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Pretraining with Adolescents in Group Psychotherapy: A Special Case of Therapist Iatrogenic Effects

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The effects of pretraining adolescents for group psychotherapy were investigated. Twenty-one adolescents from a residential treatment facility participated. Pretraining addressed the processes of risk taking, self-disclosure, and giving and receiving feedback through verbal, video, and/or experiential instruction and were compared with a control condition. Pretraining was not found to be beneficial when measured on satisfaction, therapeutic factors, and peer relation factors. However, a potential confounding variable was the exposure to a "psychonoxious" therapist who was found to have a significantly negative impact on group satisfaction ratings. The implications of group pretraining for adolescents are considered, as are the iatrogenic effects of therapists and the "therapeutic milieu."

KEY WORDS: pretraining; group psychotherapy; adolescent; iatrogenic effects.

Diverse social science disciplines, such as psychology, sociology, anthropology, and political science, have all shown an interest in group behavior (Forsyth, 1990). Likewise, the professional application of groups is equally diffuse ranging from business and industry to education, criminal justice, and the military. Despite a different perspective, a collective dilemma for using groups in almost any discipline is the recruitment and socialization of new members in order to foster a productive group environment. Unless a group can acquire additional members and effectively

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manage their socialization, it cannot survive for a significant amount of time and reach its goals.

Unfortunately, the experience of joining a group is often stressful and many individuals relinquish their membership before the group has truly formed and begun its process. This is particularly the case in psychotherapy groups. Often individuals have vague, inappropriate, or unrealistic expectations about group psychotherapy. Similarly, people may be unaware of certain skills and techniques which can contribute to a more meaningful and satisfying group experience. Endeavors to assist new members in gaining a better understanding of realistic expectations and useful communication techniques comprise what is referred to as pretraining in the group psychotherapy literature.

For several years there has been a strong applied interest in the utility of pretraining for group psychotherapy. Clinicians have intuitively approached the idea of preparing individuals for group therapy in order to enhance their therapy experience. However, this has moved beyond the realm of intuition into that of empiricism. The underlying rationale driving this research follows the intuitive path built by practicing clinicians. Initially, the group psychotherapy experience is difficult and even awkward for the majority of inexperienced participants. Kaul and Bednar (1994) compare the entrance into group therapy to "riding in an open-cockpit airplane, especially if you have never done it before" (p. 155). Feelings of both experiences may include exhilaration, as well as dread. Furthermore, perceiving that one's safety is dependent upon someone else is usually distressing. This seems to be an inherent component of being in a group therapy situation.

Clinicians have posited that preparing individuals for group psychotherapy through role induction interviews, cognitive instructions, behavioral practice, and/or modeling exercises enhances the quality of the group experience and fosters meaningful intrapersonal, as well as interpersonal, relationships. Some assert that people need guidance and structure in order to minimize their anxiety about the group therapy process (Kaul & Bednar, 1994). Researchers have incorporated this assertion into numerous studies which investigate the techniques and effectiveness of pretraining for group psychotherapy. Strategies for pretraining and how they affect both group processes and individual outcomes have been the focus of such studies. Implications have varied; however, the most fundamental conclusion appears to be that pretraining is effective in promoting and enhancing the group psychotherapy experience.

Piper and Perrault (1989) define pretraining for group psychotherapy as "any procedure conducted prior to group therapy that attempts to prepare the patient for the task of working in a therapy group" (p. 17). Kaul and Bednar (1994) state that pretraining "involves preparing individuals

for their client/member roles" (p. 160). Generally, reviews of the literature on pretraining are quite favorable about its benefits, as are reports from clinicians who have implemented its various forms. Empirical literature on pretraining has existed since the early 1960s although some argue (Piper & Perrault, 1989) that many of these studies are methodologically weak.

The effects of pretraining for group therapy with adults have been frequently studied in the group therapy literature. In general, pretraining has referred to setting realistic expectations, introducing roles of effective group therapy participants, building group process skills, and establishing basic rules for group therapy sessions. Some of the immediate effects of pretraining include high self-ratings of readiness for group therapy (Hilkey, Wilhelm & Horne, 1982), motivation to change and anxiety (Curran, 1974), and knowledge about group therapy in general (Jacobs, Trick & Withersty, 1976). Support can also be found for pretraining enhancing group attendance (Piper, Debbane, Garant & Bienvenu, 1979; France & Dugo, 1985; Piper, Debbane, Bienvenu & Garant, 1982), interpersonal communications (D'Augelli & Chinsky, 1974), cohesiveness (Evensen & Bednar, 1978; Bednar & Battersby, 1976), patient role behavior (Garrison, 1978) and decreasing drop-out rates (Yalom, Newell & Rand, 1967; Heitler, 1973).

Although the research base on the effects of pretraining with adult groups is broad, it is limited when considering pretraining with adolescent groups. The existing literature on pretraining with adolescent groups focuses primarily on the presentation of different techniques for pretherapy preparation, rather than on empirical testing of these techniques (Dennison, 1988; Corder, 1994). This is surprising considering how popular group therapy is in adolescent treatment facilities, and how straightforward it is to test the effects of pretherapy training. Corder (1994) notes that, because pretraining with adults enhances interpersonal skills of group members, it seems particularly relevant to adolescent groups as maladaptive social skills are often the presenting problem. Therefore, pretraining adolescents for group therapy would seem to be a logical step in the therapeutic process.

Having well prepared group members is an important component in facilitating change; however, it alone is not sufficient. Once group therapy has begun, there are a number of "therapeutic factors" that have been suggested as prerequisites to change (Yalom, 1995). Group cohesiveness is one factor which suggests the importance of quality relationships among the group members. Fuhriman and Barlow (1982) have suggested that cohesion is to group therapy what the relationship is to individual therapy. Cohesiveness has also been described as being multidimensional, reflecting variables in the following domains: individual member, group development,

group characteristics, and process variables (Drescher, Burlingame, & Fuhriman, 1984).

The importance of cohesiveness in promoting therapeutic group processes and change is well documented in the literature. An important part of facilitating cohesiveness is the relationship the therapist has with the members in the group. For instance, Dies (1994) in summarizing research on group therapists highlights the importance of interventions that foster this factor. Nevertheless, research documents the possibility of negative outcome due to therapist factors (Lambert, Bergin, & Collins, 1977; Lieberman, Yalom, & Miles, 1973; Mohr, 1995; Sachs, 1983; Yalom & Lieberman, 1971). The research of Yalom, Lieberman and colleagues (1971, 1973) suggests that negative outcomes in group psychotherapy may result from five "mechanisms of injury" (p. 194). These mechanisms include: (1) attack by leader or by the group, (2) rejection by leader or by the group, (3) failure to attain unrealistic goals, (4) coercive expectations, and (5) input overload or value shuffle (Lieberman, Yalom, & Miles, 1973). They also suggest that the style and approach of the group leaders can result in a negative outcome (Yalom & Lieberman, 1971). For instance, leaders who were impatient and authoritarian had more casualties in their groups. These leaders utilized an aggressive, intrusive approach that involved intense challenging of the group members and demanded immediate self-disclosure, emotional expression and attitude change (Lieberman, Yalom, & Miles, 1973; Yalom & Lieberman, 1971).

With regard to therapist-induced deterioration in group therapy, one group of researchers (Lambert, Bergin, & Collins, 1977) concluded that "groups are often less deleterious but can produce more deterioration than individual psychotherapy" (p. 465). They suggest that research should continue to investigate the role that therapist skill level, training, and personality characteristics plays in deterioration or negative outcome in psychotherapy. More recently, Sachs (1983) demonstrated that quality of technique or the skill level of the therapist was highly related to outcome. This research as well as more recent reviews of the literature (Dies, 1994; Lambert & Hill, 1994; Mohr, 1995) suggest that therapist variables are important aspects that can play a role in deterioration or negative outcome in psychotherapy.

Therefore, this study takes a unique perspective by initially studying pretraining in adolescent psychotherapy groups and later uncovering iatrogenic therapist effects. Specifically, we synthesized several adult pretraining techniques for adolescent group therapy and then tested the effects of pretherapy training on curative climate of the group, attitudes and feelings of participants about peers in their therapy group, and satisfaction level with the group. It was hypothesized that pretraining would have a positive effect

on these variables leading to a more curative climate as well as increased satisfaction and positive feelings about those in their group. As therapist effects became a powerful confound, our attention turned to study their effects, hypothesizing that exposure to a "psychonoxious" therapist would have a negative impact on group satisfaction that overwhelmed any benefit achieved by pretraining.

METHOD

Participants

Participants were obtained from a residential treatment facility. Initially, letters were sent out to parents of the participants describing the study and seeking consent for their adolescent son or daughter to participate in the study. These letters indicated that this study investigated procedures that may enhance treatment for adolescents in group therapy. Parents were asked to return the consent form if they were willing to allow their son or daughter to participate in the study. Of the 67 consent forms that were mailed out, 27 were returned, a response rate of 41%. After the consent forms were returned, the adolescents were then asked whether they would like to participate in the study. This process eliminated 4 additional participants. Of the 23 remaining participants, two moved out of the facility within the first week of the study. As a result, twenty-one adolescents (10 males, 11 females) ranging in age from 14 to 18 years (mean age of 16.7) were included in the study.

Instruments

Prior to pretraining, as well as during the course of group psychotherapy, the participants completed several measures. The instruments used were the Self-Report of Readiness for Group Counseling (SRGC, Kochendorfer, 1974), the Curative Climate Index (CCI, Fuhriman, Drescher, Hanson, Henrie, & Rybicki, 1986), the Index of Peer Relations (IPR, Hudson, 1992), and the Self-Report of Satisfaction Scale (SSS, Kochendorfer, 1974).

Readiness for group therapy was measured using the Self-Report of Readiness for Group Counseling (SRGC, Kochendorfer, 1974). The SRGC is a is a 5-point Likert scale of 30 items which possesses adequate reliability (split half, .88). Items were selected to assess expectations of receiving help from a group, expectations of behaving in a facilitative manner, and readiness to talk openly about one's self in a group session. It was given to all

group members prior to the pretraining session to assess any differences in the readiness for group psychotherapy between groups.

The Index of Peer Relations (IPR, Hudson, 1992) is a 25-item scale (with 7 response categories) used to assess the attitudes and feelings of participants about peers in their therapy group. It measures the problems that a participant may currently be experiencing with their peers. Data indicate that this test has excellent internal consistency (.94).

The Curative Climate Index (CCI, Fuhriman, Drescher, Hanson, Henrie, & Rybicki, 1986) was designed to assess curative factors in group therapy. This scale specifically assesses cohesion, catharsis, and insight—three of Yalom's "therapeutic factors" (1995). The authors endorse these factors as being valued most by group members in various settings, thus they are central to the therapeutic process. This instrument contains 14 items with a 5 point Likert scale connected to each item. Data suggest that this index has moderately high internal consistency estimates (.79 and above).

The Self-Report of Satisfaction Scale (SSS, Kochendorfer, 1974) assesses participants' satisfaction level, as well as their problems with the group. It is a 10-item instrument measured on a 5-point scale with adequate reliability; split-half correlation of .78.

Procedure

Participants were randomly assigned to one of three treatment conditions: (1) full treatment, (2) partial treatment, and (3) control. The pretraining group sessions focused on risk taking, self-disclosure, and giving and receiving feedback. The full pretraining condition consisted of subjects receiving verbal instruction, video presentation, and experiential practice (see Table 1). Verbal instruction involved a group discussion of three group therapy skills: risk taking, self-disclosure, and giving and receiving feedback. This discussion was an interactive process that stressed the role these skills play in improving groups. The video presented analogue adolescent therapy groups demonstrating positive models of each of the three skills. The groups which were assigned to the full pretraining condition also practiced the skills after viewing and discussing the video. Experiential practice was discussed and participants were invited to experiment with the skills in their actual therapy groups.

The partial treatment condition included only verbal and video presentation. As described above, verbal instruction involved a group discussion of three group therapy skills: risk taking, self-disclosure, and giving and receiving feedback. Individuals in the partial treatment group also watched

Table 1. Self-Disclosure, Risk Taking, and Giving and Receiving Feedback

Verbal Instruction
Group leader discussed purpose of these three skills in group therapy.
Examples of the skills are given.
Group members are asked to give examples of each of these skills.
Discussion about these skills and how they will improve group.
Group members questioned about whether they feel that self-disclosure, risk-taking, and giving and receiving feedback and receiving feedback will improve group.
Video Vignette
Video presents an analogue adolescent groups.
First clip shows a girl self-disclosing an eating disorder (risk taking).
Second clip demonstrates self-disclosure by a male regarding low self-esteem.
Third clip presents a group member taking a risk by challenging a more "powerful" group member about his lack of respect for her.
Fourth clip displays a group member soliciting feedback from the group, because he does not feel a part of the group, as well as the feedback he receives from the members of the group. This clip also shows him accepting this feedback thoughtfully.
Experiential Practice
Group members split off in pairs.
Each member practices each of the skills.
Group leader watches and provides feedback.
Group leader leads discussion about what it was like to self-disclose, takes risks, and give and receive feeback.
Group leader encourages group members to utilize these skills in their group.

the same video which presented analogue adolescent therapy groups demonstrating positive models of the three skills described above. The no treatment condition served as the control group and received no pretraining.

All three groups completed the measures prior to receiving the pretraining, as well as after the first and third weeks of therapy. It was expected that the pretraining would have immediate (after one week of therapy) and delayed effects (after three weeks of therapy). The groups at the treatment facility containing the research participants were randomly assigned to one of the three treatment conditions Thus, each of the eight groups was pretrained according to one of the three conditions described above, regardless of whether all members were participating in the study. Three of these groups received the full treatment, three received the partial treatment, and two served as control groups. This method insured that all members of the group received the pretraining although only the research participants took part in the actual study. As a result, within each group there was consistency with regard to the type of pretraining to which members were exposed.

RESULTS

The full treatment group (n = 6), partial treatment group (n = 7), and control group (n = 8) were compared on the instruments, prior to pretraining exposure. No reliable differences were found.

Due to the small sample size, we relied on post-treatment t-tests to test for equality of means. Few significant differences were found. Those that were found, indicated that pretraining was not beneficial which was contrary to our initial hypothesis. In fact, the differences that were found made it appear that the pretraining produced negative rather than positive effects. For instance, comparisons between the full treatment and control groups resulted in significant differences on the IPR after one week of therapy (p = .01). An examination of the mean scores for these two groups indicated that control group scores improved between the first and second tests. Individuals in the control group indicated fewer problems with peers after one week of group treatment while the scores for the full treatment group did not appear to change in any reliable fashion.

Comparisons between the partial treatment group and the control group resulted in significant differences in peer relations (IPR) at week one (p = .01) and week three (p = .04). In each case, the control group rated their group peer relations as significantly more positive, indicating fewer problems and more positive attitudes and feelings about the peers in their group while the partial treatment group scores became slightly worse. There were no other significant findings regarding pretraining treatment conditions. Table 2 summarizes pre- and post-comparisons of treatment condition mean values on all measures.

While conducting this study, it was learned that a new therapist at the facility was having a seemingly negative impact on several of the groups being investigated by this study. Specifically, the co-leaders and members of the groups involving this therapist independently noted his authoritarian and demanding leadership style. For instance, prior to developing a positive therapeutic relationship with group members, he actively confronted group members and criticized "unproductive" group processes. The negative effects of this therapist style consistently emerged with a high enough frequency across all groups that the director of the agency was forced to administratively intervene. Unfortunately, this therapist was present in virtually every full and partial treatment condition group (five of the six) raising the possibility of a therapist confound.

Given this observation, an additional analysis was performed which examined the dependent variables for the groups in which this therapist was involved irrespective of initial pretraining condition. Subjects were divided into those that had exposure to this therapist (n = 11) and those

Table 2. Effects of Pretraining Conditions

Measure	Full		Partial		Control	
	M	SD	M	SD	M	SD
Time 1						
Index of Peer Relations (IPR)	25.17	6.5	27.43	10.6	20.25	7.6
Curative Climate Index (CCI)	47.67	8.1	51.43	10.0	48.5	6.2
Self-Report of Satisfaction Scale (SSS)	23.83	6.7	18.43	3.1	20.38	4.0
Time 2						
Index of Peer Relations (IPR)	25.5[a]	3.9	28.0[b]	7.4	17.86[ab]	4.8
Curative Climate Index (CCI)	48.83	5.2	51.71	10.2	46.57	7.7
Self-Report of Satisfaction Scale (SSS)	22.83	6.2	19.43	5.1	20.86	2.5
Time 3						
Index of Peer Relations (IPR)	24.4	5.3	28.6[c]	8.7	16.6[c]	6.5
Curative Climate Index (CCI)	46.0	7.0	55.8	10.3	48.0	7.9
Self-Report of Satisfaction Scale (SSS)	22.17	6.2	17.8	7.3	20.2	3.9

[a]control group reported significantly fewer problems than full treatment group.
[b]control group reported significantly fewer problems than partial treatment group.
[c]control group reported significantly fewer problems than partial treatment group.
IPR: higher score = higher severity of peer related problems
CCI: higher score = more positive perception of group
SSS: higher score = lower level of group satisfaction

that had no exposure (n = 10). The therapist in question began to lead the groups concurrent with the initiation of the study but after the pretreatment measures were collected which showed no significant differences between the two groups (p = .05) prior to his presence. However, two significant findings were obtained in examining scores once treatment began and once the therapist became involved with the groups. Groups which

were exposed to this therapist rated themselves as significantly less satisfied with their group experience (SSS) at week one ($p = .02$) and week three ($p = .03$). Groups not exposed to this therapist became more satisfied over time and those that were exposed to this therapist became increasingly dissatisfied with the group.

Interestingly, the differences in peer relations (IPR) in the analysis of treatment conditions reported above that prompted this new analysis were not associated with this therapist (see Table 3). A correlational analysis found no relationship between the IPR and the SSS at weeks one and three ($r = .09, p = .74$, and $r = -.05, p = .82$). In addition, no relationship existed between the IPR and the CCI at weeks one and three ($r = -.11$, $p = .65$, and $r = -.19, p = .49$). However, a relationship existed between the SSS and the CCI at weeks one and three ($r = -.58, p = .008$, and $r = -.73, p = .001$).

CONCLUSIONS

The initial purpose of this study was to develop a pretraining protocol for adolescent group psychotherapy and test its effectiveness. This goal was achieved; however, the data were not supportive of pretraining. None of the measures indicated that the full or partial treatment groups improved following pretraining. Rather, in some cases, negative change followed pretraining. While the time frame under examination was relatively short (i.e., three weeks), the significant differences obtained between the full, partial and control groups provide partial support to suggest that the control group was achieving positive change (peer relations) while the full and partial groups were not.

While no conclusive statements can be made about the impact of pretraining on adolescent therapy groups, several important issues became apparent while conducting the pretraining sessions. First, the issue of generalizing adult pretraining techniques to adolescents needs to be further addressed. The pretraining protocol in this study utilized techniques and training formats typically applied to adult groups. It is unknown how capable adolescent groups are at processing such models and perceiving effective therapy skills. Therefore, it is not clear how much information the groups were able to receive from watching a video model. In addition, the cognitive and psychological demands necessary for an adult to apply material learned in an experiential practice to an actual therapy group are significant. Thus, it may be overly optimistic to expect adolescents to do so, as many adults find it a difficult process. Another consideration is the focus in the literature on pretraining for adolescent groups is primarily on

Table 3. Exposure to Therapist Iatrogenic Effects

Time 1				
Measure	Exposure		None	
	M	SD	M	SD
Index of Peer Relations (IPR)	24.0	8.8	24.1	8.8
Curative Climate Index (CCI)	49.82	6.3	48.6	9.7
Self-Report of Satisfaction Scale (SSS)	22.0	4.2	19.3	5.5
Time 2				
Measure	Exposure		None	
	M	SD	M	SD
Index of Peer Relations (IPR)	21.8	7.0	25.6	6.8
Curative Climate Index (CCI)	47.9	7.3	50.2	8.8
Self-Report of Satisfaction Scale (SSS)	23.3[a]	4.2	18.6[a]	4.2
Time 3				
Measure	Exposure		None	
	M	SD	M	SD
Index of Peer Relations (IPR)	20.86	10.5	25.25	5.7
Curative Climate Index (CCI)	47.63	9.7	51.75	8.3
Self-Report of Satisfaction Scale (SSS)	23.38[a]	4.5	17.0[a]	5.6

[a]exposure groups reported significantly lower levels of group satisfaction than no exposure group.
IPR: higher score = higher severity of peer problems
CCI: higher score = more positive perception of group
SSS: higher score = lower level of group satisfaction

initial interviews with adolescents and their parents in preparation for outpatient therapy groups. Thus, pretraining for inpatient or residential treatment groups has, in general, not been investigated. It remains to be seen which methods of instruction best benefit these populations, which constitute a large proportion of the adolescents receiving group treatment.

One possible reason for the lack of findings is the small sample size (i.e., sample size ranging from six to eight). However, these results provide a starting point for examining pretraining with adolescents in group psy-

chotherapy. Due to the small sample size, an exploratory *t*-test was most appropriate; however, the investigators acknowledge the cautious nature of this analysis. It seems further empirical investigation of pretraining adolescents for group psychotherapy is needed, as is further consideration of the impact of iatrogenic effects.

Although research is contradictory and further investigation and replication is needed with regard to pretraining, Piper and Perrault (1989) offer reasons why there remains considerable enthusiasm about its use and study. First, the rationale for pretraining for group psychotherapy "makes good sense" (p. 30). Common difficulties experienced by new group members have been long observed and are well known. Thus, any techniques which have a chance of reducing anxiety, establishing relationships, clarifying expectations, and strengthening useful group skills are welcomed. Second, because many clinicians intuitively believe in the effectiveness of pretraining, empirical evidence is viewed as necessary to justify its use. While some believe that research data are not required to support a technique's efficacy, it is still desirable to have data to support one's therapeutic strategies. Third, while the benefits of pretraining may be modest at most, its costs are relatively limited. Thus, pretraining may be justified on an economic basis, if nothing else.

A possible confounding variable was the iatrogenic effect of a single therapist. Previous research findings from studies on negative therapist variables suggest that group leaders who adopt a premature, intrusive and demanding therapeutic style will tend to alienate themselves from group members, and produce high drop out rates and negative outcomes (Lambert, Bergin, & Collins, 1977; Lieberman, Yalom, & Miles, 1973; Mohr, 1995; Sachs, 1983; Yalom & Lieberman, 1971). These findings appear to be supported by the results of this study. This suggests that an authoritarian group leader will most likely reduce satisfaction levels of group members and increase group member reports that they are having problems with their groups. The implications of these results relate to the importance of the "therapeutic milieu." Changing one component of therapy can have a significant impact across the entire therapy experience. Although these results are preliminary, they appear to support Dies' (1994) conclusion from the adult group literature that "a positive relationship between the therapist and group members plays a significant role in the development of constructive group norms and in facilitating therapeutic change" (p. 136).

It is intriguing to note that the groups that were exposed to the therapist in question did not have differences when the curative climate was evaluated. The CCI assesses issues related to cohesion, catharsis, and insight, and no differences were found between groups that were exposed to this therapist and those that were not. This is surprising, as we would have

expected differences in the climate based on the reports we received from co-leaders and members of the group. Perhaps this is because on the CCI the subjects were simply asked to rate how helpful they perceived each of the three therapeutic factors. Since their perceptions of the helpfulness of these factors are not necessarily related to their perceptions of the group leaders, it is possible they had positive attitudes about the therapeutic factors concurrent with negative feelings about the groups and the leaders. A second explanation lies in the fact that the CCI was developed and tested on an adult population. Are therapeutic factors measured from an adult literature generalizable to adolescent groups? This question awaits further explanation with measures like the CCI.

In addition, no differences were found on a measure of peer relations with regard to the therapist in question. This finding may be more understandable when one considers that peer relations in group may be more independent of the group therapist's influence than the climate of the group. In this study, it appears that peer relations were relatively unaffected by exposure to this therapist. Problematic therapists have deleterious effects on a member's overall satisfaction with the group but did not seem to have direct effects on measures of group process related variables in this study; CCI and IPR. This does not mean that satisfaction with the group is unrelated to group process variables. In fact, value for therapists factors linearly and increase with group satisfaction; however, satisfaction and therapeutic factors measures only share between 35 to 50 percent common variance. Given the small sample in this study, these relations clearly need to be replicated in future research.

Fundamentally, no support for the efficacy of pretraining was found in the present analysis. It was initially thought that this result was due to a potential therapist confound (iatrogenic effects). However, secondary analyses of the IPR using the therapist variable did not explain the differences favoring controls in the pretraining analysis.

One major problem with trying to understand therapist iatrogenic effects in this study is the fact that no measures were given which explicitly asked about feelings and perceptions of the group leaders. The present data regarding the attitudes toward the group leaders have been extracted from the data on perceptions about the groups, as well as the anecdotal accounts regarding the leaders given by group members and other leaders. In order to truly understand the impact of this therapist, or of any other therapist, it would be necessary to solicit responses which directly target the group leaders. Attitudes toward group leaders change as groups progress through different developmental stages. Often these types of changes in attitudes toward group leaders occur, irrespective of therapist style and characteristics.

In conclusion, it appears that the question of pretraining with adolescents in group psychotherapy remains. While a particular approach to pretraining adolescents for group therapy in a residential treatment setting was detailed and tested, data collected suggest that this pretraining format is not effective. It can be hypothesized that positive pretraining effects may have been present, but they were masked under the impact of negative group leader effects. This may be an important statement about pretraining; that is, that even if pretraining has positive effects on attitudes toward group therapy, it cannot reverse the negative effects created by an iatrogenic therapist effect. Nevertheless, because of the theoretical and practical importance of preparing people for group therapy experiences, it would be worthwhile to further investigate the pretraining protocol used in this study, as well as those suggested in existing literature.

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