A Leadership Intervention Perspective on the Creation, Monitoring and Maintenance of the Group Therapeutic Relationship

A modified systematic literature review with clinical illustrations.

Christopher Defibaugh

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Department of Psychotherapy

Primary Supervisor: Dr. Andrew Duncan

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or any other institution of higher learning.

Signed: _____Date:_____

Dedication

Dedicated to ‘the group’: Elizabeth, Dave, Craig, Kathryn, Ryan, Helen, Steve, Brendan and Wendy – and their partners who joined us. Linda, Mark, Emma and Julie. Your courage to take the adventure and “speak the truth in love” changed my life and the way I am in relationship. For this I am truly grateful.

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I am also very grateful to my talented supervisor Andrew Duncan for his attunement to my personality, his love for groups and his belief that this enormous topic could and would be covered in this short paper.
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Abstract

A 1991 Gallup Institute survey revealed that 40 per cent of all Americans eighteen years of age and over are involved in small groups that meet regularly and provide care and support for those who participate. The majority of the participants attended the group at least once weekly and had been participating for at least three years. The types of groups being researched in this dissertation I am simply calling ‘therapeutic groups’. Therapeutic process groups act as training cultures expressly organised to examine the interpersonal field of the group in search of psychosocial insights and reparative relational experiences for their members. They are defined in terms of three factors: 1) that the group relies on verbal communication, 2) that the individual member is the object of the treatment and 3) that the group itself is the main therapeutic agency. The group exists for the benefit of its individual members and for no other reason.
This dissertation is an investigation into what the therapeutic group literature has to contribute to small group leadership. A review of the existing literature has been done on the evaluation of therapeutic group leadership and the effectiveness of their interventions. It is hoped that these findings will give some clear guidelines that can inform the training of group facilitators inside and outside of the professional community.

This work investigates what type of group leader interventions the literature suggests make a constructive difference to the group and its individual members. The study examines the research on therapeutic group leadership from a wide variety of literature and gives an overview of the history, evolutionary themes, theory building and ultimately the leadership interventions seen as fundamentally therapeutic for these groups.

There is a gap in the literature in regards to models that link group developmental stages, therapeutic factors and leader interventions. The findings of this paper present group leaders with a synthesis and intervention

framework of these three critical areas. This contribution demonstrates how the stages of group development are crucial in making maximum therapeutic use of the leader variables, therapeutic factors and in making decisions about appropriate interventions. The framework also allows for greater clarity and utility of these factors and variables. While research in the field of psychotherapy is normally qualitative, this research includes both qualitative and quantitative information.

Introduction

Polls continue to demonstrate the enormous interest there is in belonging to a small group (Wuthnow, 1994; Lieberrman & Snowden, 1993). Groups that meet regularly and provide care and support for their participants are in high demand. Self-help, recovery, religious, life-stage, personal growth, reflective, and experiential groups are only a sample of what is available in this professional, semi-professional and largely non-professional field. Just how well leaders provide care and support in these groups is the impetus behind this enquiry. This task would, however, be beyond the scope of this paper; therefore the focus of this work is upon group leader interventions and their influence on the therapeutic potential of groups.

Group therapeutic endeavours are intricate. Providing leaders with research on how they can be most effective is essential for their complex task. The clinical question being investigated is: *What does the research literature indicate is best practice in regards to leader interventions in therapeutic groups?*

Group leaders make innumerable clinical decisions in the often fast-paced life of a therapeutic group. Leaders regularly assume the professional stance of 'juggler', deciding moment by moment what material to attend to and what to let fall to the ground (Ward, 2006). The therapeutic groups being studied are process oriented and, as I will show, it is the leader's ability to facilitate the group's reflection on its process that is arguably their core responsibility. This research is an attempt to find guidelines to assist group leaders in this decision-making process, allowing them to feel some sense of consistency in the interventions they make.

My personal interest in this topic stems from opportunities I have had to work therapeutically with many kinds of small groups. Within the milieu of these

groups I am continually asking myself two questions: “What would be therapeutic for this particular individual at this moment?” and “what does the group-as-a-whole need?” During these times I am aware of working with the group environment as a therapeutic agent and also conscious of my responsibility to be attentive to the needs of individuals. Often I leave these meetings wondering about the usefulness of interventions I have made and interventions that I failed to make.

The source of my enthusiasm for working with therapeutic groups stems from my own historic deficits. I grew up in a family with problems of attachment; a family whose members were, in my experience, isolated from any authentic form of community or place of belonging. This deficit has influenced my life profoundly. It is out of this history that I found myself drawn into the fields of individual and group psychotherapy. In these two compelling fields I have found more personal authenticity, greater connections in one-to-one and group settings, as well as a professional community in which I can belong.

A second source of enthusiasm is my twenty-year involvement with the Evangelical Christian community and in particular their small groups. These groups (‘Home Groups’, ‘Cell Groups’, ‘Life Groups’ etc.) are frequently purported to be the environments for real-life expressions of faith and loving relationships; however, in my experience this is frequently not the case. Throughout my years of I involvement I held an intuitive sense that something was missing from our groups. As a leader in many of them I would try to remedy this problem by changing parts of the structure or the content but this left them still unsatisfying. However throughout my professional training, and the therapeutic groups that played such an integral part, I now understand what it was that I was seeking. It was a change of focus from the group’s ‘content’ to its ‘process’ that I was craving. *I came to discover that ‘what we were doing’ in a group was intimately connected with ‘how we were doing’ as a group.* In fact how we were doing in the group gave what we were doing much of its meaning and purpose. As I noticed this I also grieved the lack of

attention to process in my own family and at times I have considered certain groups to be ‘families of choice’ for myself (Bradshaw, 1990).

At the end of 2002 and my first ‘experiential training group’ at university I formed a group entirely dedicated to focusing on its own process. This group of ten men and women met consistently for two-and-a-half-hours each fortnight for more then five years. ‘The group’ was the most meaningful interpersonal experience of my life and one that changed me permanently. For this reason I have dedicated this dissertation to ‘the group’. The group-as-a-whole, as well as the richness that each individual added to my life is a powerful contributor to this research and my ongoing work with groups. The experience of being supported and healed by the therapeutic power of a group is tangible to me whenever I am a member or a leader, Yalom sums it up so well: “The healing ambiance of a good therapy group is almost tangible and good things happen when one enters into its aura” (2001a).

Therapeutic Groups in New Zealand

Currently there is no association specifically focused on group work in New Zealand. However there are plans for a group analytic association: The Association for Group Analysis NZ/Aotearoa (AGANZA). This is a professional body for group analytically trained therapists seeking membership, affiliation and the protection of practice standards. The new association resulted from the efforts of the Hakanoa Group. This group of colleagues, who have been meeting monthly since 2000, are part of the Group Analytic Society (London) and have been an important medium for making international contacts. The group’s aims are to provide professional development in group work for its members as well as providing opportunities for this in the professional community (Carson, Farrell, & Manning, 2008).

An unexpected observation in my research was noticing how group therapy values and practice guidelines bear direct relationships to the principles of the Treaty of Waitangi (Durie, 1998). The majority of therapeutic group guidelines

in my research assume the concepts of partnership, participation and protection in their own professional language. One example is the Practice Guidelines for Group Psychotherapy (American Group Psychotherapy Association, 2007), which makes these concepts very clear. The appropriateness of my research for Maori is unknown since it is beyond my scope to consult with Maori, but I hope it will be useful to both Maori and Pakeha who are seeking to facilitate effective relational, instructional or therapeutic small groups.

It is hoped that my findings will give some clear guidelines that can inform the training of group facilitators inside and outside of the professional community. Therapeutic group research may be of interest to groups seeking to make spiritual connections, to take action on social justice issues or to engage in various forms of recovery. These results will be available through publication of this dissertation.

Chapter Outline:

Chapter 1:	Describes the research methodology, data sources, inclusion and exclusion criteria and what was found.
Chapter 2:	Presents the genetic history and evolutionary themes of therapeutic groups.
Chapter 3:	Reviews the literature on research into therapeutic groups including therapeutic factors, leader variables, stages of group development, leader roles and FOCI and general leader interventions.
Chapter 4:	Presents a leader intervention synthesis of stages of group development, therapeutic factors and specific leader interventions.
Chapter 5:	In conclusion, a discussion on the findings of the research, its limitations and implications for practice, as well as suggestions for further research.

Chapter One

Methodology

The Research Question

This chapter details the research methods used to address the clinical question: *What does the research literature indicate is best practice in regards to leader interventions in therapeutic groups?* It briefly delineates the approach embarked on in conducting the research and outlines the decisions that were made in setting criteria for the literature search. The procedure for addressing ethical issues related to this research is also mentioned.

The Modified Systematic Literature Review

This research uses a modified systematic literature review to identify and synthesise the relevant literature. "A systematic review is a method of comprehensively identifying, critically appraising, summarising and attempting to reconcile the research evidence on a specific question" (Petticrew, 2001). Systematic reviews assist in managing and summarising large amounts research data to answer focused research questions (Dickson, 1999).

Systematic reviews have been used in the social sciences for decades to inform theory and practice (Petticrew & Roberts, 2005). The classic systematic literature review helps to clarify two important things. Firstly, they assist in determining whether findings across studies on a given subject are consistent, dependable, and may be generalised to broader applications. Secondly, they serve to identify gaps in the research literature to point the way forward in the development of future investigations.

Standard systematic reviews concentrate on gathering quantitative data. However in the therapeutic group field the vast majority of research is based on clinical observations, theory, interviews and self-report questionnaires. Therefore; the data within this type of research tends to be qualitative, hence the need for a modified systematic review (Milton, 2002). Goodheart (2006) claims research is a critical part of psychotherapeutic practices and one that informs clinical work; however psychotherapy “may never be able to technologize existence and develop complete certainty” (p. 162). The use of quantitative technology to examine therapeutic processes is very limited due to the subtleties and complexities of the field. Conceptualizing therapeutic group phenomena poses a major challenge to those concerned with group practice and research. While group research methods have become more sophisticated and some quantitative research is available, most of the evidence is of a qualitative nature.

Clinical Illustrations and Ethical Approval

A further variation from the classic systematic literature review is the incorporation of clinical vignettes to provide illustration. These illustrations are placed within this review in the form of possible leader verbal interventions. These are not taken from actual therapeutic group situations but are examples of the kinds of possible verbal interventions used by group leaders. Due to the fact that these are ‘possible’ rather then real clinical illustrations, ethics approval was not required.

Studies of Therapeutic Groups

‘Levels’ of evidence have been categorised to describe the scientific value of various types of research. The most highly regarded data in qualitative research are those with high degrees of complexity and detection found in grounded theory, phenomenology or ethnography (Kearnly, 2001). Those regarded as the lowest levels of evidence are findings restricted by the application of a fixed set of ideas without consideration of new insights and

modifications that may be made throughout the research procedure (Hylton, 2007).

Systematic reviews of randomised control trials are the quantitative studies which are the most highly regarded (in the mainstream research) and meet the highest levels of evidence. The studies judged as having the least reliability are those using opinion or description (Sackett, 2005).

There is an enormous amount of research in this body of literature covering the range of ‘levels’ of evidence. Methodologies ranging from simple case studies to complex sequential equation modelling are available and have become increasingly sophisticated. This is in keeping with the complexity of a system (group research) that attempts to track member-to-member, leader-to-member, and member-to-leader interactions (Betz, Wilbur & Wilbur, 1981). Consequently for this dissertation a range of studies has been collected within both the qualitative and quantitative research literature that include varying levels of evidence.

From an empirical point of view much of this evidence is limited, as case study and clinical observations provide subjective information about situation-specific issues and therefore cannot be generalised to broader applications (Grant & Giddings, 2002) but it does provide useful ideas. Within the qualitative framework this material is considered to be moderate level evidence. In the context of this research investigation – where clinicians in this field rely on these types of evidence to better inform their clinical work – it is clear that the strengths of case study material outweigh the weaknesses. Therefore this research, while having its limitations, also has its place in the contribution to effective therapeutic group leadership.

Inclusion/Exclusion Criteria

In addressing the issue of intervention parameters it was decided that only interventions that took place after the physical group itself commenced would be included. This was decided due to word limitations of the dissertation and to hold the focus of the research on the leaders' verbal in-group interventions as they pertain to the stages of group development. This excludes all leader interventions done prior to the group meeting such as composition decisions, pre-group preparation and any prior professional involvement. Also excluded were publications not in English, groups aimed at particular pathology, groups deemed to be not process-oriented and child or family therapy groups.

As this study was envisioned to be used in training therapeutic group leaders it has been limited to such research and therefore many important inter-member therapeutic factors have been excluded. Shared or co-leadership of therapeutic groups also remains outside the scope of this study. The focus of the work stays as close to the group leader's interventions in promoting therapeutic outcomes as possible. It is argued that in spite of these limitations a very rich exploration of leader interventions is possible.

Search Strategies and Data Collection

The following tables show the terms used to search for literature within the selected databases and catalogues. The tables also display the number of results found and the refined number of items that were relevant to the research question.

PsycINFO: Used because it is the largest catalogue of psychological literature available.

Pro-Quest: Yielded a small amount of research.

Auckland University of Technology Library: Shelves were hand-searched and provided a significant portion of the literature used.

Reference Lists: As literature was examined, reference lists were checked; articles that fit the research question were also collected.

PsycINFO and Pro-Quest

Search Terms	Results	Relevant
("group$ leader$" and "intervention$" and "research").	63	18
("group$ leader$" and "group$ psychotherapy" and "intervention$" and "research").	20	3
("person centred group$").	3	3
("person centered group$").	14	4
("process group$" and "leader$").	37	9
("reflective group$").	19	1
("psych$ education$ group$" and "leader$").	7	1
("encounter group$" and "leader$").	115	37
("experiential group$" and "leader$").	34	7
("closed group$" and "leader$").	10	2
("closed group$" and "group$ psychotherapy").	51	3
("private practice" and "group$ psychotherapy").	90	23
("group$ counsel$" and "leader$" and "research").	88	44
("T-group$" and "leader$").	78	18
("analytic group$" and "Leader$").	50	12
("group psychotherapy" and "research" and "leader$").	160	28
("growth group$" and "leader$").	56	14
("group$ leader$" and "intervention$").	256	19
("group$ leader$" and "group$ psychotherapy" and "intervention$").	93	11
("group$ leader$" and "group$ psychotherapy" and "intervention$").	614	28

("group psychotherapy" and "leader$").	1348	133
("training group$" and "leader$").	179	3

(Note: $ is a truncation symbol used to guide the search engine to include, for example, group/s, leader/s/ship, intervention/s etc.)

Summary

The PsycINFO database proved to be the largest source of relevant literature. In the remaining databases, specific searches attempting to locate data on therapeutic group leadership produced very little literature. More general searches relating to therapeutic group leadership were conducted including hand searching the AUT library and the libraries of other group therapists. Overall much more than sufficient research material was found to address the research question.

Chapter Two

History and Evolutionary Themes

"By the crowd they have been broken; by the crowd they shall be healed."
L. Cody Marsh (1931) Early Group Therapist

The therapeutic use of groups has a long and nonlinear history. This history draws on group research and group applications from diverse fields and covers an array of topics from skills-based psycho-education to psychoanalysis. Often the lines are blurred between disciplines. The boundaries between laboratory training groups, social-psychology, group-psychology, sociology and group-psychotherapy are amongst those most commonly crossed (Barlow, Burlingame & Fuhriman, 2000). In understanding the historical origins of therapeutic groups and the research tradition from which they emerged one can get a clearer picture of this field's further evolution. However, due to space limitations, from this large history I will briefly describe only major themes.

The now widespread use of therapeutic groups can trace its lineage back through two major streams in history. The first is Kurt Lewin (1938), the founder of the Research Centre for Group Dynamics. Lewin's early research groups were called "Sensitivity Training Laboratories" but were quickly dubbed "T" groups. These laboratory groups, originally three weeks long, were eventually held at the National Training Laboratories (NTL), which became a prestigious group training facility in the USA after Lewin's early death. The second historical stream comprised several post war innovators from the field of psychoanalysis (Slavson, Bion, Foulks and Wolf). These men began using group treatment in response to the large influx of those needing psychological assistance after World War II.

The work on 'group dynamics' by Kurt Lewin represents the earliest stages of small group research. Lewin and his followers had their roots firmly planted in

the social sciences and were strong believers in the dictum “No research without action; no action without research.” In contrast Slavson, Bion, Foulks and Wolf, as well as other innovators, were steeped in the philosophies and practices of psychoanalysis. However both became interested in using groups to further their professional work. These two streams, while continuing their separate development, would come together to produce a group movement and social phenomenon that profoundly changed the way that groups would be used as therapeutic agents.

The rise of humanistic philosophy, the influence of the ‘human potential’ movement and the general social upheaval of the 1960s would take both of their contributions to group work out of the laboratory and consulting room and into the lives of thousands. These two groups came together in the late 1950s when NTL trainers began to see the interrelatedness of social and clinical approaches to group dynamics. At that time deliberate efforts were made to bring more clinically oriented trainers to NTL, most of whom held either Freudian or Rogerian viewpoints. The stage was set for what would become a group movement named by Carl Rogers, “The Encounter Era” (1970). Through the late fifties and into the sixties thousands of people, most of whom were from the corporate business community, flocked to NTL as the reputation of the T-groups soared. Enormous amounts of energy and research went into the field of therapeutic small groups during this time as interest spread through the academic community and the new human development field.

While Lewin’s followers remained focused on group research, the new trainers began treating the groups more therapeutically. Quickly the language and interpretation of events became more psychodynamic and less sociological and Lewinian. In the end the focus of the T-groups became almost entirely about sharing impressions and gaining greater understanding of oneself and others (Highhouse, 2002).

As the popularity of the NTL groups grew, so did the temptations by trainers to take T-groups ‘on the road’ for greater financial reward. As this began to take place both the length and standards of the original T-group dropped as trainers succumbed to the pressure to make the groups shorter. Inevitably more and more untrained leaders around the United States were giving eager consumers ‘group experiences’. By the late 1960s the groups had become a part of the popular culture and the restraints of science were taken away. Eventually these groups would lose their credibility particularly amongst the professional community. ‘Encounter groups’ were sensationalised by the media and were called by some “group therapy for the well” (Yalom, 1995). At that time the professional therapeutic community began backing away and criticising the movement for being dangerous and out of control (Highhouse, 2002).

One of the positive aspects of this tumultuous time from a research perspective was that the field had a unified name and body of research. Having turned their backs on a therapeutic movement that was becoming embarrassing, researchers also turned their backs on the terms “encounter” and “T-group”. Having lost its unifying terms the field has, in the last thirty years, splintered and lost a central way of organizing research findings. The splintered literature is described by Yalom:

> *“Encounter group” is a rough, inexact generic term that encompasses a great variety of forms and has many aliases: human relations groups, training groups, T-groups, sensitivity groups, personal growth groups, marathon groups, human potential groups, sensory awareness groups, basic encounter groups, and experiential groups” (Yalom, 2005, p. 526).*

To Yalom’s list I would add process groups, client-centred groups, training groups, reflective groups, counselling groups and in some cases psycho-educational groups. The encounter group and the scientific tradition from which it evolved became the source of the most sophisticated small group research ever attempted (Yalom, 1973, 1995; Highhouse, 2002).

Consequently much of the research that I will cite throughout this work has its origins in the Lewinian and encounter group traditions (Barlow, Burlingame & Fuhriman, 2000). It is in this therapeutic group history that this dissertation finds its origins; it is hoped that this new research will contribute positively to a long and rich research tradition.

The efficacy of group psychotherapy is well established in the empirical literature and reviews of this modality point out that it reliably exceeds gains made by minimal treatment and wait-list control groups (McRoberts, Burlingame & Hoag, 1998). Consequently efficacy will not be a focus in this dissertation. Most theory building occurred during the height of the group movement when group dynamics and sociometry models were being developed. However evolutionary themes continue to weave their way through the literature as group research has moved from concerns about leadership dynamics (Lieberman, Yalom & Miles, 1973), to member's interactions, therapeutic factors (Yalom, 1975), developmental stages (Tuckman & Jensen, 1977) and specific leader interventions.

The influence of the early pioneers on modern therapeutic group theory and practice can hardly be overstated. Nor can the need for modern practitioners and researchers to continue in their same innovative spirit. It is from these adventurous and ground-breaking group leaders that much of my own inspiration is drawn to continue in their dictum of both research and practice.

This chapter has established the history and evolutionary themes in therapeutic group research and practice. What has been stated places this dissertation on a conceptual and developmental timeline. The following chapters will bring into focus research on leader interventions and how they might be placed into a developmental framework, bringing them into greater clarity and utility.

Chapter Three

Literature Review

"The intimate healing ambiance of a good therapy group is almost tangible and good things occur when one enters into its aura."

Irvin Yalom "The Gift of Therapy"

Introduction

In this chapter I will define the type of groups that are the focus of this research. I will then introduce therapeutic group theory, therapeutic factors, leader variables, stages of group development and review general leader interventions. Because this is such a large literature this summary is selective and covers a very broad range.

Defining Therapeutic Groups

The type of groups being researched in this dissertation I will simply call "therapeutic groups." Therapeutic process groups act as training cultures expressly organised to examine the interpersonal field of the group in search of psychosocial insights and reparative relational experiences for its members (Highhouse, 2002). Therapeutic process groups serve as social microcosms that mirror larger issues inherent in society (Lewin, 1938).

These groups are unified by several common elements: they range from five to twenty members so that they are large enough to have group like interactions and small enough to allow all members to participate in intimate interactions not afforded in larger groups (Rutan, Stone & Shay, 2007). These groups distinguish themselves from basic support groups by their use of 'here-and-now' interactions as a primary therapeutic tool. They value self-disclosure, emotional honesty, exploration of unconscious dynamics; the putting aside of social roles, interpersonal feedback, self-awareness, and the practicing new interpersonal skills (Kaplan & Sadock, 1993). According to

Shultz (1973) these types of groups are most effective when group members are able to say anything freely and are able to take responsibility for what they say. When the point is reached where members are willing to have anything they are known to the group, it is said to be heading in the right direction (Yalom, 2005).

The definition provided by Siegfried H. Foulkes and E. James Anthony (1957) is one that I prefer because of its clarity and simplicity. They defined their psychotherapeutic groups in terms of three factors: 1) that the group relies on verbal communication; 2) that the individual member is the object of the treatment and; 3) that the group itself is the main therapeutic agency. “The group is treated for the sake of its individual members, and for no other reason” (p.36 - 37).

It is noteworthy that in the vast majority of the empirical research on group leadership researchers fail to define the groups they are studying. They are typically labelled by some generic description like “personal growth groups”, (Morran, Robison & Stockton, 1985; Kivlighan, Jauquet, Hardie, Francis & Hershberger, 1993; Stockton, Morran & Clark, 2004), “semistructured groups”, (Kivlighan & Tarrant, 2001) “any type of counselling or therapy group”, (Johnson, Burlingame, Olsen, Davies & Gleave, 2005) “counselling groups”, (Pan & Lin, 2004) “interpersonal growth group” (Kivlighan, Multon & Brossart, 1996.) This appears to be a significant problem in the research literature because studies are not strictly comparable. Perhaps this problem exists because of the absence of a unifying name for these types of groups since the end of the encounter group movement (Yalom, 1995). It seems to be taken for granted that these groups who operate under many different names share the common elements as defined above (Betz, Wilbur & Wilbur, 1981). While this remains an unresolved problem in the field I have concluded that the research is sufficiently comparable to merit inclusion in my systematic review.

Therapeutic Group Theory

A therapeutic group is understood theoretically as being something more then the sum of its parts. They are viewed as entities in themselves (Vannicelli, 1989). While it is the individuals that are the focus of treatment it is not only the leader who is providing treatment but the group-as-a-whole (Agazarian & Gantt, 2000; Marziali & Blum, 1994). “The theory of group therapy assumes that individuals are always presenting the salient elements of their personalities and their conflicts in the group; thus, when possible, attention is focused on the in-group action, where the elements are more available for direct analysis” (Rutan, Stone & Shay, 2007, p.179).

There are three major theoretical models in therapeutic group work: intrapersonal, interpersonal and integrative (group-as-a-whole). These three models have a significant impact on the kind of interventions group leaders choose and will be described in detail in this chapter (Kaplan & Sadock, 1993). These three conceptualisations in their pure form attempt to accomplish similar objectives although they differ greatly in their theoretical approach (Klein, Bernard & Singer, 1992). However they are very often blended in clinical practice.

In each of these groups the leader, and then other group members, learn to identify unconscious feelings, themes and behaviours in the group and at individual levels (Rutan, Stone & Shay, 2007). Paying attention to unconscious themes involves the scrutiny of verbal and non-verbal behaviours such as seating arrangements, facial expressions, tone of voice, posture, avoided relationships or topics and attendance, all of which can be clues to the manifestation of unconscious material (Shaffer & Galinsky, 1974).

Therapeutic Factors

The term “therapeutic factors” has become common currency for group theorists and leaders since Corsini & Rosenberg (1955) published the first major review of this literature. From that time until now the concept of therapeutic factors has been a central feature of group theory (Kaplan &

Sadock, 1993). The concept of “therapeutic factors” as defined by Crouch, Bloch, and Wanlass (1994) means “elements of group therapy that contribute to improvement in a patient’s condition and can be a function of the actions of the group therapist, the other group members, and the patient himself” (p.270). The most widely accepted (AGPA Guidelines 2008, p.41) set of therapeutic factors was first formulated by Irvin Yalom in 1975. They are presented here from his latest work, “The Theory and Practice of Group Psychotherapy” (2005).

1. Instillation of hope: Group members come to realise the efficacy of the therapeutic group.
2. Universality: Group members come to recognize that other members share similar feelings and problems.
3. Imparting information
4. Altruism: Group members improve their self concept through extending help to others.
5. The corrective recapitulation of the primary family group: Members have the opportunity to experience reparative relationships and corrective emotional experiences.
6. Development of socializing techniques
7. Imitative behaviour
8. Interpersonal learning: Group members receive feedback and gain insight about their “standard interpersonal impact” on others.
9. Group cohesiveness: The feelings of acceptance, belonging, warmth, trust and ‘groupishness’ experienced by the members.
10. Catharsis (regression in the service of the ego): Group members have the opportunity to release strong repressed, denied or minimised feelings about past and present experiences.

11. Existential factors: Group members together face and accept the problems inherent in human existence – responsibility, isolation, death and meaning making.

Significant research has been conducted on the factors with recent reviews citing hundreds of studies (Yalom, 2005). Kivlighan and Tarrant's (2001) research highlights the leader's need to focus on group cohesion rather then individual member work. Pan and Lin's (2004) rank order findings place cohesiveness and instillation of hope as the most important therapeutic factors. Kivlighan, Multon and Brossart's (1996) work notes the profound place of catharsis and interpersonal learning in group work. And finally Yalom's (2005) own research placed interpersonal learning, catharsis and cohesion at the very top of what makes groups therapeutic. Consequently therapeutic factors are an essential part of any model of leader intervention and will be used to form an intervention synthesis in chapter four. The leader as therapeutic factor is discussed in the next section.

Leader Variables

Studies in this category attempt to manipulate or measure some leader attitude or behaviour explicitly or report on a unique leader effect. Interestingly, most findings are based on secondary or post hoc results and there is a striking absence of studies that are designed to examine leader effects directly or primarily (Yalom, 2005). The literature offers little specific assistance to leaders in organizing and assigning priorities to group phenomenon (Masson & Jacobs, 1980; Rutan, Stone & Shay, 2007). In this domain therapeutic impact is defined by the group members' perceptions of how they have been helped by what the leader did or did not do (Kivlighan, Multon & Brossart, 1996).

There is a vast body of literature on leader variables. Due to space limitations three key studies are used here to summarise the research. These studies were chosen for their empirical rigor, critique and the utility of their outcomes.

Kivligan, Multon & Brossart's (1996) principle components analysis revealed four underlying leader variables. These variables were labelled: emotional awareness-insight; relationship climate; other versus self focus; and problem solving-behaviour change. This research suggests that leaders conceptualise helpful session impacts as relational and task, with task impacts being of two different types: those involving acquiring awareness and insight into problems, and those involving defining and working through problems.

In 1973, Leiberman, Yalom and Miles performed the most extensive controlled research inquiry into the effectiveness of groups that purport to change behaviour and personality. The study measured the outcomes and the relationship between outcome, leader technique, and group process variables.

> *"There was no standard encounter group experience; there were eighteen different groups, each with a distinct culture, each offering a different experience, and each with very different outcomes. In some groups, almost every member underwent some positive change with no one suffering injury; in other groups, not a single member benefited, and one was fortunate to remain unchanged". (Yalom, 1995, p. 497)*

It was quickly discovered that it was leader behaviour rather than ideological school that determined member outcomes. A factor analysis of a large number of leader behaviour variables resulted in four basic leadership functions:

1. Emotional Stimulation: (Challenging, confronting, risk-taking and high self-disclosure).
2. Caring: (Support, affection, praise, warmth, and acceptance).
3. Meaning Attribution: (Explaining, clarifying, and providing a cognitive framework).
4. Executive Function: (Setting rules, goals, group norms, managing time).

The most effective leaders were those who gave just enough stimulation and executive function while at the same time giving high levels of caring and meaning making.

> *"Caring and meaning attribution had a linear relationship to positive outcome: the higher the caring and the higher the meaning attribution, the higher the positive outcome. The other two functions, emotional stimulation and executive function, had a curvilinear relationship to outcome – the rule of the golden mean: too much or too little of this leader behaviour resulted in lower positive outcome." (Yalom, 1995, p. 498)*

From my review of the literature this study appears to act as the gold standard in therapeutic group research, as its findings dominate the research landscape. The practice guidelines of the American Group Psychotherapy Association (AGPA, 2008) affirm that "Though this work was done more than 30 years ago, no better schema has been developed for thinking about the different matters to which a group therapist must attend" (p. 41).

However an investigation of the Lieberman et al. (1973) study of the 26 group leader characteristics by Tinsley Roth & Lease (1989) found no support for the factor structure that was reported. In their research an eight-factor solution was adopted: cognitive direction, affective direction, behavioural direction, non-verbal exercises, nurturant attractiveness, charismatic expertness, group functioning and personal functioning. This study attempts to critique the methods used by Lieberman et al. in its use of leader self-report rather then group-member and observer ratings. However it seems highly questionable to me that that these findings would be clearer in that they further distance the research from its primary data, which in my view, is its members' own assessments of what was most helpful about their group experience. It is my opinion that this study did not provide a more useful way of looking at the Leiberman et al. results.

Each of these studies demonstrates in its own way the group's need for the leader to be attuned to feelings and thinking – relationship/process and task/function. Highlighted also is the need for flexibility in the leaders

communication and behaviour (Kivlighan, Flohr, Proudman, Mullison & Francis, 1992). This body of research also reveals the complexity involved in studying and quantifying therapeutic leader interactions (Ward, 2006).

Stages of Group Development

Following naturally from therapeutic factors and leader variables are group developmental stages. Group development theory is introduced and its importance is established. Significantly influencing all of a group leader's clinical decisions is the group's stages of development (Tuckman & Jensen, 1977).

In a recent survey of group textbooks and guidelines (Klein, Bernard & Singer, 1992; Kaplan & Sadock, 1993; Corey & Corey, 1997; Donigian & Malnati, 1997; Whitaker, 2001; Yalom, 2005; AGPA Guidelines, 2007; Rutan, Stone & Shay, 2007) the author found that all discuss some stage model of group development and all appear to use a version of Tuckman & Jensen's (1977) stages: forming, storming, norming, performing and adjourning. Burn (2004) refers to this model as "the most famous sequential-stage theory" (p. 28). I describe it here and will further use it as the core framework of an intervention synthesis in chapter four.

Five Stages of Group Development:

1. Forming: The forming stage refers to the initial phase of gathering together, exchanging information, identifying commonalities. In these tentative interactions concerns over ambiguity, power, self disclosure and the search for meaning in the group are usually hidden (Rogers, 1970). The focus at this time is on dependency and inclusion (Bion, 1961).
2. Storming: At this stage dissatisfaction begins to develop as each member faces their autonomy conflict with the group (Bradshaw, 1990). This is sometimes referred to as the differentiation or fight-flight stage (Bion, 1961). Power and control concerns are now manifest in the group and displays of rebellion or aggression are common (Fall & Wejnert, 2005).

3. Norming: The norming phase of development is characterised by the growth of cohesion. Within this stage group members have stabilised their individual autonomy conflicts well enough that they can feel accepted by the group and maintain their individuality (Donigian & Killacky, 1999).
4. Performing: In this phase members develop the capacity to be both supportive and confrontational, creating an environment in which interpersonal patterns can be identified and challenged (Cloud & Townsend, 2003). Members by now are assuming responsibility for their therapeutic work, being present to the work of other group members and the group-as-a-whole climate (Egan, 1973).
5. Adjourning: Termination represents the final stage of the group's life and often brings on a wide range of feelings for members. Feelings as disparate as joy and dread can often be experienced simultaneously as the group prepares to end (Rutan, Stone & Shay, 2007). Defensive attempts at denial, minimisation, or flight behaviour alternate with periods of productive work (Kaplan & Sadock, 1993). Termination also brings up the existential themes of death, isolation, responsibility and meaning; themes that members and leaders often unconsciously collude to avoid (May, 1981).

This is an extremely brief description due to the limits of this paper. See Tuckman & Jensen (1977) for a full description.

Clinical observation and experience in this literature place considerable weight on the Tuckman & Jensen (1977) model. However, for example, Rational Emotive Behavioural Therapy (REBT) and Solution Focused Therapy (SFT) attempt to start their groups at the 'performing' stage by using specific techniques like pre-screening and goal setting measures to ensure group members start their therapeutic work immediately (Donigian & Hulse-Killacky, 1999; Heimberg & Becker, 2002). In addition REBT's focus on the 'performing' group does not allow groups to "flounder in a nondirective manner, nor to acquire a prejudice in favour of becoming absorbed in its members' early history, in their "family" relationship to each other, in their attachment to the leader, or in their obsessive-compulsive interest in the group's process itself"

(Ellis, published by Donigian & Hulse-Killacky, 1999). In my view these highly directive approaches hold an important place in the world of therapeutic groups, however their lack of attention to process dynamics limits them significantly.[1]

In my experience, monitoring a group's developmental stages remains one of the most effective ways for a group leader to track the health and direction of a group. Furthermore leader activity and interventions are significantly influenced by group stages of development (Rutan, Stone & Shay, 2007).

Roles & FOCI of the Group Leader: General Interventions

In this section I list what I am calling 'general leader interventions.' These are in distinction from the 'specific leader interventions' I will discuss in chapter four. By general interventions I mean simply the 'roles' and 'foci' of the leader. For heuristic purposes I have used the leadership dimensions described by Rutan, Stone and Shay in their work "Psychodynamic Group Psychotherapy" (2007). Rutan, Stone and Shay's leader "roles and foci" dimensions capture masterfully and accessibly the polarities of possible interventions faced by any group leader during any stage of a group's development. In spite of this the model could be viewed by some as overly analytical or even microscopic in its approach. The three leader roles in this model are considered in parallel.

Leader Roles:

Roles are described on three continuums:

Activity ←----------→ Non-activity

Transparency ←----------→ Opaqueness

[1] Also Yalom (1985) makes use of pre-group preparation sessions to educate new group members how to best make use of the group, a practice for which there is considerable evidence of support (Magyar & Apostal, 1977; McCanne, 1977; Masson & Jacobs, 1980; Paritzky & Magoon, 1982; Morran & Hulse, 1984; Kivlighan, Jauquet, Hardie, Francis & Hershberger, 1993; Kivlighan, Multon & Brossart, 1996; Roback, 2000; Rutan, Stone & Shay, 2007; Stockton, Morran & Clark, 2004). While there are those who see goals and structure as an intrusion into the therapeutic process, this author included, they appear to be the minority voice (Rogers, 1970; Schultz, 1973).

Gratification ←----------→ Frustration

Activity versus Non-activity

A leader's 'executive function' (activity-non-activity) implies their taking responsibility for setting rules, goals, norms, managing time, duration, pacing, intervening, termination etc (Lieberman et al.1973). Both Yalom (2005) and Anderson (1985) cite 'the rule of the golden mean' in regards to executive function: too much or too little of this leader behaviour resulted in lower positive outcomes. Using too little executive function results in a *laissez-faire* group which flounders and too much control creates a stilted, overly structured authoritarian group (p.272).

The literature suggests that neophyte group leaders are often prone to positions of exaggerated activity or inactivity in the face of the emotional demands of a therapeutic group (Yalom, 1966, 2005). To defend against the overwhelming amount of data as well as perceived loss of control, leaders are tempted to either abdicate their responsibility altogether and allow the group to flounder, or they may attempt to deny or control the complexity of the work by using an authoritarian style of leadership (Ward, 1985 p.59).

In Kivlighan, Flohr, Proudman, Mullison & Francis' 1992 empirical research on "Good verses bad group counselling sessions" it was found that leader flexibility played the greatest role in members rating the sessions as 'good'. The results suggested that no particular leader position correlated with 'bad' session outcomes but the leader's adoption of any rigid position within the group matrix or with any individual. Specifically, good sessions were characterised by the group leader holding a less extreme position in the areas of executive function and caring dimensions. It was seen that in the good sessions the leader's behaviour seemed more variable. The leader would sometimes exert executive control and sometimes sit back. This flexibility was noted both across the group, with individual members and at different times during a single session. This impressive piece of research found that leader

flexibility contributed more to ‘good’ session outcomes then did even session content, thus confirming the clinical observations of some in the field (Vannicelli, 1989; Marziali, 1994).

Transparency versus Opaqueness

The continuum from transparency to opaqueness in therapeutic group leadership has been the subject of great debate. This continuum runs the gamut from an extreme analytic position of the “blank screen” to the leader as group member – “nothing more”, of the encounter tradition (Schultz, 1973). The main objection to leader transparency emanates from the traditional analytic belief that the primary therapeutic factor is the resolution of client leader transference (Jones & Butman, 1991). This view holds that the leader must remain opaque to foster transference feelings toward them. The counter position argues that a more involved, personal leadership style facilitates member self-disclosure and does not prevent transference (Yalom, 2005).

Some relational psychoanalysts call for the spontaneous expression of the leader’s subjectivity, stating that it is in the client’s best interest that leaders be seen as they really are (Dalenberg, 1998). Obfuscation by the group leader is viewed as undermining the member’s chances to gain a sense of accuracy of their own perceptions in the interpersonal world (Wright, 2004). Opaqueness is then viewed as an attempt to defend against the powerful and often disturbing feelings stimulated by unrestrained primitive transferences (Wright, 2004, p. 242). However some self-psychologists (Bacal, 1985), contend that leader subjectivity needs to be “set aside” for some group members until they are developmentally more advanced and able to cope with this level of disclosure (Klein, Bernard & Singer, 1992). Morran, Robison and Stockton’s (1985) research also points out the importance of timing for leader disclosure in the group’s stages of development. Much more could be said about this important issue if space permitted.

Gratification versus Frustration

Typically a balance between gratification and frustration is sought by group leaders to create what has come to be known as “optimal frustration” (Rutan, Stone & Shay 2007; Marziali & Blum, 1994). This theoretical position is built on the premise that frustration creates a regressive pull in the group which in turn works to uncover unconscious affects (Yalom, 1980). Once brought into awareness these distorted unresolved feelings and defensive responses can be worked through (Donigian & Killacky, 1999). However if the leader fosters too much frustration the group may be hindered from becoming a cohesive working entity but on the contrary in an overly gratified group their may be insufficient anxiety to produce change (Marziali & Blum, 1994). The requirement of frustration means that the leader in their role is called upon to deny themselves and their group members any gratification which does not further the therapeutic work. Equally, this requirement means that the leader abstains from any frustration of their members which does not advance the therapeutic task.

One of the group leader’s difficult tasks is to help build cognitive resources and cohesion to make it possible for the group members to tolerate the therapeutic experience (Billow, 2005). This is achieved partially through leader attunement to gratification and frustration dynamics in the group. Yalom’s “emotional stimulation” leadership function rests on this frustration-gratification continuum (1995). Emotional stimulation encompasses a leader’s challenging, confronting and risk-taking functions. As with ‘executive function’ the rule of the golden mean applies. The goal in working on this continuum is then to allow optimal frustration for each member and the-group-as-a-whole as well as not to interfere with the members’ abilities to deal with their feelings and relationships (Rutan, Stone & Shay, 2007). While this is the psychodynamic point of view, and I feel one of its major strengths, the literature outside of this perspective does not seem to address gratification and frustration dynamics directly.

Leader Foci:

These dimensions describe with clarity the types of leader interventions that can be generalized and are applicable across theoretical group approaches. The six continua on the focus dimension can be considered as a hierarchy with the leaders attention first focused on the past here-and-now future continuum, then on the group-as-a-whole interpersonal individual continuum, and so on. Note this hierarchy is one of sequential attention rather than of therapeutic importance. For example cohesion – which is repeatedly found in research as the primary therapeutic factor in groups – is placed in the last leader foci under Insight versus Relationship.

Past ←----------(Here-and-now)----------→ Future

Group-as-a-Whole ←--------(Interpersonal)---------→ Individual

(and subgroup)

In-Group ←----------→ Out-of-Group

Affect ←---------- → Cognition

Process ←----------→ Content

Insight ←----------→ Relationship

(Corrective Emotional Experience)

<u>Past-(Here and Now)-Future</u>

Past

According to Yalom (2005) two important “pasts” develop in the life of a group, the history of each member and the group’s shared history. Group members discuss their past and others serve as witnesses to each member’s history assisting them in creating a more coherent story (Wright, 2004). Effective therapeutic groups generate further recollection of past memories and in turn further modify the member’s reconstitution of the past (Weiss, 1993).

The second “past” which develops is the group’s shared history. Yalom (1995) describes the leader in their roles as “historians” and “time keepers.” Therapeutic groups “develop oral legacies” that can be recounted as therapeutic interventions in themselves (Rutan, Stone & Shay, 2007 p. 58). One of a leader’s functions in their commentary on the group’s process is reflections on the group’s development (Egan, 1970). Focusing on the group’s history helps to give it “groupishness” or promotes cohesion (Rogers, 1970). Other more cognitively oriented leaders have little interest in the past and work to keep group members focused on future concerns in a way which I believe thwarts the development of vital cohesion (Donigian & Killacky, 1999).

Interpretation and Transference Analysis

Crucial to the reconstitution of the past for members is the leader’s ability to make therapeutic use of transference and countertransference (Buchele, 1997). Group leaders observe and interpret transference making links for members to their past, present (outside the group), here-and-now toward individuals (in the group), the group as a whole, and to the leader. Therapeutic groups have the advantage of providing a forum where a variety of transferential perspectives and consequent interactions can emerge for examination (Klein, Bernard & Singer 1992; Rutan, Stone & Shay, 2007; Vannicelli, 1989).

Group-as-a-whole transference is a unique aspect of therapeutic groups (Hyde, 1991). Theoretical perspectives on groups vary in the degree that they focus on group-as-a-whole phenomena but most agree that it is an important level of transference which adds to the complexity of working with groups and to the depth of therapeutic change for group members (Kieffer, 1997). However group-as-a-whole interpretations can be viewed by intrapersonalists as confusing for individual therapeutic work with the leader or as distracting by others who see transference as irrational (Donigian & Killacky, 1999).

Countertransference

The emotional responses of the leader are viewed by most as fundamental components of successful facilitation (Yalom, 2001). Leaders can address the past by using their own countertransference which may include feelings toward individual members, subgroups and the group-as-a-whole (Kieffer, 1997). These feelings are believed to offer important clues to what is happening in the here-and-now of the group (Marziali & Blum, 1994).

Many view a group leader's relationship as being with the group as an entity in itself (Donigian & Malnati, 1997; Agazarian & Gantt, 2000). Powerful group level forces can pressure and/or inhibit a leader into or from action (Yalom, 1995). From this view point the leader's function is to use their countertransference in the service of the group therapeutic relationship (Whitaker, 2001). Again, however, leaders whose focus is singularly directed on out-of-the-group behaviour modification may make no use of countertransference (Heimberg & Becker, 2002) potentially to the detriment of their groups.

Here-and-now

Perhaps the most unique and arguably the most important feature of therapeutic groups is their focus on the here-and-now (Yalom, 2005). Yalom defines the 'here-and-now' as: the nature of the relationship between interacting individuals (1995). It is believed that the degree to which the leader can focus the therapeutic group on the here-and-now it increases its power and effectiveness (Rutan, Stone & Shay, 2007). This assumption however is based much more on clinical experience and tradition then quantitative research.

The emphasis on the here-and-now stems from the conceptualisation of the group as a social microcosm (Yalom, 2005). Therapeutic groups act like specialised societies "that specifically attempt to reconcile the paradox of individual adaptation and collective assimilation to help patients with their

relational problems" (Kaplan & Sadock, 1993 p.700). It is presumed that in interpersonally focused groups members will recreate the same interpersonal dynamics and problems as they have in their life outside of the group (Yalom, 2005).

This interpersonalist perspective is strongly contrasted by modalities favouring cognitive restructuring and behavioural management (Donigian & Killacky, 1999). Reality therapists, for example, prioritise leader involvement and developing positive and responsible out-of-group behaviours rather then focusing on the here-and-now of the group's process (Shaffer & Galinsky, 1974; Heimberg & Becker, 2002).

However working in the here-and-now is seen by interpersonalist and integrative theorists as the primary task of the group leader (Yalom, 1995; Rutan, Stone & Shay, 2007). The first stage in the here-and-now process is an experiential one: the group members live in the here-and-now; they develop strong feelings and opinions toward the other group members, the leader and the group itself (Rutan, Stone & Shay, 2007).

Yet this here-and-now focus will quickly reach the limits of its usefulness without a second stage, which is commentary on the process itself (Kaplan & Sadock, 1993). Research outcomes are clear on this matter, for positive change to take place in group members the group must transcend the emotional and experiential and apply itself to the integration and understanding of that experience (Leiberman et al. 1973; Morran, Robison & Stockton, 1985; Tinsley, Roth & Lease, 1989; Pan & Lin, 2004). If only the first stage is experienced by the group it will still be intense and members may feel deeply moved but it is likely to be an "evanescent experience" (Yalom, 1995; Kivlighan & Tarrant, 2001). This seems to be the mistake made by many of the early encounter group leaders (Highhouse, 2002). Conversely if only the second stage of the here-and-now process is experienced the group quickly degenerates into an intellectual exercise an error made by many cognitively

focused groups (Shaffer & Galinsky, 1974; Donigian & Killacky, 1999; Rutan, Stone & Shay, 2007).

Future

It is assumed in the literature that all therapeutic interventions throughout a group's life are in the service of the future of its members (Pan & Lin, 2004). The large research literature on member goal setting addresses this area but has been excluded as explained in chapter 2. More will be said about the attention to member transfer of learning and future focus in chapter 4.

Group-as-a-whole-(Interpersonal)-Individual

Intrapersonal/Individual Groups

Intrapersonalists stress the centrality of individual psychodynamics in therapeutic groups and see the group environment as essentially a replica of the one to one treatment model (Kaplan & Sadock, 1993). Intrapersonalists conclude that the pathway to therapeutic change is found in the analysis of individual defences and resistances and in working them through (Buchele, 1997).

This view, however, is challenged by the persuasive research of Kivlighan & Tarrant (2001) which concludes that group members will increase their active involvement with the group when leaders refrain from doing individual therapeutic work. According to this research unlike individual therapy group leaders need to de-emphasize their relationship with individual group members and concentrate on maintaining a cohesive group atmosphere.

Interpersonal Groups

For interpersonalists the critical therapeutic elements are found in the group's ability to offer corrective emotional experiences for members as well as a safe environment where life's universal problems can be validated, new self-

understandings integrated and new behaviours practiced (Wright, 2004; Shaffer & Galinsky, 1974). From this perspective the leader plays the roles of “technical expert” and “model setting participant” who works to generate a cohesive group culture where self-disclosure and authentic member interactions predominate (Yalom, 2005, p.123).

It is hypothesised that it is the group members themselves who, in their interactions, set in motion the therapeutic factors described earlier (Rutan, Stone & Shay, 2007). Yalom's (1995) hypothesis that group climate mediates the group's relationship with the leader has been tested (Kivlighan & Tarrant, 2001). Individual therapeutic work in this study was negatively related to treatment benefit and safe environment was positively related to an increasingly active and engaged climate, which was directly related to treatment benefit. The importance of leaders focusing on group processes rather than individual change has also been highlighted (Kivlighan & Tarrant, 2001; Johnson, Burlingame, Olson, Davies & Gleave, 2005). In this research an active and engaged group climate uniquely predicted member rated benefit.

Integrative Groups

The integrative model views the group-as-a-whole as the central focus of the leader’s attention and the source of therapeutic change (Whitaker, 2001). When this view is held in its extreme the integrative leader will be inclined to relate to the group-as-a-whole exclusively (Kaplan & Sadock, 1993).

Whitaker’s “group focal conflict theory” (2001) gives a thorough conceptualisation of the integrative approach. It is theorised that at any stage of the group’s life there are two opposing forces that can be discerned: a disturbing motive or wish and a reactive motive or fear. According to this theory the group-as-a-whole is continuously making efforts to manage those conflicting forces; this is called “the group solution”. It is believed that these forces constitute a shared unconscious conflict called “the group focal conflict”

(Whitaker, 2001). From this perspective groups become therapeutic when they change from operating on restrictive solutions – those that perpetuate unconscious wishes and fears – to the use of enabling solutions which express them openly (Kaplan & Sadock, 1993). Yalom, from an interpersonalist perspective, minimises and critiques the traditional group-as-a-whole approach and suggests a simplifying principle: that the purpose of a group-as-a-whole interpretation be only to remove an obstruction to the progress of the entire group (Yalom, 2005).

Modifications have been made to group focal conflict theory over the years but it has not gained wide acceptance perhaps because of the rigidity there appears to be around group themes and group-as-a-whole interpretations (Kaplan & Sadock, 1993). I would agree with Kaplan and Sadock that this view seems to become fixated on the group-as-a-whole, therefore taking away from the purpose of therapeutic groups, which is the treatment of individuals. A noted exception here would be the work of family therapy.

The crucial differences among these three therapeutic group models are: how and when leaders decide to involve group members; how central the leader sees themselves to the group; and the level of here-and-now or there-and-then focus (Kaplan & Sadock, 1993). On this matter I find the research of the interpersonalist's convincing. This perspective keeps the focus on the group itself as the healing agent for its members while refraining from undertaking individual therapy with an audience or becoming overly preoccupied with group-as-a-whole dynamics.

In-Group versus Out-of-group

The same principles apply for the in-group out-of-group continuum as for the past-present-future continuum. Leaders of modern therapeutic groups usually welcome, as well as scrutinize, both in-group and out-of-group material (Rutan, Stone & Shay, 2007). In my review I found no research studying the effects of this continuum.

Affect versus Cognition

My research brings me to the conclusion that the affect-cognition continuum more then any other polarises group leadership approaches. This seems to reflect the 'split' in human experiencing between feelings and thinking (Bradshaw, 1990) that undoubtedly translates into this field as well.

Leading therapeutic groups requires a great deal of complex thinking and ability to tolerate ambiguity (Ward, 2006). Equally, the emotional holding and containing function of the group leader needs to be well developed so that powerful expressions of affect do not become contagion and can be therapeutic (Whitiker, 2001). Yalom comments on his 1973 research with Lieberman et al.

> *"The importance of meaning attribution received powerful support from another source. When members were asked to report (at the end of each session) the most significant event of a meeting and the reason for its significance, we found that those members who gained from the experience were far more likely to report incidents of cognitive integration. (Even so revered an activity as self-disclosure bore little relationship to change unless it was accompanied by intellectual insight)" (Yalom, 1995 p. 499.)*

What takes place in an effective group experience seems to be a combination of feeling and understanding. Research conducted by Kivlighan, Multon & Brossarts (1996) revealed that the most robust type of helpful session impacts were those moments in which a group member gains an important personal insight through 'knowing' and 'experiencing' their own feelings. However leaders who emphasise the cognitive polarity of group intervention tend to work specifically to challenge thinking and behaviour and I believe miss out on many of the other motivations dating back from early history that underlie human behaviour (Heimberg & Becker, 2002; Shaffer & Galinsky, 1974).

Leader Self-Talk and Intentions

Recently important research attention is being given to the leader's own cognitive experiences in and leading up to group sessions. However, due to space limitations and as the focus of this paper is on 'leader verbal interventions', this research remains outside of the scope of this study.

Process versus Content

On this continuum process can be understood as a counterpoint to content: where content refers to the specific words being spoken by group members during an interaction, process asks the question; "what do these words, the way they were spoken and the nature of the discussion, tell about the interpersonal relationship of the group members?" (Rutan, Stone & Shay, 2007)

Feedback as both Content and Process

Early T-group theorists considered feedback the *sine qua non* of group learning (Kaplan & Sadock, 1993). Feedback takes place when group members or the leader share their personal perspectives regarding a member's behaviour with that member, allowing the person to see themselves as others do (Egan, 1973; Schultz, 1973; Kivlighan, Jauquet, Hardie, Francis & Hershberger, 1993; Toth & Erwin, 1998).

Feedback research studies the effectiveness of feedback by studying: who is giving the feedback (leader or member), its valance (positive or negative) and at what stage in the life of the group is it being delivered (Davies, Burlingame, Johnson, Gleave & Barlow, 2008). According to Morran, Robinson, & Stockton (1985) research points to the conclusion that group leaders initially give more effective feedback than group members but that this difference fades over time. The strongest outcomes are the findings that negative feedback was less effectively given and less accepted then positive feedback. With the assumed importance of negative feedback for the growth of group members, leaders will need to focus on process interventions that make the content of

negative feedback easier to give and receive (Morran & Hulse, 1984; Shoemaker, 1987; Toth & Erwin, 1998).

Insight versus Relationship

Therapeutic process groups act as training cultures expressly organised to examine the interpersonal field of the group in search of psychosocial insights and reparative relational experiences for its members (Kaplan & Sadock, 1993; Rutan & Stone, 2001). Answers to interpersonal problems in these environments are typically "grown rather then given" and insight is viewed by many as a relational process (Fay, 2006 personal communication). This continuum captures the polarising concepts of; "the healing is in the relationship" (Yalom, 2001) espoused by the process-oriented relational approaches and "the truth shall make you free" (John 8:32, KJV) focus of the insight-oriented and cognitive behavioural traditions.

Most theoretical schools conclude in differing ways that change takes place when truth is presented in relationship (Crabb, 1987). Billow (2006) describes two competing sets of human needs that he calls "truth needs" and "relational/safety needs". He proposes that humans are by nature "truth driven" or as Yalom puts it they are "meaning seeking creatures" (Yalom 2001, p.133).

> *"Tschuschke and Dies (1994) on the basis of a review of 135 studies, found that leader structure and especially meaning attribution show a consistent positive relationship to group member outcome. Meaning attribution involves providing concepts for the members to use in understanding their individual experience of group events. A positive relationship with the leader was also related to group member outcome."*

Flanked by the need for truth is the equally important need for relational safety (Marziali & Blum, 1994). Billow submits that group members resist, rebel or refuse emerging truth because of developmental limitations in their capacity to process it. In order to process, members require the safety of the emotional

holding and containing function of the leader as well as the group. Relationship and trust needs must be met before significant truth can be tolerated by the group or by individual members (Billow, 2005). From this relational point of view the primary therapeutic task is not to gain insight but to offer group members a safe environment and enough genuine concern so their inevitable effects on the group can be examined and processed (Wright, 2004 p.242; Klein, Bernard & Singer, 1992 p.169). Billow refers to this leader function as one of "titrating the truth" (Billow, 2006). The leader's fundamental task is then to protect the group from too much truth, or too little (Billow, 2003.)

Cohesion

Amongst the eleven therapeutic factors cohesion (relational/safety) is regarded in the empirical research and from clinical observations as the foundation of therapeutic groups (Donigian & Killacky, 1999). There is an enormous amount of literature on cohesion which can only be briefly summarised here. Essentially cohesiveness expresses the member's feeling that they are in a special group with common goals and a mutual commitment to understand and work with each other (Rutan, Stone & Shay, 2007). Research suggests that cohesiveness is stronger when it is deepened over time (Anderson, 1985; Yalom, 2005 p.136; Kivlighan & Tarrant, 2001). It has been noted that cohesiveness tends to be high in groups where leaders use structured exercises to 'jump-start' first meetings but this quickly decreases over time and restricts member outcomes (Anderson, 1985 p.276). Yalom is very clear in his view regarding cohesion:

> *"The more important the members consider the group, the more effective it becomes. I believe that the ideal therapeutic condition is present when clients consider their therapy group meeting to be the most important event of the week. The therapist is well advised to reinforce this belief in any available manner." (Yalom, 2005 p.136)*

There is strong evidence for cohesion as the major therapeutic factor in successful groups (Lieberman at el, 1973; MacKenzie, 1998; Kivlighan, Flohr, Proudman, Mullison & Francis, 1992; Kivlighan & Tarrant 2001; Pan & Lin, 2004) however high levels of cohesiveness can also serve as a defensive function (Whitaker, 2001). Miller (1976) in his review of the early T-groups cited the phenomenon of “cohesive-self-defeating-in-groups”. Miller reminds group leaders that the purpose of therapeutic groups is to affect member’s attitudes and behaviours inside the group in ways that will produce change outside the group. Miller notes that if such changes are based only on ‘identification’ with the cohesive ‘in-group’ atmosphere that transfer of learning to outside situations will be highly unlikely. Miller argues that only when members move through the stages of ‘compliance’ and ‘identification’ with the leader to ‘internalization’ of new attitudes and behaviours will they be able to transfer their learning to outside situations without needing the group (Miller, 1976; Anderson, 1985; Billow, 2005; Yalom, 2005).

I resonate strongly with Miller’s concept of the self-defeating-cohesive-in-group. I have personally experienced several groups who have slipped into self-defeating cohesion and whose progress in my opinion was significantly stunted. One of these groups over time found ways to reflect on this impediment and worked it through while others did not. When what is arguably the most important therapeutic factor for a group begins to work against the purpose of the group, its leader needs to have the courage to ‘rock the boat’ and create a therapeutic disruption to the group’s defensive cohesion.

Summary

In this chapter therapeutic groups were defined. Therapeutic group theory, therapeutic factors, leader variables and stages of group development were also introduced. Also in this chapter general leader interventions have been listed and relevant research associated to them was discussed. Rutan, Stone and Shay's (2007) framework was used to structure the review of the literature and the ground work has been laid for understanding the specific interventions to be addressed in chapter 4.

Chapter Four

Intervention Synthesis

"Interventions often have a kind of affective 'shimmer' which is part of the intervention itself. The accompanying 'affective message' may be as important as the content – sometimes, more important."

Dorothy Stock Whitaker – "Using Groups to Help People"

Introduction:

The central task of this chapter is to present an intervention synthesis composed of specific leader verbal interventions. This consists of what group leaders say, when in the life of the group these verbal interventions are used, and what the literature suggests may be best practice. Leader interventions are illustrated and the impact of group stages of development on interventions is considered for maximising their effectiveness.

The second task of this chapter is to bring the "therapeutic factors" and "leader variables" research into greater clinical accessibility. In these extremely important but clinically cumbersome bodies of research lie the answer to the proposed research question: *What does the research literature indicate is best practice in regards to leader interventions in therapeutic groups?*

This leadership intervention synthesis harmonises the core components of therapeutic group theory reviewed in chapter three. They are as follows: (1) Stages of development:

(See discussion in chapter three p. 29-31)

- Forming
- Storming

- Norming
- Performing
- Adjourning

(2) Group therapeutic factors:

(See discussion in chapter three p. 25-27)

- Instillation of hope
- Universality
- Imparting information
- Altruism
- Corrective recapitulation of the primary family group
- Development of socializing techniques
- Imitative behaviour
- Interpersonal learning
- Group cohesiveness
- Catharsis
- Existential factors

(3) Leader variables, (Yalom, 2005, Rutan's et al., 2007):

(See discussion in chapter three p. 27-29)

- Emotional Stimulation
- Caring
- Meaning Attribution
- Executive Function

Roles and Foci:

(See discussion in chapter three p. 31-48)

- Roles: Activity←→ non-activity
- Transparency ←→ opaqueness
- Gratification←→ frustration
- FOCI: Past←(here-and-now)→future
- Group-as-a-whole←(interpersonal)→individual
- In-group←→out-of-group
- Affect←→cognition
- Process←→content
- Insight←→relationship

(4) Theoretical group models:

(See discussion in chapter three p. 37-40)

- Intrapersonal
- Interpersonal
- Integrative

(5) To group modality influenced leader interventions:

- Client Centered Therapy (CCT)
- Rational Emotive Behavioural Therapy (REBT)
- Interpersonal Psychotherapy (IP)
- Systems Centered Therapy (SCT)
- Psychodynamic/Analytic Therapy (P/AT)

In practice these conceptualisations combine and overlap, however they are presented in this framework to give greater clarity for thinking in the profession about the group leader role and the potential group leader. It may help at this point to remind ourselves that what we know empirically about therapeutic group effectiveness is that outcome is much more highly correlated with an attachment to a cohesive group than with the application of any specific techniques (McWilliams, 2004). However work has been done to integrate leader interventions. Donigian & Killacky, (1999) conceived of a framework that begins with group “critical incidents” but this work degenerates into “chaotic eclecticism” (Jones & Butman, 1991 p. 384). Also Waldo (1985) suggests a fascinating synthesis that starts with “group concerns” and ends with therapeutic factors. In my opinion this work fails to provide leaders with clear intervention strategies and gives only vague suggestions. While Waldo did include group developmental stages they were not central but instead he chose to make group “concerns” the focus, thus limiting his “Curative Factor Framework”.

This author has not found a framework which allows group leaders to focus their attention on to the pertinent therapeutic factors as they directly relate to stages of group development. The synthesis presented here provides leaders of any type of therapeutic group with a powerful integrated framework enabling them to conceptualise basic treatment plans, intervention strategies and more concretely bridge theory and clinical practice.

A Brief Word on Modalities

Group leaders generally believe that there choice of interventions will to a large degree depend upon the modality that guides their perceptions of a given group event. Subsequently they assume their theoretical orientation greatly influences the technique they employ to manage that event (Donigian & Killacky, 1999, p.361). I am suggesting that the specifics of interventions independent of modality are more important. While the modality variable is significant I have excluded any thorough examination of modalities. Instead I have focused on an integrated developmental framework and concentrated on

interventions. Modalities have been selected for their contrast value only. The selected modalities in my observation represent divergent ends of the 'leader variable continuums' to highlight the leader roles and foci. For example the activity←→ non-activity continuum is vividly contrasted by REBT's very active approach and CCT's non-directive stance.

In the rest of this chapter I am presenting my intervention framework. Every component in this framework is taken directly from the literature but how it has been placed together is my conceptualisation. What is offered represents only an illustration of possible leader interventions but they are a key sample. As well, interventions aligned with a particular modality are only typical but by no means exclusive to that approach. Obviously the discussion could be greatly enlarged upon but space limitations prevent that. This sample of interventions could be usefully expanded upon in subsequent work should the synthesis prove useful for other leaders.

Leader Intervention Framework

(See outline in appendix 1)

First Developmental Stage: Forming

Pertinent Therapeutic Factor/s: Universality, Altruism, Instillation of hope.

Related Leader Variables: Executive function, Activity ←→ Non-activity, Transparency ←→ Opaqueness, In-Group←→Out-of-Group.

From my review of the literature and my experience in leading groups these therapeutic factors and leader variables find their natural place in the forming stage of the group's life. Hope for change is needed and belief in both the group's process and the leader as a useful authority (Corey & Corey, 1997).

Modality One: Client Centered Therapy. This modality is well known for representing the transparent end of the Transparency ←→ Opaqueness continuum and for its minimal use of "executive function" (Corey & Corey, 1997; Rodgers, 1970, 1971).

Group Models:

Intrapersonal Intervention/s:

Many initial interventions serve the purpose of normalising (universality) the new group member's experiences (Rogers, 1971). *"I get the feeling that it's a little scary for you starting the group tonight. I usually feel a little anxious myself. This is an issue worth exploring."* (Transparency ←→ Opaqueness)

Interpersonal Intervention/s:

Linking interventions can instil hope and can be some of the initial building blocks for later cohesion (Donigian & Killacky, 1999). *"It sounds like the two of you have come to the group for similar reasons – you may have a good chance of working together on this issue."* (Activity ←→ Non-activity) Silences can be useful or troubling (Brown, 2008). An intervention for an unproductive silence at the early stage of the group might be: *"I wonder what some of you have been thinking about or feeling during the silence that you have not said?'* (Executive function)

Integrative Intervention/s:

Addressing the group-as-a-whole at the start of the first session (Rogers, 1970), *"This is a group with extraordinary freedom and it will become whatever we make of it; so let's get started."* Or simply; *"How should we start?"* (Executive function)

Modality Two: Rational Emotive Behavioural Therapy is known for its purposeful use of the 'executive function' and heavy weighting on the 'activity' and 'out of group' ends of these two continuums (Donigian & Killacky, 1999).

Group Models:

Intrapersonal Intervention/s:

Particularly in a short term REBT group a directive focus can ensure that members use the time productively (Ellis in Donigian & Killacky, 1999). *"Brendan, I want you to bring in the details of the problems you are having with your partner and we will all work on them together. But most importantly we will be very interested in your problems* ***about*** *your problems."* (In-Group←→Out-of-Group)

Interpersonal Intervention/s:

By focusing on member problems rather then group processes the leader can act more as teacher and director (Shaffer & Galinsky, 1974). *"Now what we are going to do in these group therapy sessions, is to focus in on any of the things that trouble you – or, in REBT terms you choose to trouble yourself about."* (Activity ←→ Non-activity)

Integrative Intervention/s:

When leaders want group members to be highly active and thinking about the work they have come to the group to do they can start by being very active themselves (Ellis as cited in Donigian & Killacky, 1999). *"Let me explain my main reasons in forming this group – I understand that all of you are here because you would like to improve your emotional health and I believe that REBT will bring you the results you hope for…" "We will not be interested in the group process itself but in your real life problems outside the group."* (Executive function) This may be as close to an integrative intervention as REBT would allow.

Second Developmental Stage: Storming

Pertinent Therapeutic Factors: Development of socialising techniques.

Related Leader Variables: Emotional Activation, Gratification←→ Frustration, Process←→Content

From my research, the above therapeutic factor and leader variables need to be central in a leaders thinking about interventions at the storming stage (Corey & Corey, 1997; Donigian & Malnati, 1997).

Modality One: Interpersonal Psychotherapy is known for its attention to inter-member processes. Its focus is on the process side of the Process←→Content continuum and belief in the group as the major therapeutic mechanism (Sullivan, 1955; Yalom, 2005).

Group Models:

Intrapersonal Intervention/s:

Process illumination can be intrapersonal, for example: *"I notice that you seem to tense up when Wendy and Craig start disagreeing with each other. Can you say what's happening for you inside?"* (Process←→Content) (Yalom, 1995) However intrapersonal comments can include others indirectly. *"You know I think you are right Helen, it is difficult at times for people to directly deal with conflict and sometimes an intermediary helps, as you just did."* (Gratification←→ Frustration) Leaders can model the personalisation of speech through the use of "I" statements. The direct communication of interpersonal messages works to create a group culture of intrapersonal ownership of feelings and opinions (Ward, 1985).

Interpersonal Intervention/s:

The target of interpersonal interventions can be toward sub groups (Leszcz, 2008) *"I can't help but noticing that there are several more men in the group then women and we have not spoken about that, I wonder how the women are feeling?"* (Emotional Activation) Toward group developmental issues (Fall & Wejnert, 2005), *"The gist of this discussion seems to be about who is going to be in control."* (Process←→Content) Or in the service of reframing a stuck situation: *"It seems like the group has been trying to get Ryan to talk about his feelings but we still haven't discussed just why it is so important to everyone?"* (Process←→Content)

Integrative Intervention/s:

Group-as-a-whole interventions can give permission for new interpersonal behaviour, *"The group seems frustrated tonight and I am imagining the anger may be directed towards me for not providing more direction."* (Emotional Activation) They can also challenge emerging group norms that may be counter-therapeutic, *"Do we have an unspoken rule in our group about not being able to express anger toward the leader?"* (Process←→Content) (Corey & Corey, 1997) Also giving a 'read-out' of group events can help the group trace the roots of a current issue. *"When we first started today there was a long silence and then Craig started to talk about his PhD project and then…."* (Process←→Content) Including in the 'read-out' a comment on what has not happened helps to focus the group on its own process (Whitaker, 2001). *"In the last hour we have spoken about everyone in the group but so far no one has mentioned Steve being absent tonight."* (Process←→Content)

Modality Two: Psychodynamic/Analytic therapy is recognized for its concentration on the historic content end of the Process←→Content continuum. Also its use of 'optimal frustration' for its regressive pull and 'emotional activation' on the Gratification←→ Frustration continuum is well known (Brown & Zinkin, 2000; Pines, 2000).

Group Models:

Intrapersonal Intervention/s:

Interventions linking people to the past, *"Katherine, do David and Elizabeth remind you of anyone when they vocally disagree like they are now?"* (Process←→Content) can also serve to prepare them to reconsider the present (Pines, 2000). *"Do you know what you might need from the rest of the group that could make this angry exchange a different experience for you?"* (Emotional Activation)

Interpersonal Intervention/s:

Well timed interventions gratify as well as frustrate (Pines, 2000), *"It feels like there might be a power struggle between the men for who is going to 'act' as the co-leader for this group – does anyone else feel that?"* (Gratification←→ Frustration)

Integrative Intervention/s:

Facilitating feedback to a group member about the interpersonal consequences of their behaviour can be good modelling for the group at this stage (Cloud & Townsend, 2003). *"How did the rest of the group feel, just now when David criticised Helen so directly?"* Or *"Craig, what happened just now as a result of the advice you offered to Wendy?"* (Process←→Content)

Silence in therapeutic groups is a common phenomenon with many possible forms, uses and meanings, and leaders can view it as important communication (Brown, 2008). Simply remaining silent can therapeutically frustrate the groups implied request for more structure. On the contrary after a period of time silence can become counterproductive and take on a life of its own becoming too intense for some members to manage (Brown, 2008). *"I am wondering how this silence is feeling to the group right now?"* (Gratification←→ Frustration)

Third Developmental Stage: Norming

Pertinent Therapeutic Factor/s: Cohesiveness, Imitative behaviour, Imparting information.

Related Leader Variables: Caring, Affect←→Cognition

I place these factors and variables in the norming stage where feelings of greater safety are beginning to develop allowing the first stages of work to start i.e. imitative behaviour and imparting information (Corey & Corey, 1997).

Modality One: Systems Centered Therapy is known for it attention to imparting information about the systemic nature of affect, cognition and behaviour. Also its concern for system cohesion is well noted (Agazarian & Gantt, 2000, Donigian & Malnati, 1997).

Group Models:

Intrapersonal Intervention/s:

Interpersonal work that incorporates a systems metaphor allows for a variety of identifications in the group (Agazarian & Gantt, 2000). *"Steve, I was aware of feeling like you got left behind by the group last session – as if the bus pulled away with out you. I wondered if you had thought about it during the week."* (Caring)

Interpersonal Intervention/s:

Here the leader includes themself in a subgroup systems intervention (Marziali & Blum, 1994). *"The three of us seem to be communicating a lot differently this week and I think the rest of the group looks relieved."* (Affect←→Cognition) And here communicates trust in the group as a system (Agazarian, 2006). *"I think this is an issue that the other members of this group can handle without my input."* (Caring)

Integrative Intervention/s:

Leaders take responsibility for naming an avoided issue. *"Everyone seems concerned in some way about our last session. Let's get those concerns out in the open and see where they take us."* (Caring) Interventions can reframe a difficult session into one that could produce cohesion (Agazarian & Gantt, 2000). *"It looks like the group feels as if it has run a marathon (referring to the last session) and is trying to decide if it's going to need to run another one or if we rest together now as exhausted but successful fellow runners."* (Caring)

Modality Two: Client Centered Therapy is perhaps the best known modality in regards to its 'caring' function and empathic attunement focus on the Affect←→Cognition continuum (Donigian & Killacky, 1999).

Group Models:

Intrapersonal Intervention/s:

Here the leader is taking generalized talking and asking individual members to take ownership of what they are saying (Donigian & Killacky, 1999). *"Though sometimes the group speaks of all this in general terms, of what everybody does in certain situations, I suspect the group members are speaking very much for themselves."* (Affect←→Cognition)

Interpersonal Intervention/s:

Interventions can demonstrate useful self disclosure and model giving negative feedback while still accepting a group member and trusting in the power of the group (Rogers, 1970). *"Kevin, like some of the other group members I am feeling frustrated with our relationship in that I have let you into my feelings but do not feel that has been reciprocated. However I believe in you and in the group's ability to work on its own process."* (Caring)

Integrative Intervention/s:

In congruence with client centered practice the group is reminded of its freedom and its leader's role (Rogers, 1970). *"As you know this group is choosing its own direction and can go where ever it wishes to. I will do my best to help the group remain in the present with regard to the way we are experiencing each other but that is all."* (Caring)

Fourth Developmental Stage: Performing

Pertinent Therapeutic Factor/s: Corrective recapitulation of the primary family experience, Catharsis, Interpersonal learning/self understanding.

Related Leader Variables: Meaning Attribution, Past←(Here-and-Now)→Future, Insight←→Relationship (Corrective Emotional Experience)

At this stage the core work of the group is being done. The above factors are in my view the most demanding on members and leader, a stage only

achieved after passing through the previous stages of development (Corey & Corey, 1997; Donigian & Malnati, 1997).

Modality One: Interpersonal Psychotherapy is known for its interest in the potential for groups to provide 'corrective emotional experiences' through the recapitulation of the primary family and its use of catharsis (Rutan, Stone & Shay, 2007; Yalom, 2005).

Group Models:

Intrapersonal Intervention/s:

A leader checking back in with a group member for clarity while acknowledging empathic limitations is demonstrated here (Klein, Bernard & Singer, 1992). *"Brenda I am not sure that you are feeling understood by me. I have never been through the trauma you have just described but I want to really hear you. Would you be willing to try again?"* (Insight←→Relationship) (Corrective Emotional Experience)

Interpersonal Intervention/s:

Here the leader is helping to make content and interpersonal links (Yalom, 2005). *"Wendy has taken a big risk just now by disclosing her real reason for being in the group, Elizabeth you shared a simular issue could you give Wendy some feedback?"* (Insight←→Relationship) (Corrective Emotional Experience)

Integrative Intervention/s:

Often leaders will need to bring the attention back to a member who has been emotionally deserted. This intervention also assists the 'performing' stage of the group (Egan, 1973). *"I noticed that we all quickly moved away from the intense feelings that Justin brought up and kind of left him hanging. This is*

very vulnerable stuff. Would anyone be willing to say what their reactions were?" (Insight←→Relationship) (Corrective Emotional Experience)

A "joining the group" intervention involves sharing a personal opinion or feeling about a shared dilemma (Whitaker, 2001). *"You know this issue concerns me as well particularly about how we might handle this in the group."* (Past←(Here-and-Now)→Future)

Modality Two: Psychodynamic/Analytic theory is known for its attention to 'meaning attribution' of the primary family experience, catharsis and the focus on greater self understanding on the Past←(Here-and-now)→Future, Insight←→Relationship continuums (Klein, Bernard & Singer, 1992).

Group Models:

Intrapersonal Intervention/s:

Here the leader intervenes on behalf of a group member in offering protection and expressing confidence in their ability to find a solution in the future. *"Brendan I think you will find a way to tell Ryan how you feel when he says something hurtful."* (Meaning Attribution) Or offering needed recognition to a member in this 'performing' stage, for example: "*That's a new behaviour for you isn't it? Up until now you haven't been able to do this"*. (Past←(Here-and-Now)→Future) Or *"It's good to hear you be so direct with how you are really feeling"* (Meaning Attribution) (Yalom, 2005).

Interpersonal Intervention/s:

Leaders can model giving useful feedback, for example: *"When you say or do that, I feel …"* (Meaning Attribution) rather then making evaluations or offering interpretations of others feelings or motives (Rosenberg, 2003).

Integrative Intervention/s:

Bringing ‘there-and-then’ stories into the ‘here-and-now’ can keep the group working in the ‘performing’ stage. *“We have been talking about difficult things that happened in our early family relationships. I wonder if any of those things are happening here in this group.”* (Insight←→Relationship) (Corrective Emotional Experience) *Or: ”We have spent a considerable amount of time talking about the mixed feelings people have about their parents. This issue is important to practically everyone, are each of you aware of the particular work you are doing in this area?”* (Past←(Here-and-Now)→Future) (Vannicelli, 1989)

Here the leader is asking the group to state what is already known but heretofore has been unspoken (Whitaker, 2001). *“I think everyone can see that Bruce and Kate are spending time together outside the group and yet we do not speak of it, how is the group feeling about this?”* (Past←(Here-and-Now)→Future)

Fifth Developmental Stage: Adjourning

Pertinent Therapeutic Factor/s: Existential factors.

In my opinion the existential factors are a predictable, appropriate and therapeutic focus in the adjourning stage of the group (Corey & Corey, 1997).

Related Leader Variables: At this point all leader variables have been employed.

Modality One: Again, Interpersonal Psychotherapy is known for its interest in the potential for groups to provide ‘corrective emotional experiences’ through the recapitulation of the primary family and its use of catharsis (Rutan, Stone & Shay, 2007).

Group Models:

Intrapersonal Intervention/s:

Members are often unaware of their feelings about endings. Well placed interventions can work to make these feelings conscious. *"Ryan I am aware that we are coming to the end of our group and also that you seemed to have grown distant. Are you conscious of this or am I misreading you?"* (Whitaker, 2000)

Interpersonal Intervention/s:

At this point in the group leaders can take the opportunity to attend to the transfer of learning into the member's out-of-the-group life (Miller, 1976; Yalom, 2005). *"This is an important time in the group's life where we work to consolidate the gains each of you has made. Let's begin to articulate these so they won't get lost in saying our good-byes." Or simply; "How will your lives be different after having been to this group?"*

Integrative Intervention/s:

In this intervention a metaphor for what could be a wider group issue is explored. *"It seems that each of you in one way or another is talking about relationship break-ups do you think partly it is the group that is being talked about – we only have two sessions left"* (Rutan, Stone & Shay, 2007).

Modality Two: Psychodynamic/Analytic therapy of the existential school focuses on the issues of: death (endings), meaning (who am I now), isolation (leaving the group behind) and responsibility (taking charge of my life now with out the group's help), (Yalom, 1980, 2001, 2005; May, 1981).

Group Models:

Intrapersonal Intervention/s:

Interventions that check on member support systems are important here (Marziali & Blum, 1994). *"I know that this course of therapy has been both a struggle and rewarding for you Katherine, who will be supporting you in your*

gains after we conclude?" Endings are often emotionally avoided so interventions that enquire about this are useful (Pines, 2000). *"Can some of you say how you normally do endings?" "Would you like to end this group differently then you normally would?" "What would that look like?"*

Interpersonal Intervention/s:

Here the leader is in their 'meaning attribution' role. *"Would some of you be willing to say what this group has come to mean to you?"* or *"Could some of you offer specific feedback to others about how they will be remembered by you?"* (Yalom, 1980)

Integrative Intervention/s:

Naming the unmentionable or avoided existential issues is often important at this last 'death' stage of the group – "being-through-having-been" (Erikson, 1950). *"This is a time in the group's life that I do not look forward to but one that we should not ignore. We will be ending after two more meetings and I wonder where the group is with this issue?"* (Yalom, 1980)

Conclusion

What I have achieved in this model is an integration of the therapeutic factors, leader variables and group stages of development synthesised for greater clarity and utility. I demonstrate how the stages of group development are crucial in making maximum therapeutic use of the leader variables, therapeutic factors and in making decisions about appropriate interventions. I also note that group models bear a significant effect on the way a leader will approach the group or its individual members. Also illustrated are the central differences amongst selected modalities, used to compare and contrast intervention possibilities, in how and when leaders decide to involve group members or group-as-a-whole processes. For example the REBT group leader demonstrated the most explicit form of structuring, whereas the client-centered and psychodynamic leaders demonstrated the least (Donigian & Killacky, 1999, p. 339-340).

According to Billow:

> *"Ultimately, what holds a group together is the therapist's ever expanding understanding of the psychic reality of the group and its members, and the therapist's success in interesting others in reaching and deepening such understanding, however painful and unwelcome." (Billow, 2003 p.42)*

My clinical experience in using this model demonstrates to me its usefulness in understanding the "psychic reality" (refer to the quote above) of the groups I lead and by using this model I have succeeded in interesting group members in deepening their self-understanding. This synthesis has broadened the scope of my intervention possibilities and intensified my developmental understanding of group processes. Both of which I believe have increased the therapeutic impact of the groups that I lead. However it remains untested empirically. The challenge it seems for any leader intervention synthesis, this one included, is in bridging therapeutic group theory and practice. Specifically, that is, the rich but cumbersome accumulation of theory with the practicalities of clinical work. An evidence based group therapy practice is truly a difficult ideal to attain. However I believe that the model presented here has brought me much closer to this ideal.

Chapter Five

Discussion & Conclusions

Summary and Overall Conclusions

Yalom (2005) describes the therapeutic group as a “way station” and a “dress rehearsal” for the work that can only be done with family and friends. While therapeutic groups are no replacement for outside family and friends groups can be a powerful environment for this sort of “dress rehearsal” to take place. My interest in therapeutic groups arose from the detachment and lack of relational authenticity in my own developmental history. Into this deficit came my Christian faith and small group involvement. Following on from this many year’s later I undertook my professional training and participated in the therapeutic groups that were such an important part of my development. My interest was almost immediate and starting my first group seemed natural. Upon the ending of my initial training group I had already decided to write my masters dissertation on therapeutic groups and now this dream is complete. A modified systematic literature review has been used for this task and this vast literature has been examined. Severe limitations have had to be put on the breadth of the topic to make the literature manageable. Also therapeutic group history and evolutionary themes have been outlined. This dissertation has given a review of the literature on group leader interventions and of the validating research, which is extant. What has been developed is a model that integrates the therapeutic factors, leader variables and demonstrates the importance of group developmental stages and their place in creating a framework for specific leader interventions.

The therapeutic factors have been taken from the traditional list format and placed within this developmental framework. It is understood that while all of the therapeutic factors can be relevant at any stage of a group’s development,

according to this author, they are most likely to be pertinent to the stages in which they have been placed. This, I believe, creates an important and effective bridge from theory into clinical practice. Furthermore for heuristic purposes five modalities were used to compare and contrast leader variables and the possible corresponding leader involvement with the group. Successful leadership from the perspective of this model involves empathic attunement to the group's overall development and to its psychological as well as sociological needs. Or as Billow (2005) states it the group's "truth needs" and "relational safety needs" (p. 3)

The literature reviewed in chapter 3 affirms that effective group leaders have a vast storehouse of ideas about what 'might be going on' in their therapeutic group at any given moment (Kivlighan & Quigley, 1991). However what the literature also points out is that the most effective leaders are those who are comfortable being incorrect about any of their ideas and interventions and who can remain flexible, accepting, connected and most of all interested in what's happening in their group (Wright, 2004). It appears from the research that the more concepts/ideas/theories a leader has about what 'might be happening' in the group and what they can do with it, the easier it is for them to let go of interpretations and interventions that have been rejected or are just not working (Kivlighan, Markin, Stahl & Salahuddin, 2007; Nutt-Williams & Hill, 1996). It is this storehouse of possibilities that my intervention synthesis attempts to capture (without degenerating into chaotic eclecticism) allowing leaders to remain emotionally flexible knowing they have many other options for thinking about and responding to group events (Bradshaw, 1990). What constitutes effective group leadership from the perspective of the literature that I have reviewed and my model is emotional and intellectual flexibility and connectedness. I believe this is accomplished when leaders learn to bring their interventions into synchrony with the group and its members by following the therapeutic relationship and making coherent ties from one topic to another and from one member's frame of reference to another (Friedlander, Thibodeau, Nichols, Tucker & Snyder, 1985). Effective leaders give attention to the group and its member's stages of development as well as have

confidence in the therapeutic factors and the power of the group's process to help its members (Yalom, 2005).

Implications for Clinical Practice

The benefit of this review for my clinical practice is apparent to me in my increased ability to stay attuned to the cognitive and affective needs of the groups I am leading. I have found that my capability as a leader to conceptualise a group's stage of development and change my interventions accordingly has improved significantly. Researching general leader interventions has broadened my clinical skills while at the same time thinking developmentally has sharpened the interventions that I use and has allowed me to become more precise and deliberate.

Because I am often working with groups within the Christian tradition, where members, in my experience, tend to value harmony over interpersonal honesty, Miller's (1976) critique of 'cohesive-self-defeating-in-groups' was illuminating. His notion of cohesion becoming a defensive function has been particularly instructive. I found his writing could be used as a critique of my leadership style, general group disposition, Christian sub-culture and was practical for my clinical work.

The unstructured group convention that my leadership style has emerged from has also been challenged by my review of the literature. Some of my core assumptions have been critiqued and I am left with choices between a leadership style that I have become comfortable with and evidence from the literature. Specifically I have been challenged to reassess my approach on all three of Rutan, Stone, & Shay's, (2007) leader 'roles': 'activity verses non-activity', 'transparency verses opaqueness' and 'gratification versus frustration'. I have come to realise that my leadership style in these three

areas reflected the approach of my early mentors much more then the available research.

Furthermore this study could also be highly valuable for those interested in training experienced or novice group leaders. Trainers specifically seeking a developmentally oriented intervention synthesis thoroughly grounded in modern group theory for their work with leaders will also benefit from this research.

Limitations of this Study

Due to the enormity of the literature on therapeutic group leadership and the limitations of space, it was necessary to exclude many important leadership issues such as co-leadership, conjoint therapy, pre-group preparation, leader directed goal setting and the transfer of training. Unfortunately these exclusions limit the value of the review for those seeking to understand these important leadership issues.

Another limitation is in the failure of the literature to provide adequate definition for the groups being studied. As noted earlier, they are typically labelled generically. While in my opinion the research was of comparable quality to merit systematic review it is not strictly comparable.

Future Directions

The literature offers little specific assistance to leaders in organising and assigning priorities to group phenomena. Leadership variables or principles are what have been relied upon to make clinical decisions on a myriad of group interactions. Perhaps the most important recommendation of this dissertation is that more research be conducted to provide group leaders with models that assist them in organising and prioritising clinical group data.

This dissertation on group leadership will be useful for furthering research on group leadership interventions, particularly those interested in forming developmental approaches. Studies further assessing the association between therapeutic factors and stages of group development or the relative strength of therapeutic factors in relation to group leader interventions warrant further investigation.

Conclusion

At its conception stage, several university staff members who consulted on the idea for this research thought that it would not possible because the literature would simply be too large. They were correct about its size. Chapter 3 alone was pruned from over twenty thousand words to five thousand. However the reader can judge whether the compromises made for brevity to fulfil the requirements of the word limit have left a worthwhile piece of work. In my view it has been a valuable experience and an extremely useful end result.

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Appendix 1

Developmental Stage, Therapeutic Factors & Leader Variables Synthesis

First Developmental Stage: Forming

Pertinent Therapeutic Factor/s: Universality, Altruism, Instillation of hope

Related Leader Variables: Executive function, Activity ←→ Non-activity, Transparency ←→ Opaqueness, In-Group←→Out-of-Group

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Second Developmental Stage: Storming

Pertinent Therapeutic Factor/s: Development of socialising techniques.

Related Leader Variables: Emotional activation, Gratification ←→ Frustration, Process←→Content

⬇

Third Developmental Stage: Norming

Pertinent Therapeutic Factor/s: Cohesiveness, Imitative behaviour, Imparting information.

Related Leader Variables: Caring, Affect←→Cognition

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Fourth Developmental Stage: Performing

Pertinent Therapeutic Factor/s: Corrective recapitulation of the primary family experience, Catharsis, Interpersonal learning/self understanding.

Related Leader Variables: Meaning Attribution, Past←(Here-and-now)→Future, Insight←→Relationship (Corrective Emotional Experience)

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Fifth Developmental Stage: Adjourning

Pertinent Therapeutic Factor/s: Existential factors.