alessi, 2008; Martin, 2010) suggest clear policies should be in place around (a) mobile devices in session; (b) therapist boundaries regarding "friend requests"; (c) group leaders' online presence appropriately; (d) social network contacts outside of group; and (e) determination of boundaries for both group members and leaders in a clear and thoughtful manner.

For example:

> I agree not to use electronic forms of communication, such as blogging, texting, social media (e.g., Facebook, Twitter) to communicate the identity of group members or the content of group sessions. Examples of "communicating identity" would include taking photos of group members and posting them on social media sites or otherwise communicating identifying information about group members in the social media. I will also maintain the boundaries of the group treatment by not seeking any alternative forms of outside contact or searching for information about other group members (e.g., accessing Facebook pages, "friending" group members, seeking out information on the Internet).

This statement serves as an example of the kind of statement a center may wish to employ. Each center should carefully consider its own policies to comply with ethical codes and laws as well as salient diversity variables that may result in modification of such statements to allow for contact outside of group.

Choosing What Groups to Offer

The final aspect of planning involves choosing the most effective groups to offer. Coordinators must decide which groups can appropriately meet the needs of students, fit with the setting and its systems, and can be delivered competently by therapists. Each group should be selected based on a combination of research review (for resources, see Johnson, 2008), needs of the center, intended goals, possibility of change within time limits (Piper, 2008), relevant diversity variables (Chen, Kakkad, & Balzano, 2008), salience to underserved communities, and a wide variety of other factors. Moreover, group leader competence and interest should also be considered (Parcover et al., 2006).

Theme Groups

Theme groups are defined as "time-limited, multisession group intervention exclusively focused on a developmental issue or resolution of a specific theme, issue, challenge, or problem common to the participants" (Drum & Knott, 2009, p. 495). Current theme groups include anxiety (26.1%), grief and bereavement (24.2%), body image (16.5%), eating disorders (15.3%), depression (14.6%), AOD (14.4%), self-esteem (13.4%), and trauma (11.3%) (Barr, et al., 2011). Since theme groups are, by definition, homogenous by problem area (e.g., communication skills, coping skills, dissertation support), cohesion and universality develop quickly (Yalom & Leszcz, 2005). Drum and Knott suggested five goals for theme groups: (1) skill acquisition (e.g., how to manage conflicts); (2) developmental pathway progression (e.g., transitioning from dependent to independent); (3) management of life transitions (e.g., learning to cope being away from parents by forming intimate friendships); (4) management/coping skills relative to specific disorders (e.g., progressive muscle relaxation and positive self-talk for Anxiety Disorders); and (5) maintenance of recovery (e.g., predicting relapse in those with addictions and preparing strategies to deal with it).

Theme groups are also expected to have clear change strategies that are explicitly stated, session-by-session objective, and a clear plan to meet those objectives (Drum & Knott, 2009). However, theme groups may present scheduling difficulties since they rely on a sufficient number of members with common issues who can meet at a mutually-agreeable time.

Examples can be found at the Clearing House for Structured/Thematic Groups housed within The University of Texas at Austin (http://cmhc.utexas.edu/clearinghouse/index.html) or through lists of evidence-based groups on suggested websites cited in Johnson (2008).

When identity development is considered as a sixth goal, then diversity-based groups are also theme groups. Group identity has been found to considerably impact minority student adjustment (Lee, Draper, & Lee, 2001), influencing hope for the future, self-esteem, life satisfaction, and depression (Cameron, 1999). Strong ethnic identity links predict the likelihood of involvement with campus ethnic groups and greater ability to obtain social support while on campus (Marmarosh, 2009).

Steen, Griffin, and Shi (2011) offered suggestions for group outreach to support students of color and promote

retention, focusing on academic and social support drawing on the collective wisdom of the group. Salazar (2009) provides over 75 activities to address and utilize diversity in psychoeducational and counseling groups while Molina, Monteiro-Leitner, Garrett, and Gladding (2005) also suggested activities and structure to aid in discussions of diversity.

Psychoeducational Groups, Workshops, and Classes

Psychoeducational groups are offered frequently in UCCs and can allow members to learn and practice new skills in an emotionally safe environment (DeLucia-Waack, 2009). They can range from stress management to Alcohol and Other Drug (AOD) groups and are proving increasingly popular as they allow leaders to work within very brief time limits on discreet goals, utilizing structured material and exercises. Stress management (28.3%) groups and Dialectical Behavior Therapy (DBT; 8.6%; Linehan, 1993) are the most utilized psychoeducational groups in UCCs (Barr et al., 2011). However, for the last of these, it is unclear whether these are offered to clients diagnosed with Borderline Personality Disorder, as the treatment was prescribed, or whether they are offered in modified form to a subclinical population. Linehan (1993) suggests that centers wishing to utilize DBT groups for clients with Borderline Personality Disorder (rather than subclinical) do so on a center-wide basis and take extra steps to prevent therapist burnout.

CBT groups could be viewed as therapy groups, theme groups, psychoeducational, or all the above, depending on how they are led. Group Cognitive Behavioral Therapy (GCBT) is an efficacious treatment for depression, with some studies suggesting that it outperforms other group treatments (Oei & Dingle, 2008). In UCCs, GCBT is surprisingly not widely used, with only 7% indicating offering such groups (Barr et al., 2011). Bjornsson et al. (2011) suggested this may be because of high attrition rates associated with GCBT and its underutilization of therapeutic factors. They suggested adding nonspecific treatment factors that focus on developing relationships between members (such as facilitating supportive comments and generating self-disclosure) to strengthen effect. Bieling, McCabe, and Antony (2006) and White and Freeman (2000) offer specific guidance on how to run GCBT for a wide range of problems and populations.

Mindfulness groups have also been increasing considerably over the last decade, with the work of Kabat-Zinn (1990) and others becoming more widely accepted as its research base expanded. There has been a recent trend toward mindfulness based groups for depression, anxiety, and subclinical eating disorders (Baer, 2006). Burns, Lee, and Brown (2011) reported individual meditation reduced depression, anxiety, stress, and perfectionism. Mindfulness approaches utilized within group therapy have also shown promise. Mindfulness Based Cognitive Group Psychotherapy (MBCT; Segal, Williams, & Teasdale, 2002) has been found to have comparable outcomes to maintenance depressive psychopharmacological interventions in preventing relapse in depression (Lau, 2010). While such groups provide wide inclusion criteria and are appealing to both clients and therapists, care must be taken to follow inclusion and exclusion guidelines carefully, since there are contraindications for each type of group (Dobkin, Irving, & Amar, 2011). Group leaders should also carefully evaluate inclusion and exclusion criteria as well as outcomes and ensure that these groups do not become a panacea applied to all clients, regardless of presenting problem and underlying mechanism of change.

With theme or psychoeducational groups, adequate screening is essential, since there is a need to accurately target members most able to benefit from the group while also providing a functional group dynamic. Assessment can aid in this process. For example, anger management groups might utilize the Aggression Questionnaire (Buss & Warren, 2000) to separate those with characterological anger problems (such as those with antisocial traits) from those with situational anger problems (such as those with roommate disputes). Groups should also be organized to work within the mission and purpose of the UCC with respect to its ability to offer services to specific groups. For example, a center that does not wish to implement long-term services for those with substance abuse problems might utilize an insight-based, brief stages of change model (e.g., Velasquez, Maurer, Crouch, & Di Clemente, 2001) while a center with a mission to intensively treat this same population might prefer a longer-term model (e.g., Flores, 2007).

Single session workshops and classes can also be effective ways of addressing common issues for college students.

Workshops offered by some counseling centers include stress management, social skills, surviving divorce, grief, career decisions, test anxiety, and others. They offer advantages in terms of providing a prophylactic against stressors for some less severely distressed or wait-list clients who may only need basic skills building.

Anecdotal evidence suggests that while some centers experience considerable success with single-session groups and workshops, others have problems with difficulties with failure to launch. Therefore, considerable attention should be paid by the group coordinator to track likelihood of these groups meeting a need within the center and in a time slot that is likely to be amenable to student schedules.

Process and Therapy Groups

As can be seen from the chapter on Attachment in this *Handbook*, there is considerable empirical support that connects attachment security to managing the transition to adulthood, overall regulation of affect, and a wide variety of mental health concern. Thus, the compelling connection between attachment security and the process of separating from home while adjusting to university life makes process groups a particularly relevant treatment modality for this population (Marmarosh, 2009). Care should also be taken in terms of understanding diversity variables at the screening stage. For example, Kearney, Draper, and Baron (2003) cautioned that Asian American students might find process groups to be inconsistent with their expectations of group therapy and that a psychoeducational and directive approach is more expected. Therefore, clinical judgment is required to assess the degree of acculturation and cultural expectations of groups with respect to the tasks expected of clients within the therapy group.

Significant demands of the group leader are made at every stage (pregroup preparation, screening, and conducting the group) of process groups (Johnson, 2009). Facilitating groups that are heterogeneous in problem areas requires leaders to clearly establish a working alliance in both screening and early in the life of the group. Process groups also require a strong grasp of brief interpersonal approaches (e.g., Johnson, 2009; Piper & Ogrodnickzuk, 2004; Yalom & Leszcz, 2005) and demand a great deal from leaders at both a theoretical and technical level (Drum & Knott, 2009).

However, because of the semester system, most groups in UCCs are practicing de facto brief process groups. For short-term process groups, it is particularly important to screen well to prevent toxic dynamics undermining and destroying the group before it has had a chance to begin (Yalom & Leszcz, 2005). Brief process groups also need to establish clear treatment goals, maintain a focus on those goals, provide active and efficient leadership, and maintain a here-and-now focus (Piper & Ogrodnickzuk, 2004; Yalom & Leszcz, 2005). Goals are presented to members as a starting point for further growth outside of group. The group leader's task is then to keep group members goal-focused and time-focused by frequently reminding them that “There are only (insert number here) sessions left, so if you have not worked on your goal yet, today might be a good time to address that.” Moreover, within such process groups, rigorous examination of multicultural group dynamics is essential given the multiple cross-cultural interactions and group-as-a-system diversity issues (Rubel & Okech, 2006). Group leaders should be prepared to ask the group how issues related to multiple identities might impact interactions. For example, a client who is expecting to be rejected because of their sexual orientation who comes out to the group might be encouraged to discuss what fears, hopes, and anxieties they had of other people and how those were affirmed or contradicted.

Process groups can offer considerable scheduling flexibility since they allow members with heterogeneous issues to assemble in a group. However, these groups may also require additional explanation of how such a group would work to a potential group member. Group leaders must describe groups in ways that alleviate anxiety and outline potential gains (Johnson, 2009; Parcover et al., 2006).

Conclusion

In an era of increasing demand and client severity, group counseling and psychotherapy is an effective and efficient means of addressing the needs of UCCs and the clients they serve. College students' struggles with developmental and contextual issues can significantly impact their ability to succeed in college, and groups are uniquely suited to help. Whether targeting specific conditions, such as a group for students struggling with stress management, working with marginalized groups on identity and confronting oppression, or providing a process group experience to enhance relationship skills, students can benefit from the combined effects of the treatment method, the group leaders, and their peers. At this developmental stage, gains in insight, behavior change, emotional awareness, and relational skill can have benefits across not only their current setting but can also set the course for future academic and personal success. Effective group coordination that promotes utilization of best practices, attention to diversity variables, and integration of assessment can help centers better activate this population-appropriate treatment modality by avoiding failures to launch and failures to thrive while optimizing group and individual outcomes.

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Chapter 27 Groups in Behavioral Health Settings

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Changes in the healthcare system and within the specialty of group work have led to increased utilization of groups in behavioral health and medical settings (Drum, Swanbrow-Becker, & Hess, 2011). Group approaches are time- and cost-efficient (Conyne, 2011), and their flexibility can be used advantageously to address a wide array of concerns specific to particular health conditions or unique to given populations (e.g., dietary changes for diabetes, pain management techniques for cancer, coping skills for cardiac conditions). Groups are conducted across healthcare settings, including acute and postacute care hospitals, other postacute inpatient settings (e.g., skilled nursing facilities and intermediate care facilities), outpatient rehabilitation facilities, and specialty clinics.

Group approaches have been applied to the wide variety of conditions and populations typically encountered in behavioral health and medical settings (McCarthy & Hart, 2011), including catastrophic illnesses (e.g., cancer, HIV), traumatic injuries (e.g., spinal cord injury, brain injury), and chronic disabling conditions (e.g., diabetes, chronic pain). Group participation provides an opportunity for people to learn about and plan for impending difficulties that otherwise might be unanticipated. It can be helpful to hear from others who live with similar medical concerns and learn how they handle various aspects of the condition, manage symptoms, solve related problems, and prepare for events such as medical procedures or surgeries. For example, group members may learn about controllable aspects of a particular medical condition or potential side effects of medications or treatments. Observing others who have adjusted well or who have successfully managed health concerns, which impose even greater limitations than one's own, is another benefit gained from group participation. In general, universality (the recognition among group members that they share similar thoughts, feelings, and experiences) is especially salient for people with health concerns, who often feel misunderstood and isolated (McCarthy & Hart, 2011).

Group formats commonly utilized in behavioral health and medical settings include educational/psychoeducational, support, and psychotherapy groups, but other group formats have potential value, including counseling and task groups (cf. ASGW, 2000). *Educational groups* are particularly relevant because taking the time to ensure that patients understand their medical issues and the steps necessary for care can be a challenge for healthcare providers. Groups allow healthcare professionals to disseminate necessary medical information to a number of patients at once. In addition, group members benefit from contact with others who have experienced similar concerns or medical conditions. Thus, group work offers a unique opportunity not just for education but to promote understanding through discussion (McCarthy & Hart, 2011). Educational groups most often are conducted to provide targeted information to group members with specific illnesses or medical concerns, but such groups also have a preventative role in promoting health and wellness, as in the case of HIV-prevention groups discussed below.

In addition to allowing efficient provision of specific health-related information, *psychoeducational groups* incorporate and convey techniques and strategies such as stress management and coping skills (Spira, 1997). For third-party payers and health plans, psychoeducational groups have the appeal of decreasing avoidable medical complications and reducing unnecessary utilization of resources (Drum et al., 2011). As discussed below in the case of pain management, psychoeducational groups often are a component of interdisciplinary treatment programs. Such groups typically feature experts from different disciplines working as coleaders (e.g., a physical therapist with a psychologist) to ensure that detailed and complex information is provided accurately to group members (Johansson, Dahl, Jannert, Melin, & Andersson, 1998). This interdisciplinary approach is highly desirable, because many medical conditions require specialized information and extensive changes in everyday routines to maintain health, promote quality of life, and prevent further complications.

In response to managed care and the need to reduce healthcare expenditures, both peer and professionally led *support groups* have become increasingly common across medical settings and conditions such as cancer (Gottlieb

& Wachala, 2007), multiple sclerosis (Holmes, Ford, Yuill, Drummond, & Lincoln, 2012), and diabetes (Markowitz & Laffel, 2012). In addition to providing an opportunity to learn and obtain emotional support from peers with similar health concerns, an obvious benefit of support groups is their near-universal accessibility. As illustrated below in the examples of group work with individuals with limb loss or HIV, support groups typically are free, open to the public, and require only that participants share the diagnosis or condition addressed.

Psychotherapy groups in behavioral health settings focus on psychological and interpersonal issues that impede and complicate adjustment to health and medical concerns. As with psychotherapy groups in general, the theoretical orientation of the group leader guides the direction, goals, and process of psychotherapy groups in healthcare settings. As discussed below in the examples of HIV, spinal cord injury, acquired brain injury, and chronic pain, psychotherapy groups embedded in cognitive-behavioral therapy (CBT) models have proven especially relevant for a broad range of participants in healthcare and medical settings (Elliott & Jackson, 2005). CBT treatment models (e.g., Social Problem Solving, D'Zurilla & Goldfried, 1971; Transactional Model of Stress and Coping, Lazarus & Folkman, 1984; Coping Effectiveness Training, Folkman et al., 1991) provide clear directives for affecting change, so it is straightforward to put group procedures into standardized protocols that can be adapted for use across settings, health conditions, and medical diagnoses. CBT models also provide testable explanations of behavior and behavioral change (see Rath & Elliott, 2012, for an overview), so they easily can be examined in group outcome research.

This chapter considers illustrative applications of group work to representative conditions common in contemporary healthcare settings (chronic pain, HIV and AIDS, spinal cord injury, limb loss, acquired brain injury). Key findings from the literature are highlighted for the specific group interventions and conditions presented. Finally, the role of focus groups in healthcare settings and emerging approaches to extending group services to individuals who face disparities in access to behavioral health services are discussed.

Groups for People Living with HIV

Group work for people living with HIV has been a treatment of choice since the earliest days of the AIDS pandemic (Gushue & Brazaitis, 2003). Advances in medical management have led to significantly increased life spans of those living with HIV. Nonetheless, long-term survivors may struggle with issues such as depression, loss, and anxiety regarding the future. Support groups focusing on coping strategies are among the most common group formats for addressing the behavioral and psychological sequelae of HIV/AIDS (Sikkema et al., 2007). One study, aimed at reducing depressive symptoms in older adults living with HIV, reported greater benefits for support group participants compared to individual psychotherapy participants (Heckman, Sikkema, Hansen, Kochman, & Hev, 2011). The support group model also has been extended to bereavement groups for those who have experienced the loss of loved ones with AIDS (Sikkema, 2011). Themes in these support groups generally relate to coping with AIDS-related deaths and other losses such as diminished social status, health, and employment. Paralleling support groups for other populations, therapeutic factors such as catharsis, cohesiveness, and imparting of information, particularly with regard to coping strategies, are integral to support groups for individuals living with HIV (Sikkema, 2011).

Gushue and Brazaitis (2003) discussed changes in support group dynamics and subsequent group cohesion over time, as medical management of HIV has evolved. Following dramatic improvements in life expectancy that occurred with the introduction of highly active antiretroviral therapies (HAART), Gushue and Brazaitis found that earlier themes of anger, loss, and impending death were still salient, but an atmosphere of hopefulness and increased optimism also emerged, with a greater emphasis on "life" (enjoying improvements in health, managing relationships, work, stigma, etc.). Group dynamics became more complicated as members differed in their individual medical responses to HAART. Leaders were now required to navigate frustration, anger, and shame in individuals who were not responding, in combination with the hope and guilt of those who were responding. The discrepancy also highlighted social and economic differences associated with access to HAART, resulting in more dynamic and sometimes conflictual group processes. Leaders generally intervened by understanding, containing, and interpreting these reactions and conflicts.

Psychotherapy groups, particularly those addressing stress-management techniques, cognitive restructuring, and problem-solving skills, result in reductions in risky behaviors in people living with HIV (Kalichman, Rompa, & Cage, 2005). Evidence also indicates that psychotherapy groups, especially those based in CBT, are cost-efficient in promoting prevention behaviors among persons at risk for HIV. One recent study with HIV-positive participants compared a CBT-based psychotherapy group, emphasizing self-efficacy and behavior change, with a comparison group geared toward topics such as community support and medication adherence. At six month follow-up, only the psychotherapy group showed continued reductions in risky transmission behaviors (Kalichman et al., 2005). Another study examined Coping Effectiveness Training (CET; Folkman et al., 1991), a CBT-based intervention derived from Lazarus and Folkman's (1984) Transactional Model of Stress and Coping, which emphasizes development of adaptive skills for coping with stress. In a sample of 149 men living with HIV, group CET demonstrated effectiveness in reducing stress and "burnout" and increasing coping efficacy (Chesney, Chambers, Taylor, Johnson, & Folkman, 2003). Consistent with such groups for other populations, salient therapeutic factors in psychotherapy groups for individuals living with HIV include instillation of hope, imparting of information, cohesiveness, catharsis, and interpersonal learning, particularly from peers with similar circumstances.

Group work also enhances the effectiveness of HIV prevention programs (Centers for Disease Control and Prevention, 2011). For example, educational groups have been found to reduce high-risk sexual behaviors, particularly in adolescents (Mustanski, Newcomb, DuBois, Garcia, & Grov, 2011). Obstacles to establishing HIV prevention groups include difficulty with recruitment; however, once established, educational groups developed through HIV-prevention community outreach initiatives may later evolve into support groups and social networks that reinforce risk-reducing behavior (Mustanski et al., 2011).

Practice Guidelines

- Education, prevention, and instruction about risk-management techniques should be goals of intervention across groups (see Kalichman et al., 2005).
- Group leaders should be sensitive to differential responses to medications and subsequent health status (see Gushue & Brazaitis, 2003).
- Development of coping skills is beneficial across stages of illness (see Chesney et al., 2003).
- Target recruitment efforts for educational groups to specific high-risk groups (e.g., individuals with substance use disorders).

Groups for Chronic Pain Management

Benefits of psychotherapy groups for individuals with chronic pain parallel those of psychotherapy groups across other medical conditions, including enhancement of individual treatment, peer instruction and feedback, reduction of isolation, identification with others in similar circumstances, and cost-effectiveness (Thorn, 2004; Thorn & Kuhajda, 2006, 2011). Because pain can be secondary to many different medical conditions and group leader communication with medical providers is often necessary, participation should be limited to those with medical conditions that are within the range group leaders' expertise (Thorn, 2004).

Operant-conditioning approaches to pain management are based on the premise that "pain behaviors" have been positively reinforced, while healthy behaviors have not been adequately reinforced or have been extinguished or punished (see seminal work by Fordyce, 1976). Psychotherapy groups based on operant models therefore are geared toward increasing pain-incompatible behaviors, decreasing disruptive pain behaviors, and subsequently reducing distress and increasing activity level (Flor & Turk, 2011). Such groups generally are conducted for 12 highly structured two-hour sessions and do not permit discussion of pain so as not to reinforce this observable pain behavior. Emphasis across group sessions includes (a) reducing pain behaviors (e.g., grimacing) and enhancing well behaviors (e.g., being physically active, not complaining about pain, not taking unnecessary medication), (b) increasing physical activity and physical tolerance, (c) reducing medication consumption, (d) increasing work-related activity and scheduling, (e) making changes in use of the healthcare system, and (f) social-skills training. Treatment also incorporates intervention with significant others as "the most important reinforcing agent for the chronic pain patient," by altering their maladaptive responses to the patient's observable pain behaviors (Flor & Turk, 2011, p. 396). Role playing alternative responses is implemented between dyads to encourage behavior change via reinforcement of pain-incompatible behaviors in the patient, as well as extinction of pain-eliciting behaviors in the significant other. For instance, a dyad may participate in a role-play where the patient expresses pain, and the significant other rushes to his or her side to help in whatever way possible. The group then examines the scenario and provides feedback to the dyad about potential new ways of responding.

CBT-based psychotherapy groups for chronic pain address the influence of thoughts on feelings, behavior, and physiological responses (Beck, 2005), as well as incorporating Lazarus and Folkman's (1984) model of stress and coping (see above), in which patients' beliefs are posited to influence adjustment to pain (Thorn & Kuhajda, 2006). In contrast to operant-conditioning approaches, CBT-based psychotherapy groups for chronic pain address disruptive cognitive patterns, conceptualized on three dimensions: (a) primary appraisals, or initial judgments regarding the pain (e.g., the belief that the pain results in a threat and/or loss), (b) secondary appraisals, or situation-specific cognition (e.g., the belief that all pain can and should be "cured" by physicians), and (c) cognitive coping (e.g., thoughts that help manage pain or focus attention away from pain; Thorn & Kuhajda, 2006). Thorn (2004) described a 10-session CBT group for chronic pain, designed to be integrated into a more comprehensive pain management program. Each 90-minute session included review of the previous session, discussion of session objectives, worksheets, and a homework assignment. The emphasis was on restructuring disruptive thought patterns that contribute to problems with effective pain management and coping techniques. Clinical reports indicated improvement in group members' ability to "recognize distorted thoughts, evaluate and challenge those thoughts, and construct alternative thoughts" within the first several weeks, as well as long-term gains in ability to "manage appraisals of pain and associated stressors" (Thorn, p. 76).

Empirical research supporting the efficacy of CBT-based psychotherapy groups for chronic pain patients includes two recent studies. In the first, McCracken and Gutiérrez-Martínez (2011) examined an adaptation of *Acceptance and Commitment Therapy* (ACT), a CBT-based intervention. Outcome data demonstrated improved mood and reduced disability following three to four weeks of intensive group ACT. In the second study, a randomized controlled trial supported the efficacy of the Back Skills Training (BeST) program, a CBT-based group intervention for individuals with chronic back pain (Lamb et al., 2012). In addition to these research findings, practical considerations such as cost-effectiveness and additional therapeutic benefits, such as group interaction, support the use of psychotherapy groups to facilitate change in individuals with chronic pain. Across group psychotherapy interventions for pain management, salient therapeutic factors include imparting of information

and interpersonal learning, as participants learn new ways to respond to pain.

Practice Guidelines

- Participant selection should consider medical conditions within the group leader's range of knowledge and expertise (e.g., if the provider is unfamiliar with phantom limb pain, individuals with such conditions may not be appropriate for that particular group).
- Both maladaptive behaviors and disruptive thoughts that can reinforce pain symptoms should be targeted (see Thorn, 2004).
- Because significant others can play a crucial role in the reinforcement of pain behavior, when a partner is available, interventions such as role-plays with group feedback that incorporate alternative responses may reduce these behaviors in the patient.

Groups for Spinal Cord Injury

Psychological interventions for individuals with spinal cord injury (SCI) often include psychotherapy groups to provide emotional support, peer role models, teach new coping skills, and decrease social discomfort. Craig, Hancock, Dickson, and Chang (1997) compared outcomes between individuals with SCI who participated in a 10-week CBT-based psychotherapy group with those who received standard rehabilitation therapies without psychological intervention. Among individuals in the psychotherapy group, those who were depressed at baseline showed greater and more sustained reductions in depression, compared to those in the comparison group. An extension of this work indicated that individuals with SCI who participated in CBT-based group psychotherapy during initial inpatient rehabilitation had enhanced perception of control over their lives two years post-injury (Craig, Hancock, Chang, & Dickson, 1998). King and Kennedy (1999) reported that an adaptation of CET (Folkman et al., 1991), a CBT-based group psychotherapy approach initially developed for improving coping skills in individuals living with HIV (see above), resulted in greater reductions in depression and anxiety in comparison to individuals with SCI who received no such intervention (see also Duchnick, Letsch, & Curtiss, 2009; Kennedy, Duff, Evans, & Beedie, 2003).

Mehta et al. (2011) examined five studies that utilized CBT-based psychotherapy groups during inpatient SCI rehabilitation. Groups ranged in size from 4 to 9 participants, with intensity varying from 1 to 2 hours per week for 7 to 10 weeks. Interventions included coping skills training, cognitive restructuring, problem solving, stress management techniques, and attention-diverting pain-management strategies. They concluded that CBT is a promising approach for improving psychosocial functioning in individuals with SCI. Family members of individuals with SCI also benefit from group work; multiple-family group psychotherapy has been found to be an effective tool for facilitating family adjustment (Rohren et al., 1980). Salient curative factors across group psychotherapy interventions for SCI include interpersonal learning, especially from peers who have adjusted well, as well as imparting of information.

Practice Guidelines

- Include training in coping skills for management of physical, emotional, and psychosocial sequelae of SCI (see Kennedy, 2008, for a treatment manual).
- Include peers who have adjusted well to SCI to serve as role models.
- Initiating groups during inpatient rehabilitation improves long-term outcome.
- Incorporate pain management strategies (e.g., training in coping skills and cognitive restructuring).
- Including family members in group work facilitates adjustment to SCI.

Groups in Acquired Brain Injury Rehabilitation

There is a growing need for group interventions to reduce cognitive and emotional symptoms following acquired brain injuries (ABI), such as traumatic brain injury (TBI), stroke, brain tumor resection, and other neurological conditions (Bertisch, Rath, Langenbahn, Sherr, & Diller, 2011). Individuals with ABI often experience cognitive deficits, emotional symptoms, difficulties with social interaction, and adjustment issues related to quality-of-life changes post-injury (Rath & Elliott, 2008). Psychoeducational groups provide information about the cognitive and emotional implications of brain injury, peer support and feedback, an opportunity to share effective ideas and coping strategies, a sense of feeling helpful, an easing of isolation, and comparisons of one's abilities and limitations with those of others with similar injuries (Langenbahn, Sherr, Simon, & Hanig, 1999). Group leaders facilitate semistructured discussions on topics related to cognitive, emotional, and interpersonal factors that interfere with optimal functioning. Common themes include changes in emotions or expression of emotions, changes in relationships post injury, and coping with family members who may have difficulty recognizing and relating to the group members' "invisible" cognitive-emotional disabilities (Bertisch et al., 2011). Consistent with such groups for other populations, the primary curative factors in psychoeducational groups for ABI rehabilitation include instillation of hope, imparting of information, and imitative behavior.

Bertisch et al. (2011) and Langenbahn et al. (1999) discussed adapting traditional psychotherapy group approaches for individuals with reduced cognitive functioning following ABI. CBT-based psychotherapy groups conducted within D'Zurilla and Goldfried's (1971) seminal social problem-solving framework have empirical support in outpatient ABI rehabilitation (Rath, Simon, Langenbahn, Sherr, & Diller, 2003). In a randomized clinical trial, Diller and colleagues (Rath et al., 2003) evaluated a two-phase group intervention grounded in the social problem-solving model. The first phase targeted group members' emotional reactions and maladaptive beliefs about their ability to manage everyday problems (see Rath, Hradil, Litke, & Diller, 2011). This novel therapeutic approach was essential to facilitating an adaptive approach to problems before progressing to problem-solving skill training (defining the problem and setting realistic goals; brainstorming possible options; examining potential consequences and selecting an optimal solution; and enacting a solution, monitoring its effectiveness, and making modifications as necessary) in the second phase of the group intervention. Outcome included gains on self-report and objective problem-solving measures, with anecdotal reports of generalization to real-life behaviors. Therapeutic factors in psychotherapy groups for ABI include instillation of hope, imparting of information, and imitative behavior, as well as opportunities for altruism, as group members support each other, and catharsis and universality, as group members express their shared experience of functional losses (Bertisch et al., 2011).

Practice Guidelines

- Adjust group pacing relative to level of cognitive impairment (e.g., provide more support, repetition, and reinforcement for individuals with more significant limitations).
- Use notetaking, practice, and repetition to enhance ability to follow and retain information (Langenbahn et al., 1999).
- Check group members' comprehension of information being discussed.
- Recognize cognitive causes of behavior such as missed appointments, traditionally interpreted psychodynamically (Bertish et al., 2011).
- Maladaptive beliefs that can impede or disrupt successful application of problem-solving skills should be addressed in group interventions (see Rath et al., 2011).

Groups for Individuals with Limb Loss

Increasing incidence of medical conditions leading to limb loss and traumatic amputations has led to growing interest in effective psychological interventions for this population (Wegener, Mackenzie, Ephraim, Ehde, & Williams, 2009). Support groups can be effective in addressing both physical pain and psychological sequelae of limb loss (e.g., anxiety, PTSD, and depression). Consistent with support groups for other populations, a key function of these groups is to enhance the therapeutic factors of hope and imitative behavior through relationships with other individuals with limb loss who have achieved positive adjustment (Wald & Alvaro, 2004). Support group participation has been shown to result in lower levels of distress at eight months after amputation (Waites & Zigmond, 1999), and data suggest benefits of social support in alleviating post-amputation depression, phantom limb, residual limb, and/or back pain (Wegener et al., 2009). Meeting other individuals with limb loss has demonstrated benefits in fostering adjustment (Oakesford, Frude, & Cuddihy, 2005), so it appears that peer support groups may be especially beneficial.

Research on amputation has found that perceived life control, finding positive meaning, optimistic attitude, and active coping strategies such as seeking social support have been linked with psychosocial adjustment. In this regard, psychotherapy groups have been implemented with individuals who have experienced limb loss and may include teaching stress-management skills, thought stopping, modeling, and role-play (Wald & Alvaro, 2004).

Practice Guidelines

- Emphasize both pain management and emotional concerns of limb loss (see Wald & Alvaro, 2004, for a description).
- Build positive cognitions (e.g., enhancing core belief that group members can cope with limb loss).
- Including peers who have adjusted well to limb loss can be a powerful component of group interventions.

Extending Group Work to Underserved Populations in Behavioral Health Settings

Task Groups

Task groups—especially in the form of focus groups—occupy a vital role in healthcare (cf. Parsons & Greenwood, 2000). Focus groups generally are used to collect data on a specific topic through a semistructured group interview process (Krueger & Casey, 2009). In behavioral health settings, they have been used to understand patients' and family members' needs and perspectives relevant to health and well-being in order to identify programs, interventions, and resources that can reduce barriers and promote health. This is particularly relevant in the case of individuals from underserved and vulnerable populations, known to experience disparities in access to healthcare, as in the examples of problems experienced by menopausal African American women in obtaining healthcare (Ruff, Alexander, & McKie, 2005), emotional issues of older individuals living with macular degeneration (Owsley et al., 2006), and barriers to services experienced by families of children with special healthcare needs (Resch et al., 2010).

Consistent with such groups in other settings, focus groups in behavioral health settings generally involve two approaches. The first examines interactions that occur in groups of 6 to 10, conducted by a trained facilitator (Ruff et al., 2005). Tape recordings provide access to nuances of the discussion, while note taking is used to capture nonverbal behavior. Ideally, this format adheres to a rigorous qualitative process in which questions are selected carefully, group discussion is monitored, and the resulting data are subjected to an iterative content analysis that entails data reduction, data display, and conclusion drawing and verification (Richards & Richards, 2006). A second approach, the Nominal Group Technique (NGT; see, e.g., Elliott & Shewchuck, 2002), harnesses group dynamics by structuring interactions to ensure equal opportunity for all group members. This typically is accomplished by posing a well-defined question of concern to a representative group, then providing a quiet period for participants to write their responses. A round-robin sequence follows in which responses and ideas are articulated, discussed, clarified, and prioritized by the group. The group process determines the outcomes of focus groups conducted with NGT, with the outcome are readily apparent to participants and staff on completion (e.g., Elliott & Shewchuk, 2002).

Long-Distance Technologies and "Virtual" Groups

Long-distance technologies present innovative ways to extend group services to vulnerable individuals who face disparities in access to traditional face-to-face psychological services. Several studies indicate that telephone applications can be used effectively to provide peer support groups for persons with SCI (Jalovcic & Pentland, 2009) and multiple sclerosis (Mohr, Burke, Beckner, & Merluzzi, 2005) and a CBT-based psychotherapy group (e.g., a coping improvement group for older adults living with HIV; Heckman et al., 2006). Many people without ready access to traditional healthcare services may have access to the Internet, so a variety of group services have been adapted for Internet applications. An online self-guided support group for women with early-stage breast cancer has shown positive effects (Owen et al., 2005), and there is some indication that these effects may be due, in part, to the dynamics of socialization and interaction in the group (H⊘ybye, Johansen, & Tj⊘rnh⊘j-Thomsen, 2005). Virtual "chat rooms" have been studied as "places" to conduct focus groups with patients who have inflammatory bowel disease (Stewart & Williams, 2005), provide group psychotherapy for patients returning home from treatment (Golkaramnay, Bauer, Haug, Wolf, & Kordy, 2007), and reduce loneliness among persons with severe physical disabilities (Hopps, Pepin, & Boisvert, 2003). The NGT, too, has been modified for use in teleconferencing (Levine et al., 2006) and in virtual Internet environments (Kristofco, Shewchuk, Casebeer, Bellande, & Bennett, 2005). More work is needed to identify characteristics of those who do not benefit from online support groups and particularly of those who do not seem to take advantage of them despite availability and accessibility (Owen, Boxley, Goldstein, Lee, Breen, & Rowland, 2010).

Summary and Implications for Group Research and Practice

This chapter has considered applications of a variety of group-treatment formats to several representative conditions and populations common in today's behavioral health and medical settings. These approaches can be extended to the wide range of conditions and concerns encountered in healthcare, such as weight management (e.g., Andenæs, Fagermoen, Eide, & Lerdal, 2012), smoking cessation (see Stead & Lancaster, 2005), cancer (see Gottlieb & Wachala, 2007), diabetes (e.g., Markowitz & Laffel, 2012; Weinger et al., 2011), cardiac conditions (Song, Lindquist, Windenburg, Cairns, & Thakur, 2011), and renal failure (e.g., Duarte, Miyazaki, Blay, & Sesso, 2009) to name a few, and can be implemented in either traditional face-to-face or "virtual" formats (Wright & Bell, 2003).

The same group elements that have the potential to provide accurate information, social support, and modeling of adaptive behavior can be tainted by misinformation, negative interactions, and interpersonal rejection and model maladaptive, destructive behaviors (Forsyth & Elliott, 1999). Group leaders must consider these issues when developing group interventions for use in healthcare settings. There are many situations in which peers can facilitate support groups effectively, but in other group formats (e.g., psychotherapy groups), it is imperative that a trained group leader with clinical acumen and a firm grasp of factual information work within the group (e.g., to accurately teach cognitive-behavioral concepts and skills).

Cost containment and the efficiency of addressing the needs of more than one person at a time may be the initial selling point that convinces healthcare administrators to allocate necessary resources for group interventions (McCarthy & Hart, 2011). Few studies to date have directly addressed the economic benefits of group work, so it is difficult to make definitive assertions about the cost-cutting benefits of group interventions (Tucker & Oei, 2007). As changes in the healthcare system continue to unfold, it is crucial for researchers and clinicians to demonstrate and effectively communicate the cost-effectiveness of group work.

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Chapter 28 Group Treatments within the Department of Veterans Affairs

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The early years of group psychotherapy were intricately related to the emergent needs of treating scores of shell-shocked and battle-fatigued troops both in the United States (Grotjahn, 1947) and Europe (Thalassis, 2007) during and immediately after World War II. Long before "evidence-based treatments" became the latest buzzword in mental health, clinicians were offering bold, innovative group treatments to soldiers suffering from traumatogenic experiences in the field and their astute observations provided the basis by which the military (Brill, n.d.) came to strongly endorse this modality. The Department of Veterans Affairs (DVA) quickly followed suit in their need to cope with a tidal wave of soldiers returning home from war and needing mental health services (Baker & Pickren, 2007). That war did not bring an end to war and the consequent need to heal the battle scarred. In the past decade, some 300,000 U.S. soldiers who served in Iraq and Afghanistan are estimated to suffer psychiatric sequelae (Tanielian, Jaycox, & Rand Corporation, 2008), with Posttraumatic Stress disorder (PTSD) being one of the most prevalent psychiatric disorders (Kulka et al., 1990).

Given these data, we begin this chapter with an overview of state-of-the-art efforts within the DVA to treat combat veterans struggling with the emotional scars of war. But from its very inception, the DVA has been committed not just to healing the traumatized but in treating the whole spectrum of health needs for veterans. Thus, we also focus on two other prominent areas in which group work is implemented: (1) the myriad of health issues plaguing the veteran population and (2) recovery-oriented group programs to help veterans return to the community.

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Combat-Related Ptsd

While the de rigueur groups of earlier eras, such as long-term inpatient groups or the rap groups for returning Vietnam veterans of the 1960s, have faded into the history of the mental health movement, group work for combat veterans is rigorously being practiced and assessed (Foy, Drescher, Watson, & Ritchie, 2011). The DVA has invested substantial effort in developing both inpatient and outpatient specialty programs for the treatment of PTSD (Rosenheck & Fontana 2007), including several innovative group approaches. Two recent surveys suggest a good fit between PTSD and its treatment in group contexts (Harpaz-Rotem & Rosenheck, 2012; Hunt & Rosenheck, 2011). Intriguingly, the latter study revealed that veterans in group therapy attend almost four times as many sessions as those in individual psychotherapy, suggesting that groups may be a more engaging treatment context for veterans. This study also found that veterans diagnosed with PTSD were more likely to attend psychotherapy, either group or individual or both, than veterans without PTSD; the finding of increased likelihood of attending group therapy among those diagnosed with PTSD (compared to those without PTSD) was replicated in a second survey of a nonveteran population (Harpaz-Rotem & Rosenheck, 2012). Unfortunately, these surveys used large administrative data sets, which precluded deeper analysis into and insights about the putative fit between PTSD and group psychotherapy.

Particularly over the last decade, there has been an upsurge of scientific investigations of the effectiveness of group psychotherapies for the traumatized, offering partial validation in treating such PTSD symptoms as anger, mood disturbance, and authority problems (Creamer, Elliott, Forbes, Biddle, & Hawthorne, 2006; Fontana & Rosenheck, 1997; Frueh, Turner, Beidel, Mirabella, & Jones, 1996; Johnson et al., 1996; Khoo, Dent, & Oei, 2011). The accumulating empirical evidence data, while promising, is far from conclusive at this early point, however. Several reviews of the extant research (Barrera, Mott, Hofstein, & Teng, 2012; Bisson & Andrew, 2009; Bradley, Greene, Russ, Dutra, & Westen, 2005; Foy et al., 2011; Sloan, Feinstein, Gallagher, Beck, & Keane, 2011) have all been cautiously optimistic, but the limited number of studies and the significant limitations in methodological rigor preclude more definitive conclusions. Consistent with this tentativeness, the clinical practice guidelines, prepared jointly by the DVA and the Department of Defense (The Management of Post-Traumatic Stress Working Group, 2010) recommend only that group psychotherapy *may* be considered for the treatment of PTSD.

Clinical observation and expertise provide another form of evidence that more strongly endorses the idea of group psychotherapy for treating PTSD. As Foy et al. (2011) posited:

> Using group approaches for combat-related trauma benefits individuals by providing a group context in which to improve the coping with trauma consequences such as isolation, alienation, shame, and restricted or diminished feelings. Combat-related trauma groups are especially appropriate because many former combatants feel ostracized from society and have not shared their combat experiences, and they may even perceive judgment or blame from others for their distress. Other advantages of a group approach include acknowledgement and validation of members' combat experiences, normalization of their trauma-related responses, and validation of behaviors required for survival during combat-related traumas. (p. 126)

We suggest that, in addition to the feeling of "universality" uniquely offered by the small homogeneous group, this clinical context also fosters a sense of connection, cohesion, and camaraderie that replicates the reassuring "got your back" experience of safety of active duty. Again, however, it needs to be emphasized that much more research and clinical observation will be needed to better understand under what conditions (i.e., for what patients and in what specific formats) group therapy can be optimally effective for treating trauma.

Cognitive-Behavioral Group Psychotherapies (CBT)

The cognitive-behavioral group psychotherapies— that set of treatments that include Trauma Focused CBT (Beck & Coffey, 2005), Cognitive Processing Therapy (CPT) (Chard, Resick, Monson, & Kattar, 2008), and Prolonged Exposure Therapy (PET) (Foa, Hembree, & Dancu, 2002)—are among the most empirically studied groups for treating PTSD. Outcome studies of group CBT have shown a moderate to a strong effect size of clinical improvement in PTSD symptoms (Khoo et al., 2011; Ready et al., 2012; Ready et al., 2008); moreover, these treatment effects remain significant from 6 to 12 months post-treatment.

The underlying principles that guide these CBT therapies are the notions that in PTSD: (1) normal adaptive reactions to a perceived danger are overgeneralized to situations that do not involve actual threat (e.g., a fear of a trash bag in a war zone extends to any foreign object on the side on the road in a safe environment) and (2) distorted cognitive attributes (e.g., a mistrust of local people in a war zone) is generalized to a mistrust of everyone. Based on this model, the overgeneralized anxious reactions to a fearful stimulus (when no real threat is present) need to be extinguished and distorted cognitions associated with the trauma need to be reconstructed.

In all CBT therapies, during the initial phase of the treatment, therapists typically provide psychoeducation about PTSD, outlining the learning principles by which PTSD develops and is maintained, and also establish rapport by building trust and mutual respect. A conceptual framework is offered to help veterans understand how common PTSD symptoms represent, under normal circumstances, an adaptive reaction to a stressful event but how in PTSD they represent problems in overgeneralizing and distorting.

Following this, patients are typically asked to "reprocess" their original traumatic experience with the help of others in the group. The aim here is to assist the veterans in reconstructing the original memory into a more coherent and meaningful story and to be able to have better control over emotions associated with the traumatic memory (i.e., mental representation) in contrast to the actual trauma. This controlled exposure to the traumatic memory within a therapeutic context allows the patient to think and talk about the trauma safely. For example, a platoon commander might share his decision to lead his men in one direction that ultimately resulted in the death of two of them. The group provides an opportunity for him to hear feedback from others that his decision made sense at the time and that other options may have proved even deadlier. Such feedback can help the patient rethink and reconstruct his beliefs about the event and gain control of the guilt reaction linked to the trauma recollection.

Cognitive restructuring is the crucial component in the CBT. While distorted cognitions across all life's domains are worked on in CBT, in CPT this restructuring is limited to those schemas associated with safety, trust, power and control, esteem and intimacy (Resick, Monson, & Chard, 2007). In the group and through homework assignments, patients are taught techniques to assist them to recognize and challenge maladaptive cognitions in their daily living.

The behavioral component of CBT refers to interventions designed primarily to change clients' avoidant and hypervigilant behaviors. Clients are asked to build a hierarchical sequence of real-life situations that generate increasing fear in the absence of a real danger. For example, some veterans avoid crowded places such as the shopping mall. The veteran is asked to go to the mall, tolerate the anxiety and not flee the situation for a substantial amount of time to allow for normal habituation to occur (Foe et al., 2002). Although this exposure takes place outside the group setting, the support and encouragement of other group members in this process is essential. The underlying theoretical rationale guiding this behavioral activity is rooted in classical fear conditioning, which demonstrates that extinction of the fear reaction will eventually take place if no real anxiety-arousing stimulus is present.

Overall, Trauma Focus CBT delivered in a group format allows the veteran the opportunity to receive and/or offer hope and inspiration through the group process (cf. Foy, Ruzek, Glynn, Riney, & Gusman, 2002; Schnurr et al., 2003). The basic premise is that the peer setting can promote the feeling of safety among veterans and thus enhance engagement and capacity to tolerate the anxiety associated with exposure because many veterans share

similar experiences. Moreover, the group setting helps veterans feel that they are helping fellows soldiers and to normalize the symptoms they experience as a result of the exposure to trauma, because veterans disclose to the group members their most painful and disturbing memories, relying on each other and the group leader for support and empathy. As the research literature attests, there is a developing data base that demonstrate the efficacy of these several group-based CBT models (cf. Alvarez et al., 2011; Bolton et al., 2004; Sutherland et al., 2012).

Other Group Modalities for PTSD

Beyond CBT oriented groups, the DVA has developed a variety of other group modalities for treating PTSD. Supportive group psychotherapy was an early part of mental health treatment offered to veterans of the Vietnam War to assist in their coping with a variety of readjustment issues and the burden of PTSD, and it continues to play a major role in the mental health services offered to veterans diagnosed with PTSD (Hunt & Rosenheck, 2011). This modality is routinely practiced not only within the nationwide VA Medical Centers but also in community Vet Centers and Readjustment Counseling Services (Sipprelle, 1992). The primary goal here is to provide a safe and supportive environment for veterans to explore their life experiences and their problems with PTSD. The group setting allows for the installation of hope and inspiration by listening to fellow veterans' ways of coping with stress. Moreover, veterans can experience a sense of altruism by helping others, a crucial therapeutic factor. It is well documented that both post-deployment social support and supportive veteran networks serve as therapeutic factors (Tsai, Harpaz-Rotem, Pietrzak, & Southwick, 2012). Unfortunately, comparative research studies of different group modalities are too scarce to permit conclusions about the superiority of one form of group over another; moreover, our observations suggest that in actual practice, interventions often combine elements of social support and cognitive-behavioral principles.

One major comorbid condition associated with PTSD is substance use disorders (SUD) (Petrakis, Rosenheck, & Desai, 2011) with about one in five veterans with PTSD also carrying a diagnosis of SUD. This high rate of co-occurrence has led to the major hypothesis that substance use is a form of self-medication to relieve the burden of PTSD symptoms (Brady, Back, & Coffey, 2004). In the past, veterans who were struggling with these co-occurring conditions had to negotiate two separate treatment programs that might vary in their philosophies; however, today it is more common to offer veterans an integrated treatment approach. Throughout the DVA, Substance Use PTSD teams (SUPT) have been developed (Fontana & Rosenheck, 1997) that focus on substance abstinence and/or the reduction in frequency and extent of substance use, as well as the management and treatment of psychiatric disorders. Group psychotherapy is a central component in these programs. The SUPT group focuses initially on substance abuse, anger management, and impulse control, based on the assumption that these issues, if unaddressed first, might jeopardize engagement and compliance in the treatment process. Thus, clients are encouraged to address their use of substances and how their PTSD symptoms contribute to it. In the next phase of treatment, similar to CBT, psychoeducational information is offered on how substance abuse and PTSD interact, common maladaptive thinking associated with substance abuse and PTSD, and models of relapse prevention. The following stage of the group treatment shifts the focus to the processing of the combat trauma while maintaining abstinence. As in any other group therapy, the SUPT group relies on the trust and rapport among its members.

The DVA has incorporated expressive art therapies into its mental health services, allowing veterans new forms of expressive outlets in coping with emotions, thoughts and behaviors associated with PTSD such as groups for creative writing, painting/drawing, and dramatic performances (cf. Collie, Backos, Malchiodi, & Spiegel, 2006) as well as such group interventions as yoga, mindfulness, and meditation. Although not empirically researched, our clinical impressions suggest that these group-based creative art and adjunctive therapies help veterans reduce stress and increase self-awareness and insight.

For many years now group psychotherapy has played a central role in the treatment of PTSD within the DVA. Our own clinical work clearly supports the prevailing formulations about how both specific therapist techniques and common, nonspecific factors within the psychotherapy group work together in providing combat veterans with the sense of universality, altruism, instillation of hope, and the development of new social skills and cognitive capacities that ameliorate PTSD symptoms (Kingsley, 2007). As manifested by its own PILOTS database (National Center for PTSD, n.d.), the painstaking accumulation of all the extant research on trauma, the DVA continues to take a leadership role in documenting the evidence for and in developing ever more effective group treatment models for those suffering from PTSD.

Health Promotion Groups

The DVA has a long history of providing cognitive-behavioral and psychoeducational groups to support veterans experiencing a myriad of health concerns. In our VA, we have initiated health promotion and disease prevention activities targeting smoking cessation and weight loss, as well as programs to promote self-management of chronic medical conditions. All the groups described below are "works in progress," continually being evaluated and modified to meet the changing needs of our veteran population.

Smoking Cessation

Smoking prevalence among veterans is estimated at 27% (Brown, 2009). Consequently, the DVA has initiated a directive for smoking cessation programs that emphasizes assessment/education regarding supports for cessation as part of routine primary care and that offers evidence-based counseling and medications (U.S. Department of Veterans Affairs, 2008a). Detailed practice guidelines for smoking cessation efforts have been developed that focus on successfully identifying individuals who are dependent on tobacco and providing effective treatment(s) for them (Fiore et al., 2009); these guidelines are consistent with the DVA directive and our own smoking cessation program.

Veterans at our site are typically referred by their primary care providers, because screening for tobacco use is a required part of routine medical care within the VA. The format of the program is an open group design, allowing veterans to initiate their participation at any time. Sessions are held once a week for 60 minutes, and attending multiple sessions is strongly encouraged to receive support throughout all phases of the quit process. Especially for those with a recently failed attempt, attending a drop-in group session immediately to get support to prevent full relapse or to shorten the length of time between quit attempts may boost their chances of success. Research referenced in the practice guidelines indicates that social support and problem solving/skills training are two particularly effective aspects of intervention. The group format naturally provides a social support element, and details below illustrate how the second component of problem solving is achieved in our group treatment format. Further, a recent Cochrane review showed that group treatment for smoking cessation based on behavioral intervention strategies such as those described below was more effective than self-help approaches and that chances of quitting successfully were nearly doubled in those utilizing group treatment (Stead & Lancaster, 2009).

Our weekly group incorporates basic cognitive and behavioral intervention strategies such as stimulus control (e.g., monitoring and limiting exposure to smoking triggers), reinforcement through social support and self-talk, viewing oneself as a nonsmoker, role-play for declining offered cigarettes, managing withdrawal symptoms using such coping strategies as distraction. We also use motivational interviewing (Rollnick, Miller, & Butler, 2008) and assess patients with regard to their stages of change (Prochaska & DiClemente, 1998), as described below.

Each week, the group leader identifies newcomers, gathering information regarding smoking and quit attempts, reasons for attending the group, and confidence in their ability to quit. Each attendee's particular needs regarding quitting is addressed while group discussion is facilitated about successful strategies and barriers experienced. The program combines the leader's provision of support and encouragement, motivational enhancement (e.g., processing ambivalence), developing a therapeutic group process (e.g., reinforcing supportive statements), and training in problem-solving and coping skills (e.g., developing a relapse prevention plan). The group varies each week in composition of individuals at each stage of change, so group discussions shift over sessions to match each veteran's stage of change as their particular efforts are addressed by the group leader.

For veterans in the precontemplation stage, content revolves around risks of smoking, benefits of quitting, and the addictive nature of nicotine. Sources of possible motivation from financial, social, and personal areas of functioning are reviewed to facilitate veterans' conceptualization of smoking as a problematic behavior. For those in the contemplation stage, the group leader helps work toward resolution of ambivalence about quitting, assisting veterans in evaluating the relative balance between personal incentives for smoking and reasons for quitting. For those in the action stage, discussion shifts to establishing self-paced and action-oriented goals to reach during the following week to achieve abstinence or reduce smoking. These goals are customized for each veteran, usually including a mixture of adjusting behaviors (e.g., using nicotine gum during acute cravings) and the environment (e.g., removing ash trays from home). For those are in the maintenance stage who have successfully quit, and also for all group members in general, methods for coping with tempting situations and preventing full relapse are presented. This comprehensive approach is supported by evidence that although motivation is predictive of quit *attempts*, it does not predict relapse or abstinence (Zhou et al., 2009). Factors that *are* associated with relapse, such as exposure to smoking cues, craving, and lack of smoking cessation aids, are discussed in the group to supplement motivational enhancement.

As the practice guidelines also illustrate that counseling and medication are more effective when combined compared to either treatment alone (Fiore et al., 2009), the leaders contact referring providers if and when any group member indicates willingness to consider a pharmacological quit aid or nicotine replacement therapy. They also follow up in subsequent visits to provide accountability and assistance in veterans' efforts to obtain and use the quit aid(s). Further, a general recommendation of the practice guidelines is that counseling provided telephonically via quit lines can be effective and is beneficial because of its accessibility. All group members are frequently reminded during weekly sessions about using a quit line as a resource outside of group sessions. Due to the numerous health risks associated with smoking, these interventions are designed to be as comprehensive as possible to support veterans' quit attempts.

MOVE! Group Program

The Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) program was implemented nationally by the DVA in 2006 (VA MOVE! program handbook 1101.1) to address the high rates of obesity among veterans (Das et al., 2005). MOVE! is a weight-loss program designed to be comprehensive, evidence based (Wing, 2004), and multidisciplinary.

Our program, incorporating elements derived from effective programs described in the extant literature, consists of a weekly, hour-long, multidisciplinary psychoeducation group co-led by a nutritionist, a physical therapist, and a clinical health psychology intern. Each group cycle is 10 weeks long and veterans are able to participate in any number of groups. Three different topics are discussed each week: (1) a specific weight loss topic, such as reading food labels, making healthy choices when eating out, and incorporating fiber into one's diet; (2) relevant exercise strategies, such as how and why to track physical activity, demonstrating chair exercises and stretches participants can do at home; and (3) topics related to behavioral changes associated with weight loss, such as tips to maintain motivation for weight loss (e.g., setting small, achievable goals), how to control the impulse to eat (e.g., using distraction techniques), and how to overcome self-defeating thoughts (e.g., cognitive restructuring).

Group Interventions to Improve Chronic Disease Self-Management Skills

The Healthy Living Group is our monthly psychoeducational group covering a variety of topics related to health and wellness. It was developed to address the Nine Core Healthy Living Messages defined by the VA National Center for Health Promotion and Disease Prevention: (1) to be tobacco free, (2) physically active, (3) eat wisely, (4) strive for a healthy weight, (5) be safe, (6) manage stress, (7) limit alcohol, (8) get recommended screenings and immunizations, and (9) be involved in one's own health care (Kinsinger, Pittman, & Shiffler, 2011). The group typically entails psychoeducation and instruction of relevant skills, as well as group discussion and practice of the skills presented. Veterans can attend the entire series to learn cognitive-behavioral tools for dealing with a variety of health-related issues or attend only the meetings relevant to their specific presenting problem.

Because the group is drop-in, each meeting is treated as a stand-alone session; the biopsychosocial model is reviewed in brief in each meeting and cognitive and behavioral tools that are specific and applicable to the topic at hand are introduced. For example, in the “Manage Stress” session veterans discuss common sources of stress and negative consequences of stress, learn several types of relaxation techniques (e.g., progressive muscle relaxation), learn to identify and alter catastrophic or “fortunetelling” thinking that exacerbates stress, and discuss the role of physical activity in alleviating stress. Group members are encouraged to participate in providing examples and role-playing newly acquired skills.

Personalized goals are set at the end of each session and those who return to the next group are asked to discuss their progress. Veterans are encouraged to utilize the SMART goal approach (Doran, 1981) of setting specific, measurable, action oriented, realistic, and time-based goals. For example, rather than a general goal of “exercising more,” a veteran is encouraged to set a goal of walking three times per week for 20 minutes after work.

The variety and scope of these health promotion and disease prevention groups such as those described here as well as others like our groups on inpatient psychiatric wards and our newly developing groups that are integrated with primary care services are a testament to the DVA's commitment to providing high-quality, patient-centered care to those who have served in the U.S. military. The use of groups in the DVA builds on the long military tradition of supporting fellow soldiers. Many of our veterans truly enjoy and benefit from the opportunity to learn from and assist their fellow veterans, making the use of group treatments particularly well received for this population.

Psychosocial Rehabilitation and Recovery-Oriented Groups

The President's New Freedom Commission on Mental Health (2003) set the stage for the transformation of mental health care across the country toward a recovery-oriented system of care. In 2008, the DVA responded by creating a blueprint (VHA Handbook 1160.01) for changing how mental health care should be delivered in VAs nationally. One of its components involved converting existing day treatment centers and partial hospital programs to Psychosocial Rehabilitation and Recovery Centers (PRRCs) and creating new PRRCs where day programs did not exist. Prior to this movement, most VA day treatment programs provided outpatient stabilization for veterans with serious mental illness with little attention to recovery and community integration. The mission of PRRCs is to "provide Veterans with a transitional educational center that will inspire and assist them to reclaim their lives, instill hope, validate strengths, teach life skills, and facilitate community integration in meaningful self-determined roles" (VHA Handbook 1163.03, p. 2). PRRCs are expected to include the following: individual recovery planning and psychotherapy, social skills training classes, illness management classes, psychoeducational classes, wellness programming, family psychoeducational and educational programs, peer services and treatment of co-occurring substance use disorders (VHA Handbook 1160.03). To deliver many of these services, PRRCs typically provide an array of recovery-oriented group-based interventions led by an interdisciplinary team of professionals and peer specialists (U.S. Department of Veterans Affairs, 2008b).

Social Skills Training and CBT Groups

Social Skills Training is one of the typical recovery-oriented groups within the PRRC that offers evidence-based treatment for social impairment for individuals with schizophrenia. Cognitive impairment associated with schizophrenia often interferes with the person's ability to engage in and maintain social roles (Bellack, 2004). These skill deficits often are chronic if they are not addressed with psychosocial interventions (Mueser, Bellack, Douglas, & Morrison, 1991); however, viewed as a learnable skill and not a fixed trait, social competence can be taught through structured behavioral interventions. Over the past 40 years, a number of social skills training programs have been developed to improve interpersonal communication for people with schizophrenia. Based on social learning theory, they share commonalities of goal setting, modeling, behavioral rehearsal, prompting, positive reinforcement, corrective feedback, and planned generalization training (Bellack, 2004). Meta-analyses of randomized, controlled trials of social skills training programs for individuals with schizophrenia (Kurtz & Mueser, 2008; Pfammatter, Junghan, & Brenner, 2006) have found empirical support for their effectiveness on measures of social skill acquisition and, to a smaller extent, on measures of community functioning and psychopathology.

The VA Social Skills Training (VA-SST) program (cf. Bellack, Mueser, Gingerich, & Agresta, 2004) aims to enhance the ability to read social inputs, to more accurately analyze information and situation, and to generate socially appropriate verbal responses and nonverbal behaviors such as facial cues and gestures. The model is recovery-oriented focusing on behavior rather than symptoms, teaching skills to promote independence, while fostering choice, hope, and self-efficacy. Training methods involve modeling, behavioral rehearsal, shaping, positive reinforcement, overlearning and generalization of learning. Each group session follows a prescribed format starting with review of homework, providing a rationale for the specific skill taught in the session, discussing relevant experiences, explaining the steps of the skill, modeling of the skill by the group facilitators, practicing the skill by each group member and receiving feedback from the others in the group, and assigning homework. The facilitators try to generate positive and corrective feedback in the role-playing exercises. The curriculum begins with four basic skills (listening to others, making requests, expressing positive and unpleasant feelings) and then offers a range of practical skills, including ones on conversation, assertiveness, conflict management, communal living, friendship and dating, health maintenance and communicating with providers, vocational, and coping skills for drug and alcohol use.

Group facilitators strive to incorporate real-life examples that reflect daily struggles into the group sessions. For example, when working on the skill “Refusing Requests” role-play situations are conducted in which the participant: (1) must refuse a request from a friend who wants to borrow money, (2) refuse a request from another veteran in the program who is asking for a cigarette, or (3) refuse a request to go to a bar for a beer with a former friend. Homework is assigned to practice these scenarios in real life and we follow up in the next session by asking how the situation went, congratulating them on applying this in their lives or asking what got in the way and problem solving, if the assignment went poorly.

Another prominent group in our PRRC is CBT, which is now recommended as an adjunctive treatment to medication in the treatment of schizophrenia (Dixon et al., 2010), based on studies that have demonstrated its effectiveness (Wykes, Steel, Everitt, & Tarrier, 2008). We use the Three Cs (i.e., Catch It, Check It, and Change It) model developed by McQuaid et al. (2000). In the Catch It step, veterans work on recognizing their mood shifts and identifying any automatic thoughts when their moods change. Next, in the Check It step, veterans learn how to challenge or question their automatic thoughts. They are taught to ask themselves if the thought is distorted or getting in the way of their daily lives. Last, in the Change It step, they work on replacing negative and distorted thoughts with alternative ones that are more balanced and reasonable. Group work includes thought-challenging exercises, strategies for coping with symptoms, activities on reducing delusional beliefs, and encouraging adherence with medical recommendations.

Group facilitators consistently emphasize the understanding and internalizing of this cognitive model as well as using questions to challenge thoughts. They encourage the incorporation of veteran examples and experiences,

thus providing group members the opportunity to identify their own emotions, thoughts, and behaviors. We have found this group is often most effective when veterans who have regularly attended the group and have begun to apply the cognitive model to difficult situations in their own lives share their experiences and insights with newer group members. This not only provides opportunities for all group members to see cognitive techniques applied but also fosters a sense of group cohesion and support.

Illness Management and Recovery (IMR)

Both “illness management” and “individualized recovery planning” are additional core evidence-based services (Hasson-Ohayon, Roe, & Kravetz, 2007; Levitt et al., 2009; Mueser et al., 2002) we provide. IMR is a broad-based therapeutic intervention, incorporating a number of content areas—recovery goal setting, practical facts about mental illness, social support, medication, substance use, relapse prevention, coping skills, and negotiating the mental healthcare system—offered through a variety of treatment modalities, including cognitive-behavioral, motivational interviewing, and psychoeducation.

One of the strengths of the IMR is its emphasis on the stigma of mental illness imposed by both self and society. We offer a powerful opportunity to dispel a variety of harmful myths about serious mental illness, foremost being these that individuals with these diagnoses cannot live meaningful lives. Following the progress on established recovery goals of one or more group members from week to week has been helpful in illustrating that success in recovery is indeed possible for group members. We have found that our IMR group is most impactful when facilitators integrate education, empowerment, and veteran goals and experience.

Vet-to-Vet

In recent years there is a growing utilization of trained peer-counselors who deliver semistructured supportive group psychotherapy to their fellow veterans. Empirically validated (Davidson et al., 1999), the model has been adopted and further developed by the DVA. Started in 2002 by Moe Armstrong, a decorated Vietnam combat veteran and self-identified person in recovery from schizophrenia, Vet-to-Vet is a consumer-professional partnership model, where consumer-provided mental health services are offered in many PRRC programs (Resnick, Armstrong, Sperrazza, Harkness, & Rosenheck, 2004). As explained in the Vet-to-Vet manual (Armstrong & Pinson, n.d.), "We can overcome shame and stigma through sharing strength and hope through mutuality. Mutuality means that the learning and sharing is done through community and not by lone individuals" (p. 11). Group meetings are typically voluntary, convene two to five times per week for forty-five minutes, open to all veterans and focus on topics such as Disability Awareness, Disability Pride, Mental Illness Anonymous, Wellness, Recovery Workshops, and Writers' Workshops. Veterans alternate reading materials aloud, with time for questions and discussion. While the readings provide structure, much of the discussions center around the veteran experience, and how veterans can live rich lives in spite of mental illness and addictions.

Vet-to-Vet facilitators are veterans receiving mental health services and are nominated by their peers. They differ from staff in that they share information by introducing a reading and participating in a discussion with their peers rather than teaching or counseling. The VA staff support Vet-to-Vet facilitators through training, supervision, and consultation.

In a recent survey of veterans in Vet-to-Vet programs, Barber, Rosenheck, Armstrong, and Resnick (2008) found that the mean satisfaction score was 3.7 out of 5.0 (SD = 0.91), falling between "moderately" and "quite satisfied." Moreover, these scores were correlated directly with an overall sense of engagement in meaningful activity and recovery attitudes.

Other PRRC Groups

Family members play a critical role in the management of serious mental illness. Higher levels of expressed emotion in families such as criticism and emotional over-involvement have been associated with higher levels of relapse and symptom exacerbation (Hooley, 2007) while positive and supportive family interactions can promote better illness management, better support for the achievement of recovery goals, and better collaboration with mental health professionals (McFarlane, 2002). The VA has acknowledged the importance of family involvement in the treatment of serious mental illness by developing family psychoeducation and multifamily group therapy as core services within the PRRC milieu. The primary objectives of these treatments are to decrease the likelihood and frequency of relapse to a symptomatic state and to cultivate a supportive social environment in which the client can achieve his or her goals for recovery and live as full and rewarding a life as possible (McFarlane, 2002).

Given the changing demographics within the DVA, we have incorporated group programming for specific populations into the larger milieu, such as our "Positively Silver" groups for older adults with serious mental illness, and groups tailored for Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) and female veterans. The availability of groups for these special populations allows for more choice for veterans in directing their own recovery, as well as providing veterans within these special populations an opportunity to develop social support networks with other individuals with similar experiences and goals for recovery.

Group Work beyond the Veteran

Learning the lessons of the relative neglect, or worse, of the homecoming of Vietnam veterans, clinicians both within the DVA and outside are providing psychological interventions, much within groups, to those returning from war (Sherman, Fischer, Sorocco, & McFarlane, 2011). And as this literature sensitively reveals, the work is not just helping the veteran assimilate back into home and family life but, in dialectic fashion, helping the family accommodate to their soldier-now-civilian. As this chapter began, so it ends; war affects everyone. Group work that was proven so helpful over a half century ago with a different war continues to help heal all involved.

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Part V Introduction to Special Topics

Cynthia R. Kalodner

This is the largest and broadest section of the book. In it, we include 18 chapters that concern some *special* aspect of group work. The topic of a chapter may be organized by the experience of a psychological disorder or trauma, by the common factors of the members (gender or age), or it may be the specific kind of treatment approach, as in the chapter on mindfulness and dialectical behavior therapy. The chapters in this section are grouped so that readers can organize their attention to important clinical problems, population-based groups, and issues that may concern many people at different stages in their lives. Each chapter integrates science and practice so that practice informs science and science informs practice.

True to all the chapters in this section is the notion that groups show incredible potential to provide cost-effective and time-efficient care. And because they are groups, they allow and encourage interpersonal support that reduces the sense of being the only one with a problem.

The first two chapters, on use of groups for depression (Beiling, Milosevic, & McCabe) and anxiety disorders (McCabe, Milosevic, & Bieling), are strong in their focus on the scientific basis for the use of groups to treat the disorders. “Best Practice Guidelines for Empirically-Supported Group Treatments” are included as appendices. Piper, Ogrodniczuk, & Sierra Hernandez in their chapter on complicated grief, provides the state-of-the art in clinical practice and research on this topic with excellent clinical examples throughout the chapter. Faragher and Soberay's chapter focuses on best practices in working with clients suffering from a wide range of substance misuse disorders, presents a model including the stages of change, and incorporates that into prevention and treatment groups. Interpersonal violence (Schwartz, Waldo, & Parsons) and offenders (Morgan, Romani, & Gross) are topics for which the power of group may be especially important, and each of these chapters presents the unique issues present in using groups. *Interpersonal violence* is used to describe violence and abuse in any relationship or interaction between people and replaces the terms *spouse abuse, domestic violence*, and *intimate partner violence.* Morgan and his colleagues write that a common mantra from correctional mental health professionals is “If you can facilitate groups in here, you can facilitate groups anywhere.” Offender groups present problems not typical of therapy groups in other settings, and this chapter addresses all those and provides concrete guidelines.

The chapter on attachment is new to this edition and I am so pleased that Marmarosh and Markin were able to convey the science that helps us work within the context of attachment disorders and attachment in groups. They write, “In group treatment, members not only experience current relationships in the group but they reexperience the prior injuries from significant others in the past, implicitly and explicitly, that left them struggling to maintain intimacy.” Reviewing styles of attachment and providing examples, this chapter on attachment will enhance group work across clinical problems and populations. Gerrity's chapter on childhood sexual abuse is important because it brings to the surface the issues that may be uniquely associated with group work for children, adolescents, and adults who have been sexually abused as children. This chapter provides the basis for training in sexual abuse issues, and group therapy intervention is necessary to appropriately address the needs of the group members.

Windle, Newsome, Waldo, and Adams’ chapter on mindfulness and dialectical behavior therapy brings readers the most current information on therapeutic modalities that have incredible power in group settings. Mindfulness group interventions that focus specifically on the interpersonal benefits of mindfulness and samples of how mindfulness is currently being utilized in group therapy are included. The chapter on eating disorders (Kalodner, Coughlin, & Seide) focuses on both prevention and early intervention for those who struggle with body image issues and includes the cognitive-behavioral treatment model that is a gold standard on this topic. Bullying (Raczynski & Horne) continues to be of critical importance; this chapter examines childhood bullying and psychoeducational and counseling group approaches to preventing and addressing the problem.

Kees and Leech, in their chapter on group work for women, describe the philosophical perspectives and the current research on women's groups. They share the current practice trends in women's groups and offer best

practice recommendations for conducting women's groups. Kiselica and Kiselica do the same in their chapter on groups for men. More recent research suggests that the trend for men to participate less often and effectively than women in counseling and psychotherapy may be changing, and Kiselica and Kiselica's chapter highlights the ways in which groups can challenge men's restrictive gender role beliefs, increase men's comfort with other men, expand their emotional capacities, and help them develop new interpersonal styles and behaviors. Both chapters make readers aware of the power of gender in group work.

Shechtman's chapter on children and adolescents reviews the literature and provides suggestions for developing groups for this age group. As she states, it is a huge mistake to generalize information about adult groups to children's groups because children have unique developmental needs and operate differently. Psychoeducational and expressive-supportive counseling and psychotherapy groups are presented with examples and research. Conyne, well known for his work in prevention, brings prevention and groups together in this chapter. He presents the basis for this type of group work, reviews current literature, and offers recommendations for best practices.

Dagley and Calhoun's chapter looks at work and workplaces to add further perspective regarding the importance of career groups and sets the stage for a brief description of several traditional groups offered throughout the life span. Transition groups are based on the idea that moving into and through ages, stages, school levels, relationships, births, deaths, economic cycles, global conflicts, international crises, and other situational changes are transitions that challenge people. Groups are a way to support people throughout the career and transitions in their lives. Adventure-based group work (Gillis, Gass, & Russell) is a special kind of group that goes outside of the traditional group room. Gass, Gillis, and Russell define adventure therapy as “the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on cognitive, affective, and behavioral levels.” This chapter explains the power associated with working outside and provides the research to support this work. Finally, in the age of increasing natural disasters, Bemak and Chung write about how group counselors play a critical role in assisting disaster survivors and present the Disaster Cross-Cultural Counseling Model (DCCC), a multicultural social justice group counseling model designed to work with survivors of natural disasters. They describe the phases of the model and their work using this model in Haiti.

This section of the book covers a tremendous amount of material. Common to all is, of course, the focus on the power of group to provide intervention. Over and over, readers will see that groups have unique curative effects for disorders within special populations and for life events that affect many or few of us.

Chapter 29 Groups for Depression

Peter J. Bieling
Irena Milosevic
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In the United States, approximately 16.6% of people will experience clinical depression at some point in their life (Kessler et al., 2005). This highly prevalent and recurrent psychiatric disorder affects 121 million people worldwide (Murthy et al., 2001) and causes more disability than any other mental illness. Depression is associated with substantial impairments in multiple domains of functioning (e.g., Hays, Wells, Sherbourne, Rogers, & Spritzer, 1995) and in quality of life (Rapaport, Clary, Fayyad, & Endicott, 2005). It is currently ranked as the third worldwide contributor to the burden of disease, as assessed by disability adjusted life years (DALYs), although it occupies first place in middle- and high-income countries. It is expected that depression will become the leading worldwide cause of DALYs by the year 2030 (Mathers, Boerma, & Fat, 2008). By extension, depression is also associated with a considerable social and economic burden, with the annual cost of the disorder in the United States totaling to $83.1 billion (Greenberg et al., 2003). The level of disability among individuals with depression equals or exceeds that of individuals with chronic medical illnesses, such as hypertension and diabetes mellitus (Davidson & Meltzer-Brody, 1999; Hays et al., 1995).

A major depressive episode involves at least two weeks of depressed mood or loss of interest or pleasure in usual activities. It is additionally characterized by four or more other symptoms, including changes in weight or appetite, dysregulated sleep, physical agitation or retardation, loss of energy, feelings of worthlessness or excessive guilt, impaired concentration, and suicidal ideations, plans, or an attempt (APA, 2000). A major depressive episode forms a core component of a number of mood disorder diagnoses. When it presents in its most simple form (in the absence of other kinds of mood symptoms), the diagnosis of Major Depressive Disorder (MDD; also known as unipolar depression) is the most appropriate. MDD is the most prevalent mood disorder and the most prevalent single mental disorder (Kessler et al., 2005).

Empirically Supported Group Treatments for Depression

Given the extensive personal and social costs of depression and its high prevalence in the general population, psychotherapy researchers have devoted considerable effort to the development of effective interventions for this disorder. Several treatments have garnered strong empirical support, as detailed on the Division 12 website of the American Psychological Association (APA, Division 12, n.d.), which maintains up-to-date information about effective treatments for psychological disorders.

Compared to individual format treatments, group-based interventions have received less empirical attention. Groups, however, are a promising avenue for the delivery of cost-effective, time-efficient (i.e., therapist time per client) care, and they hold the unique benefit of being able to facilitate interpersonal support among group members and to reduce individuals' sense of isolation in terms of their mental health concerns. The treatments described below are those that have a strong evidence base and that have been adapted to and investigated in group format.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) emerged from Beck's cognitive model of depression (Beck, 1967). According to this model, some individuals are vulnerable to depression due to global, rigid, and overgeneralized dysfunctional beliefs that develop from early learning experiences. These core beliefs might remain latent until they are activated by life events that are congruent with one's negative representations of the self (e.g., "I'm unlovable."), the world (e.g., "Life is unfair."), and the future (e.g., "Nothing will work out."). They also influence the development of maladaptive assumptions, rules, and values (e.g., "I must be perfect to be accepted."). Depressed individuals' underlying beliefs distort their interpretations of events, which, in turn, negatively influence their emotional, behavioral, and physical reactions.

CBT thus focuses on identifying negative, automatic thinking patterns and utilizes a "hypothesis-testing" approach to promote reappraisal of distorted cognitions. To develop more realistic and balanced thoughts and, by extension, change their depressed mood, clients are taught to test the validity of their beliefs and interpretations through verbal discussion, written assignments, and behavioral techniques. Behavioral strategies are also used to increase clients' engagement with their environment and to facilitate experiences associated with mastery and pleasure.

CBT is the most extensively researched psychotherapy for depression, and its efficacy in reducing depressive symptoms is well established (e.g., Butler, Chapman, Forman, & Beck, 2006), making it the psychological treatment of choice for this disorder (e.g., Hollon & Ponniah, 2010; Hollon & Shelton, 2001; Parikh et al., 2009). CBT has demonstrated superiority to minimal treatment controls and pill-placebo, and it has been shown to be as effective as other empirically supported interventions, including antidepressant medications (for a review, see Hollon & Ponniah, 2010). Much of the support for CBT's efficacy is based on treatment of mild to moderate depression. It has also been shown to be as effective as medications for severely depressed patients (e.g., DeRubeis, Gelfand, Tang, & Simons, 1999; DeRubeis et al., 2005), although this area has not been as extensively investigated. CBT appears to be more effective than antidepressants at preventing relapse/recurrence following the end of acute phase treatment for depression (e.g., Vittengl, Clark, Dunn, & Jarret, 2007).

Depression was the first kind of disorder to which a group CBT (GCBT) format was formally applied. Although there are fewer studies in this area compared to those investigating individual CBT, GCBT has demonstrated superiority to no-treatment control groups, as well as comparable effects to antidepressant medication and other psychological treatments for depression (Oei & Dingle, 2008). GCBT has also been shown to be effective in reducing residual symptoms of depression in individuals who had already received an adequate trial of antidepressant medication (Enns, Cox, & Pidlubny, 2002). When implemented in combination with medication, GCBT facilitated significant improvements in depressive symptoms and social functioning of patients with treatment (i.e., medication) resistant depression), with gains maintained at a one-year follow-up (Matsunaga et al., 2010).

Of note, while Oei and Dingle did not observe differences between GCBT and other bona fide psychological treatments, they also found no differences between GCBT and nonspecific treatment (e.g., supportive therapy). One explanation for these findings is that GCBT has not formally accounted for group process factors and thus fails to take advantage of them to facilitate better outcomes (Bieling, McCabe, & Antony, 2006; Burlingame, MacKenzie, & Strauss, 2004). Comparisons of GCBT with individual format CBT suggest that the two are equally effective in reducing depressive symptoms based on pooled effects across a number of studies (Oei & Dingle, 2008). However, examination of individual studies with variable methodologies reveals that they do not uniformly support GCBT's equivalence to individual treatment, with the latter demonstrating superiority in some cases (e.g., Wierzbicki & Bartlett, 1987). Further research is necessary to determine whether the two formats can be considered equivalent.

Behavioral Activation

Behavioral activation (BA) treatments arose from the behavioral theory of depression (Lewinsohn, 1974), which posits that low rates of behavior (i.e., deactivation) in depression are caused by a lack of positive reinforcement from the environment. Treatment thus involves promoting behavior that is likely to be rewarding to clients, with key components emphasizing activity monitoring and scheduling. Scheduling encompasses activities related to pleasure, mastery, goals and values, problems that require solving, and avoided behaviors (for a review, see Kanter et al., 2010).

BA has been developed as a stand-alone treatment (e.g., Lejuez, Hopko, LePage, Hopko, & McNeil, 2001; Lewinsohn, Sullivan, & Grosscap, 1980) and as a component of CBT (Beck, Rush, Shaw, & Emery, 1979) for depression. Research has demonstrated that BA in both group and individual format is superior to wait-list and no-treatment comparison groups and that it performs as well as individual and group cognitive therapy (Cuijpers, van Straten, & Warmerdam, 2007a; Ekers, Richards, & Gilbody, 2008; Mazzucchelli, Kane, & Rees, 2009). Further study, however, is necessary into its effects beyond three months and into the relative efficacy of different variants of the treatment (Mazzucchelli et al., 2009).

Problem-Solving Therapy

Problem-solving therapy (PST; D'Zurilla & Goldfried, 1971; D'Zurilla & Nezu, 2007) is based on the premise that the impact of stressful life events on well-being is mediated by one's problem-solving attitudes and skills. Effective problem solving is thus expected to reduce distress and increase functioning. The major aims of PST are to facilitate a positive problem-solving orientation (i.e., one's appraisals of problems and beliefs about problem solving) and an effective relational problem-solving style (i.e., the application of skills to solve problems). PST is a flexible intervention that can be delivered in individual and group format, as a stand-alone treatment and as part of a broader treatment protocol, such as CBT (Nezu, 2004).

PST has been established as an effective treatment for depression. It has demonstrated efficacy comparable to other psychological treatments (e.g., CBT) and medication, as well as superiority to no treatment, treatment as usual, and support/attention placebo comparison groups (Bell & D'Zurilla, 2009; Cuijpers, van Straten, & Warmerdam, 2007b; Malouff, Thorsteinsson, & Schutte, 2007). Group PST, in particular, has similarly been found to be effective in treating depression (Arean et al., 1993; Cuijpers et al., 2007b; Nezu, 1986). There is some evidence to suggest that group PST has larger effects than individual treatment (Cuijpers et al., 2007b). Groups might be particularly facilitative of strategies such as brainstorming or selection of the strongest solutions, where the exchange of ideas among group members may reduce the likelihood that any one member will become “stuck” during these processes. However, due to considerable variability across studies in terms of what constitutes PST, further research is necessary to better understand the specific conditions that contribute to the efficacy of this treatment (Cuijpers et al., 2007b; Nezu, 2004). Nezu (2004) emphasized that problem-solving skills training on its own does not equal PST because the former typically only emphasizes problem-solving skills (e.g., problem definition, generation of alternative solutions), whereas PST places emphasis both on problem-solving orientation and the application of skills. Indeed, PST has been found to be more efficacious than problem-solving skills interventions in reducing depressive symptoms (Bell & D'Zurilla, 2009; Malouff et al., 2007; Nezu & Perri, 1989).

Self-Management Therapy

Self-management therapy (SMT, also called self-control therapy; Fuchs & Rehm, 1977; Rehm, 1977) is a manualized CBT program, which targets hypothesized deficits self-regulatory processing, such as selective attention toward negative events and immediate consequences of behavior, excessively stringent self-evaluation, attributional errors (e.g., taking credit for negative outcomes and minimizing one's role in positive outcomes), high rates of self-administered punishment, and low rates of self-reward. The treatment was developed for administration to groups but can also be applied individually.

The efficacy of group SMT has been tested in several earlier studies with formats of six (Fuchs & Rehm, 1977; Rehm, Fuchs, Roth, Kornblith, & Romano, 1979; Thomas, Petry, Goldman, 1987), 10 (Rokke, Tomhave, & Jocic, 2000), and 12 (Roth, Bielski, Jones, Parker, & Osburn, 1982; van den Hout, Arntz, & Kunkels, 1995) sessions. Fewer sessions generally signified a stronger behavioral emphasis (e.g., setting goals for short- and long-term accomplishments, using self-reward as motivation to pursue goals). SMT has been found to be as effective as cognitive therapy in reducing symptoms of depression (Thomas et al., 1987), and it has demonstrated superior efficacy when compared to assertiveness training (Rehm et al., 1979), treatment-as-usual (van den Hout et al., 1995), and wait-list control groups (Fuchs & Rehm, 1977; Rokke et al., 2000). One study reported on its greater efficacy relative to supportive therapy (Fuchs & Rehm, 1977), whereas another, in which treatment was administered to older adults, found no differences between SMT and an educational support group (Rokke et al., 2000). Comparable reductions in depressive symptoms were observed when SMT was delivered alone versus in conjunction with antidepressant medication (Roth et al., 1982).

Interpersonal Psychotherapy

Interpersonal psychotherapy (IPT) for depression emphasizes the role of the social context in the development and maintenance of depressive symptoms (Klerman, Weissman, Rounsaville, & Chevron, 1984). Clients are presented with a model of depression as a medical illness while also being encouraged to make changes in one or more of four key interpersonal domains, including grief, interpersonal disputes, role transitions, and interpersonal deficits. Treatment targets include improvements in communication, modification of expectations, and development of more effective use of social support networks (Stuart & Robertson, 2003). IPT is a structured and manualized treatment, which can be delivered in individual and group formats.

IPT, alongside CBT, is considered a first-line psychological treatment for acute depression (Malhi et al., 2009). It has demonstrated superiority to wait-list, drug placebo, and treatment-as-usual comparison groups and is broadly comparable in efficacy to CBT (Cuijpers et al., 2011; de Mello, de Jesus, Bacaltchuk, Verdeli, & Neugebauer, 2005). Comparisons of IPT's efficacy to that of antidepressant medications have yielded mixed results (e.g., Cuijpers et al., 2011; de Mello et al., 2005; Parker, Parker, Brotchie, & Stuart, 2006) and warrant further investigation. Of note, in a review of psychological therapies for mood disorders, Hollon and Ponniah (2010) established that IPT is an efficacious and specific treatment for major depressive disorder but also emphasized that recent studies have not been as uniformly supportive of its efficacy as was earlier work conducted by advocates of this approach.

Individual IPT was initially adapted to a group format (IPT-G) for the treatment of binge eating disorder (Wilfley, Frank, Welch, Spurrell, & Rounsaville, 1998). IPT-G has since been manualized (Wilfley, MacKenzie, Welch, Ayres, & Weissman, 2000) and applied to a number of psychiatric conditions, including depression (MacKenzie & Grabovac, 2001). It has demonstrated efficacy in reducing depressive symptoms across diverse populations (e.g., Bolton et al., 2003; Mulcahy, Reay, Wilkinson, & Owen, 2010), and it might also be effective in reducing symptom severity in depressed clients who respond to antidepressant medication during the acute phase of treatment (Levkovitz et al., 2000).

Preventing Depressive Recurrence and Relapse: Mindfulness-Based Cognitive Therapy

All the approaches detailed above are acute phase treatments; that is, they are implemented when depressive symptoms are active. Given the highly recurrent nature of depression (Judd, 1997), however, there is considerable need for relapse prevention—strategies to prevent the return of symptoms. Accordingly, mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002) was developed around the differential activation hypothesis (Teasdale, 1988), which posits that repeated associations between depressed mood and negative thinking patterns during depressive episodes increase the likelihood of the reactivation of such patterns during subsequent sad mood states. MBCT is a manualized, group-based intervention that aims to interrupt these associations with a combination of traditional cognitive therapy (Beck et al., 1979) and mindfulness-based stress reduction (Kabat-Zinn, 1990). Mindfulness has been defined as a present-centered awareness in which thoughts, feelings, and/or sensations that rise in one's attentional field are acknowledged and accepted without elaboration or judgment (Kabat-Zinn, 1990; Segal et al., 2002).

There are a handful of randomized controlled trials evaluating the effectiveness of MBCT in reducing the recurrence/relapse of major depression, and further research is required to establish MBCT as an efficacious treatment. Systematic reviews of existing studies offer promise for its effectiveness in relapse prevention, with findings supporting the additive benefit of MBCT to usual care for clients with a history of recurrent MDD, particularly in the case of three or more previous episodes (Chiesa & Serretti, 2011; Coelho, Canter, & Ernst, 2007; Piet & Hougaard, 2011). MBCT has also demonstrated comparable effects to maintenance antidepressant medication in preventing relapse, as well as superiority to medication in improving quality of life (Kuyken et al., 2008). In the most comprehensive efficacy study conducted to date, Segal et al. (2010) studied patients who were initially treated with an antidepressant medication and were then randomized either to discontinue the medication in order to receive MBCT, to continue taking the medication for 18 months, or to switch to a placebo. In this study, patients characterized by an unstable pattern of remission showed a 73% reduction in relapse risk when they received MBCT or antidepressant medication. Moreover, MBCT and medication performed equivalently. Although MBCT has not yet been directly compared to other empirically supported psychological approaches, the magnitude of its reductions in rates of depressive recurrence/relapse (up to 50%) parallels that of CBT (e.g., Bockting et al., 2005; Fava et al., 2004).

Best Practice Guidelines

Best practice guidelines for each treatment model are presented in Table 29.1, and the different treatment approaches are illustrated in Table 29.2 with a case example. Because a detailed description of the treatment protocols is beyond the scope of this chapter, we have provided references to key readings and/or treatment manuals (see Table 29.1).

Prior to the initiation of group treatment, we recommend that therapists meet with clients individually to assess their symptoms and suitability for group. In addition, the depressive symptoms of each group member should be monitored weekly, which can be accomplished efficiently with the administration of a self-report measure (e.g., Beck Depression Inventory-II; Beck, Steer, & Brown, 1996) several minutes prior to the beginning of each session.

Clinical Considerations and Challenges during Group Treatment for Depression

Diagnostic Uniformity, Comorbidity, and Symptom Severity

Given the heterogeneity of depression and comorbidity rates, when assessing clients' eligibility for group treatment, it is important to assess for not only the mood disorder of interest but also for other presenting problems. Some clinicians will elect to treat clients with only MDD as opposed to those with dysthymia (a less severe but more long-standing form of depression) or a combination of both. The decision regarding whether to be inclusive of comorbidity with other common conditions (e.g., anxiety disorders) is complex and considered in greater detail elsewhere (Bieling et al., 2006). Problems are more likely to arise when pretreatment diagnostic screening has not been of sufficient depth or breadth, resulting in undetected comorbidity. Once clients are enrolled in a group, the presence of comorbidity will often affect both group process and the implementation of treatment techniques. Decisions regarding comorbidity are thus best made before the group starts. When issues surrounding undetected comorbidity are observed during a group, therapists will be pressed to rapidly decide if and how to modify the protocol to address this problem.

A common problem during group treatment occurs when one group member considers himself or herself, perhaps accurately, as more depressed and impaired than some others in the group. This person might not participate as actively in the group. Importantly, there is research showing that lower participation in the group is a significant predictor of treatment dropout (in the case of CBT; Oei & Kazmierczak, 1997). Both group leaders and participants play a key role in resolving this problem. The response to pessimism and hopelessness is a combination of empathy, encouragement, and persistence. Indeed, this happens almost naturally in most groups. An ideal and quite typical response is for other group members to empathize with the member who is pessimistic, possibly by relating times when they have felt this way themselves. If this does not occur spontaneously, empathy, support, and encouragement can also be modeled by group leaders, who need to carefully balance this support with gentle persistence about continuation with the treatment protocol. This approach is a critical tool for managing other "depressogenic" group processes, including social comparison, rejecting of help, and even suicidal or self-harm ideation. In each case, the validity of the group member's position must be acknowledged while the possibility of change is also communicated to him/her.

Cognitive–Behavioral Therapy

Group Composition and Format	Treatment Components and Techniques
• Up to 12 group members • 17 two-hour sessions • First 14 sessions are weekly, remaining sessions are biweekly • Two therapists • Each session follows a structured format: 1. Status check of group members' symptoms relative to previous session 2. Review of group members' experiences since previous session, including homework 3. Review of previous session's content and how it relates to planned agenda 4. Collaborative setting of session agenda 5. Presentation of new material 6. Assignment of homework	• Psychoeducation, including CBT model of depression • Goal setting • Behavioral activation (see below) • Cognitive strategies for negative automatic thoughts - Thought monitoring/records - Identifying cognitive distortions - Evidence gathering for/against thoughts - Behavioral experiments to test validity of thoughts - Problem solving, when there is some truth to a thought • Cognitive strategies for core beliefs - Strategies for automatic thoughts also apply to core beliefs - Exploration of *meaning* of automatic thoughts - Connecting conditional assumptions/rules and core beliefs - Development of narrative for how beliefs were learned • Relapse prevention

Additional Considerations

- Socratic dialogue should be modeled by group leaders and encouraged among members to facilitate cognitive change
- When one group member uses a questioning strategy to help another, therapist should check whether this member is learning to ask such questions of his/her own negative cognitions
- Session agenda is a balance between treatment protocol being followed and clients' wishes for material to be covered
- Sufficient time at the end of each session should be reserved for assigning homework; 10 minutes is recommended
- Behavioral activation typically precedes cognitive techniques in the course of therapy because it enhances the client's energy level, which is necessary for engagement with cognitive work
- An entire session should be devoted to initial discussion of thought content (e.g., to highlight the shared experience of negative thoughts and their role in depression) because group members have likely not explored it before (see Chapter 10 in Bieling et al., 2006, for further details about the content of this session)
- Sessions on core beliefs can lead to higher levels of affect because they focus on firmly held "deep" cognitions that are tied to early life events; these sessions tend to be less structured because clients rely on many strategies already learned in treatment to understand and challenge their core beliefs

Key sources for further reading: Bieling et al. (2006); Greenberger & Padesky (1995)—recommended as companion manual

Behavioral Activation

Group Composition and Format	Treatment Components and Techniques
• Up to 12 group members • 10–12 two-hour sessions • Two therapists • Each session follows a structured format: 1. Review of progress/homework since previous session 2. Setting of agenda	• Psychoeducation • Behavioral goal setting • Monitoring of activity and mood • Presentation of mastery and pleasure concepts • Scheduling of mastery and pleasure activities to establish balance of reinforcement
Behavioral Activation	
3. Presentation of new material; soliciting feedback from group members 4. Assignment of homework	

Additional Considerations

- Daily activity records should be broken down by the hour and include mood ratings for each waking hour of the day
- Examination of monitoring records should include consideration of whether group members are exposed to adequate reinforcing situations and of the balance of pleasurable events and those that promote a sense of accomplishment (mastery)
- Group members should be encouraged to comment on one another's monitoring homework
- To identify potential new activities, group members can be asked about past activities/pastimes that were enjoyable or activities they have always wanted to try; they can also be presented with a pleasant events list (e.g., MacPhillamy & Lewinsohn, 1982)
- Group members who predict that an activity will not make them feel better should be encouraged to test this prediction by completing the activity

Key sources for further reading: Bieling et al. (2006); Martell, Dimidjian, & Herman-Dunn (2010)

Problem-Solving Therapy

Group Composition and Format	Treatment Components and Techniques
• Up to 12 group members • 10–12 weekly 90-minute sessions; depending on setting, six-session protocols are also available • Two therapists • Each session follows a structured format: 1. Review of homework from previous session 2. Didactic presentation of new material 3. Practice of skills 4. Assignment of new homework	• Psychoeducation • Training in a positive problem-solving orientation to - Accurately recognize problems when they occur - Attribute problems to correct source - Appraise problems as a challenge rather than a threat - View problems as solvable and oneself as capable of solving them - Reduce avoidance of problems • Problem-solving skills training - Problem definition and goal formulation - Generation of alternative solutions (brainstorming) - Decision making (selecting best solution) - Solution implementation and verification

Additional Considerations

- PST can focus on changing the nature of stressful life situations and/or on maladaptive response to such situations
- Problem-solving beliefs and abilities can be assessed with the Social Problem Solving Inventory-Revised, a 52-item self-report measure (D'Zurilla, Nezu, & Maydeu-Olivares, 2002)
- Progress should be monitored weekly with a record of coping attempts, which includes recent problem or stressful situation, thoughts and feelings before, during, and after event, description of attempts to resolve problem, rating of satisfaction with outcome of coping attempts
- Decision making involves cost-benefit analysis of each alternative solution
- If an implemented solution is not effective, the problem-solving cycle needs to be reinitiated

Key sources for further reading: D'Zurilla & Nezu (2007); Nezu & Nezu (2001)

Self-Management Therapy

Group Composition and Format	Treatment Components and Techniques
• Up to 12 group members • 14 weekly 90-minute sessions	• Psychoeducation • Monitoring of positive activities, mood, self-statements
Self-Management Therapy	
• Two therapists • Each session follows a structured format: 1. Review of homework from previous session 2. Didactic presentation of new material 3. Group discussion 4. Written exercises 5. Assignment of new homework	• Examination of relationship between moods and activities • Learning to attend to positive events and delayed outcomes • Reattribution for events (i.e., learning that the reasons for some negative outcomes are external and not personal; writing self-statements that reduce blame on oneself for negative events) • Goal setting • Contingency management: Use of rewards to facilitate progress toward goals; use of positive self-statements as rewards • Development of assets list to identify positive traits

Additional Considerations

- Self-monitoring of mood and pleasant activities is ongoing throughout the course of treatment
- Two sessions at the end are allocated to the practice of material taught during the course of treatment

Key sources for further reading: Rehm & Adams (2005)

Interpersonal Therapy

Group Composition and Format	Treatment Components and Techniques
• 8–10 group members • 12–20 weekly 90-minute sessions (fewer total sessions requires greater structure during sessions) • Two therapists • Each session follows a semistructured format, which adheres to the goals of the treatment phases and incorporates group process • Events from the past week are reviewed in each session • No formal homework is assigned but practice of interpersonal skills and implementation of solutions to interpersonal problems is emphasized	• Pregroup individual meeting to administer the interpersonal inventory and establish target goals in one or more problem areas (grief, role disputes, role transition, and interpersonal deficits) • Treatment is divided into three phases 1. Management of negative affect; testing out and refining target goals within the group 2. Group members work together toward common goals; new social skills are practiced within the group and applied to problem areas in clients' lives 3. Consolidation of gains; preparation for termination • Treatment strategies include - Psychoeducation - Communication analysis and communication skills training, including communication of affect - Problem solving - Modification of expectations about disputes - Enhancement of current social supports or development of new ones

Additional Considerations

- Client characteristics that might increase suitability for IPT include a relatively secure attachment style, ability to coherently describe one's interpersonal interactions, a specific interpersonal focus for distress, good social support (Stuart & Robertson, 2003)

Interpersonal Therapy

- Emphasis in early group sessions is on cohesion and establishment of positive group norms; group members are encouraged to commit to working together on individual target goals
- Prolonged discussion of symptoms is discouraged after review of symptoms in early sessions
- Group environment is used to explore behavioral and affective responses to social interactions and to practice social skills

Key sources for further reading: Stuart & Robertson (2003); Wilfley et al. (2000)

Mindfulness-Based Cognitive Therapy

Group Composition and Format	Treatment Components and Techniques
• 10–12 group members who are in remission from depression • 8 weekly two-hour sessions • Two therapists • Each session follows a structured format: 1. Mindfulness practice 2. Group discussion about reactions to practice 3. Homework review 4. Presentation of new material (cognitive therapy exercises and/or meditation) 5. Distributions of handouts of session material and homework 6. Assignment of new homework	• Development of nonjudgmental awareness of moment-to-moment experiences - Awareness of how quickly and easily the mind wanders - Formal meditation practices (body scan; mindfulness of the breath, body, sounds, and thoughts) - Awareness of how the mind's wandering can facilitate negative thoughts and feelings • Development of more flexible, deliberate responses to mood shifts - Taking a breathing space before responding to negative thoughts - Allowing thoughts and feelings to come and go from awareness without acting on them - Treating thoughts as thoughts/mental events and not facts - Recording thoughts - Challenging validity of negative thoughts - Engaging in actions that elicit pleasure or a sense of mastery • Development of action plans for times of potential relapse • Homework assignments include daily meditation practice, as well as cognitive therapy techniques

Additional Considerations

- Clients who achieved recovery from depression with medication might have a biological model of the illness; it may thus be helpful to discuss the role of both biological and psychological factors in depression during their pretreatment assessment
- The developers of MBCT (Segal et al., 2002) recommend that practitioners incorporate mindfulness into their daily lives before teaching it to clients
- When group members report difficulty with completing homework (e.g., due to time constraints), the occasion should be used as an opportunity to approach the problem with curiosity; those struggling with homework completion should be asked to apply an inquiring mind to instances when homework is not completed and to bring awareness to the thoughts and feelings that might be associated with its noncompletion
- Group members who fall asleep during daily meditation practice should be encouraged to try meditating at times when they are less likely to be tired or sleepy
- It is common for group members to come to sessions striving for specific outcomes or with the sense that there is a "right" way of practicing meditation; members should be reminded that emphasis in MBCT is instead on being in the moment and letting go of the tendency to fix or change

Key sources for further reading: Segal et al. (2002)

Case: Sonya is a 50-year-old woman who has been diagnosed with recurrent MDD. She experienced her first depressive episode after the dissolution of her marriage 5 years ago, which remitted partially after a trial of antidepressant medication. Sonya began to experience an exacerbation of depressive symptoms after the recent death of her mother, with whom she had a conflictual relationship. She initially coped with these symptoms by immersing herself in her job. However, due to the worsening of her mood and energy, as well as considerable disruptions in sleep and concentration, it became increasingly difficult for her to complete her duties at work and at home. Once highly capable of completing these tasks, she felt "stupid" for currently being unable to do so. Sonya's employer expressed concern about her productivity and reduced her hours, which further contributed to her low mood and sense of worthlessness. Sonya spent much of her free time in bed and ultimately asked for a leave of absence from work because she feared further criticism from her boss. She felt like a failure in various domains of her life. Several close friends tried to offer support, but she limited her contact with them because it made her feel worse to consider how much "better off" they were.

Treatment	Possible Treatment Targets for Sonya
Cognitive-Behavioral Therapy	Withdrawal from daily activities; lack of activities that contribute to pleasure or a sense of mastery; her appraisals of her own and others' accomplishments, of the reason for why her work hours were reduced, and of others' perceptions of her; maladaptive assumptions (e.g., "If I cannot complete a task when feeling unwell, I am stupid"); core beliefs about being incompetent and worthless
Behavioral Activation	Withdrawal from daily activities; lack of activities that contribute to pleasure or a sense of mastery
Problem-Solving Therapy	Poor recognition of problems when they are occurring; appraisals of her boss' feedback as threatening rather than as a challenge to be resolved; avoidant approach toward problems (e.g., immersing self in work to cope with exacerbation of symptoms; leaving job); lack of problem-solving skills (e.g., not contacting physician to consult about antidepressant medication)
Self-Management Therapy	Lack of rewarding activities; negative self-statements; focus on short-term negative outcomes
Interpersonal Psychotherapy	Interpersonal deficits, with exploration of patterns of conflict and distress in relationships with others, including ex-husband, mother, boss, and friends; social isolation; grief surrounding loss of mother
Mindfulness-Based Cognitive Therapy	Not applicable during acute phase of depression; appropriate time for MBCT would have been after remission of previous depressive episode

Suitability for Group Treatment

In some cases, certain group members might have needs that exceed the capacity of the group. Individuals with very serious suicidal ideation and intent, and those whose concentration and ability to understand the material falls well below the group average, might need to be seen individually. Occasional instances of a group member's lack of understanding or severe pessimism should be tolerated within the group; in this case, the material should be clarified and empathy and encouragement offered to facilitate the client's engagement with treatment. Only if members consistently demonstrate poor understanding or low interest in the group process should other treatment options be considered.

A rigorous screening process also contributes to minimizing the number of individuals who might need an alternative approach. Bieling and colleagues (2006) proposed several important considerations regarding clients' suitability for group CBT, which were adapted from a screening tool for individual CBT in depression (Safran & Segal, 1990). Many questions from this suitability assessment can be generalized to other models of group treatment for depression and should evaluate the following: the extent to which the client accepts responsibility for change; compatibility between the client's view of the problem and the treatment model; the duration of the client's problem with depression; the client's ability to focus on a specific problem; the client's optimism that change is possible; the client's ability to form an initial therapeutic alliance (i.e., during the assessment/screening phase); and the extent to which any disruptive interpersonal processes may interfere with treatment. Bieling et al. synthesized these domains into four distinct factors, including the capacity to reflect on one's own mental experiences, compatibility with the treatment rationale, clinical considerations related to the disorder (e.g., chronicity), and interpersonal process factors.

Working with Group Process

With the exception of IPT, in which the group serves as the basis for exploring responses to interpersonal relationships, empirically supported group treatments for depression do not overtly rely on process factors to create therapeutic change. Group process is nevertheless an important aspect of these treatments because it has the capacity to both hinder and facilitate treatment outcomes. For example, a common group process problem arises when one group member considers himself or herself to be more depressed and impaired than other members. This individual might not actively participate in the group and might voice pessimism about the effectiveness of treatment strategies. Both the therapists and other members can contribute to resolving this problem by offering empathy and encouraging persistence to attempt a given therapeutic activity. Such a response often occurs naturally among members, who have likely felt similarly at times; if not, therapists need to model this response and engage the group in discussion that draws on common experiences of hopelessness and pessimism.

The group environment provides each patient with access to a range of often novel perspectives volunteered by other group members and with opportunities to give others feedback based on material learned in sessions. This form of mutual sharing and support can enhance the group's cohesion, as well as individual member's motivation and acquisition and practice of new skills. Therapists should be vigilant that patients do not focus on offering feedback to others to the neglect of working on their own problems. When patients apply therapeutic strategies (e.g., generating a list of pleasant activities, challenging negative thoughts) to other group members, it is helpful to ask the patients how they have been using these strategies to address their own concerns.

Summary

There are several efficacious group treatments for acute depression. Many of them, including CBT, BA, PST, and SMT, are comprised of cognitive and/or behavioral techniques. Of these, CBT is the most comprehensive approach, and it has the strongest empirical basis. IPT is also a well-supported group treatment for depression, and by contrast to the aforementioned cognitive and/or behavioral interventions, it focuses expressly on group process and utilizes it to facilitate therapeutic change. Finally, MBCT is an emerging secondary prevention group-based treatment for clients who are in remission from previous depressive episodes. Because it is a relatively novel approach, it warrants further evaluation to establish its effectiveness. The existing data suggest that MBCT is a particularly promising treatment for individuals with a history of three or more depressive episodes. Overall, the current evidence supports the use of psychotherapeutic group interventions for depression across a broad range of populations. Directions for future research in this area include greater focus on group process factors and treatment mechanisms, both which remain poorly understood but which hold considerable promise for improving treatment outcomes.

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Chapter 30 Groups for Anxiety Disorders

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Anxiety disorders are characterized by excessive anxiety, fear, and/or worry, and by the maladaptive strategies used to cope with these symptoms, such as avoidance and compulsive rituals (see Table 30.1 for features of individual disorders). As a group, they are the most commonly occurring mental disorders, with a lifetime prevalence estimate of 28.8% (Kessler et al., 2005). They are associated with high medical and loss of productivity costs (Marciniak, Lage, Landbloom, Dunayevich, & Bowman, 2004), impaired functioning (Stein et al., 2005), decreased quality of life (Olatunji, Cisler, & Tolin, 2007), and significant personal distress. Based on a 1990 estimate, the annual economic cost of anxiety disorders in the United States totaled to $46.6 billion, accounting for 31.5% of mental health–related expenditures (DuPont et al., 1996). Accordingly, there is a strong demand for evidence-based treatments for anxiety disorders.

The current psychological treatment of choice for anxiety disorders is cognitive-behavioral therapy (CBT). CBT is aimed at modifying maladaptive cognitions (e.g., negative, unrealistic, and/or biased thoughts, beliefs, and appraisals) and behavioral responses that maintain anxiety. It can be delivered individually and in group formats. CBT is the most widely studied treatment for anxiety disorders, and it has received substantial empirical support for its effectiveness. The mechanisms of therapeutic change in CBT are not well understood; however, there is considerable theoretical and empirical activity in this area, which holds promise for future refinement of CBT methods and their efficacy. Techniques commonly used in group CBT for anxiety disorders are described in Table 30.2.

This chapter provides an overview of empirically supported group treatments for specific anxiety disorders as well as more recent transdiagnostic group treatment approaches. Best practice guidelines for conducting group treatment with individuals who have an anxiety disorder are discussed, followed by strategies for trouble-shooting common treatment obstacles.

Empirically Supported Group Treatments of Individual Anxiety Disorders

Panic Disorder

There are several variants of CBT for panic disorder (PD), of which cognitive therapy (Clark et al., 1999) and panic control treatment (PCT; Craske, Barlow, & Meadows, 2000) have received the most extensive empirical support. Cognitive therapy emphasizes the catastrophic interpretation of bodily sensations associated with panic symptoms (e.g., interpreting heart palpitations as a sign of an impending heart attack). Key treatment strategies include modification of these interpretations (i.e., cognitive restructuring) through dialogue and behavioral experiments, the latter of which involves gathering evidence to evaluate the validity of one's catastrophic beliefs (e.g., "If I faint, people will laugh at me."). PCT aims to modify fear of bodily sensations and apprehension of panic through the purposeful induction of somatic symptoms (i.e., interoceptive exposure), as well as cognitive restructuring, breathing retraining, and *in vivo* exposure to feared situations in cases where agoraphobia is present.

Disorder	Features
Panic Disorder With or Without Agoraphobia	• *Panic attacks*: Discrete episodes of intense fear or discomfort that peak rapidly and involve four or more physical (e.g., pounding heart, trembling) and/or cognitive (e.g., fear of losing control) symptoms • *Panic disorder*: Panic attacks are experienced repeatedly and unexpectedly and are accompanied by persistent concern about future panic attacks, worry about the consequences of the attacks, and/or behavioral changes in response to the attacks • *Agoraphobia*: Fear or avoidance of situations where escape might be difficult or help might be unavailable in the event of a panic attack
Social Anxiety Disorder	• Excessive or unrealistic fear of social and performance situations in which a person might be scrutinized or judged by others, embarrassed, or humiliated • Phobic situations almost always trigger an anxiety response and are avoided or endured with extreme discomfort • Individual recognizes that his or her fear is excessive or unrealistic
Obsessive-Compulsive Disorder	• Presence of obsessions, compulsions, or both • *Obsessions*: recurrent, unwanted, and intrusive thoughts, images, or urges that cause marked anxiety (e.g., contamination fears, doubts about actions, distressing religious, aggressive, or sexual thoughts) • *Compulsions*: repetitive behaviors or mental acts (e.g., checking, washing, counting, or repeating) performed to reduce anxiety generated by obsessions or to prevent negative outcomes
Generalized Anxiety Disorder	• Persistent, uncontrollable, and excessive worry about everyday events and problems accompanied by several physical and/or psychological symptoms (e.g., headaches, muscle tension, irritability)
Post-Traumatic Stress Disorder	• Onset follows exposure to traumatic event that elicits intense fear, helplessness, or horror • Symptoms include reexperiencing of the event through intrusive recollections, persistent avoidance of stimuli and situations associated with the event, and increased arousal (e.g., exaggerated startle response, difficulties falling or staying asleep, hypervigilance)
Specific Phobia	• Excessive or unreasonable fear cued by the presence (or anticipation) of a specific object or situation (e.g., specific animals, heights, sight of blood) • Object or situation is usually avoided, or exposure to it is endured with intense anxiety

Note: Adapted from the *Diagnostic and Statistical Manual of Mental Disorders (DSM-TR)*, (4th ed., Text Rev.). (2000.) Washington, DC: American Psychiatric Association.

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Technique	Definition
Psychoeducation	• Presentation of information about the nature of anxiety • Presentation of CBT model / treatment rationale
Cognitive Strategies	• *General definition:* Cognitive strategies are aimed at changing unrealistic/distorted threat-focused thoughts, beliefs, and appraisals (for detailed descriptions of cognitive strategies, see Antony & Swinson, 2000; Bieling, McCabe, & Antony, 2006) • *Thought records:* Regular monitoring and documentation of situational triggers, thoughts, emotions, and behaviors to gain understanding of the connections among them • *Cognitive restructuring:* Exploring evidence and challenging distorted thoughts to facilitate more realistic thinking • *Behavioral experiments:* Method of cognitive restructuring that involves testing out catastrophic predictions by gathering evidence (behaviorally) to examine their validity (see case example below)
Exposure	• *General description:* Exposure strategies require patients to face their fears, most commonly in a stepwise manner (i.e., by developing an exposure hierarchy), starting with moderately fear-provoking stimuli/situations and moving toward increasingly more fear-provoking stimuli/situations (for detailed descriptions of exposure-based strategies, see Antony & Swinson, 2000; Bieling et al., 2006); during exposure, patients are asked to eliminate any maladaptive coping strategies (i.e., safety behaviors) • *In vivo exposure:* Real-life exposure to feared stimuli/situations • *Imaginal exposure:* Feared stimulus/situation is imagined in great detail (description could be established in writing, on an audio recording, or verbally by the patient and/or therapist) • *Interoceptive exposure:* Purposeful exposure to uncomfortable physical sensations (e.g., dizziness) via a variety of exercises (e.g., spinning in a chair) • *Exposure and ritual prevention (ERP):* Exposure to feared situations with simultaneous elimination of compulsions, rituals, and protective behaviors typically used in such situations
Social Skills Training	• Teaching and rehearsal of social skills (e.g., nonverbal communication, assertiveness training, dealing with conflict, presentation skills, dating skills)
Problem-Solving Training	• Emphasizes approach rather than avoidance of problems • Skills taught include problem definition, goal formulation, solution generation, decision making, solution implementation, and evaluation
Relaxation Training	• Application of relaxation methods (e.g., diaphragmatic breathing, progressive muscle relaxation) to lessen the physiological symptoms of anxiety/worry; patients are asked to practice technique(s) regularly to learn how to readily initiate relaxation response in anxiety-provoking situations
Relapse Prevention	• Review of treatment progress • Identification of possible triggers for symptom relapse

Individual and group CBT for PD have been extensively evaluated, with findings supporting the robust efficacy of both formats (e.g., Lidren et al., 1994; Telch et al., 1993). Few studies, however, have directly compared the two modalities. A recent randomized controlled trial evaluated standard individual, brief individual, and group CBT for PD with agoraphobia (Marchand, Roberge, Primiano, & Germain, 2009). The brief treatment consisted of seven sessions, whereas the other two treatments each included 14 sessions. Compared to a wait-list (WL) control group, all three treatments similarly produced greater reductions in symptom intensity, increases in quality of life, maintenance of gains over time, and lower rates of relapse. Group CBT for PD in community mental health clinics has yielded outcomes comparable to controlled trials (Garcia-Palacios et al., 2002). Both group and individual CBT for PD are more cost-effective than pharmacotherapy (Otto, Pollack, & Maki, 2000), and group treatment has been found to be more cost-effective than individual treatment (Marchand et al., 2009).

Social Anxiety Disorder

CBT for social anxiety disorder (SAD, also known as social phobia) is commonly delivered either in individual or group formats, both of which have been shown to be effective (e.g., Powers, Sigmarsson, & Emmelkamp, 2008). Depending on the protocol, this treatment includes various combinations of several key components, including exposure-based strategies, cognitive therapy, social skills training, and applied relaxation. The gold-standard group treatment for SAD is Heimberg's cognitive-behavioral group treatment (CBGT; Heimberg & Becker, 2002), which has been found to be superior to supportive psychotherapy (Heimberg et al., 1990). Preliminary research on a modified version of CBGT supports its effectiveness for reducing SAD symptoms in patients with coexisting SAD and a substance use disorder (Courbasson & Nishikawa, 2010).

A meta-analysis of 32 randomized controlled trials of CBT for SAD demonstrated that this treatment is significantly more effective than WL, psychological placebo, and pill placebo control conditions, with gains maintained at follow-up assessments (Powers et al., 2008). The authors did not observe differences in efficacy between individual and group formats, which is consistent with other meta-analytic studies (e.g., Federoff & Taylor, 2001). The few individual studies that have directly compared individual and group treatment have produced mixed findings, with some indicating generally equivalent effectiveness (Wlazlo, Schroeder-Hartwig, Hand, Kaiser, & Münchau, 1990) and others favoring either group treatment (Scholing & Emmelkamp, 1993) or individual treatment (Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003). These differences are likely because of methodological limitations of the research.

Obsessive-Compulsive Disorder

Exposure and ritual prevention (ERP) is the psychological treatment of choice for obsessive-compulsive disorder (OCD). This treatment method has received considerable empirical support (for a review, see Foa, 2010). Components of the treatment that have been identified as important in improving treatment outcomes include strict ritual prevention (versus gradual or partial prevention), therapist-assisted exposure (versus self-exposure), and combined imaginal and *in vivo* exposure (versus *in vivo* exposure only; Abramowitz, 1996).

Despite the established efficacy of ERP, most treatment completers continue to struggle with OCD symptoms to some extent. Thus, there has been increasing interest in the application of cognitive techniques to augment treatment outcomes. Cognitive therapy (CT) has been shown to be an effective alternative to ERP (e.g., Whittal, Thordarson, & McLean, 2005), and ERP and ERP/CT (i.e., CBT) have generally demonstrated comparable effectiveness (e.g., Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008), although one meta-analysis points to the superiority of ERP (Eddy, Dutra, Bradley, & Westen, 2004). While current evidence suggests that CT and CBT are no more effective than ERP, CT appears to be particularly beneficial in reducing treatment dropout (for a review, see Abramowitz, Taylor, & McKay, 2005). The overall equivalency among these treatments might be attributable to overlap in their procedures because it is difficult to establish a comparison between "pure" behavioral and cognitive techniques.

Research has demonstrated that OCD can be treated effectively in group formats (e.g., Jónsson, Hougaard, & Bennedsen, 2011), with long-term maintenance of treatment gains (e.g., Braga, Manfro, Niederauer, & Cordioli, 2010; Cabedo et al., 2010). Recent findings on group CBT for OCD emphasize the importance of achieving full symptom remission at the end of treatment (Braga et al., 2010). However, as mentioned above, it is uncommon for patients with OCD, when treated by any form of CBT, to attain full remission. Another factor that has been associated with less improvement in CBT for OCD is poor insight into the excessive nature of the symptoms (Raffin, Guimaraes Fachel, Ferrao, Pasquoto de Souza, & Cordioli, 2009).

Comparisons of individual and group formats have generally demonstrated that both are effective but that individual treatment has some superiority over group treatment (e.g., Jónsson et al., 2011). For instance, patients who completed individual treatment have been shown to benefit from a greater rate of recovery (Raffin et al., 2009) and symptom improvement (Cabedo et al., 2010). Group ERP or CBT for OCD is nevertheless a viable option, particularly in settings where resources limit the availability of individual treatment.

Generalized Anxiety Disorder

Both CBT and relaxation training have received empirical support for reducing symptoms of generalized anxiety disorder (GAD). Specific components included in CBT protocols for GAD vary as a function of the model from which the treatment is derived. For an extensive review of theoretical models of GAD and their corresponding treatments, see Behar, DiMarco, Hekler, Mohlman, and Staples (2009). A meta-analysis of 10 studies of CBT for GAD (Covin, Ouimet, Seeds, & Dozois, 2008) found that treatments based on the intolerance of uncertainty model, including those in group format, produced the largest improvements, although further research is necessary to determine the relative efficacy of different protocols given the small number of studies included in the analysis.

Relaxation training is a general anxiety-reduction strategy that teaches individuals to relax in the presence or anticipation of anxiety (for treatment manuals, see Bernstein & Borkovec, 1973 [progressive relaxation] and Öst, 1987 [applied relaxation]). When compared directly, CBT and relaxation training have been shown to be similarly effective (e.g., Borkovec & Costello, 1993; Dugas et al., 2010). However, compared to relaxation training, CBT has demonstrated greater superiority to WL conditions and further symptom declines following treatment (e.g., Borkovec & Costello, 1993; Dugas et al., 2010). Meta-analytic findings indicate that CBT is more effective than treatment-as-usual and WL control groups (Hunot, Churchill, Silva de Lima, & Teixeira, 2007) and that it is equally as effective as pharmacotherapy (Mitte, 2005). Compared to pharmacotherapy, dropout rates are lower for CBT.

Current evidence supports the efficacy of group CBT for GAD (Covin et al., 2008; Hunot et al., 2007). Although a meta-analytic comparison suggests that individual treatment is superior to group treatment in reducing pathological worry (Covin et al., 2008), the outcomes from group treatment were nevertheless maintained over time, with a continued decrease in worry at 6- and 12-month follow-up assessments; by contrast, individual treatment showed comparatively little change from post-treatment to follow-up. Another meta-analysis found that group and individual formats are equally effective in terms of clinical response and reductions in worry and depression but that group treatment is associated with greater dropout (Hunot et al., 2007).

Post-Traumatic Stress Disorder

Prevention and Early Intervention

There has been considerable interest in the development of psychological strategies that prevent the worsening of trauma-related symptoms and/or the development of post-traumatic stress disorder (PTSD) following exposure to trauma. A widely cited intervention, critical incident stress debriefing (CISD; Mitchell & Everly, 1996) promotes the sharing of thoughts and feelings among those who have experienced a traumatic event to help them make sense of it. CISD was initially developed as a single-session group intervention, but it can also be applied individually. It is intended to be administered to all individuals exposed to a given traumatic incident within several days of its occurrence. Although a popular early intervention, CISD has been found to be ineffective at reducing distress and preventing PTSD (Van Emmerick, Kamphuis, Hulsbosch, & Emmelkamp, 2002), and it has also been shown to have negative long-term effects (e.g., Mayou, Ehlers, & Hobbs, 2000).

More promising findings have been reported for early cognitive-behavioral interventions targeted at a more restricted range of individuals exposed to a traumatic event, specifically those with high levels of distress or with indications of acute stress disorder (for a review, see Ehlers & Clark, 2003). This treatment includes education about the psychological effects of trauma, imaginal and/or *in vivo* exposure, cognitive restructuring, and possibly relaxation training. It can be delivered individually or in groups and typically includes four to six sessions that commence within the first month following trauma. This form of CBT has been shown to be superior to supportive counseling in reducing PTSD symptoms, general anxiety, and depression (e.g., Bryant, Sackville, Dang, Moulds, & Guthrie, 1999).

Treatment of PTSD

An extensive empirical literature supports several forms of CBT for the treatment of PTSD (for a review, see Cukor, Olden, Lee, & Difede, 2010). Psychological treatments featuring exposure therapy, in particular, are first-line interventions for this disorder (Ballenger et al., 2000). Two treatments that have received the strongest empirical support include prolonged exposure (PE) therapy (Foa, Hembree, & Rothbaum, 2007) and cognitive processing therapy (CPT; Resick & Schnicke, 1993). PE focuses on gradual exposure to thoughts, objects, places, and situations that evoke memories of the trauma, and it can be combined with cognitive techniques. CPT instead emphasizes the modification of beliefs about the meaning of the trauma, although it also includes elements of exposure (i.e., writing about the event).

A number of meta-analytic studies on the efficacy of psychological treatments for PTSD have been conducted (e.g., Bisson et al., 2007; Ponniah & Hollon, 2009), and they have consistently shown that trauma-focused CBT (which includes the two aforementioned treatments) is effective. This treatment method has demonstrated superiority to WL and treatment-as-usual conditions in reducing symptoms of PTSD, anxiety, and depression. The same studies have also found that another psychological treatment, eye movement desensitization and reprocessing (EMDR; Shapiro, 1995) is as effective as CBT. EMDR involves pairing eye movements with cognitive processing of traumatic memories. Though effective, it is considered by some to be controversial. Given a lack of differences in efficacy between EMDR and exposure-based treatments, some authors have argued that the mechanism of change in EMDR is merely exposure and that eye movements are a superfluous component of the treatment (e.g., Davidson & Parker, 2001).

Group CBT for PTSD has not been investigated as extensively as its individual format counterpart. Existing data suggest that it is an effective treatment (Ponniah & Holloh, 2009), although some studies have failed to find differences between trauma-focused CBT and treatment control groups (Schnurr et al., 2003). However, when the outcomes of group members who attended at least 24 of 30 group sessions were examined, group CBT demonstrated greater reductions of avoidance and numbing symptoms. Meta-analytic findings on group CBT suggest that it promotes greater improvements in trauma-related symptoms than WL or treatment-as-usual groups

(Bisson et al., 2007). Furthermore, the addition of group CBT to pharmacotherapy has been shown to improve outcomes for patients who did not previously have an adequate response to medication (Otto et al., 2003). A recent randomized pilot study demonstrated that group CBT for chronic PTSD was superior to a minimum contact comparison group in terms of symptom reduction and remission from the disorder (Beck, Coffey, Foy, Keane, & Blanchard, 2009). These gains were maintained at a short-term follow-up. The outcomes of the two groups did not, however, differ on measures of anxiety, depression, and pain. Overall, current evidence suggests that trauma-focused group CBT is an effective treatment, but further research is warranted given the dearth of methodologically rigorous studies in this area.

Specific Phobias

The most robust and durable outcomes in the treatment of specific phobias are achieved with exposure-based interventions, particularly *in vivo* exposure (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008). Single- and multiple-session treatments have both received empirical support, although research suggests that the latter might promote greater long-term maintenance of treatment gains (Wolitzky-Taylor et al., 2008). Conclusions regarding the extent to which cognitive techniques enhance the efficacy of exposure are limited by a small number of studies evaluating CT for specific phobia. There is some evidence to suggest that CT alone or in combination with exposure is effective for claustrophobia (e.g., Öst, Alm, Brandberg, & Breitholtz, 2001) and dental phobia (e.g, Willumsen & Vassend, 2003), but findings regarding its efficacy for other phobias have been mixed (Choy, Fyer, & Lipsitz, 2007). A recent comparison of exposure treatment and CBT for spider phobia demonstrated that both are equally effective in reducing spider fear and that an important mechanism accounting for this reduction in both treatments is cognitive change (Raes, Koster, Loeys, & De Raedt, 2011).

Exposure-based treatments for specific phobias are typically conducted individually, and few studies have examined the effectiveness of group treatment. Öst (1996) compared small (3–4 patients) and large (7–8 patients) groups for spider fear, both of which consisted of a single 3-hour session of *in vivo* exposure. Significant improvements were observed in both groups, with gains maintained at a one-year follow-up. The authors noted a trend for the smaller group to yield better effects. In subsequent work, direct group treatment was found to be more effective at reducing phobic fear than two observational treatments (either direct or indirect [via video] observation of others' group treatment; Öst, Ferebee, & Furmark, 1997).

Transdiagnostic Treatments of Anxiety Disorders

Given a high rate of comorbidity among anxiety disorders, there has been growing interest in the development of treatments that are broadly applicable across the disorders (i.e., transdiagnostic treatments; for a review, see McManus, Shafran, & Cooper, 2010). Current protocols are limited in their ability to address comorbidity, because they are designed for specific disorders and often validated in patient groups with a single anxiety disorder diagnosis. In clinical practice, individuals who have multiple diagnoses are first treated for the disorder that causes the most distress and impairment. Those who suffer from clinical anxiety but who do not meet criteria for one of the major anxiety disorders (they would instead be diagnosed with Anxiety Disorder, Not Otherwise Specified) are typically referred for individual treatment, which can be problematic in settings where such treatment is not readily available.

Several theoretical transdiagnostic models of anxiety disorders, which focus on common processes across the disorders, have been developed (e.g., Barlow, Allen, & Choate, 2004; Norton, 2006). Research on the efficacy of treatments based on these models is yet in its infancy (McEvoy, Nathan, & Norton, 2009). Should transdiagnostic treatments garner empirical support with future research, they hold considerable promise for improving the cost-effectiveness, accessibility, and efficacy of group treatments for anxiety disorders.

Best Practice Guidelines

Group CBT is a time-limited, structured treatment that emphasizes learning new skills to resolve current problems. Treatment sessions broadly adhere to the following agenda: (1) check in with group members about weekly progress and any questions arising from the previous session, (2) review of homework (i.e., practice exercises, such as thought records and exposures, completed regularly between sessions), (3) presentation of new material and in-session practice or discussion of this material, and (4) assignment of homework based on new material. Concepts are introduced and applied through *collaborative empiricism*, whereby therapists and patients work together to evaluate ideas (Tee & Kazantzis, 2011). Collaboration toward mutual discovery is also encouraged among group members. Disorder-specific treatment guidelines are presented in Table 30.3.

Table 30.4 presents a case example featuring part of a group session for SAD. It includes therapists' presentation of a rationale for a behavioral experiment, which involves having the patients test the validity of their negative predictions. The vignette also illustrates the collaborative dialogue between therapists and patients and the therapists' Socratic style of questioning. Finally, the example highlights group process issues, including therapists' efforts to involve all members in discussion and their approach when a group member (Robert) presents information that might reinforce other members' negative beliefs.

Panic Disorder With or Without Agoraphobia	
Group Composition and Format	**Treatment Techniques**
• 5–8 patients with PD as primary disorder • Balanced in terms of demographic factors, symptom severity, and presentation • 12 weekly two-hour sessions • Two therapists	• Psychoeducation • Cognitive strategies • Exposure: *In vivo*, interoceptive, and combined • Additional strategies as needed (e.g., breathing retraining, relaxation) • Relapse prevention
Additional Considerations	
• Group members who have experienced rare, negative outcomes during panic (e.g., fainting, vomiting) might challenge information presented by therapists and trigger fear in other members → Therapists should acknowledge that negative events may sometimes occur but shift focus to realistic probabilities • Group members who have medical conditions that produce panic-like physiological symptoms (e.g., cardiac problems, lung disease) present a unique challenge → Therapists should ensure that certain aspects of treatment (e.g., exposure) are not contraindicated with the medical condition by having patients consult their physicians; therapists should emphasize that subjective, negative interpretations of objective medical symptoms can result in amplification of these symptoms, much as in PD without a medical comorbidity	
Social Anxiety Disorder	
Group Composition and Format	**Treatment Techniques**
• 5–7 patients with SAD as primary disorder • Balanced in terms of demographic factors, symptom severity, and presentation • 12 weekly two-hour sessions • Two therapists (ideally one male, one female)	• Psychoeducation • Cognitive strategies • Exposure • Social skills training • Relapse prevention
Additional Considerations	
• Groups with >9–10 members might result in greater social inhibition and dropout early in treatment • Depending on group composition, a member might be uncomfortable about being noticeably different from the others (e.g., sex, age) → Therapists should discuss such differences with the patient before start of group to assess if they might be an issue • Patients with SAD commonly express apprehension about group treatment → Therapists should emphasize that all group members are anxious about this and that discomfort will decrease during the course of treatment • Individual therapy should be considered for patients with poor insight into the excessiveness of their anxiety or those who endorse suspiciousness of others	
Obsessive-Compulsive Disorder	
Group Composition and Format	**Treatment Techniques**
• 4–7 patients with OCD as a primary disorder • Balanced in terms of demographic factors, symptom severity, and presentation • 14 weekly (with last two biweekly) 2 to 2.5-hour sessions • Two therapists	• Psychoeducation • Exposure and ritual prevention (ERP) • Cognitive strategies • Relapse prevention
Additional Considerations	
• OCD is a highly heterogeneous condition and heterogeneity among group members might result in some members feeling different from others or uncomfortable with disclosing the nature of their symptoms (e.g., aggressive, religious, or sexual obsessions) → It is useful to have more than one member in each group with these types of obsessions • Some group members might trivialize the concerns of others → It is important to educate the group early in treatment about various presentations of OCD and to emphasize the commonalities among them • Because patients commonly have different symptom profiles, some aspects of group treatment need to be individualized (e.g., patients might work on their own during exposure practices) • Some group members may reinforce avoidance behaviors of others or share information that strengthens others' dysfunctional beliefs → Therapists should clarify the treatment rationale and provide corrective feedback if this occurs • A patient's OCD symptoms can vary widely (e.g., washing, checking, repeating), making it challenging to decide which to focus on first → Select those that cause the most distress and impairment and that the patient is interested in tackling first • Some patients with OCD experience shifts in symptoms over time (e.g., shift from contamination fear to doubts about completion) → Therapists should emphasize general principles of treatment and their application to a wider range of symptoms; homework practices might have to be adapted to address new symptoms	
Generalized Anxiety Disorder	
Group Composition and Format	**Treatment Techniques** [a]
• 5–8 patients with GAD as primary disorder • Balanced in terms of demographic factors, symptom severity, and presentation • 12 weekly two-hour sessions • Two therapists	• Psychoeducation and worry awareness training • Uncertainty recognition and *in vivo* exposure to uncertainty-inducing situations • Cognitive restructuring of beliefs about the usefulness of worry • Problem-solving training • Imaginal exposure • Additional strategies as needed (e.g., relaxation training) • Relapse prevention
Additional Considerations	
• Some group members might present with worry about current, serious problems (e.g., illness of loved one), whereas others might report worry about the possibility of such problems (e.g., possible future illness of a loved one) → Therapists should discuss with the group differences between current and *possible* problems and the distinct strategies used to address them (i.e., problem solving for the former and cognitive restructuring for the latter)	
Post-Traumatic Stress Disorder	
Group Composition and Format	**Treatment Techniques**
• 4–6 patients with PTSD as primary diagnosis • Nature of trauma should be similar among group members (e.g., sexual assault, motor vehicle accidents, military trauma) to enhance group cohesion • 12 weekly two-hour sessions (see Additional Considerations regarding longer treatment protocols)	• Psychoeducation • Relaxation training with focus on breathing retraining • Cognitive strategies • Imaginal exposure • *In vivo* exposure • Additional strategies as needed (e.g., anger management, social skills training) • Relapse prevention
Additional Considerations [b]	
• Patients might present with heightened anxiety, irritability, or anger, which can disrupt the group → These symptoms should be normalized during psychoeducation; group members should be taught relaxation early in treatment and asked to practice regularly • Discussion of a group member's traumatic experience(s) might increase other members' distress or trigger reexperiencing of symptoms → At the onset of treatment, therapists should set norms for the type of information that will be shared during sessions; exposures focused on reviewing detailed descriptions of one's trauma might best be assigned as homework • Some forms of group CBT for PTSD involve repeated exposure to each group member's trauma narrative (e.g., Foy et al., 2001); such treatment protocols are markedly longer in duration (30 sessions), with exposure introduced midway through treatment • Certain trauma populations have a high prevalence of chronic pain (e.g., motor vehicle accident survivors) → Appropriate accommodations should be made to the physical group environment (e.g., comfortable seating) and with discussion of group members' comfort and individual needs in early sessions • Patients with mixed trauma (i.e., those who have experienced different traumatic events) are best treated individually because they might be embarrassed or ashamed to discuss their trauma in front of group members who have not experienced similar events	
Specific Phobias [c]	
Group Composition and Format	**Treatment Techniques**
• 7–8 patients is adequate; 3–4 patients is optimal • Group focused on particular phobic subtype • Single-session treatment: 3 hours • Multiple-session treatment: 5–8 weekly one-hour sessions • Two therapists	• Psychoeducation • *In vivo* exposure (imaginal exposure if necessary) • Cognitive strategies (may be particularly beneficial for claustrophobia and dental phobia) • Relapse prevention
Additional Considerations	
• Imaginal exposure may be particularly useful in cases where regular or scheduled *in vivo* exposure is impractical (e.g., thunderstorms, flying) or as an entry point for patients who initially refuse to partake in *in vivo* exposure • Therapists should plan in advance and also collaborate with patients about gaining access to phobic stimuli and situations • Treatment of blood-injection-injury (BII) phobia, particularly fainting, involves the additional technique of applied tension (for protocol, see Antony, Craske, & Barlow, 1995)	

Note. All group members should be assessed individually prior to the beginning of treatment to determine their eligibility for the group. Treatment techniques are listed in the order in which they are typically presented in treatment.

[a] Except for relaxation training, techniques are based on the intolerance of uncertainty model of GAD (Dugas & Robichaud, 2007).

[b] Considerations for group CBT for PTSD are discussed more extensively by Beck and Coffey (2005).

[c] Guidelines for specific phobias are limited by a dearth of studies on group treatments.

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b Considerations for group CBT for PTSD are discussed more extensively by Beck and Coffey (2005).

c Guidelines for specific phobias are limited by a dearth of studies on group treatments.

Therapist:	Today, we will discuss ways of thinking about situations more objectively or realistically. One way of doing so is to conduct a behavioral experiment. What do you think of when you think of an experiment?
Sophie:	Testing things out?
Therapist:	That's exactly right, Sophie. What types of things might we consider testing out?
Sophie:	Different situations?
Therapist:	We will definitely be testing things out in different situations. What specifically do you think we need to be focusing on in these situations?
Robert:	How anxious they make us!
Cotherapist:	And what have you learned so far about what contributes to your anxiety?
Abdi:	Well, for me, it's always thinking that I will run out of things to say when speaking with people.
Sophie:	Same for me, and then worrying about if they think I'm dumb!
Cotherapist:	So it's your anxious thoughts that we will be putting to the test. One way to view your thoughts is to think of them as hypotheses. What do you know about hypotheses? Do any of you recall learning about them in science classes?
Anya:	Yes, you use them to predict what you think will happen when you're creating an experiment. Like, what will happen if you mix two chemicals together.
Therapist:	That is an excellent example, Anya. What we will be doing is very similar to what you described. When we treat our thoughts as predictions rather than facts, we have an opportunity to test whether our predictions are accurate, just as you would in an experiment.
Cotherapist:	Let's consider Abdi's prediction that he will run out of things to say when speaking with people. How might he create an experiment to test it out?
Abdi:	I could just speak with them, I guess.
Cotherapist:	Yes, that's a great start. Abdi, do you usually avoid speaking with certain people?
Abdi:	Oh yeah, I usually don't start conversations with new people, or if I have to, I try to end them pretty quickly.
Robert:	Maybe you can see what happens if you get into a conversation and stick with it. Although I don't know about that. Once, I was having a conversation with someone at a party and when I couldn't think of what to say next, the person literally walked away from me. I was so embarrassed.
Therapist:	That sounds like a difficult situation, Robert. What do you think happened?
Robert:	I don't know. I guess I was too boring, or maybe she thought I was weird.
Therapist:	Are there any other possibilities based on what happened that night?
Robert:	Well, she went straight to the bathroom after walking off, so maybe she wasn't feeling well.
Therapist:	That sounds like a plausible scenario. In general, how many times has this kind of situation happened to you—where you've had nothing to say and someone then walked away from you?
Robert:	Just this once.
Therapist:	Do you recall any other situations where you were short of things to say?
Robert:	Oh yeah, plenty. It happens to me all the time.
Therapist:	So it seems that the probability of someone leaving in the middle of a conversation with you is actually quite low.
Robert:	Yeah, I guess it is.
Therapist:	So perhaps that's something that Abdi can keep in mind as he tests his prediction that he will run out of things to say. In addition to that, Abdi, have you considered what might happen if you did in fact run out?
Abdi:	Well, it would be horrible! I would be so embarrassed, and like Robert and Sophie said, the other person would probably think I'm stupid or strange.
Therapist:	Sounds like you have some more hypotheses. How might we test these out?
Sophie:	He could maybe see what happens if he does run out of something to say. Like, what does the other person do then?
Abdi:	You mean purposely say nothing?
Cotherapist:	That's right!
Abdi:	That would be awful.
Cotherapist:	That's one possibility, but there are others. There is only one way to find out.
Sophie:	To try it. Maybe I can try it too, and Abdi and I can compare what happens.
Group:	[Continues discussion about developing behavioral experiments to test validity of threat-focused beliefs. Some experiments are practiced in session and others are assigned as homework.]

Considerations of Group Process

Therapists' recognition of and engagement with group process can enhance treatment outcome and resolve problems that commonly arise in the group context. Group process, however, has received scant consideration in the theoretical and empirical literature on CBT groups, with emphasis instead on cognitive-behavioral techniques as the core method of intervention. The extent to which group process factors are addressed in manualized group protocols for anxiety disorders in clinical trials is not clear and warrants further empirical attention. Available data indicate that patients in CBT groups view group process factors as important to the therapeutic experience (Glass & Arnkoff, 2000). These factors (e.g., emotional experience in group) have also been shown to predict patient improvement (Castonguay, Pincus, Agras, & Hines, 1998).

In their volume on CBT groups, Bieling, McCabe, and Antony (2006) provide a comprehensive discussion of group process, defined broadly as the interpersonal interactions among group members and between members and group facilitators. Rooted in the seminal work of Yalom (Yalom & Leszcz, 2005), they propose a model of group process within a CBT framework and outline process-based mechanisms of change and therapeutic strategies (examples of these are provided here in parentheses) that can be used to facilitate them. The mechanisms include (1) *optimism/inspiration* (e.g., using group members' experiences to promote positive expectations), (2) *inclusion* (e.g., linking group members' symptoms and experiences to promote a sense of belongingness and reduce isolation), (3) *group-based learning* (e.g., facilitating dialogue that promotes a range of perspectives and appraisals), (4) *shifting self-focus* (e.g., promoting a shift from the self to the group by encouraging group members to provide support and share information), (5) *modification of maladaptive relational patterns* (e.g., facilitating awareness of interpersonal patterns and the effect one has on other group members), (6) *group cohesiveness* (e.g., providing a safe environment for self-disclosure and making connections among members' experiences), and (7) *emotional processing in the group setting* (e.g., encouraging expression of feelings in the here-and-now).

Particular attention should be paid to group process during homework review, presentation of new information, and skills or exposure practices. Lack of attention to group process factors in these instances has the potential to alienate group members and facilitate low engagement with treatment (e.g., "zoning out" while homework is reviewed with another member). By contrast, creating an interactive atmosphere that reinforces members' participation and feedback to one another and that makes connections between their respective experiences will enrich the treatment via the process-based change mechanisms reviewed above.

Trouble-Shooting Possible Challenges during the Course of Group CBT

Group-Induced Anxiety

It is important for therapists working with anxiety groups to be aware of the anxiety-inducing nature of the group format itself. This is particularly true for social anxiety disorder. Meeting with patients individually prior to the start of group to provide information about the group and address any concerns or questions can help reduce group-related anxiety. The therapist can normalize this anxiety and help patients feel more comfortable by highlighting the similarities of other group members (e.g., each member is experiencing the same anxiety problem and will also be feeling anxious), as well as the benefits of the group experience.

Differences in Pace of Progress among Group Members

Group members whose anxious thoughts are resistant to change may pose a challenge to group process when members who are ready to move on become frustrated by a member's "stubbornness." If this occurs, therapists should encourage the individual who is struggling to keep an open mind and to continue practicing cognitive techniques. Moving the group along to behavioral strategies might also help. Generally, most members will experience individual setbacks at some point during the course of treatment. Therapists should promote the reframing of this issue as a learning experience and discuss strategies to manage setbacks within the group. For example, members can be taught to identify common triggers for their setbacks (e.g., life stressors) and to apply problem-solving skills to resolve them.

Motivation and Availability

Low motivation is a marker of poor suitability for group treatment because there may be little time to deal with individual motivational issues in group unless it is covered as a focus for the whole group. Low motivation can result in missed sessions, homework noncompletion, and dropout, which disrupts both the patient's own treatment and that of other group members. Individual treatment, where motivation can be addressed in greater depth, may be more appropriate in this case. Alternatively, some settings offer groups specifically designed to enhance motivation and readiness for change.

Individuals with limited availability are also not appropriate for group treatment if they cannot commit to attending all or most sessions. If a patient's availability changes from week to week, individual treatment might be more suitable, because absences are noticed by other group members and can affect group morale.

Homework Noncompliance

Noncompliance with homework not only hinders the progress of the individual who is struggling with it but it may also have a negative impact on the group. Group leaders need to determine the reasons for noncompliance (e.g., motivational factors, poor understanding of the treatment rationale, symptom severity) and to manage them accordingly by boosting motivation, reviewing the rationale, or troubleshooting specific treatment strategies. In some cases, a group member might require individualized attention for concerns that cannot be managed in the group setting. An individual session may be warranted to address the issues and to reassess treatment needs and suitability for continuing in the group.

Medication Use

Some patients might taper off medication during group treatment. Therapists might consider discussing this issue with the group and highlighting the benefits of CBT in managing reactions to possible withdrawal symptoms. It might also be necessary to provide education about the hindering effects of as-needed benzodiazepine use for anxiety management in terms of therapy outcomes. Group members can be encouraged to reduce such use and to

incorporate reductions in benzodiazepines into their exposure hierarchies.

Summary

Across the anxiety disorders, group CBT offers an empirically validated treatment option that provides an efficient use of resources to maximize care delivery and minimize treatment costs in comparison to CBT provided in an individualized format. Although further research is necessary, recent developments in transdiagnostic group CBT approaches hold promise for flexibility in treating individuals with various anxiety disorders within the same group. Effective group CBT for anxiety disorders requires careful attention to both the delivery of CBT techniques and group process factors that may interfere with or enhance treatment outcome.

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Chapter 31 Group Psychotherapies for Complicated Grief

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Losing a significant person through death is a painful human experience that unfortunately increases in frequency as we grow older. Typical grief reactions include shock, denial, sadness, irritability, insomnia, preoccupation with the loss, yearning for the lost person, searching for the lost person, and experiencing intrusive images and memories about the lost person. Whether such reactions are regarded as normal or abnormal depends on their intensity and their duration. If they are experienced at mild to moderate intensities for short periods of time (e.g., one or two months), they tend to be regarded as normal and appropriate. However, if they become intense and enduring, the grief reactions are regarded as unresolved and perhaps in need of treatment. This is particularly the case when there are comorbid complications, such as depression; anxiety; health-compromising behaviors such as excessive drinking or smoking; and social, occupational, and familial dysfunction. The combination of unresolved grief symptoms and continuing dysfunctional complications is generally regarded as Complicated Grief (CG; Stroebe et al., 2000).

A number of researchers have examined the prevalence of CG among psychiatric outpatients. Our research team conducted a large-scale study that investigated the prevalence of loss and CG among a large number of patients (N = 729) who sought services in two outpatient psychiatry clinics—one in a suburban community hospital and the other in an urban university hospital (Piper, Ogrodniczuk, Azim, & Weideman, 2001). The patients' average age was 42. Their most frequent losses involved parents, grandparents, and friends rather than partners or children. More than 55% of the sample had experienced one or more losses through death; the average was nearly three losses. Two levels of CG—moderate and severe—were defined on the basis of loss-specific symptoms, social dysfunction, and time since the loss. Patients who did not meet the criteria for CG were categorized as having minimal disturbance. We found that of all the patients who sought services at the two outpatient clinics, 17% met the criteria for moderate CG and 16% met the criteria for severe CG. Thus a total of 33% met or exceeded the criteria for moderate CG. In general, the three groups were well differentiated in terms of loss-specific variables, social dysfunction, and variables not specific to loss. The level of disturbance among those with severe CG was high.

Along with empirical findings that investigate the prevalence of CG among older adults (Forstmeier & Maercker, 2007), survivors of victims of disaster events (Shear, Jackson, Essock, Donahue, & Felton, 2006; Ghaffari-Nejad, Ahmadi-Mousavi, Gandomkar, & Reihani-Kermani, 2007; Neria et al., 2007), and survivors of suicide victims (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; de Groot et al., 2007), the results from our investigation of the prevalence of CG among outpatient psychiatric outpatients suggest that CG appears to occur at a rate equal to or greater than some of the more well-known psychiatric disorders, for example, obsessive-compulsive disorder or bulimia (Kaplan & Sadock, 1998). Thus, it becomes imperative to develop treatments that are specifically tailored to meet the unique needs of people experiencing CG.

This chapter primarily introduces the reader to two group therapy approaches developed by our research team for the treatment of CG: interpretive group therapy and supportive group therapy. In particular, this chapter (a) discusses the benefits of group therapy for the treatment of CG, (b) explains the objectives of interpretive and supportive therapy, (c) describes the screening of CG and the importance of group composition for the treatment of CG, and (d) notes some of the limitations of short-term group therapy.

Benefits of Group Therapy for the Treatment of CG

In our past work, we have argued that group therapy may be the treatment of choice for CG (Piper, McCallum, & Azim, 1992; Piper, Ogrodniczuk, Joyce, & Weideman, 2011). Many problems that patients with CG present with have their origins in complex human attachment, interpersonal relationships, and social milieus (Yalom & Leszcz, 2005). Thus, the social learning opportunities that group therapies provide are particularly well suited for addressing a variety of problems (Phares, 1992) such as CG.

Hughes (1995) provided an exhaustive list of beneficial features of groups for people who have suffered a death loss. Group treatments are capable of mobilizing strong forces for change. The group, which is sometimes referred to as a *cohesive social microcosm*, can exert considerable pressure on patients to participate. It is capable of eliciting the typical maladaptive behaviors of each patient. Once these maladaptive behaviors are identified, other patients in the group can then observe, provide feedback, and offer suggestions for change. The patient can subsequently practice adaptive behavior. Other patients may learn through observation and imitation—a process commonly referred to as interpersonal learning. Simply recognizing that other patients share one's difficulties (universality) and helping other patients with their problems (altruism) can be therapeutic. These various processes (cohesion, interpersonal learning, imitation, universality, and altruism) are regarded as powerful and unique therapeutic factors of group therapy (Yalom & Leszcz, 2005).

The following clinical example illustrates how interactions within a loss group allow patients to recognize commonalities among each other. Also recognized as the therapeutic factor of commonality, this recognition appears to be of some benefit to the patients in the group.

Therapist: What is it—it's about emotions—what you're feeling—try to put them into words. (Silence)

Greg: So much pain and anger. I know her disease caused her too much pain and I wouldn't want her to be here in that much pain but why her?

Judy: It is the same for me. I wouldn't want my mom to suffer so I found a kind of strange relief she is not suffering anymore but now the pain is too much for me to handle.

Therapist: That's definitely it. Most of you have mixed emotions. You recognize that your loved ones were not in a good place but deep down you still want to keep them here, at least to alleviate your own pain.

John: Yes. I am glad I am not the only one feeling like this. I know it is kind of selfish but I just can't help it—it is either my pain or his—it is terrible to say it but it is true.

There are other facilitative features of group therapy as well. Intense negative transference toward the therapist is less likely to occur in group therapy than in individual therapy because group therapy is less intimate, and strong affects such as rage are diluted because of multiple targets for expression. Similarly, the patient may dismiss feedback from the therapist in individual therapy as being biased. Dismissal of feedback is much less likely to occur in group therapy as feedback is provided by several peers (and not only the therapist) in the group.

In addition, common events in groups such as patient lateness to sessions, absenteeism, and dropping out often trigger feelings and conflicts similar to the reactions that patients had experienced toward people whom they were losing and people whom they eventually lost. Although such events are usually regarded as disruptive and problematic in most therapy groups, they can be examined and used productively in loss groups. Termination of the group, as well, provides an opportunity for patients to examine their reactions to an immediate loss, compare them to previous reactions, and attempt adaptive reactions. Similar to the other naturally occurring events, termination can be used productively. Patients often shared the fantasy that termination, whether of an individual patient or the group, is not permanent. They often make reference to future meetings even though they rarely, if ever, are held.

Interpretive Psychotherapy

Overall Objectives

The primary objective of interpretive psychotherapy is to enhance the patient's insight about repetitive conflicts (intrapsychic and interpersonal) and trauma that serve to underlie and sustain the patient's presenting problems. This is part of a process of achieving self-understanding and control that continues beyond the termination of psychotherapy, which in psychodynamic theory is commonly referred as the process of working through. Typical conflicts dealt with in interpretive therapy for CG include wanting yet fearing a close relationship with someone, wanting to be self-sufficient yet fearing isolation, and experiencing ambivalent feelings toward the lost person. It is assumed that insight into such common conflicts will allow patients to resume a normal mourning process, which has been impeded, and to develop tolerance for ambivalence toward the people whom they have lost. The secondary objective of interpretive psychotherapy is to help the patient successfully adapt to and, when possible, alleviate the presenting problems that brought the patient to the therapist.

Session Objectives

In each of the 12 weekly sessions of interpretive therapy, the session objective is to create a state of tolerable deprivation and anxiety during the therapy sessions. With a focus on unconscious processes, the therapist attempts to explore the patients' internal conflicts through the use of immediate (here-and-now) experience. Working with the group in the here-and-now allows for an exploration of the relationship between the therapist and patients and the relationship among patients.

Therapist Techniques

In parallel to the therapy and session objective of interpretive therapy, the therapist attempts to create and maintain a climate of tolerable tension and deprivation through the use of seven techniques. First, the therapist should maintain pressure on the patients to talk. Second, the therapist should encourage patients to explore uncomfortable emotions. Third, the therapist should make interpretations about the patients' unconscious conflict. Fourth, the therapist should direct attention to patients' subjective impressions of the therapist. Fifth, the therapist should make links between the patients' relationships with the therapist and/or each other and the patient's relationships with others in their lives. Sixth, the therapist should focus on the patients in the here-and-now treatment situation. Seventh, the therapist should direct his/her attention to the patients' subjective impressions of others outside the treatment situation. Through the use of these techniques, the therapist is actively focusing on the group defenses, transference reactions, termination issues, and unconscious themes by engaging in activities that characterize the interpretive approach to psychotherapy.

The following brief clinical example illustrates how the therapist can use technical features within interpretive psychotherapy to maintain pressure on the patients to talk, encourage the patients to explore uncomfortable emotions, and provide the patients with interpretations of conflict.

(Lengthy silence followed by therapist's interpretive statements.)

Therapist: I think the group is resisting putting what you are feeling into words. I wonder if you can put them into words.

Doug: Well, I'm trying but I can't find the words. Therapist: But this seems to be the problem with everyone, not just Doug. What about others?

Sarah: I just feel that our problems are hopeless.

Therapist: That is definitely the feeling, along with feeling sad. You seem to be on the verge of tears. All of you are in the same boat— feeling hopeless and sad as it sinks in a sea of tears.

Sarah: Well, you push us to do our best but we are just hopeless.

Therapist: You don't know what to do with liking me and hating me at the same time. Liking me because I helped you recognize your feelings and hating me because our group is almost finished and you are losing me.

Supportive Psychotherapy

Objectives

Use of the supportive approach to short-term groups for CG is based on the assumption that improvements in symptomatology and life functioning can be made through the precision of support. Once such improvements occur, the resumption of the mourning process will naturally occur and continue until its completion. As such, the primary objective of supportive psychotherapy is to address problems directly and to improve the patient's immediate adaptation to his or her life situation. In many cases, there is a crisis-intervention orientation, even if the “crisis” is relatively minor and repetitive. The secondary objective of supportive psychotherapy is to teach the patient problem-solving skills that can be used in the future. This includes such skills as learning how to define problems, consider alternative solutions, consider the advantages and disadvantages of solutions, try out solutions, and evaluate the outcomes of attempted solutions. In psychodynamic parlance, this is referred to as building ego strength.

Session Objectives

In supportive psychotherapy the session goal is to create a state of gratification and decreased anxiety wherein patients can share common experiences and feelings. In each of the 12 weekly sessions of therapy, the therapist attempts to achieve this state throughout the therapy sessions by offering praise (reinforcement) to the patients for their efforts at coping, by being directive and conversational, and by providing patients with examples, reflections, and clarifications.

Therapist Techniques

With a focus on conscious processes, the therapist creates a supportive group environment through the use of seven techniques. First, the therapist gratifies the patients' efforts to discuss their experiences and to cope. Second, the therapist provides noninterpretive interventions. Third, the therapist provides guidance to the patients. Fourth, the therapist engages in problem-solving strategies in order to support the patients. Fifth, the therapist externalizes responsibility for the patients' problems. Sixth, the therapist praises the patients. Seventh, the therapist discloses personal information, opinions, and values.

The following brief clinical example illustrates how the therapist can use supportive technical features within supportive psychotherapy to gratify patients and to provide guidance in noninterpretive interventions.

Therapist: Despite the silence, I think that members of the group are working very hard to deal with their issues.

Bob: Yes, I know I am. For instance, I am now able to put things into words and get things out of my chest.

Therapist: Sounds like you recognize some kind of progress. Why don't you take a stab at it? Sometimes if one person is able to start others are able to start too.

Amy: Well, I've been feeling angry, hopeless and sad, but strangely enough, I also feel good about what I've learned in here in the group.

Therapist: Yes, this has been happening in spite of the fact that our group will end next week. I suspect that in some ways we will all miss parts of each other.

Screening for CG and Group Composition

Screening

Because assessment time is limited for most health providers and the amount and range of information they must collect during an interview are considerable, questions concerning losses and reaction to losses may not often be asked. It is conceivable, therefore, that the presence of CG would be missed. What would be useful for health providers is having a small number of screening questions that possess high sensitivity (i.e., identification of patients with CG) and high specificity (i.e., identification of patients without CG). Thus, we conducted a study (Piper, Ogrodniczuk, & Weideman, 2005) that attempted to identify just such a set of questions. We examined the responses of 235 outpatients to a set of items that have been used to define CG. We found that two items correctly identified nearly 90% of patients with and without CG. These items were transformed into questions that can be used in initial assessments. The questions were: During the past week did pictures about the loss pop into your mind? and During the past week did you try not to think about your loss? If a patient responded positively to one or both of these questions, the interviewer can acquire further information about the losses and/or refer the patient to someone who specializes in the assessment and/or treatment of patients with CG. We suspect that requesting assessors to ask two questions will succeed in identifying more patients with CG than requesting them to conduct a thorough assessment. In other words, less may provide more.

Quality of Object Relations

Given the different emphases of supportive and interpretive therapy, how should clinicians determine which treatment is right for which patient? Several factors should be considered, such as patient needs and expectations. However, our research shows that one factor may be particularly important in this regard. Quality of Object Relations (QOR)—a person's capacity for interpersonal relatedness—has been shown to strongly influence the indicated treatment. Patients with high QOR (i.e., those who tend to form mature relationships, characterized by reciprocity and stability) seem more likely to benefit from interpretive therapy than supportive therapy, while those with low QOR (i.e., those who tend to form primitive relationships, characterized by destructiveness and instability) are more likely to benefit from supportive therapy than interpretive therapy (Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001). However, both high-QOR and low-QOR patients benefit most when the group contains at least a certain proportion of high-QOR members. Therefore, our models rely on careful assessment of QOR, among other factors, to determine optimal treatment approach and group composition.

In general terms, the patient's interpersonal characteristics reflect the likelihood of the patient making good use of the relationship opportunity afforded by the therapist or the opportunities afforded by the group. Patients with a more mature QOR or with a more secure attachment style tend to have fewer issues with the establishment of a collaborative relationship with the therapist and are thus more likely to engage readily in the kind of work required by the therapy approach being implemented.

Establishing a sense of the patient's capacity for interpersonal relatedness (Clementel-Jones, Malan, & Trauer, 1990; Moras & Strupp, 1982) is regarded as a critical therapist task during the preparation of the patient for psychotherapy or during the early stage of treatment. To this end, the therapist can address the patient's interpersonal history (e.g., significant losses, involvements, and separations), the patient's interpersonal functioning in current close relationships, or the patient's characteristic way of viewing relationships. The latter perspective addresses the patient's perceptions of relationships, beliefs regarding relationship issues such as trust and reciprocity, and wishes and anxieties about the costs and provisions of relationships, all subsumed under the construct of “quality of object relations.” Generally speaking, object relations refer to the conscious and unconscious mental representations of past interpersonal interactions, developed through the processes of internalization over the course of the individual's interpersonal history. These representations of self and others include cognitive, affective, and experiential components and function to regulate and direct current interpersonal behavior (Blatt, Wiseman, Prince-Gibson, & Gatt, 1991).

A variety of measures and methods of assessment have been developed to evaluate patients’ QOR in clinical research (Object Relations Inventory [ORI] of Blatt et al., 1991; Reflective Functioning Scale [RFS] of Fonagy & Target, 1997; Core Conflictual Relationship Theme [CCRT] of Luborsky & Crits-Cristoph, 1998; Social Cognition and Object Relations Scale [SCORS] of Westen, 1991). For a review of these measures, see Huprich and Greenberg (2003). Our research group developed the QOR Scale and the construct has had a central role in all our treatment effectiveness studies.

We define QOR as a person's internal enduring tendency to establish certain types of relationships (Azim, Piper, Segal, Nixon, & Duncan, 1991). These relationship patterns range along a spectrum from primitive (characterized by destructiveness and instability) to mature (characterized by reciprocity and mutuality). At the primitive level, the person reacts to perceived separation or loss of the object, or disapproval or rejection by the object, with intense anxiety and affect; there is inordinate dependence on the lost object, which provides a sense of identity for the person. In contrast, at the mature level, the person enjoys equitable relationships characterized by love, tenderness, and concern for objects of both sexes, and there is a capacity to mourn and tolerate unobtainable relationships. The QOR construct thus refers to the recurring pattern of relationships over the individual's life span rather than to relationships during any one period (e.g., recent interpersonal functioning). Although for measurement purposes we focus on external relationships, we assume that these reflect the internal object representations and conflictual components of the patient's internal world. Again, what the QOR assessment attempts to capture is the patient's predominant pattern of relationships over the course of his or her life span.

The reliability and construct validity of the QOR variable is detailed in Piper and Duncan (1999). In general, QOR has been found to be independent of demographic and historic characteristics of the patient. The construct has also not been found to be related to Axis I diagnoses. As one would expect, patients with lower QOR scores (i.e., less than 4.5) tend to show more symptomatic disturbance and are more likely to have an Axis II diagnosis than patients with higher QOR scores (i.e., equal to or greater than 4.5), although this overlap is not considerable. The QOR variable has emerged as a strong direct predictor and moderator of therapy process and outcome in time-limited forms of dynamically oriented psychotherapy.

Composition of Group

Personal qualities of patients, such as QOR, appear to be significant determinants of the process and outcome of treatment for CG. However, the effect of such personal qualities in group therapy should not be considered as independent of the group. Instead, by their very nature, groups are interactional, and as such, the effect of personal qualities of group members should be considered within the particular group context of the group. This is otherwise known as the group's composition.

In general, across a number of studies (Piper, Azim, Joyce, McCallum, et al., 1991; Piper, Azim, McCallum, & Joyce, 1990; Piper, de Carufel, & Szkrumelak, 1985; Piper, Joyce, McCallum, & Azim, 1998; Piper, McCallum, et al., 2001), high-QOR has been shown to function as an important patient-treatment match for interpretive or expressive forms of group psychotherapy. The high-QOR patient's history of meaningful give-and-take relationships appears to allow for the establishment of a strong collaboration with the therapist and greater readiness to make use of the interpretive approach. High-QOR patients also appear to have greater tolerance for the therapist's use of transference interpretations (Piper, Azim, Joyce, & McCallum, 1991). We engaged in a more detailed examination of the association of high-QOR and benefit in the interpretive form of short-term group therapy for CG, in order to identify the mechanism through which this relationship might emerge (Piper, Ogrodniczuk, McCallum, Joyce, & Rosie, 2003). The focus in this analysis was the experience and expression of positive and negative affect during group sessions, as rated by the patient, the other members, and the therapist. High-QOR patients tended to demonstrate a greater *balance* of positive and negative affect expression, as reported by their peers in the group and the therapist, and a balanced expression of affect was associated with greater improvement on grief symptoms. The finding suggests that a favorable outcome in the therapy is facilitated by a greater tolerance and acceptance of the expression of conflicting feelings regarding the lost relationship. The high-QOR patient was more likely to demonstrate this in the therapy process. This finding corresponded well to the view expressed in the literature on grief that better adaptation following the loss of a significant other is associated with a greater tolerance of the ambivalent feelings involved in the grief process (Bonanno & Kaltman, 1999).

Though the evidence is less strong, there is reason to believe that low-QOR patients stand to gain more from a therapy approach oriented to the provision of support, problem solving, and advice regarding current circumstances. The treatment itself can provide the low-QOR patient with the experience of a clearly bounded and gratifying relationship, countering a lifelong experience of depriving or abusive relationships (see also H⊘glend, 1993a, 1993b; Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984). Even within a supportive treatment, however, the low-QOR patient's relationship with the therapist can have a bearing on the success of the therapy. In a clinical trial of short-term group therapies for CG (Piper, McCallum, et al., 2001), we examined patients' feelings of dissatisfaction with their therapist. Patients in interpretive therapy provided higher ratings of dissatisfaction with their therapist than those in supportive therapy, in line with the more depriving and confrontative stance taken by the interpretive therapist. However, ratings of dissatisfaction were inversely predictive of outcome only for the supportive therapy approach, and the lower the patient's QOR, the stronger this relationship. The implication is that the low-QOR patient experienced negative feelings toward the therapist but suppressed these out of a concern about eliciting the therapist's rejection; at the time of the outcome assessment following the end of the group therapy, these feelings may have been expressed in terms of poorer outcomes (Ogrodniczuk, Joyce, & Piper, 2007). Low-QOR patients also apparently have less capacity to work with transference interpretations, indeed appearing to find this therapist technique at times injurious (Ogrodniczuk, Piper, Joyce, & McCallum, 1999; but see H⊘glend et al., 2006). Clearly, the evidence suggests that patients with low-QOR may bring their maladaptive interpersonal style into the therapy process and, without sufficient efforts on the part of the therapist to address these patterns, be at increased risk of problematic outcomes.

Low-QOR Group Composition Clinical Example

To better understand the role played by QOR in the process and outcome of time-limited dynamically oriented psychotherapies, we provide the following two clinical examples that illustrate how therapy groups composed by either high-QOR or low-QOR patients interact with each other and with the therapist.

Characteristic of low-QOR patients, the interactions between low-QOR group members in this clinical example (patients' QOR scores ranged from 2.7 to 3.3) display high levels of unmodulated hostility toward people outside the group as well as anxiety about their discussion in the group. Rather than empathizing or working through their feelings with one another, group members simply vent their own frustration in response to one another's comments.

Ana: One of the things I found with my dad is there'd been so much bad stuff that happened between us since my mom had died, but even long before that, we just always fought. Um, I mean, I wanted to kill him so many times. Uh, but I didn't want him dead. I realized that when push comes to shove, I still wanted him around.

Dan: Uh, me too—my dad always pissed me off, made me furious.

Ana: Do you know why you were angry?

Dan: No. I just knew I was angry.

Ana: Yea, I didn't even know that most of the time.

Dan: He wasn't emotionally there for me. I just never felt like he loved … I don't even remember what the hell I was talking about.

Therapist: Well, people not being there in a way that you needed them. And also about feelings but not knowing what to do with those feelings.

Ana: Oh, well, Dad … you would come home with 95% on a math test, and tell Dad, and he'd say what happened to the other five? And I got that from him all my life. It was that he wanted us to all be able to survive. He figured we needed to be tough. And it's been good in a lot of ways, but god damn it, the thing that sometimes is gonna kill me is the things I won't admit that I can't do, like feel pain, hurt—

Therapist: Sadness, fear—

Ana: Yeah.

Therapist: —regret, relief.

Ana: Yeah.

Therapist: All those things I suspect.

Melanie: Ya know, we're talking about childhood issues, and I'm just remembering being in the basement hiding and my parents fighting, and you know, it's like, is this a safe place? I know in my head it is. But it's like, you know, 'cause when you guys were talking, I remember my childhood, and what it came down to was, uh, for me, was the realization that I realized, wouldn't it be nice to have a father who came here to support his kids, 'cause they lost their mom, wouldn't that be nice?

Ana: I needed a father to be around when I needed him.

Alison: Oh, yeah.

Melanie: You know, it's like he's so … he's right here living in the city. He's not dead, but he may as well be.

Therapist: I think it illustrates very well Dan's point, and, Ana, your point, as well, you need to have your parents there for you, but—

Melanie: It's not gonna happen!

High-QOR Group Composition Clinical Example

In contrast to groups composed by low-QOR group members, high-QOR groups are often characterized by high displays of empathy, concern, and compassion for one another. Group members also tend to engage in dynamic work throughout the therapy sessions. Affects are not simply expressed— they are discussed and interpreted. The following clinical example illustrates these characteristics of groups composed with high-QOR patients (QOR scores ranged from 4.2 to 7.3).

Maria: Well, I guess I feel really, really needy. Last week, when I left here … the talk at the end of last session about marriage break-up and that, ah, brought up a lot of stuff for me. Um, my mom … she's unconscious and not taking any fluids or anything you know, or medication for her pain … it's just a matter of time. And I feel it's all related to being all alone, 'cause I'm all alone there with her all the time.

Therapist: Maria is describing feeling very needy, which raises the question, what need? The need for what?

Matt: Help.

Amy: Comforting.

Diane: Compassion.

Maria: A friend who's been my friend since we were three and four … I had lunch with her yesterday. We talked about other people's weddings and stuff, but I didn't tell her about my mom or the dog.

Diane: Maybe you feel that the person won't understand.

Maria: You know, you're right. With her, I can't talk, I can't go there with her and when I went there with my marriage stuff it was "Maria, don't be stupid." But you know it's just the fact that with her, I can't go there with my pain.

Lisa: Well let it out. You can let it out here.

Amy: And quite often, when you're asked here if you have anything to say you say "I forget" and let us move on to someone else. But really, you've got it all boiling in there, so we would like to hear from you.

Lisa: Yup, just let it out. 'Cause this is … when you say you are all alone … in a way I would hope that at least once a week you don't feel like you're alone when you come here.

Therapist: Maria mentioned a number of different stressors and it looks as if the group is overwhelmed, a number of you look …

Matt: I guess it depends on what I am overwhelmed with. I can't take much more, I'm full.

Maria: And that's the way it's been. So um, yeah, it's like, give me a break. And I have certainly been told a lot I'm overreacting. People don't understand.

Amy: I don't think you're overreacting. I think it's been like sticks piled on each other and they're getting wobblier as they get higher.

Lisa: Well what are you going to do? 'Cause it sounds to me like you're going to burst or … what are you going to do?

Maria: I'll carry on.

Amy: Are you going to be more afraid? Are you going to be more afraid when your mom is gone? Of being alone,

‘cause in some ways you know it's time for her to go on.

Maria: Yeah, but it's not easy.

Amy: Oh I know.

Clinically, then, a formulation of the patient's internal object relations can reflect his or her capacity to form a collaborative working relationship with the therapist. A predisposition to establish a relatively trusting give-and-take relationship with an authority figure is an important indicator for a positive therapy process, an effective termination, and treatment benefit. The object relations formulation can provide an estimate of the patient's capacity to tolerate frustrations in the therapy relationship and facilitate predictions regarding the transference reactions that are likely to emerge (Joyce & McCallum, 2004). The more mature the patient's QOR, the more likely an expressive therapy approach can be undertaken. The more primitive the patient's QOR, the more problematic the patient's representations of interpersonal relatedness and capacity for self-regulation. With these patients, a supportive and open-ended therapy approach is more feasible, but the evidence suggests that the therapeutic collaboration can still be fraught with pitfalls given these patients’ problematic representations of relationships. Whether engaging with the low-QOR patient in an interpretive or supportive approach, it is critical that the therapist monitor the patient's experience of the relationship and address negative feelings as they arise. The patient's QOR should thus be considered a primary determinant of the approach to therapy and the therapist's strategy within sessions.

Evidence from a more recent study from our research team indicates that the composition of the group may directly influence the benefit achieved by the members, including those of low QOR. In the previous study, we reported aptitude-treatment interaction findings regarding QOR, where low-QOR patients showed greater benefit in the supportive short-term group treatment, while high-QOR patients demonstrated more improvement in the interpretive short-term group, for general and grief symptoms (Piper, McCallum, et al., 2001). A study of groups composed to optimize this interaction (i.e., homogenous high-QOR membership in an interpretive group and homogenous low-QOR membership in a supportive group versus two approaches with a heterogeneous membership) was recently published (Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007). The test of group homogeneity versus heterogeneity proved to be nonsignificant. However, a different composition effect was identified: The greater the proportion of more mature QOR patients in the group, the better the outcome for all patients in the group, regardless of the form of therapy or the individual patient's QOR score. This “group-level effect” suggests that the more mature patients engage in the therapeutic relationship opportunities offered by the group, “pulling” the less mature patients into a working group process and facilitating improvement for the group as a whole. Clinically, this finding suggests that the group clinician should seek to have a “critical mass” of high-QOR patients among the membership, either when establishing a new group or when replacing departing members. Such a group composition, particularly if an expressive or interpretive technical strategy is planned, can ensure that the low-QOR patients have a model of positive therapy process to follow, increasing the likelihood of treatment benefit for these patients.

A clinician engaged in the assessment of a patient for psychotherapy, including forms of short-term group therapy, must evaluate a number of dimensions to determine that patient's appropriateness for the planned treatment. A substantial number of patient characteristics have been empirically studied and evidence has been obtained that many function as direct predictors of therapy outcome, as moderators of the patient's response to certain intervention strategies and approaches, or are even associated with certain change processes (mediators) that occur during the therapy experience. This is highly useful information for the clinician and should not be discounted when engaged in assessment of patients for psychotherapy.

Even so, the study of patient characteristics is still very much in its infancy. Simple relationships between certain patient variables and indices of therapy process and outcome may be modified when additional patient characteristics are addressed in a multivariate perspective; at present, the field offers very little information on how patient characteristics might function in an interdependent or even synergistic fashion (see Beutler, Clarkin, & Bongar, 2000). Similarly, identification of important interactions between patient and treatment dimensions that illuminate the nature of change processes occurring during the therapy interaction has to date occurred only

infrequently. Studies addressing these issues are still urgently needed and, indeed, are most likely to have an impact on clinical practice and our understanding of how psychotherapy brings about change in our patients.

In this chapter, the empirical literature regarding an admittedly selective set of patient characteristics was reviewed. Personality variables should be assessed to determine the patient's motivation for treatment and the "fit" between the patient's usual style of thinking or coping with problems and the therapy approach being considered. Measures of interpersonal relatedness also have a bearing on the consideration of a patient-treatment "fit," but more importantly reflect the degree to which the patient is likely to engage in the process and make good use of the opportunity provided by the therapist and therapy.

Are there other reasons why our treatment outcome appeared to be significant and substantial while other attempts to discover effective treatments have not been particularly successful? First, in carrying out our trials, we were careful to avoid certain methodological shortcomings that have been present in other studies. In our studies, these included the use of reliable measures, large sample sizes, and manualized treatments. Second, we believe that our sample of subjects definitely met criteria for CG. They came to the clinics not as volunteers for a study but as patients requiring assistance. In addition to reporting typical symptoms associated with CG, they reported difficulties in carrying out everyday role functions. Third, we believe that certain therapeutic factors that are only present in group therapies were actively present in our groups.

We have provided short-term therapy groups for patients with CG and training for therapists in two separate clinical settings. Each was an outpatient psychiatry clinic located in a large university hospital. At each setting, there were approximately 8–10 full-time therapists, who routinely conducted initial intake interviews and who provided psychotherapy when indicated. Group therapy was a commonly used method of treatment in the clinic. A subgroup of therapists, who were interested in conducting loss groups, met once weekly for one hour for purposes of training, supervision, or consultation, dependent on one's level of experience. During some sessions, tape-recorded excerpts from loss groups were discussed and at other sessions, relevant papers (e.g., papers about themes and roles that emerge in loss groups) were discussed. Therapists typically observed or coled a loss group before leading one by themselves. Thus, training was practice oriented and on-the-job. Since 1986, we have treated patients and trained therapists in over 100 loss groups.

In addition to on-the-job training, we have often held training workshops at the annual meetings of organizations such as the American Group Psychotherapy Association and the Canadian Group Psychotherapy Association. Also, there is no reason why training in the assessment and group treatment of patients with CG cannot be a part of practicum, internship, or residency training.

Finally, in regard to future research directions, there are several crucial areas that deserve attention. There is a lack of information about the prevalence of CG in the general population. There is a lack of standard criteria for defining CG, although criteria have been proposed. There is a lack of baseline data on many variables prior to the loss. There is a lack of longitudinal data, which makes it difficult to understand certain causal relationships (e.g., the relationship between CG and comorbid conditions).

Although we think that we have identified some interesting and clinically useful findings concerning the matching of forms of therapy and patient personality characteristics, as well as the entire composition of the group, we know very little about the specific mechanisms that follow from these features to bring about favorable outcome. We would like to discover what mediated the composition-outcome relationship. Identification of mediating mechanisms may suggest how they could be activated by means other than restrictive group composition (i.e., by excluding low-QOR patients). Instead, patient preparation or therapist technique could be used. That would facilitate including greater numbers of psychiatric patients with low QOR in short-term therapy groups for CG.

We believe that brief group therapy holds a great deal of promise as a therapy technique and when directed at problems such as CG can serve as an excellent model for exploring a variety of research topics. We hope that this chapter will inspire other clinicians and researchers to pursue some of the questions raised in this *Handbook* that as yet do not have answers.

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Chapter 32 Group Approaches for Addictive Behaviors

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Introduction

This chapter will address group approaches that are appropriate for a broad concept of addiction, in particular, substance dependence and abuse, which includes alcohol and both legal and illegal prescription pharmaceuticals. Many of these same approaches are effective for nonsubstance use addictive behaviors such as gambling, sex, and eating. This chapter focuses on best practices in working with clients suffering from a wide range of substance misuse disorders. Common factors that appear to be associated with all addictions, followed by information on the specific and unique factors associated with several of the most common substance misuse addictions addressed in group counseling, will be described. An understanding of these common and specific factors is critical to providing the most effective and efficacious group therapy experience.

Despite ever-expanding attempts to prevent its devastating impact, the misuse of substances continues to play a prominent role in the mental health issues of a growing number of individuals. The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS). About 8.7% of all persons age 12 and over are involved in use of illegal drugs or the nonmedical use of prescription drugs (SAMHSA, 2010).

Much of this chapter focuses on the misuse of alcohol because the NSDUH results indicate that alcohol continues to remain the most commonly used substance. It's difficult to exaggerate the extent to which the misuse of alcohol impacts mental and behavioral health. It's estimated that approximately 50% of clients currently seeking mental health treatment are experiencing difficulties associated with their own or a family member's misuse of alcohol (Corrigan, Mueser, Bond, Drake, & Soloman, 2008). More than half (51.9%) of those surveyed over the age of 12 reported current use of alcohol. Nearly one quarter of this group reported engaging in binge drinking. Almost 7% reported heavy drinking. Binge drinking is considered having five or more drinks at one occasion at least once in the past 30 days. According to the survey results, 23%, or about 57 million people over age 12, met that definition.

The statistics cited above were determined using the standards established by the *DSM IV-TR.* The number of clients meeting the criteria for new Substance Use Disorder category in the *DSMV* are likely to be substantially higher than the number that met the *DSM IV-TR* diagnosis of Substance Dependent for the simple reason that a client now needs to meet only 2 of 11 criteria versus the previous standard of 3 of 7 criteria in the *DSM IV-TR* (O'Brien, 2011). The use of this “broader net” will result in a much greater number of alcohol users who will meet the criteria of Substance Use Disorder because of this lower standard.

According to the 2009 NSDUH findings, rates of substance use other than alcohol have vacillated somewhat since 2002. The use of some drugs has declined while other types of substance use have increased. In particular, the survey has shown an alarming increase in the abuse of prescription-type psychotherapeutic drugs. The past month use of prescription-type drugs increased significantly, especially the abuse of pain relievers. Of the 7 million who reported nonmedical use of prescription drugs, 5.2 million were using painkillers. In 2002, only 4.1% of the population aged 18 to 25 reported abusing pain relievers, but that percentage jumped to 4.9% by 2006. Nonmedical use of tranquilizers also increased since 2002, from 1.6% to 2% for the same age group.

In 2009, 55.3% of 18- to 25-year-old users reported they obtained their pain reliever substances at no cost from a friend or relative.

According to the survey, the following are the most commonly abused drugs

- Marijuana, by 16.7 million people, or over 7%
- Cocaine, 1.6 million users
- Hallucinogens, including Ecstasy, 1.3 million users
- Prescription drugs, 7 million nonmedical users

Theoretical Models and Assumptions

What is Addiction?

Many researchers have identified similar foundational components that underlie addictive behaviors. For example, Shaffer (2011) listed three factors that consistently seem to be associated with engaging in a behavior in a way that could be considered "addictive." According to Shaffer, addiction has the following three characteristics:

1. Behavior motivated by emotions
2. Continued use in spite of adverse consequences
3. Loss of control

This three-factor model differs from the more traditional conceptualizations of addiction as being restricted to an unhealthy relationship between a pharmacological agent and an individual's physiological predisposition. Simply stated, the thoughts, feelings, and behaviors of addicted individuals seems to be a more useful way of understanding addiction than does the search for biological or pharmacological factors. For example, heroic efforts have been made to identify the biological characteristics of individuals likely to become addicts as well as the pharmacological characteristics of substances that seem to endow these substances with addictive potential. Too often, the issue of "why" someone with a "biological" predisposition would continue to engage in a harmful relationship with an "addictive" pharmacological substance is neglected. Shaffer's (2011) factor that weighs the importance of the effect of substance use on feelings or emotions opens the door to exploring the group member's motivation to continue to use in apparently "out of control" ways despite adverse consequences.

The implications for group leaders are that the group leaders should introduce dialogue regarding the emotional or affective outcomes of each group member's specific emotional experience with their addictive substance. It is common for the emotional or affective "payoff" to differ significantly from member to member. For example, many addicts use to actually intensify feelings while others in the same group will report they use to numb their feelings. Frequently, the feelings that members expect to enhance or numb will differ from person to person. For example, in a group of problem gamblers it is common to identify two distinct populations referred to as "action" and "escape" gamblers. Action gamblers report experiencing feelings of excitement and arousal while escape gamblers report feelings of "numbing out" or disassociation. Differences such as these can be found across all addictions.

Stages of Change

One of the most significant advances in the understanding of treatment process in addictive behaviors is the concept of "readiness to change." Alternately referred to as "stages of change," the concept relates to the observation that change is almost always a process rather than a singular event. That is to say, change is observed to occur over time rather that occur in perhaps a moment of insight or advanced self-awareness (Miller, Forcehimes, & Zweben, 2011).

The process of change is associated with a continuum of stages, each with characteristic ways that clients report thinking, feeling, and behaving. This reconceptualization of change as a process rather than an isolated event in time has led to substantially more effective ways of working with addiction clients individually and in groups. It is important to note that the "stages-of-change" phenomena is not restricted to any particular type of individual or group treatment approach but is, rather, an intrinsic characteristic of all individuals attempting change in their lives (Stevens & Smith, 2013).

Group leaders should be familiar with the stages of change through which addiction clients transition (DiClemente, Schlundt, & Gemmell, 2004). The stage of change guides the selection of interventions and group interactions that will be most helpful at that time. It is also important to recognize that these stages of change do not necessarily progress in a linear fashion. Addicts commonly vacillate between denying any need to change only to vow to change the next day. It's especially useful for group leaders, as well as the members, to provide feedback to members regarding observed variations in stages of change.

Several instruments have been developed to identify which stage of change best characterizes a group member's current status. The University of Rhode Island Change Assessment (URICA; McConnaughy, Prochaska, & Velicer, 1983) and the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) (Miller & Tonigan, 1996) are the most commonly used inventories. URICA is generic and can be applied to any behavior in need of change while SOCRATES specifically addresses substance use issues.

Each stage of change brings with it a constellation of ways of thinking and behaving. It is essential that the group leader be familiar with these predictable emotions and cognitions. This familiarity allows the group to respond to each member where they are at cognitively and emotionally. For example, a common mistake made by substance abuse counselors is to begin discussing effective methods for change (Action Stage) while the group member remains unconvinced that change is necessary (Precontemplation). Continuing a dialogue in which a group leader or group members are not in harmony with the other member is akin to "two ships passing in the night" and is often the catalyst for the resistance and denial often observed in substance-abusing clients.

Table 32.1 illustrates these changing and sometimes overlapping stages with associated cognitions and counselor interventions.

Group Models

A multitude of group models can be used in addiction counseling. While most of them address the group processes listed above, the way this is accomplished or the particular focus depends on the specific goals of each group. These different models fall within three general group approaches: (a) psychoeducational, (b) directive, and (c) nondirective or process focused.

Psychoeducational Models

The primary goal of this group models imparting information relating to a specific addiction. Methods include slide presentations, lectures, handouts, video presentations, and group discussion facilitated by a knowledgeable and experienced group leader. Topics include the effect of the addiction on the person and family, the availability of community support services, the influence of peer groups, and effective self-help strategies (SAMHSA, 2009).

Psychoeducational groups function to stimulate group members' self-awareness through nonjudgmental presentation of factual material without the intent of confronting or challenging the group members' behavior. Information presented in this way often results in members considering the costs versus the benefits of continuing their addictive behavior. It often plants a seed of concern that can tip the balance from a position of "no problem here" to uncomfortable thoughts and feeling that "this behavior really has caused lots of problems in my life" (Kaminer, Burleson, & Goldberger, 2002).

With the growth of Employee Assistance Programs and the movement of the criminal justice system into the realm of treatment and rehabilitation (e.g., drug courts), many of the group members in this type of group are involuntary or in some way mandated to attend group. Consequently, it is common for these group members to believe that they do not have a problem and are attending group only because it is required. An important quality for leaders of addiction psychoeducation groups is an awareness of the negative mindsets of many of these members. Because many are attending against their will, they may feel anger at having to pay to attend while others believe they have done nothing to warrant their coercion into this process. The leader should nonjudgmentally accept these feelings while helping the members understand that the group is not necessarily a component of the criminal justice system but rather a community resource often used by the correctional system in lieu of incarceration or monetary fines. Many states have established manualized treatment protocols for clients in the criminal justice system. Motivational enhancement in conjunction with indicated cognitive-behavioral approaches are the most commonly used approaches and evidence to support their effectiveness is growing as follow-up data is examined. In general, motivational enhancement moves the client to an acceptance of the extent of harm from their substance use behavior and the cognitive-behavioral strategies move the motivated client toward healthy alternative lifestyle changes.

Stage of Change	Group Member Attitude	Leader/Group Intervention
Precontemplation: At this stage, the participant may not realize that he or she has a problem.	"That damn cop. . . . he had no right to pull me over. I only had a couple of drinks!"	Validate angry feelings. Build trust. Encourage self-exploration.
Contemplation: The participant evaluates the advantages and disadvantages of the addiction by performing a cost/benefit analysis.	"Sometimes I just get tired of what's going on in my life! Something has to change."	Reflect ambivalence. Honor the approach/avoidance struggle (i.e., "Part of you wants to but another part doesn't want to . . .").
Determination/Preparation: The group member plans and prepares to make specific changes.	"That's it! I'm going to make some definite changes in my life. I need friends with different habits."	Support, encourage, and help define plan and identify obstacles.
Action: The participant seeks out new ways of handling his or her addiction behavior. This can include self-help, the support of addiction help group, or professional guidance.	"Well I did it! I gave my checkbook and credit cards to my husband!"	Build self-efficacy and explore ways to reframe feelings of loss. Reinforce success and self-respect.
Maintenance: After a few months, the participant's behavior has been changed and now seeks to maintain these gains.	"I can't believe it's been half a year since I gambled!"	Encourage continued implementation of relapse preventions tools. Attempt to identify future high risk situations.
Relapse: Although not inevitable, relapses are a normal part of the change cycle and if handled well, can serve as a learning experience in overcoming an addiction.	"Damn! When I woke up this morning I couldn't believe what I did last night. I'll always be a failure!"	Help reframe "failure" to a single "bad choice." Normalize the struggle people have changing well-learned habits. Explore the triggers that led to "lapse." Discuss additional ways to handle cravings and urges.
Termination: Once a participant has sustained a long period of change, they may choose to discontinue treatment services with the knowledge they are free to return as needed.	"I can't believe I don't even think about scratch tickets anymore! When I see people buying tickets, I actually feel sorry for them!"	Reinforce this change in self-concept as a "non-gambler." Remind member he or she is free to attend sessions in the future for whatever reason even if the behavior hasn't again become a problem.

Directive Models

While psychoeducational approaches sometimes precipitate behavioral change, often more directive interventions are necessary to move the client to an acceptance of the harm they are causing and the motivation for positive change.

Motivational Interviewing

Motivational Interviewing (MI) is an approach predicated on an inherent ambivalence that exists within the client (Miller & Rollnick, 2013). Ambivalence is defined as the coexistence of both positive and negative feelings and attitudes toward a particular person, object, or behavior (Magill, Stout, & Apodaca, 2012). Ambivalence is a trademark feature of addictions, because, despite potentially tremendous cost, the individual is reaping some benefit from engaging in his or her addictive behavior. The goal of MI is to facilitate a shifting of the individual's ambivalence toward emphasizing the costs of the behavior, thereby increasing the individual's motivation to change (Miller & Rollnick, 2013).

Motivational interviewing techniques can be used to facilitate change as either a component or primary method of treatment for addictions (Jackson, 2004). Treatment completion among court-mandated substance abuse patients participating in a motivational group has been found to be significantly higher compared to those not receiving MI (Lincourt, Kuettel, & Bombardier, 2002). This is consistent with the finding that the higher the level of motivation to change, the more likely change will occur (Norcross, Krebs, & Prochaska, 2011). While no specific group protocol exists to address this finding, it is clear that group leaders and members must interact with individual members according to each member's readiness to change.

Ambivalence is best understood as an approach-avoidance conflict in which the addict is repeatedly pushed and pulled back and forth between not wanting to continue the behavior that is the source of their distress while not wanting to part with what has become an important part of their emotional life. While the group must address the group members where they are in their stage of change, a large portion of Motivational Interviewing is helping group members move from ambivalence or Contemplation to the Determination stage. Determination/Planning is characterized by group members making firm decisions to change their behavior sometime within the next 30 days. For example, any group member recognizing that their behavior is causing problems and then makes a list of nonsubstance-using friends from the past to contact has moved from Contemplation to Determination. Accordingly, actually meeting with the old friends for a fishing trip would exemplify moving from the Determination to Action stage of change.

Motivational Interviewing as a process fits hand-in-glove with the underlying dynamics of group psychotherapy. Its major premises are that group facilitators do the following:

- Express Empathy: Rather than aggressively confronting members about their self-destructive behavior, relationship building and motivation for change follow the group's respect for and acceptance of the member's point of view and values. Example:

Leader: *"Bev, you don't appear to agree that your alcohol use has caused distress in your marriage. It seems this accusation is annoying and irritating to you."*

- Develop Discrepancy: As the group member shares disappointment and frustrations regarding his or her present condition, group members can help point out the differences in the addict's values and aspirations and how the current behavior is at odds with the group member's goals. Example:

Member: *"With your 4.0 grade point average in biology, it looks like you might actually get accepted to medical school. Have you checked on what different medical schools' policies are of drug convictions?"*

- Roll with Resistance: The defensiveness seen in many addiction group members is not necessarily a natural condition of addiction. Many addicts have experienced years of aggressive and sometimes cruel confrontation from those close to them. Therapeutic gains are most often associated with expressions of support and understanding rather than argumentation. Example:

Member: *"Sorry I've upset you, Sue. It's not my place to judge you and I do recognize that ultimately you're the best judge of whether what you're doing is getting you to where you hope to go."*

- Support Self-Efficacy: Traditional approaches often sought to shame and embarrass the addict into changing their harmful behavior. Evidence consistently supports the opposite approach. That is, change comes from feelings of power and efficacy often associated with high self-esteem (Apodaca & Longabaugh, 2009). The group must communicate that it believes in the member's ability to make whatever changes are necessary. Example:

Leader: *"John, I must mention that I'm very impressed with challenges you've met head-on and overcome since you joined the group. It's clear there is a part of you that won't settle for less than success in the areas that are important to you."*

A final point of importance in considering behavior change within a Motivational Interviewing format is the concepts of "ready, willing, and able." Any dialogue reflecting these ways of thinking should be underscored through reflection or summarization by group leaders and members.

Examples:

Lois: *Yes, there's no question that the price I've been paying is way higher than what I've gotten out of it. Something has got to change! (ready)*

Bill: *Sounds to me like you feel strongly about this. Are you really saying you're ready to stop using?*

Lois: *Definitely! This just isn't worth what I'm going through. I'm going to make a plan to do whatever it takes to turn this around. (willing)*

Mary: *You seem to remember life was better before you were using?*

Lois: *Yes. I was able to enjoy life without drugs and I know I can do it again. (able)*

Cognitive and Behavioral Groups

Cognitive Models

Cognitive and behavioral theoretical approaches to the treatment of addiction can be implemented independent of one another, or they can be combined into cognitive-behavioral therapy (CBT) (Ladouceur, Sylvain, Boutin, & Doucet, 2002). Most individual and group sessions combine indicated behavioral and cognitive methods.

Cognitive models of addiction treatment focus on the erroneous and maladaptive beliefs and patterns of thinking that perpetuate an individual's addictive behavior (Ladouceur et al., 2002). Cognitive strategies typically help members identify three levels of thinking or cognitions that contribute to their addictive behavior. These three levels have been conceptualized as layers of an onion with each layer deeper and less accessible to conscious awareness. These theoretical levels have been identified as (1) automatic thoughts, (2) assumptions, and (3) schema or core beliefs (Beck, 2011).

As indicated above, at the surface are automatic thoughts that are represented by our ongoing streams of consciousness or moment to moment thinking. Typically, clients are able to learn to identify automatic thoughts and associate them with the feelings or moods they are experiencing.

Example of Automatic Thoughts:

John: *I'm really getting upset with the way Bev is relating to me.*

Leader: *It's good that you're able to identify and label how you are currently feeling.*

I wonder if we could explore what your thoughts are about how Bev is relating to you. Can you identify what thoughts you were having when you realized you were becoming angry with Bev.

John: *Well … yes. It seems like she is always talking down to me.*

Frank: *I'm wondering … when you think you are being talked down to, it makes you think what …?*

John: *That I'm not important and that people aren't respecting me.*

Leader: *So believing you are valued and worthwhile is important to you? Maybe we could look at some other situations in which you believe your importance is discounted.*

The second or deeper level of cognition involves assumptions. These are typically unquestioned or unanalyzed beliefs that guide people's interpretation of situations. Often they are associated with “should” or “ought” beliefs.

Example of Assumptions:

Ann: *I'm getting pretty upset with Ben's attitude.*

Leader: *I wonder what about Ben's attitude is leading to your reaction to Ben.*

Ann: *I don't know. … it's just the way he comes across.*

George: *Can you tell me about a time when Ben made you to feel mad?*

Ann: *It seems that I get upset when he challenges you.*

Lois: *… how about when he challenges other members of the group?*

Ann: *No, that doesn't bother me. Many of us need to be challenged.*

Leader: *So leaders or authority figures should be treated more "respectfully" and not challenged?*

Ann: *Yes, I think that's a big part of it. I've always believed that we have a responsibility to respect those in authority or positions of responsibility.*

The third and deepest level of cognition involves core beliefs or schemas. These are often learned early in life and act as a lens through which our perceptions are altered to fit into our worldviews. Schemas are rarely self-evident to an addict and often difficult to identify but eventually become apparent as certain foundational ways of viewing the world reoccur over the course of several group meetings.

Example of Core Beliefs:

Ted: *Well, I finally got the promotion I'd been working for.*

Leader: *That's certainly an accomplishment. Can you share with us what this means for you?*

Ted: *Actually, I'm somewhat disappointed. I expected a bigger raise to go with the promotion.*

Susan: *It seems for you that there are often two sides to everything. I remember that last week you were disappointed that you had to split your lottery jackpot with another person that had also picked the winning number.*

Ted: *Yes, I think you're right. It seems that things that happen to me are always less than what they could have been.*

Critical evaluation of these three levels or layers of thinking allows group members an opportunity to assess their accuracy and usefulness. The group member is encouraged to find evidence that supports their current ways of thinking as well as evidence that suggests that other ways of interpreting their world might more accurately reflect the reality of their situation. The feedback of other group members is invaluable in this process. For additional information, there are a multitude of books, manuals, and resources on the Internet describing the standard treatment protocol. Success rates using cognitive-behavioral approaches have been repeatedly validated (Wenzel, Liese, Beck, & Friedman-Wheeler, 2012).

Process and Interpersonally Focused Models

Other approaches are grounded theoretical frameworks, including attachment theory, psychodynamic therapy, and object relations (Flores, 2004, 2007; Hunter-Reel, McCrady, & Hildebrandt, 2009). It is through the formation of healthy interpersonal relationships and attachments within the context of therapy that individuals work through their addiction (Flores, 2001). However, it is important to note that there is not a clear delineation between process- and content-oriented groups. In fact, a given group can, and often does, incorporate elements of multiple theoretical frameworks.

Example:

Leader: *Ed, I've observed that although you are demonstrating some possibly strong feeling about what many of the group members have shared, you have said very little about your feelings and thoughts since you joined the group last month.*

Ed: *Yes, it seems that I relate intimately with the pain and struggles that group members have shared, but I never really know what to say.*

Ruth: *I've suspected that you are emotionally affected and then it seems like you want to say something but then you just lean back in you chair.*

Ed: *It seems like this is a pattern with me. I rarely share what I'm feeling at work either.*

Leader: *I wonder if this is a recent condition or one of long standing. What family messages you received as a child might relate to this?*

Ed: *Now that you mention it, I remember whenever I expressed what I was thinking and feeling as a kid my parents would always interrupt me and tell me that "kids are to be seen and not heard."*

Treatment Goals

Traditional treatment services, such as those characteristic of 12-step, disease model interventions, are founded on the belief that through abstinence, and only through abstinence, a person can overcome their addiction (Marlatt & Witkiewitz, 2002). However, in the 1970s researchers and practitioners began to investigate whether moderation rather than abstinence could be a viable goal for addiction treatment (Sobell & Sobell, 1973). More recently, the goal for many is to moderate their behavior in such a way as to reduce the negative impact their behavior is having on their overall functioning. Both research and clinical observations over the past 40 years confirm that a substantial number of people recover from addictive patterns while continuing to engage in the behaviors that brought them to treatment (Tatarsky & Marlatt, 2010). These observations have led to treatment approaches now universally referred to as "harm reduction."

Advocates of harm reduction models indicate that such models are effective, do not preclude abstinence as a therapeutic goal, allow therapy to be tailored to each individual, and facilitate the counselor(s) in addressing the client "where he or she is at" (Marlatt & Witkiewitz, 2002). However, harm reduction models have yet to be fully embraced; in fact, many treatment-seeking drug users tend to identify abstinence as their goal of choice (McKeganey, Morris, Neale, & Robertson, 2004). Further, opponents of harm reduction models indicate that these models are, in fact, suggesting that addictive behaviors, such as drug use and gambling, are acceptable, which undermines messages and goals of abstinence-oriented programs (MacCoun, 1998). Consequently, it is critical to determine what each client hopes to achieve or acquire in therapy and to gauge clinical progress relative to each client's individual goals, whether they are continued use in a nonharmful way or total abstinence.

Client Selection and Appropriateness

In any form of group counseling, including addiction-focused groups, purposeful and meticulous member selection can be a critical factor in determining therapeutic outcomes (Krogel, Beecher, Presnell, Burlingame, & Simonsen, 2009). Sandahl, Busch, Skarbrandt, and Wennberg (2004) make the following recommendations regarding member selection for an addiction-focused psychotherapy group: aim to add diversity among the members, avoid having too many members with a tendency to act out during sessions, screen for severe narcissistic personalities, and screen for excessively anxious clients. Reading (2004) contributes the following criteria for member selection: choose individuals with well-formed goals, it can be helpful to have members with varying behavior goals, and members must be willing to attend sessions in a nonintoxicated state. Flores (2007) further added that addicted individuals with previous positive group experiences are more likely to serve as positive additions to a therapy group.

Co-Occurring Disorders

Individuals with problems related to substance use and abuse frequently present with co-occurring disorders. However, Flynn and Brown (2008) found that only 15.5% of individuals with co-occurring serious mental illness were receiving treatment for both their addiction as well as for their co-occurring disorder.

There are certain disorders that tend to be more commonly found among individuals presenting with addiction-related difficulties. In a survey of mental health providers, the following estimated rates of co-occurrence were found for each of these disorders: mood disorder (40–42%), anxiety disorder (24–27%), post-traumatic stress disorder (24–27%), antisocial personality disorder (18–20%), and borderline personality disorder (17–18%) (McGovern, Xie, Segal, Siembab, & Drake, 2006). Stinson et al. (2008) also found an increased rate of narcissistic personality disorder among this population. Rates of co-occurring disorders have been found to positively correlate with the number of addictive behaviors (Flynn & Brown, 2008). Addiction treatment that also focuses on co-occurring disorders has been found more effective than treatment focusing solely on the addictive behaviors (Brown, Evans, Miller, Burgess, & Mueller, 1997; Kim, Grant, Eckert, Faris, & Hartman, 2006). Therefore, addiction groups should either incorporate a focus on co-occurring mental health issues or leaders should ensure that clients are receiving outside therapy for any co-occurring disorders.

Co-Occurring Addictions

This chapter has focused primarily on substance addiction. However, there exist a multitude of other behaviors that are commonly engaged in by substance misusing group members. For instance, addiction to electronic devices is increasingly observed in the form of texting, e-mailing, chat rooms, and massive online gaming. Other addictions commonly observed include gambling, sex, eating, working, relationships, shopping, and hoarding (Ciarrocchi, 2002; Carnes, 2009; Hudson, Hiripi, Pope, & Kessler, 2007). It is beyond the scope of this chapter to describe the details of each addiction. Although many of these other behavioral addictions may function through mechanisms similar to substance addiction, it is incumbent on group leaders to have a working knowledge of the variety of addictive behaviors in which their group members may engage.

Conclusion

The *DSM-V* now views many mood altering nonsubstance use behaviors to be potentially addictive. This broader recognition of the breadth of behaviors considered addictive will translate into a substantial increase in individuals meeting the criteria for addiction. Consequently group leaders will most likely witness an increased number of people referred for addiction treatment. Further, the growing role of managed care in the treatment of psychological and behavioral disorders has increased the demand for evidence-based services to an ever-growing number of people. These considerations will inevitably lead to the increased use of group counseling and psychotherapy in the treatment of addictive disorders.

Historically, the addictions field emerged from grass roots efforts by those in recovery to provide support and encouragement to those desiring help with their addictions. Experience as an individual "in recovery" rather than training and professional supervision was the entry-level standard in the early days of addiction treatment. However, following four decades of research, there now exists an extensive body of knowledge in addiction studies resulting in the need for formal study within the addictions treatment field. All states now offer a formal and graduate level, education track to become a certified or licensed addiction counselor. It is likely that this growth in clinical and research-based knowledge will lead to progressively more specialized group approaches tailored to the treatment of specific addictions.

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Chapter 33 Group Work with Individuals who have Committed Interpersonal Violence

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In this chapter, we provide a background on the prevalence of interpersonal violence, the characteristics of individuals involved in interpersonal violence and the history of treatment to prevent its reoccurrence. We discuss the implications of this information for group treatment for individuals who have committed interpersonal violence, focusing on group developmental stages and the therapeutic factors available in groups. We describe three different formats for group treatment of abuse—psychoeducational, counseling, and therapy—and review outcome studies evaluating these approaches. Finally, we offer suggestions for future practice and research.

In this chapter, the term *interpersonal violence* is used to describe violence and abuse in any relationship or interaction between people. This term is more inclusive than *spouse abuse, domestic violence*, and *intimate partner violence* and conveys the view that abuse is a behavior rather than a type of person, which is implied by labels such as *batterers, perpetrators, offenders*, or *abusers.* Further, interpersonal violence is not limited to abuse or violence between intimate partners. Previous evidence has been cited that men rather than women are more likely to perpetuate specific subtypes of interpersonal violence, such as intimate partner violence and do more physical damage when they are abusive (Stets & Straus, 1990); however, there is a growing body of evidence that women are also involved in interpersonal violence and may have some of the same motivations for engaging in abusive behavior as men (Archer, 2006; Hines & Malley-Morrison, 2001). When interpersonal violence is considered more broadly, it is evident that both men and women can exhibit such behavior, although in examining intimate violence it is important to consider context (McCloskey, 2007). There is evidence in the literature that intimate partner violence occurs in same-sex relationships at the same rate as heterosexual relationships (Miller, Bobner, & Zarski, 2000), suggesting that it is not solely determined by gender specific relationship dynamics. Despite the prevalence of violence in same-sex relationships, group treatment with these populations has not received significant research attention. In an effort to address deficits in the literature, the focus of this chapter is on group treatment for individuals who have engaged in abusive behavior toward another person, inclusive of gender, sexual orientation, and other relevant characteristics.

Interpersonal Violence Prevalence and History of Treatment

Interpersonal violence is a prevalent and serious problem in our society. Given the inclusive definition of interpersonal violence, definitive rates of prevalence are not easily ascertained. The prevalence of interpersonal violence could be assessed within specific subtypes, such as nonfatal violent crimes and intimate partner violence. The National Crime Victimization Survey (NCVS) measures rates of nonfatal crimes, both reported and not reported to the police, against persons age 12 or older from a nationally representative sample of U.S. households. It includes four categories of crime that fit a definition of interpersonal violence: rape, sexual assault, aggravated assault, and simple assault (Truman, 2011, p. 2). Those four categories and robbery are referred to as serious violent crimes in the NCVS. According to the NCVS estimate of criminal victimization in 2010 excluding robbery, around 3.3 million victimizations by serious violent crimes occurred during that year (Truman, 2011, p. 2). Additionally, evidence indicates that approximately 7.4 million people experience physical violence by an intimate partner (Tjaden & Thoennes, 2000, p. 10). Summary results of the 2010 *National Intimate Partner and Sexual Violence Survey* indicate that more than one-third of all adult women in the United States experience violence committed by an intimate partner at some point in their lifetime (Black et al., 2011, p. 39). The NCVS estimate of criminal victimization in 2010 also revealed that from 2001 to 2010, just over half of all violent crime victimizations were perpetrated by nonstrangers. Nonstrangers were defined as intimate partners, other family members, friends, and acquaintances. More female than male victims knew their offender (Truman, 2011). In addition to the physical injuries sustained in incidents of interpersonal violence, victims often suffer from prolonged psychological and physical health problems (Goldsmith, Freyd, & DePrince, 2012; Norris, Foster, & Wesshaar, 2002). Children who witness partner abuse often experience a variety of emotional and social problems (Margolin, 1998), including subsequent involvement with abuse as adults (Schwartz, Hage, Bush, & Burns, 2006). Children who witness partner abuse often experience conduct disorders (Meltzer, Doos, Vostanis, Ford, & Goodman, 2009). Children who live in a household in which both parents are working are four times less likely to witness partner abuse (Meltzer et al., 2009). Family violence has been described as an "epidemic," and more efforts to treat and prevent violence have been called for (Poirier, 1997). The U.S. Department of Health and Human Services has identified efforts to treat and prevent family violence as a major objective for improving the health of all Americans (U.S. Department of Health and Human Services, 2012).

Historically, interpersonal violence has been viewed as a crime and as a cause for punishment, not treatment. Specific subtypes of interpersonal violence, such as intimate partner violence and child abuse, were viewed as private matters. Intimate partner violence only began to receive public attention in the 1970s in response to the efforts of the women's movement (Hage, 2000). There now are a large number of community-based programs providing shelters and counseling for domestic violence victims (Stark & Flitcraft, 1996). Police response has moved from a reactive stance to a proactive one (Belfrage, 2008; Belfrage & Strand, 2008). Treatment for men who have committed intimate partner violence developed because of the recognition that couples involved in partner violence often choose to remain together (Finn, 1985) and the belief that it is the individuals who perpetuates violence against their intimate partners who need to change (Waldo, 1986). The first program specifically designed for men who have committed partner abuse was opened in 1977 (Adams, 1994). There are now domestic violence offender treatment centers across the country as well as in various countries around the world (Gerlock, 1997). The majority of these centers were created as adjuncts to shelters and counseling centers for victims of domestic violence (Adams, 1994). The most effective interventions for men who have committed partner abuse have involved the interweaving of social services, counseling, and corrective efforts by police and the courts (Murphy, Musser, & Maton, 1998).

Group work is a commonly accepted format for treatment of individuals who have committed intimate partner violence (Babcock, Green, & Robie, 2004; Lawson et al., 2001; Lawson & Brossart, 2009). Groups for male perpetrators initially focused on feminist-oriented consciousness raising. Later, cognitive-behavioral techniques were added to help men challenge sexist beliefs and develop nonsexist attitudes (Gondolf, 1997; Stover, Meadows, & Kaufman, 2009). The groups evolved into sociocultural/feminist-based programs that sought to both hold men accountable for their abuse and remove the stigma from women who were abused (Gondolf, 1997). It was also assumed that men helping men was the most effective way to combat intimate partner violence (Wexler, 1999). In

the late 1980s, the prevalence of court-mandated counseling dramatically increased and diversified the group counseling approaches used by intimate partner violence programs (Gondolf, 1991). During this period, battered women's advocates and intimate partner violence program staff raised concerns regarding the quality of the varied group approaches being used (Gondolf, 1997). These concerns led to the development of standards for treatment that were adopted in 11 states (Gondolf, 1997). The standards mandated treating abuse as a tactic used by men to gain power and control in their relationship, specified the training needed to conduct groups, and set guidelines for prioritizing the safety of the person who was abused. The standards are not universally accepted. Professionals remain uncertain about the characteristics of men who have committed intimate partner violence and the best format for working with them in groups (Gondolf, 2000; Stover et al., 2009).

Understanding Individuals who Have Committed Interpersonal Violence

It is important to understand the causes of interpersonal violence to inform and design appropriate treatments (Holtzworth-Munroe & Stuart, 1994; Waltz, Babcock, Jacobson, & Gottman, 2000). While a single, thorough review of the literature on the characteristics of individuals who commit interpersonal violence is not currently available, Jasinski and Williams (1998) provide a comprehensive review of men who commit intimate partner violence. Their review indicates that many issues contribute to interpersonal violence, suggesting the need for multifaceted treatment. There currently are no universally accepted typologies of individuals who commit interpersonal violence. Researchers have investigated societal influences and gender socialization, witnessing or experiencing violence in the family of origin, substance abuse, and personality or pathological characteristics as root causes of men's interpersonal violence (Caldwell, Swan, & Woodbrown, 2012; Gortner, Gollan, & Jacobson, 1997).

Kernsmith and Kernsmith (2009) reviewed the prevalence and characteristics of female perpetrators of interpersonal violence, primary in the form of intimate partner violence. They were investigating contrasts in state policies addressing female versus male perpetrators who are mandated to treatment for intimate partner violence. They noted a distinction between female aggressors who fundamentally acted out of self-defense and female aggressors who were the principal perpetrator of violence or who met the definition of either mutual violent control or common couple violence. *Mutual violent c*ontrol is "a relationship in which both partners use violence and control" and common couple violence is a relationship that "involves aggression by both parties without the desire to control" (Kernsmith & Kernsmith, 2009, p. 343). The difference between interpersonal violence that is an act of self-defense versus violent behavior that is based in patterns of aggression may impact treatment strategies and their efficacy. Victims who resort to violence in self-defense may need assistance developing skills for self-care, making positive choices regarding relationships, and learning to be assertive. These skills could empower them to transform or move out of abusive relationships so they are no longer at risk of using violence for self-defense. Those who have developed a pattern of aggression need these skills as well, but also may need external controls (law enforcement) and/or changes in attitudes toward violence so that they no longer see violence as a viable means of relating (Cho, 2007). The Duluth Model of group work addressing interpersonal violence takes this approach (Pence & Paymer, 1993). Participants in the group are challenged to recognize their violence is an inappropriate and ineffective attempt to gain illegitimate control over their partners. This approach is justified by the rationale that participants believe they have a right and responsibility to use violence in their relationships, and that they will not change their behavior until their beliefs change.

Societal Influences and Gender Socialization

A number of theorists and researchers have hypothesized that societal influences and gender socialization contribute to interpersonal violence. Feminist theory proposes that men are socialized to take a patriarchal role with women and control them through psychological and physical abuse (Johnson, 2011; McCloskey, 2007; Pence & Paymer, 1993). The portrayal of men's abuse of women in popular media, including music, television, and movies, has also been theorized to contribute to spouse abuse (Lore & Shultz, 1993). The feminist perspective has been supported by findings that men who approve of the use of violence toward women tend to be more violent toward women (Kaufman-Kantor, Janiski, & Aldorondo, 1994; Straus & Gelles, 1990). Also, research suggests that men who hold patriarchal ideologies have higher rates of abusive behavior (Moore & Stuart, 2005; Stith & Farley, 1993). Patriarchal ideologies suggest that men are responsible to protect, care for, and guide women. Men, and in particular husbands, are seen having the right and obligation to control women. When other forms of control are ineffective, physical force can be seen as acceptable. As a result, some men justify their violence against their female partners as necessary in their effort to ensure their partners adhere to their direction (Brownridge, 2002). Although patriarchy has been identified as an important variable, it has not offered a comprehensive or sufficient explanation of the cause of interpersonal violence (Gortner et al., 1997; O'Neil & Harway, 1997). Research has demonstrated that not all men who hold patriarchal ideologies are abusive (Dutton, 1995).

Another way of conceptualizing how male socialization contributes to interpersonal violence is through gender role conflict or stress theory. O'Neil, Good, and Holmes (1995) defined gender role conflict as a psychological state in which socialized gender roles have negative consequences on the person or others. Gender role conflict has been hypothesized to cause shame and powerlessness and to be related to abusive behavior (Jennings & Murphy, 2000; O'Neil & Harway, 1997). Gender role conflict can lead to shame when men accept the stereotype that they are unfailingly strong and independent at all times, and then find themselves feeling dependent on their female partners. It also occurs when men, in an effort to not be weak or appear to be homosexual, ignore their feelings of fear and sadness and limit their openness and development of caring relationships with other men. Ignoring emotions, isolating oneself, and denying vulnerability in intimate relationships can take a significant toll on psychological well-being. The stress of gender role conflict may leave men on edge and more prone to violence. If men experience a break in their façade of strength and autonomy, they may experience shame and anxiety that results in panic, and they may engage in violence in a desperate attempt to demonstrate their power (Umberson, Anderson, Willams, & Chen, 2004). In a study of men who were court mandated to treatment for committing intimate partner violence, Schwartz, Merta, Waldo, and Bloom-Langell (1998) found that gender role conflicts, in particular gender role conflicts resulting in having difficulty forming relationships with other men, were related to abusive behavior. In addition, masculine gender role stress (cognitive appraisals of specific situations that may be perceived as stressful to their construct of masculinity) has been related to men's increased attribution of negative intent to their partners, expression of more irritation, anger, jealousy, endorsed aggressive responding, and increased reporting of abusive behavior (Copenhaver, Lash, & Eisler, 2000; Eisler, Franchina, Morre, Honeycutt, & Rhatigan, 2000). These findings suggest that gender role conflict and stress may be related to men committing intimate partner violence.

In a study of whether individual distress, severity of violence, and dyadic adjustment vary according to gender, Anderson, Dial, Ivey, and Smith (2011) found distinct differences in levels of individual distress and adjustment based on gender. Their study found that in instances when the violent aggressor is female, her relational satisfaction increases when the violence begins but that her satisfaction then decreases when the violence becomes critical. Such variance in distress and adjustment could influence an individual's response to treatment. Anderson et al. (2011) found that violently aggressive men's relational satisfaction progressively decreases from the initial violence through any subsequent violence, whether the violence increased or decreased in severity. Those gender differences in the variance of distress and adjustment may help inform a counselor's preparation for and approach to providing treatment to individuals who commit interpersonal violence.

Abusive Behavior in Family of Origin

Witnessing or experiencing abusive behavior in their families of origin has been related to individuals perpetrating interpersonal violence, specifically men subsequently engaging in interpersonal violence (Gortner et al., 1997; Lawson, 2008). Social learning theorists, such as Bandura (1973), suggest that children who witness violence in their family of origin demonstrate the influence of parental modeling when they exhibit violence as adults (Gortner et al., 1997). Witnessing or experiencing violence in the family of origin also has been hypothesized to have a detrimental effect on self-esteem, resulting in men being vulnerable to threats to their self-concept and depression (Murray & Baxter, 1997). There is a higher rate of depression among men who have abused their partners (Pan, Neidig, & O'Leary, 1994). Dutton (1999) posited that witnessing or experiencing violence in the family of origin, feeling shamed, and having insecure attachments are traumas that can lead to personality disorders, primarily Borderline Personality Disorder. Borderline Personality Disorder and Antisocial Personality Disorder have consistently been found in men involved in intimate partner violence and thus may be correlated with general interpersonal violence (Fowler, & Westen, 2011; Rhodes & Iwashyna, 2009). The disruption of early relationships caused by experiencing or witnessing abuse as a child could also prevent individuals from developing working models of healthy relationships and lead to their having difficulties with self-concept and intimacy in future relationships (Bowlby, 1988). It has been suggested that childhood trauma from witnessing or experiencing child abuse could cause individuals to identify with the aggressor in order to feel more powerful, perpetrate the same trauma onto others in order to gain a sense of control over the trauma, and/or defend against painful memories through anger and aggression (Saunders, 1996; Schwartz et al., 2006).

Substance Abuse

Substance abuse, particularly alcohol abuse, has been linked to violence (Hirschel, Hutchison, & Shaw, 2010). Gorney (1989) found that 60% to 70% of violent men assault their partners while they are under the influence of alcohol. The relationship between substance abuse and violence is complex, and the effects of substances are mediated by relationship variables, personality traits, and beliefs about the substance as well as the direct effect of the substance (Stuart et al., 2008). Pence and Paymer (1993) point out that alcohol can be used to minimize and deny responsibility for abusive behavior. Evidence suggests a potentially escalating circular relationship between violence and substance abuse, as follows: One or both people in a relationship respond to conflicts by increasing their substance abuse, impairment resulting from substance abuse decreases the ability to effectively deal with conflict, extending and increasing the conflict and resulting in even more substance abuse. The disinhibition associated with increased substance abuse results in use of violence to address the unresolved conflicts (Moore & Stuart, 2004). Because substance abuse masks other problems and prevents learning adaptive attitudes and skills, many interpersonal violence prevention groups will not accept members until their substance abuse problems have been addressed (Scott & Easton, 2010), although there is growing evidence that integrated treatment is more effective (Schumacher, Fals-Stewart, & Leonard, 2003).

Advantages of Group Work

Group work has a number of distinct advantages for helping individuals who have engaged in interpersonal violence. Men who are court mandated for counseling may be uneasy about engaging in treatment and resist counselors' guidance (Waldo, 1987). Groups provide a reassuringly familiar environment for most individuals because they are like classes or other group settings in which individuals may have been involved. Also, group work is more economically efficient than other forms of treatment, which makes it more accessible to individuals in need of services (Yalom & Leszcz, 2005). And group dynamics generate peer influences that may be more compelling than the influence of therapists who may be seen as aligned with the authority structures that mandated their referral (Yalom & Leszcz, 2005). Theory and research suggest that the great advantage of group work comes from therapeutic factors that are generated in groups (Schwartz & Waldo, 1999). Therapeutic factors in interpersonal violence prevention groups will be described in detail in the next section of this chapter. Brief examples of how groups can take advantage of the factors are offered below.

As indicated in the previous section, there appear to be a number of issues that contribute to perpetration of interpersonal violence, including family of origin, personal history, interpersonal contexts, social, and political and substance abuse influences. The therapeutic factors available in interpersonal violence prevention groups (Waldo, 1987) have the potential to simultaneously address this wide array of issues, making groups particularly useful when therapeutic gains need to be made in a variety of areas (e.g., addressing gender role socialization, understanding and managing difficult emotions, increasing self-esteem, changing beliefs, and learning new behaviors). For example, in some situations perpetration of interpersonal violence may be experienced as a desperate act. This desperation may come from the people perpetrating the act thinking that they are responsible to control their partner and that nothing but violence will work, and/or it may come from their feeling isolated, having a high level of dependence on their partners, and panicking when they face the possibility of their partners leaving them. Therapeutic factors in groups can simultaneously address each of these potential sources of violence. The group setting can be used as a forum to promote belief in egalitarian relationships (information) and teach appropriate conflict resolution skills (socializing techniques). This learning could occur within the supportive social context of the group (cohesion), which counters isolation. Learning the skills and seeing others use them successfully (modeling) could reduce participants' fears that their relationships will fail (instillation of hope).

The following is an example of how different therapeutic factors could help different group members during one segment of interaction in a group. One member of a group may resist acknowledging his violence because he fears being stigmatized as a wife beater. As a result, he is not addressing his problem and is not making any progress on changing. Another group member may have difficulty accessing and appropriately expressing emotions such as fear and anger. These emotions build and are expressed inappropriately through violence in his intimate relationship. The leader of the group might talk briefly about the importance of expressing feelings (information) and express some difficult feelings he has had in his relationships (modeling). The leader's encouragement combined with the acceptance and support of other group members (cohesion) could provide a safe environment for the second member to feel and appropriately express his emotions (catharsis), reducing his tension and putting him in a position to learn effective ways to manage his feelings. Hearing the second member express his feelings could result in the first member realizing that other men, like him, have problems with anger, fear, and violence. He may feel less isolated and afraid of stigma (universality), allowing him to begin to deal more directly with his issues.

Therapeutic Factors in Groups for Individuals who Have Committed Interpersonal Violence

The therapeutic factors Yalom and Leszcz (2005) and others have identified have been the subject of extensive research on the effectiveness of group interventions, including groups for men being treated for interpersonal violence (Schwartz & Waldo, 1999; Waldo, Kerne, & Van Horn Kerne, 2007). Each of the therapeutic factors offers potential benefits to individuals who have engaged in interpersonal violence.

Universality

Individuals who are being treated for interpersonal violence often experience overwhelming shame and often respond to shame with denial (Dutton, 1995). They reject responsibility for the violence, potentially sabotaging their treatment because they refuse to accept help or initiate changes to address a problem they claim they do not have (Pence & Paymer, 1993). Universality in groups helps members overcome denial. Because the group is organized for and made up by individuals who are dealing with the same problem, members have an experience of universality. They recognize that they are not alone or unique. They discover their essential commonality with other individuals and they see violence as a problem to be overcome rather than hidden. Group leaders can promote universality by talking about the phenomena of interpersonal violence in language and using examples that are relevant to group members. Leaders can further promote universality by asking each member to share their experience with interpersonal violence in the group (Erdman, 2009).

Instillation of Hope

By the time individuals who have engaged in interpersonal violence reach treatment, they are often deeply discouraged. Their relationships are likely to have been severely disrupted, including relationships with partners on whom they may have been highly dependent (Dutton, 1995). Groups can counter these negative emotions by instilling hope for a better future for group members. The fact that groups have been organized to help (instead of further punish) individuals who have engaged in interpersonal violence sends the message that help is possible. The commitment, caring, and competence demonstrated by group leaders offers the individuals further reason to believe they will receive assistance. Perhaps most important, when individuals engaged in interpersonal violence enter ongoing groups consisting of experienced members, they can see that other individuals have been dealing with the problems they have and have been making progress. Instillation of hope motivates group members to invest in their futures, take responsibility for their behaviors, and try to get the most out of treatment. Group leaders can promote hope by expressing their belief that what participants will learn in the group will help them end violence and improve their relationships. Positive research results can increase participants' confidence in the effectiveness of groups. Perhaps most convincing, leaders can further promote hope by asking experienced members who have had success improving their relationships to share their experience with the group (Erdman, 2009).

Catharsis

Individuals who engage in interpersonal violence, particularly men who have committed intimate partner violence, have difficulty managing their emotions (Guerney, Waldo, & Firestone, 1987; Schwartz et al., 1998). Often they repress their sadness, fear, helplessness, and hurt, converting these feelings into anger or jealousy. Also, they typically do not express anger or jealousy when they first occur (Berns, Jacobson, & Gottman, 1999). Instead, they store these volatile feelings up until they reach a breaking point and explode (Holtzworth-Munroe & Stuart, 1994). When they see the negative consequences of their emotional outbursts, they become sadder, more fearful, helpless, and hurt and also more cautious about experiencing and expressing emotions, resulting in more repression. When more anger and jealousy are generated, their feelings build up to higher and more dangerous levels until the next explosion. A pattern of escalating emotional outbursts develops that can lead to an escalating cycle of violence (Walker, 1984). Catharsis can help break this cycle. Groups offer safe environments that encourage and accept emotional expression. Group members benefit from the relief associated with emotional release and have a reduced need to employ defenses against emotions. They also can gain understanding and acceptance of the feelings they have that come before anger (such as hurt and fear) and develop appropriate means of communicating their feelings. These benefits help individuals who have engaged in interpersonal violence end the destructive cycle of emotional outbursts. Group leaders can promote catharsis by empathically acknowledging the strong feelings members display as they talk about concerns in their relationships. Leaders can also directly ask members to share their feelings, and they can model expressing feelings by talking about their own experiences (Kivlighan, London, & Miles, 2012).

Corrective Recapitulation of the Primary Family Group

Groups offer individuals who have engaged in interpersonal violence a chance to correct the abusive pattern that many have experienced or witnessed in their family of origin (Dutton, 1999). Because groups have a leader (or leaders) who can symbolize parental authority and members who can symbolize siblings, they reenact some of the dynamics members experienced in their families earlier in their life. However, since groups are structured and emotionally healthy settings, they do not allow a replay of abuse. Instead, emotions are appropriately managed, and positive relationships are maintained between group members and the leaders. This allows for a corrective reworking of family dynamics the members previously experienced, helping them develop healthy internal models of family interaction that they can generalize to their relationships with their partners, other family members, or friends. Group leaders can promote family reenactment by asking group members to generate and share Genograms of their family histories. Describing their Genograms often helps members identify dynamics in their families of origin that may have contributed to interpersonal violence. Examining those dynamics in the safe, family-like environment of the group can help reduce their influence (Yalom & Leszcz, 2005).

Cohesion

Many individuals who have engaged in interpersonal violence are isolated (Browne, Saunders, & Staecker, 1997). For those who have engaged in intimate partner violence, their low self-esteem results in their being reluctant to establish relationships outside of the relationship they have with their partner (Holtzworth-Munroe & Stuart, 1994). Groups offer members an experience of closeness with other individuals. They can feel valued and accepted, which raises their self-esteem and reduces their dependence on their partners. Reduced dependence on their partners makes members less vulnerable to the desperate possessiveness that may trigger their violent behavior. Most participants in interpersonal violence groups have been court ordered to treatment, with the understanding that if they engage in violence again, they will be terminated from the group and sent back to court. Cohesion can motivate members to adhere to the group's goal of ending violence, because they want to remain involved with a cohesive group and are likely to be terminated from the group if they are violent again. Group leaders can promote cohesion simply by saying they value the group members and by pointing out the positive relationships group members have developed with each other (Burlingame, McClendon, & Alonso, 2011).

Altruism

Participation in a group offers all individuals a chance to help others. Focusing on another individual's suffering can help individuals move past obsession with their own pain and anger (Berns et al., 1999). Group members' success at helping others can increase their sense of self-efficacy. Furthermore, offering advice to other members on how to avoid violence and improve their relationships makes it more likely the advice givers will follow the advice they are giving. Group leaders can promote altruism by asking members to share experiences they have had that they feel might be useful to other group members (Yalom & Leszcz, 2005).

Interpersonal Learning

Relationships between members in groups become social microcosms of their lives outside of group. Aspects of members' interpersonal styles that cause problems in relationships outside of group (Dutton, 1999; Holtzworth-Munroe & Stuart, 1994) cause problems in the group as well. When problems arise in the group, other members give the members involved feedback about how they are coming across. The experience of receiving feedback can constitute a critical incident for group members. Feedback provides them with insight into their maladaptive relational patterns and offers them a corrective emotional experience in that they recognize that their destructive patterns are not necessary or desirable. Feedback about the way individuals interact with each other in the group can be more powerful than feedback about their attitudes or reported behavior in relationships outside of group. This is because the interactions are immediate and witnessed by other members, reducing opportunities for distorted perceptions or reporting. In addition, the feedback is coming from other members who many perceive to

be less biased than their partners, counselors, family, or friends (Dutton, Ginkel, & Starzomski, 1995). Leaders can help participants in interpersonal violence prevention groups give and receive feedback by describing the process to them, modeling it, and encouraging them to share their impressions of each other. Leaders who followed these steps in domestic violence prevention groups were able to significantly increase group members' experience of interpersonal learning (Waldo et al., 2007).

Imparting of Information

Most individuals who engage in interpersonal violence have had minimal exposure to information about interpersonal violence and how it can be prevented (Pence & Paymer, 1993). Group offers an ideal setting for individuals to learn new information and attitudes that can help them better understand how to live without violence. Group leaders can impart information through lectures, handouts, presenting videos and asking group members to share information they have (Center for Substance Abuse Treatment, 2005). An example of imparting information that occurs in most interpersonal violence prevention groups is presentation of the "Cycle of Violence" (Pence & Paymer, 1993). A common statement made by individuals who have engaged in interpersonal violence following a presentation of the cycle of violence is "If only I had known all this two years ago!"

Imitative Behavior

Many individuals who have engaged in interpersonal violence witnessed or experienced abuse in their families of origin (Dutton, 1998). Group can help individuals overcome the negative effects of prior violent models by providing positive nonviolent models. Positive group members serve as models for each other. The leaders also serve as models because they have status in the group and are proficient in the skills they are sharing with group members. The effectiveness of the leaders as models is increased if members can see similarities between themselves and the leaders. For individuals who have committed intimate partner violence, female/male coleadership can be particularly effective in modeling an equal relationship (Nosko & Wallace, 1997).

Development of Socializing Techniques

The family of origin experience of many individuals who have engaged in interpersonal violence provided them few opportunities to develop effective relationship skills. Instead, their families and friends often reinforced the use of negative interaction patterns (Gortner et al., 1997). Groups offer numerous opportunities for members to practice new ways of relating. Once members have decided to develop new relationship skills (often in response to interpersonal learning in the group), have learned information about the skill and viewed it being modeled, they can practice it while interacting with other members during sessions. For example, a man who has received feedback that he is passive could learn about assertiveness, see it modeled by the leaders and other members, and then practice appropriate assertiveness during subsequent sessions. The leaders' and members' positive responses to his skill development reinforce his continued use of the skill, both in and outside of group. Assertiveness in his relationships could help him avoid developing a backlog of resentment that eventually explodes in an emotional outburst.

Existential Factors

Many individuals who have engaged in interpersonal violence fail to recognize their responsibility in perpetrating abuse. Instead of accepting responsibility, they blame their partner, the acquaintance, friend or family member they assaulted, that person's family, the legal system, and a variety of other targets (Pence & Paymer, 1993). Individuals can be encouraged to recognize that they are choosing how they respond in group, which in turn can help them recognize the choices they made that led to violence, their responsibility for those choices, and their responsibility for their choices in the future. Because their involvement in a group inevitably ends, groups also help individuals recognize that time and opportunities to change are limited. Recognizing these existential realities can motivate group members to take responsibility for choosing nonviolence with others. Leaders can help participants in interpersonal violence groups recognize their choices, the meaning and importance of their choices,

and their critical responsibility they have in a short period of time by simply asking the question, "What would you like your children to learn from you about relationships?"

Group Stages

Tuckman and Jensen (1977) suggested that groups go through a series of developmental stages, as follows: Forming, Storming, Norming, Performing, and Adjourning. The stages have been described as having dynamic characteristics that help generate therapeutic factors (Waldo, 1985). The dynamics associated with developmental stages of groups have particular advantages for treatment of individuals who have engaged in interpersonal violence (Waldo, 1987). Each stage will be described below, including a description of leader initiated activities that fit the group dynamics thought to be prevalent at that stage and the therapeutic factors those activities might promote.

The dependency fostered by the Forming Stage of group encourages group members to be cooperative and have faith in treatment, promoting the therapeutic factors of universality and instillation of hope. The strong emotions that emerge during a group's Storming Stage can overcome the individual's denial of feelings and give them an opportunity to manage their emotions appropriately, promoting the therapeutic factors of catharsis and corrective recapitulation of the primary family group. The warmth and caring generated between members during the Norming Stage of group helps promote the therapeutic factors of cohesion and altruism. After having passed through the Forming, Storming, and Norming Stages, groups reach the Performing Stage and are ready to work. It is at this stage that members are able to benefit from interpersonal learning generated by feedback, imparting of information, imitative learning, and trying new socializing techniques. When group members face terminating with the group (Adjourning Stage), they are forced to recognize the existential reality that while they may not have perceived themselves to have had a choice about entering the group, they did have a choice and responsibility to make good use of the sessions and their relationships with other members. They can see that these realities apply to their various interpersonal relationships outside the group as well. While they cannot control their partners, other family members, friends, or acquaintances, they do have choices in how they respond to them and responsibility for their choices. And like the group, those relationships are also ultimately time limited.

Research on encounter groups identified four major functions fulfilled by a leader that can be seen as corresponding to the five stages of group described above (Waldo, 1985). The leader functions are executive (taking charge, directing), emotional stimulation (evoking feelings, inspiring), caring (providing support and friendship), and meaning attribution (facilitating insight). These functions can be seen as directly relevant to specific group stages, conducive to fostering specific therapeutic factors, and useful in moving groups from one stage to another (Waldo, 1985). For example, the executive function satisfies group members' dependency when a group is in the forming stage and can foster members' experience of universality and hope. Leaders' provision of emotional stimulation can help move a group from the forming stage to the storming stage and generate catharsis. Leaders' provision of caring during the storming stage can generate corrective recapitulation of the primary family group and move groups to the norming stage, fostering cohesion and altruism. By backing off and providing occasional meaning attribution, leaders can help groups take responsibility for their work, resulting in their moving from the norming to the performing stage. Members of a group that is performing will generate feedback, information, modeling, and socializing techniques. Leaders' provision of meaning attribution can facilitate these therapeutic factors and help the group realize existential benefits as it faces termination. This alignment of group stage, leadership functions, and therapeutic factors suggests that effective leadership of interpersonal violence prevention groups will include flexible use of a variety of leadership functions (Waldo, 1987).

Types of Groups Applied to Interpersonal Violence Treatment

Three types of groups are discussed in this section: psychoeducational, counseling, and therapy. When categorizing groups into one of these types, it should be recognized that groups rarely fit exclusively within one category (Waldo & Bauman, 1998). Therapy groups may include psychoeducational procedures, and psychoeducational groups may pursue therapeutic goals. Self-help groups may include both psychoeducational and therapy goals and processes. The problem of categorizing interpersonal violence treatment groups that are reported in the literature is further complicated by authors who describe these groups not having identified the specific group treatment approaches that were used (Gondolf, 1997). Because treatment of individuals who have engaged in interpersonal violence is focused on remediating a serious problem, violent behavior, all group approaches to interpersonal violence may be considered to have a therapeutic goal. The categorization of groups offered below is based on the process typically employed in the group, as follows: psychoeducational groups are dominated by teaching; counseling groups focus on supportive interaction between group members; and therapy groups evoke self-exploration, personal disclosure, and in-depth analysis of intrapersonal problems.

Psychoeducational Groups

The predominant psychoeducational groups in interpersonal violence counseling are feminist/sociocultural educational groups and cognitive-behavioral/skill-based groups (Stover et al., 2009; Wexler, 2000). Many current interpersonal violence treatment models now combine these two (Ceasar & Hamberger, 1989). Some combined groups emphasize sociocultural reorientation (Duluth Model; Pence & Paymer, 1993), while others focus on cognitive-behavioral skills (Feminist Cognitive-Behavioral Treatment [FCBT], Saunders, 2000). For example, techniques such as time-out and positive self-talk were first introduced in anger management curriculums and are now often employed in feminist/sociocultural educational groups (Common Purpose, 1996). In this review, types of psychoeducational groups will be differentiated by their primary focus and approach as follows: The Duluth Model groups are feminist/sociocultural educational groups that focus on confronting individuals (primarily men) on their use of abuse to dominate another, usually women. Duluth Model groups integrate cognitive-behavioral approaches such as positive self-talk (Pence & Paymer, 1993). In contrast, FCBT groups primarily focus on increasing men's respect and equal treatment of women and employ a primarily cognitive-behavioral approach (Saunders, 2000; Stover et al., 2009).

Psychoeducational groups based on a feminist/sociocultural theoretical perspective are the most prevalent type of group today (Wexler, 1999). State guidelines for court-mandated treatment programs for individuals who have committed interpersonal violence often include the feminist/sociocultural treatment model (Gondolf, 1997; Wexler, 1999). The Duluth (Pence & Paymer, 1993) and Emerge (Adams, Bancroft, German, & Sousa, 1992) programs are two of the most popular examples of this type of treatment model. Physical violence and other forms of abuse are viewed as tactics of maintaining power and control in their relationships (Adams et al., 1992; Pence & Paymer, 1993). Individuals who have committed interpersonal violence are held responsible for their behavior and often encouraged to recognize violence as a method of coercion and intimidation (Adams et al., 1992; Pence & Paymer, 1993). Group members are educated about gender socialization, patriarchal beliefs are exposed, and minimization and denial of abuse are confronted by group leaders and group members (Pence & Paymer, 1993). The programs explicitly do not focus on providing therapy for group members (Common Purpose, 1996; Pence & Paymer, 1993).

Strengths cited for the feminist/sociocultural approach include encouraging group members to take responsibility for their abusive behavior and maintaining an environment that challenges rather than colludes with group members' attempts to minimize, deny, and blame others for their violent behavior (Adams, 1994; Pence & Paymer, 1993). The view that violent behavior is learned and socially reinforced suggests the need for reeducation through group treatment (Dobash & Dobash, 1979). Feminist/sociocultural models provide reeducation on gender socialization that leads to the use of power and control through violence in various relationships in life (Stover et al., 2009).

Criticisms of the feminist/sociocultural approach include questioning the value of using extensive confrontation with individuals who are already experiencing shame (Browne et al., 1997; Dutton, 1998). It has been noted that empathetic group leaders of interpersonal violence treatment groups are more effective than confrontational ones and that a confrontational approach may exacerbate resistance (Murray & Baxter, 1997). Others state that failing to provide therapy for apparent psychological and emotional issues related to violent behavior is problematic (Schwartz & Waldo, 1999; Wexler, 1999). Finally, it has been noted that these psychoeducational groups fail to consider other possible causes of interpersonal violence besides social influences (Dutton, 1995).

There are limited outcome data on pure forms of the feminist/sociocultural educational groups. Sheppard (1992) conducted a five-year follow-up study with 100 men who were mandated to a feminist/sociocultural educational group. Sheppard found a 40% recidivism rate. The number of sessions attended and completion of the treatment program did not predict recidivism. The characteristics of the men who committed intimate partner violence, such as chemical dependency issues, a history of abuse as children, and a history of criminal behavior, did predict recidivism. Petrik, Olson-Petrik, and Subotnik (1994) conducted a study on 26 men who completed treatment in feminist/sociocultural educational groups. They found that treatment failed to decrease the men's feeling of powerlessness or to increase their tolerance for being controlled. Gondolf (2000) completed a 30-month follow-up of 402 court-referred men in four cities who attended feminist/sociocultural educational groups. Forty-one percent of the men committed reassault during the 30-month follow-up period. Program dropouts were more likely to have recidivism of violence than participants who completed at least three months of treatment. Two major experimental studies using the Duluth Model that were conducted with random assignment to treatment and control groups (Davis, Taylor, & Maxwell, 1998; Feder & Forde, 2000) showed little to no program effects. In both studies, difficulties in implementing the random assignment of subjects, substantial dropout rates, and relatively low follow-up response rates limited confidence in the results (Gondolf, 2001). Finally, Edleson and Syers (1990) compared three treatment models, a feminist/sociocultural structured education model, a self-help model, and a combination of the two. They found that the educational model was more effective than the self-help model and combined model in reducing violence and terroristic threats at a six-month follow-up.

Programs focused on skill-building or cognitive-behavioral approaches often include a combination of problem solving, anger management, interpersonal skills, stress management/relaxation skills, and empathy (Saunders, 1996). Cognitive approaches target anger as the cause of aggression and focus on the role of cognitive distortions and irrational beliefs as leading to the arousal of anger (Saunders, 2000; Sonkin & Durphy, 1985). Behavioral approaches focus on interpersonal skills, specifically assertive communication (vs. aggressive or passive aggressive) to alleviate an individual's aggression (Holtzworth-Munroe, 1992; Saunders, 2000). Behavioral approaches take advantage of the group format by using role plays of anger management scenarios. These differ from feminist/sociocultural groups (Gondolf, 1990), because they focus on individual-level impulse control as opposed to societal-level gender issues. Cognitive-behavioral/skill-based approaches have been used in couples group counseling with violent couples following completion of group by the male partner (Gondolf, 1997; Guerney et al., 1987). Couples counseling is controversial because of concerns that men will abuse women as a result of the joint sessions (Walker, 1984). The majority of conjoint therapy groups for violent couples follow a cognitive-behavioral framework that is similar to anger management group formats for abusive men (Geffner, Mantooth, Franks, & Rao, 1989).

A strength noted for the cognitive-behavioral/skill-building approach is that it teaches concrete skills that individuals can use to change their behavior (Lawson et al., 2001). In addition, this approach is based on empirically validated principles that have been used successfully to treat other aggressive behavior (Saunders, 2000). One criticism of this approach is the concern that a broader, more comprehensive treatment may be needed to deal with the effects of the early traumas that many abusive men have experienced (Dutton, 1998; Wexler, 2000). Also, concerns have been raised that if this approach is not integrated with a feminist/sociocultural approach, there is a danger of ignoring the social reinforcement for interpersonal violence in society (Pence & Paymer, 1993; Saunders, 2000).

A number of outcome studies have investigated primarily cognitive-behavioral and skill-based groups. Two studies comparing cognitive-behavioral skill-based treatment approaches to no treatment found significantly reduced

recidivism at follow-up for the treatment groups (Dutton, 1986; Waldo, 1988). Dutton found a 4% recidivism rate for those who completed treatment after three years of follow-up and a 40% recidivism rate for a comparable group that did not have treatment. Waldo found 0% recidivism after one year of follow-up for men who completed treatment compared to 20% recidivism for those who were not referred to treatment and 20% recidivism for those who were referred but never engaged in treatment. Studies of cognitive-behavioral and skill-based groups with no comparison or control group demonstrated significant reductions in self and partner ratings of both physical and psychological abuse (Faulkner, Stoltenberg, Cogen, Nolder, & Shooter, 1992; Petrik et al., 1994; Waldo, 1986). In one of these studies, the men also showed significant improvements in their communication skills (Waldo, 1986). Saunders (1996) conducted a comparison study where men were randomly assigned to a Feminist Cognitive-Behavioral Treatment or a Process Psychodynamic Treatment. Men with dependent personalities had better outcomes in a Process Psychodynamic Treatment. Men with antisocial traits, substance abuse problems, and hypomania had better outcomes in the Feminist Cognitive-Behavioral Treatment group. These findings suggest that the Feminist Cognitive-Behavioral Treatment may provide the structure and skill training needed for antisocial, hypomanic, and substance abuse problem groups. Finally, Saunders found that the Feminist Cognitive-Behavioral Treatment led to increased relationship satisfaction, possibly due to the focus on communication skills. An early study of interpersonal violence treatment among adolescents evaluated a cognitive-behavioral and skill-based group approach (Miller, 1995). Miller studied the impact of a ten-week program with both African American and Caucasian male and female participants aged thirteen to eighteen. The results showed potential but further study and longitudinal follow-up is needed to determine generalized applicability.

Group Counseling

Group counseling for individuals who have committed interpersonal violence typically takes the form of minimally structured self-help groups. Members usually define the topics covered and former members often facilitate the meetings (Edleson & Syers, 1990). Goffman (1980) developed a self-help group titled Batterers Anonymous, which follows a 12-step model similar to Alcoholics Anonymous. The support and identification with other group members available in counseling groups have been hypothesized to be important factors in creating change in abusive men (Jennings, 1987; Waldo, 1987). The unstructured counseling group provides an environment that facilitates new skill development in an atmosphere where new skills can be practiced and transferred to the other environments (Gondolf, 1987; Jennings, 1987).

Jennings (1987) and Wexler (1999) cited the benefits of men helping other men overcome violence in an environment of support as a strength of self-help group counseling. Criticisms include a lack of focus on confrontation and education of men to take responsibility for their abusive behavior (Dobash & Dobash, 1979; Pence & Paymer, 1993).

There are few outcome studies on self-help counseling groups. In one outcome study, Edleson and Syers (1990) found that self-help groups were not as effective in reducing violence and terroristic threats at six-month follow-up as feminist/sociocultural educational groups.

Therapy Groups

Theories that explain interpersonal violence, specifically intimate partner violence, as a reaction to childhood trauma led to the creation of a Process-Psychodynamic Treatment (PPT) model (Browne et al., 1997; Jennings, 1987; Saunders, 1996). This is a minimally structured model that assumes that therapy happens through the process of supportive, nondidactic group relationships (Jennings, 1987). The leaders create a supportive environment, which decreases isolation and allows individuals to explore the childhood roots of sex-role expectations and shame-based behaviors, reexperience childhood traumas, grieve their losses, give up control over others, learn to empathize with others, increase their emotional investment in others' welfare, and increase their capacity to express feelings directly and responsibly (Browne et al., 1997).

Psychodynamic process groups are the most common types of therapy groups for individuals who have committed interpersonal violence. Other types of therapy groups focus on the attachment deficits of individuals who have committed interpersonal violence. Self-psychology groups (Wexler, 1999) are based on the belief that men who have committed intimate partner violence did not have sufficient "mirroring self-objects" (p. 137). Treatment is focused on addressing psychological issues and offering respect for the group members' feelings of powerlessness and emotional injuries resulting from their primary relationships. The Compassion Workshop (Stonsy, 1995) is a therapy group format based on the idea that most men who have committed intimate partner violence cannot sustain attachments. Group activities and homework focus on developing compassion for the self. Finally, solution-focused therapy groups (Lee, Greene, Uken, Rheinscheld, & Sebold, 1997; O'Hanlon & Weiner-Davis, 1989) are based on focusing on the strengths and resources of the individuals rather than on problems and deficits.

Strengths cited for the therapy group approaches include the benefits individuals derive from creating relationships and learning to nurture one another (Jennings, 1987; Waldo, 1987). Jennings (1987) believes that therapy groups can help individuals develop self-help skills, learn tolerance and patience, feel emotional safety, and experience mutually supportive relationships. Therapy groups are also believed to aid individuals in the expression of shame and related emotions (Wallace & Nosko, 1993). Feldman and Ridley (1995) pointed out that most groups primarily focus on violent behavior rather than broader issues, including self-esteem, personality disorders, and depression. Therapy groups are more likely than sociocultural psychoeducational groups or self-help counseling groups to address the attachment issues, relationship insecurities, and personality disorders that research suggests are related to abuse (Babcock, Waltz, Jacobson, & Gottman, 1993; Dutton, 1999; Holtzworth-Munroe & Stuart, 1994). Browne et al. (1997) suggested that unstructured process groups can respond more flexibly to the needs of group members. Criticisms of the therapy group approach have been made by proponents of feminist/sociocultural groups. They believe that the psychodynamic groups create an atmosphere of collusion rather than a group atmosphere that confronts abusive behavior (Pence & Paymer, 1993). Furthermore, concerns have been raised that a supportive and empathic group environment may reinforce rationalization of interpersonal violence and that the therapy groups may take too long to change violent behavior (Adams, 1994). There have been few outcome studies on therapy groups. In one study, Saunders (1996) found that men with dependent personalities had better outcomes in a Process-Psychodynamic Treatment group.

Integrated Treatment

A small number of studies have attempted to integrate group treatment approaches (Lawson et al., 2001; Saunders & Hanusa, 1986). Lawson et al. (2001) integrated feminist, cognitive-behavioral, and psychodynamic approaches. Saunders and Hanusa combined cognitive-behavioral and counseling approaches. Potential strengths of integrated treatment approaches include their ability to address the multifaceted issues that contribute to violent behavior and their ability to create new treatment models based on existing research and theory (Carden, 1994; Lawson et al., 2001). Criticisms of integrated approaches focus on the lack of theoretical rational for integration (Gondolf, 1987). The two studies cited above evaluated integrated treatment approaches they employed and found them to be moderately successful in curtailing violence and issues related to violent behavior (Lawson et al., 2001; Saunders & Hanusa, 1986). The idea of integrative treatment to deal with the multidimensional problem of interpersonal violence appears to be gaining in popularity in the literature (Carden, 1994; Gondolf, 1987; Lawson et al., 2001).

Problems with Research on Treatment of Interpersonal Violence

There are two major problems that make conducting research with individuals who have engaged in interpersonal violence difficult: measurement problems and group attrition. There are three types of data that can be collected to measure the effectiveness of interpersonal violence treatment groups: self-report from the group participants, reports from the participants' victims or those engaged with the participants in a pattern of interpersonal violence, and police/court information. There are problems with each of these sources of data (Gondolf, 1997). The motivation to stay out of trouble and not to violate probation may result in individuals and their partners, family members, or friends not providing follow-up data or underreporting instances of interpersonal violence (Tolman & Bennet, 1990). The people most likely to be responding at follow-up are individuals with positive outcomes, potentially biasing results in a positive direction (Gondolf, 1997; Moffit et al., 1997). Furthermore, utilizing police or military arrest reports may underestimate actual recidivism rates due to inconsistencies in the responses to violence by legal systems (Tolman & Bennet, 1990). Finally, few studies have used outcome measures other than incidents of physical violence. More comprehensive and detailed information needs to be gathered on psychological abuse, threats, and measures of successful behavior (positive caring behavior, increased communication, relationship equality) (Gondolf, 1997; Rosenfeld, 1992).

Second, it has been hard to evaluate the effectiveness of interpersonal violence treatment because of high attrition rates from groups for those who have committed intimate partner violence (Hamberger, Lohr, & Gottlieb, 2000). A number of outcome studies have demonstrated that up to half the participants involved in group treatment drop out before the completion of the group (Edelson & Syers, 1990; Gondolf & Foster, 1991). High attrition results in a limited and potentially biased sample (Hamberger et al., 2000). Studies of individuals who drop out of group could help explain why they are dropping out and what can be done to influence them to stay.

Suggestions for Practice and Research

Practice

There is limited definitive information on the causes of interpersonal violence and even less information on the effect of groups to prevent it. Given this dearth of knowledge, suggestions for best practices in interpersonal violence prevention groups should be viewed as tentative and subject to revision as new information becomes available. Based on the information that is available, the following best practice suggestions seem reasonable at this time:

1. Potential group participants should be screened based on the nature and extent of their violence, with more serious offenders receiving more intense and carefully controlled treatment.
2. Group participants should receive a thorough orientation to the group that focuses on increasing their motivation and solicits their understanding and agreement regarding the group's process and goals.
3. Groups should focus on therapy as opposed to punishment. Perpetrators of interpersonal violence need to be held accountable for past and (especially) future violence by law enforcement and the courts. Groups should focus on helping participants achieve positive change.
4. To meet the varying needs of participants, groups should address a variety of topics and employ a variety of approaches, generating a variety of therapeutic factors. Topics should include potential societal, attitudinal, family of origin, psychological, systemic/cyclical, substance abuse, and situational factors that may contribute to violence, and knowledge, attitudes, and skills that counter violence. Psychoeducational, counseling, and therapy approaches should be used, including lectures, video presentations, reading, homework, in group processing, intermember feedback, and skill practice activities.
5. Assessment of group members' progress should include acquisition of knowledge, attitudes and skills that counter violence, abstinence from violence, and improvement in relationship quality. Assessment should include participant self-report, victim report, and legal records.

Research

There really is no area related to group work for prevention of interpersonal violence that could not benefit from additional research, including the five best practice recommendations listed above. In particular, additional research needs to be done on retaining members of interpersonal violence treatment groups. Evidence suggests that individuals who drop out of treatment have higher recidivism rates than those who complete treatment (Dutton, Bodnarchuk, Kropp, Hart, & Ogloff, 1997). Research has investigated client characteristics and system and treatment variables that affect completion, including age, education/employment, court-mandated status, ethnicity, and minority group status (Gondolf & Foster, 1991; Hamberger et al., 2000; Rondeau, Brodeur, Brochu, & Lemire, 2001; Tolman & Bennet, 1990; Williams & Becker, 1994). Hamberger et al. (2000) found that personality variables are particularly important, with paranoid personality characteristics predicting early dropout and borderline personality characteristics predicting late dropout. Studies have found that structured pregroup orientations can be successful in increasing completion rates (Tolman & Bhosley, 1990). Taft, Murphy, Elliott, and Morrel (2001) found success utilizing motivational enhancement therapy to reduce low session attendance and high dropout in group counseling for men involved in interpersonal violence. Rondeau et al. (2001) found that a therapeutic alliance between the client and therapist was the strongest variable in predicting if individuals would complete treatment. Taft et al. found that supportive and personalized communication from the therapist was especially effective in retention of minority group members. Williams and Becker (1994) suggest the need for interpersonal violence programs to improve their level of cultural competence and preparation for working with culturally diverse clients to reduce dropout rates among minority groups. These areas need further study.

Also, additional research needs to be done addressing recidivism of interpersonal violence among those individuals who complete treatment (Holtzworth-Monroe, Beatty, & Anglin, 1995). There are problems with accurately measuring recidivism because of inconsistencies in reporting from legal systems, individuals and their partners, family, or friends minimizing the extent of violence, and group members not providing follow-up information (Edleson & Syers, 1990). Even though recidivism is probably underreported, Hamberger and Hastings (1990) found that between 25% and 50% of men who attended intimate partner violence treatment were reported in outcome studies to be violent during follow-up periods of six months to two years. Gondolf (2000) conducted a 30-month follow-up study of four treatment centers and found that the majority of recidivism happened in the first six months of treatment. Recidivism steadily decreased during the 30-month follow-up period. These findings suggest that treatment may have a cumulative impact and that the small minority of individuals who are the most violent may need alternative treatment.

Research is also needed on how community court systems and treatment centers can hold individuals who have engaged in interpersonal violence accountable through strong and consistent legal repercussions for failure to complete treatment and/or reoccurrence of abuse (Murphy et al., 1998). Mandated long-term treatment in maintenance groups (similar to those used in substance abuse programs) would allow extended follow-up assessment and provide participants with ongoing support (Myers & Salt, 2000). Communities need to carefully coordinate the activities of treatment programs, legal authorities, and police advocates (Murphy et al., 1998). It is also critically important for communities to focus on the safety of persons who were abused or assaulted, providing them with counseling and support groups (Gerlock, 1997; Jacobson, 1994).

Finally, treatment and research could be advanced through improved assessment of the multifaceted causes of violent behavior (Lawson et al., 2001). It is important to address those causes through treatment approaches that are most likely to meet the individual's needs (Holtzworth-Munroe et al., 1995; Saunders, 1996). There is also a need for new and innovative treatment approaches.

Conclusion

Interpersonal violence appears to be a multifaceted problem, which calls for multifaceted approaches to treatment. Groups offer multiple benefits (including empirically identified therapeutic factors) that can address the multifaceted causes of abuse. There are no definitive findings on what kind of group is most effective (psychoeducational, counseling, therapy). Limited outcome research on group treatment has demonstrated positive results in reducing recidivism, but recidivism remains high. Limited research suggests that integrated approaches to treatment will be most effective (Lawson et al., 2001), and that matching the characteristics of individuals who have committed interpersonal violence to treatment approaches could increase treatment effectiveness (Saunders, 1996). There is also some evidence that recidivism rates could be further reduced by identifying the minority of individuals who are most violent and providing them with specialized services (including ongoing monitoring) (Gondolf, 2000).

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Chapter 34 Group Work with Offenders and Mandated Clients

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Resistant, difficult, full of attitude, and hostile: all words that have been used by mental health professionals to describe mandated clients. It should be no surprise that these clients often evoke negative reactions from practitioners (De Jong & Berg, 2001). In addition, corrections (jail, probation, prison, parole) is a unique environment in which to maintain a career (Hawk, 1997), a reality experienced by mental health providers, including group therapists. In fact, due to the uniqueness of working with offender and mandated clients, a common mantra from correctional mental health professionals is, "If you can facilitate groups in here, you can facilitate groups anywhere." Offender groups present problems not typical of therapy groups in other settings (e.g., a perceived lack of institutional support, confidentiality and client safety issues, a lack of supervision; Morgan, Steffan, Shaw, & Wilson 2007; Morgan, Winterowd, & Ferrell, 1999). Although, there remains a paucity of empirical studies examining group treatment strategies with offenders and other mandated clients (Cameron & Teifer, 2004; Morgan, Flora, Kroner, Mills, Varghese, & Steffan, 2012; Riordan & Martin, 1993), group psychotherapy with offenders, including mandated clients, results in positive treatment gains across a range of clinical and criminal justice outcomes (e.g., Morgan & Flora, 2002). The purpose of this chapter is to review effective strategies for group work with offenders and mandated clients, including identification of treatment goals, and best group therapy practices for these populations.

It should be noted that for purposes of this chapter, the term *offender* refers to people involved in the criminal justice system and includes both incarcerated (i.e., housed in a secure correctional environment) and nonincarcerated (i.e., parole, probation) offenders, whereas *mandated clients* refer to clients required to attend treatment services by a governing agency (e.g., a department of corrections, the judicial system, parole/probation officers). In addition, although the term offender is used for reader convenience and to be consistent with the corrections literature, in a therapeutic setting, this term would be pejorative and stigmatizing.

The Necessity of Groups in Corrections

Given the high demand for mental health services in corrections and the staggering ratio of mental health service providers to offenders (e.g., Bewley & Morgan, 2011; Boothby & Clements, 2000) utilizing group therapy is a more time- and cost-efficient method of providing needed mental health treatment when compared to individual therapy (Sawyer, 2002). In spite of group services demonstrating effectiveness, offenders generally continue to prefer individual therapy services to group services (Morgan, Wilson, & Rozycki, 2001). Consequently, only approximately 20% of incarcerated populations participate in group treatment programs (Morgan et al., 1999) and approximately one-half of all offenders receiving mental health services (either voluntarily or mandated to attend) participated in group services (Morgan, et al., 2001). Although it may seem unlikely that incarcerated offenders would choose to attend therapy, among those diagnosed with a severe mental illness most offenders voluntarily receive services, while only approximately 10% are mandated to mental health services (Bewley & Morgan, 2011). It is important to note that a meta-analytic review of group therapy programs found that inmates referred and mandated to attend group mental health services "fared no better or worse" (p. 214) on general mental health outcomes than inmates who volunteered for services (Morgan & Flora, 2002). That is, mandated clients were just as successful as voluntary offenders suggesting that policy makers, correctional administrators, and judges should continue to refer inmates to group treatment programs as an alternative to punitive sentences (e.g., incarceration without rehabilitative services) because it is clear that treatment is significantly more effective than punishment alone (Andrews, Zinger, et al., 1990; Gendreau, Goggin, French, & Smith, 2006). Group treatment is a viable treatment option with the potential to reach a larger number of offenders and/or mandated clients, but just how effective is group treatment?

Historically, treatment outcome research on group work with offenders and mandated clients has been plagued by inconsistent findings; however, group therapists perceive their services as effective (Morgan et al., 1999) and empirical reviews corroborate therapists' reports. Specifically, the results of a meta-analytic review of 26 studies (from an initial sample of 238 published studies) that met the criteria for meta-analytic review provided compelling evidence regarding the utility of group psychotherapy with offender and mandated populations (Morgan & Flora, 2002). Specifically, positive treatment effects from group psychotherapy with incarcerated offenders were found across all outcomes assessed in the review, including institutional adjustment (Mean Effect Size [ES] = 0.43), anger (Mean ES = 0.45), anxiety (Mean ES = 0.94), depression (Mean ES = 0.57), interpersonal relations (Mean ES = 0.36), locus of control (Mean ES = 0.64), and self-esteem (Mean ES = 0.31). The results of this meta-analysis also indicated that the use of homework significantly improved outcomes. In addition, there tended to be improved outcomes when cognitive-behavioral strategies and a mix of structured and unstructured group formats were utilized. Similarly, sex offender groups were at least as effective as individual services and appear to offer advantages over an individual treatment modality, such as offender's benefitting from shared experiences, improving interpersonal skills, assistance in coping with stigma and being challenged by other offenders (Ware, Mann, & Wakeling, 2009). Thus, the efficacy of group treatment for offender and mandated clients is no longer of question. But what group format is best?

Formatting Groups with Mandated Clients

As previously mentioned, when examining types of offender groups, research indicates that the most favorable results occur when cognitive-behavioral or behavioral approaches are incorporated into rehabilitation treatment programs (Andrews, Zinger, et al., 1990; Garrett, 1985; Gendreau & Ross, 1981) and when there is increased group structure (e.g., Jennings & Sawyer, 2003; Leak, 1980; Morgan & Flora, 2002). Given the importance of these factors, psychoeducational groups may be a preferable treatment modality for group work with offenders and mandated clients. Notably for this population, the structure provided in psychoeducational groups may provide direction and focus in early group sessions that are less prevalent in other types of group work (i.e., group counseling, group psychotherapy). This is particularly relevant for offender and mandated clients because they are frequently resistant to the therapeutic process (Milgram & Rubin, 1992; Rappaport, 1982) and may actively pursue efforts to avoid engaging in treatment (Riordan & Martin, 1993).

In both counseling and psychotherapy groups, cognitive-behavioral therapy appears to lead to the best results for offenders broadly (Andrews, Zinger, et al., 1990; Morgan & Flora, 2002); however, it has been argued by some that cognitive-behavioral therapy may not be the most effective group therapy approach for some offender types (see Cameron & Teifer, 2004, for an in depth review). Counseling groups may include institutional adjustment and vocational groups in addition to standard counseling groups (e.g., relationship enhancement). In fact, the social support received from counseling groups may allow incarcerated offenders to cope with the circumstances and problems of incarceration (Mathias & Sindberg, 1986). One distinction between counseling groups and therapy groups is the emphasis on the “here-and-now” in group therapy, with a focus on the dysfunctional interactions as they occur within the group (Yalom, 1995). A “here-and-now” focus is particularly relevant for offender and mandated therapy groups because these clients are often unaccustomed to dealing with difficult interpersonal interactions directly, responsibly, and prosocially. “Here-and-now” focus allows these clients, often for the first time, to examine their behavior, examine the effect of their behavior on others, and finally the interpersonal consequences of the effects of their behavior on others with regard to how they are subsequently treated (see Morgan & Winterowd, 2002, for a review of implementing Yalom's process-oriented group psychotherapy with offenders and mandated clients). For example, the lead author once processed the effect on group interaction when an offender fell asleep during group session. The offending client (no pun intended) erroneously believed that other group members did not care what he did in group and was surprised to learn that other group members felt disrespected and disappointed in his lack of commitment to the group. His behavior changed, not because he was told to stay awake by the lead author, rather because he learned that his behavior negatively affected his peers (the outcome was undesirable for him). This “here-and-now” focus is often new for offender and mandated clients and can lead to significant insights and behavioral change. Simply stated, group to include group cohesiveness, expressiveness of members, and leadership within the group is just as relevant in offender and mandated client groups as it is in nonoffender and mandated therapy groups (Marshall & Burton, 2010).

In reality, the distinction between the differing types of groups is ambiguous with much overlap (Corey, 1995; Gazda, Ginter, & Horne, 2001) and group therapists may find themselves frequently switching approaches. It is not uncommon during a group psychotherapy session that a therapist may need to educate group members about various issues. For example, the authors of this chapter frequently maneuver from a psychotherapy group to a more psychoeducational approach when leading a group for offenders with mental illness when teaching terminology to increase mental illness awareness, symptom management, and to improve communication about mental illness. This appears particularly relevant for group therapists working in corrections whereby practitioners provide services aimed at multiple and varied presenting problems with heterogeneous offender populations (Boothby & Clements, 2000). Although offenders may present with a number of different problems, therapist interventions tend to target specified treatment goals, including engaging in self-exploration and insight, exploring group relationships, exploring substance abuse, learning healthy behaviors and attitudes (e.g., conflict resolution), increasing rule compliance, improving prosocial behavior, improving general lifestyle (e.g., career issues or diet), and institutional adjustment, if incarcerated (Bewley & Morgan, 2011; Morgan, Garland, Rozycki, & Reich, 2005; Winterowd, Morgan, & Ferrell, 2001). Several of these goals are not unique to group work with offenders

or mandated clients; however, several of these factors (i.e., prosocial behavior modification, conformity issues, and institutional adjustment issues) are unique to group work with these special populations. More importantly, these group goals are consistent with known criminal risk factors of offenders (Andrews & Bonta, 1994; Andrews, Bonta, & Hoge, 1990) and critical to effective treatment programming (Gendreau et al., 2006). Furthermore, these group goals can provide a framework and structure to the therapeutic milieu, which may be preferred by both inmates and group facilitators.

Evidenced-Based Practices for Group Therapy with Offenders

We now know that group therapy works for offenders and group therapists generally discuss similar topics during group sessions. However, the necessary therapist strategies and techniques for effective groups are less clear, but utilizing the essential components of group treatment programs that have worked and understanding the general treatment needs of offenders will allow for the identification of best practices for the enhancement of group therapy outcomes. Evidence shows favorable results for treatment programs that (a) incorporate the Risk-Need-Responsivity model of offender intervention, (b) utilize cognitive-behavioral therapy (CBT), (c) include at least some structure in the therapeutic environment, and (d) require homework. Below we outline each of these practices.

Risk-Need-Responsivity

To yield the best potential outcomes for offenders, treatment programs, including group interventions, must incorporate the Risk-Need-Responsivity (R-N-R) model of service delivery (Andrews, Bonta, et al., 1990). R-N-R is a guide to effective interventions and is rooted in an abundance of empirical data.

According to the Risk principle, the intensity of the therapy group (e.g., frequency, duration) should be matched to the risk of the offender (i.e., high risk offenders receive high intensity services; Andrews, Bonta, et al., 1990). In general, more intensive services yield the best outcomes (see Aytes, Olsen, Zakrajsek, Murray, & Ireson, 2001; Bourgon & Armstrong, 2005), but again they should be reserved for those offenders classified as higher risk. Understanding the risk level of group members will allow a group therapist to appropriately decide how many times per week to meet, the length of each session, and how many sessions will be necessary for successful completion of group treatment. In general, intensive services should span a minimum of 3 months (Gendreau, 1996).

According to the Need principle, for treatment to be effective it has to be tailored to the unique treatment needs of the group members (Andrews, Bonta, et al., 1990). Thus, it is important to not only address the offenders' presenting concerns but also dynamic or changeable criminal risk factors (i.e., antisocial personality, criminal thinking, criminal associates, family and marital dysfunction, poor school and work achievement, absence of prosocial leisure and recreational activities, substance abuse). These dynamic risk factors, if left unchanged, will continue to predispose offenders to criminal involvement (for a more detailed review, see Andrews & Bonta, 2006). Integrating these risk factors as treatment foci will be discussed in greater detail below.

Last, the Responsivity principle states that the services delivered needs to match the learning styles and ability of the group members (Andrews, Bonta, et al., 1990). Group therapy needs to be engaging for the offenders in the group, and simplified to allow for group members with a limited educational background to participate in group discussions and complete corresponding assignments related to the group material. In addition, strategies taught in group must be overlearned so they become a natural instinct that replaces former antisocial instincts when the offender confronts real-world problems (Morgan, Kroner, & Mills, 2006). Without matching services to the learning style of the group, group members may not fully benefit from the treatment program and disengage with the program and potentially become disruptive to the therapeutic process (see Morgan & Winterowd, 2002).

Cognitive-Behavioral Theory

Group treatment programs that utilize CBT interventions yield more positive results when looking at recidivism (e.g., new arrests/convictions, return to incarceration) and mental health outcomes (Friendship, Blud, Erikson, Travers, & Thornton, 2003; Morgan & Flora, 2002). CBT approaches and strategies appear to increase offender responsivity to treatment by maximizing their ability to learn (cognitive) and applying what they learn to change their behavior by addressing the unique treatment needs of offenders with minimal adaptation. For example, cognitive-behavioral theory emphasizes relapse prevention, improving cognitive strategies for dealing with stressful situations (Henning & Frueh, 1996) and developing problem-solving skills (Zamble & Porporino, 1988) all of which are essential when working with offenders. The unmatched efficacy of CBT-based programs may also be attributed to the emphasis placed on challenging and altering (e.g., cognitive restructuring) maladaptive cognitions (i.e., antisocial attitudes) as one of the primary factors sustaining a criminal lifestyle (Andrews & Bonta, 2006).

Structure

Structured group treatment yields more favorable results when compared to unstructured (e.g., psychodynamic approaches) group treatment programs (Leak, 1980; Morgan & Flora, 2002; Pomeroy, Green, & Kiam, 2001; Saunders, 1996). Structure can be increased in group work by defining a specific set of rules and expectations within the group, having clearly defined treatment goals, and developing concrete learning objectives and tasks for each group meeting. The group therapist also serves as an agent of structure by strictly adhering to the expectation,

rules, and goals established at the outset of treatment.

Homework

Out-of-group exercises (homework) improve outcomes for offenders and, likely, mandated group members (Morgan & Flora, 2002). Therefore, group facilitators should incorporate homework that extends the learning, strategies, or techniques into the group member's real-world to ensure that learned strategies are overlearned so they become the de facto response and replace former antisocial responses to real world problems (Morgan et al., 2006). Not surprisingly, compliance is essential for homework effectiveness. Notably, a recent study found that public commitment (i.e., the therapist asks the group members to publically commit to each other to complete the assignment) and modeling (i.e., the therapist completes a similar assignment during group to demonstrate how to complete the homework) were useful in enhancing homework compliance and quality (McDonald & Morgan, in press). In addition, homework can often be used to facilitate group process and address criminal thinking directly as seen in Case Study B.

Offenders and Comorbidity

Group therapy with offender populations is complicated by issues of comorbidity—not the traditional mental illness and substance comorbidity but issues of mental health concerns and criminality. Persons with mental illness are overrepresented in the criminal justice system as current estimates posit that 14.5% of incarcerated males and 31% of incarcerated females in jail have a serious mental illness (Steadman, Osher, Robbins, Case, & Samuels, 2009). Major disorders occur up to four times more frequently in inmate populations (Hodgins, 1995), as mentally ill individuals are at increased risk of being arrested and incarcerated compared to those who have no mental illness. In fact, persons with mental illness are three times more likely to be incarcerated than hospitalized in a psychiatric facility (Munetz, Grande, & Chambers, 2001; Teplin, 1984, 1990). Furthermore, individuals involved in the criminal justice system with mental disorders often have multiple Axis I diagnoses in addition to substance abuse. A meta-analysis on the prevalence of mental illness in prison populations found that up to 15% of offenders had four to five comorbid mental health diagnoses (Sirdifield, Gojkovic, Brooker, & Ferriter, 2009). Given these findings, what are the clinical needs for this population? Recent findings indicate we are treating an offender and a person with mental illness. That is, offending behavior and mental illness are comorbid problems.

Morgan, Fisher, Duan, Manaracchia, and Murray (2010) found that incarcerated persons with mental illness displayed similar levels of criminal thinking when compared to offenders without mental illness, and comparable psychiatric presentations to persons with mental illness who were not justice involved. Additionally, Wolff, Morgan, Shi, Fisher, and Huening (2011) found similar results but indicated that those with severe mental illness, compared to those without severe mental illness, displayed higher levels of criminal thinking. Results from these studies provide important information regarding the concurrent presence of mental illness and criminal thinking/antisocial attitudes in incarcerated PMI. Thus, it appears that persons with mental illness are not simply criminals because they are mentally ill, but criminals who happen to also have a mental illness (Morgan et al., 2010).

Correctional mental health professionals serving incarcerated persons with mental illness focus primarily on mental health symptomatology at the cost of reducing criminal risk (Bewley & Morgan, 2011). Yet we now know that even evidence-based mental health treatment programs fail to reduce criminal behavior (see Calsyn, Yonker, Lemming, Morse, & Klinkenberg, 2005; Morrissey, Meyer, & Cuddeback, 2007). However, group treatment programs for offender populations also cannot ignore the mental health issues. The goal of correctional interventions for incarcerated persons with mental illness must focus on dual issues of criminality and mental health (Draine, Salzer, Culhane, & Hadley, 2002; Hodgins et al., 2007; Morgan et al., 2010).

Case Study A: Identifying Links to Criminal Behavior

Group therapy with offenders and other mandated clients is most effective when the treatment reaches out into their everyday world (which is likely why homework improves outcomes as previously discussed). Beyond empirical assessment of group therapy outcomes (see Chapter 14), when we see our group work impacting everyday decisions, that is when we know we are having a positive effect. Whether collectively or individually, when offenders think about prosocial behavior outside of the group setting, positive change is possible. In a recent group emphasizing recognition of criminal behavior (among other treatment targets), offenders were allotted a one-day furlough from their residential treatment center. During the furlough, some of the group members visited a local fast food restaurant to eat together. To save money, one group member requested water and was provided a clear plastic water cup. Although it appeared as if he was making a wise financial decision (therapeutic progress in and of itself), in actuality he requested water to receive a free cup that he promptly filled with a clear soda (Sprite). He was demonstrating his criminal behavior in the form of theft.

Notably, while filling his cup with soda, the fellow group members in attendance promptly labeled his behavior as criminalness (the verbiage used in the group to label all antisocial behavior) and challenged him to alter his behavior. Although it is unknown if the offender did in fact alter his behavior, it was notable that group members recognized criminal behavior even in a rather benign situation (benign relative to their criminal pasts) and challenged for behavioral change in the real-world environment.

At the next group session, those group members who were present reported the offending behavior. The therapist, utilizing interpersonal process-oriented strategies, elicited discussion that labeled the offending behavior as criminalness and more importantly identified the criminal thinking (cognitive processes that support and maintain a criminal lifestyle, the presence of which significantly increases risk for continued criminal behavior) that preceded the offending behavior. Importantly, they were also able to identify how small, seemingly inconsequently behavior may actually contribute to and perpetuate their overall criminal behavior and perspective in life. Perhaps most importantly, they were actually able to identify the behavior, were excited to do so, and enjoyed a subsequent discussion of the behavior. This discussion, in a traditional interpersonal process-oriented approach to group therapy took the form of "here is your behavior, this is the effect of your behavior on you and others, are you satisfied with this effect, and, if not, how are you going to change your behavior?" The therapist in this case positively reinforced group participants for their ability to identify criminalness and the greater impact of even minor offenses for perpetuating a lifestyle of criminality. Most importantly, however, was that group members provided reinforcement (and some punishment) to one another, which clearly displayed their expanding set of skills.

Case Study B: Homework

Therapist: Today I'd like to do something a little different. I've noticed that recently some members have not been doing their homework, and other group members appear unhappy about it. I'd like everyone who is willing today to publically say that they will do their homework for the next group.

Clients A, B, C: I am willing to do it.

Client D: (said angrily) I don't understand why we are talking about this. We know we have to do the homework, it's that simple!

Client E: I don't feel like doing my homework so I'm not going to say it.

Client C: (said calmly) Ryan, you have to do your homework like the rest of us. You may not want to do it now, but it will help you later.

From here, the therapist has a number of ways to directly intervene and process what group members are thinking and feeling. Depending on how other group members react and previous patterns noted, the therapist can choose to (a) address Client D's apparent anger toward people not doing what he or she wants, (b) address Client E's disregard for homework itself and connect this to educational or vocational issues, or (c) positively reinforce Client C's behavior. What might the group therapist actually say?

As the therapist, instead of focusing on the act of completion of homework, we suggest focusing on the group interactions. Primarily, providing positive feedback to Client C while discussing how Client C's interaction is different than the other members of the group, the therapist can discuss how others are likely to respond. Additionally, Client E can be brought into the discussion by being asked how he responds whenever he is told what to do. The benefits and consequences of this mode of behavior can be discussed. By bringing together the interaction styles of Clients D and E, offenders can learn how these patterns of behavior inevitably lead to conflict and that only changing patterns of behavior will get them what they want.

Conclusion

In brief, there is little doubt that group therapy with offenders is at least as effective as individual therapy for improving general mental health outcomes. By providing best practices through the R-N-R model, a group therapist can expect treatment gains from these often resistant clients; however, it is less clear how these gains translate to reduced criminal involvement (i.e., desistence from crime). Much more research is needed to assess how group therapy contributes to the rehabilitative process, with specific focus on crime reduction. It is important to improve general mental health outcomes, but it is imperative that we also contribute to offender rehabilitation.

Although we provide a summary of group therapy research and best practices for treating offenders and mandated clients in therapy groups in this chapter, a group therapist working with this population must be prepared to tackle issues that are described in several other chapters in this *Handbook* (e.g., substance abuse, mental illness). It is also worth noting that although CBT approaches and strategies lead to more favorable outcomes, an interpersonal process approach remains an important therapeutic approach with offenders and mandated clients. Regardless of the topic being discussed or taught in group, an effective group therapist can always relate the discussion back to the impact that the topic has on the offender's criminal behavior and thus most likely be targeting one of the factors that places the offender at risk for repeated criminal behavior (e.g., poor interpersonal functioning, avoidance of responsibilities, avoidance of prosocial expectations).

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Chapter 35 Group Psychotherapy and Insecure Adult Attachment

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Insecure attachment has been related to problems throughout the life span, including difficulties adapting to preschool (Sroufe, 1983), adjusting to college (Kenny, 1987; Lapsley & Edgerton, 2002; Marmarosh & Markin, 2007), maintaining adult romantic relationships (for review of 41 studies see Mikulincer & Shaver, 2007), choosing a career (O'Brien, 1996), satisfaction with work (Hazan & Shaver, 1990), fulfillment in marriage (for a review of 58 studies see Mikulincer & Shaver, 2007), coping with childbirth (Simpson, Rholes, Campbell, Tran, & Wilson, 2003), adjusting to parenthood (Simpson & Rholes, 2002), and aging and bereavement (Juri & Marrone, 2003; Shear et al., 2007). Mikulincer and Shaver (2007) reviewed the attachment literature and report that there are more than 100 studies that have explored the relationship between adult insecure attachment and symptoms of anxiety and depression. It is fair to say that counselors and mental health practitioners will work with many people who have insecure attachment styles, and attachment theorists are applying attachment theory to the treatment of insecure attachments and the many symptoms that co-occur.

Attachment based treatments have been applied to individual counseling/therapy (Fosha, 2000; Holmes, 1996; Wallin, 2007), psychoanalytic treatment (Bowlby, 1988; Cortina & Marrone, 2003; Fonagy, 2001), couple psychotherapy (Johnson & Whiffen, 2003), family psychotherapy (Hughes, 2007), eating disorder treatment (Tasca, Ritchie, & Balfour, 2011), and substance abuse treatment (Flores, 2004). Almost all these interventions emphasize the importance of the therapist/counselor identifying clients' attachment organizations and how these attachments relate to symptoms, coping style, interpersonal relationships, and the therapy process. The major premise of attachment theory is that the therapist/counselor, similar to a primary caregiver, acts as a secure base that provides the client (individual, couple, or family) a new relational experience that contradicts earlier attachment failures. The clinicians almost always emphasize empathy, attunement to deep emotional experiences in the here-and-now, active listening and engagement, openness, and curiosity. Clinicians focus on both verbal and nonverbal interactions, the tracking of underlying emotions, and enactments of attachment related issues. The goal of counseling is the ability to sustain intimate relationships, the ability to regulate emotions in productive ways, and the ability to feel better about oneself regardless of the situation, with increased self-esteem.

Although there have been some empirical support for group treatments based on attachment for eating disorders (Tasca, Taylor, Bissada, Ritchie, & Balfour, 2004; Tasa, Ritchie, et al., 2006; Tasca, Balfour, Ritchie, & Bissada, 2007), borderline personality disorder (Bateman & Fonagy, 2003; Ogrodniczuk & Piper, 2001; Wilberg & Karterud, 2001; Wilberg et al., 2003), depression (MacKenzie & Grabovac, 2001), and post-traumatic stress disorder (Schnurr et al., 2003), there has been little written about the overall application of attachment theory to group counseling and psychotherapy (Marmarosh, 2009). Kilmann and colleague's (1999) were one of the few to develop the first published manualized attachment focused group treatment and compare their treatment to another form of group therapy. They found that group participants in the attachment focused treatment reported higher self-esteem, less anger, and greater management of emotions (Kilmann Urbaniak, & Parnell, 2006). Although Kilmann and colleagues (1999, 2006) found empirical support for their attachment based group treatment, few have written about or studied their manualized group intervention. Most of the literature has focused on how diverse group treatments (cognitive-behavioral, dynamic, interpersonal) influence members with insecure attachments and how leaders can best help insecure members in these diverse group settings. This chapter will explore how all group therapy/counseling can facilitate changes for individuals who come to group treatment with an insecure attachment style, regardless of their diagnosis or presenting problems and how group therapy, without being manualized, can foster changes for members with insecure attachments.

Attachment Theory Applied to Group Counseling and Psychotherapy

Similar to individual therapy, a group re-creates the opportunity for clients to explore prior interpersonal injuries that have left them unable to maintain intimate relationships, develop the ability to cope with emotions that have been overwhelming or inaccessible, and facilitate their ability to create a cohesive narrative that helps explain their automatic avoidance, dissociation, or anxiety when in social situations (Fosha, 2000; Holmes, 1996; Wallin, 2007). In group treatment, members not only experience current relationships in the group but they reexperience the prior injuries from significant others in the past, implicitly and explicitly, that left them struggling to maintain intimacy. They do this within the context of the here-and-now of the psychotherapy process through group members' reenacting early attachment experiences within the group, and the group becomes a social microcosm of what group members experience in close relationships outside of the group (Yalom & Leszcz, 2005). Mikulincer and Shaver (2007) describe how the therapy group comes to function as a secure base, facilitating more secure attachments in the members and providing members with a corrective emotional experience by empathizing with their experience, embracing their vulnerability and honesty, and encouraging their openness and feedback. For example, the frightened member learns that others are not shaming and repulsed by his need for connection or expression of feelings, and the self-sufficient member learns that her avoidance of needs pushes people away and prevents her from feeling.

Although there are many ways to classify and measure adult insecure attachments, the current chapter will focus on two main dimensions of insecure adult attachment: anxiety and avoidance (Bartholomew & Horowitz, 1991). Greater attachment anxiety corresponds to increased fearful preoccupation with relationships and difficulty regulating affect, especially when triggered in interpersonal situations, while attachment avoidance corresponds positively with increased avoidance of intimacy and negative views of dependence and closeness in relationships (Mallinckrodt, 2000). Adults with more attachment anxiety tend to be sensitive to abandonment, harbor intense fears of rejection, and engage in *hyperactivating* relational strategies. Hyperactivating strategies include behaviors aimed at inducing caregiving from others and attention such as expressing strong emotions as a cry for help, engaging in self-destructive behaviors, or being overly solicitous with others. Adults with more attachment avoidance, on the other hand, are uncomfortable with closeness, turn away from relationships in times of need, and engage in *deactivating* strategies. Deactivating strategies include withdrawal, avoidance of emotions, and turning away from social support.

The Anxiously Attached Adult Group Member

Alice attends her interpersonal process group therapy religiously. She is involved, vivid, emotional, passionate, and dedicated to the group. She desires intimacy with the other members and leaders, all of whom she holds in high regard. Yet despite her enthusiasm and commitment to the group and her desire to connect with others, she continues to feel alone in a room full of people. Group is about to begin, and although she has participated for months now, her palms begin to sweat and her heart races. She scans the room, taking in the other members and leaders for cues, some clues, as to how they feel about her and her thoughts begin to spiral out of control.

Alice becomes lost in her anxiety, her panic, because she firmly believes that she cannot survive her divorce without the group rescuing her. Her emotions rush in like a volcano about to burst the moment group begins. Although she tries to remain calm, she often feels hurt that others do not recognize her pain and fearful that others will abandon her. I will just die if the group rejects me right now, *she tells herself.* Maybe if I show the group my desperate need for them, then they will stay and take care of me. *Unfortunately, Alice is so preoccupied with how to go about soliciting closeness from the group and with detecting any cues of potential rejection that she never notices that Mark, another group member, has been trying to get her attention the entire session. Mark wanted to tell Alice that he has been thinking of her and wondering how she has been feeling since her divorce last week.*

Alice's experience of group therapy is characteristic of more anxiously attached clients, whose fears of abandonment and loss make them distrustful of others and hypersensitive to rejection from individuals and groups (Bartholomew & Horowitz, 1991; Jurist & Meehan, 2008; Smith, Murphy, & Coats, 1999). Clients with an anxious attachment style have learned from an early age that assertiveness and independence fail to solicit empathic attachment responses. Instead, as children, they learned that in order to reach their self-preoccupied caregiver, they needed to display their dependency needs intensely, escalating distress and "maximizing" attachment strategies (Dozier, Stovall, & Albus, 1999; Main, 1995). As adults, anxiously attached individuals engage others with helplessness and emotionality, suppressing their autonomous self in an attempt to solicit caregiving from others (Wallin, 2007). Sadly, these hyperactivating strategies, used by anxiously attached individuals to facilitate intimacy and belonging, ultimately push others away, because significant others in the client's life, and eventually the therapy group, come to feel suffocated and used (Connors, 2011; Wallin, 2007). This is the plight of anxiously attached group members; their attachment needs and accompanying feelings are so loud that others grow deaf to their callings for help and connection.

The Anxious Group Member: In-Group Experiences and Behaviors

In the beginning of a group, anxiously attached group members can be experienced as charming and even seductive to others, because they are experts in reading what other people want from them. Similarly, anxious clients in individual therapy may initially come across as the "ideal client" because they sense what would please the therapist (Wallin, 2007). These clients are often experts in pleasing others because they come to therapy with a history of having to carefully read the mood and state of mind of their caregivers in order to get their attachment needs met (Connors, 2011; Dozier et al., 1999). Through initially idealizing the group, more anxious members make other group members and even leaders feel special and good about themselves. However, the cost of idealizing others, while simultaneously denigrating the self, is the anxious member's own self-esteem (see Wallin, 2007). Consistent with this notion that the more anxious members idealize the group early in treatment, Lindgren, Barber, and Sandahl (2008) found that anxious members tend to view the group more positively in the beginning stages of group, compared to other group members. These researchers empirically studied the relationship between attachment style and the alliance to the group-as-a-whole and found that anxiously attached members tended to rate the alliance to the group higher, compared to other group members. In essence, anxiously attached members, who are more concerned with being liked, tend to rate the group more positively early in treatment. Theoretically, one might hypothesize that anxious members idealize the group in a subconscious attempt to ward off potential rejection; after all, it is more difficult to reject someone who puts you up on a pedestal! In summary, the group may initially feel attracted to anxious members who are well adept at making others feel special and important and who genuinely view the group positively in this stage of the group's development.

Although initially anxious members tend to view the group positively and may be well liked by other members, over time, anxious members are likely to become angry over perceived slights from others (Bartholomew & Horowitz, 1991; Smith et al., 1999) and to hold ambivalent, both positive and negative, attitudes toward others in the group (Mikulincer, Shaver, Bar-On, & Ein-Dor, 2010). Mikulincer et al. found that anxiously attached individuals feel ambivalent about their desire for closeness due to past traumatic experiences in which their attachment needs were inconsistently responded to by caregivers. This may help explain why despite anxious members' thirst for intimacy and a sense of belonging, research suggests that, at times, anxious members have negative experiences and interactions within their groups. For example, as one may expect, research suggests that anxiously attached group members tend to be preoccupied with being accepted or rejected by the group and are hypersensitive to their emotional reactions to the group, which typically include anxiety, fear, and disappointment (Rom & Mikulincer, 2003; Smith et al., 1999). Furthermore, Rom and Mikulincer (2003) found that group members with greater attachment anxiety revealed greater perceptions of threatening group interactions, less self-efficacy during group tasks, and more negative memories of group tasks compared to less anxious members. Chen and Mallinckrodt (2002) found that members higher in attachment anxiety displayed problematic interpersonal behaviors in the group, such as nonassertiveness, vindictiveness, and intrusiveness. Anxious group members appear to display problematic behaviors within the group as their relational difficulties are reexperienced within the group.

Yalom and Leszcz (2005) describe how the therapy group becomes a social microcosm of each group member's interpersonal world outside of therapy. Anxious group members are likely to eventually experience the same feelings of disappointment and rejection within the group as they do with significant others outside of therapy. How does this come to be? In their thirst for connection and reliance on others to regulate their emotions, anxious clients often come across as too needy and clingy to others (Bartholomew & Horowitz, 1991). These clients attempt to control their anxiety over abandonment and loss by minimizing emotional distance and soliciting displays of affection from others (Bartholomew & Horowitz, 1991; Feeney & Noller, 1990). Similar to significant others in the client's life, in the therapy group, these hypervigilant interpersonal behaviors have the unintended consequence of pushing other group members away (see Mikulincer & Shaver, 2003). In turn, the withdrawal of others in the group is likely to be interpreted by anxiously attached group members as "proof" that others will ultimately reject them, reminiscent of the rejection they once experienced earlier with caregivers. Although painful to experience for group members, the social microcosm of the group can be therapeutic for group members, and

for anxious members specifically, if the group can provide a different relational experience wherein anxious members feel a sense of acceptance and belonging in the group (Yalom & Leszcz, 2005).

The Anxious Group Member, Leader, and Group Interactions

How other group members and leaders respond to anxiously attached members may depend on the other group members' and leaders' own attachment style. Group members with more of an avoidant style may feel frustrated or even disgusted with the anxious members' perceived neediness. On the other hand, more anxiously attached members may join with a fellow anxious group member in an implicit agreement to sooth one another's attachment anxiety. In the individual therapy literature, Dozier, Cue, and Barnett (1994) found that case managers who were more insecure were more likely to react in accordance to the client's immediate presentation, intervening with greater depth and perceiving more dependency in anxious clients. Similarly, anxious group members may elicit hyperactivating strategies from others, especially other group members and leaders with a proclivity toward an anxious attachment style.

Wallin (2011) describes certain strengths and vulnerabilities that he believes are associated with an anxious/preoccupied therapist. These strengths include accessing feelings and intuition, a greater capacity for empathic contact, and warmth. In this sense, a group leader with a preoccupied or anxious attachment style may be able to effectively empathize with anxious members' intense emotional experience. These leaders may lean toward, rather than away from, anxious members' intense needs for closeness, contact, and support. On the other hand, Wallin (2011) argues that anxious/preoccupied group leaders' biggest vulnerability is that they are more likely to accommodate in order to avoid abandonment, which can play out in their relationships with group members. For example, preoccupied group leaders may be less likely to challenge, interpret, articulate alternative perspectives, or set healthy boundaries with anxious group members (Wallin, 2011). Instead, anxious group leaders may be more likely to overidentify with anxious members, divert conflict away from them, and to magnify similarities between themselves and their anxious members while minimizing autonomous differences (Wallin, 2011). On the other hand, the more avoidant group leader may be more likely to avoid or dismiss the anxious member out of frustration with the member's "dramatic" emotional presentation. Wallin (2011) theorizes that therapists with a more avoidant/dismissive attachment are more likely to have "merger wariness," which can lead them to withdrawal rather than pursue intimacy.

Goals for Group Therapy with Anxiously Attached Group Members

Increasing Reflective Functioning Abilities

Anxiously attached group members have a difficult time accessing the reflective functioning abilities necessary to regulate and make meaning out of their intense emotional experiences (Fosha, 2000; Main, Goldwyn, & Hesse, 2003; Tasca, Ritchie, et al., 2011). Reflective functioning refers to the ability to understand how others think, to tolerate others having different perceptions of reality, and to understand that others cannot know what one is thinking or feeling unless it is expressed (Fonagy, Gergely, Jurist, & Target, 2002). We suggest that the therapy group can help anxious members strengthen their reflective functioning abilities through three avenues elaborated below, including verbalizing feelings, adopting a stance of curiosity into the underlying dynamics of one's experience, and processing interpersonal feedback within the here-and-now of the group.

Verbalizing Feelings

Anxiously attached group members have a difficult time using language to verbalize their overwhelming emotional experiences (Tasca, Ritchie, et al., 2011; Wallin, 2007). The ability to talk about feelings is essential to reflecting on and regulating affect (Fonagy et al., 2002). Group members, as well as leaders, can serve as a model for the anxious member on how to use language to verbally express their affect, as others in the group self-disclose their feelings and reflect on them. The group can also more directly help anxious members identify and explore their own feelings through asking questions and giving suggestions and guidance. For example, Alice becomes instantly self-critical when another group member expresses disappointment in the group and blames herself for the other member's discontent. A third group member expresses anger toward the displeased group member, stating that it is his fault that he has not benefited more from group since he has yet to put himself out there to the group. This modeling of the direct expression of anger allows Alice to consider if she also feels angry with the other member and not with herself for her perceived failings and inadequacies.

Curiosity

The therapy group can help anxious members develop a stance of curiosity about their feelings and behaviors (Tasca, Ritchie, et al., 2011), providing these members with some distance from their typically overwhelming emotions (Mikulincer, Shaver, Sapir-Lavid, & Avihou-Kanza, 2009). For example, a group leader may ask, “Alice I can see this really upsets you, but let's slow things down, take a step back, and look at this together as a group. What did the group observe happening for Alice right before she started to cry? How can we understand this?” Often, group members say that they do not know why they behave in a certain way or where a particular feeling comes from. However, while this may be true, this fact does not preclude the group from exploring and figuring things out together (Tasca, Ritchie, et al., 2011). Essentially, the group leader, with the help of the group, helps the anxious member reflect on his or her experience.

Interpersonal Feedback

Interpersonal feedback within the here-and-now of the group helps the group member receiving the feedback to empathize with others and to better understand his or her interpersonal patterns in relationships (Yalom & Leszcz, 2005). For example, Ben gives Alice feedback that “I feel like you are always watching me just waiting for me to do something to hurt you and it feels like a test, which makes me want to keep my distance from you.” This feedback helps Alice better understand how she exists in the mind of another person in the group. In this example, Ben feels angry not because there is something inherently unlovable about Alice but because her actions have made him feel “tested.” Once group members understand how they come across to others in relationships, then they have the choice whether or not to change their behaviors (Yalom & Leszcz, 2005).

Altering Internal Working Models: Internalizing the Group as a Secure Base

Anxiously attached clients have difficulty trusting that others will consistently respond to their attachment needs (Bartholomew & Horowitz, 1991; Wallin, 2007). Consequently, they fear becoming separate and independent selves who, in a state of separateness, would feel completely alone or might miss chances to have their attachment needs finally met (Bartholomew & Horowitz, 1991). Because of their wish for intimacy, anxious group members may work hard to facilitate group cohesion, highlighting similarities between group members and establishing intimacy in the group (Markin & Marmarosh, 2010). In turn, experiencing group cohesion may facilitate more secure internal working models for anxious group members, providing them with a sense of belonging and acceptance not experienced in childhood. The feeling of being a part of a larger group challenges anxious members' belief that they are fundamentally unlovable and helps shape a more positive view of the self as worthy of group membership. Working toward this goal, a group leader might say, "Alice, I hear the group saying that they really missed you last week when you didn't come to group because you are a vital part of this group. What is it like for you to be a part of something?"

Moreover, experiences in which group cohesion is challenged, but remains intact, may help further alter the more anxious group members' insecure internal working model of others. Group cohesion is strengthened when group members can openly disagree and accept differences (Yalom & Leszcz, 2005). Yet given anxious group members' fear of being rejected by the group (Smith et al., 1999), they may have difficulty trusting that the group is able to tolerate conflict and instead strive to please others and suppress within group differences and tensions (Markin & Marmarosh, 2010). Consistent with this, Tasca, Balfour, and colleagues (2006) found that while, overall, ruptures and repairs in the alliance transpired over the course of Group Psycho dynamic-Interpersonal Therapy, group members with an anxious attachment needed to experience the underlying group climate as increasingly engaged over the course of the therapy to have a positive outcome. The researchers suggest that anxious group members need to experience more group cohesion to meet their attachment needs and to make full use of the therapy (Rom & Mikulincer, 2003; Tasca, Balfour, et al., 2006; Tasca, Ritchie, et al., 2011). At the same time, it is important to note that these researchers also found ruptures and repairs in the alliance over the course of successful group therapies for anxious members, suggesting that within the context of a positive and supportive group climate and a cohesive group, it is helpful for anxious members to experience ruptures and repairs in the alliance. As anxious group members begin to have experiences within the group where working through group members' differences and in-group conflict lead to increased intimacy, rather than loss and rejection as feared, they may begin to see that autonomy and separateness do not necessarily lead to abandonment. Instead, the group may be internalized as a secure attachment that is consistently present even in times of distress and conflict.

Similar to facilitating more secure attachments for those with attachment anxiety, group therapy can facilitate changes for individuals with more avoidant attachments as well. These more avoidant group members are less afraid of abandonment and rejection and have more difficulty tolerating closeness, dependency, and emotional vulnerability.

The Avoidant Group Member: Implications for Group Psychotherapy

John came into the initial session and immediately started to take charge. "Let's see," he said sarcastically, "who needs to go first?" During the group sessions, he often interrupted the leaders, and rather than sharing his own needs in the group, to address his many ongoing relationship struggles, he opted to dish out advice and bring up topics he believed "other" group members would benefit from discussing. To make matters worse, he dismissed the leaders' authority and, without insight, managed to offend members with comments such as, "I never struggled with THAT, " "I am lucky; I do not have THOSE issues," "I do not need the group like others do," and "Why are we talking about feelings again?"

John's experience of group therapy is characteristic of more avoidantly attached (dismissive) clients, whose fear of dependency and weakness makes them distrustful of others and hypersensitive to needing others and groups (Bartholomew & Horowitz, 1991; Jurist & Meehan, 2008; Smith et al., 1999). Clients with an avoidant attachment style have learned from an early age that depending on others fails to solicit an attuned attachment response and does not ameliorate distress (Schore, 1994). These children learned to turn off their bids for comfort and split off vulnerable emotions that were too painful to manage alone (Dozier et al., 1999; Main, 1995). As a matter of fact, the proximity seeking that should provide relief actually increases their stress levels because their bids for comfort were met with rejection or neglect. The repeated experience of longing for comfort and experiencing rejection led to the adaptive, yet defensive, practice of turning off the proximity seeking behaviors. The process of *deactivation* shifts the attention away from the caregiver during distress and reduces the emotional shame and despair that follows. As adults, more avoidantly attached individuals suppress their connection to others and deny any needs for caregiving from them (Wallin, 2007).

Sadly, these *deactivating* strategies, used by more avoidantly attached individuals to facilitate independence and self-sufficiency, ultimately leave the individual isolated and alone, because significant others in the client's life, and eventually the therapy group, come to feel neglected and minimized by them (Connors, 2011; Wallin, 2007). This is the plight of avoidantly attached group members; their attachment needs and accompanying feelings are so removed that others become frustrated with them, reject them, or learn to ignore them.

The Avoidant Group Member, Leader, and Interactions with Other Members

According to Wallin (2007), avoidant clients often evade emotions that stir up feelings of vulnerability, and they have a particularly difficult time coping with these emotions when they are stirred up in treatment. These members are more inclined to say “everything is fine” in therapy while clenching their fists, averting eye contact, or smiling during emotionally painful times.

The avoidance of emotions is one example of the deactivation that characterizes these individuals. To maintain their sense of self-cohesion, these individuals have learned to dismiss their needs for others, and this includes the group members, leaders, and the group-as-a-whole. Chen and Mallinckrodt (2002) found that high attachment avoidance in group members was negatively correlated with group attraction, a measure similar to group cohesion. Avoidant group members also displayed the least self-disclosure in adolescent therapy groups (Shechtman & Rybko, 2004), and they scored the lowest on productive client behaviors and positive reactions and the highest on resistance, unproductive behaviors, and negative responses in therapy groups (Shechtman & Dvir, 2006). Researchers also found that once group therapy started, group members with avoidant attachments, who prefer to rely on themselves to manage stress, not only avoided self-disclosure but they were less appreciative of disclosures by others in the group as well.

Group therapy is challenging for these individuals because the help they seek also challenges their internal working model of themselves as being strong and of others being weak. Needing the group or acknowledging their vulnerability in the group has the potential to rouse early painful losses, but continuing to defend against their vulnerability with self-sufficiency or superiority leaves them lonely or rejected. Unfortunately, this struggle can often lead to premature termination from group treatment. Tasca et al. (2004) studied attachments in women with anorexia, and they found that the women with more attachment avoidance were more likely to drop out of the therapy group.

Because these group members are challenging and at-risk of premature termination, it is helpful for the group leaders to keep their painful pasts in mind when working with them. Although they can often appear aloof, arrogant, or independent on the surface, they have learned to negate others to survive and are often truly seeking relief from emotional pain without the ability to seek support from others.

How other group members and leaders respond to avoidant members may depend on the other group members and leaders’ own attachment style. Group members with more of an anxious style may feel frustrated or even enraged with the avoidant members’ lack of empathy or avoidance of emotions in the group. The more anxious a group leader, the more likely he or she might be to take the focus off of the avoidant member out of frustration with the member's avoidance of vulnerability (Wallin, 2007). On the other hand, avoidant attached members may join with other avoidant members in an implicit agreement to avoid threats to their independency and to avoid emotional intimacy. In the individual therapy literature, Dozier et al. (1994) found that case managers who were more insecure were more likely to react in accordance to the client's immediate presentation, intervening with less depth and perceiving less dependency in avoidant clients. Similarly, avoidant group members may elicit deactivating strategies from others, especially other group members and leaders with a proclivity toward an avoidant attachment style.

Goals for Group Therapy Members with More Attachment Avoidance

When it comes to group therapy, empirical research shows that dismissive group members may fare better in group treatments that are more structured initially since group members can slowly adjust to the group treatment. Tasca et al. (2007) found that group therapy that focused mainly on interpersonal relationships and affect exploration triggered more attachment representations in the group sessions. In essence, a more dismissing group member would be more activated in a relational group that is focused on intimacy and interpersonal relationships. The same dismissing member would be less activated in a structured group. Although the dismissive member would be less activated in a more structured group setting, a treatment that never addresses the interpersonal struggles, in the here-and-now of the sessions, would not help him/her address the core issues he/she was struggling with. In essence, an interpersonal process group may be extremely beneficial to more avoidant members.

Tasca and colleagues (2007) argue that interpersonal dynamic group therapists, those who work within the interpersonal process of the group, should first identify dismissive members who may be at-risk during the pregroup screening and thoroughly prepare them for the more process focused groups. Specifically, they say, "These preparations may require more time and effort at imparting group norms, teaching about the value of interpersonal exploration through group therapy interactions, and increasing the avoidantly attached individual's motivation for this type of work" (p. 12).

Increasing Reflective Functioning Abilities

More avoidant group members, like anxiously attached members, have a difficult time accessing the reflective functioning abilities necessary to regulate and make meaning out of their interpersonal experiences (Fosha, 2000; Main et al., 2003). Group can help avoidant members to strengthen their reflective functioning abilities through three avenues elaborated on below, including modeling the verbalization of feelings, learning how to empathize, adopting a stance of curiosity into the underlying dynamics of one's experience, and interpersonal feedback within the here-and-now of the group.

Verbalizing Feelings

Because dismissive group members avoid the experience and expression of their true feelings, it is sometimes difficult for these members to identify their underlying emotions or internal working models of self and others. Fraley and Shaver (2000) found that dismissive individuals engage in a defensive memory process, which inhibits their access to painful memories. Despite a childhood filled with divorce, neglect, or loss, they report a happy childhood where everything was great. One way to understand how these individuals truly experience themselves is through the feelings and experiences they induce in others they interact with via projective identification (Wallin, 2007).

Yalom and Leszcz (2005) defined projective identification as the “process of projecting some of one's own (but disavowed) internal attributes into another, toward whom one subsequently feels an uncanny attraction-repulsion” (pp. 365–366). A wonderful example of projective identification in group therapy with an avoidant member is depicted in Yalom's (Yalom & Gadban, 1990) video demonstration. In one of the first sessions of a therapy group, a more avoidant group member comes late to group and consistently avoids participating fully in the sessions. Several members confront this member and express their desire for him to come on time. He minimizes the impact his tardiness has on the others and finds multiple excuses for his lateness. When asked why he comes to group and what he gets out of group, he blames his third wife for making him come and describes a similar issue with her. She too seems to always be angry with him and complains about his unavailability. Over the course of the session, the members’ anger escalates as he becomes more and more defensive, and Yalom finally invites all the female group members to tell him what it would be like to be married to him. Remarkably, this member continues to look calm and unphased while each female tells him how lonely and painful it would be to be his wife. Not surprisingly, he becomes more defensive and continues to dismiss the feedback. Later in the session, we learn, from another member who spoke with this member outside of the group, that he was very frustrated with the group and often felt that it was a waste of his time. We also learn that as a child, he struggled with his parents’ divorce and alcoholism and his own feelings of inadequacy and rejection. We can imagine that this individual's bids for emotional connection were insufficiently met, and he learned to disavow his own needs, feelings of anger, and his experience of disappointment in relationships. These split-off parts appear to be induced in the others through his withdrawing behaviors, and this appears to be what happens in both his marriage and the group. He denies having any needs or feeling angry while those around him feel completely needy, ignored, and enraged.

To help this avoidant member, Yalom steps back from the enactment to reflect on the here-and-now of the group process. He wonders aloud what is happening when the one member withdraws and the group becomes “louder and louder” as they attempt to pursue this avoidant group member. In attachment terms, Yalom is exploring the deactivating behavior in one group member and how it is pulling for hyperactivating behaviors in the others. In addition, Yalom tries to label the angry feelings and wonders with the group member about his own angry feelings that are denied. Yalom also focuses on how the avoidance in the group prevents this member from getting his needs met in the group, remaining angry and disappointed, yet again.

In addition to being attuned to the group process and projected affect, it is also important for the leader to focus on nonverbal behaviors in the group that may indicate underlying emotions related to interpersonal experiences (Wallin, 2007). The goal for the leader is to help the avoidant member get to the underlying affect that is out of awareness. One way to get to emotions is to stop the avoidant group member in the moment and inquire how he

or she is experiencing feelings within his or her physical body. If his fists are clenched, it is helpful to notice and wonder what feelings may be residing there.

The here-and-now of the group process often elicits core affects. For example, more avoidant members are more inclined to feel frustrated and angry when they are uncomfortable with the intimacy or vulnerability developing within the group. The leader may look for opportunities to explore the avoidant member's annoyance or disgust during the sessions to expose what may be uncomfortable for the member.

Empathy

One of the reasons dismissive individuals do not have access to certain painful emotions is because of their early experiences with an unempathic caregiver (Schore, 1994). The lack of an attuned other is one of the reasons children develop insecure attachments and the presence of attuned others is the main ingredient of a successful group psychotherapy (Burlingame, Fuhriman, & Johnson, 2002; Johnson, Burlingame, Olsen, Davies, & Gleave, 2005).

An empathic leader holds back from challenging, too soon, the natural defenses that these avoidant individuals have relied on over the course of their lifetimes. It is helpful for the leaders to acknowledge these members' self-sufficiency and their desire for independence, which comes at odds with opening up and joining the group. In many ways, these members struggle with a challenging dilemma—if they want to stay strong and rely on themselves, they will be alone and isolated; if they open up and depend on the group, they will stir up feelings of being weak and needy. More importantly, there has been no relationship where they have felt connected, valued, and loved when they were vulnerable.

In the face of this dilemma, the group leader can admire the group member's independence, which has gotten him this far, but also address how this self-sufficiency has left him alone and feeling disconnected to people, probably what brought this individual to group treatment in the first place. For the dismissive group member, the price he pays for not feeling is "isolation, alienation, emotional impoverishment, and at best, a brittle consolidation of self" (Fosha, 2000, p. 43).

Empathizing with the Avoidance of Affect

It is important to empathize with the avoidance of affect and vulnerability. Given that dismissive individuals may not have access to painful memories, they may struggle to clearly articulate their feelings or how these feelings may relate to earlier experiences (Fraley & Shaver, 2000). The one emotion that may readily surface is anger. For example, a leader might say, "I can imagine how frustrated and angry you feel when we keep asking you to think about how you are feeling right now in the group. Maybe you can say more about why sharing your feelings feels like such a waste of time."

Although group therapy is complex, it is one of the best ways to foster empathy since members receive empathy from multiple sources, are able to observe the interactions of others from a safe distance, and there are multiple ruptures and opportunities for repair. For example, a dismissive group member can witness others taking risks and slowly see how emotional expression can lead to closeness and intimacy in the group. Unlike their families, where emotional vulnerability may have been ignored or shameful, genuineness and openness are admired and cherished in group.

Curiosity

It is important to model curiosity and to help the avoidant member begin to wonder about his/her experience in the group. The leader may say, "As I was sitting here today, I started to wonder what was happening in the group. We started talking about all these different topics, and I started to get lost. It feels very different than last week's session. What do you all think?"

In addition to modeling curiosity, the group leader can ask open-ended questions and facilitate avoidant members' access to their feelings and thoughts. "This is so important, Mary. You came late again, and I noticed your arms are crossed. If you were being honest and did not filter any of your thoughts or feelings, what would you say about how you are feeling about being here in the group right now?" It is also helpful to bring in other members to help explore the interpersonal experience. In one example, the female coleader invited the group members to explore their different impressions of the other leader and wonder about where they came from. "I appreciate John sharing his reactions. I wonder how others feel or what they are thinking now."

Altering Insecure Internal Working Models: Internalizing the Group as a Secure Base

The major task of group therapy is helping insecure members move from a fearful and anxious orientation to one that is more relational and eventually more secure. This requires that the individual rework internal models of others as superior, weak, or inferior and of the self being inadequate, superior, or self-sufficient. This is no easy task and involves challenging these implicit patterns of relating as they occur in the here-and-now of the group process. Because insecure members have learned to cope with painful emotions such as shame and aloneness, they often lack the capacity to access these emotions and experience them relationally in a different context, in a secure relationship (Fosha, 2000; Holmes, 1996; Wallin, 2007). Group therapy can provide a secure relational experience where painful emotions are understood, contained, and this leads to positive emotions such as gratitude, hope, and affection (Fosha, 2000). These repeated positive relational experiences within the group facilitate the revision of negative internal representations of the others and a positive experience of intimacy, and they lead to more effective emotion regulation and enhanced self-esteem (Kilmann et al., 2006).

Conclusions

Group therapy, unlike many other forms of treatment, facilitates the direct exploration of the many ways people have learned to navigate relationships in order to maintain safety and self-cohesion. Some individuals have learned to avoid emotions and rely on themselves in times of duress, those with more avoidant attachments, and this way of coping can lead to loneliness, isolation, and other means of self-soothing such as substance use (Flores, 2001). Group therapy can directly help these individuals learn to identify feelings that have been minimized or denied, challenge their avoidance of dependency and vulnerability, and help them understand the origins of their avoidance. Researchers have already shown that more avoidant individuals can benefit from group therapy, but they are at risk of dropping out of treatment (Tasca et al., 2007). Group leaders who are sensitive to the more avoidant members' fears of being weak and their need to maintain control over vulnerable feelings will be able to empathize with their anxieties and address their underlying concerns so they can remain committed to the group.

In addition to helping more avoidant individuals, group therapy can also facilitate changes in people who come to the group unable to regulate emotions, extremely dissatisfied with their relationships, struggling with an internal sense of emptiness, and fearful of abandonment and rejection, those with more anxious attachments. These more preoccupied individuals tend to devalue themselves, and group therapy can foster their ability to tolerate painful emotions without being overwhelmed and regain a healthier sense of self that is not fearful of rejection.

Future research is needed in order for us to understand the full impact that members' attachment styles have on the therapy group process and outcome. Researchers need to study how group members' different attachments interact during the group process and how this influences group cohesion and treatment outcome. This research will shed light on the selection of group members with different attachment styles and how attachments should be considered when determining group composition. In addition, research is needed to explore how the leader's attachment styles influence the group process. Social psychologists have studied the impact of insecure leadership on military groups and found that insecure leaders can have negative impacts on group cohesion (Mikulincer & Shaver, 2007). It is critical for group therapy researchers to study the impact of leader attachment on the process and outcome of group therapy.

Despite the need for additional empirical work, it is clear that the relational histories that members come to group with not only influence the symptoms they experience, the emotions that they avoid or that paralyze them, and the interpersonal struggles they want to address but they also influence the group process and the types of interventions that promote change. More importantly, group therapy has the power to facilitate the felt security members need to take risks and learn new ways of relating with others that revise negative perceptions of self and other.

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Chapter 36 Groups for Survivors of Childhood Sexual Abuse

Deborah A. Gerrity

CSA/Incest is the exploitation of a child by an older person or persons for the adult's satisfaction while ignoring a child's developmental status (Courtois, 1999). “Sexual abuse includes fondling a child's genitals, intercourse, incest, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials” (National Clearinghouse on Child Abuse and Neglect Information, 2002, p. 3). Based on the population sampled and definition of CSA, 7%–36% of females and 3%–29% of males have been sexually abused as children (Finkelhor, 1993). Most CSA is incest perpetrated by males who are family members or known by the child (Courtois, 2010).

This chapter presents the research and best practices of leading groups for both children and adults who have experienced childhood sexual abuse (CSA). Ethical practice dictates that leaders be well versed in common aftereffects of and interpersonal dynamics common to survivors of CSA. For in-depth information on CSA, the author recommends Courtois, 2010; Finkelhor, 1986; and Herman, 1992.

Long-Term Aftereffects of Childhood Sexual Abuse

CSA treatment is often long term, multimodal, and multidimensional because of the pervasive effects of abuse, the compounded consequences due to delayed treatment, and the complexities of the post-traumatic responses (Courtois, 2010). Many groups are designed for adult survivors who were never treated in childhood or continue to have unresolved issues as adults. Often, treatment resembles reparenting, with the goal being to help move from victim to survivor, gain hope, and individuate (Courtois, 2010).

Research demonstrates that the aftereffects of the abuse are modified by demographic and abuse variables: survivor's gender (Dube et al., 2005; Little & Hamby, 1999; Romano & De Luca, 2001), race (Clear, Vincent, & Harris, 2006; Newcomb, Munoz, & Carmona, 2009; Parsons, Bimbi, Koken, & Halkitis, 2005), age of onset and duration of abuse as well as gender of perpetrator. Treatment becomes more complex when addressing commonly occurring comorbid symptoms such as suicidality, eating disorders (Harper, Richter, & Gorey, 2009), self-injurious behaviors (Weaver, Chard, Mechanic, & Etzel, 2004), sexual risk taking (Parsons et al., 2005; Puffer, Kockman, Hansen, & Sikkema, 2011), and aggression/sexual exploitation of others (Christopher, Lutz-Zois, & Reinhardt, 2007).

Recent research has also addressed poly-victimization and revictimization of CSA targets. Finkelhor, Ormrod, and Turner (2009) interviewed 1,467 children and their caretakers and found 80% had experienced at least one incident of victimization (33 types from bullying and property crime to sexual abuse). They then looked at polyvictims with nine or more victimizations and found that, by age 18, 60% had experienced at least one type of sexual assault. Barnes, Noll, Putnam, and Trickett (2009) found that once a child is sexually abused, she or he is twice as likely to be sexually and physically revictimized. The second victimization often results in physical injury by a nonpeer.

Group interventions (a) normalize the aftereffects of abuse, (b) identify and develop therapeutic relationships among group members, (c) highlight universality, (d) break the secrecy and acknowledge abuse, (e) provide a support network, (f) create a context to explore and challenge emotions, beliefs, and childhood messages, (g) allow a grief forum, (h) have a place to observe and explore interpersonal patterns and client dynamics, and (i) recognize ineffective and maladaptive dissociation (Briere, 1996; Courtois, 2010). Group advantages include “benefits of lessened isolation and stigmatization, reduced shame … the opportunity to help as well as be helped—a process that supports self-esteem and lessens the sense of being a deviant, passive recipient of treatment” (Briere, 1996, p. 170). In addition, Talbot et al. (1998) related that therapy with a peer group helps lessen the perceived power of the authority figures (leaders) and helps break down resistance and regression that may occur in individual treatment. In the only study that looked at types of services provided for CSA survivors, Forseth and Brown (1981) reported that 75% of programs offering treatment for abused children provided group interventions. The specific type of group utilized (e.g., psychoeducational, counseling, therapy) is often dependent on the survivor's current stage of healing from the abuse.

Obviously the impact of CSA on future functioning is extensive and pervades multiple areas of the survivors’ lives. Due to the propensity for lifelong difficulties, it is imperative that both early interventions and long-term interventions be effective. Since group therapy is a cost-effective method of treatment, research on its efficacy is critical.

Efficacy Research

Consistently, groups for CSA survivors have been highly recommended (Briere, 1996; Courtois, 2010; Herman, 1992) but inadequately studied. Research has been limited by relatively few studies, many with small samples and instruments with poor or no reliability/validity information. Obstacles for researchers reside in the complexity of CSA. This multiplies the process and outcome variables to be studied and researchers often choose different symptoms to study making it difficult to compare studies. Also, CSA survivors are especially conscious of privacy and confidentiality concerns due to intense feelings of shame and stigma. Many have never disclosed the abuse to anyone. This makes them difficult to recruit for research and even more difficult to contact for long-term follow-up.

Nevertheless, there is a small body of group research and some important findings to start the process of developing best practice guidelines. To date, there is not a rigorous and statistically sound meta-analysis of just CSA group research. However, current research includes several meta-analyses that review individual, family, and group treatments collectively with one of the variables being type of treatment.

Harvey and Taylor (2010) published a meta-analysis of 39 studies of psychotherapy (family, individual, mixed, and group) for child and adolescent survivors of CSA. A meta-analysis by Hetzel-Riggin, Brausch, and Montgomery (2007) of 28 studies found similar results. Basically, any treatment was better than no treatment at all. For all outcome goals, group interventions had medium to large effect sizes meaning that there were significant gains in dealing with negative outcomes of CSA for children and adolescents. All intervention types were effective. Considering the efficiency and lower cost, group interventions may be the most effective way to work with minors. In addition, involving family in some way and using a mix of interventions was found to significantly increase mental health.

A third meta-analysis of 44 studies on the effects of psychotherapy for adult survivors of CSA (Taylor & Harvey, 2010) compared other treatments with a small number of group studies. The authors noted that it was difficult to find studies of group research that met their inclusion criteria (i.e., reporting of information to calculate effect sizes, studies based on only a handful of people, dearth of quantitative research). Treatment effect sizes were predominately and consistently moderate to large for *PTSD/Trauma, Internalization, Externalization*, and *Global Functioning*, but *Interpersonal Functioning* had a small effect size. Although many studies did not include follow-up data, those that did indicated positive effects of treatment were maintained or increased over time for individual, couple, group, and mixed treatments. Only for *PTSD/Trauma* symptoms was group therapy significantly less effective (small & moderate effects) than other interventions (large effect sizes).

In summary, the meta-analyses for all ages support that group therapy is successful at helping members address their goals. In some situations, group was more effective than other types of interventions and in others it was equal or less effective (but still effective). For some outcome goals, mixed interventions were most helpful. Depending on outcomes desired, there were different components that influenced the outcome. Practitioners should design their interventions by first choosing desired outcomes and then adjusting treatment to maximize effectiveness. It is safe to say that CSA groups are effective as well as cost-efficient. The next step for researchers is to design studies with multiple process and outcome measures and collaborate with practitioners to recruit larger sample sizes.

Critical Therapeutic Issues

Leadership

The adoption of a therapeutic framework for developing CSA groups is only one of the issues that leaders face. It is imperative that leaders be cognizant of potential legal issues, sexual abuse aftereffects, and best practices of group therapy (Puffer et al., 2011). Since group members may disclose continuing or current abuse of minors, knowledge of legal statutes regarding mandated reporting is critical. The multiple aftereffects of CSA may be chronic or acute and/or appear and remit periodically and spontaneously. The abuse may affect children's abilities to learn and develop platonic and/or romantic relationships (Reeker, Ensing, & Elliott, 1997). CSA survivors are at risk of abusing others (Christopher et al., 2007), abusing themselves (Weaver et al., 2004), and being in abusive relationships (Courtois, 2010). Chronic depression is the most common symptom. Generalized anxiety, fear, apprehension, anxiety attacks, sleep disturbance, nightmares, and various phobias, including agoraphobia, claustrophobia, and fear of the dark, continue into adulthood (Courtois, 2010). Weaver et al. (2004) found that lifetime prevalence of self-injurious behaviors (SIB) such as biting nails, chewing lips, and grinding teeth were reported by 80% of CSAs. Survivors frequently report self-loathing, emotional numbness, feelings of isolation, stigmatization, negative self-concept and self-esteem, and inability to trust. They may experience guilt, shame, betrayal, or lowered self-image because their body was aroused or climactic despite lack of consent, resistance, and/or fear.

"Since the abuse often occurred in what should be the safest of places—their homes and in intimate relationships—they [CSA survivors] are skeptical and suspicious about the therapist's promise of a safe atmosphere" (Buchele, 2000, p. 183). Leaders need to understand that when disclosing, group members may have two fears: (1) that others will see them as defective and (2) that there will be retribution for the disclosure. Often, perpetrators tell the victim that if they tell anyone about the abuse, something bad will happen to them or others. As group members share their stories, their isolation turns to a sense of affiliation, and they begin a trustful relationship with someone in authority. Leaders should expect members to vacillate between idealization and anger directed at them in their authority role. It is the exploration of these transferences that assist group members in working through their trust and authority issues (Buchele, 2000). As the healing progresses, CSAs struggle with losing a central piece of their identity. For most of their life, the sexual abuse may have been a defining characteristic of who they are, and they may fear the emptiness and void left as they let go of this identity. Leaders help members see that they are integrating the strengths from their previous identity into the growing identity of themselves as a whole individual.

Gartner (1997) described the dynamic between patients and therapist as one in which the patient tries to recreate the abusive relationship. Therapists can teach patients that it is possible to have a caring relationship that does not include abuse or sex. Buchele (2000) discussed common countertransference issues such as dreading sessions; feeling unskilled and incompetent; wishing to rescue members; feeling voyeuristic; and experiencing anger, fascination, extreme frustration, and paranoia. Therapists may feel that they deserve special status and entitlement for working with this population. Reactions of shock and horror to the abuse details can cause a leader to hurry the member into awareness and insight without appropriately exploring affect and other aftereffects (Gartner, 1997). Leaders need to be aware of their reactions to member stories and use them in a self-diagnostic manner. Little and Hamby (1999) found that female therapists were more likely to feel anger, hopelessness, and disgust while male leaders were more likely to blame the survivor or be sexually aroused when hearing about the abuse. Listening to patients tell horrific details about both sexual and physical violence has been shown to create vicarious trauma for therapists (Courtois, 2010). When leaders experience too much emotional reaction and the inability to stop the intrusion of thoughts, or desensitization and numbing, they need intervention via supervision or counseling. Failure of group leaders to address these countertransferences can lead to retraumatization of group members.

A compounding factor is the personal history of the leader. Little and Hamby (1999) found that 26% of therapists (female = 33%; male = 20%) reported being sexually abused as children. About 17% of CSA therapists had been hospitalized at some point in their treatment. Their results showed that there were no differences in screening, diagnosis, or assessment of harm by CSA and non-CSA therapists but CSA therapists reported more

countertransference issues and rated coping strategies as more important, especially supervision. One way to address transference, countertransference, and boundary issues is coleadership. Many authors agree that CSA groups should be coled (Courtois, 2010; Herman, 1992; Knight, 2006). The stress and risk of burnout is high; having another professional with whom to review personal reactions, group dynamics, and countertransference issues is valuable. Coleaders can model healthy discussion and confrontation as they interact with each other within the group sessions (Herman, 1992).

Boundaries

Because boundaries have been transgressed for CSA survivors, many have few or poor boundaries (Mathews & Gerrity, 2002). CSA survivors also can be very skillful at pushing boundaries and pressuring on group leaders to interact outside of group in a social or mentoring relationship. This elicits concerns about dual relationships. Therapists said they modify their boundaries with CSA survivors for four main reasons: therapist anxiety about survivor safety, feelings of resentment toward the survivor, worry about the survivor's feelings, and wanting to connect, give hope, or balance power in therapy (Harper & Steadman, 2003). Due to incidence of borderline qualities in CSA survivors, it is especially important for therapists to consistently monitor their reactions, maintain strong boundaries, and use supervision either with a coleader and/or a third party.

Depending on the theoretical framework and the types of groups being led, there is disagreement on another boundary issue: whether, and to what degree, leaders should self-disclose (Gerrity & Mathews, 2003). In feminist theory, self-disclosure is a tool to balance power dynamics and develop an egalitarian relationship. In psychodynamic theories, self-disclosure is a countertransference issue (Little & Hamby, 1999). Often, leaders are asked by members whether they themselves are survivors. The question itself allows the leaders to explore with members in what ways this knowledge will be helpful to them and how they think it would affect the group experience. This can help members reflect on what they need for trust and safety and how leadership by a survivor or nonsurvivor might make a difference to them. If they choose to disclose, leaders should reflect on their self-disclosure before and after to assess its impact on the group and on individual members.

Memory

There is an ongoing debate about whether group members should describe their abuse experiences in detail. Turner (1993) says that shame and guilt are dispelled by publicly airing the secret, having others hear the story, and placing the responsibility on the perpetrator. Herman (1992) asserted, “[I]nvariably the group offers a fresh emotional perspective that provides a bridge to new memories” (p. 224). Palmer, Stalker, Harper, and Gadbois (2007) discussed vicarious trauma of group members from listening to the stories of other survivors. They found that 60% of inpatients in their group reported some problems with listening to the stories of others and 20% had significant reactions leading to dropping out or increased emotional distress. They suggested that leaders need to be especially watchful of the reactions and structure abuse disclosure in a way that is not flooding participants beyond their ability to deal with the content.

However, Clancy, Schacter, McNally, and Pitman (2000) stated that “individuals who report frequent episodes of dissociation (disruptions in consciousness) may be especially likely to confuse the products of imagination and the products of perception” (p. 26). Courtois (1999) suggests that therapists should primarily focus on the consequences of the trauma. It is important to help survivors stabilize aftereffects and empower them to function as healthy individuals who make meaning of their own history. Memories of abuse should be addressed as they occur naturally in treatment not something required of members. Goals are to validate and normalize the experience, while moderating the intensity of the group. Practitioners should employ informed consent procedures that address risks and benefits of treatment, the treatment framework, roles, boundaries, limitations, safety issues, and treatment alternatives.

Organizing a Group

Screening for Adult Groups

Since group treatment is more intense than individual and leaders and members have less capacity to control the speed and content of the group, it is important to choose members carefully. Herman (1992) stated, "Just as it is never safe to assume that a traumatized individual's family will be supportive, it is never safe to assume that a group of people will be able to rally and cohere simply because all its members have suffered from the same terrible event" (p. 219). Palmer et al. (2007) suggested that in groups where abuse details are discussed, individuals with multiple hospitalizations, inability to feel safe, self-soothe, or regulate affect, and/or identify too strongly with others' pain should not be included. For additional information on screening criteria for adults, see Briere (1996), Chard, Weaver, and Resick (1997), Courtois (1999), and Harris (1998).

Herman (1992) theorized stages through which survivors need to progress to heal. Because boundaries were violated, the needs of the child were dismissed, and trust was broken, survivors in the first stage need to learn to create safety and become aware of their own basic needs. For CSA survivors who have not addressed safety and trust issues, the group should be cognitively oriented and structured. Psychoeducational groups best fit this stage because they allow the exchange of information on trauma aftereffects, symptom patterns, and self-care strategies. Groups should focus on strengths and coping abilities of the survivor while protecting against being overwhelmed. Group process is related to maintaining boundaries and offering support.

In the second stage, group members need to clarify and integrate the abuse experience. Members have amassed the resources necessary to confront the reality of the abuse and its effect on their lives. Through telling the story of the abuse to a small group of others, it has the effect of "releasing her from her isolation with the perpetrator and readmitting the fullness of the larger world from which she has been alienated" (Herman, 1992, p. 222). In these counseling and therapy groups, leaders need to actively structure the sessions and orient members to work with their memories. Time-limited groups work best for this stage. Herman believes that the focus is in the past and the goal is mastery over the content and memories of the abuse. The task is to remember, validate, and mourn.

In reconnection groups, survivors need to integrate their abuse identity into who they are as complete and healthy individuals. Counseling groups may address different coping styles, interpersonal functioning and relationships, and sexual dysfunction. Since dysfunctional styles of relating to others may take a long time to erase, open-ended therapy groups provide a safe place to practice relating to others in a healthy, consistent manner. The more competent survivors become in their interpersonal skills, the more they benefit from a diverse, heterogeneous group composition.

Screening for Child Groups

Appropriate screening and selection of child participants is also extremely vital (Friedrich, 1990) and attention is given to selecting children who are of similar developmental age and physical size (Jones, 2002). Likewise, children who have recently been abused are often treated in individual therapy before going into the group setting (Homeyer, 1999; Jones, 2002). Yancey, Hansen, and Naufel (2011) explored the screening results of 101 children/adolescents. They found four clusters: The *Highly Distressed* had significantly high scores on all self and parent report screening measures and had high internalizing and externalizing symptoms. The *Problem Behavior* set had high parent-report scores and low self-report scores indicating high externalizing symptoms. *Subclinicals* scored below the mean on all measures. Finally, the *Self-Reported Distress* group had high self-report and low parent-report scores suggesting internalizing issues. The authors recommended that prescreening and formatting future interventions to fit the target group may improve group therapy outcomes for participants. As an example, for the *Highly Distressed* children, a group designed for creating safety and structure in their lives would be most beneficial while the *Self-Reported Distress* group might benefit more from communication skills.

Group Structure

Support groups, short-term or time-limited groups, long-term or open-ended groups, and retreats are all employed

(Courtois, 1999). Structure can be a very important tool in the intervention process, providing safety and allowing survivors to observe consistent, clear, and explicit boundaries regarding the therapeutic process. Most practitioners agree that a session should be at least 1½ to 2 hours long for adults (Gerrity & Mathews, 2003) and an hour or less for children (Harvey & Taylor, 2010). However, this can vary, based on the attention span of group members, types of activities employed, and the setting. The number of sessions may differ, based on the theoretical framework as well as the type of setting, the goals of the group, and whether the group is a psychoeducational, counseling, or therapy group.

Adolescent and Adult Groups

Most psychoeducational groups are designed for children but those for adults are intended to work with survivors in the first of Herman's (1992) stages. The Women's Safety in Recovery (Talbot et al., 1998) groups are designed for acutely ill individuals. The goal is to educate members about trauma and self-care in order to establish safety and control. The groups are coled by female and male leaders to model mixed gender cooperation and collaboration.

In counseling and therapy groups, therapeutic models related to group interventions for sexual abuse populations come from several frameworks. According to Taylor and Harvey's (2010) meta-analysis, cognitive-behavioral and eclectic interventions were very effective for treating most outcome goals. Insight-oriented therapy was as effective for PTSD/trauma, externalizing, global functioning, however, much less effective for internalizing/psychological distress and self-concept/esteem. Interventions that included homework were more effective than others. For all outcome variables, longer sessions, semistructured treatments, and more active therapy were related to better effects.

Existential/Process

Yalom (1995) delineated group treatment that focuses on the process of interaction among group members in the here-and-now. He described therapeutic factors, including vicarious learning, instillation of hope, universality, group cohesiveness, and catharsis. Randall (1995) compared the curative factors rankings across three female incest survivors groups. He found that cohesiveness, self-understanding, and family reenactment were the top reported therapeutic factors in the two long-term treatment groups. For short-term groups, catharsis and existential learning were reported most frequently.

Interpersonal Process

CSA survivors with interpersonal problems were more likely to have been abused at an earlier age (Pistorello & Follette, 1998). Interpersonal groups place emphasis on interactions between individual group members and between group members and leaders to help members learn and practice skills that can be applied outside the group (Callahan, Hilsenroth, & Price, 2004). The most frequent themes related to relationship problems for survivors "revolved around sex-related (e.g., dissociation), survivor-specific (e.g., confusing partner and perpetrator), partner-specific (e.g., personal difficulties), relationship-specific (e.g., difficulty expressing emotion), and attitudinal (e.g., negative attitudes toward men) themes" (Pistorello & Follette, 1998, pp. 478–479). Male groups also address gender-related dynamics, including concerns about sexual orientation for members whose perpetrators were male (Friedman, 1994).

Affect

Groups with a focus on affect expression and regulation encourage survivors to fully experience their emotions and feelings in a healthy, stable manner. While dissociation was useful at the time of the trauma, survivors tend not to learn how to manage and regulate feelings and often have pervasive numbing of all affect, marked emotionality, or intense swings between these two extremes. The impact can increase destructive patterns that lead to revictimization, personality disorders, and a host of other negative consequences.

Shaffer, Brown, and McWhirter (1998) used a four-phase plan to help address dissociative coping in the group context. The goal was for members to realize the triggers that led to dissociation and acquire methods of remaining present in the here-and-now, even when triggers were present. Another approach (DiVitto, 1998) to disrupt dissociative coping uses a grounding box that includes sensory stimuli to bring members back to the here-and-now: "Peppermint for taste, cinnamon and perfume for smell, and ice packs, and velvet and satin swatches for touch. Verbal redirection to open the eyes and look at the therapist stimulates sight. The patient is encouraged to use counting or poetry reciting, spoken out loud to stimulate hearing" (p. 82). Group members are encouraged to monitor dissociation in themselves and other members and assist each other in using the grounding box.

Cognitive-Behavioral

Survivor groups with cognitive and behavioral restructuring goals focus on changing how members think about their experiences and learning and practicing new skills. Chard et al. (1997) described a combined individual and group intervention based on cognitive processing theory (CPT). Individual therapy was designed to address the clients' memories of the abuse and help them reconstruct, integrate, and process the abuse experience. In the group, members were introduced to information processing theory, PTSD symptomatology, and family systems dynamics and asked to reflect on positive and negative relationships and to focus on cognitive concepts by identifying antecedent events, beliefs, and consequences to those beliefs. Members identified social support networks and discussed coping skills.

Feminist

Feminist theory states that each client is an expert on his or her own life and experiences and that egalitarian relationships among members and with leaders is crucial to healing (Courtois, 2010). Therefore, feminist group leaders try to break down power dynamics and increase autonomy and empowerment for group members. Leaders emphasize members' control from the start, giving information and reinforcing choices. The development of safety in the group and acknowledgment of the strength necessary to seek help are important. In addition, leaders give affirmation, answer questions, and offer reassurance.

Feminists have supported group therapy as a powerful, significant intervention for females who have been sexually abused (Rittenhouse, 1997). Relationships and intimacy facilitate maturation and development. "Because pain, terror, and shame have been linked with relating to important others, survivors find it hard to know whom to trust or how to behave in a trustworthy fashion" (p. 112). Courtois (2010) and Herman (1992) suggested that part of the healing from sexual trauma for women is learning to relate in a healthy manner and create supportive, nurturing connections with nonabusive others. This reduces isolation, shame, and guilt and teaches survivors ways to develop healthy judgments regarding whom to trust. Feminist therapists use the group to educate members about political and societal influences that contribute to their problems and to externalize the blame to those who had power in the abusive situation. Members are assisted in developing their own sense of self in relation to the group and then to also generalize that learning to the outside world.

Groups run from this framework include Maxine Harris and the Community Connections Trauma Work Group (CCTW; 1998) and Fallot, Freeman, Zazanis, and Dende (as cited in Harris, 1998) modified version for male CSA survivors.

Children's Groups

Groups designed for preadolescent children differ considerably from adolescent and adult groups in terms of structure and content. Members are selected by age and gender. Preschool groups provide services to children between the ages of 4 and 6 years and are usually either mixed gender (e.g., Grosz, Kempe, & Kelly, 2000) or only female (Pescolido & Petrella, 1986). Latency groups, ages 7 to 11, usually contain same-sex children (Friedrich, 1990). The topics addressed remain consistent: feelings regarding abuse and the perpetrators, feelings toward self, sex education, sexual abuse prevention, court preparation, and identification of a support system (e.g., Grosz et al., 2000; Heiman & Ettin, 2001).

According to Harvey and Taylor's (2010) meta-analysis, cognitive-behavioral groups are most effective with outcome goals such as PTSD (post-traumatic stress disorder)/trauma, internalizing, and academic and risk prevention goals. For externalizing/sexualized behavior, global functioning, self-esteem and social skills outcome goals, supportive, abuse-specific, and eclectic theories worked. Homework was a strong positive moderator of effects for all outcomes. Treatments of less than one hour and longer durations (greater than or equal to 20 sessions) significantly increased the effectiveness of treatment except for self-esteem, which was better less than or equal to 10 or greater than or equal to 20 sessions. Children of color experienced higher gains than Caucasians, as did those with less intrafamilial abuse.

Preschoolers

Preschool-aged children are in Piaget's preoperational stage of cognitive development, making it difficult for them to understand abstract concepts (Burton, Rasmussen, Bradshaw, Christopherson, & Huke, 1998). Therefore, preschool groups use concrete, action-oriented activities and interventions. Group membership is usually limited to four to eight children who meet for 10 to 12 weekly sessions for one to two hours (e.g., Homeyer, 1999). While there is literature showing open groups (Grosz et al., 2000), most preschool groups are closed and time limited, allowing group cohesion and safety to develop more quickly. Concrete language and experiential interventions are routinely utilized (Burton et al., 1998). In addition, most groups incorporate a snack and play time (e.g., Mitchum, 1987; Pescolido & Petrella, 1986) to provide a nurturing reprieve from intense feelings and to promote peer interaction.

Counseling groups using nondirective play therapy techniques are the most effective treatment because they are developmentally appropriate (Homeyer, 1999). Preschoolers lack a cognitive framework to understand the trauma they have experienced, making verbal, emotional expression difficult. Play therapy allows emotional expression through the “language of play” (Homeyer, 1999, p. 299) that may even be more accurate than a child's verbal statements. Children should have access to a range of materials chosen to facilitate creative and expressive play (Jones, 2002). Children are not pressured to verbalize frightening experiences and beliefs, but communicate via play and group leaders receive, validate, and interpret the messages that the child is sending. Reflecting feeling to the child and interpreting the meaning behind it aids in the development of the therapeutic alliance between the child and therapist.

Several behavior patterns commonly emerge within a play therapy group. Children may exhibit aggression toward the therapist or peers, withdraw from the group, become hypervigilant, reenact the abusive situation, dissociate, or be unable to negotiate conflict with peers. Boundary issues may also be apparent, as children become regressive and/or adopt adult roles and demonstrate sexualized behaviors (Jones, 2002). See Stauffer and Deblinger (1996) for a manualized, cognitive-behavioral therapy group for preschool-aged children.

Latency-aged

These groups are generally same sex (Hiebert-Murphy, DeLuca, & Runtz, 1992), contain more discussion, and begin to shift the focus to concepts that are more abstract (i.e., self-esteem feelings, social interactions, and abuse prevention education). Many groups incorporate snacks, nondirective play therapy, and sharing time to discuss the previous week.

Researchers and practitioners continue to explore alternative formatting and conceptualizations for group treatment. Misurell, Springer, and Tryon (2011) reported on a group for elementary school children that employed a game-based cognitive-behavioral therapy (GB-CBT). The boys and girls were predominately African American (77%) and Latina/o (19%) from middle and lower socioeconomic homes. The GB-CBT group used rule-governed, team strategies to encourage participation and engender friendly competition. Play was structured with repetition opportunities for skill building of social and emotional skills. Results showed improvement in children's knowledge of healthy sex and self-protection skills.

Parents

Many therapists offer parallel, nonoffending parents groups (Smith & Kelly, 2008). Therapists and researchers assert that parental support after disclosure of abuse is a major determinant of the impact the abuse has on the child and the child's ability to progress in treatment (Stauffer & Deblinger, 1996). Parallel groups also assist in treatment through alleviating parental resistance about discussing the abuse and addressing issues of isolation and guilt that may be present for nonoffending parents. Additionally, nonoffending parents of children who have been sexually abused may often experience a number of other reactionary, psychological, and physiological symptoms (Stauffer & Deblinger, 1996).

Conclusions

Group leaders have a multitude of factors to take into consideration. Previous training in sexual abuse issues and group therapy interventions is necessary to appropriately address the needs of the group members. Other concerns, such as boundary and memory issues, must also be addressed to effectively manage the group experience as it unfolds. Extensive planning and organization is required to create an effective sexual abuse group. This chapter discusses a number of ways to conceptualize a CSA group. Clearly, there is no right way to resolve all these issues, but group leaders need to be aware and carefully plan their group to maximize the therapeutic effect for members. Treatment needs and group goals and procedures also have to be adapted for various age groups. Future research needs to focus on more rigorous research designs with control groups and longitudinal data. Sequencing of treatments at various ages and stages of healing to discover if there are cumulative health effects over treatments would also be very valuable information since so many adult survivors spend much of their life seeking help for the aftereffects of abuse.

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Chapter 37 Mindfulness and Group: Mindfulness-Based Stress Reduction and Dialectical Behavior Therapy

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Introduction

Mindfulness is emerging as an important experiential group intervention. Mindfulness entails paying attention to the present moment with awareness and without judgment (Kabat-Zinn, 1990). This increased awareness allows one to relate to personal experiences more effectively, increasing emotional awareness, improving self-regulation (Shapiro, Carlson, Astin, & Freedman, 2006) and enhancing relational connectedness (Langmuir, Kirsh, & Classen, 2012). Mindfulness has been incorporated in therapeutic interventions as a secular practice for improving the lives of individuals struggling with various mental and medical health ailments, such as depression (Felder, Dimidjian, & Segal, 2012), social anxiety (Goldin & Gross, 2010), binge eating (Kristeller & Wolever, 2011), and hypochondriasis (McManus, Surawy, Muse, Vazquez-Montes, & Williams, 2012).

In this chapter, we explore mindfulness group interventions, focusing specifically on the interpersonal benefits of mindfulness and the unique advantages of employing mindfulness in a group setting. To provide the reader with a sample of how mindfulness is currently being utilized in group therapy, we describe two of the most popular and researched structured group programs utilizing mindfulness, Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990) and Dialectical Behavior Therapy (DBT; Linehan, 1993).

Mindfulness as a Group Intervention

Mindfulness, and specifically mindfulness meditation, is a 2,500-year-old practice originating from the heart of Buddhist meditative teachings (Kabat-Zinn, 2003). Kabat-Zinn (1993) defined mindfulness as a concept based on cultivating awareness "with the aim of helping people live each moment of their lives—even the painful ones—as fully as possible" (p. 260). Mindfulness frees one to directly experience bodily sensations, thoughts, and emotions, whether pleasant or unpleasant, thereby allowing one to let go of the struggles associated with avoiding unpleasant experiences. Because of the focus on nonjudgmental awareness, mindfulness meditative practices inspire a sense of tranquility and peace of mind, despite daily difficulties that arise (Kabat-Zinn, 1990). In contrast to mindfulness, *mindlessness* is characterized by engaging in behavior with little conscious awareness (i.e., being on automatic pilot in daily activities; Kabat-Zinn, 1990), which is associated with ineffective communication, emotional reactivity, poor self-control, and difficulty resolving interpersonal conflict (Horton-Deutsch & Horton, 2003).

There is substantial theoretical support and growing empirical support for the use of mindfulness in group settings. Theory (Yalom & Leszcz, 2005) and research (Kivlighan & Holmes, 2004) suggest that therapeutic factors occur in counseling groups and have a positive effect on participants' adjustment and development. Mindfulness groups offer opportunities for participants to experience a variety of therapeutic factors. For example, the description of mindfulness and its benefits can provide members a sense of universality and instillation of hope. Experiencing and letting emotions pass can result in catharsis. Dealing with emotions openly in group while not being overwhelmed by them could counter maladaptive approaches to emotions group members experienced in their families of origin (family reenactment). The comradeship between group members who are learning mindfulness together can result in feelings of cohesion. Helping other group members learn and apply mindfulness can provide participants with an experience of altruism. The process of teaching mindfulness can emphasizes four therapeutic factors, as follows: explanations of mindfulness (imparting information), demonstrations of mindful practice (imitative behavior), engaging in mindful activities (development of socializing techniques), and receiving feedback during discussions after practice (interpersonal learning). Recognizing participants have a choice to practice mindfulness and concentrating on awareness in the moment can provide group members with the opportunity to experience existential factors.

Additional support comes from the authors' anecdotal experiences as group facilitators for a variety of mindfulness-based groups and workshops. As we recount the feedback we have received from group members, one theme that consistently emerges is how much participants enjoy the opportunity to share feedback with one another and to learn from each other's struggles and successes in practicing mindfulness.

As mental health practitioners and researchers have begun incorporating mindfulness into couples' work, communication skills training, organizational settings, and a variety of group modalities, empirical support for its use as an interpersonal intervention has grown. Horton-Deutsch and Horton (2003) found that the use of mindfulness as a social process helped people work through intractable conflict. Another study examined the use of mindfulness in group treatment for trauma survivors (Langmuir et al., 2012). Results indicated that participants experienced increased awareness of their internal experiences, as well as their impact on others, and were better able to communicate their experiences to others, thereby facilitating enhanced intimacy and connectedness with other group members. As interest in the processes of mindfulness groups grows, there is sure to be increased empirical support for the specific interpersonal mechanisms and therapeutic factors that contribute to successful outcomes.

Mindfulness-Based Stress Reduction Groups

Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990) was one of the first empirically validated group interventions using mindfulness and continues to be one of the most utilized treatment approaches. MBSR groups were developed by Jon Kabat-Zinn (1990) at the University of Massachusetts Medical Center's Center for Mindfulness (CFM) in 1979. The CFM was created to help patients struggling with chronic pain and anxiety symptoms that were not ameliorated with more traditional Western medical treatments (Kabat-Zinn, 1990). MBSR groups were created as an effective public health intervention because they were designed for large groups (up to 35 participants) with a wide range of medical and mental diagnoses. According to the CFM, over 19,000 participants have completed MBSR programs at their site alone (http://www.umassmed.edu/cfm/home/index.aspx). This does not include 830 practitioners teaching MBSR worldwide (http://www.umassmed.edu/cfm/home/index.aspx). Clearly, MBSR groups are proliferating and evaluation research suggests they are effective (Shapiro & Carlson, 2009). The following section includes a description of the specific practices emphasized in the groups, the format of MBSR groups, facilitator considerations, other types of mindfulness groups adapted from the MBSR model, and a summary of current MBSR research.

Formal and Informal Mindfulness Practice

Throughout the group, participants are exposed to both formal and informal mindfulness practices. Formal practices include a body scan awareness exercise, sitting and walking meditation, and gentle yoga (Kabat-Zinn, 1990). At the beginning of the group, members are guided through the process of eating one raisin mindfully. This experience helps concretize the concept of mindfulness and acts as a catalyst for group discussion wherein members are encouraged to share observations and reactions with one another.

Following the mindful eating exercise, group members are led through a body scan practice in which they are slowly guided through each body part, from the feet to the head (participants generally lie down and close their eyes). Themes of gratitude, awe, and love may be suggested, but the overarching goal of the body scan is to notice whatever thoughts, feelings, and sensations arise (Shapiro & Carlson, 2009). The body scan helps participants develop a number of mindfulness skills, including increasing body awareness, building attention skills, developing attentional flexibility, and cultivating kindness and nonjudgment (Kabat-Zinn, 1990; Shapiro & Carlson, 2009).

One of the core experiential practices in MBSR is sitting meditation, the ultimate form of "non-doing." This practice usually begins with a focus on breath awareness, noticing the breath as it comes into the body on the inhale and as it leaves the body on the exhale. Given the mind's tendency to wander, this practice emphasizes "beginning again and again" when the mind has wandered and refocusing on the breath with a compassionate and nonjudgmental attitude (Kabat-Zinn, 1990).

Walking meditation is a movement meditation in which the act of walking is slowed down and each part of the step attended to (e.g., lifting, moving, and placing the foot on the ground). Themes of present moment awareness, appreciation for one's ability to walk, and non-striving are emphasized (Kabat-Zinn, 1990).

Gentle yoga is used in MBSR to cultivate strength, flexibility, and balance, both physically and psychologically. Athleticism is not the main aim of yoga; rather, the ultimate goal is to increase awareness of sensations of the body through slow and careful movements and to cultivate kindness toward and acceptance of any limitations in the body (Kabat-Zinn, 1990).

Near the end of the MBSR program, participants attend a 6-hour silent retreat on the weekend between classes 6 and 7. A theme of non-doing is emphasized, and participants focus on the simplicity of sitting, walking, lying down, gentle yoga, and eating in a silent atmosphere in which no contact between group members occurs. Members are asked to notice whatever thoughts or feelings (e.g., boredom, sadness, guilt, happiness, peace) or physical sensations (e.g., discomfort or pleasure, tension) arise throughout the day. Loving-kindness, a type of meditation that emphasizes kindness and compassion toward oneself and others, is introduced in the day-long retreat and subsequent MBSR group sessions (Kabat-Zinn, 1990).

Informal practices are also emphasized throughout the MBSR curriculum. These practices help participants generalize the benefits of their formal practices to their everyday life. This may include increasing awareness and attention to daily activities such as eating, showering, driving, and speaking (Kabat-Zinn, 1990). The following is an example of an informal mindfulness assignment given to group members to encourage cultivating mindfulness in everyday life.

> Throughout the day, tune into the rhythm of your breath. Notice the presence of this rhythm when engaged in daily tasks (e.g., washing your hands, getting dressed, talking on the phone, checking your e-mail). These simple daily tasks present an opportunity to pause, become aware of your surroundings, and be present in your life as it is this moment.

Exposing group members to a variety of mindfulness practices helps meet the varying cognitive, affective, and physical needs of the participants (Kabat-Zinn, Chapman, & Salmon, 1997). This may help explain why MBSR has been found to have high adherence rates three years and longer after treatment (Kabat-Zinn & Chapman-

Waldrop, 1988; Miller, Fletcher, & Kabat-Zinn, 1995). Research suggests that participants usually have a personal preference for one of the three mindfulness practices (i.e., body scan, sitting or walking meditation, or gentle yoga). In fact, Kabat-Zinn et al. (1997) found that individuals with particular presenting problems tend to prefer certain mindfulness practices. For example, individuals who experience anxiety somatically (e.g., physical symptoms such as gastrointestinal distress) tend to prefer meditation, whereas those who experience anxiety cognitively (e.g., racing thoughts) often prefer yoga.

Group Format

MBSR is done in a large group setting with up to 35 participants over a period of 8 weeks. Group members meet weekly for 2.5 to 3 hour sessions, and also attend a 6-hour silent retreat on a weekend between classes 6 and 7. To increase the effectiveness of the treatment, members are asked to practice meditation and yoga outside of class for 45 minutes, six days per week (Kabat-Zinn, 1990). The facilitators lead the groups in formal mindfulness practices. Practice is generally followed by time spent processing group members' challenges and insights related to practice and transferring experiences into everyday life. Facilitators also directly provide support and feedback as they foster a warm and supportive environment (Shapiro & Carlson, 2009). Although maintaining the integrity of MBSR protocol is recommended in order to achieve maximum benefits, the protocol of MBSR has been adapted to fit the needs and constraints related to particular issues, settings, and client populations.

Facilitator Considerations

It is important to note that there is a strong belief that in order to teach MBSR, it is also important for group leaders to have their own daily meditation practice (Shapiro & Carlson, 2009). The guided meditations provided by the facilitators during the group are not scripted but rather are statements based on the thoughts, sensations, and metaphors that have been helpful to the facilitator during their meditative practices. MBSR group facilitators work to embody and encourage the core mindfulness attitudes of nonjudging, patience, beginner's mind, trust, non-striving, acceptance, and letting go (Kabat-Zinn, 1990). While not all MBSR facilitators have official certification through the Center for Mindfulness in Medicine, Healthcare, and Society, it is highly encouraged. Certification includes a graduate degree in the field of health care, ongoing daily practice and regular attendance at meditation retreats, attendance at a professional 7-day training, and supervised practicum experience teaching MBSR (Shapiro & Carlson, 2009).

Adapting MBSR Groups

A number of modified MBSR groups have emerged over recent years to facilitate work with specific populations. These groups include, but are not limited to, mindfulness-based cognitive therapy (MBCT), mindfulness-based relapse prevention (MBRP), mindfulness-based eating awareness training (MB-EAT), mindfulness-based art therapy (MBAT), and mindfulness-based relationship enhancement (MBRE; Shapiro & Carlson, 2009).

MBCT uses a small group format (up to 12 members) and applies a synthesis of MBSR and cognitive-behavioral therapy to treat depression (Segal, Williams, & Teasdale, 2002). MBRP integrates mindfulness meditation with cognitive-behavioral relapse prevention skills in substance use treatment (Bowen, Chawla, & Marlatt, 2011). MB-EAT incorporates MBSR and cognitive-behavioral therapy to address topics related to size, weight, and eating (Kristeller, Baer, & Quillian-Wolever, 2006). MBAT has been developed for women with cancer, and combines elements of MBSR and art therapy in a group setting (Monti et al., 2005). MBRE is focused on enhancing relationships that are relatively healthy and uses an MBSR format with a relational focus, including dyadic exercises (Carson, Carson, Gil, & Baucom, 2006).

Relevant Research

There is a growing body of research on MBSR groups. A meta-analysis of 20 empirical studies with an effect size of 0.5 ($p < 0.0001$) found that participation in MBSR groups resulted in improvements on measures of physical and mental well-being, both for clinical populations dealing with pain, cancer, heart disease, depression and anxiety, and for stressed nonclinical populations (Grossman, Niemann, Schmidt, & Walach, 2004). These results illustrate that MBSR groups may be helpful for a range of populations dealing with stress, or physical and/or mental health problems.

More recent meta-analyses confirmed previous findings about the benefits of MBSR groups. Greeson (2009) conducted a meta-analysis of 52 studies reviewing MBSR or other mindfulness interventions' effects on the body, mind, brain, and behavior with a diverse range of client issues. Overall, cultivating mindfulness in groups was associated with decreased emotional distress, increased positive states of mind, improved quality of life, better immune functioning, and increased positive health behaviors related to sleeping, eating, and substance use.

A meta-analysis of 39 studies examining the effects of MBSR groups or MBCT (a therapy specifically for depression closely aligned with the MBSR curriculum) totaling 1,140 participants found that symptoms of anxiety (Hedges' g = 0.63) and depressed mood symptoms (Hedges' g = 0.59) decreased. For participants who were diagnosed with anxiety and mood disorders, effect sizes were even more robust (Hedges' g = 0.97 and 0.95, respectively). Effects were unrelated to number of treatment sessions and were maintained at a mean follow-up length of 27 weeks (Hofmann, Sawyer, Witt, & Oh, 2010).

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is another popular and empirically validated group intervention that relies on mindfulness as a core principle. DBT is a cognitive-behavioral, psychosocial treatment initially developed for the treatment of chronically suicidal individuals (Dimeff & Linehan, 2001). DBT is a comprehensive treatment approach comprised of individual therapy and telephone coaching, combined with group skills training and ongoing consultation team meetings. Since its inception, DBT has been used in the treatment of a variety of concerns (e.g., Borderline Personality Disorder, binge eating, depression) and with a variety of populations (adults, adolescents, elderly individuals, etc.; Dimeff & Linehan, 2001). The following section describes the development of DBT, its theoretical tenets, supporting research, and relevant therapeutic considerations. The group skills training component of DBT will be emphasized, including presentation of a sample outline for a DBT-informed group session.

DBT originated out of unsuccessful attempts to treat complex, chronically suicidal individuals with standard cognitive-behavioral therapy (CBT; Dimeff & Linehan, 2001). DBT's founder, Marsha Linehan, recognized that the emphasis on changing maladaptive thoughts and behaviors with CBT often left clients feeling invalidated and misunderstood, prompting therapy-interfering behaviors such as attrition, withdrawal, and attacks on the therapist. Furthermore, helping clients acquire new skills was extremely difficult in the context of frequent crises and suicidal behaviors (Dimeff & Linehan, 2001). In response to these problems, Linehan developed treatment manuals that incorporated not only change strategies but also a dialectical stance and mindfulness strategies that serve to strengthen the therapeutic relationship and promote change. The dialectical stance allows both clients and therapists to acknowledge opposing themes (e.g., acceptance vs. change, willingness vs. willfulness, wanting to die vs. wanting to live) with the goal of integrating these themes (Linehan, 1993). DBT focuses on therapists' acceptance and validation of clients' pain, thereby encouraging clients to engage in radical acceptance of self. The result is a therapeutic experience that balances change with acceptance—the primary dialectic in DBT. In addition to incorporating dialectical theory and mindfulness practice, Linehan developed a comprehensive treatment program that combines weekly individual therapy with weekly skills groups, frequent telephone coaching sessions, and weekly consultation team meetings comprised of multiple treatment providers *and* the client. This comprehensive approach requires a great deal of commitment from clinicians and clients, including several hours of treatment per week for a duration of one year (Koerner & Dimeff, 2007).

Goals of Group Skills Training

DBT aims to help individuals more effectively regulate their emotions. Clients learn to do this by acquiring four interrelated skill sets: (1) mindfulness, (2) emotion-regulation, (3) interpersonal effectiveness, and (4) distress tolerance. These skills are acquired primarily during weekly group skill development sessions, which are only one part of a comprehensive DBT program. Information on how to conduct a DBT skills group is summarized in Linehan's (1993) *Skills Training Manual for Treating Borderline Personality Disorder.* A comprehensive look at how to implement DBT programs across settings, including therapeutic issues related to individual therapy, phone sessions, and consultation team meetings, can be found in Dimeff and Koerner (2007).

In DBT skills training groups, mindfulness is the first skill taught, as well as the only skill reinforced continuously throughout treatment, because it provides a foundation for learning the other DBT skills. Linehan based DBT mindfulness skills on Zen and Eastern meditation practices (Linehan, 1993). An overarching goal of DBT mindfulness training is to help clients integrate their "reasonable mind" with their "emotional mind" to form their "wise mind" (Linehan, 1993). Clients are taught specific "what" and "how" skills they can use to achieve a "wise mind." The first "what" skill, *observing*, entails attending to an emotional or behavioral experience without trying to change the experience. The second "what" skill, *describing*, involves being able to label an experience or emotion with words, with the goal of separating the objective description of the experience from one's interpretation of an experience. The final "what" skill, *participating*, is being fully present and attentive "in the moment" without distracting thoughts or self-conscious feelings. The second set of mindfulness skills, the "how" skills, address the process by which one engages in mindfulness practice. The "how" skills include taking a nonjudgmental stance, focusing on only one thing in each moment, and doing what is effective (Linehan, 1993).

There is research supporting the relative importance of mindfulness as the foundation for other DBT skills. Studies have shown that clients tend to use mindfulness skills more frequently than other DBT skills (Lindenboim, Comtois, & Linehan, 2007; Stepp, Epler, Jahng, & Trull, 2008), and that they describe mindfulness as one of the most helpful skills learned in DBT (Miller, Wyman, Huppert, Glassman, & Rathus, 2000). Examples of mindfulness activities that help promote skill acquisition include sensory awareness activities related to the 5 senses, focusing on one activity at a time, and observing one's thoughts, feelings, and sensations without judgment (Linehan, 1993).

Interpersonal relations tend to be challenging for individuals who have emotion regulation concerns because of their heightened sensitivity to interpersonal cues. DBT focuses on development of interpersonal skills to help clients pursue three objectives: (1) achieving goals/getting needs met, (2) maintaining relationships, and (3) preserving self-respect. Skills training includes psychoeducational activities using handouts and acronyms. Additionally, behavioral rehearsal (e.g., role-playing), both within and between skills training sessions, is considered to be necessary for effective skill acquisition (Linehan, 1993).

Emotion regulation skills are an integral part of DBT group skills training. An important goal in helping clients regulate emotions is to assist them in understanding the difference between primary and secondary emotions. Primary emotions are often adaptive and understandable responses to stressors. On the other hand, secondary emotions (e.g., shame, rage, misery) are judgments about one's experience of a primary emotion, and are often the source of the distress that an individual experiences (Linehan, 1993). Linehan (1993) describes the following specific emotion regulation techniques taught in DBT skills training groups: (1) identifying and labeling emotions, (2) identifying obstacles to changing emotions, (3) reducing vulnerability to "emotion mind," (4) increasing positive emotional events, (5) increasing mindfulness to current emotions, (6) taking opposite action, and (7) applying distress tolerance techniques. Emotion regulation skills require that individuals carefully attend to their own internal experiences; thus, it is especially important that clients have begun mindfulness practice prior to learning emotion regulation strategies (Linehan, 1993).

The final skills taught in the skills training group are designed to help clients increase their ability to tolerate distress. Engaging in effective distress tolerance means acknowledging that some amount of pain and distress in life

is inevitable. Distress tolerance entails accepting oneself *and* the distressing situation in the moment without trying to change the situation or one's emotional reactions to the situation. Linehan (1993) emphasized that in order for clients to feel validated and to successfully acquire distress tolerance skills, group leaders should emphasize the distinction between accepting a painful situation and approving of that situation. In other words, distress tolerance does not mean that one agrees with the situation or that the situation is desirable. In many ways, using distress tolerance skills is like applying core mindfulness skills to distressing situations (Linehan, 1993). Distress tolerance skills are also referred to as "crisis survival strategies" (Linehan, 1993, p. 97). There are four specific skills: (1) using distraction, (2) self-soothing, (3) improving the moment, and (4) thinking of pros and cons of tolerating distress. The dialectic of willingness v. willfulness is a key theme. Clients are encouraged to balance their desire to protest against their reality with a desire to radically accept their current reality in order to reduce suffering (Linehan, 1993).

Strategies for how to conduct effective skills training groups, as well as important practical issues and therapeutic themes, are included in Linehan's (1993) manual. Facilitation strategies that can enhance skill acquisition include modeling, contracting, reviewing diary cards, rehearsal and reinforcement of appropriate behaviors, and skill generalization (Linehan, 1993).

Group Format

In standard DBT, group skills training occurs weekly, and each group session lasts approximately 2.5 hours. Four skills are stressed: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance skills. These skills are taught over a 6-month period. To reinforce skill acquisition, the modules are then repeated, resulting in a year-long skills training group (Koerner & Dimeff, 2007). With the exception of mindfulness skills, the ordering of the other three modules may depend on the specific needs of the population or the constraints of the therapeutic setting. Each individual group session generally begins the same way. Opening rituals (e.g., breathing meditation) and homework review are done in the first half of the group. The second half of the group begins with teaching new skills and ends with a closing ritual (e.g., ringing a bell). As with the ordering of the skills, there is flexibility with regard to the length and frequency of sessions focusing on skills. Clinicians are encouraged to consider how deviating from the suggested format could impact skills acquisition as well as the potential for therapy-interfering behaviors (Linehan, 1993).

Facilitator Considerations

The highly structured nature of the skills training group, coupled with the unique challenges that can arise when working with populations that can benefit from DBT, make it especially important that leaders are properly trained in DBT. Linehan (1993) highly recommended that the leadership responsibilities for the skills group be shared between two facilitators: a primary group leader and a coleader. The primary leader is responsible for reviewing homework material, teaching new skills, and ensuring that the group stays on track. The coleader, in contrast, is attuned to the concerns of each individual group member and may help diffuse tension between members and leaders, embodying a dialectical opposite of the primary group leader that allows for synthesis. Moreover, sharing responsibilities can provide mutual moral support and reduce the likelihood of clinician burnout (Linehan, 1993).

Adapting DBT Skills Training Groups

Employing the standard, comprehensive DBT model with some populations or in some settings may be unfeasible because of practical constraints (e.g., financial limitations, therapist availability). In these situations, treatment providers may wish to use an approach that has been adapted from DBT, otherwise known as "DBT-informed treatment." In their chapter dedicated to applying DBT across settings, Koerner, Dimeff, and Swenson (2007) suggest several strategies to aid treatment providers in making decisions regarding whether to *adapt* versus *adopt* a DBT program. Most importantly, the authors recommend that providers take a dialectical stance toward this decision. In other words, the most effective program will be a synthesis that aims for treatment integrity *and* feasibility, given the resources and constraints of the setting.

The following outline provides an example of a skills group that was adapted from Linehan (1993). This outline focuses on mindfulness "how" skills and was used in week 5 of an 8-week, 1-hour 45-minute DBT-informed skills group one of the authors cofacilitated at a university counseling center (Windle & Morse, 2010).

1. Beginning ritual: Begin session with ringing of harp and deep breathing exercise. (5 minutes)
2. Review practice efforts with emotion regulation skills. (30 minutes)
    1. Ask each member to discuss steps they have taken to apply emotion regulation skills. Be specific and behavioral while continuing to reflect radical acceptance.
    2. Reinforce positive steps and "efforts."
    3. Problem solve barriers to using skills effectively. Encourage other group members to engage in brainstorming process.
3. Break. (5 minutes)
4. Introduce, discuss, and practice mindfulness "how" skills. (45 minutes)
    1. Taking a nonjudgmental stance:
        1. The goal is to take a nonjudgmental stance when observing, describing, and participating. Judging is engaging in labeling or evaluating something (e.g., good or bad, valuable or invaluable, worthwhile or worthless). An important mindfulness skill is *not* judging things in this manner.
        2. Judging what a person does is different than observing or describing the consequences of what someone does.
        3. Thinking of things in terms of good and bad can be harmful or destructive. Ask participants to share personal experiences with this.
        4. Sometimes judging is easier than owning your feelings and explaining that someone's behavior has an impact on you. Share personal example.
        5. Judging is essential at times, but most people overdo it, especially when judging themselves.
    2. Focusing on one thing in the moment:
        1. The goal is to focus attention on only one thing or activity at a time, bringing the whole person to bear on a task or activity. This can apply to both physical and mental activities.
        2. You can switch back and forth, but try to have your mind completely on what you are doing in the moment.
        3. What is the opposite of focusing on one thing in the moment? Mindlessness and distraction. Share personal example and get personal examples from group members.
    3. Being effective:
        1. Focus on what works rather than what is right or wrong. This requires knowing what your goal or objective is.
        2. React to the actual situation, not what you think the situation should be.
        3. When have you "cut off your nose" to prove a point? Give personal example first, and then ask for examples from participants.
        4. Which "how" skill is your strength? Which will be most difficult for you? Ask members to share.
5. Develop practice commitments. (15 minutes)

    1. Discuss with each person what 1–3 skills he/she will practice during the coming week. Group members can choose to practice across a wide array of situations, or they can pick a recurring problem situation. In the latter case, the objective is to use a variety of skills in the problem situation.
    2. Ask each participant to agree to practice mindfulness "how" skills.
    3. Troubleshoot problems in implementing practice.
6. Ending ritual: End session with deep breathing and ringing of harp. (5 minutes)

Relevant Research

Since the impetus for DBT came out of attempts to treat Borderline Personality Disorder (BPD) and self-injurious behaviors, most of the outcome studies have focused on DBT's effectiveness in treating BPD. A recent meta-analysis of 16 studies reported that DBT was effective in reducing suicidal and self-injurious behaviors when compared to "treatment as usual" among those diagnosed with BPD (Kliem, Kröger, & Kosfelder, 2011). DBT has also been shown to be efficacious in treating depression in older adults (Lynch, Morse, Mendelson, & Robins, 2003) and in reducing eating pathology in women with Binge Eating Disorder (Telch, Agras, & Linehan, 2001). Additionally, DBT-informed treatments have proven effective at reducing depression and hopelessness in suicidal individuals (McQuillan et al., 2005), reducing depression and clinical symptoms, and increasing neuropsychological functioning in adults with Attention Deficit Hyperactivity Disorder (Hesslinger et al., 2002). Based on their meta-analysis, Kliem et al. (2011) called for more studies examining the long-term efficacy of DBT and research on the specific processes that make DBT effective.

Conclusion

Mindfulness-based or informed group therapies offer great promise to individuals suffering from various mental and physical health problems. Indeed, mindfulness has been associated with such positive intra- *and* interpersonal outcomes that it would benefit nearly any type of group to include mindfulness practices. Mindfulness practices could be added to groups in a variety of ways—at the beginning or end of a group meeting, during periods in which group process is stuck or stalled, or even as a homework assignment for group members.

Although the benefits of mindfulness have been repeatedly demonstrated, many questions have yet to be empirically tested. For example, what specific group processes impact and are impacted by mindfulness practices? What populations are likely to benefit most from practicing mindfulness in a group setting? One area of particular interest for further research may be how group therapeutic factors, such as universality and existential concerns (Yalom & Leszcz, 2005), relate to group participants' acquisition and practice of mindfulness skills. It is interesting to note that because most studies on mindfulness interventions are group interventions, it is unclear how much of the efficacious findings are a function of group processes versus the mindfulness skills. Research is needed to compare the effectiveness of mindfulness-based groups to other types of groups and to mindfulness interventions taught in individual counseling sessions.

As demand for mental health services increases, group therapy will likely be increasingly utilized as an efficient and effective treatment modality. Mindfulness-based groups will likely only increase as a first line choice to decrease suffering, given their versatility and usefulness for a wide variety of populations and concerns. Mindfulness-based groups are also a preventative intervention as they enhance well-being and teach resilience skills that may be lacking in the general population. "And in connecting with ourselves, we can form connections with others" (Satir, Gerber, Banmen, & Gomori, 1991, p. 300).

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Chapter 38 Psychoeducational and Counseling Groups to Prevent and Treat Eating Disorders and Disturbances

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Groups of various types are widely used to prevent and treat individuals with eating disorders and disturbances. Several therapeutic properties of groups may be especially useful in helping clients work through issues typically associated with eating disorders, including body image disturbance, preoccupation with food and weight, secrecy, shame, and isolation. Groups offer the support of peers (Illing, Tasca, Balfour, & Bissada, 2011; Oesterheld, McKenna, & Gould, 1987; Zimpfer, 1990) and provide a safe forum for identifying distorted beliefs, self-perceptions, and expectations that drive dieting behaviors. They also provide a social context for reality testing some of these cognitions and for exploring the consequences of repeatedly engaging in disordered eating behaviors. Furthermore, the group setting provides an interpersonal context for understanding links between eating disorders and relationships (Laberg, Tornkvist, & Andersson, 2001) and an opportunity for participants to practice new ways of relating to and communicating with others.

In this chapter, we define the major eating disorders and focus on diagnostic issues to consider when forming a group. We suggest general guidelines for planning psychoeducational, counseling, or psychotherapy groups for eating disorders, especially pertaining to screening potential members and preparation for groups. This chapter provides examples of psychoeducational groups focused on treatment and prevention of eating problems and describes cognitive-behavioral and interpersonal therapy treatment groups, as well as some innovative group approaches. We summarize the state of the art research supporting the use of groups to prevent and treat eating disorders and disturbances. We do not intend for readers of this chapter to be able to lead eating disorders groups without an experienced coleader. Rather, this chapter presents an introduction to the group approach to a prevention and treatment of eating disturbances and disorders. Treatment of eating disorders is complicated because these are disorders that are often comorbid with anxiety and depressive disorders and sometimes with substance abuse disorders and personality disorders (American Psychiatric Association [APA], 2000). Prevention and early intervention efforts can be conducted by individuals with less training and thus more attention is devoted to that work.

Definitions

Those with eating disorders meet criteria defined by the American Psychiatric Association (2000) in the *Diagnostic and Statistical Manual* (*DSM-IV-TR*). Eating disturbances are less clearly defined but refer to abnormal relationships with food that co-occur with body image disturbance. A diagnosis of an eating disorder indicates a higher level of pathology, morbidity, and impairment; however, eating disturbances are not clinically insignificant and can progress to full-criteria eating disorders. The term *eating disorders* refers to anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and eating disorder not otherwise specified (EDNOS), a category used for people who have a clinically relevant eating disorder that meets most, but not all, of the criteria for AN, BN, or BED (APA, 2000). Briefly, AN is defined by a refusal to maintain a minimally normal body weight, an intense fear and avoidance of weight gain, and a disturbance in one's experience of one's weight and shape (APA, 2000). BN is characterized by recurrent episodes of binge eating, engagement in compensatory behaviors to prevent weight gain, and a self-evaluation unduly influenced by body weight and shape (APA, 2000). BED is characterized by recurrent binge eating episodes, defined as the consumption of an unusually large amount of food in a discrete interval of time and the experience of loss of control (APA, 2000). These episodes are often associated with guilt, disgust, and depressed mood; however, individuals with BED do not engage in the compensatory weight control behaviors that are characteristic of BN.

EDNOS is a heterogeneous diagnostic category for individuals who have an eating disorder but do not meet all the criteria for AN, BN, or BED (APA, 2000). An example of EDNOS is an individual with elevated body image disturbance who has lost a significant amount of weight through extreme restriction but has not yet hit a body mass index (BMI) that would warrant a diagnosis of AN or someone who engages in regular compensatory behaviors after eating high calorie foods but does not engage in binge eating. A diagnosis of EDNOS does not imply minor clinical significance; instead, such a diagnosis is cause for serious concern and requires clinical treatment.

Prevalence

The American Psychiatric Association reports a prevalence of AN and BN as 0.5% to 1% and 1% to 3% of adolescent and young adult females, respectively (APA, 2000). Hoek's (2003) review of prevalence data reported that the average prevalence rate for anorexia nervosa for young females was 0.3%. The prevalence rates for bulimia nervosa were 1% and 0.1% for young women and young men, respectively. The estimated prevalence of binge eating disorder is at least 1%. In a variety of studies with college populations, 6% of female students reported concerns about anorexia or bulimia, whereas 25% to 40% reported moderate problems falling under the umbrella of EDNOS, including body image worries, problems stemming from weight management, and out-of-control eating (Schwitzer, Rodriguez, Thomas, & Salimi, 2001). To find out how many high school age students may have eating disturbances or disorders, Haines et al. (2011) conducted the first nationwide eating disorders screening initiative for high schools in the United States. A total of 270 high schools participated with a sample size of 3,286 females and 2,332 males. Approximately 14% of females and 4% of males scored at or above the threshold of 20 on the EAT-26, a common measure of eating disorder symptoms. Approximately 24% of females reported that they were preoccupied with being thinner usually or always, whereas 8% of males reported being preoccupied with being thinner often, usually, or always. Nearly 12% of females and 3% of males reported vomiting to control their weight in past 3 months and 17% of females and 10% of males reported binge eating one or more times per month over the past 3 months. This study demonstrates the significant usage of unhealthy eating attitudes and behaviors that could be indicative of eating disorders. It also suggests the importance of prevention programs, to be discussed shortly.

Eating disorders have often been thought of as a problem of white, middle- to upper-class women only, and it is of critical importance to break down this stereotype because the data do not support its validity (Nelson, Castonguay, & Locke, 2011). The prevalence rates among women of color for eating disorder symptoms are similar to those of European American women (Kronenfeld, Reba-Harrelson, Von Holle, Reyes, & Bulik, 2010). In an important article that concerns eating concerns in women of color, Talleyrand (2012) describes many sociocultural factors that could influence the manifestation of eating disorders in women of color. Additionally, a recently published article aptly named “Considering J.lo and Ugly Betty: A Qualitative Examination of Risk Factors and Prevention Targets for Body Dissatisfaction, Eating Disorders, and Obesity in Young Latina Women” shows that Latina women must be considered in the population of at-risk individuals (Franko et al., 2012).

A Rationale for Using Groups in the Treatment and Prevention of Eating Disorders

There are many group properties that support their use in eating disorders. Despite the importance of these group dynamic variables, few researchers have examined the development of positive group process in the treatment of eating disorders (Illing et al., 2011). Recent work on this topic examined the relationship between adult attachment and group climate for individuals with eating disorders. Based on the results, Illing et al. (2011) recommend that clinicians treating those with an eating disorder may need to be sensitive to the initial level of attachment avoidance. They recommend that pregroup preparation of the attachment avoidant individual, especially concerning the benefits of self-disclosure, might help these individuals engage in group. Assessment of attachment style was done using the Attachment Style Questionnaire (Feeney, 1994). Findings suggest that individuals with an eating disorder who had higher levels of pretreatment attachment avoidance were more sensitive to other group members' experience of group engagement (Illing et al., 2011, p. 265). Clinicians need to be aware that certain individuals with an eating disorder may be more sensitive to the group's atmosphere when it comes to expectations of closeness and bonding with others.

In a qualitative study of participants' reactions to group treatment for BN, Laberg et al. (2001) interviewed seven participants who completed a cognitive-behavioral therapy group with an interpersonal focus. Many aspects of the group experience were noted as important to the members, including connecting with others who were struggling with the same problem, feeling support from members of the group, and learning to trust others. Data regarding these qualitative features are important because they highlight that group treatment may work due to the unique properties inherent in a group approach. Used appropriately, group therapy can help patients feel less isolated, more understood and supported in a way that individual therapy does not. Participants in the Laberg et al. (2001) study also indicated that learning they were not the only ones living with an eating disorder provided some relief. Being treated in a group provides opportunities to develop outside relationships with group members, and these often develop into friendships that continue throughout recovery. In another study, Hobbs, Birtchnell, Harte, and Lacey (1989) questioned members of an all-female group, ranging in age from 21 to 30 years, who participated in an eclectic 10-week group counseling intervention. Participants rated self-understanding, vicarious learning, universality, and instillation of hope as the most valued therapeutic factors in the group experience. Again, some of these therapeutic factors are uniquely associated with group counseling or therapy.

General Guidelines for Facilitating Psychoeducational and Counseling/Therapy Groups

Group facilitators should ask organizing questions as they plan group interventions. For example: Who are the participants or members? Is this a prevention or treatment intervention? What symptom(s) are being treated? What are the severity levels? What is the intended outcome? How long will the intervention last? Are the goals realistic for the length of the group? The answers to these questions, contained in this chapter, will allow leaders to consider the needs of the individuals being served and choose a group format that appropriately addresses these needs.

Participants may be individuals who do not yet have any eating symptoms, in which case prevention programs are offered. Given the prevalence of eating concerns (not disorders), prevention programs are important for children and adolescents. Once a person has been diagnosed with an eating disorder, treatment groups with a cognitive-behavioral or interpersonal focus are recommended. Information follows on these treatment approaches. Group size is dependent on the type and purpose of group. Psychoeducational groups are larger than counseling groups, which typically have 8–10 participants. Many school-based psychoeducational programs operate in classrooms and include more than 20 people. The gender of qualified therapists appears to be of less importance in the treatment of eating disorders than perhaps the gender of group members (Romano, Quinn, & Halmi, 1994). Female cotherapists seem to be more common than a male-female dyad—this may be because more female mental health providers have an interest in eating disorders. It is our experience that both males and females can effectively facilitate groups for eating disorders.

Generally, for outpatient groups, it is best to avoid admitting group members who are not motivated and willing to commit to treatment (Romano et al., 1994). This is of particular relevance because lack of motivation and resistance to treatment are highly common among individuals with eating disorders and can lead to treatment attrition, failure, and relapse (Feld, Woodside, Kaplan, Olmsted, & Carter, 2001). People with eating disorders are often ambivalent about participating in treatment (Feld et al., 2001) and may present for treatment at the insistence of parents or other family members, friends, or physicians. Feld et al. (2001) compared people with eating disorders to those with addictions, indicating that both groups are often unmotivated to participate in counseling. It was this recognition that led to the development of the pretreatment motivational program, which has its roots in the addictions field. Feld and colleagues studied the effects of a pretreatment motivational enhancement therapy on individuals with eating disorders (AN, BN, and EDNOS). The intervention included four hour-long sessions that focused on “the benefits and costs of having an eating disorder; predicting life in 5 years with and without an eating disorder; and life values and goals in relation to an eating disorder” (p. 196), after which assessments of readiness to change and other psychological measures were collected. Participants were more motivated to change and viewed their behavior as a problem after the intervention. Most of the members entered a treatment program and indicated that the pretreatment motivation sessions positively influenced their decision to enter therapy.

A brief questionnaire, developed by Gusella, Butler, Nichols, and Bird (2003), based on Prochaska and DiClemente's model, is useful in assessing readiness to participate in a group treatment program. Counseling groups generally exclude individuals who are abusing alcohol or drugs, psychotic, and/or suicidal (Telch, Agras, & Linehan, 2001). Individuals with personality disorders, in particular borderline personality disorder and thought disorders, should also be carefully considered prior to inclusion in group treatment for eating disorders (Romano et al., 1994). Concurrent individual therapy may allow such individuals to benefit from group.

Psychoeducational Groups

Psychoeducational groups focus on educating group members about an identified issue or risk factor and reducing the risk or occurrence of that cognitive, affective, or behavioral component. For example, the objectives of a psychoeducational program might be to increase participants' awareness of the media's tendency to provide a distorted representation of women and to reduce participants' acceptance of societal standards of beauty (Coughlin & Kalodner, 2006). Psychoeducational groups often follow an informational/discussion format and use structured material for group meetings. Through psychoeducation, people with eating disorders and those at risk of developing eating disorders are presented with accurate information to address gaps in knowledge and misinformation that may influence unhealthy eating practices. See below for some materials that may be helpful in implementing programs.

Individual or group-based psychoeducation may involve the use of a self-help book, such as *Overcoming Binge Eating* (Fairburn, 1995). This classic manual has a psychoeducational focus in the first chapters (describing binge eating and its various forms and associated problems and providing a rationale for the self-help approach and model). The second section contains the steps of the self-help program, which addresses how to assess and change eating behaviors. Peterson, Mitchell, Crow, Crosby, and Wonderlich (2009) compared three types of treatment for binge eating disorder to determine the relative efficacy of self-help group treatment compared to therapist-led and therapist-assisted group cognitive-behavioral therapy. Using 20 weeks of therapist-led, therapist-assisted, or self-help group treatment or a waiting-list condition, they found that therapist-led group cognitive-behavioral treatment for binge eating disorder led to higher binge eating abstinence rates, greater reductions in binge eating frequency, and lower attrition compared to group self-help treatment. Although these findings indicate that therapist delivery of group treatment is associated with better short-term outcome and less attrition than self-help treatment, the lack of group differences at follow-up suggests that self-help group treatment may be a viable alternative to therapist-led interventions.

More examples of group based guided self-help are appearing in the literature. For example, Integrative Response Therapy (IRT; Robinson, 2013) is a group-based guided self-help treatment program for BED that is primarily based on affect regulation theories of binge eating, while adding emphasis on cognitive restructuring techniques, reducing vulnerabilities and, when possible, negative events that contribute to problematic emotional responding and cognitions. IRT's 10 group sessions last 60 minutes each and are administered over the course of 16 weeks. It is manual based, with a focus on cessation of binge eating, and the therapist is active and directive in session, with significance placed on rapport between therapist and patient and homework is used.

The field of eating disorder prevention has made significant strides in the past two decades and in particular in the past decade (Levine & Piran, 2004; Levine & Smolak, 2006). There are over 50 prevention programs whose evaluations were published in the scientific literature between the years 1994–2005 (Neumark-Sztainer et al., 2006). The newer prevention programs have a broader focus to promote the overall positive well-being of youth. Given the comorbidity of eating disorders with other psychological problems and health-related issues, particularly mood disorders and substance-related disorders, it seems reasonable to address factors that might underlie not only eating problems but also other problems This strategy may be able to change a variety of behavioral and mental health problems and is likely to appeal to educators and public officials concerned about violence, depression, substance abuse, obesity, and poor nutrition.

Also newer to the prevention literature is attention to obesity concerns. There is a growing prevalence of obesity among youth, and research suggests considerable overlap between obesity, eating disorders, and disordered eating behaviors (Neumark-Sztainer, 2003). Overlapping ground between eating disorder and obesity prevention includes healthy weight management, healthy eating patterns, increased physical activity-enhanced media literacy, positive body image, and effective skills for coping with negative affect and with stressors. A different possibility is seen in the approach advocated by Heinberg, Thompson, and Matzon (2001). These researchers agree that prevention should foster an acceptance and appreciation of nonweight-related features (muscles, balance, skills, skin color, etc.) that can contribute to a positive body image.

Primary prevention programs for children in elementary school focus on nutrition, encourage healthy, moderate exercise, the diversity of body shapes, the development of a positive body image, healthy eating rather than caloric-restrictive dieting, and critical evaluation of media messages about body shape and nutrition (Eating Smart, Eating for Me; Smolak, 1999; Smolak, Levine, & Schermer, 1998). Berger et al. (2011) has been studying several programs for preadolescent girls and boys (aged 10–15 years) developed in order to prevent eating-related problems (both eating disorders and obesity). Their work also focuses on primary prevention. Initial data suggest that girls in 6th grade showed significant improvements in eating attitudes and self-esteem about their bodies, whereas boys only improved their knowledge about eating and physical activity.

Also, new in the prevention literature is a focus on including parents in groups. Nicholls and Yi (2012) describe a prevention group for parents, highlighting the need to intervene with parents of adolescents. In their group, they focused on parental concern about changes in eating behavior and/or weight loss, and their pilot study showed that a parents' group might be effective for addressing the specific emotional experience of parents; pilot data show significant improvements in knowledge, skills, confidence, understanding and their child's adherence to meal plans as a result of a 6-week parent group intervention. Others (Clemency & Rayle, 2006) have also developed programs including families in the group treatment, such as a nine-session, multiple family psychoeducational prevention group experience for families with adolescent females who are at risk for developing disordered eating habits.

Counseling and Psychotherapy Groups

Cognitive-behavioral therapy and Interpersonal therapy are the treatment of choice for eating disorders. There is much more research on their use with bulimia and binge eating disorder, and a limited review follows. This literature is challenging since many studies focus on the type of therapy rather than the therapeutic modality. Regardless, these treatments have empirical support and there are many treatment manuals available to guide their use. Interestingly, sequencing cognitive-behavioral and interpersonal group formats (Nevoven & Broberg, 2006) may provide individuals with eating disorders the opportunity to experience the curative factors in both types of therapeutic approaches, which are described below.

Cognitive-behavioral therapy (CBT) is perhaps the most extensively researched and supported treatment for BN (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). When comparing CBT to other psychotherapies, specifically, interpersonal therapy, dialectical behavioral therapy, hypnobehavioral therapy, supportive psychotherapy, behavioral weight loss treatment, and self-monitoring, CBT fared significantly better in remission response rates for bulimia nervosa (Hofmann et al., 2012). Shapiro et al. (2007) attempted to answer the question, "What is the evidence for the efficacy of treatments or combinations of treatments for BN?" When compared directly, both group and individual administration of CBT showed decreases in objective and subjective binge episodes, vomiting, laxative use, overexercise and Eating Disorder Inventory (EDI) bulimia, drive for thinness, and body dissatisfaction subscale scores. Group CBT was associated with greater decreases in anxiety; individual CBT was associated with significantly higher rates of abstinence.

CBT generally includes three stages of treatment: establishing control over eating behaviors (Phase 1), identifying and modifying dysfunctional beliefs that contribute to maladaptive behaviors (Phase 2), and maintaining change (Phase 3). The first phase of CBT is generally more behavioral in nature, with the main goal being symptom reduction. One technique used in this phase of treatment is self-monitoring. Through daily log entries, eating patterns are identified by recording time and location of meals, quantity/type of food, circumstances surrounding the eating episode (e.g., individuals present, mood states), type of eating episode (e.g., binge, meal, snack), and any extreme weight control behaviors that were used (e.g., use of laxatives or purges). In Phase 1, behavior modification strategies are often introduced to encourage group participants to experiment with new eating behaviors. For example, in a group for individuals with BN, leaders may instruct participants to eat more regularly throughout the day, delay time between bingeing and vomiting, and practice relaxation between binge episodes and purge episodes. Relaxation exercises and stress management are part of this phase, providing group members with strategies for reducing anxiety when faced with urges to engage in extreme eating behaviors. For example, group participants are taught to use relaxation exercises as they increase their exposure to feared, avoided, and "forbidden" foods.

Phase 2 of CBT groups for eating disorders is more cognitive, with an emphasis on challenging distorted beliefs about food, eating, weight, and body image. The goal is to correct faulty reasoning and erroneous assumptions that maintain dysfunctional eating behaviors. For example, the belief that "thinness leads to happiness" can be challenged and reconstructed to a more valid and logical statement that includes other factors that lead to happiness and reasons why thinness does not necessarily produce life satisfaction. Such statements can be discussed within the group, with an emphasis on elucidating the process by which distorted thinking leads to eating disorder symptoms. As group members learn to use cognitive techniques, they can challenge illogical and faulty statements that are revealed in the group and assist one another with creating more reality-based and logical belief systems. Group leaders may encourage members to identify and challenge these unhealthy thoughts when they hear them in the group, and members can also suggest other more positive self-statements.

In Phase 3, maintenance, group participants are encouraged to integrate and apply the techniques covered in the first two stages of group while focusing on continued symptom reduction and reality-based thinking. This stage, often referred to as relapse prevention, allows group members to prepare for setbacks that will occur. In group sessions, visualization exercises can be used to prepare participants for potential events that might put them at risk for relapse. Group members can be encouraged to understand that lapses of dysfunctional eating behaviors are

opportunities to learn, instead of indicators that they will never recover.

Dialectical behavior therapy (DBT), an intervention that evolved from CBT (Linehan & Kehrer, 1993), is a widely used intervention for the treatment of borderline personality. It focuses on emotional regulation, with the primary objective being to teach clients skills to regulate negative emotions and manage emotional distress. Because it has been hypothesized that binge eating serves to temporarily relieve negative affect, this method of treatment has been considered in the treatment of BED. Telch et al. (2001) developed a 20-week group treatment program adapted from Linehan's DBT for borderline personality disorder. In the DBT group, 16 of 18 (89%) participants were abstinent from binge eating by the 20th week of treatment. This was very encouraging when considering that only 2 of 16 (12.5%) participants in the wait-list group had stopped bingeing. Among those who participated in the DBT group, 67% were abstinent at 3-month follow-up and 56% at 6-month follow-up. DBT, although derived from CBT, does not directly focus on eating behaviors. Instead, DBT focuses on affect and developing skills to manage extreme emotional states. Telch and colleagues suggest that DBT may be similar to interpersonal psychotherapy, an intervention that we discuss in the following section.

Interpersonal Counseling and Psychotherapy Groups

Interpersonal psychotherapy for eating disorders (IPT) is based on the idea that understanding the interpersonal context (relationships that include family and friends) in which the eating disorder developed and has been maintained is necessary to change disordered eating behaviors (Fairburn, 1997). The premise is that to help people stop their eating problems, it is necessary to find out and understand fully what is keeping the eating problems going. Many binges are associated with an interpersonal trigger, such as an argument with a friend or family member, or feelings of loneliness. In IPT there is no attention or direct discussion about eating habits or behavior. Instead, the group leader helps clients study their past and present relationships and interactions and understand how they might be related to their eating disorder.

Fairburn, the developer of this approach for use with eating disorders, has written and researched the use of IPT (Fairburn, 1997; Fairburn, Jones, Peveler, Hope, & O'Connor, 1993) and suggests that 15–20 sessions over 4 or 5 months is necessary to address eating disorders using this approach. In the beginning of treatment, the therapist works to study four different histories: (1) the eating problem (how it started, dates of first binge and purge), (2) relationships (family, friends, peers), (3) other life events and relationships with others (might include a move, parental divorce, starting college), and (4) specific problems with self-esteem and depression. This information is used to create a life chart that shows how the eating problem, relationships, life events, and self-esteem/depression are related. Presented in order of frequency in which they occur, they are interpersonal role disputes (64%), role transitions (36%), interpersonal deficits (16%), and grief (12%; Fairburn, 1997).

In IPT, the goal is to resolve an individual's interpersonal problems by clarifying the problem in the relationship, considering the possibilities for change, and helping the client make positive changes in these relationships. For example, in the category of role transitions, the issue is usually one of establishing independence from parents. Other common transitions include beginning or ending college, changing jobs, getting married, or becoming a parent. Group therapists work with members of the group to understand the changes that go along with these transitions. For individuals who are working to establish independence from parents, the group therapist might explore the kind of relationship the person wants to have with parents and help guide the development of healthy independence. Within the inpatient setting, members frequently are spending a great deal of time together and therefore conflicts frequently arise between members. The interpersonal group can be used, in these instances, to practice healthy conflict resolution and establishing boundaries.

During the group sessions focused on interpersonal problems, few clients bring up their eating disorder. They rarely describe binge eating or purging, or body image issues. However, in the last few sessions, it is more common for clients to talk about their eating problems as they plan for the end of the group sessions. Therapists often tell clients that eating problems may be a kind of Achilles' heel, meaning that the eating problems may recur in times of emotional stress. Thus, the final sessions are planned to solidify the interpersonal changes that have been made during the process of psychotherapy and to reduce the risk of relapse.

Although studies of CBT have dominated the research literature, there have been a number of studies assessing the effectiveness of IPT for BN (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Fairburn et al., 1993; Fairburn et al., 1995). Research shows that IPT is an effective treatment for eating disorders. In an early study comparing the effects of IPT, CBT, and behavioral therapy on young women with bulimia (Fairburn et al., 1993), results indicated that both CBT and IPT promoted significantly superior reductions in eating disorder behaviors in comparison to behavioral therapy. Although CBT was superior to IPT immediately following treatment, no significant differences were found between the two interventions one year after treatment. In a study that evaluated the longer term effects of treatments for BN (CBT, behavioral, and IPT; Fairburn et al., 1995), those women who received CBT and IPT had significantly greater remission rates at 6-year follow-up than those who participated in the behavioral intervention. Furthermore, there were no significant differences in remission rates between those who participated in CBT and IPT at long-term follow-up. Similar to earlier findings, Agras et al. (2000) found that CBT was clinically and statistically superior to IPT immediately following treatment in reducing the behavioral symptoms of eating disorders (self-induced vomiting and dietary restraint). There were,

however, no significant differences immediately following treatment in regard to weight and shape concerns, self-esteem, and interpersonal functioning. As in previous studies, when considering post-treatment status, no significant differences were detected between the two treatments. This suggests that, although CBT may be faster at reducing the behavioral symptoms associated with eating disorders, IPT is comparable to CBT when considering the longer term post-treatment rates of recovery maintenance and remittance of symptoms.

Group IPT has been demonstrated to be an effective treatment for eating disorders (Wilfley et al., 1993). When group CBT and group IPT for individuals with nonpurging bulimia/BED were compared to wait-list controls, CBT group therapy and group IPT had similar effects on binge eating behaviors. More specifically, both group treatments produced significant reductions in binge eating behaviors at 6-month and 1-year follow-up. These results not only suggest that group IPT is an equally effective group treatment for the treatment of BED, it emphasizes the importance of addressing social functioning and interpersonal issues in the group treatment of disordered eating behaviors.

Cautions and Remaining Issues

As with any kind of treatment, there are cautions to consider. Clinicians have noted that in a group setting, those who are more disturbed may undermine the progress of those with less severe disorders. It is also possible that those with less severe disturbances will consider themselves "not that bad" and inhibit their efforts to recover. They raise the commonly heard concern that individuals will teach each other symptoms and unhealthy practices and that some may become overly dependent on others. Leaders need to be aware of these possibilities and monitor the group for indications of these cautions. Although group can clearly offer therapeutic benefit in a supportive environment, the clinician should be aware of the possibility of "peer contagion," which refers to imitation, identification, and competition that can occur in the group setting (Vandereycken, 2011). Whenever indicated, the clinician should be sure to candidly discuss the positive and negative feelings that may arise with being in close contact with fellow patients.

Other issues that influence the type of treatment selected and the outcome of treatment are the co-occurring psychological problems, such as substance abuse/dependence, depression, and anxiety disorders. These issues complicate treatment of the eating disorders. It is difficult to help a person with an eating disorder who is also dependent on alcohol or other drugs. Likewise, when a person has an eating disorder and depression or an anxiety disorder, the treatment must attend to both problems.

It is difficult to assess the role of the group environment in the effectiveness of these interventions. Very few studies have included a measure of group cohesion or any other group variable. The focus in psychoeducational and counseling and therapy treatment groups is on the outcome, tied to the symptoms of the eating problems rather than the process by which the change occurs. The group appears to be a way to reach more people at the same time, a kind of issue of efficiency rather than one based on using the power of the group to influence change. Future research using group treatment would benefit from an explicit use and evaluation of the effect of the group as part of the therapeutic approach. Research evaluating the effectiveness of groups should include a measure of group cohesion, in addition to outcome measures associated with eating disorders.

Another problem is the definition of the outcome of recovery. For BN, recovery is usually described in terms of reductions in the frequency or severity of binge eating, purging, or other problematic behaviors, or the proportion of people who stopped or reduced these behaviors. For AN, recovery is framed as the amount of weight gained or the proportion of individuals who achieved a weight that is a percentage of ideal weight. In BED, recovery can be measured in terms of reduction in frequency of binges but is rarely associated with changes in weight for overweight or obese patients. What is missed in this assessment of change is the change in attitudes about body image. In AN, this includes the intense fear of gaining weight or becoming fat and disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight. In BN, this includes the notion that self-evaluation is unduly influenced by body shape and weight (APA, 2000). Also, associated issues, such as depression, anxiety, and other psychological adjustment, are rarely reported.

Group work with individuals with eating disorders is hard work and requires careful planning, screening, and ongoing supervision. This chapter includes information that is useful in the planning of psychoeducational, counseling, or psychotherapy groups for eating disorders and provides examples of groups focused on eating disorders. The reader is encouraged to read the sources cited in this chapter and seek supervision before embarking on a group program with this population.

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Chapter 39 Psychoeducational and Counseling Groups for Bullying

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All children deserve a safe, nurturing environment in which to grow and develop, but childhood bullying threatens children's safety and interferes with healthy development (Arseneault, Bowes, & Shakoor, 2010; Orpinas & Horne, 2006). The purpose of this chapter is to examine childhood bullying and psychoeducational and counseling group approaches to preventing and addressing the problem. We begin with a short summary of childhood bullying and move into an examination of group counseling approaches to bullying prevention.

What Do We Know about Childhood Bullying?

Definition of Bullying

Bullying has been defined as *intentional, imbalanced*, and *repeated* (Newman, Horne, & Bartolomucci, 2000). That is, bullying causes intentional harm. The victim of bullying also has less power (e.g., physical strength, popularity, intellectual ability) than the perpetrator; thus the relationship is imbalanced. Finally, the behavior is repeated; it happens over and over. Bullying is a subset of aggression and often precedes violence; although we focus on bullying in this chapter, our goal is to prevent all types of aggressive behavior.

Types of Bullying

Bullying may be perpetrated through physical, verbal, relational, and technology-based means. *Physical bullying* includes hitting, tripping, destroying belongings, and other actions that threaten physical safety. *Verbal bullying* includes taunting, threats, and put-downs. *Relational bullying* damages a person's relationships through rumors, backstabbing, exclusion, and other forms of social manipulation. Finally, *cyberbullying* includes using the Internet, cell phones, or other forms of technology to embarrass or intimidate the victim (Willard, 2007, p. 1).

Prevalence of Bullying

The prevalence of bullying is high and it is a global problem, with approximately 30%–40% of students aged 13–15 reporting being the victim of recent bullying (Due, Holstein, & Soc, 2008). U.S. representative studies indicate that bullying is commonplace. For example, in a survey of 15,686 students in grades 6 through 10 in public and private schools, 29.9% of the sample reported experiencing moderate or frequent bullying within the current school term, as a victim (10.6%), bully (13.0%), or both (6.3%) (Nansel et al., 2001).

While everyone is familiar with physical bullying, verbal and relational bullying appear to be the most common forms experienced among adolescents in the United States. In a nationally representative sample of 7,508 students in grades 6–10, the highest percentage of students (53.8%) reported being the perpetrator or victim of verbal bullying, followed by relational bullying (51.4%), physical bullying (20.8%), and cyberbullying (13.6%) (Wang, Iannotti, & Nasel, 2009). Some children experience bullying with troubling frequency. About 8% of students in grades 6–10 reported being bullied weekly (Nansel et al., 2001), and 6.6% of students ages 12–18 reported being bullied almost every day (Robers, Zhang, & Truman, 2010). These students are at particular risk for negative outcomes associated with bullying and are especially in need of adults to take effective actions to prevent bullying.

Bullying Roles

There are several roles that students may take with regard to bullying: some students bully others, some are victims, and some report both bullying and being bullied. Several bystander roles have also been identified, such as students who defend the victim, students who support the bully, and students who remain uninvolved (Orpinas & Horne, 2006; Salmivalli, Lagerspetz, Bjorkqvist, Osterman, & Kaukiainen, 1996). The roles that students play may be fluid across occasion, context, and time. A student may be a victim of bullying one year and perpetrate bullying later; a bystander may defend certain victims and yet remain uninvolved in other circumstances. The importance of context to the development and nature of bullying behaviors is discussed in the next section.

Outcomes of Bullying

Bullying is associated with a wide range of negative outcomes. In a review of the literature, Arseneault et al. (2010) reported victims of bullying may exhibit symptoms of mental health problems, and the negative impact of bullying can be long-lasting. Bullying has been linked to depression, anxiety, social isolation, self-harm behaviors, suicidal ideation, violent behaviors, weapon carrying, and psychotic symptoms. Further, being the victim of bullying appears to contribute to problems in adulthood, including internalizing and externalizing problems, adjustment problems, and referral for psychological services. All these conditions contribute to lower academic achievement, thus making the problem of bullying a major educational concern.

Theoretical Framework for Understanding Bullying

The focus of bullying prevention efforts is to enhance protective factors and reduce risk factors— including effective social interaction, problem solving, decision making, and conflict resolution skills— to diminish the likelihood that bullying behaviors will develop and persist. Risk and protective factors for bullying and victimization exist at each level of the ecological model. Group counselors should focus efforts on the levels of the ecological model that they are most able to modify. Typically, these are individual, family, and school-level characteristics. At the individual level, the goals of group approaches to preventing bullying include enhancing connectedness, building effective social interaction and prosocial problem-solving skills, and advancing positive values and empathic understanding. At the family level, appropriate goals include enhancing the positive relationship among family members, providing skills for appropriate communication and monitoring, effective discipline, and developing high expectations for children on the part of parents. Counseling groups that aim to prevent bullying at the school level should enhance positive school climate (for a detailed description of the components of positive school climate, see Orpinas & Horne, 2006).

Group Approaches to Bullying Prevention and Intervention

Two types of groups have commonly been employed to prevent or respond to bullying: psychoeducational groups and counseling groups. *Psychoeducational groups* are primarily concerned with using educational methods in a group setting to disseminate information and to develop skills (Brown, 1997). Psychoeducational groups generally include structured activities, and the goals of the group are often set by the group leader (Brown, 1998, p. 4). Examples of psychoeducational groups for addressing bullying include classroom-based skill-building activities for students, parent groups that raise awareness of bullying and teach ways of supporting students, and teacher groups that offer strategies for responding to bullying (Horne, Stoddard, & Bell, 2007).

Counseling groups are typically used to target specific problem behaviors and focus on enhancing self-awareness and meeting individual goals. Where psychoeducational groups are more preventative in nature, counseling groups are more focused on remediation (Brown, 1998, p. 4). Group members are screened for inclusion, and the size of the group is generally smaller than psychoeducational groups (Gladding, 2008, p. 31). Examples of counseling groups to reduce bullying include targeted interventions for bullies or victims in which specific aspects of the problem are explored, discussed, and addressed (Horne et al., 2007). One potential concern with counseling groups for aggressive students was raised by Dishion, McCord, and Poulin (1999), who described two randomized intervention studies involving peer groups of high-risk adolescents where negative behaviors appeared to be reinforced instead of reduced in group processes. The authors argued that high-risk youth may be more susceptible to deviant peer influences and that it is desirable to include a mix of prosocial and aggressive youth in counseling groups. We believe this issue can be best addressed by careful planning of the group, by selection of members, and by a highly skilled group leader.

When we work with schools and other organizations on issues of bullying, we stress the importance of prevention over intervention. While both prevention groups *and* counseling or therapy approaches are essential in addressing school bullying problems, people often wait until there is a problem that cannot be ignored before taking action. This is especially true in schools, where there are so many competing demands for time, energy, and resources. However, it is much more efficient to use preventive group approaches (i.e., psychoeducational groups) for avoiding bullying problems than it is to intervene once bullying has taken hold (Conyne, Horne, & Raczynski, 2013).

Mr. Jackson had his hands full with his third period science class. The most challenging—and heartbreaking—student was Tony. When everything was just right—he was in a good mood, he was engaged in the content—Tony could "keep it together" in class. But anything could set Tony off: if another student looked at him "the wrong way"; if he forgot his pencil in another class; if he was just in a bad mood. And when Tony was set off, he was belligerent, erratic, and difficult to calm down. He lashed out at other students and Mr. Jackson, and he showed no fear for what would happen to him as a result. Mr. Jackson was an experienced teacher with lots of strategies for working with challenging students, but interacting with Tony tested his limits and left him feeling exhausted. And the more Mr. Jackson learned about Tony's dysfunctional home life, the more helpless he felt to make a difference with Tony.

We think of bullying prevention and intervention efforts in terms of the phrase "Few, Some, All." *Few* students will be at high risk for frequent bullying and/or being the target of regular bullying. These students, like Tony, have a large number of risk factors and few protective factors to counterbalance these risks. The erratic behavior, anger, and difficult home life that interfere with Tony's ability to engage in class also put him at high risk for being involved in bullying, likely as someone who bullies and is bullied by others. These types of students are in need of intensive interventions focused on their individual circumstances. While Mr. Jackson is doing what he can to help Tony succeed in class, it is likely that Tony will need additional services, such as working with a social worker, counselor, and/or psychologist. In difficult cases such as Tony, individual work may be more productive for preparing him for future group engagement because he isn't likely amenable to group engagement without adequate preparatory work. It is our experience that group counseling with students who are engaged in frequent bullying requires a considerable degree of skill on the part of the group leader and even then there is a risk of group efforts backfiring if the group is not managed well.

Aiden recently transferred to Rockbridge Middle School. His teachers all found him a joy to be around: He was a very polite student, always on-task and eager to please. However, the gym teacher noticed that during team activities, Aiden hung out off to the side by himself, and the other students didn't pay him any attention. Aiden's homeroom teacher noted that before school, Aiden always sat alone reading a book while the other students were chatting. Further, Aiden often came to his math teacher's room during lunch to work on his homework. Aiden's teachers discussed what they had noticed about Aiden's behavior. It was becoming evident that while Aiden was comfortable with adults, he was also shy and having a hard time fitting in with the other students who already had friend groups established.

Some students will have elevated risk for bullying or being bullied. They may already be involved in infrequent bullying and/or may display characteristics, such as a quick temper or difficulty establishing friendships, which serve as warning signs for future problems with bullying. These students are in need of early intervention to help them gain the skills they need to interact with others in a more positive manner. In the vignette above, Aiden exhibited characteristics that may place him at higher risk for being bullied. Namely, he seemed to be struggling to make connections with his new classmates and was becoming withdrawn. Having few friends is a risk factor for being bullied (Orpinas & Horne, 2006), but it is obvious that Aiden has a lot of positive characteristics as well. Given some support in developing relationships with students at his new school, Aiden will likely find his place in the social hierarchy and will no longer be at risk for being picked on as an outsider. Aiden is one who would most likely benefit from a classroom psychoeducational social skills training effort, a new student group, or a support group for students who have been treated as outsiders by other students. Children who bully are expert at identifying friendless students who are very vulnerable to bullying and harassment; support groups run by counselors who are able to encourage positive peer influence may have an important impact on these students. Support groups may also be offered through other organizations, such as Boys/Girls Clubs, YMCA/YWCA, and church groups.

Ms. Bennett doesn't have a lot of rules in her 4th grade classroom, but she is very serious about the rules that she does have: Be nice, Be responsible, Be respectful. On the first day of school, she takes at least a half an hour to talk with her students about what these rules mean and why they are important. During the year, she takes the time to get to know her students and understand their backgrounds. Students know that they can talk to her if they have a problem, and she also makes a point to have fun with her students: sharing jokes over lunch, adding a little bit of silliness to her lessons (especially lessons that cover difficult concepts), and laughing at her own mistakes.

Brooke came into Ms. Bennett's class at the beginning of the year as an energetic and impulsive student. Ms. Bennett appreciated Brooke's vivacity but also saw that she could get snippy with her classmates when things didn't go her way. When Brooke called Michelle a mean name in class, Ms. Bennett immediately responded to it, calmly saying, "Brooke, we don't call people mean names in this classroom. That's not nice or respectful." Brooke and Ms. Bennett had already had a few private conversations about Brooke's quick temper, and Brooke had been practicing calming herself down when she was upset. Brooke didn't want to hurt her friendship with Michelle or disappoint Ms. Bennett, who was her favorite teacher. Brooke took a deep breath. "I'm sorry, Michelle," she said, "I wasn't being very nice. Can you forgive me?"

All students need a safe and nurturing school environment. In a classroom such as Ms. Bennett's, a large number of potential bullying incidents will be avoided because of the caring environment and warm personal relationships that Ms. Bennett has nurtured with her students. A student like Brooke who is quick to anger may be at elevated risk for developing bullying behaviors. However, Ms. Bennett has taken the time to help her develop protective factors—the ability to calm herself down and think through the consequences of her actions—that make it much less likely that Brooke will bully others. Psychoeducational groups for teachers can be an effective way for teachers to develop skills and resources for enhancing positive classroom and school environments, and there are a number of bully prevention programs that emphasize teacher groups (e.g., Davis, 2007; Hoover & Oliver, 2008; Horne, Bartolomucci, & Newman-Carlson, 2003).

Research on the Effectiveness of Bullying Prevention Programs

A well-developed body of literature exists describing the causes and consequences of bullying. The majority of school-focused programs emphasize group engagement, most generally through classroom psychoeducational groups. However, there remains much to be learned about implementing effective bullying prevention programs.

Although no single program has demonstrated universal effectiveness, overall bullying prevention programs appear to be impactful. The model proposed by Olweus (1978, 1994) is one of the earliest and best known bullying prevention programs, focusing on schoolwide engagement of teachers and students. It has been shown to be effective in Scandinavia (Olweus, 1994), though replications in the United States have been less successful (e.g., Bauer, Lozano, & Rivera, 2007). On the other hand, a meta-analysis across 44 different school-based bullying prevention programs estimated an average decrease of 20%–23% for bullying and 17%–20% for victimization (Farrington & Ttofi, 2009). More intensive programs and programs that were of longer duration were more successful at reducing bullying and victimization. In the meta-analysis program, elements that were associated with reductions in bullying were (a) group parent trainings/meetings, (b) improved playground monitoring, (c) disciplinary methods, (d) classroom management techniques, (e) teacher training, (f) classroom rules, (g) whole-school anti-bullying policies, and (h) cooperative group work among professionals. Cooperative group work among professionals was defined as "the cooperation among different professionals (usually among teachers and some other professional groups) in working with bullies and victims of bullying" (Farrington & Ttofi, 2009, p. 64). Program elements associated with reductions in victimization were (a) disciplinary methods, (b) parent training/meetings, (c) videos and virtual reality computer games, and (d) cooperative group work among professionals. Another meta-analysis of 26 studies found that whole-school multidisciplinary programs more often reduced bullying and victimization than other approaches, including stand-alone social skills groups and classroom curricula (Vreeman & Carroll, 2007). A critical component of effective interventions is an ability to facilitate group engagement and process.

What do these findings imply for specialists in group work? We believe that group work is often an important component of bullying prevention programs, but that stand-alone groups may not be powerful enough to effect lasting, positive change. Group work should be incorporated into a more comprehensive, multidimensional approach that addresses risk and protective factors at multiple levels of the ecological model. Psychoeducational groups are a natural fit for this type of comprehensive program. Psychoeducational groups can be developed across the ecological model; for example, psychoeducational groups may be targeted to students to address their universal learning experiences, teachers and administrators to prepare them for leadership and facilitation of change, and parents to prepare them for the support and encouragement needed for their students. Psychoeducational groups can be used by teachers in teacher support groups to support other elements of the bullying prevention plan, such as improved classroom management techniques. For example, psychoeducational groups for teachers could be used to disseminate information, bolster skills related to classroom management, and provide for empathic support from colleagues.

Counseling groups may also be employed as part of a bullying intervention strategy, although group workers should be aware of the potential problems associated with bringing together aggressive youths (e.g., Dishion, McCord, & Poulin, 1999). In groups of students who bully, norms in support of bullying may be reinforced rather than reduced among group members. However, counseling groups with more heterogeneous groups of students may be more productive. For example, Shechtman (2001) described positive results stemming from a counseling group, which was composed of aggressive and nonaggressive students. In this case study, participation in the small prevention group was associated with a reduction in aggressive behavior.

Considerations for Leading Bullying Prevention Groups

We expect that readers of this chapter are familiar with the Association for Specialists in Group Work's (ASGW) professional standards for the training of group workers (2000). It is beyond the scope of this chapter to comprehensively describe the knowledge and skills that group leaders may need in order to conduct groups for bullying, especially given that these groups may look very different given the group type (i.e., psychoeducational, counseling, or therapy) and intended participants (e.g., children, teachers, parents). Instead, in this section we provide an overview of some of the considerations in leading groups with different types of participants, with special focus on leading psychoeducational groups for teachers.

Working with Children and Adolescents

In a discussion of psychoeducational groups for children and adolescents, DeLucia-Waack (2006) describes several differences between groups with students and groups with adults. In particular, in working with children she notes the importance of a high degree of structure for the group leader to help students learn how to appropriately interact with other members of the group. The focus of the group is generally on teaching and practicing new skills. Furthermore, the group sessions will likely need to be shorter with children than adults.

Shechtman (2007) works with bullying and aggression reduction groups for students and she advises group leaders to engage very actively in counseling groups. The group leader helps children identify their goals and encourages them to commit to the group and themselves to engage in self-change. She notes that helping students with group process, such as learning "how and when to risk appropriate self-disclosure, how to articulate problems verbally, and how to provide helpful feedback and respond constructively to others" (p. 299), is also critical.

Group leader beliefs are very important in imbuing the group with a tone of hope. An obvious prerequisite is that the group facilitator believes that all students can learn and make positive changes. The group process should be seen as a way to encourage positive growth, not as a punitive way to "straighten kids out."

Psychoeducational and Training Groups with Teachers and Other Educators

Conducting groups with teachers brings a different set of considerations for group leaders. The goal of the group leader is not to simply disseminate information about bullying. Instead, the goal is to encourage teachers to become aware of the problem, evaluate the extent of the problem, brainstorm and try new solutions, and assess the effects of these actions. The role of the group leader is to be skilled in the process of problem solving, while remembering that teachers, not the group leader, are the experts on what goes on in their classroom.

It is imperative that the facilitator believe in the group process and see the group as a powerful engine for growth and change. The group leader serves as a role model for many of the skills and attitudes that help prevent bullying. For example, the facilitator models respectful interactions among group members, flexibility and collaboration, and a commitment to the group. One important skill is modeling a solution-focused perspective. For example, if a teacher is blowing off steam by speaking negatively about a "hopeless" student, the group facilitator can steer the conversation into looking for solutions instead of dwelling on problems. An example of a script is "That sounds like a very frustrating situation. It can be overwhelming to try to teach when students are not sitting in their seats or listening to what you have to say. I appreciate your honesty in discussing what went wrong in that class period. Let's talk about some strategies that other teachers have used when they've gotten to the end of their rope, so we can all be more effective in these types of situations. What suggestions do other group members have?" As this example demonstrates, the group leader is instrumental in communicating empathy, positive expectations, and a hopeful outlook. These are key for facilitating the change process.

It is the responsibility of the group leader to build relationships with all group members and be flexible and responsive to the needs of the group. We recommend that the group have a predictable routine, but remain flexible in terms of the topics that are discussed. The group leader maintains this group structure, by sharing an agenda or outline for each group meeting, soliciting input for future topics of discussion, allowing for ample discussion time, and incorporating group rituals. For example, one group ritual that we use as an opening activity is "Prouds and Sorries." In this activity, each group member shares something from the previous week that made them happy or proud—such as a positive interaction with a challenging student—along with something that made them sad or sorry, such as a time when they lost their cool in front of the class. This ritual allows each group member to share their successes, identify common struggles, and brainstorm solutions.

An Example of a Group Based Bullying Prevention Program

The Bully Busters series is a school-based bullying prevention program that emphasizes psychoeducational groups for students, parents, and teachers. There are currently four books in the Bully Busters series: an elementary school book for grades K–5 (Horne, Bartolomucci, & Newman-Carlson, 2003), a middle school book for grades 6–8 (Newman, Horne, & Bartolomucci, 2000), a high school book for grades 9–12 (Horne et al., 2012) and a guidebook for parents (Horne, Lind Whitford, & Bell, 2008). Each book provides a framework for conducting psychoeducational groups for bullying prevention and intervention.

The use of groups is embedded across the Bully Busters program. Within the elementary and middle school program, teachers form Bully Busters support teams. The support team is a group of 4–8 educators who meet regularly to discuss the content of the book and the successes and difficulties each member is having preventing bullying and fostering a positive school climate. The group time is intended for educators to learn from the curriculum and also from each other, and it serves as a regular reminder for educators to continue to focus on addressing the problem of bullying. They also serve as professional development opportunities for teachers to learn from their peers, to practice new skills, and to develop a deeper understanding of their students and the problems they are experiencing. The goals of the content and activities are to support excellence in teaching, to help educators become more aware of strengths and problems, and help them develop appropriate policy actions toward bullying. A primary objective is developing positive school values, including caring, respect, and positive expectations for all students. Each of these activities and objectives is conducted through group interaction using modeling, role-playing, and practice.

While it appears the emphasis of the teacher support group is on learning how to manage and implement a program, in fact the most important component is the leadership modeling given by the group facilitator. It is essential that facilitators have group process and group engagement skills and be able to model effective group leadership. This includes every aspect of group process and group dynamics, from orienting members, to personal engagement (eye contact, physical proximity), to membership engagement (“let's do a round-robin of introductions in which we mention a special concern about bullying, which we will discuss later once we all know one another”), to membership connectedness (“Marsha, I saw you attending closely to what Mark was saying about wanting to use physical force when confronting a bullying situation; what thoughts do you have for Mark on that topic?”) to group progress (“We've discussed and role-played/practiced some excellent management skills; let's develop a one-week plan for how we will use our skills moving forward”). To consider the process “teaching a class” would be to miss out on the major focus of group facilitation: to engage and inspire by modeling.

Student groups are an integral part of the elementary and middle school programs, because counselors or educators conduct activities with a classroom of students. The goals of these activities are to enhance student connectedness, build problem-solving skills, and advance positive values in students, all using group interactions to demonstrate, model, practice, and evaluate the interpersonal skills necessary for effective peer interaction—both in group settings and in individual encounters. The activities relate to increasing awareness of bullying and to encouraging students to take steps to prevent and reduce it. The activities provide students a group opportunity to develop and practice important skills to limit their own involvement in the bully-victim interaction, such as recognizing emotions, diffusing anger, and applying problem-solving techniques. Activities are differentiated to be developmentally appropriate for different age groups. An example of a (modified) classroom activity is provided in the last section of this chapter.

In the high school curriculum, counselors train peer leaders on how to facilitate groups with younger students. The counselor does the training of peer leaders by conducting psychoeducational groups with the students, demonstrating group process skills, engagement activities, role-playing, and management of conversation flow. The group becomes a learning experience about life skills to share with younger students and also a learning laboratory on group facilitation and engagement with younger students. The purpose of these student groups is to enhance connectedness among students who might not have known one another and to promote the specific skills that allow students to be interpersonally successful. The group sessions include discussion, role-play, and skill

building centering on topics, including building trust and empathy, listening and communication skills, internal and external influences on choices and behavior, conflict resolution, relational aggression, verbal aggression, physical aggression, cyberbullying, cliques, intolerance, and healthy and unhealthy dating relationships.

The parenting book is best implemented in a group setting as well. Because many of the chapters cover content that is similar to the information provided in the other Bully Busters books, some schools provide parenting groups as one component of their schoolwide plan to prevent bullying. The goals of the Bully Busters parenting guide are to help parents acquire basic knowledge about aggression and bullying, become more aware of the family's strengths and weaknesses, improve communication and connection within the family, and empower parents to take action to intervene in bullying situations. Again the parent group facilitator needs to be highly skilled in group procedures and be comfortable managing group engagement.

Final Thoughts on the Use of Groups for Bullying Prevention and Intervention

We have not attempted to provide an overview of group processes and models; those points are covered very ably in other chapters of this volume and in considerable detail in books specifically developed for learning group approaches to helping address people's problems. Our goal was to provide an overview of the problems of bullying and aggression and to emphasize that groups in schools and community agencies are a natural means of impacting the problem but not in the usual group counseling/therapy approach. Rather, we place a strong emphasis on psychoeducational groups. Prevention efforts through interpersonal skills training in such areas as friend making, conflict management, problem solving, awareness induction, effective modeling and role-playing, and empathy training are critical—both as a universal service for all students and as a targeted group treatment approach for those exhibiting problems related to bullying.

When more severe problems are evident, more intense engagement is necessary; group counseling can be one of the avenues of approach, but homogenous groups of students who bully or students who are victimized may be problematic. We have sufficient experience to suggest that when a group is comprised of students who have been bullies, they are likely to reinforce one another in their bullying tactics. On the other hand, when a group is made up of students who are victims of bullying, the groups often devolve into discussions about how they aren't the ones needing treatment, that the system is unfair, and there is nothing to do but feel hopeless.

To facilitate either of these approaches, counselors must have advanced group skills along with a number of additional characteristics not usually described in group textbooks. All the therapeutic characteristics of being a group counselor or therapist are required, including being able to provide the therapeutic conditions so clearly defined by group leaders, particularly Yalom (Yalom & Leszcz, 2005). Being able to instill hope, explore the universality of problems, develop an environment of altruism, engage in cathartic experiences, and the other conditions are essential. The counselor must also approach this particular area of group treatment with intensity of purpose, commitment to a social justice agenda, and a demand for change. Thus, the group facilitator must possess

- a keen awareness of the etiology of the bullying problem, knowledge of the characteristics and traits of bully/victim dyads, and an ability to know when it is happening even if the events are not observable.
- a strong ability to be authoritative and assertive. The counselor must be able and willing to use this authoritative stance to make clear that there will be total openness to caring for students but zero acceptance of the continuation of the problem. As an example: We know that one of the primary interventions that works on school playgrounds is to have a peer tell a bullying student to stop. Period. Stop. To say, “We don't do that at our school, so stop it now.” Often students don't have the authority or agency to be impactful in this arena. It is essential that the counselor is able to demonstrate these skills and then demand the expected behaviors. Failure to do so will cause the group members to lose confidence in the leader and lose faith in the group process.
- an appreciation of contextual conditions. At times, what may appear as bullying may actually be rough and tumble playing or good-natured banter among friends. The counselor must possess the skills to determine what behavior is abusive versus play.
- a willingness to go above and beyond the group. Bullying is a systemic problem, and the group facilitator will need to extend beyond the group to be influential. This includes providing training, supervision, and support for teachers, including those who don't think they need it. It also means reaching out to parents to engage them in developing an awareness of the problem and steps that are necessary to alleviate the concerns. This can often be a confrontational experience, so the group leader must be both prepared and willing to take on these challenges.

Summary

There are a number of bullying prevention programs available that have a group emphasis. The primary model of group work is psychoeducational in emphasis rather than group counseling or group therapy. Specific programs include the work of John Hoover and Ronald Oliver (2008) with an emphasis on specific activities and skills counselors may teach young people to avoid bullying. The Olweus program is the best known of the bully prevention programs, and it offers teacher support groups (Limber, 2004). Stan Davis' *Schools Where Everyone Belongs* (2007) provides extensive practical strategies for teachers and counselors to use in classroom groups and support sessions. Susan Swearer, Dorothy Espelage, and Scott Napolitano (2009) have a program on bullying intervention that is also very teacher-group engaging and provides directions for school psychologists on managing bullying problems. The S.S. Grin Program (DeRosier & Marcus, 2005) is a group based manualized social skills training program, which emphasizes gaining prosocial skills using behavioral and cognitive strategies. William Porter with the Cherry Creek, Colorado, schools is a member of the *Bully Proofing Program*, and they have a series of programs addressing school and family bullying, with an emphasis on psychoeducational group interventions (Garrity, Jens, Porter, Sager, & Short-Camilli, 2000). Psychoeducational group leadership skills are essential for bully prevention group facilitators.

Classroom Activities and Discussion Questions

In this section, we provide two modified activities from the *Bully Busters* program. The first activity introduces a problem-solving technique that is described in the elementary, middle, and parenting books. The second activity is modified from the middle school book.

Activity 1: The Big Questions

The Big Questions are a problem-solving strategy that focuses on finding solutions rather than dwelling on the problem. The Big Questions are an effective technique that can be used by anyone—teachers, parents, and students of any age. Read through the following example of the Big Questions, which are in bold, and use the discussion questions to engage in a group conversation.

> **What is your goal?** My goal is to conduct this group session to help students learn to manage their emotions, but Nathan keeps whispering and it's distracting the group and me.
> **What are you doing?** I'm getting more and more frustrated. I just want our time to be over, and I think the group can sense that.
> **Is what you are doing helping you achieve your goal?** No, I am not being an effective leader, and I'm not setting a good example for the group.
> **If not, what can you do differently?** First, I need to take a few deep breaths, calm myself down, and remember how fun this group usually is. Next, I need to calmly remind Nathan of our group rule against side conversations. Finally, I need to do something to get the group back on track. **What generally works?** It typically gets the group's attention if I tell them a silly story about my own life. I'll try that.

Discussion Questions

- Identify a real or hypothetical personal problem that could be examined using the Big Questions. How does using the Big Questions help you think about the problem and generate solutions in a different way?
- Identify a real or hypothetical problem that may be encountered with a student or within a group. How can you use the Big Questions with the student/group member to help them work through the problem?

Activity 2: Framing the Bully

Framing the Bully is an activity that we use with elementary and middle school students, but we find that it is a great way for adults to process their own thoughts and beliefs about bullying.

Directions

- On a blank sheet of paper, define *bullying* by drawing pictures, using symbols, and writing a few words.
- Use the following questions to conduct a group discussion about bullying. During the discussion, group members may continue to add additional words and pictures to their paper that they feel apply to bullying. One group member may want to record the main ideas of the group.

Discussion Questions

- Think about a bullying incident from your youth. Who was involved, and where did the incident take place? What happened? What role did you play? How did you feel?
- How do you react now when you encounter a person (a student or another adult) who has the characteristics of a bully?
- How do you think the aggressive person sees these characteristics in himself or herself?
- How do you think the aggressive person develops these characteristics?
- Is someone who bullies a bully in all situations? What are some examples?
- If there is a difference in how you see the aggressive person and how the person sees himself or herself, why do you think that is?
- How might we redefine the negative characteristics of the aggressive person as positives and help the aggressive person use these characteristics in a positive way?

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Chapter 40 Women's Groups: Research and Practice Trends

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Introduction

What is the status of women's groups today and what is being done to meet the diverse needs of women in groups? Women's groups are being used to meet the expanding needs of women, complicated by issues such as being refugees or recent immigrants to the United States (e.g., Suh & Lee, 2010), substance abuse (e.g., Washington & Moxley, 2003), domestic partner violence (e.g., Kaslow et al., 2010), sexual assault (e.g., Hébert & Bergeron, 2007), and poverty (e.g., Jones, 2007). One of the most common benefits expressed by participants in many of the women's groups studied is overcoming isolation and realizing they are not alone in their experience (Loewy, Williams, & Keleta, 2002). Women who may think they have nothing left to offer anyone are finding that in a group setting they are giving support, empathy, courage, and hope to other women (Fernando, 2009). More research is being conducted on women's groups and that research is using more effective research designs to better understand the efficacy of group interventions and the lived experiences of women in groups.

The purposes of this chapter are to (a) describe the philosophical perspectives evident in the women's group literature, (b) describe the current research being conducted with women's groups and discuss best research practices, and (c) delineate the current practice trends in women's groups and offer best practice recommendations for conducting women's groups. Case examples, discussion questions, and training suggestions are also offered.

Philosophical Background

Cultural Relevant and Culturally Sensitive Perspective

The importance of making women's groups culturally relevant is even more evident in the literature published since the first edition of this *Handbook.* Terms such as culturally informed, culturally grounded, culturally specific, culturally relevant, culturally based interventions, and culturally modified therapies are being seen more often in the literature to describe the types of groups being designed for increasingly diverse populations of women (Fernando, 2009; Jones, 2007; Kaslow et al., 2010; Loewy et al., 2002; McWhirter et al., 2010; Rayle, Brucato, Sand, & Ortega, 2006; Suh & Lee, 2006). These include considerations such as having food at each session because this is seen as a sign of respect within the members' culture, such as Korean (Suh & Lee, 2010), using interpreters or bilingual leaders so that members can express themselves in their first language (Fernando, 2009), incorporating traditional ceremonies, role models, stories and words as part of the group interventions (Loewy et al., 2002; McWhirter et al., 2010), and maintaining connections between members and leaders during and after the group experience because not to do so would be considered rude within the members' culture (Carr, Koyama, & Thiagarajan, 2003; Nitza, Chilisa, & Makwinja-Morara, 2010).

Another important consideration that is often difficult for group leaders to navigate is how to separate cultural norms and traditions from oppression within a culture. Nitza et al. (2010) discussed this issue in their *Mbizi* empowerment groups for adolescent girls in Botswana. Focusing on helping girls make decisions regarding their sexuality, thereby hopefully limiting the spread of HIV/AIDS, these psychoeducational groups discussed cultural proverbs that maintain male dominance over women. They also role-played potential barriers and consequences for going against these cultural roles and helped members develop strong support networks. The groups were coled by the two Botswana coauthors who were fluent in the members' native language and customs and traditions. The authors emphasized the importance of collaborative goal setting in order to make sure the group was meeting members' goals rather than the leaders' goals for them. In a country where there are three HIV positive girls for every one HIV positive boy, challenging oppression in culturally sensitive ways is literally a matter of life and death (Nitza et al., 2010).

This group, and others, demonstrate a growing trend in the women's group literature toward the "globalization" of women's groups in which group leaders are either going to the countries where the women are and finding themselves working within very different cultures or staying put and working with more diverse, international, and immigrant populations in women's groups here in the United States. In either case, using "cultural brokers" and interpreters will be essential to understand cultural norms and become more culturally competent group leaders (Fernando, 2009; Loewy et al., 2002; Nitza et al., 2010; Nussbaum, 1999, 2000).

Feminist and Systemic Perspectives

Utilizing a feminist theoretical foundation continues to be an important theme found in the research (Hébert & Bergeron, 2007; Parker, Fourt, Langmuir, Dalton, & Classen, 2008) and practice-based literature on women's groups (Colchamiro, Ghiringhelli, & Hause, 2010; Duba, Kindsvatter, & Priddy, 2010; Singh & Hays, 2008) and basic feminist principles continue to guide women's group research and practice. Some of these principles include the following: developing an egalitarian relationship between leaders/researchers and members/participants; assessing group members' needs and goals and using mutual decision making and goal setting: understanding the systemic origins of many of the individual challenges women face and ameliorating these obstacles by providing child care, transportation, food, and a safe environment for women in order to make participating in groups and group research possible (Kees & Leech, 2004).

In one feminist-based group study, Buckroyd, Rother, and Stott (2006) assigned homework to the members of their weight loss groups for obese women that included contacting and supporting each other outside of group. They also used a cognitive-behavioral approach focused on increasing self-esteem rather than weight loss and found that members showed increased self-acceptance and reduced emotional eating behaviors. Martinez and Wong (2009) found that using phone call prompts and written reminders to participants helped double attendance at their support group for female survivors of domestic violence. Feminist group leaders and researchers realize that women may not be resisting attending groups as much as they are often dealing with multiple demands in their lives that make attending difficult and that, with additional support, attendance issues can be lessened and benefits increased (Kees & Leech, 2004).

Getz (2002) described ways in which a family systems perspective can provide women's group leaders and members with an understanding of the gendered stereotypes and expectations that limit women's opportunities and choices. Having members create a three-generation genogram of how feelings and emotional caretaking were handled within their families of origin and then acting out these scenarios through family sculpting, the women in Getz's groups discovered some systemic and generational patterns that helped explain some of their individual experiences of burn out, trauma, and relationship issues. This type of systemic understanding of the potential intergenerational origins of women's individual challenges helps group leaders deconstruct the traditional pathological labels assigned to many women and is an essential component of feminist psychology (Nussbaum, 2000).

Social Justice Perspective

While the feminist perspective has always advocated social action to change the inequitable systems within which we all live, the recent literature on women's groups is showing an even stronger and more direct emphasis on social justice counseling and competencies. Social justice initiatives for advocacy and empowerment are seen in social justice groups for young homeless mothers (Coker, Meyer, Smith, & Price, 2010) and groups for survivors of intimate partner violence (Chronister & Davidson, 2010) and their children (McWhirter, 2010). Social justice groups are covered within other chapters in this text and, for that reason, will not be covered in depth here. For more information on social justice counseling, see Counselors for Social Justice (CSJ; 2011), a division of the American Counseling Association.

Toward an Integrated Perspective

Crethar, Rivera, and Nash (2008) described a major step toward an integrated approach to working with clients by identifying common themes between multicultural, feminist, and social justice approaches to counseling. These include (a) understanding the individual within social and systemic contexts, (b) awareness of unearned privilege, (c) empowerment, and (d) advocacy, which includes the concepts of equity, access, participation, and harmony. Applying this integrated approach to working with and understanding women in groups, group leaders and researchers will need to assess members' needs from a holistic perspective and work to cocreate with members the best group interventions to meet individual goals as well as goals for systemic change. This approach should include assessing the inequities, limits to privilege, and restricted access many women have to full participation and decision making in their lives, as well as assessing the systemic contexts and origins of many of the psychological issues women often experience (McWhirter et al., 2010). See the section on best practices at the end of the chapter.

Research and Practice Trends in Women's Groups

Research on Women's Groups

Research on women's groups has been lacking for many years (Leech & Kees, 2005). For this analysis of research on women's groups, two major search engines (PsycINFO and ERIC) were used to find articles with the key words *women* and *research*, combined with the Boolean logical operator *and*, and *group counseling* and *group therapy*, combined with the Boolean logical operator *or.* The two searches were combined with the operator *and.* The search with ERIC yielded 29 products and the search with PsycINFO yielded 2,550. Articles were included in the analysis of research using the following guidelines: data were collected and reported in the article and the words *research, group*, and *women* were in the title and/or abstract. All other articles, including book chapters, unpublished papers, articles with young women or adolescents, articles with focus groups, books, dissertations, and articles not written in English were not included. Following these guidelines, after deletion of articles that did not fit the criteria, 20 research articles remained published since 2001. For the current chapter, nine major topics were extracted from each article including the populations studied, the sampling procedures, the topics, the type of therapy used in the groups, the sample size, the number of groups researched, the age range of the participants, the research designs and data analyses being used, and the results. Table 40.1 presents much of this information for each article.

What issues and populations are being studied? There were multiple issues and populations studied in the 20 articles. Three articles focused on participants who had cancer at some point in the past (Cohen & Fried, 2007; Garlick, Wall, Corwin, & Koopman, 2011; Vilhauer, 2011). Two studies investigated women who were homeless (González-Prendes, 2008; Martinez & Wong, 2009) and one studied Black homeless women (Jones, 2007). One study focused on women and career issues (Peng, 2001). Buckroyd et al. (2006) and Crino and Djokvucic (2010) studied women with eating disorders. Two studies (Lundqvist, Svedin, Hansson, & Broman, 2006; Parker et al., 2008) examined women who had experienced abuse as children. Chemical dependency was another issue reported (Gilbert & Beidler, 2001).

Article	Topic	Type of Therapy	Sampling	*N*	#	Age Range	Results
Buckroyd et al. (2006)	The effects of group therapy for women who eat compulsively	Cognitive-behavioral, psychodynamic, self-psychology, and existential	Criterion; Recruited by ads	27	2 and control	—	Quantitative data showed little change for attitudes and self-esteem; qualitative data indicated changes occurred in attitudes and emotional functioning
Cohen & Fried (2007)	The effects of a cognitive-behavior (CB), relaxation and guided imagery (RGI), or control group on physical, psychological symptoms and locus of control for women diagnosed with breast cancer	Cognitive-behavior and relaxation and guided imagery	Convenience; Recruited by nurses at oncology department; Randomly assigned to groups	114	2 types of groups (ranging from 6–8 members) and control group	Mean = 53.5 years	The participants in the intervention groups reported decreased psychological distress; the RGI participants had lower levels of fatigue and sleep problems; the CB participants had lower external locus of control
Coon et al. (2003)	Group for women caregivers focusing on depression and anger	Psychoeducational	Criterion; Recruited through ads; Randomly assigned to groups	169	2 with wait-list	50 or older	Both the anger and depression focused group participants had lower levels of hostility, depression, and anger; the participants in the anger control group had higher coping skills
Crino & Djokvucic (2010)	Effects of group cohesion, attendance, and early treatment on eating disorder symptoms	Cognitive-behavior	Convenience; Patients at an eating disorder program	36	1	15–35	Participation in the group positively affected eating disorder symptoms; compatibility was found to be related to attendance and response to treatment
Garlick et al. (2011)	Women with breast cancer and the effects of Psychospiritual integrative therapy (PSIT)	Psychospiritual integrative therapy (PSIT)	Criterion; Recruited through ads	24	1	40–66	Participation in the group increased psychological, spiritual, and physical well-being
Gilbert & Beidler (2001)	The effects of using narrative approach with chemically dependent mothers	Narrative	Convenience; Women at a group home	6–9	1	Late 20s–late 30s	Women felt they did not have any: power, honesty, sense of self, sense of community, joy in life, words for feelings, trust, and attention span
González-Prendes (2008)	Anger control group for women recovering from alcohol and/or drug addiction	Cognitive-behavior	Convenience; Living in residential treatment facility; Randomly assigned to groups	13	2	32–53	Groups were found to be similar at pretest; the anger control group had higher ratings of the moral model than the relapse-prevention group
Hall & Hawley (2010)	The use of interactive process notes in a group for women dealing with depression and anxiety	Transactional Analysis and Rational Emotive Behavioral Therapy with a here-now emphasis	Convenience	4	1	24–47	Five categories were identified including stage formation, monitoring participation, therapeutic factors, psychological insight, and boundaries.
Hébert & Bergeron (2007)	Effects of a feminist approach to group intervention for survivors of sexual abuse	Feminist model that focuses on awareness and action	Convenience; All women requesting services were included in the study	51	8 groups and wait-list	18–67	The intervention reduced psychological distress and was maintained at 3-month follow-up
Jones (2007)	Culturally relevant group experience for low-income Black women to decrease depression and stress, and increase locus of control and active coping	Claiming Your Connections (CYC; Jones & Hodges, 2002)	Convenience; Black women from a local long-term shelter; Randomly assigned to groups	21	1 with control	18–55	Women in the CYC group had significantly lower depressive symptoms and stress levels, higher locus of control and coping
Kaslow et al. (2010)	Culturally informed interventions for low-socioeconomic-status African American women with a recent history of domestic violence and a suicide attempt	Psychoeducational	Recruited from hospital that served indigent, urban population; Randomly assigned to groups	208	1 with control group	18–64	Women were assessed at baseline, post-intervention, and 6- and 12-month follow-up; women in the culturally informed group showed more rapid decrease in depression symptoms, general distress, and less suicidal ideation
Lundqvist et al. (2006)	Women who have been sexually abused as children and the effects of a 2-year trauma focused group	Yalom (1985) and Kreidler and Burns England (1990)	Convenience; Women in treatment	52	10 and wait-list	20–54	Group participation reduced psychological and PTSD symptoms; sense of coherence also increased
Martinez & Wong (2009)	The effects of prompts to increase attendance at a support group for survivors of domestic violence	Support	Convenience; All residence available at the time participated	15	1	Over 18 years old	Prompting the clients doubled attendance
McWhirter (2010)	Women who have experienced trauma and the effects of being in community-based therapy compared to women in a nonclinical program	Cognitive-behavioral and Gestalt	Convenience; Women living in a homeless shelter and women in a not-for-profit employee mentoring organization	69	4 and control	22–65	Both groups increased social networks for the women, decreased social isolation and financial stress; women in the community-based therapy had increased self-efficacy
Parker et al. (2008)	Women who had self-report history of child maltreatment before 18 years old completed the Women Recovering from Abuse Program (WRAP)	Women Recovering from Abuse Program (WRAP)	Convenience	7	1	31–71	Themes emerging from the interview data included doing therapy, the healing journey as a continuous process, and breaking trauma-based patterns
Peng (2001)	Anxiety regarding career choice for college women	Cognitive restructuring intervention	Criterion; Ads for participation	35	2 with 1 control	Mean = 20 years old	The participants in the treatment groups had lower anxiety than the control group members
Suh & Lee (2010)	Understanding Korean expatriate women	Modified Reality Therapy	Purposeful sampling	7	1	26–39	Group participants had increased self-esteem, well-being, and group cohesiveness 12 weeks after the group ended; stress was reported from language issues, cultural adaptation, financial issues, homesickness, family relationships, and low self-esteem
van Lankveld et al. (2006)	The effects of cognitive-behavioral therapy, cognitive-behavioral bibliotherapy or wait-list for women with vaginismus	Cognitive-behavioral, cognitive behavioral bibliotherapy	Criterion; Referred by outpatient sexology clinics; Randomly assigned to groups	117	6–9 per group	18 years or older	14% of the participants in a treatment group had successful intercourse at post-treatment
Vilhauer (2011)	Interviews with women with metastatic breast cancer who had participated in a mixed-stage and/or stage-specific group	—	Criterion; Referred by oncologists or community support centers	8	3 (the groups were not the focus of the study)	Mean = 53 years	Participants in mixed-stage groups did not feel supported; in stage-specific groups participants felt understood and became more informed about the illness
Washington & Moxley (2003)	Women recovering from being chemically dependent	Cognitive-behavioral and experiential	Convenience; Residential inpatient treatment; Randomly assigned to groups	93	2 and wait-list	Mean = 33.6 years	No group comparisons were conducted; women reported learning to "calm their spirits" (p. 152), release energy without becoming angry, decision making, how to confront chemical dependency

Finally, the other eight articles focused on different populations including Black women who had experienced partner abuse (Kaslow et al., 2010), women who were caregivers for a person with dementia (Coon, Thompson, Steffen, Sorocco, & Gallagher-Thompson, 2003), Black women suffering from chemical and/or alcohol addiction (Washington & Moxley, 2003), women suffering from depression and anxiety (Hall & Hawley, 2010), Korean expatriates (Suh & Lee, 2010), women who had recently had a major life transition (McWhirter, 2010), women suffering from vaginismus (van Lankveld et al., 2006), and women who had experienced sexual assault (Hébert & Bergeron, 2007). From this list, it is evident that the populations and issues studied are very broad, providing little sense of continuity between or among these studies.

What sampling procedures are being used? Of the 20 articles identified, as shown in Table 40.1, only one used purposeful sampling; Suh and Lee (2010) used purposeful sampling to locate Korean expatriates. Six articles used criterion sampling; for example, Buckroyd et al. (2006) had flyers in the community to find women to participate in their study who ate compulsively, and Vilhauer (2011) sent letters to oncologists and included flyers in the community to locate women who had metastatic breast cancer and had participated in mixed-stage and/or stage-specific groups. Four studies used advertisements in the community for participants (e.g., Coon et al., 2003; Garlick et al., 2011). All the other articles utilized convenience sampling. This extensive use of convenience sampling is unfortunate because convenience sampling does not make generalizations past the sample very informative. In fact, "convenience sampling involves drawing samples that are both easily accessible and willing to participate in a study yet may not be the most appropriate to answer the research questions … [and] often result in biased data" (Teddlie & Tashakkori, 2009, pp. 170–171). Positive aspects of using convenience sampling include that the therapist may already have a relationship with the client/group and would therefore be able to identify themes in the data more easily, the clients may be more comfortable with the researcher if they are not seen as an "outsider," clients are more accessible, and commonly are not paid.

What research designs and data analyses are being used? The type of research designs and analyses used is important to consider because utilizing rigorous research designs and analysis impacts how the overall study and results will be viewed. Of the 20 articles, five articles were exploratory and fifteen were confirmatory. Interestingly, all the confirmatory studies used a pre/post design. The majority of these confirmatory studies included a control group, wait-list group, or more than one treatment, except for three (i.e., Crino & Djokvucic, 2010; Garlick et al., 2011; Martinez & Wong, 2009) who included only one group in their study. The analyses used in the confirmatory studies ranged from basic statistics (e.g., chi-square, *t* tests) to very complex analysis (e.g., HLM). Eight of the exploratory studies investigated one group using a phenomenological design with either interpretive phenomenological analysis (i.e., Vilhauer, 2011) or constant comparison analysis (i.e., Hall & Hawley, 2010; Parker et al., 2008; Suh & Lee, 2010). The use of pretests and posttests are helpful in understanding how women change from the experience of being in a group. Furthermore, the use of control groups increases the rigor of the studies such that the reader can see if the group experience was what created the change.

Best Practices for Researching Women's Groups

Based on the research on women's groups, a number of best practices can be identified. For example, the majority of the research used a pre/post design with a control group or comparison of two treatment groups. This is helpful, because having a baseline measure of the group can assist the researcher in understanding if participation in the group had an effect. Even better is the addition of a control group, which allows the researcher to assess if the treatment is truly what is affecting change.

There are many additional best practices that could be utilized with research on women's groups. In only one study (i.e., Kaslow et al., 2010), the authors used HLM, a type of multilevel modeling, to analyze the data. Hox (2010) describes multilevel modeling as "Social research [that] regularly involves problems that investigate the relationship between individuals and society … [who] are conceptualized as a hierarchical system of individuals nested within groups" (p. 1). Multilevel modeling accounts for the nesting of the data, which is perfect for research on groups as the data are nested within the group. Furthermore, multilevel modeling accounts for the data not being independent; the data from group members will be more similar to one another than the data from

women in different groups (Hox, 2010). It will be important for future studies to use multilevel modeling to address some of the problems that currently exist in the extant literature including the effects of independence and nesting.

Group studies are regularly fraught with small sample sizes, which make generalizing to the population more difficult, and these 20 studies are no exception. Having small samples makes generalizing to the population more difficult. Additionally, the use of random sampling would make the research much more rigorous. To increase the confidence in future research findings, it would be beneficial for authors to consider using larger samples that come from several different groups, randomly assigning the women to treatment condition(s) or at minimum randomly assigning treatment condition to the counseling groups and addressing both the outcome and process of the group environment.

The vast majority of research on women's groups shows that participation in the group is beneficial. Regardless of design, population, or topic discussed, the groups assisted the participants in experiencing less depression (Coon et al., 2003; Jones, 2007; Kaslow et al., 2010), increased spirituality (Garlick et al., 2011), more self-esteem (Buckroyd et al., 2006; Suh & Lee, 2010). As one participant from Suh and Lee (2010) stated when asked about the experience of being in the group, “My life became more alive. I came to know how to think when faced with hardships. I came to think of all things positively. I came to understand and accept reality” (p. 365).

Best Practices for Leading Women's Groups and Case Examples

Based on these 20 research studies of women's groups, as well as a review of 20 descriptive articles on women's groups published since 2002, best practice recommendations for leaders of women's groups will be discussed and case examples from the literature provided.

Assess Members' Needs and Co-Create Group Goals, Methods, and Processes

Assessing members' needs is extremely important with diverse and underrepresented group populations. Colchamiro et al. (2010) conducted focus groups with staff and participants evaluating the traditional materials used in educational groups for the Women, Infants, and Children (WIC) program in Massachusetts. They found that while the staff liked the traditional "teach and tell" materials, the mothers took offense to them and wanted staff to know they were proud of their parenting skills and ability to care for their children. New emotion-based materials were introduced, building on participants' knowledge and experience, and mothers reported feeling more empowered. Staff also found that they liked the new materials, which have become a model for nutrition education in Massachusetts and other states as well.

After interviewing 13 ethnically diverse marginalized women with breast cancer for their art-based support group, Collie and Kante (2011) found that these women did not like the term support group because it suggested that without it they would "fall down." They also liked the idea of focusing on art work rather than talking and recommended the art projects be focused on practical skills they already had, such as knitting, quilting, and beading so that they could also teach these skills to each other. This helped overcome the "I can't draw" fear found in many art-based groups as well as the mistrust they had related to the stigma of receiving counseling services.

Rayle et al. (2006) began their psychoeducational group for 10 monolingual Mexican women who were recent immigrants to the United States with structured exercises focused on wellness and developing a sense of *comadre* or sisterhood. Conducting the group entirely in Spanish, the group shifted fairly quickly to a support and process focus based on the members' needs and as comfort and trust levels increased. Members began sharing their challenges of parenting, loneliness and isolation, and alcoholic or abusive partners. They found empowerment through common experiences and offering each other their wisdom and advice.

Focus on Resiliency, Role Models, Empowerment, and Protective Factors

Several research studies focused on the effectiveness of using a strengths-based, empowerment model with women's groups (Jones, 2007; Kaslow et al., 2010; Washington & Moxley, 2003). Jones (2007) conducted a controlled study with African American women experiencing depression and living in a long-term shelter community. She found that the culturally relevant group with a primary intervention of reading literary works by Black women authors significantly reduced depression and stress for women in the treatment group compared to the no-treatment control group.

In another example, Washington and Moxley (2003) conducted a quasi-experimental group intervention with low-income, African American women recovering from chemical dependency. Based on Bandura's model of self-efficacy, the researchers described several group interventions that showed promise in helping their participants in their recovery process. These included increasing awareness of feelings and substance use through Gestalt experiments, using homework assignments in prayer and meditation, discussing stories of people overcoming obstacles, sharing pictures of successful African American female role models, and using visual art to stimulate discussions around substance abuse.

Kaslow et al. (2010) developed a culturally informed psychoeducational group intervention called Nia that focused on empowering low-income African American women who had been abused and had attempted suicide within the past year. The Nia intervention utilized African American role models, art, and stories, among other strategies, to help empower women and increase protective factors. Using hierarchical linear modeling for their

analysis, the authors found that the Nia intervention showed promise in reducing depressive symptoms and suicidal ideation in women experiencing intimate partner abuse.

Understand the Power of Narrative and Sharing One's Story

The importance of narrative and sharing one's story has taken on new significance in the women's group literature. In one example, McWhirter et al. (2010) described the power of women sharing, hearing, and re-creating their life stories in a "culturally grounded" narrative based group for "marginalized urban American Indian women" (p.134). After conducting a 2-day workshop with community members and leaders to assess the needs and focus of the group, McWhirter et al. developed a group focused on instilling hope, increasing self-esteem, and enhancing understanding across tribes. Members were eight urban Native American women age 19–22 representing five tribes. The groups were scheduled in two 7-hour sessions two weeks apart to accommodate transportation and child care needs. Women shared their own stories and heard stories from two women elders who joined the group for a 2-hour session. One of the primary outcomes of the group was women realizing they were not alone in their experiences and that they had many similarities with women from other tribes.

In another example, Duba et al. (2010) developed a narrative counseling group model for middle-aged women dealing with body image issues. The authors suggested that a narrative approach in a group setting can help members deconstruct the problem of dissatisfaction with their bodies, externalize the problem and understand its societal origins, look for exceptions to the problem, and help reconstruct a new story. Members' ability to share their wisdom as experts of their own story as well as sharing ideas about each other's stories helped break through the focus on body image issues as an individual problem.

Match Group Methods to Women's Needs and Abilities

Some leaders of women's groups are moving away from traditional models of group therapy and matching their techniques to the needs and abilities of their members. In one example of this, Belt and Punamaki (2007) described an intensive group therapy experience for new mothers with substance abuse problems and their babies. Creating a holistic approach for this high needs population, the leaders provided mothers with an "experience of care" by nurturing them with a warm, comforting environment, soft blankets, gentle touch, and food. In turn, the mothers were able to nurture, calm, soothe, feed, and gently touch their own babies as part of this group experience. Amazingly, out of six groups of 3–4 mother-child dyads, these groups had no dropouts. Women who thought they had nothing of value to offer anyone realized that they were able to be helpful to themselves, their babies, and to each other and this realization surprised many of them.

Use creative and nontraditional methods

Creative and nontraditional methods such as art, mandala, meditation, play, and healing circles are showing a good deal of promise in group work with women (Daher & Haz, 2010; Erickson & Young, 2010; Singh & Hofsess, 2011; Slakov & Leslie, 2003). Slakov and Leslie (2003) described a creative support group model for women during the first year after their cancer treatment ends, a time when many women feel on their own without the support they had during treatment. The group creates a playful approach to topics, allowing time for silence, breathing, centering meditation, focusing art activities and rituals, and journal writing in order to help members focus on their inner wisdom, current feelings, and present moment experiences.

One example of using a creative activity was when the group cocreated a mandala around the word *change*. Moving in silence around the large piece of paper with the word change in the middle, members added to the images and drawings based on their own experiences and interactions with other members' contributions. In postgroup evaluations, women expressed that the activities helped them calm down and stay in the present moment, understand commonalities without a great deal of talking, and tap into both group and individual wisdom (Slakov & Leslie, 2003).

Go Where the Women are and Where They Feel Safe and Practice Humility in the Face of Overwhelming Adversity and Resilience

Leaders of women's groups are also moving out of traditional therapy environments and going where their members are. In one example of this, Fernando (2009) described her experience of traveling to Sri Lanka to provide a support group for seven female survivors of the 2004 tsunami. Working with a local priest to help set up the groups, Fernando met with the group six times over a five-week period. While this group met six months after the tsunami had hit, the women were still experiencing severe levels of trauma, anxiety, depression, and displacement.

What the group members found helpful was the ability to share practical information with each other about available resources and realizing that they were not alone in their feelings and experience. Similar to the women in Belt and Punamaki's (2007) group, the women expressed surprise that they, who had literally lost everything, had something of value to share with others in the group. This ability to give to others instilled hope within the group members.

Having been born and raised in Sri Lanka and trained in group work in the United States, Fernando was able to serve as group leader and "cultural broker," being able to bridge the differences between her traditional group counseling training and Sri Lankan cultural norms through increased awareness, self-reflection, and respect. She describes in her personal journal the humility she felt listening to the women's stories of courage, pain, grief and loss, survival and sadness, and she allowed herself to stay with her own pain and sadness, turning it into empathy, in order to become a compassionate witness to the women's stories.

Another story of survival, resilience, humility, and hope was described by Loewy et al. (2002) in their counseling group for traumatized East African refugee women living in the United States. All six women in the group had escaped civil war in their home countries of Eritrea and Ethiopia by trekking to Sudan and being in refugee camps in Kenya. All six had been raped, tortured, and malnourished and had seen at least one family member killed. Going where the women felt most safe and comfortable, the group met in the home of one of the members for two hours a week for six weeks. The group intervention was focused around the East African Kaffa (coffee) ceremony, which served as a catalyst for the group process as well as a metaphor for the women's experience in the group.

Loewy et al. (2002) described the process of the Kaffa ceremony, conducted by a woman in the group, and its relationship to the stages of the group. These steps included (1) the roasting of the beans, during which time the beans open up (as the women get settled and check in); (2) taking the roasted beans around to the group members to appreciate and be wafted by the smoke of the beans (helping the women become focused in the present as one); (3) crushing the beans and placing them in boiling water to steep, adding flavorings and appreciating the aromas (the group gets ready to begin sharing); and (4) the coffee being poured at three different times at about 30-minute intervals (sharing begins, deepens, and moves toward closure). The metaphor of the Kaffa ceremony for the group process as well as for what these women had tragically experienced is beautiful and is not done justice by this brief description. For a more complete description of this process, its history and significance please see Loewy et al. (2002).

Loewy et al. (2002) discussed the role of the group leader as a witness to the unspeakable and that which may never have been shared before. As the ceremony and the group progresses, group members "begin to break through the isolation of their individual trauma and share their painful stories of war, forced migration, and separation from family. They realize they are not alone. … In this way the group can heal itself" (p. 182). For many of these women, speaking in the group helped them overcome their shame from having been "forced to negotiate with their bodies for food, water, and security" (p. 183). The women at times wailed together in common bonds of grief and sadness. As a result of the group, these women moved "from fearful, isolated individuals to an empowered group of women who were determined to be successful in their new country and to let go of the shame they felt about their past" (p. 184).

Both Fernando (2009) and Loewy et al. (2002) discussed the importance of self-care, supervision, and support for group leaders in order to ameliorate the effects of vicarious trauma when leading groups with trauma survivors. Supervision is also important to help group counselors navigate the ethical considerations when utilizing nontraditional group methods such as in-home counseling and practicing in a foreign country (Fernando, 2009; Loewy et al., 2002). The rewards, however, can be well worth the additional efforts for both the members and leaders.

A Summary of Practical Recommendations for Leading Women's Groups

The following is a summary of practical recommendations for leaders of women's groups. It is not meant to be prescriptive as much as a synthesis of best practice guidelines from the feminist, diversity, and group counseling literature. These guidelines will need to be modified depending on the type of group (task, psychoeducational, counseling, or psychotherapy) one is leading and are meant to serve as a baseline on which to build and adapt as necessary.

Screening Members

When screening members for women's groups, it is helpful to include questions related to child care and transportation needs, current support systems and living situations, cultural background and history, and, if appropriate, trauma history. This information will be helpful for leaders in providing members the support they need to successfully participate in the group.

Egalitarian Relationships

Leaders of women's groups will want to establish, as much as possible, egalitarian relationships between themselves and their group members. This means reducing power differentials in the group through appropriate use of leader self-disclosure, encouraging member input in the content and focus of the sessions, and helping members take ownership of the group. Examples of this could include establishing a phone tree so members can support each other in between sessions and in coming to sessions, cocreate beginning and closing group rituals that members could be responsible for, and in members sharing food, language, cultural stories and metaphors, and their own expertise as part of the group process.

Establishing Goals and Setting Agendas

Goal setting and agenda building within women's groups should be a collaborative process between leaders and members. Group leaders will want to assess members' strengths, history, and experience as well as their needs, expectations, and goals when setting up relevant group agendas. Content and processes of groups should be based on members' input, experience, history, and stated needs. Members should be aided in establishing manageable goals for change as their readiness for action increases.

Group Facilitation Skills

Leaders of women's groups should use appropriate group facilitation skills to help establish a safe and productive group atmosphere. Some of these skills include (a) letting group members know that you as the leader may not always be looking at them as they are speaking and that you will be scanning the group to observe other members' reactions to what the member is saying, (b) helping members understand the importance of speaking to each other rather than to or through the leaders and helping members do that by redirecting them to speak to other members, and (c) letting members know that you may be cutting off or redirecting members' comments to each other as necessary in order to maintain a safe environment and help facilitate good communication skills in the group (Jacobs, Masson, Harvill, & Schimmel, 2011).

Understanding and Working for Systemic Change

Leaders of women's groups need to understand the systemic nature of many women's individual struggles, educate their members on these societal origins, and work toward changing, as much as possible, the inequitable systems within which their members live and work. For example, helping women understand the systemic origins of many of their individual concerns such as body image and eating disorders and supporting efforts for educating women and girls to make healthy choices or working to change legislation that would limit women's access to

contraceptive information.

Continued Supervision

It is important for leaders of women's groups to be aware of their own beliefs and biases related to women, power, equality, poverty, race, culture, oppression, and access within societies and the counseling profession. Therefore, ongoing supervision is critical when working with women's groups. Group leaders will want to investigate ways in which they may be maintaining inequitable systems by helping their members adjust or adapt to injustice without challenging or changing the sources of the oppression. Leaders will also want to explore ways in which their own biases may present in group situations through impatience with group members' progress toward change, interpreting member absences or resistance as lack of commitment rather than lack of resources, or over or under functioning for group members. And finally, leaders will want to seek supervision and counseling for dealing with the secondary trauma they may experience when working with the trauma and abuse many of their female members will have experienced.

Conclusions

Women's groups continue to serve multiple functions. They help women overcome isolation and realize they are not alone in their experiences. They help women understand the systemic origins of many of their individual experiences and leaders work with members to help change the oppressive environments within which women work and live. Groups provide women with support, hope, and empowerment to overcome adversity and they provide knowledge and education to help improve women's individual situations in life. Members realize they have worth and can give back to each other through shared experiences, wisdom, and courage. Group leaders and researchers will need to be open to cocreating with their participants, the most appropriate designs for group practice and research in order to meet the needs of participants and fully understand the lived experiences of the women being studied. This can require leaders' humility in the face of often overwhelming adversity that some of the women in their groups and studies have survived and realizing that women themselves are the experts on their experiences, needs, and pathways for overcoming adversity and effecting change.

Discussion Questions

1. What steps would you be willing to take to make sure your groups are culturally relevant and meaningful to your group members?
2. What research questions are you interested in answering related to women's groups? What type of research design and methodology would you use?
3. Women are targeted worldwide for many types of oppression and methods of victimization. How would you help develop comprehensive and empowering group experiences for women who have experienced multiple forms of violence, oppression, and victimization?
4. What types of systemic interventions might you participate in, or initiate, in order to help create more socially just systems within which your group members live and work?
5. What biases and beliefs about women, power, equity, culture, oppression, or feminism would you need to work through in order to be a competent leader of women's groups?

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Chapter 41 Gender-Sensitive Group Counseling and Psychotherapy with Men

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Traditionally, men have been conceptualized as reluctant to participate in counseling and psychotherapy and resistant to traditional methods of treatment (Blazina & Shen-Miller, 2011). This characterization was not made without warrant and understanding. Extensive empirical research from the late 1980s and early 1990s suggested that men were less likely than women to seek therapy for a variety of problems (Addis & Mahalik, 2003). The reluctance of men to ask for help and to participate in therapy is hypothesized to stem from restrictive gender role socialization dictating that men should be individualistic, tough, and in control of their emotions, which are traits that are at odds with the help seeking, exploration of vulnerability, and emotional openness that are often necessary for effective participation in mental health services (Vacha-Haase, Wester, & Christianson, 2011). Consequently, as Steigmeier (2001) has noted, historically men have tended to enter therapy only when coerced to do so or when they are desperate about some situation in their lives.

More recent research suggests that the trend for men to participate less often and effectively than women in counseling and psychotherapy may be changing. In a study of 283 Midwestern adults, gender did not significantly predict mental health service use (Nour, Elhai, Ford, & Frueh, 2009). Additionally, a survey of 5,877 individuals in the United States and Canada revealed that gender was not a significant predictor of mental health treatment dropout (Edlund et al., 2002). Moreover, several statewide and national male-sensitive demonstration projects have been effective in recruiting populations of adolescent and adult men who were historically resistant to counseling to participate in male-only psychoeducational support groups (Achatz & MacAllum, 1994; Brown, 1990; Klinman, Sander, Rosen, Longo, & Martinez, 1985; Romo, Bellamy, & Coleman, 2004). These results are encouraging and may suggest that the concerted efforts of scholars in the field of men and masculinity to improve men's access to and experience with mental health services are beginning to have a positive impact on men's utilization of counseling and psychotherapy, including their participation in men's therapeutic groups.

Why Group Counseling and Psychotherapy for Men?

According to Brooks (2009), traditional men tend to resist individual therapy because they are uncomfortable with the face-to-face emotional interactions required in individual therapy. Additionally, a traditional man in individual therapy may manifest feelings of inadequacy or weakness, viewing himself as one of few men who asks for help (Brooks, 2009). Groups may overcome these obstacles because they do not require one-on-one intimacy and provide individuals with examples of other males who are in need of help. Moreover, men may feel more comfortable in all-male groups because they resemble social and professional organizations, such as fraternities, athletic teams, and army units, in which men commonly participate (Andronico, 1996).

Men who feel hopeless or incapable of change on their own may benefit from groups featuring men mentoring men. More experienced group members instill newer group members with the confidence to make successful changes because they have already gone through this process (Brooks, 1996). Additionally, mentors provide valuable guidance on what it means to be a man in a society where such explicit direction is often absent (Horne, Joliff, & Roth, 1996). Mentors benefit from the mentor-mentee relationship as well. It validates their success thus far, promotes practice and passing on of the behaviors learned in group, and provides them with a new, meaningful role to follow (Horne et al., 1996; McPhee, 1996). Thus, the existence of counseling and psychotherapy groups in which men mentor other men may increase male utilization of mental health services, making groups a vital option if we are to reach hesitant or resistant men in need.

In addition to the benefits of male-male mentoring, all-men groups may be advantageous in certain circumstances. For example, all-male groups are preferable for men who are obsessed with flirting or impressing women. Having only men in the group eliminates the distraction of men trying to place themselves in a favorable light with women (Joliff & Horne, 1996). Also, men are more likely to express their rage in the presence of other men rather than women, because men know that other men are more comfortable with each other's rage and know how to help each other control their anger (Joliff & Horne, 1996).

A wealth of research evidence suggests that group counseling and psychotherapy is an effective treatment modality for men from a variety of populations. For example:

- Recently separated men participating in a gender-role reevaluation group experienced significantly greater positive changes in emotional expression, psychological well-being, and capacity for intimate contact than did men participating in a nongender focused group (Nahon & Lander, 2010).
- Incarcerated men with AIDS participating in a group intervention consisting of AIDS education and psychological support achieved significantly greater increases in their knowledge of AIDS and significantly greater reductions in their symptoms of depression, anxiety, and trauma than did inmates assigned to a nontreatment comparison group (Pomeroy, Kiam, & Green, 2000).
- HIV-positive men completing a bereavement coping group intervention experienced significantly greater reductions in grief distress symptoms than a comparison group of HIV-positive men who received individual mental health and psychiatric services (Sikkema, Hansen, Kochman, Tate, & Difranceisco, 2004).
- Men with histories of physical and psychological violence toward women who received group treatment emphasizing feminist perspectives and narrative therapy methods demonstrated numerous positive changes from pretest to posttest, including more concern about their abusive behavior, less use of denial about their harmful actions, reductions in the frequency of perpetrating physical and nonphysical abuse, and increased utilization of services for psychiatric conditions (McGregor, Tutty, Babins-Wagner, & Gill, 2002).
- Depressed men who received group cognitive behavior therapy experienced significant pretest to posttest improvement in symptoms of depression (Watson & Nathan, 2008).
- Compared to a nonexperimental group of fathers who received no treatment, fathers in a parent education group demonstrated significantly greater improvements in communication skills used with their families and were judged to make significantly greater improvements in their father-child relationships (Levant & Doyle, 1983).

- Middle-aged men who participated in a qualitative study regarding group adventure therapy (AT) reported that they gained new perspectives on how to approach life, developed trust, and shared personal issues with other men through the AT experience (Scheinfeld, Rochlen, & Buser, 2011).
- Compared to men participating in a hospital-based, day treatment program, college-age men who completed group Alexithymia Reduction Treatment achieved significantly greater reductions in their endorsements of traditional masculinity ideology and in normative alexithymia (i.e., deficits in the ability to access, identify, and express emotions (Levant, Halter, Hayden, & Williams, 2009).

Because group counseling and psychotherapy is an effective means of treating a number of the clinical and subclinical problems that men may experience, it behooves mental health professionals to utilize group approaches when planning interventions to help men, know some common goals of male-oriented group counseling and psychotherapy, and employ best practices in group work with men.

Goals for Group Counseling and Psychotherapy with Men

There are common goals that cut across the different types of men's groups that have been reported in the literature. These aims have been centered on challenging men's restrictive gender role beliefs, increasing men's comfort with other men, expanding their emotional capacities, and helping them develop new interpersonal styles and behaviors.

Fostering Male-Male Intimacy and Friendships

Men tend to lack emotional intimacy and support in comparison to women (Vacha-Haase et al., 2011). Indeed, research suggests that males tend to be lonelier (Knox, Vail-Smith, & Zusman, 2007), observe more discrepancies between their real and ideal friendships, and experience lower quality and more conflict-ridden friendships (Demir & Orthel, 2011). Scholars in men and masculinity have long theorized that these relationship difficulties are linked to men's unwillingness to grow close to other men and their overreliance on female romantic partners for intimacy (O'Neil, 2008).

Counseling and psychotherapy groups are great forums for addressing these issues. Groups provide men with an opportunity to form a community, which combats men's excessive self-reliance and alienation, allowing men to grow more comfortable relying on other males for social support (Andronico, 1996). In this way, men satisfy their desire for close friendships and reduce their reliance on women for emotional closeness. For example, during the crisis of an unplanned pregnancy and early parenthood, adolescent fathers tend to rely heavily on their partners and their mothers for support, while experiencing the loss of important relationships with other males. Providing psychoeducational support groups to adolescent fathers helps them to reconnect with other young men with whom they can bond while sharing the challenges and joys associated with early paternity (Kiselica, 2008). Similarly, men's groups can be powerful vehicles for forming communities of support for men who are isolated within the toxic environment of a prison and physically separated from the supportive women in their lives. Through their participation in therapeutic groups, incarcerated men can help each other learn how to heal their wounds, explore and confront how they ended up in prison, learn skills for coping in the prison culture, develop emotional literacy, and formulate constructive future goals (Spitzer, 2002).

Improving Men's Ability to Understand and Cope with Tender Emotions

Levant (1990) theorized that traditional men have “difficulty identifying and processing emotional states” (p. 310) because they have been socialized to associate tender and vulnerable emotions with femininity or weakness. Consequently, they tune out sadness, anxiety, and affection and channel most of their emotional experiences into anger and rage, which very traditional men view as the only acceptable forms of male emotional expression (Levant, 1995). In support of these conjectures is an extensive body of research demonstrating traditional men tend to experience restricted emotionality (O'Neil, 2008). Teaching men who emote in this restricted way to understand, cope with, and express the full range of human emotions is an important goal of group therapy. For example, Levant, Williams, and Hayden (2008) have developed a group psychoeducational approach to working with men that involves helping men to realize when they are having difficulty naming an emotion, teaching them labels for the emotional experiences they are having, and encouraging them to be more emotionally expressive in their lives.

Therapy groups facilitate emotional expressions by allowing men to explore and state their feelings in a safe environment. Men do not have to fear being rejected for their emotional expression because there is a relationship of trust and respect in the group (Brooks, 1996). The role of the facilitator during this process is to encourage men to articulate their feelings and to affirm men who take the risk to demonstrate emotional vulnerability. Within this supportive environment, men become more comfortable with feeling and expressing emotions that they normally suppress, such as sadness or remorse. Furthermore, men in groups can release their strong emotions without fear of hurting themselves or others because the group members agree to protect each other (Joliff & Horne, 1996). By releasing pent-up anger and rage, men can let them go, experiencing a catharsis. This letting go is an emotional and social learning experience: men learn that they can express their emotions without becoming out of control, making future emotional expressions easier and less stressful (Glicken, 2005).

Improving Men's Interpersonal Skills and Behaviors

In addition to deficits in emotional understanding and expression, some men exhibit a variety of maladaptive behaviors. One particularly salient example involves their typical means of engaging in interpersonal communication (Levant, 1995). Men who are obsessed with dominating others tend to engage in one-sided listening, listening only so that they can counter rather than empathize and acknowledge another person's point of view (Brooks, 1996). This interpersonal style is in line with their traditional male role as aggressive, in-charge, and emotionally closed. Lacking reciprocal conversation skills, men may frustrate others, leading to interpersonal difficulties. Thus, another important goal of men's therapy should be improving communication skills.

In group, men engage in extensive discussions with the facilitator and other members that can be great learning experiences. During these interactions, group members will likely display their one-sided communication styles. The facilitator and other group members provide feedback on the negative effects of this way of communicating and encourage the group member to practice new forms of communicating that are more reciprocal (Brooks, 1996). This process of problem recognition, empathic feedback, and positive practice can be applied to change a variety of negative behaviors. As with emotions, the group provides a social learning environment for positive behaviors in which they can be practiced and generalized beyond the group.

Best Practices in Group Counseling and Psychotherapy with Men

Scattered throughout the literature are numerous recommendations regarding best practices in group counseling and psychotherapy with men. We have organized these suggestions according to the Association for Specialists in Group Work guidelines for best practices in planning, performing, and processing (Thomas & Pender, 2008).

Best Practices in Planning

Selecting a Group Focus

It is important to tailor the focus for the therapy group to the needs of the group members. Groups may center on particular mental illnesses (e.g., depression; see Watson & Nathan, 2008) or specific problems (e.g., partner abuse; see McGregor et al., 2002). Alternatively, groups may focus more generally on men's issues and include topics such as masculinity, emotion, work, intimacy and sexuality, and family of origin (Hetzel, Barton, & Davenport, 1994; Levant et al., 2009).

Recruitment of Group Members

Beyond making decisions about the gender makeup of the group, psychotherapists must recruit and select potential group members based on the group's particular focus. To recruit men to a group, practitioners may want to use public service announcements and advertisements at various organizations and centers that are typically composed of men in need of help (e.g., AA meetings and VA hospitals), in addition to making colleagues aware of the existence of a men's group to obtain referrals (Kiselica, 2008; Robinson, 1988). Potential referral sources include physicians, administrators, clergy, police officers, and staff at vocational training centers, GED programs, and recreational centers who work with men (Kiselica, 2008). Efforts to recruit impoverished men are often successful when group counseling programs have certain features and incentives, such as the provision of free meals during program activities, free transportation to and from group meetings, and paraprofessional peer counselors to facilitate group meetings (Allen & Doherty, 1996; Barth, Claycomb, & Loomis, 1988; Brindis, Barth, & Loomis, 1987; Kiselica, 2009). Effective outreach also includes leaving the office and meeting potential clients informally in places where they like to socialize, such as coffee shops, ball courts, community centers, pool rooms, street corners, and barbershops (Klinman & Sander, 1985; Lehr & MacMillan, 2001; Sander & Rosen, 1987; Weinman, Buzi, & Smith, 2005).

Screening and Selection of Group Members

During initial interviews with potential group members, the therapist describes the purpose of the group and facilitates the match of the group's membership to its goals (Rabinowitz, 2001). In these meetings, practitioners should express an understanding of men's unique problems and their relation to male gender role conflicts (such as restricted emotionality and obsession with success), while reinforcing a need for changes in behavior related to excessively adhering to these gender role norms (Brooks, 1996; Levant et al., 2009). As always, professionals should be on the lookout for problems that are beyond the scope of the group (e.g., if the client has severe psychopathology that may hinder his participation) and offer referrals if necessary.

Group Structure

A group therapist must decide how the group should be led. The group may be led by an individual facilitator or cofacilitated by two people. Individuals interested in starting a group should also consider how the sex of the therapist(s) would affect the group dynamic. Hetzel et al. (1994) reported on a group counseling model using mixed-sex leaders: The men in their group stated that having leaders of both sexes helped them relate better to both men and women, in addition to facilitating practice of nontraditional behaviors such as empathy and caring. However, some men felt uncomfortable discussing certain issues, such as sex, in front of a female leader. Since to our knowledge there is no further research on therapist sex and its effect on group work, practitioners must weigh for themselves the pros and cons of mixed-sex and single-sex therapist facilitation.

Best Practices in Performing

Group Norms

As with any therapeutic group, once a group for men is formed, it needs norms and rules to be able to function efficiently, including the following: maintaining confidentiality (American Counseling Association, 2005), emphasizing the importance of attending sessions (Rabinowitz, 2001), and respecting all members of the group, including the facilitator (Glicken, 2005). In addition, therapists may wish to place further restrictions on the group as they see fit; these additional expectations need to be stated clearly in initial interviews and group meetings (Wilbur & Roberts-Wilbur, 1994). For example, the first author of this chapter cofacilitated a substance use group in which it was made clear that members would not be allowed to participate in group if they were under the influence of drugs or alcohol.

Group Structure within Sessions

In addition to establishing rules, group leaders must decide how to structure the group sessions. A mix of structured and unstructured activities and discussions may be best for addressing men's problems, and the stage of the group may determine the level of structure necessary. In the early stages of groups, structured activities reduce group members' anxiety and encourage them to become more comfortable with one another and open up (Rabinowitz, 2001). For example, in his approach to group work with adolescent fathers, Kiselica (2008) has shown films addressing various types of fathers and then asks the young fathers in the group to react to the characters depicted in the films, which fosters structured conversations about masculinity and fatherhood issues. Structured activities may also provide psychoeducation on issues related to the group (e.g., masculinity and emotions) and build a framework for future discussions (Hetzel et al., 1994). Once an environment of trust has been built and the group members have been made aware of important issues to raise in group, the leader may move on to less structured discussions, which provides group members the opportunity to talk with each other about relevant problems and topics that are pertinent to their lives (Hetzel et al., 1994). For example, in group fatherhood training, the facilitator must be sure to follow sessions that are structured and designed to address specific topics, such as clarifying beliefs about fatherhood, with unstructured sessions that are focused on addressing current issues that might be occurring in the fathers' lives, such as their concerns about being providers or recent family conflicts that they may have experienced (Kiselica, 2008).

Utilize Knowledge of Men's Issues and Support Male Ways of Interacting

As professionals work with men in groups, they must be guided by their knowledge and understanding of men's issues while supporting male ways of interacting. Here we describe some important considerations related to these practices:

1. Men need to be allowed to be men while participating in group. They may curse, isolate, engage in self-destructive behaviors, avoid expressing emotions, express their feelings through sexuality, and refuse to cry (Joliff & Horne, 1996). Rather than shaming or scolding men for engaging in male-typical behaviors, therapists must approach men with an understanding of these ways of acting, view these behaviors as consequences of excessive adherence to male gender norms, express empathy for the pressure men feel to act this way, and encourage new, more adaptive behaviors (Hetzel et al., 1994; Joliff & Horne, 1996). For example, a common problem in the lives of traditional men is an overemphasis on competition and winning (O'Neil, 2008). The counselor who works with men whose lives are adversely affected by their hypercompetitiveness must empathize with the socialization pressures traditional men feel to always "win," challenge them to see the damage hypercompetitiveness can have on their interpersonal relationships, and encourage them to practice a less ardent way of approaching situations that don't really require competitiveness.
2. Encouraging clients to develop personal goals in therapy helps them measure progress and decide which

personal issues are salient to the group. However, early in therapy men may be confused about what they want to get out of their participation in the group (Brooks, 1996). This reluctance may be because of an unwillingness to admit having a problem, which traditional men view as a sign of weakness (Levant, 1995). Men may need to be allowed to develop goals over time after learning more about men's issues and hearing other group members commit to a need for change (Brooks, 1996).

3. Clinicians have often advanced the benefits of including action-oriented activities when working with men (Kiselica & Englar-Carlson, 2008; Kiselica, Englar-Carlson, Horne, & Fisher, 2008; Rabinowitz, 2001). Providing men with action-oriented homework activities, especially those that encourage practice of positive behaviors, may be helpful (Joliff & Horne, 1996). Team-oriented action activities are especially promising because men are accustomed to working in teams in physically and/or mentally intensive projects and will develop cohesiveness and trust by working toward common goals. Capitalizing on this tendency, researchers from the University of Texas at Austin developed an adjunct to traditional group therapy that is specifically for men and employs action-oriented activities of Adventure Therapy. The results of a pertinent exploratory investigation indicated that Adventure Therapy was successful in helping 11 middle-aged men develop trust with each other quickly, divulge personal issues willingly, and learn new perspectives on their problems and concerns (Scheinfeld et al., 2011).
4. Drawing from the positive psychology/positive masculinity perspective on helping men (Kiselica, 2011; Kiselica & Englar-Carlson, 2010; Kiselica et al., 2008), therapists should recognize and validate men's traditional strengths (e.g., their willingness to work long hours, tackle large problems without help from others, and care for the next generation; Glicken, 2005; Kiselica et al., 2008).
5. The facilitator should provide psychoeducation whenever necessary, particularly regarding male socialization and how it relates to their current experiences (Joliff & Horne, 1996). For example, in groups that are designed to help teenage fathers prepare for the duties of responsible fatherhood, it is recommended that there be psychoeducational sessions about how certain aspects of the male socialization process, such as the traditional gender role expectation that a man must be tough and self-reliant, can undermine a young man's capacity to be tender with his partner and deter him for seeking help when he is overwhelmed by the complicated challenges associated with early paternity (Kiselica, 2008).
6. Above all, when working with men it is important to set high expectations and work cooperatively with men to achieve them.

Although men have been socialized in a society that discourages any type of behavior that is perceived as threatening to their independence or autonomy, many men are capable of engaging in deep emotional expressions, experiencing long periods of introspection, or striving to maintain important relationships (Hetzel et al., 1994, p. 60).

It is important for us to consider that men have these capacities and to encourage them to work toward emotional expressiveness, introspection, and relationship enhancements.

Best Practices in Processing

Interpret and Process Nonverbal Signs of Group Members

Men often express their needs in indirect and nonverbal ways. Rabinowitz and Cochran (1987) explained that, "Absenteeism, withdrawal from participation, and boredom may be indications that the group is not meeting the needs of certain members" (p. 62). Withdrawal is an especially common tactic used by some men to avoid conflict (Brooks, 2009). Therapists also must be on the lookout for emotional body language. Stares, foot tapping, crossed arms, and other bodily cues may indicate a group member's underlying emotions (Rabinowitz, 2001). Leaders can use these cues as a gateway to explore clients' feelings about themselves and other group members.

Be Attentive to Male-Salient Discrepancies between Stated and Actual Behaviors

The group leader should draw attention to male-salient discrepancies between the members' stated and actual behaviors (Rabinowitz & Cochran, 1987), particularly at the beginning of the group when members are reluctant to challenge each other. For example, the therapist may note that while a client professes attempts at being more cooperative with his colleagues at work, he is competitively dominating the group discussion and cutting off other members. By highlighting this discrepancy, the client may come to realize that his need to be in control is hindering his work relationships. The facilitator may take a more secondary role as group members grow more at ease and begin to challenge each other. This sort of challenging is especially valuable in prison settings, where inmates participating in men's groups can be encouraged to confront each other in a no-nonsense manner to take ownership for antisocial behaviors that got them incarcerated or are undermining their prison adjustment (Spitzer, 2002).

Promote Positive Changes

In addition to challenging members' negative behaviors, practitioners must also promote positive changes. For example, group leaders may insist on the use of "I" statements, forcing the clients to take responsibility for the words they say and avoiding accusatory language (McPhee, 1996). Or they may encourage clients to verbalize their feelings so that they get practice using emotional language and addressing conflicts without allowing negative emotions to build (Rabinowitz, 2001).

Help Clients with Problematic Themes

Facilitators should also help their clients recognize common themes that have caused them trouble (Glicken, 2005). For example, the second author of this chapter had counseled a man who had unrealistic expectations of his wife based on his rigid, traditional gender role expectations. His wife was employed full-time outside of the home, just as he was, yet he expected his wife to do all the food shopping, cooking, cleaning, and laundry. He offered his wife no assistance with these duties, and he was highly critical of her whenever she fell behind in completing domestic work. He had similar expectations of his first wife, and that marriage had ended in divorce. Consequently, it was necessary to confront the client about the pattern of relationship difficulties that were linked to this rigid way of thinking and to encourage the client to experiment with reducing his criticism of his wife and to assist her with domestic responsibilities. After the client became more aware of the link between his attitudes and his relationship with his wife and tried out the changes in behavior that had been suggested in therapy, he noticed positive changes in his marital relationship.

Accentuate Positive Modeling

Throughout the group process, therapists must also remember that they and the other members of the group are

constantly modeling social behaviors. By making a concerted effort to model positive social interactions, the therapist provides an observational learning opportunity for the clients (Hetzel et al., 1994). Furthermore, the therapist may highlight the individual successes of members as models for emulation (Horne et al., 1996).

Ending Therapy

The final sessions of therapy groups should be organized to preserve the benefits of the group for the long term. Typically, ending therapy occurs in two stages. In the first stage, group members process and consolidate what they have learned and accomplished in group. At this time, facilitators may encourage members to address any unresolved male gender role conflicts and to provide praise and constructive feedback to fellow members who have risked being vulnerable and expanded their emotional skills (Rabinowitz & Cochran, 1987). Facilitators may also discuss with clients the extent to which they achieved their personal goals. In the second stage, group members plan for life after the group. They may set new goals in conjunction with the therapist, who can provide psychoeducation, literature, and homework assignments on men's issues to facilitate the clients' continued work (Rabinowitz & Cochran, 1987). Facilitators may also encourage group members to meet formally or informally to provide each other with continued support and friendship (McPhee, 1996), especially for men who have lacked close friendships with other men in the past.

Conclusion

In this chapter, we have documented that group work is an effective modality for helping men, and we have suggested several important considerations for conducting gender-sensitive counseling and psychotherapy with men. Some common goals of therapy groups with men include improving male-male relationships, increasing emotional awareness, and enhancing men's interpersonal communication skills. These goals can be accomplished by therapists who have knowledge of men's issues and ways of interacting, effectively intervene in negative behaviors while encouraging positive ones, promote mentoring in group, and provide a framework for continued practice of learned skills.

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Chapter 42 Prevention Groups

Robert K. Conyne

Introduction

Research and practice in the helping professions have coalesced to indicate that it has become possible to prevent many academic, psychological, and emotional problems *before* they take hold in people's lives (Conyne & Horne, 2013; Hage & Romano, 2013; Vera, 2012). Further, and of particular interest to readers of this *Handbook*, is that an essential prevention method is found in group work (Clanton Harpine, 2013; Waldo, Schwartz, Horne, & Cote, 2011).

Therefore, this chapter focuses on joining two powerful forces in mental health delivery: prevention and groups. Each force is important in its own right, and together they potentiate to yield more dynamic and complex properties. To augment this discussion of prevention groups, current literature is reviewed, recommendations for best practices are offered, and a case example illustrates important points. Readers are encouraged to engage actively with the text through the training activities and classroom discussion questions that are provided in the text and appendix.

Chapter Purposes and Overview

Prevention and Health Promotion Rationale

Mental health practitioners need to become preventive in their work for many reasons: (a) too few helpers exist to meet the continuing need for remedial service due, in part, to the focus on individually delivered psychotherapy (Kazdin & Blasé, 2011), a reality first highlighted by George Albee (1986); (b) seeking help for mental health problems is enshrouded in stigma for far too many (Dingfelder, 2009; Surgeon General Report, 2001); (c) a variety of health and mental health concerns can be avoided through carefully planned and delivered before-the-fact preventive interventions (Cohen, Chavez, & Chehimi, 2010; Conyne, 1997, 2004, 2010; Hage & Romano, 2010, 2013; Prevention Section, in review; Romano & Hage, 2000); and (d) health promotion and wellness, as an alternative to sickness reduction, represents the direction now supported by the U.S. government (National Prevention, Health Promotion, & Public Health Council, 2011).

Group Methods Rationale

Group counseling and other group methods are becoming an essential way to deliver the full range of mental health needs in contemporary America (Association for Specialists in Group Work, 2000; Conyne, 2011; Corey, 2012; DeLucia-Waack, Gerrity, Kalodner, & Riva, 2004; Gladding, 2011; Trotzer, 2006), a point that this *Handbook* clearly underscores. Groups are ideal delivery systems both to plan and deliver prevention programs. They are intended to develop new learning and competencies, they offer unique economy and efficiency advantages, and groups can provide a particularly rich environment for member interaction, participation, and learning (Price, 2009). Drawn from the public health tradition, preventive services are intended to be applied within an "extra-individual" approach: in small groups, social systems, and populations, all which involve groups of varying sizes. Group methods are a mode of delivery that naturally matches well with these various levels of social systems, making them an important part of many prevention programs.

Chapter Purposes

This chapter has two purposes: (a) to draw a linkage between prevention and groups and (b) to encourage training, research, and practice in the use of prevention groups. The chapter contains rationale documenting the importance of both groups and prevention and then it will present definitions for prevention groups. Although it is possible for any group work type (i.e., group counseling, group psychotherapy, task groups, or others) to be used to accomplish prevention goals, it is the psychoeducational group format and related group-centered approaches (Clanton Harpine, 2010) that afford the "best fit." This assertion is elaborated later in this chapter through definition, best practice suggestions, and a case example.

Prevention is Needed

The prevention of psychological distress and the promotion of mental health are critically important in contemporary society (Hage & Romano, 2010). As Albee (1986) warned decades ago, human psychological, emotional, and other needs far outstrip the available supply of professionally trained mental health care providers, especially if providers restrict their helping service to the individual, remedial, direct service pattern. If one considers mental health disorders within any given year, 26.2% of adults are diagnosable within the United States, with 36% of them receiving treatment (Kessler, Chiu, Demler, & Walters, 2005). For children from age 8–15, 13.1% were diagnosed with a mental health disorder in the previous year (Merikangas et al., 2010). These percentages yield large numbers of people in some form of distress, even while not including those legions of people who are at risk but are not diagnosed or diagnosable. These figures underline the importance of finding ways to prevent as well as to treat human suffering.

Paradigm Expansion: Prevention Groups

There needs to be a paradigm expansion in counseling and mental health. The historical focus on individual-remedial-direct service (Conyne, 2000), while important, limits attention needed for prevention. This expansion should emphasize health and prevention (in addition to reparation) and groups and communities (in addition to individuals). This direction is in keeping with "positive psychology" (e.g., Peterson & Seligman, 2004; Seligman, 2011; Snyder & Lopez, 2002), an emerging force within general psychology whose basic premises have enjoyed a long heritage within counseling and counseling psychology.

In general, counseling and therapy groups are recognized as being cost-effective, offering an abundance of therapeutic factors, such as universality and instillation of hope, and provide an interpersonal context for realistic experimentation, social support, change, and application (Yalom & Leszcz, 2005). The uniqueness of prevention groups is that they incorporate these very same positive therapeutic elements but, in addition, they are intended to help group members avoid negative consequences in the first place. The purpose of a prevention group, then, shifts from helping members primarily to correct existing problems and dysfunctions to helping members who may be at risk for a problem or disorder, such as for depression, develop the necessary resources to be able to avoid the dysfunction by learning how to cope effectively with future life stressors and challenges. This positive and futuristic orientation, which is characteristic of prevention and of prevention groups, is what contributes to the paradigm change that is needed (Clanton Harpine, 2010; Conyne & Clanton Harpine, 2010; Clanton Harpine, 2013; Conyne, 2014; Hage & Romano, 2013; Use of Groups for Prevention, 2000; Waldo et al., 2011).

What are Prevention Groups?

Common understanding of terms such as *prevention, groups*, and then *prevention groups* has been slow to emerge over the decades. Presented below is a current definition of prevention groups that builds on preceding ones (e.g., Use of Groups for Prevention, 2000). Two essential elements run through this definition: the necessity of the group's purpose to help members avert future significant life problems and the importance of group processes and member interaction, blended with content, in group activities.

Prevention Groups: One Current Definition

Prevention groups use group process to the fullest extent: interaction, cohesion, group process, and change. The purpose of prevention groups is to enhance members' strengths and competencies, while providing members with knowledge and skills to avoid harmful situations or mental health problems. Prevention groups occur as a stand-alone intervention or as a key part of a comprehensive prevention program. Prevention encompasses both wellness and risk reduction. Preventive groups may focus on the reduction in the occurrence of new cases of a problem, the duration and severity of incipient problems or they may promote strengths and optimal human functioning. Prevention groups encompass many formats. They may function within small group formats or work with a classroom of thirty or forty. Prevention may also be community-wide with multiple group settings. Prevention groups use various group approaches. Psychoeducational groups are popular and, while some prevention psychologists work within a traditional counseling group, others use a group-centered intervention approach. Two key ingredients for all prevention groups are that they be directed toward averting problems and promoting positive mental health and wellbeing and that they highlight and harness group processes. (Conyne & Clanton Harpine, 2010, p. 194)

Prevention Group Effectiveness

Accumulating scholarly literature demonstrates that counseling and therapy group effectiveness (e.g., Barlow, 2011) extends to prevention groups (e.g., Hage et al., 2007; Romano & Hage, 2000; Waldo et al., 2011). Well-documented mental health prevention programs point to effectiveness in such areas as child abuse prevention (Sanders et al., 2004), eating disorder prevention (Mussell, Binford, & Fulkerson, 2000), prevention of youth violence (Centers for Disease Control and Prevention, 2011; Prevention Institute, 2008), and HIV prevention with African American adolescent girls (DiClemente et al., 2004).

Two special issues of scholarly journals in the group field have devoted attention to prevention groups and their effectiveness: the *Journal for Specialists in Group Work* (JSGW) (the journal of the Association for Specialists in Group Work) and *Group Dynamics: Theory, Research, and Practice* (the journal of the Society of Group Psychology and Group Psychotherapy of the American Psychological Association).

In the first instance, Conyne and Horne (2001) coedited a *JSGW* special issue, "The Use of Groups for Prevention," that summarized an examination of a large data set attesting to the effectiveness of prevention groups. Empirical studies reported in that journal's special issue demonstrated how prevention groups that were successful in developing skills and lowering risk for specific subgroups of children and adolescents (e.g., angry and aggressive children, Shechtman, 2001), for late adolescents (e.g., college students with eating disorders, Sapia, 2001), and with adults (parents of children diagnosed with ADHD, McDonnell & Mathews, 2001) tended to emphasize interactive, participative processes, focused group discussion, and cooperative exercises.

In the second case, Conyne and Clanton Harpine (2010) coedited a *Group Dynamics* special issue, "Prevention Groups: Evidence-Based Approaches to Advance the Field," containing, among other articles, four lengthy evidence-based studies of prevention programs that relied on the use of group methods. These studies integrated the best available research on their topic, combined with clinical experience, professional judgment, cultural adaptation where needed, and collaboration in program design and delivery. The group-based prevention programs included the Strengthening Families Program (SFP; Kumpfer, Whiteside, Greene, & Allen, 2010), which demonstrated significant improvements in family functioning; the Incredible Years Parent Training Program of Webster-Stratton (Borden, Schultz, Herman, & Brooks, 2010) that showed how IY can strengthen parent and child competencies as a means for promoting resilience; two projects by P. McWhirter and J. J. McWhirter (2010), showing how a prevention group tailored at families of domestic violence can reduce violence and the threat of violence and how a prevention group program aimed at improving school-based mental health can increase positive aspects of mental health; and A. Horne's bully busting program (Bell, Raczynski, & Horne, 2010) that was able to increase teacher reports of self-efficacy, knowledge, and skills in promoting a healthier school environment as an antidote to bullying by students. I will draw briefly from one of these studies, the Incredible Years (IY) Parent Training Program (Borden et al., 2010) at the end of this chapter to illustrate one way prevention groups have been used successfully.

In addition to effectiveness, it is well accepted that groups are efficient (e.g., Spitz, 1996). When several people can participate during the same time period with one (or two) group leaders, then the professional helper-to-client ratio improves in favor of efficient practice. This fact also can provide the wrong reason for using groups, however. For instance, excessive emphasis on efficiency to the detriment of other considerations, such as failing to properly compose the group or ignoring member interaction and group process, can serve to vitiate a group's power and success.

A final point to be made about the value of groups has particular salience for prevention. The classical application of prevention, as mentioned above, is not done with one-person-at-a-time. Rather, the preventive intent, drawn from public health, is to affect large groupings—populations—if possible. For example, one needs only to think in terms of population-level efforts to eliminate cholera, malaria, polio and, more recently, with AIDS prevention. Using groups, then, to reach prevention goals is consonant with this historic approach to reaching prevention goals, while also providing mental health practitioners with a vehicle to impact greater numbers of people.

Psychoeducation: A Best-Fit Format for Prevention Groups

A range of group applications is available for use by counselors, psychologists, social workers, and other helpers. This range may be coalesced under one group application that is broadly interpreted, such as *group psychotherapy* (American Group Psychotherapy Association, AGPA; Society of Group Psychology and Group Psychotherapy, APA's Division 49) or included in the umbrella term of *group work* (Association for the Advancement of Social Work with Groups, AASWG; American Counseling Association's (ACA) Association for Specialists in Group Work, ASGW). ASGW's perspective, which I am focusing on in this chapter (ASGW, 2000; Conyne, Wilson, & Ward, 1997; Falls, 2009), details four group work types: (a) Task and Work groups (e.g., Hulse-Killacky, Killacky, & Donigian, 2001), (b) Psychoeducation groups (e.g., Brown, 2004), (c) Counseling groups (e.g., Corey, 2012; Gladding, 2011; Jacobs, Masson, Harvill, & Schimmel, 2012; Trotzer, 2006), and (d) Psychotherapy groups (e.g., Yalom & Leszcz, 2005). Prevention can be accomplished through using group work of any type and, arguably perhaps, it should be a component of all group work.

Task groups, such as a neighborhood watch group, can plan and implement safety procedures that can lower the incidence of local crime. Counseling groups can help members turn increased awareness of an interpersonal problem, such as poor relationships with others, into interpersonal skills that can improve the formation of future relationships. Therapy groups can at times help members avoid thoughts or behaviors that continually have proven to be dysfunctional so that similar problems in the future might be lessened. Psychoeducational formats seem to provide an effective approach for accomplishing prevention goals.

Psychoeducational Group Formats for Prevention Groups

As noted earlier, psychoeducational group formats for prevention are one of the eight major training domains that Romano and Hage (2000) identified for preparing counseling psychologists to assume a prevention agenda. Psychoeducational formats are directly relevant to prevention because they involve a clear focus on specific interactive factors that are central to conducting prevention (ASGW, 2007; Clanton Harpine, 2010; Conyne & Hage, 2009; Conyne & Wilson, 1999; Ward, 2000). These factors are summarized next.

Focus on Normal Human Development and Functioning and/or those at Risk

Psychoeducational group formats can readily be focused on helping members to develop existing resources and to prevent maladaptive processes from occurring. As well, these groups can be used effectively with members who are at risk developmentally for the future manifestation of psychological, behavioral, educational, or emotional disturbance.

Set Specific Goals

Goals are set clearly within a psychoeducation group format. Examples include: to become a more effective problem solver, to learn attending skills, or to prevent the onset of substance abuse.

Include Structure

The psychoeducation group format is not completely free flowing but often incorporates the use of timed events and various structured experiences, such as dyads, skill training, and role playing.

Value Efficiency

Psychoeducation group formats are time limited overall, and within each session attention is given to interacting within set timelines. Each session is formatted within the overall general plan of the group.

Enhance Education

Psychoeducation group formats seek to teach members important information about a phenomenon of interest for the group (about stress in a stress prevention group). They are informative and may include brief lectures and dissemination of relevant materials.

Develop Skills

Psychoeducation group formats are intended to enhance specific skills of members. Attention during each session generally is given to training members in the acquisition, practice, and display of a skill or skill set. For example, in a stress prevention group members might practice the skill set of relaxation and learn how to use relaxation in their lives to reduce stress.

Generate Group Member Interaction in the Here-and-Now

Psychoeducation group formats elevate the importance of member-to-member interaction, set within a here-and-now (presentized) context. They are not centered on the one-way transmission of information or by a complete focus on content and tasks. Of all the factors characterizing psychoeducation groups, creating conditions in the group where active participant engagement occurs may be the most important; without this condition being met

the potential for member connection, learning, and growth is reduced dramatically. Therefore, it is essential that leaders of these groups, while investing in the planful sequencing and goal setting that is necessary, remain centrally focused on how direct member-to-member engagement can be fostered and maintained (Clanton Harpine, 2010).

Attend to Psychological Processes and Group Dynamics

Psychoeducation groups harness member interaction and give attention to processes and dynamics occurring within the here-and-now group activities. The processing of meaning derived from these interactions and dynamics is a centrally important focus. Leaders help members within each session to draw meaning from ongoing experience and they assist members to reflect on their experience in the group over time to extract major learning. In parallel fashion, leaders need to themselves engage in processing group events and their personal and professional involvement, with what they learn appropriately influencing their ongoing work (Conyne, 1999).

Emphasize Application

Psychoeducation group formats can be shaped to attend to how members will apply learning from the group to their everyday lives outside the group. Therefore, these groups frequently include specific attention to issues of transferability to ongoing life situations.

Prevention Group Best Practice Guideline Suggestions

A general set of guidelines exists to guide the conduct of prevention groups (Conyne, 2003, 2004; Conyne & Wilson, 1999). These guidelines emerge from the definition of prevention groups, cited earlier, are adapted from the ASGW *Best Practice Guidelines for Group Workers* (ASGW, 2007) that are focused on the steps of Planning, Performing, and Processing, and are informed by the *Guidelines for Prevention in Psychology* that are being developed by the Prevention Section of the Society of Counseling Psychology within the American Psychological Association.

To conduct a prevention group, the following steps can serve as a guide. Note that although the steps are presented and numbered sequentially, circumstances may suggest an alternative order.

Planning Steps: Preparing to Facilitate or Lead the Group

Planning represents the initial step in best practice. Early in the practice of group leadership there was an idea that total spontaneity was desirable for practice and that planning somehow detracted "from the moment." It now is understood that planning is an essential aspect of best practice in group leadership, while also maintaining the ability to be flexible and adaptive to ongoing group processes.

Step 1 is to conduct an ecological assessment, using various means (e.g., interviews, surveys, focus groups) to identify target population, setting, needs, and environmental press. Ecological assessment provides the opportunity for group content and purpose to emerge from the person-environment "field," not just from an individual perspective. This broader analysis allows for a best fit with the life situation of prospective group members (Conyne, Crowell, & Newmeyer, 2008).

Step 2 is to collaborate for planning with a set of people who represent the target and setting. The data obtained through the ecological assessment provides the group leaders with material that typically is rich for action possibilities. Yet leaders should not fall prey to designing prevention groups in isolation, independent from others who represent the general population for whom a group might be helpful. Rather, it is best practice to collaborate with a team of people who might represent the life situations of potential group members (such people sometimes are referred to as "cultural informants") to coproduce the general elements of an emerging focal area for a specific plan. Using this kind of representative group collaborative planning process, while it may seem tedious, can increase the cultural validity of the plan that will be developed as well as its overall acceptability.

Step 3 is to identify a generative body of knowledge that pertains to the emerging focal area. This is the time to go to the professional literature. Given what has been learned through the ecological assessment and from the representative team of cultural informants, the group leaders can turn to published scholarly research to identify relevant work. For example, if there seems to be a need for addressing obesity among children in the community, or perhaps domestic violence, what does the professional literature contain on these subjects? Are there examples of how prevention programs involving group work have been used effectively?

The growing professional literature in prevention contains descriptions of effective prevention programs, many of which include groups as an important vehicle for learning and change. It can and should serve as an external support for idea generation (e.g., Blueprints for Violence Prevention, 2012; National Registry of Evidence-based Programs and Practices [NREPP], 2011; Substance Abuse and Mental Health Services Administration, 2011).

Step 4 is to develop agreement and support with members of the representative population about what is to be prevented through the group (e.g., sexually transmitted diseases), to be promoted (e.g., relationship development and maintenance competencies), or both. By passing through the previous three steps, leaders are armed with valuable information and they have made some important personal connections with members of the representative group. Many programs over the years intending to be preventive have failed because this step was not adequately addressed. It is perhaps especially important for prevention program development to include these kinds of participatory processes with community members due to the nature of prevention programs, which usually is to avert future problems and to enhance current strengths (Conyne, 2010). Lacking a strongly felt current need can make the member turnout to prevention groups more equivocal than for some other group types, such as psychotherapy groups, where members may experience a stronger internal press to correct nagging and more debilitating current problems. Thus, in addition to the important general ethic of collaborative participation with clients, for prevention groups, building in collaboration with representative community members increases the possibility for eventual program participation and overall success.

Step 5 is to create a written, detailed overall and session-by-session group plan that specifies such elements as group goals, group development model, recruitment, group setting, activities, strategies, resources, timelines, leader qualifications and responsibilities, processing, and evaluation. Prevention groups generally follow the psychoeducation group format, although prevention goals can be an important aspect of any group type, certainly including counseling groups. Careful overall planning and session-by-session detailing is necessary with prevention

groups to promote opportunities for goal accomplishment. Yet, as I have stressed, the plan cannot represent a default position; leaders must always give precedence to ongoing processes and events occurring in any session and be appropriately responsive to those. See the example plan contained at the end of this section.

Step 6 emphasizes brevity and structure in conducting prevention groups. Prevention groups, generally following a psychoeducation group format, typically are structured, with attention given to content, tasks, time, and to goal accomplishment, as well as to process. Thus, leaders need to include conciseness and structure within the format, while orienting the group toward goal accomplishment.

Performing Steps: Facilitating or Leading the Group

Performing is the step where the "rubber meets the road" for group leaders. It is where the actual group work occurs, where the plan is translated into practice—with modifications that are necessary.

Active group interaction is an important ingredient of all group work and this is certainly the case for prevention groups (Clanton Harpine, 2010). As has been pointed out, research clearly indicates that prevention with groups that use interactive, participative methods to reach goals are more able to be successful than those that transmit information without harnessing group dynamics. Implementing steps seven through nine, to follow, enhances the opportunity for active group interaction to occur.

Step 7 asks that leaders of prevention groups attend to the balance to be achieved among information delivery, skill development, and group processes. An all-too-common mistake made in conducting structured groups, such as with psychoeducation groups that are often so useful for prevention, is that they center on information dissemination to the exclusion of member interaction and group process. Make sure member interaction is encouraged and group processes are harnessed. A one-way style from the leader to members is to be avoided. While sometimes this approach may be useful (such as when part of a comprehensive treatment program), in a stand-alone prevention group it ignores a vitally important ingredient of all group work: promoting and learning from group interaction and processes (Clanton Harpine, 2013).

Step 8 encourages group leaders to seek to enhance cohesion in the group, including selecting members who share a similar problem set. Prevention groups can benefit from membership that is homogeneous regarding the focal area constituting the focus of the group (e.g., substance abuse prevention). Such homogeneity of membership for the focal area helps to ensure general interest in the content of the group and it accelerates interactive processes in the group, including cohesion. Heterogeneity for other characteristics can be intentionally selected for or be trusted to develop from the group composition itself as the group unfolds. A key is to design for promoting cohesion (Marmarosh & Van Horn, 2011).

Step 9 suggests that prevention group leaders approach skill development, as appropriate to the setting and population, through use of a performance model. I use and recommend one that is adapted from a behavioral modeling model (Goldstein & Sorcher, 1974). It contains these steps: (1) present content to be learned; (2) describe relevant skill; (3) demonstrate skill; (4) practice, perhaps in pairs; (5) give performance feedback; (6) discuss application to real-world settings; (7) retry skill; and (8) hold general processing discussion with entire group (Conyne & Wilson, 1999). An important goal of prevention groups generally is for members to enhance existing skills in the area of focus, such as in problem solving, and a systematic approach to training—that incorporates the active participation of group members—can be very useful.

Processing Steps: Making Sense of and Evaluating the Group

Processing occurs within sessions, at the end of the group, and for group leaders, it should be occurring between sessions. In general, processing involves reflecting on experience and through this process identifying insight, principles, and meaning that hold the potential for taking positive action.

Step 10 calls for including processing within each session to help members gain the most from their ongoing group experience. Leaders can process between sessions, with or without a supervisor, in order to promote learning, make appropriate adaptations and to consider application to real-world settings and demands. As Lieberman, Yalom, and Miles (1973) clearly demonstrated, meaning attribution is a centrally important group leader function. Members need to be helped to translate the events and experiences of group life to personal meaning and application (ASGW, 2007; Conyne, 1999).

It is necessary to make space and hold it available for processing. Time set for reflecting activities easily can be trampled, intentionally or not, by ongoing events in the group or, in the case of group leaders, by the heavy press of daily life. Therefore, group leaders need to take special care to nurture and support processing among members and for themselves. One way to do this is to schedule it, setting aside specific time within each group session, for instance, for processing to occur.

Step 11 addresses the question of group effectiveness and member learning. Leaders of prevention groups, as do all group leaders, need to evaluate group process and outcomes (over time, if possible) to determine accomplishment of prevention goals. A criticism of all group work and of prevention groups in particular, revolves around the general lack of evaluation to demonstrate effectiveness, although this situation is improving. Include evaluation from the program's initial steps through formative evaluation measures and, at the end, through summative evaluation (Stockton & Morran, 2011). As we have seen earlier, prevention groups can be effective. The challenge is to demonstrate that fact in ongoing practice. See the Appendix at the end of the chapter for the *Example Plan for a Psychoeducation Group.* It is adapted from the syllabus my colleague, Dr. Robert Wilson, and I developed for one of our group work courses in the University of Cincinnati's Counseling Program; versions of it have been presented elsewhere (Conyne, 1999; Conyne et al., 1997).

Best Practice Suggestions for Facilitating/Leading Prevention Groups

Planning Steps:

Conduct ecological assessment
Collaboratively plan
Identify generative base
Set goals for prevention and promotion
Write detailed plan
Include structure and process

Performing Steps:

Balance information, skills, and process
Enhance cohesion
Systematically present skill development

Processing Steps:

Process within and between each session
Evaluate group process and outcomes over time

Brief Case Example

A number of studies exist to describe and document the effectiveness of prevention groups. Achieving this status is an especially noteworthy accomplishment because of the inherent and difficult challenges involved with demonstrating effectiveness in either of the two realms involved—in groups or in prevention—let alone in their combination.

In this *Handbook's* first edition, I summarized an effective prevention group program aimed at social support developed by Brand, Lakey, and Berman (1995). In this chapter revision, I briefly examine another example, found in the Incredible Years (IY) Parent Training Program (Borden et al., 2010). This is a well-researched, 30-year initiative that is based on resilience and uses a collaborative group process model to strengthen parent and child competencies. In turn, the program intends to lessen specific negative child outcomes, such as conduct problems, while enhancing the resiliency of both children and their families. Evidence indicates that this program promotes positive parenting, consistency, problem solving, cohesion, the use of family support networks, and family resilience (Black & Lobo, 2008; Webster-Stratton, 2008, cited in Borden, et al., 2010).

Group facilitators in this program catalyze group discussions of desired skills through presentation of video vignettes showing children and parents interacting in a range of family contexts. Role-plays are used to help parents practice skills, verbally process their observations and experience, and consider how to include the skills in their parenting styles. Group facilitators also use cognitive reframing to assist parents to reconstrue irrational thoughts and to increase positive coping strategies, and they also consistently encourage self-praise and self-care as positive parenting strategies. Importantly, group facilitators attend to and use what the researchers term "key group process components" (e.g., creating a group environment of trust) to enhance curricular concepts. The researchers indicate that these group process components enhance the effectiveness and efficiency of the IY curriculum. See Borden et al. (2010) for an in-depth discussion of how these key group processes are embedded (e.g., in the pregroup stage, collaborating with parents about how to reduce barriers and stigma) within developmental stages of the parenting groups. Their article concludes:

Some of the critical elements that underlie the success of IY include its emphasis on a strong theory to guide intervention development; rigorous and continuous evaluation of program effects; systematic training and monitoring of facilitator skill and fidelity; repeated modeling and practicing core skills; and collaborative, Socratic approach to group facilitation and process. (Borden et al., 2010, p. 238)

Summary

Prevention groups fit centrally within a paradigm expansion that is needed in mental health. They are emerging as an especially important prevention resource, with the psychoeducation format being particularly valuable prevention groups are commanding an increasing amount of scholarly attention, including a growing number of examples of effective prevention groups. The evidence bases for these kinds of groups, along with the best practice guideline suggestions that exist, set the stage for future growth. Considerably more attention, however, still is needed in training programs, to reinforce the importance of this form of help-giving and to prepare future practitioners. It is intended that the contents of this chapter will assist in guiding readers as they engage in this effort.

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Appendix: Example Plan for a Psychoeducation Group

Note the plan's specificity. It also is important to remember that a plan, no matter how well conceived, always is subject to modification based on ongoing events and the professional judgment of the group leader(s).

1. General Description of the Type of Group Proposed (i.e., Task, Psychoeducational, Counseling, Therapy)
2. General Outline of the Structured Group Experience Proposed
    1. Background and Rationale for the Group
        - What is the contextual situation, based on your ecological assessment?
        - What sort of group do you intend to run?
        - For what population is it intended?
    2. General Goals for the Group Experience
        - What general goals do you intend to achieve for this group? (consider using Lazarus' Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relations, and need for Drugs [medications] as a framework for setting goals)
    3. Time Period for the Group
        - Hours/session, sessions/week, number of weeks
        - When does group occur in the cycle of the academic calendar?
    4. Leader(s)
        - Who (solo, coled); if to be coled, what characteristics of coleader are desired?
        - If to be coled, how will coleader selection occur?
        - How will you process your work?
    5. Methods
        - What general topics will be covered?
        - What general methods or techniques will be used?
    6. Recruitment-Screening (if appropriate for this type of group)
        - How will members be recruited?
        - How will they be screened for inclusion?
    7. Processing
        - How will you assist members to reflect on their ongoing group experience?
    8. Application
        - How will you assist members to identify learnings that can be applied in their daily lives?
    9. Evaluation
        - How will the group be evaluated to determine effect of its delivery, and member outcome?
3. Session by Session Description of Planned Events
    1. In each session, what goals do you intend to achieve? Think in terms of the SPAMO acronym: Specific, Performance-based, Attainable, Measurable, Observable.
    2. What strategy (strategies) do you plan to use to achieve each of the goals listed?
    3. How will you explore the process of your experience?

The following is an example adapted from one student's proposal. You may use it, or some modification of this idea, in reporting your session by session plans.

SESSION 1: Total time, two hours

Goal 1: To have members become acquainted.

> Member Tasks: To learn each other's names and something about each member: (a) brief introduction by each member, (b) member interviews in pairs and reports to the group.
> Time Required: Strategy A: 20 min; Strategy B: 10 min per interview; processing 20 min.
> Physical Setting: Members seated in a circle except when dividing into pairs for interviews.
> Materials Needed: None.

Method: (a) For self-introductions, each member will be asked to give his or her name and a short statement of how he or she is feeling "right now." (b) For the paired interviews, each member chooses another member and then finds a spot to interview his partner for 10 minutes.
Processing: The group leader will invite discussion of feelings about introducing self, introducing others, being introduced by others … leading to a discussion of "self-presentation" and "stage fright."

SESSION 2: Total time, two hours

Goal 1: To identify feelings about being in this group.

Member Tasks: To identify greatest benefit and greatest fear about being in this group.
Processing: Each member will be asked to disclose how it felt to talk about fears and expected benefits.

Goal 2: To begin the process of individual goal identification.

Member Tasks: To write, as concretely as possible, one goal they would like to accomplish by the end of this group; to be prepared to share this goal with the rest of the group and be open for feedback.
Processing: Each member will be provided with opportunities to reflect within sessions on group processes and events and on the meaning they are deriving from their experience.
Leader(s) will process work occurring between sessions.

Source: Adapted from the syllabus developed for one of our group work courses in the University of Cincinnati's Counseling Program. Versions of it have been presented elsewhere (Conyne, 1999; Conyne, Wilson & Ward, 1997).

Chapter 43 Career and Transition Counseling in Groups

John C. Dagley
Georgia B. Calhoun

“It's just not fair. I don't mean to offend anyone, especially since we just got here, but it just doesn't seem fair. I've done everything right in my life, at least as far as I could tell what was right. I did well in school, took a full-time position with the company where I did a ‘Leadership Internship’ as a part of my degree program and worked hard for the same company for 25 years, right up through the ranks, staying there through bottom-feeder levels (you know what I mean?) to the point where I've served as the General Manager of the place for the last seven years. For the last two years in a row, our store set national records for the company. I believed in them, and I thought they believed in me!!

“I always tried to honor and build the reputation of the company by making voluntary contributions to the community. I've run a United Way campaign for the city, served as a Little League coach, PTA President, church deacon, and what do I get at 55? FIRED! The company decided to run everything from Regional Offices, so they ‘wouldn't need experienced leaders at the local level anymore.’ Can you believe it? They replaced me with a kid with virtually no experience but at a much smaller salary! Shoot. I would have taken less money, if they'd have had the decency to ask. They said all this stuff about appreciating me for helping them build a nation-wide footprint and that they feel bad that they can't move me to the Regional Office. Sure! They've taken my best years and then just thrown me out. Who's going to hire an old man? I feel awful. I can't even look my wife in the eye, and seeing how my son looks at me is just something I can hardly bear. I don't know what I'm doing in here, but even worse, I really don't know where to go from here or what to do. I've lost faith in everything, especially in me.”

Career and transition groups do not always open with such a poignant and pain-filled statement, as did this one. But most unemployment/job loss groups comprised of middle-aged, newly unemployed members begin to deal with these themes and feelings at a fairly early point in the life of the group. Assumptions about fairness and justice in life are often shattered by the job loss experience, as are one's views of the world and of other people. Feelings about self-worth suffer too (Harris & Isenor, 2011). There is little disagreement in the helping professions about the close connections of work with physical and mental health (Blustein, 2008); negative physiological and psychological effects of unemployment and underemployment have been well chronicled (McKee-Ryan, Song, Wanberg, & Kinicki, 2005). A forced, unexpected separation from a large part of one's personal identity can be overwhelming, especially when added to new financial challenges that typically accompany such an event. In fact, forced unemployment produces such a dramatic and lasting effect on a person that it resets, apparently for life, one's expectations and perspectives of happiness and satisfaction (Lucas, Clark, Georgellis, & Diener, 2004). The experience of job loss is described in much the same ways as grief associated with the death of a loved one. Indeed the comments of the group member above reflect elements of the primary stages associated with grief: denial, anger, bargaining, and depression.

The experience of an involuntary transition, particularly related to the loss of one's work identity, is a time when career and transition groups can be especially helpful. Feelings of support that come from others in “the same boat” carry special comfort and can slowly but surely help build the kind of psychological muscle that one needs to pick up and move on. Beyond emotional support, a career group can serve each member as a vehicle for acquiring new information, for developing job-hunt strategies, and for developing new interpersonal and interview skills. Managers over 50 at the time of job loss, like the member highlighted above, fare better in the long run if they can avoid getting stuck on perceiving the experience as “the end of the line,” and focus instead on thoughts and actions that may restabilize and empower them. Group leaders strive to help members begin to nurture a budding set of beliefs that the job loss may merely have been an aberration that they can overcome and that, while work is important, there is meaning as well in life beyond the work role alone (Gabriel, Gray, & Goregaokar, 2010). Career groups have also proven effective with survivors of domestic violence, another group of individuals who are experiencing feelings of upheaval, fear, and grief (Chronister & McWhirter, 2006; Davidson, Nitzel, Duke, Baker, & Bovaird, 2012; Jagow-France, 2010). As with career groups for the unemployed, career groups for survivors aim

to help members overcome their psychological damage in preparation for successful reentry into work and society.

Career and transition groups are not always focused on reparative, reconstructive, or seemingly nontraditional efforts, as are the two referenced to this point: a small career group for the involuntarily unemployed and an empowering reentry group for the abused worker. In fact, most small groups are developmental and proactive, rather than reactive. Our goal in opening the chapter with a brief focus on two groups of involuntarily unemployed workers now routinely served in small groups was to give some sense of the intensity of some career and transition groups. Moreover, we want to redefine what's considered nontraditional when it comes to small groups focused on career and/or transition issues.

In this chapter, we take a brief look at the pace of change in modern life, especially in work and workplaces, to add further perspective regarding the importance of career groups and set the stage for a brief description of several traditional groups offered throughout the life span. Finally, we will end the chapter with an extended description of a career group for young women.

Introduction

So what are career and transition groups? How are they alike and how are they different, not only as related to each other but to other kinds of small groups? Why are such groups worthy of inclusion in this *Handbook*? The purpose of this chapter is to answer these and related questions.

Recent years have seen a dramatic change in the way in which career professionals conceptualize career development. A person's "career" concerns are no longer considered separate from their personal/social concerns or their educational concerns. An endorsement of a more integrative perspective of career development has emerged to the point that personal and career issues are seen as inseparable (Gysbers, Heppner, & Johnston, 2009). Career counseling is no longer considered a "test 'em and tell 'em" process or a once-and-for-all intervention for an individual to make a "choice." Rather, there has been a paradigm shift to a perspective that views one's career as a complex process of development that takes place throughout one's life.

A similar evolution has occurred with regard to the roles that transitions play in our lives. Transitions confront us throughout life in voluntary or involuntary ways, predictably or unpredictably, and usually consist of three basic stages of letting go, pausing, and beginning anew. Moving into and through ages, stages, school levels, relationships, births, deaths, economic cycles, global conflicts, international crises, and other situational changes are transitions that challenge us in similar yet unique ways. Successful transitions enhance personal courage and build hardiness and resiliency (Koert, Borgen, & Amundson, 2011). Work transitions represent only a portion of life transitions, but they overlap with so many areas of life that they deserve special attention (Fouad & Bynner, 2008). In this chapter we have chosen to intentionally include, and at times integrate, both "career" and "transition" groups.

Small groups have an important role to play in helping individuals deal with a rapidly changing world. As "career development" takes on a more protean/boundaryless character (Briscoe & Hall, 2006; Briscoe, Hall, & Frautschy DeMuth, 2006), career groups and transition groups change accordingly. No longer can a person count on learning something "once and for all," if ever one could. Today's pace of change requires an attitude and perspective that each individual is responsible for his or her lifelong learning. One's career development trajectory is much less predictable than in past generations, to the point that once well-defined "stages of development" are no longer very helpful constructs. Specific decisions are less significant than the development of decision-making skills; static knowledge is not as useful as "lifelong learning skills." A *protean careerist* is someone who is a continuous learner (Hall, 2004). No longer do companies or organizations serve as dependable, long-standing anchors and boundaries for career decisions. Today's and tomorrow's workers, are likely to pursue boundaryless careers where openness to experience, lifelong learning skills, resiliency, comfort with positive uncertainty, and a growth/goal-orientation are likely to become critically important personal qualities and abilities. *Boundaryless* is a constructivist term that's a bit nebulous, like the conception it defines. Basically, today's world of work has less definable structure than in earlier times. National borders once served as defining boundaries for workers, as did long-standing industries and corporations (e.g., automobile manufacturing, textiles, the telephone company). Even regional and national labor/employment contracts provided stability and identities for workers. Workers built personal/professional identities that would take such form as "I work for Ford," "I'm with Eastern." Today's organizational structures are much less formal and rigid, even to the point of management teams functioning with flexible work sites and schedules, and meetings more often than not virtual (electronic). Hence, the constructivist term, boundaryless, is used to refer to the worker's own role in constructing or creating their own work identities, free from the shifting structures of their employers.

Yet even this description of the protean, boundaryless careerist is a little awry in that it may imply more personal control over work and employment than global economic and political change permit. Perhaps Richardson (2012) is right when she says that we have inappropriately "psychologized" career development and minimized the influences of social realities of market work. The very term *career development* may imply more security and a more positive spin than is warranted in a truly boundaryless world where individual preferences and "control" may pale in comparison to tenuous and uncontrollable global market conditions. In such a world, each person can become

overwhelmed with a sense of insecurity or begin to not only prepare to have to take advantage of happenstance but also to build a lifelong commitment to developing and to continuously reshaping their own identity (Gore, Leuwerke, & Krumboltz, 2002).

Defining Career and Transition Counseling in Groups

First, it is important to note that career groups sometimes deal with transition issues, and sometimes not. The same is true with transition groups, in that some transitions directly impact one's preparation for or participation in one's career development, and others may not. We put them together in this chapter because the two often come together at many different times in life. Career groups, even those designed to help young children develop such lifelong career skills as planning and assumption of personal responsibility, often overlap with transitional ages and stages of development. Our most important reason for putting them together is that each, alone, tends to get lost in the group literature and professional practice.

Career group interventions are proven staples in the practice of counselors, particularly school counselors. Yet a surprising number of mental health professionals readily admit that they “don't do career counseling.” Even fewer lead transition groups. Still others avoid leading all kinds of groups. All such absences in practice are puzzling phenomena in the light of the omnipresent need. Transitions in life are ubiquitous and often at least unsettling, if not overwhelming. Everyone experiences transitions, predictable or unpredictable, and virtually everyone is confronted with various issues associated with the preparation for or success in work and meaningful employment, or the lack thereof. Thus, there is a need for effective career and transition counseling in groups.

In the extraordinary crises and challenges that may arise in life, the ordinary and routine parts of life are often overlooked, until the routine (such as employment) becomes a crisis too. Such is often the plight of the worker who suddenly faces “downsizing” or the young person who completes an educational program, often in debt, but unable to secure an entry-level job.

Separately and together, these types of groups are wide ranging in terms of membership, content, and process. Small group interventions include task groups, psychoeducational groups, counseling groups, and psychotherapeutic groups (Shechtman, 2007; Sink, Edwards, & Eppler, 2012). Specific needs and goals, as well as the site and the unique skills and interests of its professionals, all together determine the shape and composition of a single group. Whether developmental and proactive or reactive and targeted, career groups tend to be vibrant, challenging, and substantive. Each is likely to include affective, behavioral, and cognitive components (the ABCs of Career Groups). The presence of all three components in each group somewhat distinguishes career groups from others, at least in form and substance. While other kinds of small groups may include all three, it is very likely that career groups include these three components in a much more deliberate, consistent, and specific way. For example, it is not enough for career group members who have just suffered job loss to only share emotions (affect). Support helps, especially at first. Eventually, though, the newly unemployed and the long-term unemployed (Bhat, 2010) need to develop new job-hunting skills, seek and successfully obtain employment, reemployment, or improved employment (behavioral) that is based on new knowledge about themselves and the job market (cognitive). In the end, group members need to understand what they can do, why they may feel it is important for them to do it, develop or improve job-related skills, and implement what they have learned about how to get new opportunities to work. Information plays a role, but not nearly as key a role in career groups as in the “shared processing” of information. Effective career groups are also built on the kinds of factors that are reflected in other successful groups, including a focus on building hope, universality, cohesion, altruism, learning, socialization, modeling, and catharsis.

Career group interventions offer leaders opportunities to make a significant difference in the lives of others, primarily because work is so central to life and to one's identity. For such early psychologists as Sigmund Freud and Alfred Adler, and for vocational guidance pioneer Frank Parsons, work was considered a primary life task. To work hard doing work that is worth doing is considered important to the development and maintenance of one's self-affirmation. Over time, one's career provides a way of connecting with others. Directly and indirectly, a worker's career is a part of life that offers a person the chance to feel like he or she is making a contribution to humanity.

Empirical Support for Career and Transition Groups

Career counseling and group counseling share nearly a century of history in America's helping professions. These two major intervention modalities also share strong empirical support. The efficacy of group work, chronicled in earlier chapters of this *Handbook*, is evidenced in several studies over the past couple decades, especially through the meta-analytic studies of Burlingame and colleagues (Burlingame, Fuhriman, & Mosier, 2003). The professional literature also presents solid research evidence regarding the positive impact of career interventions (Brown & Ryan Krane, 2000; Kenny, Blustein, Haase, Jackson, & Perry, 2006; Whiston, Brecheisen, & Stephens, 2003). Results in the meta-analytic studies by Whiston and her colleagues provide strong support (average effect sizes of 0.30–0.50), not solely or specifically for career groups, but for all career interventions (Whiston & Rahardja, 2008). An example of the kind of career group program that provides data for such support is the work by Blustein and colleagues (Blustein, 2008; Kenny et al., 2006; Solberg, Howard, Blustein, & Close, 2002). The *Tools for Tomorrow* psychoeducational career group curriculum helps students build an understanding of career development in a way that positively impacts their school engagement and their sense of belonging in school.

Career counseling is effective for individuals (Whiston & Tolga, 2008) and also in conjunction with small groups and career development courses. The strongest positive effect for individuals presenting with career concerns, though, comes when individual counseling and group work are offered conjointly, in tandem, or combined in the form of career counseling groups (Brown & Ryan Krane, 2000). In turn, structured career groups have been found to produce more impact than unstructured groups (Whiston et al., 2003). When special workshops, courses, and other large seminars are included as additional forms of career group interventions, the evidence is even more persuasive that group interventions in career development are effective, particularly if there are opportunities in group to acquire new information (new learning) and to practice new behaviors. Other studies have documented the effectiveness of career groups independently and/or compared to other forms of interventions (Brown et al., 2003; Whiston et al., 2003). A study reported by Nguyen (2011) showed that participation in career group counseling resulted in positive changes in career decision making self-efficacy. Small groups have also shown positive effects on female students in programs designed to foster gender equity in an area of national priority—Science, Technology, Engineering, and Mathematics (STEM) (Rowan-Kenyon, Swan, & Creager, 2012; Schmidt, Hardinge, & Rokutani, 2012).

Critical Ingredients in Career Groups

Ryan's (1999) meta-analytic study, as well as Brown and Ryan Krane's (2000) and Brown et al.'s (2003) follow-up studies, found that five critical ingredients in career interventions positively influence outcome: (1) written exercises, (2) individualized test interpretations, (3) occupational information acquisition and discussion, (4) opportunities to observe role models, and (5) assistance in building support systems. Each of these ingredients can be included in one form or another in most career groups; apparently, the more the better. In a comparative study of the impact on students' career decision-making self-efficacy of career counseling versus a career development course, McClair (2011) found that there were no differences on career decision-making self-efficacy between the two formats but that there were significant differences regarding the number of critical ingredients experienced. In other words, as Brown and Ryan Krane (2000) found earlier, cited above, the higher the number of critical ingredients experienced, whether in class or in one-to-one career counseling sessions with a career counselor, the key contributor to a positive difference was not the format (counselor vs. class) but the number of the critical ingredients experienced in session or class. The number of ingredients experienced varied, not by design but only by attendance in either format during the focus on particular ingredients. Some subjects missed career counseling appointments, and some missed a session or two of career classes.

Some of the critical ingredients are more easily included in small groups than others, but writing seems to be involved in most. In a simple form, offered here as an example, the first ingredient (writing) can be applied by group leaders in a number of ways at various stages in the group. For example, adolescent members of a small career group in high school might be asked to bring to the group for discussion a work autobiography in which the member describes early home chores, home expectations, childhood and early adolescent responsibilities at home, their first-paid "work" activity, part-time and summer employment experiences, and volunteer experiences. The purpose of such an exercise would not only be to serve as a content-filled introductory activity that is substantive, relevant, and engaging but also to help leaders stimulate and then shape the kind of active engagement and interpersonal interaction that can facilitate goal achievement and help build cohesion. Even more importantly, the purpose is to give members a chance to talk about interests, experiences, affirming responsibilities, challenging situations, and then about what they've learned about themselves in terms of career-related styles and patterns. Written assignments for use in later stages of the group can take a number of other forms, including a *Family Vocational Genogram* (Dagley, 1976; Malott & Magnuson, 2004) that outlines jobs, aspirations, and expectations of family members through three generations. Other examples in the literature include the *Career-Story Interview* (written) as a part of group-based *Life Design Counseling* (DiFabio & Maree, 2012), and *Hopes and Expectations for the Future* (Ferrari, Nota, & Soresi, 2012), a 10-week, small group program that includes writing and other key ingredients. Obviously, the writing task leads to learning about informational sources and preferred methods of acquisition. Perhaps, most importantly, during the last stage of a career planning group, members need to develop and share written plans for next steps they plan to take. A final step in this exercise is to ask each participant to name a small group of two or three friends or relatives to whom they can make a report on a certain date as to their plan and their progress.

Each of the other critical ingredients can be included in small groups as well. A variation on the modeling ingredient that has merit as a discussion starter in the early life of a group is to ask dyads or triads to bring to the group stories about work of members of their family or neighbors. Perhaps in a more entertaining way, group members may be asked to split into dyads or triads to pick out for later presenting the name of a worker on TV (i.e., *The Office*) or in the movies who is an excellent "negative" work role model (Dagley & Paisley, 2004). The key is to help group members focus their attention on specific behaviors of the models, such as decision-making styles or failures to plan ahead. Modeling, of course, is at the heart of effective gender-fair STEM programs (Burger & Sandy, 2001). All students need to observe both genders in Science, Technology, Engineering, and Mathematics jobs.

Researching occupational information together in dyads or the full group can also be additive and quite helpful. Electronic devices can enable all members to work "in group" on accessing, describing, and evaluating career information sources on the Internet. Similarly, small groups provide an excellent opportunity to focus on "interest

test" results, with the leader interpreting and eliciting subgroup involvement in the discussion of each member's results, one person at a time, followed up perhaps with dyadic discussions. Case studies (Krieshok & Pelsma, 2002) and career dilemmas (Santos, 2004) have also been shown to serve as valuable stimuli for helping group members develop richer understandings of the sequence of information/choices/actions/results. The delivery mechanism itself, the small group, may be helpful using Internet resources. Career HOPES (Herman, 2010), an Internet-delivered group counseling intervention designed to facilitate occupational exploration and decision making, has shown significant gains on career-decidedness.

Occupational Information may seem like a boring, straight-forward activity that would not generate much interest in a group. Yet our experience in leading groups using this kind of inquiry and exchange disconfirms this assumption. An example offered as confirmatory evidence is one that involved a pre-Veterinary student in a career exploration group on campus.

"Joe" grew up in a small farm community and "always knew" he was going to become a veterinarian. In fact, his teachers thought so too, as did the rest of the community, who incidentally chipped in to create a partial scholarship for him with the expectation that he would become the community's vet on graduation. They'd had a hard time finding a vet willing to live there, so they were excited. The problem came in the form of the science courses in the pre-vet curriculum at the state university. He just couldn't get anything above Cs in two of the science requirements, which was not going to be good enough to get him admitted into the highly competitive vet school. Despondent going into the "Information" exercise, Joe (and his group partner in the exercise) found occupational options in the same field at a lower level without requiring a doctorate in Veterinary Medicine that Joe could pursue. Suffice it to say that Joe was not the only happy person in that group that day. Feeling depressed from experiencing such a public "failure" at what he wanted to do was replaced with a very acceptable alternative path that allowed him to continue in the field he loved, but at a different level. Later, we learned that with his Veterinary Technologist degree in hand (a four-year degree rather than the doctorate), he happily returned home, where he continues to serve near his home community in a role close to his original dream.

The final ingredient, support systems, is key to most career groups, particularly for such groups as the psychoeducational groups for domestic violence survivors mentioned earlier (Chronister & McWhirter, 2006; Davidson et al., 2012). Planning for postgroup support is a step that merits attention in all counseling, but particularly in these restorative career groups. There are four key areas that require detailed plans before leaving the comfort of this kind of transition group. Each member is asked to "publish" or speak aloud specific plans for physical safety, financial stability, psychological comfort, and an effective job-hunting plan before they're fully approved to leave. The group-as-a-whole is then asked to help develop alternative forms of support for members who cannot come up with one or another of these parts of a support plan. Often these groups find a way to come back on an out-patient basis for a small group that meets approximately every three weeks.

Theoretical Support for Career Groups

As described in earlier chapters, Yalom (1995; Yalom & Leszcz, 2005) has identified a set of therapeutic factors in groups: instillation of hope, universality, imparting information, altruism, corrective recapitulation of primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. Interestingly, these "factors," separately and as a whole set, play out quite significantly in the history of career groups. In fact, "imparting information"—or what use to be called guidance—has always been a major focus of career group interventions. It has been our experience that Yalom's factors are as consistently experienced in career groups and transition groups as in other types of groups. The presence or absence of factors is more often a product of specific member characteristics, and/or specific leadership characteristics or variables, than the exact focus of group goals. By and large, career groups (and transition groups) reflect such therapeutic factors as altruism, catharsis, and/or recapitulation of the family experience as natural functions of group interaction—that is, under effective leadership. Career groups are much more interpersonal and affective than some might think. It's interesting to consider whether or not career counseling groups and personal counseling groups are very similar, somewhat alike, quite different, or totally unlike each other and therefore unique? For us, the only distinguishable difference between career groups and process groups or therapy groups, is in the intentional integration of information dissemination (imparting information) and interpersonal learning in career groups. These are not incidental goals but primary goals for career group leaders. Transition groups are similar in focus but may be a shade more likely to focus a little less on information and knowledge and a little more on hope and catharsis. Regarding the role of information dissemination and processing in career groups, however, it is absolutely critical to remember that cognitive processing is merely one part of many other components involved in career decision making, along with affective processing, and career skill building. A career group that relies exclusively on information dissemination is not really a career group, much less an effective career group. It is too easy to fall into the trap of thinking that career groups are information-bound. Effective career group leaders know that affect associated with career goals can be as deeply implanted in personal aspects of self and can be as multidimensional and intertwined as one's attraction to loved ones. Work, and decisions related to choice and preparation for work, are primary life tasks (see the works of Adler and Freud).

If only the answers to questions regarding the distinguishing characteristics of career and transition groups were simple and clear, then the design and leadership of such groups would be easier. However, the number of influential variables is too great to offer a simple answer. In truth, each such question can be best answered with the phrase, "it depends." For example, it is possibly true that career groups may indeed be more informational, as mentioned earlier, and thus more likely to comprise the bulk of "psychoeducational" groups. That said, it is important to remember that even structured psychoeducational groups can be affective, cathartic, and informative. The key is for the group leader to follow Association for Specialists in Group Work's (ASGW) *Best Practice Guidelines* (Thomas & Pender, 2008) in planning, performing, and processing. The latter refers to more than just facilitating group discussion. Processing the dynamics of the group involves the facilitation of member-to-member dialogue and the exploration of the interpersonal dynamics produced by disclosure and feedback. Processing of the dynamics of group interactions is at least as important as planning for the group.

Structured groups also serve to encourage the emergence of a sense of universality, where members can feel that they are all in it together. A jobless club would warrant such a description, or a group of newly unemployed workers, or a group of yet-to-be-employed potential workers. In sum, protocols for career group interventions are not easily characterized or categorized. Career groups "learn" from each other, cathart deeply, build a somewhat unique sense of universality, and develop strong cohesiveness. To achieve such dynamic interaction may require leaders to build their "processing" skills by using such theoretical constructs as those offered by Focal Conflict Theory (FCT) (Champe & Rubel, 2012). In particular, FCT helps leaders understand the degree to which psychoeducational groups like unemployment groups may be restricted by a somewhat universal focal conflict that members may feel. For example, group members usually possess a desire to share insecurities about their abilities but fear group rejection if they do.

Kivlighan has shaped the focus on therapeutic factors in groups by identifying the factors that members assess as

most critical in their group experience. Among a number of interesting findings, he has found that the impact of therapeutic factors shifts with stage of group development (Kivlighan, Coleman, & Anderson, 2000). Such factors as hope and universality may give way to learning and catharsis as most influential factors in later stages of a group. Member characteristics, type of group, leader behavior, and cohesiveness of group also impact groups. Recent research suggests that there may be fewer, more global factors (Joyce, McNair-Semands, Tasca, & Ogrodniczuk, 2011). Yalom's eleven factors may be in actuality four or less: instillation of hope, secure emotional expression, awareness of relational impact, and social learning. Why do we focus on therapeutic factors? Simply, to make the point that if we cannot find persuasive data that confirm the existence or nature of something as basic as therapeutic factors, then how can we permit simple assumptions about how therapy group interventions and career group interventions differ and whether or not one can find affect and emotion in career group interaction. A psychoeducational task group can be deeply cathartic and emotionally taxing, as in such areas as a "job-searching support group for returning war veterans," or a social justice group for handling the feelings possibly associated with "arbitrary" exclusion of job-seekers from a minority group, lower socio-economic family, or "wrong" age or gender.

Some groups are more structured than others. A group with high structure is one that we've run on campus a number of years in the fall when it's about time for students to begin to make decisions required for enrolling in spring semester classes. The primary reason for high structure is limited time. University career counseling centers tend to see a rush of first-year students showing up in panic mode because they have to sign up for classes and have virtually no idea what courses to take or what major to declare. Increasingly, students are admitted to colleges within a university, so one might guess that they would have made at least a tentative declaration of major. But alas, right before enrollment deadlines come around, they come in flushed with anxiety, certain only that their parents are going to kill them because they don't know what they want to take. The obvious time pressure is very real, and so too is their relative ignorance relative to what they really want to do with their lives, particularly their academic/career lives. The tight structure of the small group is a product of that time crunch, because there's truly no time to dawdle (meet twice a week for three weeks). So the key is to create a group structure that is focused on the task of maximum information acquisition and processing in the shortest amount of time—A quick introductory activity that asks group members to share with each other in dyads the kind of information source each used in declaring their initial choice of majors and career goals. Of all the sources described (friends, parents, teachers, movies), few will report the use of actual information-based sources. Then the group leader shares information about tools that will help them explore data sources that might have potential for seeking information relative to majors and careers. For example, the leader introduces them to various websites for local and national information (i.e., the government's O-NET with its *Occupational Outlook Handbook*). Academic advisors around campus are incredibly busy around that time of the semester, but one of them is usually available, either in person or electronically, to highlight some useful local tools, data, and procedures. Next, a session is devoted to group and individual interpretations of career interest test results (i.e., the Strong Interest Inventory, the SDS). Each group member is asked to record in writing a family vocational genogram to bring to the group for sharing insights. For the students who find that especially problematic, for whatever reason, they are asked to submit an alternative writing project designed to help them identify what they've learned about work from their childhood or from biographies of workers or prominent people. Since time is of the essence, this activity is primarily designed to "tweak" their information-seeking behavior. An alternative used often is to ask members to conduct and write up an informational interview, which is merely a quick conversation with a person who is working in a career position or field that the student finds interesting or attractive. The goal is to help students develop interview skills. It's important to begin to think about why people work, what they get out of their work, how they have continued learning or improving in their work, and perhaps what they do not like, or what they plan for the future. Another group exercise is one that helps students develop greater awareness of how they make decisions.

Less structured groups are typically led in those same university facilities or offered in high schools throughout the land. These groups are all about making major decisions! Juniors at either the high school level or the collegiate level would be the potential group members. Why juniors? They are unusually focused at these two points of their life because they are facing such major life transition points and are often filled with approach-avoidance decision conflicts in several areas of life, including love, education/work, and friendship. Structure for such groups can become quite cumbersome, so group leaders focus mostly on facilitating process. Our experience has left us with a

conviction that there is little need for external stimuli in such a group.

Group Process in Career Counseling (ASGW Best Practices: Planning/Performing/Processing)

Career group leaders face another formidable challenge beyond the personal-career integration issue. That extra challenge evolves not so much from the content of the group but more the process. A distinguishing characteristic of career groups is the presence of content, usually in the form of information, as we have outlined earlier. Typically, participants join to learn something they have not known, whether it's about the world of work, about the job-hunt process, or about their own measured interests, values, and abilities. Because of the quasi-instructional focus, such groups often become content-laden. When instructional activity displaces a facilitative focus on group dynamics, the interactive process can become excessively controlled or constrained, to the point that the group appears to more closely resemble a class or a workshop than a small group. The most significant challenge of any intentionally structured group is to maintain a commitment to process dimensions of group dynamics without sacrificing goal directedness. Without vigilance, intentional structure can lead to excessive structure. It can result in a leader-dominated group with little member-to-member interaction.

Group process is a dynamic construct, not one that is easy to describe, define, or measure because it is complex, elusive, subtle and "linguistically nuanced" (Yalom, 1995, p. 165). Some confuse process at the microlevel (individual) with process at the macrolevel (group as a whole) (Brown, 2003). Process and content are not necessarily dichotomous (Geroski & Kraus, 2002), especially as they are often described within psychoeducational groups; they may not even belong on the same continuum. Nor are process and content entirely discrete concepts (Ward, 2002), even though they are familiar and trusted terms that have been used as though they were. Group process is a vital component of career counseling much like it is for all group counseling. Without it, groups can become content-driven and less interactive. Yet it is difficult sometimes to balance content and process. The challenging task for the leader is to be able to stay present in-the-moment with the group, helping to facilitate reflection and interaction, while being focused on the group-as-a-whole. What are we doing as a group? Is there some "social loafing" going on wherein some members are simply going along for the ride without venturing forth to enrich the journey for all?

A few years ago I (JCD) learned a painful lesson that as a group leader, good intentions are not nearly enough when it comes to giving feedback to group members. "What someone hears" is far more important than what is intended for them to hear in giving them feedback. A nine-month small group Career Planning and Readiness Project in a "Youthful Offender" prison facility provided the backdrop for this lesson. Somewhere around the twelfth weekly session, I introduced an activity called "Cool Seat," an activity introduced earlier by Daane (1972) in his Vocational Exploration Group program, as an offshoot of the earlier Gestalt-inspired "Hot Seat." The purpose of the activity was to give participants a chance to hear feedback from other group members as to what jobs their peers could see them doing/liking or not doing/disliking. The target member was to remain silent and simply listen to feedback. Somewhere near the end of the exercise, as the group leader I offered my impressions of one of the young men whose turn it was to be in the Cool Seat. The young man had been quite open and had, in many ways, been a delightful role model nearly every week. I particularly appreciated the young man's sense of humor; he had a gift of timing, seemingly knowing exactly when a group member needed support, or kidding, or challenging. He seemed quite able to walk the tightrope of humor, knowing exactly when the group needed a release and when it didn't. He was easily recognized as the most popular and in most ways was the unacknowledged leader. In my comments I focused on my appreciation for his interpersonal style, particularly the way in which he built and maintained relationships through his personality and his wit. I offered my perception that any job dealing with people on a regular basis, such as in personnel offices or human relations offices would seem to fit quite nicely, or even work crews comprised of small groups of workers. I also shared my impression that he thought the young man might find any job without coworkers boring and wasteful of his interpersonal abilities, specifically his ability to make people laugh.

I was then troubled and mystified when the young man failed to return to the group for four weeks. When he did finally come, he said, … "Call me a joker, and then expect me to come back. … I'm only here this time because my buddies tell me you're boring 'em to death!!!!"

So it was at that moment that I truly grasped the simplicity and the complexity of "providing feedback." What I thought I said did not turn out to be what was heard. I also learned that the young group member didn't really trust words. It had been okay to affirm him as a key group member with actions but not words. He'd heard too many.

Career Groups with Children and Adolescents

Professional school counselors were among the first to lead what once were referred to as guidance groups and what is now more commonly referred to as psychoeducational groups. DeLucia-Waack (2006) provides a comprehensive and exceptionally useful guide for leading these kinds of groups with this age group. School counselors have demonstrated that small groups can significantly increase academic performance and in turn help build a strong foundation for career success skills (Bostick & Anderson, 2009; Brigman & Webb, 2007; Kayler & Sherman, 2009). Some groups are designed to help develop age-appropriate knowledge and skills in such areas as career exploration (Taviera & Moreno, 2003), decision making (Teuscher, 2003), and hope (Macey, 2012). Others have career development goals integrated within a more broadly focused effort such as school-family-community partnerships (Griffin & Steen, 2010). A significant number of programs built around small group interventions target urban youth (Blustein et al., 2010; Kenny et al., 2006; Solberg et al., 2002; Turner & Ziebell, 2011). Moreover, group programs aimed at empowering African American youth have garnered some of the most significant results in helping close the achievement gap (Bailey & Bradbury-Bailey, 2010; Bruce, Getch, & Ziomek-Daigle, 2009). Finally, innovative groups have targeted parents to help them improve their abilities to provide support for their own adolescents as the students build career development knowledge, attitudes, and skills (Alliman-Brissett, Turner, & Skovholt, 2004).

Career Groups with Older Adolescents/Young Adults

The most common career intervention is the career course offered on most college and university campuses. In a comprehensive review of the history of such courses, Folsom and Reardon (2003) found approximately 80 references in the literature to career courses, with some dating back to the early years of the twentieth century. While the courses are not groups, per se, most do rely heavily on small group experiences as a primary methodology. More traditional career counseling groups are also offered on campuses in counseling centers and in career centers, as well as in various community agencies. These kinds of small groups have included social anxiety reduction groups (Damer, Latimer, & Porter, 2010), college adjustment groups for athletes (Harris, Altekruse, & Engels, (2003), stress reduction through mindfulness groups (Newsome, Waldo, & Gruszka, 2012), bereavement groups (Capone & Connell, 2010), groups for African American adolescents to facilitate transition from youth to young adulthood (Stark-Rose, Livingston-Sacin, Merchant, & Finley, 2012), genogram-based career decision-making groups for college students (Malott & Magnuson, 2004), and academic test anxiety reduction groups (Damer & Melendres, 2011).

One of our most important goals in writing this chapter was to broaden the sense of what might be construed as a career group, and what might be defined as a career intervention group program. It has been our experience that too many traditional "career groups" have been content-centered, information-sharing instructional exchanges from a leader who performed more typically as a teacher than a process-oriented group leader. In addition, we believe it is important to focus more on programs of research-based interventions that make effective use of group methodology. In addition, we wanted to highlight the seminal work of three groups of scholar-practitioners who have collectively demonstrated what could be referenced as evidence-based career intervention. These three groups include the work of Blustein and his colleagues with urban school youth, the work of Brigman and colleagues on the impact of a comprehensive K–12 focus on academic and career achievement, and on the imaginative and impactful work of Bailey and colleagues on reducing the achievement gap of minority-majority populations. In the spirit of our commitment to broaden what constitutes a career group intervention and what constitutes a transition group, we close the chapter with a practical example of a long-standing (15-plus-year performance record) career/transition intervention group with female juvenile offenders who have been destined to enter or reenter the work force on release from incarceration. Why use this group as a primary focus? In many ways, this is a population that has been neglected or all-but-forgotten all too often. It also gives us an opportunity to end with a focus on the importance of stretching perspectives of the nature of career and transition counseling in groups. To help young, incarcerated females regain a sense of positive purpose in life, as well as faith in themselves and others, we need to do more than just ignore them, expecting them to make it on their own out of an environment that did not serve them well in the first place. All career group interventions should be empowering, particularly career groups with this population. Before information can be helpful, sometimes wounds have to be healed, and cooperative, team-oriented behaviors need to be relearned. Career groups are more than information-centered intervention efforts. Some career groups build a strong base of encouragement first. The belief in oneself that you can be a positive force in making your life better and then building the same level of faith and courage in others will provide a strong base of encouragement from which a young woman can build a productive career and life.

The Girls Group: A Career/Transition Group Intervention

We offer the G.I.R.L.S. (Gaining Insight into Relationships for Lifelong Success) group as an example of a career group intervention that stretches the ordinary perspective of career groups. While the group is built on structure and planned content (including modeling and information acquisition), it emphasizes the dynamic interaction of members (group process) as the principal ingredient. For this population, the most critical pieces of a career group intervention are process-focused interactions designed to build new ways of relating, learning, and feeling stronger and more centered so that even the most preliminary steps toward career planning can take place.

The G.I.R.L.S. Project is a gender-specific group treatment intervention program that utilizes a relational model designed specifically for the female juvenile offender population in recognition of the central role that relationships play in a female's life. The primary goal of utilizing a relational group approach is to help members develop positive relationships and healthy connections to foster a sense of support, understanding, and self-pride. The goal is to increase their adaptive skills by enhancing their relational abilities and thereby decreasing their emotional isolation in order to promote psychological health (Brown, 1999). Decreasing the mistrust, anger, and isolation commonly experienced by these girls can lead to less aggression. By improving their relational abilities and confidence, they will have the knowledge, skills, and experiences to make more positive choices for their futures, especially in terms of employment and career development.

The Importance of Relational Group Work

Understanding the importance of relationships in girls' development offers a natural way for small group leaders to help girls address problematic issues and foster growth (Butler & Wintram, 1991). Group work provides an opportunity for members to come together in a therapeutic environment to experience positive and healthy relationships, with support from other girls and women. As girls begin to relate to one another and share themselves in their new relationships, their self-confidence and self-esteem can flourish (Pipher, 1994). Armed with a new sense of self, support, and confidence, the group members can begin to repair the effects of previously harmful relationships and address the hurt of prior relationships. Thus, working together within a therapeutic group allows diverse girls to come together in a supportive manner to address and challenge their experiences, to develop a new sense of female pride, and create new possibilities for their future (Denmark, 1999). "The most powerful moments of psychological healing and empowerment … were those in which, either inadvertently or by design, girls came together to talk about and address experiences of betrayal, unfairness, and hurt" (Orenstein, 1994, p. 217).

Group issues arise from conversations with girls involved in the juvenile justice system. The first step is to create a safe environment where these girls, often used to being disrespected and unheard, can find a voice. Group leaders use a style of openness and self-disclosure to encourage the girls to begin to look at issues affecting their lives. Identification of how these issues affect their lives, decisions, and futures become the ongoing questions. Several main issues are continually identified as having a major impact on the group members: limited career and educational opportunities, drug and alcohol abuse, anger, abuse and violence, sexual relation problems, pregnancy, and grief and loss. Many of these issues are closely woven together in the lives of group members, often creating a tangled bed of frustration, hopelessness, and confusion. Common themes that are shared within the groups and across groups that are linked with the central issues include feelings of disrespect, loss of voice, dreams diffused, and isolation. Commonly, these feelings lie behind the girls' offending behaviors. The outside world often sees only their offenses and their tough exteriors but not their wounds. As one group member shared, "I am like an M&M, hard on the outside, but I will melt in your hands." Group sessions center on the topics and themes in the group members' lives, enabling group members to begin to experience a shared universality with connections and commonalities. Ultimately, the girls begin to reach out to each other. The issues and themes discussed in group are fundamental to the ways in which the group members become involved in the justice system, often perpetuating their offending behaviors. The juvenile justice system addresses the observable behaviors, which are important, because they often bring harm and continual trauma into the group member's lives. Group leaders work with the members to understand their behaviors as reflections of internal conflicts, disconnections, and trauma. Hopefully, group members will reach new ways of understanding how their actions meet their needs or fail to meet their needs. Girls who participate in the groups are often survivors of abuse and neglect, frequently coming from tough neighborhoods with very few resources. They are clearly survivors who possess many hard-earned strengths; yet they struggle on a daily basis to be seen and heard. They appear to be doing the best they can to be respected; however, their choices and behaviors have more often than not jeopardized their futures. Group leaders, then, seek to connect with healthy spirits assumed to be underneath unhealthy behaviors and to serve as encouragers rather than monitors or evaluators.

Career Development Focus

The group format provides an ideal environment for the identification and exploration of career strengths and interests of group members. It provides an opportunity for group members to recognize and talk about their strengths, identify goals, and discuss possible barriers to goal achievement. As a group of women, members tend to discuss common issues such as gender role expectations and discrimination they may experience in the workplace. Together, group members problem-solve and create new options for their futures.

Group members are encouraged to identify potential barriers to academic and vocational success. Often, these include discouragement at school environment, at home because of a lack of familial support for educational advancement, adolescent motherhood, and societal discrimination. Typically from single parent and lower

economic classes, many group members have had limited positive exposure to the world of work. Thus, group activities are included to help members build their knowledge of the work world and their career opportunities. Interest tests and interpretations/discussions, visits by working role models, and sharing of concrete informational resources collectively serve as role models on several dimensions.

Currently, women comprise the majority of the country's workforce, yet many of the girls involved in the juvenile justice system do not see themselves as having the potential to join working women in meaningful careers. Leaders work to increase members' confidence and options by providing concrete examples and resources for pursuing these options, a critical ingredient of career interventions identified by Brown and Ryan Krane (2000) as Modeling. It is helpful to introduce group members to educational services such as free tutoring and the numerous scholarships available to aid them. Members are typically unaware of such assistance or eligibility requirements. Group leaders bring in working women to share their work experiences. In a feminist group model, leaders also share their own vocational lives.

Leaders of G.I.R.L.S Groups focus first on helping young women learn immediate and near-future survival skills. Needs related to daily survival predominate early discussions (how to make money for their families and/or their own children). At first, focusing on long-term goals can feel useless or overwhelming. Therefore, group leaders focus some sessions on very practical areas of daily living such as money management and school daycare. An ongoing target competency is for members to become information seekers.

Challenges and Barriers

Although group interaction frequently leads to meaningful discussions and even behavioral changes, group members do not always avoid some challenging interactions. These challenges and barriers include such realistic topics as transportation and time constraints, social and emotional concerns such as trust, and nonviolent problem solving. In addition, while collaboration between the G.I.R.L.S Project and the juvenile justice system can be rewarding, it does not come without challenges. Problems encountered often come from insufficient resources. Immediate practical problems often start with family support issues for group participation. Daily lives of girls and their families can be stressful, particularly when it involves a single parent raising children: one more meeting and one more ride can often become a tipping point. The parent(s), as well as the child, may initially experience the group as a problem, not a solution. Leaders address these problems by working collaboratively with the probation officers to assist with transportation issues. Such an intervention models positive problem solving and tangible support. Building trusting and open relationships with girls who have prepared themselves not to trust is another early challenge. Leaders offer the girls a chance to take a risk with their emotions and experiences, thereby creating a sense of vulnerability. Such a process, in order to be successful, takes time primarily because the girls have developed useful competencies in self-protection. Vulnerability is not a preferred place for them. Working together to respect their need for self-protection and self-reliance, the leaders earn permission to facilitate positive relationships. This action communicates respect for the group members and provides small affirmation that the members do have choices in the group process.

The most serious challenge in the group is creating emotional and physical safety of all group members. Conflicts and personal differences arise in almost all these groups because members have learned through experience that violence, in the form of physical fighting or an emotional attack/threat, can be an effective way of problem solving. Therefore, in setting ground rules for the group, leaders must insist on "no fighting." Leaders help members realize that everyone can have an urge to resort to violence to solve a problem; however, action on the urge frequently not only fails to solve the problem but often compounds it.

Chapter Summary

Important goals are targeted by professionals who provide career and transition counseling in groups. By this point in the professional growth and evolution of group counseling and psychotherapy, enough is known from published process and outcome research to inform us as to what should constitute these group interventions. Work, whether cobbled together into a thread that can be referred to properly as a career or not, has been dutifully noted from the very beginnings of psychology and education as centrally important to the mental and physical health of individuals and to the greater society of humanity as well. Developmental transitions that are expected and experienced by most, as well as unanticipated transitions, are also seen as having critical importance in life. So it just makes common sense that career and transition group interventions have sufficient merit to warrant our attention. Thus, this chapter presents definitions and examples of these types of group interventions, as well as the supportive theoretical and empirical bases for offering these small groups. We have attempted to provide somewhat nontraditional examples along with common group interventions, to ensure that conceptualizations of career and transition groups are given the breadth and depth the constructs deserve.

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Chapter 44 Adventure Therapy with Groups

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Slavson and Moreno, pioneers of group psychotherapy, used activities as a primary method of change in group work (Scheidlinger, 1995). Gillis and Bonney (1989) noted that if adventure experiences were known during Moreno's heyday, he would probably be heralded as an adventure therapist as well as a psychodramatist. While the activity base for group work has been abandoned for many years in favor of "talk therapies," it has been "rediscovered" by art, music, wilderness, recreation, and other more active, experientially based group therapies. The purpose of this chapter is to update the concepts of Adventure Therapy (AT) and provide readers with a rationale for the use of adventure experiences in group therapy similar to how drama techniques are used in Psychodrama or experiences are used in Gestalt Therapy.

Gass, Gillis, and Russell (2012) recently defined AT as "the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on cognitive, affective, and behavioral levels" (p. 1). This deliberately derived definition captures how AT is conducted by professionals with credentials in mental health who understand the power of group experiences—especially active (kinesthetic) experiences designed to metaphorically mirror clients' issues. There are two primary locations where AT operates: (a) in the "front country" through the use of challenge/ropes courses and through the adaptations of adventure experiences in a traditional group therapy room and (b) in the "back country" in wilderness settings such as those operated by Outward Bound, 20–60 day wilderness expeditions, and outdoor behavioral healthcare programs (http://obhic.com). The length of time involved (daily or weekly sessions vs. extended back country expeditions) and the type of programming (activities, ropes courses, rock climbing, canoeing, hiking) used characterizes both levels of intensity and immersion in the AT group experiences. Back country expeditions require a team approach to leadership, since therapists are working alongside wilderness staff. In this chapter, we focus primarily on the use of AT in traditional group work settings (i.e., "front country").

The purposes of this chapter are to (a) present a brief history of AT and discuss this research supported approach, (b) explain the use of kinesthetic metaphor in AT, (c) outline the rationale behind AT processes, (d) present a case study depicting AT assessment techniques and interventions, and (e) discuss ethical guidelines and professional issues for those who use AT with groups.

Brief History and Research on Adventure Therapy

Most of the origins of AT can be traced to the challenge experiences associated with taking groups into wilderness environments for therapeutic purposes (Bacon & Kimball, 1989) and the activities associated with group development through the use of challenge course experiences (Rohnke, 1989; Schoel, Prouty, & Radcliffe, 1988). White (2011) has provided the most complete historical context of AT. His analysis of AT starts by highlighting a heritage that includes influences from therapeutic camps in the early 1900s, Boy Scouts of America, Outward Bound, and a survival class at Brigham Young University (BYU 480) in the late 1960s. From this analysis, White draws connections to the adaptations of Outward Bound into school curricula by Project Adventure in the late 1970s and to current wilderness expeditions programs, especially those operating as outdoor behavioral healthcare (obhic.com). Gillis and Ringer (1999) earlier noted that Outward Bound, a wilderness-based program teaching self-discipline and teamwork through adventure experiences (Bacon, 1983), is a major part of AT's documented history. The philosophies of experiential learning inherent in Kurt Hahn's work may be considered one of the first uses of adventure therapy, due to Hahn's work with groups of young seamen in the 1940s and his attempts to instill within them a "will to live" through the use of challenging adventure experiences (Thomas, 1980). Kelly and Baer (1968) demonstrated that a 21-day standard Outward Bound course for groups of adjudicated youth was more effective in reducing recidivism and less costly than traditional treatment for adolescents in correctional programs. This finding led many states to invest in this therapeutic method of working with groups of youth in wilderness environments.

AT has largely been a demand-driven treatment alternative for adolescent pathology that can be utilized in a traditional group therapy room as well as in combination with the restorative, healing effects of the natural environment and the intentional use of therapeutic group experiences. AT programs are largely misunderstood in terms of their therapy, process, and practice as well as their clinical utility— despite their wide use.

Currently AT is utilized in schools, community mental health centers, residential treatment centers, and wilderness therapy programs. The most common age group for AT has traditionally been adolescents, but there are mental health programs working with children even younger than 12 (Tucker, Javorski, Tracy, & Beale, 2012) as well as with young adults (Russell, Gillis, & Lewis, 2008). The intentional use of activities, especially as metaphors for therapeutic issues, makes AT applicable for groups where the focus can be on the here-and-now experience the group is having together.

Russell et al. (2008) offered several conclusions regarding the use of AT as a group-based behavioral healthcare alternative for youth. Key among these conclusions were that these innovative programs appeal to families, social service agencies, corrections officers, and other mental health professionals looking for inclusive, less stigmatizing treatment options provided by AT.

Several meta-analyses support the effectiveness of AT as a modality (Cason & Gillis, 1993, Gillis & Speelman, 2008; Hattie, Marsh, Neill, & Richards, 1997; Wilson & Lipsey, 2000). The results from these studies should be interpreted with caution, because the current practice of AT has evolved over several decades and has been defined in many ways. Because of these multiple definitions, an array of studies is needed to generalize findings to modern AT. This is considered a shortcoming of research in the field— the difficulty of comparing and replicating studies from one program or setting to the next. Despite the limitations, conclusions can be drawn about the effects of AT on a variety of clients (primarily adolescents), involved in some type of AT program. The meta-analyses have found consistent and positive effects for AT programming with two *primary* effects on participants: (a) the positive and significant development of self-concept from participation in an AT intervention and (b) the development of adaptive and social skills due to the unique group-based treatment milieu.

Hattie et al. (1997) distinctly stated, "for social competence, cooperation, and interpersonal communication, it certainly appears that adventure programs affect the social skills of participants in desirable ways" (p. 69). Using both qualitative and quantitative methods, Russell (2003a, 2003b, 2005) showed that AT resulted in improvements in adolescents' social skills and reductions in substance use. Results demonstrated clinically

significant improvement in the Interpersonal Relation subscale of the Youth-Outcome Questionnaire (Y-OQ). These clinically significant reductions were maintained at 12 months post-treatment and in a 2-year follow-up. A review of the effects of AT programs on social skill development and substance use decline, in the contexts of group work in wilderness suggests that such programs influence the development of more socially adaptive and cooperative behavior (Russell, 2008).

For the interested practitioner, numerous books offer adventure experiences for recreational and educational purposes. Adaptations of several activities from Rohnke (1989) and Rohnke and Butler (1995) are included in this chapter. There exists an exhaustive list of activity books (available at www.wilderdom.com/games/BooksAboutGames.html). The key to selecting activities that intentionally address treatment goals is the language used by group members to their issues (Gass et al., 2012). These experiences can be referred to as "kinesthetic metaphors."

Kinesthetic Metaphors

Kinesthetic metaphors are intentional therapeutic actions with isomorphic (matching) links to clients' affect, behavior, and/or cognition that aid in the transfer of functional change through the clients' perception of their similarity. Kinesthetic metaphors mirror client's previous actions up to a point where the client's choice in the current action leads to new learning and/or a break in dysfunctional behavior patterns. Finally, kinesthetic metaphors provide an experience where successful resolution of the kinesthetic experience provides insight/pathways/clues to successful resolution of the client issue.

The use of metaphor is rooted in the psychotherapy work of Milton Erickson (Haley, 1973). As noted, most of the therapeutic interventions used by adventure therapists are also grounded in the experiential approaches of Moreno, Perls, Satir, and Whitaker. Kinesthetic metaphors are rooted in the concept of meta-communication—communication about communication. Meta-communication has been eloquently outlined by such therapeutic pioneers as Bateson (1972), de Shazer (1982), Waltzlawick, Beavin, and Jackson (1967), and Waltzlawick, Weakland, and Fisch (1974). Adventure therapists use meta-communication by listening to clients' language for clues of activities that might best parallel their therapeutic issues and then as kinesthetic metaphors when clients participate in the activities that provide a joint reality. This joint reality is often heard in the clients' language (Gass & Gillis, 1998; Gillis & Gass, 1993) where there are (at least) two meanings to words used in the adventure experience. One of these meanings represents the reality of the actual adventure experience taking place and the other is the group member's real-world reality where the activity mirrors, matches, or is isomorphic with issues in their life.

For example, after progressing through the forming stages, a group expresses dissatisfaction with why they are even in the group. They express how the purpose of the group is not clear and how they feel like a collection of individuals, not a group connected to one another. Hearing of this struggle to find focus and the group's lacking cohesion, an adventure therapist might ask them to engage in an experience where they balance a plastic cup filled almost to the top with water on a bandana and move in and around the chairs in the group room without spilling the water. To maintain the balance of the water in the cup, the group must focus on the cup and literally "pull together." There is a natural and immediate consequence of a lack of focus and cohesion—the water spills and sometimes members get wet! However, the focus on the common goal of maintaining the water in the cup requires the group to come together.

Bacon (1983) and Gass (1993) advanced the use of metaphors in the presentation of therapeutic adventure experiences by defining steps the therapist would take to cocreate metaphors with groups. Gass' (1993) steps include the following:

1. Stating and ranking the group members' goals. In the example above, the group expressed their issues with a lack of focus and reason for even being a group.
2. Selecting isomorphic (matching) adventure experience. The choice of the cup and bandana activity (Gass, 1998) was isomorphic with the lack of focus because it required the group to come together in order to maintain the water in the cup. The group's language suggested an activity that involved focusing, pulling together, and moving as one body. These elements were structurally inherent in the cup, water, and bandana activity.
3. Identifying successful resolutions to clients' goals. Were the group to focus and "pull together" and keep the bandana taut, they would be successful.
4. Strengthening the isomorphic connections. The group was told the experience of participating in the activity contained clues for how they could find their focus.
5. Reviewing/empowering the group's motivational state. The group was challenged to stop talking about a lack of focus but to try and "walk their talk."
6. Conducting the experience.
7. Debriefing by punctuating isomorphic connections. In the discussion that followed, group members shared their insights of how the task seemed overwhelmingly difficult at the beginning—especially after spilling the

water several times—but as they practiced they became more successful. The therapist used language inherent in the activity (e.g., “pull together,” “focus,” “watch out,” “go slowly”) to engage the group on their purpose for being together and how the experience of the activity might help them achieve their individual and group goals.

The seven steps of metaphor creation are further detailed in Chapter 8 (p. 161) of Gass et al. (2012) and serve as the heart of the intentional use of therapeutic activities in AT. Elements of kinesthetic metaphor are seen in the rationale for why AT can be a useful approach for groups.

A Rationale behind Adventure Therapy

Based on over 30 years of evolving practices and research with AT, the following six points provide a generally accepted rationale to support the use of AT with groups:

1. Isomorphic yet Corroborating Representations of Reality

Using adventure experiences with groups turns passive therapeutic analysis and interaction into active and multidimensional experiences. Didactic and verbal processes are augmented in adventure-based groups by concrete kinesthetic actions and experiences. Group members' behaviors are viewed in the "here-and-now" as they participate in the adventure experience (i.e., they are asked to "walk" rather than merely "talk" their behaviors). This active expression of issues is an aspect AT shares with Psychodrama or Gestalt Therapy. Group members project their issues into experiences, especially when these experiences isomorphically match their expressed group issues. Therapeutic interaction is observed and holistic, involving physical, affective, and cognitive processes for the purposes of examining group patterns and beliefs. For example, in a group of mother-son pairs, the group was asked to pair up and place a 12-foot piece around their waist while facing one another and keeping the rope taut between them (an adaptation of "On Belay, Gotcha" from Rohnke, 1997). The challenge was to try and cause their partner to lose balance by manipulating the rope around one's waist. After several rounds of falling off balance, one mother threw the rope down in frustration saying "This is exactly what goes on in my house every afternoon." Obviously the "tug of war" nature of being "jerked around" resonated with the mother. While they did not literally pick up a rope at home each day after school and "jerk one another around," the thinking, feeling, and behavior of this activity "spoke" to the mother. The group (especially the other mothers) coached the "jerked around" mother to try giving some slack to her son. In the activity this action literally caused him to fall off balance. The group then discussed ways the mother and son could work together to achieve their goals of a more peaceful home life without either of them feeling "jerked around."

2. Contrasting Experiences

An unfamiliar adventure experience provides a medium that is “contrasting” to a group member's current reality state. Group members’ entry into a contrasting experience is often the first step toward reorganizing the meaning and direction of their life (Priest & Gass, 1997b; Walsh & Golins, 1976). In the example provided earlier, balancing a cup of water on a bandana is not an “everyday” or familiar experience. Neither is standing apart with a taut rope between a mother and son. Groups project their issues onto the experience in the here-and-how. And using an unfamiliar experience is meant to provide a glimpse behind the persona of the group and group members since they have no preconceived notion of how they are to act in this new experience. Perhaps being caught off guard allows the “true self ” to be seen or heard (as was the case with the mother and her son above).

3. Production of “Eustress” as a Motivational Agent for Change

When properly implemented, adventure experiences introduce *eustress*, or the healthy use of stress, into the group member's system in a manageable yet challenging manner. This type of stress or dissonance places individuals into situations where using positive problem-solving abilities (e.g., trust, cooperation, clear and effective communication) helps groups reach a desired state of agreement or equilibrium. The process of striving to attain this state of equilibrium is sometimes referred to as *adaptive dissonance* (e.g., Priest & Gass, 1997b; Walsh & Golins, 1976), where group members change their behaviors to achieve desired positive states. Groups balancing the cup of water may find that moving slowly, speaking clearly to one another, and taking turns allows them to progress without spilling the water. In the rope example, partners might learn that strength can come from giving slack in the rope and be just as much or more effective than pulling the other off balance with sheer strength.

Combined with the activity's contrast is the appropriate use of physical and emotional eustress. Eustress differentiates AT's therapeutic process from other experiential therapies, as well as serving as a catalyst in the group change process by motivating clients to resolve critical issues. The key to picking a contrasting yet isomorphic experience is listening to the groups’ issues and matching the structure of their issue (e.g., lack of focus) with the physical characteristics of the activity (e.g., pulling the bandana tight and staying focused on the water) in order to achieve their goal.

4. Conflict Resolution Patterns to Structurally Implement Change

Adventure experiences are usually designed with internal mechanisms of resolvable conflict. These mechanisms use experiences that are organized, incremental, concrete, manageable, consequential, and holistic (Priest & Gass, 1997a; Walsh & Golins, 1976). As noted above, adventure therapists modify rules or objectives of activities used in recreational or educational settings (e.g., Rohnke, 1989; Rohnke & Butler, 1995) to match what they are hearing from the group and to achieve therapeutic purpose.

These experiences are organized to meet the needs and abilities of the group as well as progressively sequenced for specific client needs (e.g., conducted incrementally in terms of complexity and consequence). Groups begin with easier tasks and gather competency and mastery from accomplishing these tasks, and then they may attempt more difficult tasks with an established base of increased skills and confidence. For example, a group might begin with a trust lean (e.g., where one group member placing hands on shoulders behind another group member who leans against them; detailed at http://www.wilderdom.com/games/descriptions/TrustLean.html) before moving to an activity requiring a person to be lifted off the ground and passed over a rubber band fence ("Nuclear Fence"; Rohnke & Butler, 1995, p. 208). Adventure experiences are also concrete, easily recognizable, and typically visually stimulating. They generally possess a definite beginning and end point. While initially appearing insurmountable to many groups, adventure experiences can be managed or accomplished when groups utilize their collective resources. This may initially be unclear to some groups, but their collective abilities to accomplish the task are based on how group members are willing to engage with one another and explore each other's skill sets. Adventure experiences are naturally consequential, and the outcome, whether the group views them as positive (successful completion) or negative (not finishing the activity in the time allotted or "giving up"), generally have an immediate, nonarbitrary, and direct effect on the group—they often want to discuss how well they did or did not do. For the therapist whatever the group does is "grist for the therapeutic mill" since completion or noncompletion of the activity centers their attention on key issues. The interpretive meaning of the experience is with the client/group and how the activity aids in the resolution or deeper understanding of the therapeutic issue. So whether the water spills or not provides meaning in the moment for the group and how they see themselves.

5. Solution-Oriented Structures

Entering therapy can be threatening for many, heightening defense mechanisms and resistance to change. Most adventure experiences possess the natural occurrence of solutions in their structure. With unfamiliar adventure experiences, group members are presented with opportunities to focus on their abilities rather than focus on their inability. This type of orientation can diminish initial defenses and lead to healthy change when combined with the successful completion of progressively difficult and rewarding tasks. Many of the activities are enjoyable and often result in laughter that adds to their appeal. Rather than being resistant in therapy, group members are encouraged to stretch perceived limitations and discover untapped resources and strengths. Since most adventure experiences are unfamiliar to most group members, they do not have preconceived notions of how well they will or will not perform. When the therapist sequences activities to build on successful completion of activities or helps groups confront their perceived "failures" with completion, the group is able to focus on behaviors that are useful in reaching solutions.

6. Changes in Therapist's Role

Adventure therapists are active and mobile. They design and frame adventure experiences around critical issues they hear group members express, focusing on the development of specific treatment outcomes. When utilizing adventure experiences with groups, adventure-based therapists are removed from serving as the central vehicle of functional change. The “experience” takes on the central medium for orchestrating change, freeing therapists to take on a more “mobile” role (e.g., for supporting, joining, confronting) in the coconstruction of change processes with the group. Combined with the informal setting of adventure experiences, the dynamics of this approach can remove many of the barriers limiting interaction. The therapist presents the experience and steps back to let the group members engage with one another to solve the problem together.

All six of these components for AT exist in the following “Wise Guide” group therapy experience. The experience is (1) organized around treatment objectives, (2) sequenced, (3) concrete in terms of trauma issues groups might face, (4) manageable when appropriate coping strategies were utilized, (5) consequential in relation to supporting functional strategies and providing valid feedback for negative decisions, and (6) holistic in terms of multiple paths of learning. Each of these qualities contributed to the ability of the AT experience to assist the group to achieve a more functional change process by walking the talk of change.

An Adventure Experience: Keying in on the Wise Guide

The following illustration is a case example adapted from a group demonstration presented at the "Food for Thought" Conference (Georgia College & State University, 1997) using an adventure group experience as a medium for change for a woman with a background of trauma that resulted in her feeling disempowered. The therapeutic objective of this group therapy experience was to assist her to focus on solutions she had previously used in her life that could be brought to aid her in her current crisis and help facilitate functional change. Associated with this process was the ability to screen out voices and sources of negativity serving as a major source of disempowered feelings in her life. This woman was a single mother who presented herself as lacking any sense of control in her life, feeling "stuck" in a rut, and receiving little support from her family of origin and current peer group.

The group therapist said, *In listening to your story and aspects of your life that help you as well as limit you from achieving the objectives and goals you are searching for we understand that your feelings are not altogether uncommon, in fact many in this group have expressed that they, too have felt similar to you. The key to your health may lie in focusing on what has worked for you in the past rather than changing what hasn't worked into something else.*

After hearing your story, we would like to invite you to do an activity that would encourage you to hear the positive aspects of the "wise guide" inside of you. We know that this source of wisdom resides inside of you, but for some reason you are not able to hear and key into the positive messages that the guide within you has. These messages are often mixed in with voices of negativity and negative messages that can sometimes limit your ability to key in on what will work for you instead of what isn't working for you. Your success in this activity, just like in your life, may be linked to your ability to get reconnected to the wise messages that will lead you to success and block or change or screen out the negative messages that may be presented for you to listen to.

If you feel anxious about this process, that's okay. But we encourage you to key in on the positive message your wise guide can provide for you. Whether that guidance comes from an inside view or from an external source, we encourage you to focus on those positive messages.

The logistic goals of this particular activity were to have this group member clearly identify specific objectives she was working toward and, with the help of the group, identify past skills that had helped her be successful when faced with similar issues. After she had done so, she picked another group member to represent her "wise guide." The wise guide's role was to verbally lead the group member (who had her eyes closed) to walk across a set of chairs appropriately organized to provide a challenging experience for the client but one that could be successful when the client's ability keyed in on the guidance of the "wise guide." Obviously appropriately sturdy chairs were (as they always need to be) selected for this therapeutic initiative.

Other members in the group served as "spotters" and were also asked to role play the "voices of negativity" throughout the process, representing the negative peer group where the client lived. These group members also placed the obstacles/chairs in the way of the client in her path for her objective.

In the post activity discussion, the group focused on how negative voices coming from people who supported the client provided mixed messages in her family system. The discussion centered on how the client was able to hear the wise messages from the guide and separate the positive voice from the messages of negativity. Finally, how could the client listen harder to the positive voices and be even more successful? The client expressed that she had gained insights into additional support she had back at home that she had not previously thought about by listening to her "wise guide" despite what the negative voices were saying to her. She was also pleased at her ability to tune out the negativity and only focus on her "wise guide," which she knew represented her own self-talk. She made a goal to be more mindful of her own positive internal voice.

Some groups using this activity have found it helpful to have group members label each chair for specific obstacles in their lives (e.g., ex-partner, obesity, addiction). This way they can metaphorically identify what enabled and empowered them to reach and exceed each particular obstacle. When and how to engage a client in an activity

such as the “Wise Guide” links the seven-step metaphor process with a seven-step assessment and evaluation process we call CHANGES.

Assessment Capabilities and Treatment Planning

The CHANGES model (Gass & Gillis, 1995) is organized into seven interactive steps designed to acquire information for developing functional group change. The seven steps make up the acronym CHANGES: Context, Hypotheses, Action, Novelty, Generating, Evaluation, and Solutions.

- *Context.* In preparing for the group experience, the therapist gathers all the information he or she can about the group. Why have the group members entered into this experience? Are they part of an existing group within a particular setting (e.g., residential treatment) or were they selected due to having a similar presenting problem (e.g., eating disorder or addiction)? What is the age range? What are cognitive limitations or expectations? How long will they be involved in the group? What are their stated goals as a group and as individuals? Sometimes groups are closed with set beginning and ending times and may run for one day or for one month; other times, more typical of outpatient or residential groups, the membership is open and members are starting and stopping at different times. These groups may have a specific focus such as substance use, eating disorders, or conduct disorders. In these cases the context aspect includes what the therapist knows about these particular issues and how that knowledge will influence what activities may or may not work. Since AT is most powerful when group members are able to make connections between the adventure experience and their own issues, the cognitive ability to have some level of insight has been found most useful when screening clients for group.
- *Hypotheses.* After gathering assessment information, the adventure therapist establishes hypotheses about what behavior(s) might be expected from the group. These hypotheses are "tested" through engagement in carefully designed adventure experiences. For example, in the first group the therapist may wonder how engaged group members are, especially if the group members have been assigned to the group because of their presenting problem in a residential setting. The therapist might choose to assess the level of engagement by blowing up a balloon and asking the group to keep the balloon aloft with each member hitting the balloon once. The groups' level of engagement might be hypothesized to be low in a "mandatory" group and the balloon activity would confirm or deny this hypothesis.
- *Action.* Much of the material used for constructing change is obtained from the actions of group members as they involve themselves in adventure experiences. Kimball (1983) and Creal and Florio (1986) related this process to the psychological concept of "projection." Based on this premise, and similar to psychodrama and Gestalt therapy, group members project a clear representation of their behavior patterns, personalities, structure, and interpretation onto the adventure activities because they are usually unfamiliar with what is being asked of them in the experience.
- *Novelty.* As noted above, actions that are unfamiliar or new to the group causes group members to struggle with the spontaneity of an adventure experience. As a result, group members do not always know how they are expected to act, and this prevents them from hiding behind a persona, leading them to show their true behaviors and provide additional information to the group therapist. The therapist is able to observe behaviors, often positive, that can be utilized in subsequent activities. For example, the therapist may note that a group member offers helpful suggestions for solving problems the group is facing, such as how the group can arrange itself so all members can hit the balloon successfully, but the group member does so in such a soft voice that it is not heard by other group members. In subsequent activities, the therapist may challenge some members not be silent while solving of the problem, allowing this soft voice member to perhaps be heard and valued for their contributions.
- *Generating.* By careful observation of the group responses to a multitude of "actions," the skilled adventure therapist identifies behavior patterns, dysfunctional ways of coping with stress, intellectual processes, conflicts, needs, and emotional responsiveness. When properly observed, recorded, and articulated, these data can be the basis for therapeutic goals (Kimball, 1983). As noted above, the therapist may choose to challenge some members of the group through the loss of the ability to speak or to see (closing eyes) in order to highlight other member's strengths to the group or allow that member to be mindful of how much he or she dominates the group process.
- *Evaluation.* When information has been generated from observations of the group's behaviors, it can be compared with working hypotheses once again. Do group actions fit the working hypotheses? Are these

hypotheses supported or refuted? What new knowledge now exists to revisit action, novelty, and generating in the next experience? If the mandatory group was engaged with the balloon activity the therapist may hypothesize that a more challenging experience is worth trying. The therapist may issue each member their own balloon—and write one strength on the balloon—and see how long the group can keep all the balloons aloft (an adaptation of the activity Balloon Frantic, Rohnke, 1989).

- *Solutions.* Finally, and most important, when the evaluation provides a clear picture of the group's issues, it leads toward solutions of those issues. Integrating and interpreting information gathered in previous steps helps in making decisions about how to construct potential solutions to the groups' concerns much like the success with one balloon can lead to the use of multiple balloons to see if the group can transition from working on one issue to working on multiple issues, which might share similarities.

The CHANGES model provides one useful, macro way to acquire and organize information to systemically structure an AT group experience. The case example, "Wise Guide," represents how many who use adventure activities implement kinesthetic metaphors and CHANGES effectively in group work. In the use of meta-communication to create kinesthetic metaphor, the adventure therapist (in listening to the group member in the case example describe her situation during the context phase of the CHANGES model) heard her say, "I hear many of the people from my past telling me I am not good. I feel lost—I don't feel I have a path to follow. Some of my friends lead me astray saying I will never amount to anything." The skilled adventure therapist, listening to the group member's meta-communication, would then *hypothesize* about an *activity* that involved following a path. Would this activity be *novel* enough to *generate* information in order to *evaluate* the group member's ability to listen to her "healthy self" and begin to cocreate some *solutions* in the group member's treatment plan? Once the group was able to connect with the activity, the therapist could begin to offer meta-communication language, such as coaching them to listen to their own internal positive voices as their unique guide.

The key to a solution for this group member's situation was to create a kinesthetic metaphor that matched or was isomorphic with her experience. In addition, the metaphor needed to offer strategies whereby she could engage in new behaviors (being guided over obstacles by a fellow group member) more functional for her situation but offering a different outcome. The outcome of the metaphor (successfully walking on the "chair path" or potentially falling off) needed to be a natural consequence of the adventure experience to have the greatest chance of leading to a more lasting behavioral change.

As described in the second step of the how to create a kinesthetic metaphor, listening to common meta-communication from group member's conversations when they say such things as "get over," "give up," "stepped on," and "get around" helps create hypotheses for the group therapist about kinesthetic metaphors that will be most useful in connecting with group members' issues. Note that literal experiences (e.g., having the group step on a group member) where groups are put in dangerous or unethical situations should *never* be part of any AT experience.

Ethics in Using Activities in Groups

Group workers are ethically bound to perform within their area of professional competence (Association for Specialists in Group Work [ASGW], 2000). Physical activities, even the ones described in this chapter, have the potential to be dangerous in traditional group work settings (Gillis & Bonney, 1986). It is surprising to us that the classic "trust fall" is still listed in editions of some group development textbooks (Johnson, 2001) without any disclaimers to its potential physical risk. Readers are advised to only do activities that they have been trained to facilitate or activities with which they have considerable experience and competence. Adventure therapists share the goals of group therapy and other helping professions to "do no harm" and act responsibly and competently.

Not one group therapy "skill" is more important than the responsibility to competently conduct safe adventure practices. Competence in this context means knowing potential outcomes of an adventure activity and preparing for the worst (but expecting the best). AT is a field that utilizes powerful techniques that are often perceived as risky and can be dangerous. The reality is that, though very rare, people can be injured or die in this approach to therapy. Adventure therapists cannot afford to lose one life, nor can those who entrust us be fearful of our practices.

Competent and accredited programs have sought to distance themselves from the wilderness expedition programs masquerading as wilderness or AT (Russell, 2001). The field of AT must continue to educate the public as well as other mental health colleagues on how to distinguish competent programs from those that pretend to be such.

Current Issues in Adventure Therapy

Many of the debates in AT have taken place in forums and workshops held by members of the Therapeutic Adventure Professional Group (TAPG) of the Association for Experiential Education (AEE, 2012). This group is comprised of "those AEE members who use adventure-based practice and the philosophy of experiential education therapeutically within the fields of health, mental health, corrections, education, and other human service fields" (AEE, 2003). TAPG has been in existence since the late 1970s, adopted a professional code of ethics in 1992, and has an ongoing project to identify best practices for those who can call themselves an adventure therapist (c.f. http://tapg.aee.org/tapg/bestpractices). The TAPG serves as both an entry point and a place for continuing education for the group practitioner interested in using adventure experiences in their group practice. Group therapist interested in learning more about the use of adventure experiences in therapeutic settings are encouraged to join (even on Facebook!) those of like mind in the TAPG.

Summary

In a time of increasing expectations, changing conditions, and growing complexity of group member issues, group therapists may be searching for therapeutic approaches and techniques that actively empower group members' lives. AT offers a means to reach those ends through an approach to group work that provides a contrasting experience to "the problem," offers multiple and corroborating representations of reality, fosters the development of change through kinesthetic metaphors, uses experiences that have internal mechanisms of resolvable conflict with structures focused on the production of solutions, and changes the role of the therapist to be more active and mobile to maximize alliance. This approach to group work should be ventured into by those wanting to ethically and competently use kinesthetic metaphors that enhance the therapeutic process and encourage positive and lasting change.

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Chapter 45 Post-Disaster Group Counseling: A Multicultural Perspective

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Post-Disaster Group Work

Disasters can comprise many situations ranging from natural disasters such as hurricanes and earthquakes to people-made disasters, such as the campus shooting at Virginia Tech. Given the wide range of disasters and the page limitations of this chapter, the chapter focuses on group work following natural disasters. Major global climate change has resulted in the loss of lives and hundreds of thousands of survivors being displaced from their homes (NASA, 2011). In the past decade, the world has encountered frequent mammoth natural disasters such as the earthquake and tsunami in Japan; earthquakes in Haiti, Costa Rica, and China; the cyclone in Myanmar (Burma); Hurricane Katrina in the United States; and the tsunami in South Asia, destroying communities and generating loss of life.

This chapter discusses how group counselors and psychologists can play a critical role in assisting disaster survivors and presents the Disaster Cross-Cultural Counseling model (DCCC), a multicultural social justice group counseling model designed to work with survivors of natural disasters that is inclusive of marginalized groups. Examples of disasters where the DCCC model was implemented are presented, as well as a description of how supervision is employed in the model. To understand post-disaster group work, the chapter begins with an examination of the effect of natural disasters, followed by a description of post-disaster psychological interventions and the DCCC model, and a discussion of the implementation of the model. It is important to note that there is limited information and empirical research on group counseling, group supervision, and social justice work in post-disaster situations (Hobfoll et al., 2007) so this model is a first step in that direction.

The Aftermath of a Natural Disaster

Significant social, political, and economic upheaval that disrupts people's lives is the usual consequence of a natural disaster. The aftermath of a natural disaster is similar to a warlike situation, where there is massive destruction of physical structures (homes and buildings), disease and health concerns, and shortages of shelter, food, medicine, water, and sanitation. As a 9-year-old boy told the authors after Hurricane Katrina, "America got blown up." Simultaneously, there is an escalation of human trafficking, rape, murder, physical and sexual abuse, robbery, violence, and property destruction creating situations where survivors are vulnerable to predators. Given the intensity and complications of a disaster, a significant outcome is psychological distress and trauma. After Hurricane Katrina, a large number of children were estimated to have symptoms of Post-traumatic Stress Disorder (Osofsky, Osofsky, Kronenberg, & Cross Hansel, 2010). In Haiti after the earthquake, children were susceptible to human traffickers (Padgett & Ghosh, 2010). Further complicating post-disaster situations may be the lack of (or no) infrastructure or civil service system (e.g., law enforcement) that typically protects and provides order for individuals and communities (Saunders, 2007). Although many people are able to positively cope during post-disasters, others may experience post-traumatic stress disorder, anxiety, depression, increased behavioral problems in school, higher rates of substance abuse, and a diminishing sense of purpose or will to live (Dudley-Grant, Mendez, & Zinn, 2000; Jaycox et al., 2010; Norris, Perilla, & Murphy, 2001; Rowe & Liddle, 2008; Sommer, 2008).

Traditionally, psychological post-disaster work has been based on Western principles emphasizing individual counseling (Hobfoll, Briggs-Phillips, & Stines, 2003), despite findings that group interventions are optimal for addressing trauma experienced in communities (Bemak & Chung, 2011; Bloom, 1998; Nemeth et al., 2012; Nemeth, Marceaux, & Lewis, 2006). In addition, post-disaster interventions typically ignore the larger multicultural social justice issues that accompany disasters such as equal access to resources (i.e., housing, financial support, medical care, medicine, water, clothing, and shelter), despite the collectivistic orientation of many of the affected communities (Bemak & Chung, 2008, 2011; Hobfoll et al., 2007). This was evident in the aftermath of Hurricane Katrina where people of color from poor areas received minimal or no support services, which is an extension of historical sociopolitical racism, discrimination, and social injustices that contribute to a lack of services, resources, and opportunities (Chen, Keith, Airriess, Li, & Leong, 2007; Rosen, Greene, Young, & Norris, 2010), and often becomes more pronounced after a disaster. An important consequence of traditional post-disaster mental health interventions is that disenfranchised communities remain unserved or underserved (Chen et al., 2007; San Diego Immigrant Rights Consortium, 2007).

Post-Disaster Psychological Interventions

The U.S. Department of Health and Human Services (U.S. DHHS, 2003) has identified key concepts in post-disaster mental health work that distinguish post-disaster counseling from traditional psychological services. There is consensus by the U.S. government that these concepts are universal for all survivors, regardless of cultural background or geographical location. The U.S. DHHS guidelines for culturally competent post-disaster counseling consist of nine guiding principles:

1. Everyone who sees a disaster is touched by the experience;
2. Most people are resilient and can effectively manage the post-disaster experience, even though their level of ability to handle the disaster is reduced;
3. It is normal to experience stress and grief following a disaster given the unusual circumstances;
4. Problems in everyday life and existence following a disaster are the cause of a significant portion of survivors' emotional responses;
5. Most people do not require mental health support following a disaster and therefore do not seek out counseling services;
6. Mental health interventions are more practical following a disaster and subsequently do not follow traditional psychological practices;
7. It is important that mental health interventions are culturally responsive to diverse communities, which at times requires practitioners to employ different intervention strategies;
8. Proactive outreach is an important aspect of post-disaster counseling so that mental health practitioners must set aside traditional counseling methodology that avoids mental health labeling; and
9. Social support systems are critical in the recovery process.

There is evidence that group interventions offer the most effective means of protection against trauma and despair following a disaster (Bloom, 1998; Haen, 2005; Herman, 1997; Jordan, 2003; Nemeth et al., 2012; Nemeth et al., 2006; Phillips, 2009) and that psychological interventions following disasters are fundamentally different from traditional clinical interventions (Bemak & Chung, 2011; Phillips, 2009). More specifically, Bloom (1998) supports using the group environment to heal trauma after a disaster through the use of peer support, political action, art, and humor, while Haen (2005) and Phillips (2009) maintain that group interventions create a safe environment and collective support that help normalize their experience and reduce feelings of shame and alienation. They encourage utilizing techniques such as creative arts, for example, drama, trauma enactment, and fantasy in group therapy following a disaster. Jordan (2003) supports these ideas, arguing that post-disaster groups are critical components of the healing process and assist with reestablishing social networks with other survivors. An example of this could be seen when the authors experienced a group member after Cyclone Nargis in Burma, disclosing for the first time about when a 20-foot wave swept over him while he was holding tightly to a tree and he lost his grip on his 4-year-old daughter who was swept away. Sharing his painful story in the group led him to insist on reenacting parts of the event and helped heal his pain and shame for not being able to save his daughter. Thus post-disaster group interventions emphasize short-term, and sometimes even one-session meetings, and often incorporate creative techniques that respond to the immediacy of a post-disaster situation. At the same time group counseling helps disaster survivors normalize their experience, connect with other survivors, and stabilize, while also addressing essential questions about the purpose and meaning of one's life.

Disasters destroy customary social support networks. For example, a survivor of Katrina was sharing with the authors how he lived in a tent with his two daughters after Hurricane Katrina destroyed his apartment. He talked about the major difficulty being the loss of the support of friends, who for the most part had left and relocated throughout the United States. Given the unique circumstances during post-disasters, traditional coping mechanisms are disrupted, which frequently result in disorientation and a shattered sense of self. Survivors change focus to critical needs for basic survival, for example, food, water, shelter, medicine, and physical safety. The post-disaster situation requires trauma counseling to promote psychological safety, stabilization, time for mourning, and reestablishing social support networks (Herman, 1997), while at the same time generating hope and a sense of future (Bemak, 1989; Bemak, Chung, & Pedersen, 2003), and normalizing and validating the survivor's

experience (Foy, Eriksson, & Trice, 2001). Subsequently rather than advancing an individual counseling focus, post-disaster group counseling emphasizes broader community-based interventions (de Jong, 2002) that assist survivors to cope with the confusion and come to terms with the aftermath of the disaster. An example of this was when the authors worked in Burma following Cyclone Nargis, which displaced millions of people. Given the wide range of devastation, interventions were done with communities, where discussions about trauma, reestablishing new social support networks, loss, death, and coping strategies were facilitated in small and large group community meetings. The facilitation of group discussions within the community context was instrumental in dealing with the difficulty and disorder of the post-disaster situation. Also, through group counseling survivors gain a sense of universality, which facilitated a faster establishment of social support networks.

The uniqueness of the personal, family, and social turmoil generated by disasters requires creative and flexible interventions (Bemak & Chung, 2011; Phillips, 2009). Group counselors must develop critical skills in active comforting and heightened compassion by reaching out and engaging groups by adequately responding to the level of distress and trauma that accompany post-disaster situations. Examples of this can be seen with group therapists asking far more personal questions about group members psychological functioning during very early stages in the group rather than waiting to establish greater group cohesion or trust. This helps cultivate rapid therapeutic partnerships and is essential in responding to the immediacy and urgency of the situation (Bemak & Chung, 2011). Simultaneously, there is a critical need to develop interventions that are not inhibited by traditional counseling intervention structures related to issues such as confidentiality, client-counselor boundaries, and private physical meeting locations for counseling sessions. Group interventions, including both single and multiple sessions, have been found to be highly beneficial in post-disaster work (Basoglu, Salcioglu, Livanou, Kalender, & Acar, 2005; Bemak & Chung, 2011; de Jong, 2002; Goenjian et al., 1997; Hobfoll et al., 2007), despite the lack of uniformity of evidence-based best practices research (Gersons & Olff, 2005). It is also important to maintain flexibility since after a disaster, building structures are frequently destroyed and meetings often take place in public spaces. The change in physicality impacts confidentiality so that frequently other survivors gather to listen and participate in group counseling sessions. Parameters about confidentiality are also constructed differently in collectivistic cultures so that there is more acceptance to speak openly within the context of community or group (Bemak & Chung, 2011), although it is still recommended that the limitations and parameters for privacy and confidentiality be directly introduced and addressed with survivors (Myers, 1994).

In addition the degree of devastation leaves people disorientated as they struggle with the personal impact of the disaster. Hence the power of group interventions becomes even more important, cultivating universality, instilling hope, and promoting altruism, which are all strong variables in the healing process. Groups enable healing by helping individuals to reengage and hear each others' stories and normalize their reactions through the realization that others share similar experiences.

Disaster Cross-Cultural Counseling (DCCC) Model

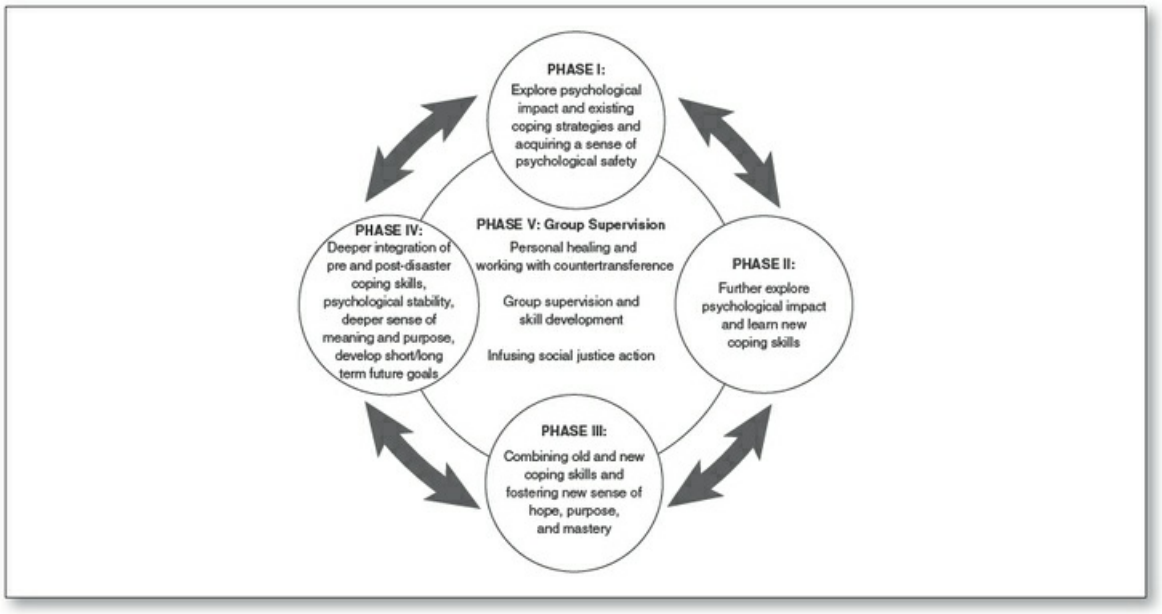
The DCCC is a model that provides culturally responsive post-disaster social justice group interventions (Bemak & Chung, 2008, 2011). The model was developed since guidelines and core group work principles (e.g., group selection, client selection, ethics, leadership, confidentiality, prescreening, single group sessions) have not been defined for post-disaster situations. The authors have continually found that the breakdown of community and social networks following a disaster creates obstacles that prevent opportunities for healing through the sharing of experiences and subsequently defined a model to facilitate group counseling following disasters.

The foundation of the model is based on the nine U.S. DHHS (2003) guidelines, the *Multicultural Counseling Competencies* (Association for Multicultural Counseling and Development, 1996), and the *Principles of Diversity-Competent Group Workers* (Association for Specialists in Group Work, 1998). The DCCC Model is consistent with the International Society for Traumatic Stress Studies and United Nations positions of providing post-disaster support and services through a public health standpoint that advances brief targeted interventions (Green et al., 2003) and the findings that show promoting social connections and contact is critical to recovery (Litz & Gray, 2002; Shalev, Tuval-Mashiach, & Hadar, 2004). The model is culturally responsive since it takes into account the vital need for understanding the historical, cultural, economic, political, and social dimensions of survivors' lives (Bemak & Chung, 2011; Goodman & West-Olatunji, 2009). Furthermore, the DCCC model recognizes, acknowledges, and respects cultural diversity by recruiting disaster group workers that are representative of the affected community. The DCCC model has five phases and offers a framework for group facilitators to assist disaster survivors to gain a sense of personal control and coping, explore the psychological impact of the disaster, and find psychological stability. The DCCC outlines how to respond and provide post-disaster counseling while being attuned and sensitive to survivors' cultural beliefs and worldviews. It should be noted that the DCCC model phases are not linear in nature so that counseling may move in and out of various phases at different times in the counseling process while simultaneously addressing psychological reactions. Figure 45.1 provides an illustration of the DCCC model's five phases.

Phase I: Explore Psychological Impact and Existing Coping Strategies and Acquire a Sense of Psychological Safety

One of the first critical steps in counseling disaster survivors is to quickly create safety and trust through the use of a warm, empathetic, and open approach. Group sessions typically begin with open-ended questions such as "How is everyone doing?" which typically results in an outpouring of feelings and a depiction of the disaster events and difficulties as survivors explore the psychological impact of the disaster. Since it is important for survivors to gain some control of their lives, in Phase I, survivors explore psychological problems they are experiencing and coping mechanisms that they characteristically use in their everyday lives. Group counselors would ask such questions as, "What have you generally done when you have had this much confusion … this much stress … or this much fear … this much anxiety, and so on." Relying on previously established skills to handle psychological distress helps survivors begin to manage the post-disaster situation while gaining a sense of psychological safety. Questions of this nature during Phase I assist in creating a comfortable and safe environment and help survivors become psychologically stable, while at the same time acknowledging the crisis and normalizing survivors' reactions. Simultaneously, group therapists must assist survivors in understanding and expressing their reactions to the crisis, redefining the problem from a practical and psychological viewpoint, and encouraging survivors to use familiar coping skills that will be helpful in managing one's life. Skills used by the group counselor include active listening, problem definition, problem solution, establishing a post-disaster therapeutic partnership, active comforting, heightened compassion, discussions about the limits of confidentiality, and follow-up survivor action steps (Bemak & Chung, 2011), as well as an exploration of former coping mechanisms. For example, a group counselor may initiate group sessions helping group members to express their reactions to the disaster, define the problem, focus on the difficulty of their situations, and discuss previously acquired coping strategies, while compassionately encouraging group members to speak directly about their personal struggles. The nature of the acute crisis following a disaster requires the group counselor to utilize intensive active listening, active comforting, and heightened compassion.

Figure 45.1 Disaster Cross-Cultural Counseling (DCCC) Model



Phase II: Further Explore Psychological Impact and Learn New Coping Skills

Some well-established coping strategies may be ineffective given the extent of the psychological impact following a disaster. Ways of coping such as talking to family members or friends at a nearby coffee shop or going to the gym to exercise may not be possible. Thus in Phase II, it is important for group therapists to continue to help survivors express their reactions to the crisis while also developing new and alternative coping methods and new skills to handle the post-disaster realities. For example, forming surrogate families is one way to cope with the loss of family members. Similarly establishing new social support networks that can be cultivated within the group may assist with healing. An example of this can be seen with 10 teenage girls in Thailand after the tsunami who participated in our group counseling sessions. They had lost family members and felt alone and afraid living in the makeshift camp. An aspect of the group counseling was to help facilitate a support network that cultivated a substitute family who lived together, shared chores, cooked together, and supported and comforted each other through this difficult time period. Another example of establishing coping strategies would be to work closely with religious and spiritual leaders to creatively form new healing rituals that can attend to the unique problems that arise following a disaster. This was evident after the Tsunami and Cyclone Nargis when bodies of family and friends could not be located so the authors, in collaboration with spiritual leaders, assisted in designing new burial rituals and ceremonies to help with the grieving process.

Phase III: Combining New and Old Coping Skills and Fostering New Sense of Hope, Purpose, and Mastery

To create a sense of hope, purpose, and mastery for the survivors, Phase III involves an integration of new and old coping skills. Group members are asked to review their discussions during Phase I and Phase II, for example, ways they handled stress and problems in the past and potential new coping strategies they imagined and created to deal with their current circumstances. During Phase III the group counselor asks group members questions such as, "How can you take the new strategy you just described that you believe will be helpful and combine that with ways of coping that have worked for you in the past?" During this phase there is an amalgamation of new and old coping skills that helps promote psychological healing and enhanced feelings of emotional stability and security, the instillation of hope, and a sense of universality, all which are essential in successful adaptation.

Phase IV: Deeper Integration of Pre- and Post-Disaster Coping Skills, Psychological Stability, Deeper Sense of Meaning and Purpose, Develop Short/Long-Term Future Goals

In Phase IV, pre- and post-disaster coping skills are combined, contributing to a better understanding and acceptance of life after a disaster, psychological stabilization, and a growing sense of hope (Bemak & Chung, 2011). Cultivating hope is achieved by psychologically "joining" survivors in an attempt to promote authentic empowerment and encourage survivors to build on their strengths and more effectively handle the post-disaster situation (Hobfoll et al., 2007; Saltzman, Layne, Steinberg, & Pynoos, 2006). Also in Phase IV, it is important to celebrate accomplishments that contribute to physical security, psychological safety, and positive life events. An example of this was when a nonprofit organization helped a group of teenage girls in Haiti who were desolate and living in a tent camp to establish a microenterprise to bake cookies. Engaging in this small business not only helped the girls gain a sense of control over their lives but also earn small amounts of money for food and contributions to their families, as well as provide a place for sharing, healing, and crying. The group counseling session celebrated their success, highlighting the accomplishment as an important aspect of the healing. During Phase IV, survivors gain a clearer understanding about how to manage the post-disaster situation and begin moving forward to rebuild their lives, while also reflecting on a greater sense of purpose and meaning about oneself and the world. Short- and long-term future goals become clearer during this phase with group members beginning to think about where they can live, how to return to school, or consider going back to work. Thus, working in Phase IV, group counselors and psychologists must always support a realistic sense of hope and future for survivors, helping them to develop a clear sense of their own future and how to handle the life changes following the disaster (Bemak & Chung, 2011).

Phase V: Group Supervision

A core foundation in the DCCC model is Phase V, Group Supervision, which is essential throughout all phases of the model. Group supervision is important in helping group workers to understand the personal impact of providing post-disaster counseling as well as developing suitable clinical skills and culturally responsive interventions. In the DCCC model, post-disaster clinical group supervision goes beyond conventional clinical supervision and skill development by equally emphasizing the strong countertransference and personal reactions that are customary after hearing numerous survivor stories filled with trauma, loss, pain, and anger. It is essential that there is a safe place where group counselors and psychologists can debrief and process what they have heard, witnessed, and experienced. The three components to the DCCC group supervision are (1) *Personal Healing and Working with Countertransference*, (2) *Group Counseling Clinical Supervision and Skill Development*, and (3) *Infusing Social Justice Action.*

The first component, *Personal Healing and Working with Countertransference*, creates an atmosphere that is conducive to psychologically safe discussion and processing. For example, in Haiti, group counselors and psychologists saw thousands of buildings and homes destroyed with bodies buried in the rubble, while in Thailand and Burma, they regularly saw corpses and animal carcasses after the disaster. Given the enormity of what group counselors and psychologists witnessed and the agonizing stories that people shared in groups, a large amount of supervisory time was spent helping group members understand their experiences and deal with their own horror, pain, guilt, and sadness. Specific questions during supervision such as asking group counselors to share images or experiences of the day that touched or bothered them or any reactions and feelings that they experienced while running groups are examples of how to provide supervision during this first component. Working carefully with personal healing and countertransference is critical to ensure the group counselor and psychologist can maintain a focus on the needs of the survivors, rather than being overwhelmed by what they have witnessed or heard.

In San Diego after the wildfires and the Gulf Coast after Hurricane Katrina, group counselors expressed their dismay at witnessing racism, inequality, and discrimination that affected the treatment and assistance provided to ethnic and low income communities. For example, some Katrina survivors blamed the disaster on the faulty levees and were angry and suspicious of government and state officials and organizations, raising issues of past historical and sociopolitical discrimination (Grunwald & Glasser, 2005). In San Diego, there were signs in English that stated, "Go to your nearby community center for assistance and resources," but in Spanish the signs read, "No food or water here." Furthermore, working with the immigrant communities close to the Mexican border, counselors observed the U.S. Border Patrol indiscriminately stopping survivors (including counselors of color from the DCCC team) to check on documentation. The arbitrary and frequently hostile screenings by Border Patrol created political countertransference and strong reactions by some of the counselors (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008). It is imperative that group supervisors understand the sociopolitical and historical effects of these actions in order to infuse culturally responsive social justice concerns into the supervision when it is appropriate, and help counselors effectively address these issues in the group work. A good way to prepare group counselors to go on-site in targeted communities is to provide information during the orientation and training sessions and facilitate follow-up discussion regarding the culture, history, economics, politics, healing practices, and beliefs about psychological health in that region.

The second component of DCCC social justice group supervision is *Group Counseling Clinical Supervision and Skill Development.* This is a critical stage for developing advanced post-disaster group counseling clinical skills. In such situations, it is important to discern differences between traditional group counseling and post-disaster group counseling. Differences between the two include such issues as active comforting, establishing therapeutic partnerships, heightened compassion, follow-up survivor action steps, time boundaries, confidentiality, meeting in public open spaces versus private spaces, and boundaries around counselor-client relationships (Bemak & Chung, 2011). In addition, clinical themes that are generalized to post-disaster situations consistently emerged in the group (e.g., trauma, loss, sadness, anger, hope) and required careful and skilled supervision (Bemak & Chung, 2011).

The third component of social justice supervision, *Infusing Social Justice Action*, adds a new dimension to the supervision process. Because post-disasters accentuate social injustices and become pervasive for many survivors, it is important to add this third supervision component. DCCC supervision incorporates identifying where and how social injustices are affecting clients, and what steps are being taken or can be taken to attend to these issues. Addressing the injustices facilitates a sense of unity and empowerment as supervisees strategize about what to do in an unfair situation. For example, group counselors and psychologists working in both national and international post-disaster situations discussed how to share resource and service information with survivors, as well as help survivors find resources for family relocation. Group leaders were also given resource lists for distribution (translated into appropriate languages) and within high illiteracy communities, social networks were identified so that family members, friends, and neighbors were asked to help read information packets. These strategies are consistent with research findings that have demonstrated the effectiveness of a combined psychoeducational and counseling approach that is culturally and linguistically appropriate (Rosen et al., 2010).

Group supervision occurred seven days a week for 2–3 hours per night. This helped address the intensity and demands of post-disaster group counseling. In Haiti and Burma, in-depth reports about the group counseling work and relevant social justice problems encountered by survivors were submitted to the nongovernmental organizations that funded and organized the details for the trips. Remarkably the DCCC group supervision helped post-disaster counseling teams keep in touch with a sense of purpose and hopefulness, reenergizing them to face the next day.

Fundamental to the DCCC Model is the importance of social justice principles. Disenfranchised communities in post-disasters often experience a continuation of already existing institutionalized oppression and discrimination through a lack of services and attention. This was evident in the San Diego wildfires where the media only portrayed the wealthy communities and large homes being destroyed by the fires, neglecting the poorer ethnic communities. The DCCC Model stresses the need for group facilitators to proactively advocate for services and resources that provide equal access and equity for all (Bemak & Chung, 2008, 2011), especially when these communities are unable to meet basic needs or access potential resources that would provide psychological and physical safety (Hobfoll et al., 2007; Rosen et al., 2010). This has resulted in the authors advocating and assisting group members to become advocates, speaking up for additional rice after Cyclone Nargis in Burma, water after the San Diego wildfires, cooking pots and pans after the tsunami in Thailand, and providing additional culturally responsive counseling services after Hurricane Katrina. Through the integration of social justice principles in the DCCC model, counselors and psychologists can help survivors become their own advocates, which is especially important for populations with a history of disempowerment and marginalization. The right to protection, services, and resources can be proactively addressed within group counseling milieu through the DCCC interventions that provide interconnectedness and healing in difficult and harsh situations.

Dccc Application

DCCC: Preparation, Orientation, and Training

It is crucial that group counselors and group psychologists working in post-disaster must undergo preparation and planning prior to entering a post-disaster situation. This is particularly important since group counselors and psychologists may be overcome by the devastation and chaos that accompanies post-disasters. Entering a post-disaster area requires a smooth transitional entry. It is essential that there is coordination with on-site organizations and agencies that can provide advance planning and organization in preparation for the DCCC team. To avoid contributing to the on-site confusion, invitations from on-site local organizations who agree to schedule the counseling team and establish up-front credibility with local organizations are invaluable.

Since preparation and cultural competence are indispensable in post-disaster counseling (Halpern & Tramontin, 2007), choosing mixed gender and interethnic and racial teams, which reflect the demographics of the affected community and who have training and experience in group, multicultural, and social justice counseling is important. Additionally, the authors have found it vital that team members also are able to be flexible, adaptable, open, self-reliant, cooperative, and culturally diverse (Bemak & Chung, 2011). Bilingual or multilingual team members are also helpful to work with survivors with limited or no English proficiency. The authors selected teams for each of the disaster sites (i.e., Hurricane Katrina, San Diego wildfires, and the Haiti earthquake). They also organized intensive predeparture training and orientation that included eight major domains: (1) an overview of the DCCC model; (2) trauma symptoms; (3) trauma interventions, and specific post-disaster counseling skills; (4) an overview about the disaster communities (e.g., legal and undocumented migrants, Native American, Latina/o and Haitian communities); (5) relevant social justice issues for that community (e.g., issues of mistrust based on years of discrimination, sociopolitical disempowerment and neglect); (6) cultural information, and appropriate culturally responsive counseling methodologies, (e.g., the role and respect given to Native American elders, the importance of silence, the speed and tone in speaking, and partnerships with indigenous healers, if appropriate (Bemak & Chung, 2011); (7) providing information and helping group counselors and psychologists who were working in migrant and ethnic communities to become more aware and sensitive to issues related to biculturalism (e.g., coming from an ethnic minority community and living within the context of the dominant culture, which is different than one's own) and the ensuing conflict and ambivalence this may cause in relationship to identity and functioning (Hernandez & Isaacs, 1998). Examples of this were seen with the Latina/o migrants in San Diego and the Gulf Coast or the Native Americans in San Diego who have roots in their cultures of origin yet must also negotiate how to survive in a different dominant culture. These issues may intensify in post-disaster situations; and (8) provide information that when working with survivors in their communities, group counselors and psychologists must always bear in mind that they are the guests in the disaster community, region, and/or country where they are working. Keeping the perspective of being visitors helps maintain a sense of openness and respect for traditional cultural healing practices, and helps eliminate judgmental and negative responses toward cultural norms such as the use of Voodoo in Haiti. The authors have coined the imposition of culturally insensitive Western values and practices when doing counseling as “psychological colonialism” (Bemak & Chung, 2011).

In many developing countries, such as Burma, Haiti, and Thailand, there are only locally based staff working in international organizations, typically without prior mental health training. To address the lack of formal mental health training in these situations, the authors have made it standard practice to offer an intensive two week culturally appropriate counseling skills training program emphasizing the DCCC model, group work, trauma symptoms, intervention strategies with trauma and post-disaster survivors, and culturally responsive social justice principles.

Group Counseling Interventions Using the DCCC Model

Post-disaster situations are unique, requiring group counselors and psychologists using the DCCC model to be flexible and creative. Group counseling post-disaster interventions entail different approaches that aim to adapt to the cultural and situational circumstances. Innovative group interventions that are rooted in community-based group work are used when employing the DCCC model. Group counselors and psychologists using the model must be proactive in reaching out to clients and finding available public meeting spaces, while also maintaining flexibility about time boundaries when conducting groups. For example, in Burma and Costa Rica, groups using the DCCC model were held in small open public spaces in villages or town squares, and people from around the village who heard about the meeting would stand and sit outside the group and inevitably participate. Similarly, on the Gulf Coast after Katrina, the Disaster Relief Center (DRCs) sites were located in school gyms or empty Kmart stores, which were the same spaces where survivors waited in line for food, water, trailers, housing, medicine, and so forth. At times, group therapists would invite survivors to join in group discussions while waiting for long periods in line, or their children were invited, with parental permission, to participate in the children's support group in another area of the DRC. Typically individuals or families who were standing or sitting in the post-disaster reconstruction area were approached and asked how they were doing, and invited to join group discussions about how things were going. Once rapport was established, group workers would slowly engage others who were also waiting nearby, asking and encouraging them to join in and share their experiences. This approach is consistent with the outreach work mentioned in the U.S. DHHS (2003) guidelines and resulted in numerous small group counseling sessions being formed.

Similarly in Haiti, makeshift tent camps where 20–30 survivors were temporarily housed served as locations to run groups. At times, group counseling was done with anxious or depressed survivors who refused to leave their cots, which quickly attracted numerous other camp residents to watch and join in the conversation, forming impromptu counseling groups. Other times, given the lack of meeting facilities in tent camps, group workers would find empty cots and initiate group counseling with survivors sitting on surrounding cots in the tent. Unlike more traditional group counseling methods, groups often formed spontaneously without prescreening of group members. Nevertheless, no one was ever forced or pressured to participate in group counseling. Group members were always supported in whether or not they decided to take part in the group counseling sessions.

The opportunity to share with others in a safe environment was welcomed by many survivors. Group participants were not concerned with confidentiality given 20–90 minute, often spontaneous, sessions that would often be single session meetings. When groups were held with targeted individuals having mental health problems such as in the Haitian tent camps, individuals always gave their permission to allow others to gather and participate. In groups following disasters rapport is established within minutes. Group members, who most often did not have the opportunity to share, opened up very quickly, sharing their experiences. The sharing created group cohesion and illuminated the therapeutic factors, including universality, altruism, cohesion, catharsis, interpersonal learning, existential factors, love, and the instillation of hope, which became rapidly evident in the groups (Bemak & Epp, 1996; Yalom & Leszcz, 2005). Typically groups would very quickly go through the initial stage (getting acquainted and establishing trust) and almost immediately enter the working stage (generating cohesion and being productive). In addition, the nine key concepts noted earlier became more evident to group members; for example, everyone was affected, most people were resilient in handling the aftermath of the earthquake, group counseling helped normalize stress and grief reactions, strong emotions were evident, individuals did not seek out counseling (but welcomed it), group interventions were designed to fit the circumstances, culture provided an important context for responsive group counseling interventions, and social support was critical in the groups and recommendations for follow-up. The outcomes for group counseling in post-disaster settings are consistent with generalized aims of group counseling through the generation of a sense of safety, reassurance, a sense of self and community efficacy, connectedness, and instilling hope (Hobfoll et al., 2007).

Part of what happened when survivors shared their experiences was an exploration of how people had coped (DCCC Phase I). Effective strategies of handling the disaster situation were shared along with an exchange of ideas about what other approaches might be useful to more effectively cope (DCCC Phase II). Inevitably group

members would provide new ideas for each other along with advice and information that would instill hope (DCCC Phases II to IV). An illustration of implementing the DCCC model can be seen in a group counseling session of parents in Haiti after the earthquake where there was an exchange of ideas and suggestions about how to cope with the deaths of family members, living in temporary housing facilities, and how to deal with the fear and anxiety of their children.

Social Justice Group Interventions Using the DCCC

Social justice plays a critical role following a disaster (Bemak & Chung, 2011; Jacobs, Leach, & Gerstein, 2011; Juntunen, 2011). Inequities become more pronounced as basic needs for shelter, food, clothing, medicine, health care, and water become critical survival needs. Disenfranchised populations may receive poorer services and fewer resources at a slower pace in the aftermath of a disaster. Historical inequities and injustices such as discrimination, prejudice, poverty, and mistrust often become accentuated. In Burma, for example, many survivors referred to their frustration and anger with a government that restricted their rights, while in San Diego Native Americans carried a long-standing distrust with the majority culture that affected their response to outsiders providing support and services. In turn, on the Gulf Coast there was anger at the meager federal response in the poorer and ethnic communities. In any circumstances where there have been social injustices, the group counselor must respond with compassion, appreciation, and understanding since the historical and sociopolitical inequities will contribute to the psychological impact of the post-disaster situation (Bemak & Chung, 2011). Thus group workers must keep in mind survivors' life experiences and respond to the historical context of survivors' stories, with awareness of cultural perspectives and sociopolitical injustices that were reignited by the post-disaster situation (Bemak & Chung, 2008, 2011).

Group workers must be cautious not to propagate "mental health colonialism" and interventions that lead to "sustained dependency" in vulnerable communities (Bemak & Chung, 2011). This can be achieved by "joining with" communities in healing rather than "doing to" communities. This facilitates authentic empowerment with partnerships that assists individuals and communities to rebuild through self-and community reliance (Chung & Bemak, 2012).

It is important to note that the mental health leaders in disaster-impacted communities have also been affected by the destruction. The personal tragedy coupled with a lack of cultural competencies and skills of the local mental health professionals to work in a post-disaster situation (Mollica et al., 2004) may create a vacuum in service provision. Subsequently professionals from outside the impacted area are often assigned to the region to provide counseling. Although these professionals are committed and trained in post-disaster work, they often lack training or knowledge about cultural and social justice issues of the affected community. Using the DCCC model as a framework has been found to be very useful to working closely with regional, state, and federal officials to advocate for culturally responsive counseling for survivors (Bemak & Chung, 2008).

A culturally responsive way of using the DCCC model and doing work with communities and community leaders can be seen in San Diego after the wildfires. The American Indian Tribal School was hesitant to have assistance from outsiders despite an invitation by the Tribal Council. To address this historical distrust of outsiders, supervision incorporated discussions that focused on ways to build innovative connections and rapport with students and staff. In establishing trust group workers shared hip-hop music, soccer and basketball games, and lunch room banter that created bonds with students. These activities led to relationships that transferred to group counseling. As a result of establishing creative connections, the group leaders were able to facilitate thoughtful conversations about the impact of the disaster from a social justice multicultural perspective. For example, student groups openly discussed the disaster in relationship to racism, discrimination, hurt, loss, and hope.

The DCCC model has also been put into action in a number of international settings, including temporary living situations and tent camps in Haiti and Costa Rica and villages in Burma and Thailand. Similar to the experiences in the United States, survivors in other parts of the world shared stories and experiences for the first time. One woman spoke to the group about losing her parents in the tsunami. Another man tearfully shared how he watched his family being swept away into the ocean. Group members would talk about nightmares and the presence of evil spirits. Some talked about profound feelings of guilt. A mother talked about her agony and guilt at being unable to extract their son from the rubble in the earthquake, while a father painfully talked about how he was to blame for his 10-year-old son's death because he didn't hold on to him more tightly when the tsunami waves swept over them. The group was an ideal place to share these difficult stories, generating a sense of shared pain and loss among survivors and providing an opportunity for psychological support and healing. Adding to the healing were

the group counselors and psychologists, who shared details about their team's efforts to impact the service system such as advocating to United Nations and local government officials, meeting with key administration officials, and making recommendations to humanitarian assistance organizations, all geared to deal with inequalities in services and help improve the conditions for survivors. The combination of group counseling with information about social justice action from the group counselors and psychologists helped create an awareness that the mental health professionals were attending to personal as well as social justice concerns.

Finally, it was important for groups to also attend to survivors' concerns about basic human needs, such as, physical safety, food, water, shelter, medicine, clothing, and protection from violence and abuse. The presence of group counseling and attention to critical basic survival needs in these marginalized communities inspired hope and helped survivors know that they were not forgotten and that there was support to address their concerns.

Conclusion

In conclusion, we believe that culturally responsive social justice oriented group counseling in post-disaster situations is a critical intervention. The DCCC model, which emphasizes social justice group work and supervision, is helpful in providing healing to disenfranchised and marginalized populations following disasters. Repeated self-reports from survivors in both national and international settings and the recurrent requests for return DCCC team visits supports the efficacy of the model. The DCCC model provides a framework for survivors to share in groups and discuss concerns about personal, family, community, and social justice needs. The model promotes culturally responsive group and community healing during a very difficult time while also combining group supervision as a means to promote social justice, healing, clinical skills, and development.

Suggested Classroom Discussion Activities

Why is group counseling important to survivors of a post-disaster?

What are some of the psychological problems facing survivors following a disaster?

What are 4 of the 9 key concepts identified by the U.S. Department of Health and Human Services 2003 guidelines for working with survivors of post-disaster situations?

What is mental health colonialism and how does it relate to culturally responsive group work?

Describe some of the differences in providing group counseling in a post-disaster situation compared to traditional group counseling settings.

Describe the 5 phases of the Disaster Cross-Cultural Counseling Model.

What are some of the social justice issues that counselors and psychologists must be aware of when providing group counseling following a disaster?

What are the 3 components involved in group supervision using the DCCC Model?

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Chapter 46 Counseling and Therapy Groups with Children and Adolescents

Zipora Shechtman

For many troubled children, counseling and psychotherapy groups may be the only place where they experience emotional relief, are listened to and accepted, identify their strengths, learn about self and others, and develop social and emotional coping skills, in a friendly and supportive climate. Through corrective emotional experiences, they learn that they are appreciated and loved, and through the opportunity to help others, they grow to appreciate their self-worth. They learn that others have similar problems, or even worse ones, and use constructive feedback to help improve their behavior. These conditions that exist in group counseling and therapy are ones that every child can benefit from but many are not lucky enough to participate in a group.

This chapter is a review of child and adolescent counseling and psychotherapy groups. One accepted typology of groups includes psychoeducational-prevention groups, counseling-growth groups, and psychotherapy growth and remedial groups (Gazda, Ginter, & Horne, 2001). Psychoeducational prevention groups are the most frequently used with children and psychotherapy groups are the least (Kulic, Horne, & Dagley, 2004). Psychotherapy groups are basically process oriented and with only a limited amount of structure; they focus on the expression of emotions in a supportive climate, therefore labeled Expressive-Support groups (Shechtman, 2007). Based on the typology of groups suggested by Kivlighan and Holmes (2004), these groups may be classified as Affective-Support groups. Research supports, in general, most group treatments with children (Riva & Haub, 2004), including the expressive-supportive counseling and psychotherapy groups (Shechtman, 2007), thus providing the evidence base for counseling groups with children. Research also shows the efficacy of the expressive-supportive groups compared to other types of groups (Shechtman & Pastor, 2005). Finally, research indicates process variables that explain those outcomes, such as therapeutic alliance, therapist verbal behavior, and client verbal behavior (e.g., Shechtman & Liechtentritt, 2010a). In light of the dearth of existing research on child group therapy in general and on process groups in particular, it is hoped that this chapter will be a viable contribution to practitioners and researchers in the field.

Introduction

The three areas where children live most of their meaningful experiences—home, school, and community—have become unsafe places for many of them. Emotional support is often lacking in these areas, and many children and adolescents are alone in coping with their difficulties. Between 17% and 22% of children and adolescents have serious developmental, emotional, or behavioral problems, and the number of children who are not diagnosed with a special problem but go through traumatic experiences, such as family breakdown, death, war, and world disaster, is on the rise (Kazdin & Weisz, 2003). All of them would benefit from emotional assistance. Yet children and adolescents do not actively seek professional help and therefore it is necessary to be more proactive to address their needs (Tolen & Dodge, 2005). Group counseling and psychotherapy is a viable format to address mental health issues for children, however much of what we know about group work with children is based on adult groups. It is a huge mistake to generalize information about adult groups to children's groups because children have unique developmental needs and operate differently. This chapter discusses the unique needs of children and adolescents and the way group counseling and psychotherapy may address them. It also reviews the theory and best practices for such groups. Finally, it provides research results to show the evidence base of such groups and points to the processes that may explain them.

Children's Unique Needs and Group Work

Developmental psychology suggests that children develop in cognitive, social, and emotional stages (Erikson, 1974; Piaget, 1986; Shaffer & Kipp, 2009). They have special needs at each stage, specific tasks to accomplish, and certain abilities suitable to their age. An understanding of normal child development is therefore essential for effective group treatment.

Based on Erikson's developmental model (1974), preschool children have short attention spans, low levels of abstract thinking, difficulties in verbal expression, limited perspective-taking skills, and difficulties in controlling their own behavior. For them, play is the major instrument used in therapeutic groups. Slavson (1945/1986) was probably the first to develop groups for young children. This activity-group therapy is based on psychoanalytic tenets, nondirective, and devoid of verbal interactions. Play-therapy, puppets and dolls, storytelling, bibliotherapy, and pictures and drawing are all techniques that permit reexperiencing of earlier conflicts in a safe environment (Huth-Blocks, Schettini, & Shebroe, 2001).

Elementary-age children (Latency: 7–11) are instrumental, eager to learn, and begin to demonstrate abstract thinking and competent verbal skills. They are able to be empathic and self-aware. The peer group provides support in the beginning of emancipation from the family and serves a prime source of self-esteem. Games, sports, crafts, and writing become the building blocks for a sense of self-confidence and can be implemented in the group therapy process, along with other techniques (e.g., creative drama, storytelling; Lomonaco, Sceidlinger, & Aronson, 2000).

Adolescents (age 12–18) struggle with separation from parents and the development of self-identity. Self-awareness and empathy are now developed and permit close relationships and friendships. Peers become an extremely important source of support; therefore, groups become the treatment of choice for them (Dies, 2000). Commonality of problems leads to a sense of universality and permits the discussion and problem solving of many disturbing issues. Although adolescents appear to be best equipped for group work, they may also be the greatest challenge for group therapists. In their struggle for independence, they are often resistant to authority. Their struggle for a clear identity leads to inflexibility and intolerance. Although talk therapy is used at this age, the therapist must structure the sessions to regulate the anxiety while allowing for freedom of expression (Nicholes-Goldstein, 2001).

Developmental considerations suggest that groups for children and adolescents require leaders with specific skills, yet most such groups are led by group leaders who are not specifically trained for group work with children and are often inexperienced in group treatment with children. The unique needs of children must be represented in a theoretical orientation of group work followed by rigorous research on the effectiveness of such groups (Gerrity & DeLucia-Waack, 2007). The current chapter attempts to respond to these gaps in the literature by addressing the following issues:

1. Why groups for children and adolescents?
2. A theory and practice of counseling and psychotherapy groups
3. The evidence base for these groups
4. Variables that affect the group process

Why Groups for Children and Adolescents?

Clinicians and researchers alike see group counseling as a viable and efficient means to respond to a wide range of problems among children and adolescents. The available literature suggests that group counseling and psychotherapy is effective with various child and adolescent difficulties (Riva & Haub, 2004), that it is at least as effective as individual counseling (Shechtman, 2004), and it is certainly preferable in terms of cost-effectiveness. More specifically Salloum and Overstreet (2008) reported results of a 10-week group intervention with a diverse population of traumatized children, comparing individual and group treatment. Results suggested that group treatment is as effective as individual treatment for traumatized children.

Ehntholt, Smith, and Yule (2005) tested a school-based cognitive-behavioral therapy program for children who experienced war trauma. Twenty-six children were randomly divided into experimental (n = 15) and wait-list (n = 11) conditions. The treatment children showed statistically significant but clinically modest improvement, but gains were not sustained at a two-month follow-up.

Springer, Misurell, and Hiller (2012) developed and tested a game-based cognitive-behavioral therapy group program for children who experienced sexual abuse. Ninety-one children participated in the study with results showing improvement in internalized and externalized symptoms, improved behavior, and better personal and safety skills, both immediately and at three-month follow-up.

Daigle and Labelle (2012) reported on a pilot study evaluating a group program tailored specifically for children bereaved by suicide. Only one group was evaluated, using both questionnaires and observations. Results indicated positive change in basic safety, realistic understanding, inappropriate behavior, physical and psychological symptoms, self-esteem, awareness, and skills.

Carven and Lee (2010) were particularly interested in first-time foster children. They reported on a unique intervention tailored to this population, named Transitional Group Therapy. The treatment was a combination of therapies, including psychoeducational, cognitive, and play therapy. Results of a pilot study involving 11 children showed a positive change in prosocial behavior and improved orientation toward peers, family, and school.

Interestingly, much of the group interventions developed for children use diverse techniques as adjunct to child group treatment. Many use the arts in psychotherapy (Gladding, 2011). Ziff, Pierce, and Johanson (2012), for example, suggested the ArtBreak—a creative group counseling program of 30 minutes per day within the school schedule. A qualitative evaluation suggested improvement in mental health of the treatment children. Schneider and Schneider (2010) suggested Pet Therapy for children with social problems, and Trotter, Chandler, Goodwin-Bond, and Casey (2008) suggested Equine Assisted Counseling (EAC) (riding horses) for children at-risk. The authors used a sample of 164 children divided in two experimental conditions: EAC and a common counseling program. Results demonstrated the efficacy of EAC for internalizing, externalizing, and maladapted behavior, compared to the standard counseling group.

The above description of research on children's groups is by no means an exhaustive review of the literature but a taste of programs, methods, and outcomes that appears in the current literature. Regardless of the theory or method used, all these studies stress the importance of the group experience itself.

Group experiences contain unique characteristics that cannot be present in individual treatment. Yalom and Leszcz (2005) suggested 11 therapeutic factors that characterize group work and contribute to its effectiveness. A study with preadolescents (Shechtman & Gluck, 2005) showed that group cohesiveness was the most frequently mentioned therapeutic factor in the children's interviews; over 50% of the children mentioned cohesion as the most important factor and referred to peer acceptance and support as its major components. For example, one girl said: “I used to think that I was ugly and felt rejected by my peers in class, but the group convinced me that I am a good person, sensitive, and empathic. Now when I look at the mirror I do not see the ugly face I used to see before.” At her age, peer acceptance and love are crucial ingredients and important markers for the development of self-esteem and social functioning. The group, in this case, provided the necessary conditions for a healthy

emotional growth process. In group, counseling and psychotherapy represent group cohesion, which is considered the most important therapeutic factor in children's groups.

Universality is another important factor in groups with children. In groups of children diagnosed with learning disabilities (LD) and attention deficit disorders, it was clear that once they heard other children expressing similar feelings and difficulties they understood that they were not that deviate or "crazy" as they used to think as Michael said: "I see I am not the only one afraid of tests, I feel much better now." Because many of the difficulties are common, the children also learn from each other's experiences. Michael shared an experience in which he tried to be admitted to a new school. He really wanted to be there because it was his only chance to continue his education at age 15. However, on arriving at school he was required to take an exam, so he gave up and went home. To the group, he said that he changed his mind about this school. Group members, however, who knew how eager he was to be admitted didn't believe him. They challenged him about his anxiety of tests, shared their own fears and sense of helplessness, and convinced him to go back and take the exam. He was eventually accepted. It was the sense of universality, support, and interpersonal learning that led to a positive outcome.

Emotional experiencing is a central factor in such groups. Children share their thoughts and feelings about important events in their life; this provides emotional relief and also leads to actual improvement. Emotional relief is often observed in groups for children of divorce. They talk about their sorrow, pain, and actual difficulties. Shelly, for example, talked about her father's new girlfriend who is her age (17). She felt anger and expressed it in the group in a loud and frustrated manner. A few days later her father died of a heart attack. She was devastated. Due to the group's support and challenge, she could express her true feelings of shame and sorrow, and a role-play enabled her to actually talk to her father and say goodbye. In such focal groups, children also imitate behavior and learn from each other to express feelings. For instance, Shelly was a verbal and spontaneous person, which enabled her to really work on her feelings and behavior, but others who were more withdrawn were able to imitate her behavior. For example, Allis said: "I would never talk in a group about my father but you made it possible for me" and continued with her story.

In summary, group counseling and psychotherapy provide a rich experience for children and adolescents to give and receive support and to learn from each other. It is growth engendering for children and adolescents, particularly for children with emotional and social difficulties. Corrective emotional experiences are important buffers to their sense of failure and rejection, fears and anxieties, despair and helplessness. For many children, home and school are not safe enough places to permit personal growth; for them, the group may be the only place to provide the conditions necessary for emotional growth. Samantha, a group member in a community center, summarized this in her own words. "This group gave me the hope that I will find my way out of my stormy life." Either tailored to a specific population or focused on a unique technique, the most important component in group treatment is the group process. Expressive-supportive groups can be used with a diverse population and actually employ many of the techniques described in the literature as will be shown in the next sections.

The Theory of Expressive-Supportive Groups

Expressive-supportive therapy groups for children and adolescents are based on an integrative orientation, including several theories used in a sequential way (Prochaska, 1999). According to Prochaska, a change process in psychotherapy is completed in stages depending on the level of awareness and motivation brought by each individual. Most clients start from a stage of lack of awareness or unwillingness to change. The clinical experience should raise the motivation to make a change and move the person to the stage of working on change until the goal is achieved. A different theory is appropriate at each stage. In the initial stage of little awareness, the humanistic approach is most appropriate as it helps establish a client-therapist bond and group climate. The process continues with a psychodynamic approach geared to help children explore their social and emotional difficulties and to develop understanding and insight. It concludes with a cognitive-behavioral orientation to help clients apply the experiences and understanding achieved in the group to real life. The extent to which each of the theories is represented in the change process depends on the therapist's orientation. In the expressive-supportive groups, cohesion and group climate are crucial, thus the humanistic principles are used in the initial stage. After rapport is created and the climate is safe, the psychodynamic principles are used, to help children express feelings and explore difficulties. The group focuses on emotions, based on the belief that where the tears are, that's where the problem is (Greenberg, 2002). Therefore, a great part of the group process is devoted to the exploration of feelings on both cognitive and emotional levels. Owing to the dual focus on self-expressiveness and group support, the groups are named “supportive-expressive” (Shechtman, 2007). While the two constructs of self-expressiveness and support are central ingredients in any group, they are particularly important when working with children and adolescents. They need to share their experiences in a safe place and be respected for who they are. How these goals are achieved in group will be explored further in the following section.

The Practice of Expressive-Supportive Groups

Children and adolescents are not the usual clients in counseling and psychotherapy. They typically do not choose to be in treatment, do not fully understand the therapeutic process, and do not possess the interpersonal skills needed to help themselves or someone else. Their attention span is limited, and their verbalization skills, particularly their ability to express emotions, are still underdeveloped.

In counseling groups that focus on self-expressiveness, it is the counselor's role to help young clients express feelings and experience catharsis, to enhance self-awareness and empathy, and to guide them in taking risks directed at behavior change. Moreover, unlike psychoeducational groups where the content guides the process, there is no *a priori* content in counseling and psychotherapy process groups. Rather, led by the counselor, group members are expected to share their unique experiences, difficulties, and feelings. This requires a creative leader whose tool chest is particularly rich in activities and who is capable of employing methods and techniques skillfully and processing them effectively.

It should be kept in mind, however, that activities, methods, and techniques are devices to help stimulate and promote the therapeutic process. They should be applied only when necessary to further group processes. Some of the most frequently used techniques in group settings in the school are bibliotherapy (the use of stories, poems, films), phototherapy (the use of personal and family pictures), and therapeutic cards (projective pictures; Shechtman, 2007).

Bibliotherapy refers to the use of literature in the service of therapy and is one of the creative or expressive arts, along with music, drama, dance, and painting (Gladding, 2011). Beyond the creativity it generates, bibliotherapy has a great amount of psychological wisdom incorporated in it, which helps young clients understand human situations better. Most important, however, is its indirect manner of treatment. Children learn through identification with literary characters without being aware that they are actually in treatment. A triadic relationship is fostered between the characters, group participants, and the counselor. The book serves as adjunct to the therapy process while creating distance between the counselee and his or her problem. This distance permits the therapist to guide the child to deal with troubling issues with greater safety and less defensiveness and resistance, as illustrated in the following example:

> In the process of identifying goals for working in the group, the counselor used the book *Like Fish in Water* (Lazarowitz, 1991). This book describes all sorts of fish—some live alone, others live in groups; some are big, some are small, and many are medium-sized. There are fish that follow the group and others that lead. In a group of six 16-year-old girls, the counselor asked each one to choose a fish and explain why. Dina selected the lonely fish because she felt rejected by classmates; Sheila chose a goldfish because she felt overprotected; and Terry selected the swordfish because she cut off relationships too abruptly. By identifying with the fish, the girls could develop awareness of some of their weaknesses or difficulties. In subsequent sessions, each of these issues was processed, including thoughts, feelings, and plans for action. There was also an extensive exchange of feedback and provision of support following the self-exposure. All this was triggered by an activity based on bibliotherapy in the initial stage of the group.

Phototherapy works in a similar way. It entails the use of personal photographs for therapeutic purposes (Weiser, 1993). The following illustrates its usage:

> In a group of adolescent girls whose parents were divorced, the phototherapy activity was conducted deep in the working stage. Sandy had brought a picture of her mom's newborn baby. This was her way of sharing with the group that since the birth of her sister, Sandy no longer lived with her mother. Her mom had become depressed after childbirth and Sandy was now in her father's custody. This was a highly meaningful session for Sandy: Not only was this the first time that she spoke of her mom's illness but she was also able to

share her anger at her mother. Linda shared a similar story about her own mother, which put Sandy's situation into perspective. The group provided feedback, suggesting that Sandy's mom could not control her illness, which further decreased Sandy's level of distress.

Finally, therapeutic cards are a special genre of games based on association and communication, also known as associative cards (Kirschke, 1998). This entails an interactive game between the player and his or her cards, in which the individual associates with or projects onto the cards. “They serve as a springboard into imagination and creativity, a tool for learning, and a catalyst for directing its players into intense communication about themselves” (Kirschke, 1998, p. 11). The following is an example.

The group was comprised of eight 13-year-old girls from a minority culture, in which self-disclosure is strongly discouraged. In the first session, group members were asked to introduce themselves through a selected card. Saya chose one with a picture of a boat on a stormy sea, saying: “I am the boat. I am struggling with events in my life just like this boat, but I will not drown because I am strong.” Rima selected a picture of a forest, explaining “I feel lost in the forest and am not sure I can find my way out.” This was a powerful exchange of self-disclosure, unexpected at the first session and of this particular population. The cards seemed to help the girls establish effective group norms and move to the working stage with little reservation.

In sum, the three methods presented rely on psychodynamic principles, particularly on processes of projection. Such processes help elicit conscious and unconscious thoughts and feelings, which may be difficult to reach otherwise. All this is achieved in a playful and nonthreatening climate. These methods are part of the tool chest that counselors of groups of children use to help them navigate the group process.

The Group Methods

The counseling groups are short-term weekly sessions (usually 12–15) lasting about one hour. They are led by trained counselors or psychologists and focus on specific issues (children of divorce, aggressive children, children with LD), with 6–8 children per group.

The process in these groups follows three main stages: a beginning stage, a working stage, and termination (Shechtman, 2007). The initial stage is extremely important in groups of children and adolescents, perhaps more so than for adults, for several reasons. First, because children are referred to counseling rather than selecting to participate, they may be less motivated to undergo a therapeutic process. Second, they are not familiar with the expectations of clients in a group. Third, children and adolescents come from a unique culture in which positive interpersonal interactions are not within their normal group norms and skills. They need to be guided and assisted in developing and using interactions that are conducive to group counseling. Consequently, the group counselor must actively provide structure to the sessions at this stage, with the aim of forming relationships, developing a language of feelings, establishing constructive group norms, and providing a sense of security. Use of structured activities and therapeutic games are excellent ways to promote group norms, a positive and safe climate, and a sense of personal empowerment. These lay the foundation for constructive development of the later stages. For example, in the first sessions the goals are to reduce anxiety, help group members get to know each other, stress the language of emotions, and increase the language of support. One activity is getting acquainted, which involves three rounds of meeting in pairs to share situations when they were angry, hurt, and happy. Following this part, they are encouraged to express a positive impression of their partners. Children usually experience some relief following mutual self-disclosure and feel good following the positive feedback. Because they met three group members on a personal level, they feel more intimate with the group already after the first session (for more activities see Shechtman, 2007).

While the initial stage is usually positive, with fun activities in a nonthreatening climate, the transition to the working stage may be a difficult one. With the expectation of therapeutic work looming, the level of resistance rises, along with hostile, sometimes aggressive behavior. Such behavior must be stopped firmly and quickly but with warmth and empathy. The work done in the stormy transition stage is the foundation on which new norms of cohesiveness, belonging, collaboration, and self-disclosure are established. This is the necessary climate to move to the actual working stage. As in adult groups, with children too, we uncover the anxiety and resistance to be explored and discussed. Often participants develop insight into their defensive behavior in the "here-and-now" but also in other situations in their lives. For example, in a group of aggressive children, at the first session, the counselor displayed a few objects on the floor, including a pencil, a book, a clock, and a stone, among others. Each child was expected to pick an object and explain his/her choice. Dan selected the stone, explaining "I need to be ready for any attack." The group explored with him his need for safety and the way he protects himself. He further shared situations outside of the group in which he acts in such defense. He told the group that he gets very anxious when he needs to go to a doctor and elaborated more on a recent situation in which he hit his little brother. "I broke the TV and almost killed my baby brother. That is how angry I was." An interpretation about anxiety that might hide behind his anger was suggested, to which he responded "yes, but I shouldn't show my weakness." This is a typical response of a violent youngster, and further work is definitely needed in order to change his attitudes and defensive behavior. However, some insight was instilled, which is an important step in the change process.

The working stage is the heart of the group process. At this stage children undergo cognitive and affective exploration, self-expressiveness, and cathartic experiences. Insight evolves over time, and change in behavior is evidenced. The children accomplish all this with the assistance of the methods and activities used to facilitate the process. Leaders take an extremely active role in the working stage, helping children to identify goals for change and guiding them throughout the process. In a group of 7th-grade girls, the counselor started the working stage with an indirect activity to help participants identify goals for group work. She used the book *Like Fish in Water*, which describes fish of many types (see example above). Each participant selected a fish that best characterized him/her. Dina, an Ethiopian girl, selected the lonely fish, saying that she wanted to be a fish that swims with the

group but her classmates reject her, call her names, push, and hit her. As she cried, some girls provided empathy and support, another girl joined her in sharing her experiences of rejection and admired her for being brave enough to bring it out. Rania provided feedback: “It's because you let them do it, you are too submissive,” she said. Another girl turned to Rania and said “it's easy for you to talk about submissiveness, because no one dares bother you, you too take part in bullying Dina.” Rania proudly agreed, stating that in the past she was a victim too and she never wants to go back there. “I know why I do this to Dina, I hate the time I was so weak.” She then turned to Dina and offered her protection against the bullies. All the involved participants gained from this activity. Dina had an opportunity to experience catharsis and received support and constructive feedback. She also gained from helping another friend to engage in the process. Rania gained insight, which changed her behavior and made her feel a better person. This activity was very effective in bringing up Dina's case. I doubt that she could have brought up her problem without the use of a metaphor.

Termination is more than the end of therapy; it is an integral part of the therapeutic process and an important force for change (Yalom & Leszcz, 2005). A successful completion of the group has a strong impact on group members’ self-esteem, sense of accomplishment, and self-confidence. It may also have a long-term impact on the child's future interpersonal relationships and behavior. As every ending is also a new beginning, the successful conclusion of the group may be the impetus to continue personal growth in real life. To further these purposes, the termination stage includes parting through positive feedback, evaluation of one's own gains and growth, assessment of the group experience, making plans for change in the future, and saying goodbye. We value the termination process so much that we devote three sessions in order to accomplish these goals, as well as to prepare the children for separation.

“Catching the Last Train” is an activity used to permit those who did not have a chance to engage in the group process to “jump on the train.” The counselor brings in a toy train or a picture to illustrate the activity. Most of the time it is the “late bloomers” who jump on the train to solve a problem, with a teacher, a parent, or oneself. In one group of 4th graders, one boy used it to solve an interpersonal problem within the group. He shared with the group his dispute with another group member who used to be a close friend but he had not talked to him since then. He wanted to make up but the other boy was a bit resistant. The group was very active in helping the two of them understand the conflict and encouraged them to make up, which led to a successful resolution of the problem.

The Evidence Base of Expressive-Supportive Groups

Evidence base of these groups was studied across different populations, ages, and settings, using a large sample size. One of the first populations selected for research purposes were lonely, shy, and withdrawn children. Many of these children could not mention the name of one close friend. The rationale for counseling these children in group was that the intimacy created in the group will be carried over to close relationships outside the group. Indeed, following the intervention, scores in intimacy in close friendship increased for treatment children but not for control wait-list children. The improvement was felt by the treatment children themselves but also confirmed by their best friends. Girls and boys gained from the group experience, but while girls grew in intimacy in the control conditions, boys improved only in the treatment group (Shechtman, 1994; Shechtman, Freedman, Kashti, & Shrabani, 2002).

Another population frequently treated and studied is comprised of children diagnosed with LD and ADHD. These children often suffer emotional, social, and behavior problems along with school failure. Peers often reject them, teachers are disappointed in them, and parents are angry with them. The goals for these children are to reduce stress and allow children to experience corrective interpersonal relationships, help them accept their disabilities, and guide them in understanding themselves and the world around them. In congruence with their difficulties, we studied variables such as adjustment, anxiety, self-esteem, self-control, social competence, and even academic achievements. All these studies indicated positive results of treatment. Treatment children improved while control children remained on the same level and even deteriorated with time (Leichtentritt & Shechtman, 2009; Shechtman, Gilat, Fos, & Flasher, 1996; Shechtman & Katz, 2007; Shechtman & Pastor, 2005).

A third major population for treatment involved aggressive children. These children are quite resistant to change and therefore we used a more structured intervention. Stories, poems, and films that pertain to the major issues of aggressive children were used, in which they could identify with the literary characters and discuss their problems and behavior from some distance (Shechtman, 2010). The studies compared individual and group treatment showing no differences between the two treatment formats (Shechtman, 2004). Research also compared this type of treatment with talk therapy and found it more effective (Shechtman, 2006). Similar outcomes were found also in a different culture (Shechtman & Birani-Nasaraladin, 2006). Finally, aggressive adolescents who participated in counseling groups showed a reduction in aggressive thoughts, behavior, anger and hate, whereas no change occurred in the wait-list children (Shechtman & Ifargan, 2009).

In summary, all these large-scale studies provide the evidence base for group interventions. These studies were based on large samples, diverse populations, comparisons with control waiting-list children, and analyzed in a nested way to control for group differences. All these measures ensure the validity and reliability of the results, leading to the conclusion that counseling and psychotherapy groups of a supportive expressive modality are effective with children and adolescents. However, the current professional literature calls for more than evidence-based studies. An important goal is to understand those processes that have an impact on outcomes (Burlingame, Fuhriman, & Johnson, 2004). Moreover, such studies bear important implications for the improvement of group counseling practice. Findings from research that looked at group process is discussed next.

Process Variables that Affect Outcomes

Several process variables were investigated in group counseling and psychotherapy with children and adolescents. One major subject of research was leader behavior. This is a topic largely understudied, certainly in groups with children. The focus was on therapist verbal behavior using the Verbal Response System developed by Hill (Hill & O'Brien, 1999). Included were encourage, information, guidance, closed and open questions, interpretations and challenges, and self-disclosure of the therapist. In an early study (Leichtentritt & Shechtman, 1998), it was pointed out that questions and structured activities were the most effective variables to engage the children in the group process. In more recent studies, it was shown that several of these behaviors had a direct impact on children's outcomes. Encourage and interpretation predicted reduction in children's anxiety; therapist self-disclosure predicted increase in children's social competence; and challenge affected outcomes negatively (Shechtman & Liechtentritt, 2010a). This reinforced the results of an earlier study (Shechtman & Yanuv, 2001), which indicated that challenging did not lead to positive responses of children in group counseling. Moreover, in another study therapist self-disclosure was actually the best predictor of children's outcomes (Shechtman & Liechtentritt, 2010b).

Another important variable that emerged from our studies was therapeutic alliance. Alliance is the most important factor in individual therapy, often referred to as the common factor. Similarly, it also was meaningful in group therapy, except that in group counseling, alliance is more complex as group alliance relates to both the therapist *and* the group members. Bonding and cohesion were related to the increase in social skills and to the reduction of anxiety, externalizing and internalizing behavior (Shechtman & Katz, 2007; Shechtman & Liechtentritt, 2010a; Shechtman & Mor, 2010), and was the most highly evaluated component in children's feedback (Shechtman & Gluck, 2005). In sum, the investigation of processes in children's counseling groups, points to two major components. The first of these is the importance of relationships in the group, particularly with the leader. This makes sense in light of developmental considerations. Children and adolescents are preoccupied with peer relationships yet need the authority of the adult in the group. The literature on adult groups suggests that group members are attached more to each other than to the leader; the opposite seems to be the case in groups with children. Second, looking at the therapist's verbal response system, questions appear to be most important and therapist self-disclosure is an impressive predictor of outcomes. In contrast, challenges were not helpful in working with children in groups. These results are very different from those known about adult groups, suggesting the unique nature of counseling groups with children.

Conclusion

Clinicians and researchers alike have claimed that group counseling is not yet a mature profession, particularly group counseling and psychotherapy with children and adolescents (Barlow, Burlingame, & Fuhriman, 2000). Counselors are often not sufficiently trained to work with children's groups, and there is not enough research to support claims for the effectiveness of such groups (Gerrity & DeLucia-Waack, 2007). The current chapter provides data to support the efficacy of counseling and psychotherapy groups of a unique type and pointed to processes that may improve group practice with children. This chapter also outlines a type of group work with children that is tailored to their unique needs. The research described is based on large samples, includes a variety of populations and difficulties, and is conducted with sophisticated methods. This goes a long way toward addressing critiques of group counseling research (Gerrity & DeLucia-Waack, 2007). Much more is needed, however, in measuring outcomes of particular populations (e.g., children with ADHD), working with parents as well as children, discovering processes that may improve treatment, and training the group counselor.

A new line of research has begun investigating consistent feedback provision to counselors regarding the progress made by children in groups. This type of research appears promising in individual therapy. In group counseling, only two such studies exist, one of which used a child population (Shechtman & Sagi, 2012). While the results did not indicate a significant effect of feedback provision on outcomes, it did provide a starting point for understanding how and when to provide feedback and especially how therapists can use this feedback effectively.

The decision to work directly with children or instead to work with their parents is another important question, as parents have a tremendous impact on their offsprings' lives. Studies investigating group counseling with parents of children with LD found a reduction of stress and an improvement in parental perception of the child's difficulties among participants in such groups (Danino & Shechtman, 2012; Shechtman & Gilat, 2005), but it is important to assess further the impact of parent training on children's functioning.

Training the group counselor in groups with children is the topic most in need of research and least studied. While some studies investigated verbal responses and have begun to understand which ones have a positive impact, many personality traits and leadership roles have not yet been investigated. More research is needed in all these areas and probably many others to move group counseling with children to a mature stage.

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Reflections and Final Comments

Ten years have passed since we published the first edition of this book. Two years have passed since we proposed and began working on this book. Now we can say with certitude that the world of groups continues to develop and mature. Our understanding of the nature of group work continues to develop, so this conclusion is not really an ending. It opens the door wider to the world of groups and leaves plenty of room for future development of groups.

As stated in the introduction to this edition, it was our goal to add to the group literature in a way that both group practitioners and researchers would be able to use this book. After reading the 46 chapters in this book, we hope that you will agree that this text provides a wealth of knowledge about groups from the history, theories, leadership and ethics, therapeutic factors, processing, training and supervision, and measurement. You have learned about groups for many culturally diverse populations, conducted in a variety of different settings, and with a focus on topics that range from depression to eating disorders, bullying and offenders.

In the end, we have answered the question, “Are groups effective?” with a definite yes! In the next 10 years, we encourage group clinicians and researchers to use groups and study them to understand their power more clearly, to develop more groups for more populations so that this work continues to grow.

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