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Bridging the Gap Between Research and Practice: Involving Group Therapists in the Development of Clinically Relevant Research Questions and Methodologies

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BRIDGING THE GAP BETWEEN RESEARCH AND PRACTICE:

INVOLVING GROUP THERAPISTS IN THE DEVELOPMENT OF

CLINICALLY RELEVANT RESEARCH QUESTIONS AND METHODOLOGIES

by

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A DISSERTATION

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

FIGURES

TABLES

ABSTRACT

In 1970 Irvin Yalom published his seminal work on group therapy, in which he presented an eleven-factor theory of psychotherapy group process. Since 1970, most research on group therapeutic factors has investigated their relative importance, depending on the therapeutic setting or modality, client population, or "developmental stage" of the group. However some authors have protested that there are methodological, definitional, or content-oriented problems with extant therapeutic factor research. The present author links these three issues by understanding them as symptoms of a research-practice gap. In order to explore the limitations of existing research and consider potential remedies, she conducted a one-time focus group of seven experienced group therapists. Interpreting the results of this study, she suggests that the scientific research paradigm, frequently espoused by psychotherapy researchers, is inappropriate to the study of group therapy, and she offers suggestions for alternative modes of inquiry.

CHAPTER I: INTRODUCTION

Although various forms of psychological helping have existed for millennia, within fields such as medicine and religion, psychotherapy as a formalized and specialized intervention has been around for only about a century, almost coterminous with the discipline of psychology, itself only a little more than a century old. Many are surprised to learn that group psychotherapy, as a sub-discipline of psychotherapy, also has a history of nearly one hundred years. The very interesting academic and theoretical aspects of psychology notwithstanding, it seems as if, from the very beginning, psychology has been oriented towards helping others in distress and coming to an increased understanding of the processes that promote psychological healing.

My own path toward researching group psychotherapy is marked by many unforeseen twists and turns. With a Bachelors of Science in Mathematics, few friends or family anticipated that I would pursue graduate training in clinical psychology. However life's big questions, such as how to find meaning in life and discover who one is and wishes to be, motivated and spurred my seeking psychological training. Along this journey, I learned that human beings are inherently social, embedded in cultural and historical contexts that permeate our ways of comprehending and moving through the world. My interest in psychology and psychotherapy became imbued with an acute awareness of, and sensitivity to, the interpersonal thread that weaves throughout human experience. For me, it was in group therapy that this interpersonal thread emerged as an exciting venue, where interpersonal perspectives on psychological phenomena came to life.

As a doctoral student in clinical psychology, I have had several opportunities to lead therapy groups, opportunities that served to increase my curiosity about group processes and group-facilitated growth. The research study presented in this work represents the culmination of this interest and curiosity, for the period that marks my graduate student years. Beginning with a review of current literature on group psychotherapy, I explored and examined questions researchers have deemed pertinent to group therapeutic work, some of which would be considered foundational to group therapy. In doing so I came across certain shortcomings, as well as areas of interest that remained unexplored, and it is into some of these gaps and remaining questions that I situate this study. In doing so I do not critique existing research in the sense of tearing down, but precisely to add developmentally to a field that I believe holds great potential for healing.

In this chapter, I offer a brief history of group therapy in order to place the present study in historical context. Next, I provide an overview of group therapy research and the rationale I developed, during the course of my literature review, for the present study; I provide a more detailed review of this literature and its impact on the present study, in terms of both research questions and methods, in Chapters II and III respectively.

History of Group Psychotherapy

Rosenbaum and Patterson (1995) divide the history of group therapy into the time period prior to World War II and the post-war era. They locate the beginning of group therapy with Joseph H. Pratt, who was an internist at Boston Mass in 1905. Pratt treated tuberculosis patients in weekly classes of twenty five, where all members were required

to keep records of physical symptoms. Rosenbaum and Patterson (1995) note that "a fine spirit of camaraderie" developed within these "supportive and inspirational" groups, which evolved from a "repressive-inspirational" attitude toward "awareness of the more dynamic self-discovery factors" (p.174).

Other pioneers of the pre-war period included Trigant Burrow, who published on the group method of analysis, Edward Lazell, who worked with groups of schizophrenic patients in an inpatient setting, L. C. Marsh, who used a combination of lecture, dance, and art with mental hospital patients, and Jacob L. Moreno, who founded psychodrama (Corsini, 1957). To this list, Rosenbaum and Patterson (1995) add: Louis Wender, who used psychoanalytic concepts with groups; Paul Schilder, who first used group therapy with outpatients; Samuel Slavson, who integrated education, group work, and psychoanalytic concepts; and Carl Rogers, who described a client-centered approach to group therapy in 1942, in *Counseling and Psychotherapy*.

Rosenbaum and Patterson (1995) note that group therapy increased after World War II because of the need to treat psychiatric patients in the armed services. At this time, enthusiasm for group therapy spread to the general population. According to Rosenbaum and Patterson, much of the group work in this period was influenced by Kurt Lewin, who ran "T-Groups" at his National Training Laboratories. In T-Groups, group members were expected to develop human relations skills through experience; there was a focus on the "here and now" of the group, members' behaviors were analyzed by others in the group, and members were encouraged to try out new behaviors (George & Dustin, 1988, p.8). Rosenbaum and Patterson also note other pioneers of this era, such as Nathan Ackerman, Alexander Wolf, and Jerome Frank. Yalom (1975) suggests that Harry Stack

Sullivan's (1953) *Interpersonal Theory of Psychiatry* provides, to this day, the most explicit and systematic interpersonal approach to conceptualizing and treating psychological problems.

So called "encounter groups" flourished in the early 1960's through the mid 1970's in the United States (Rosenbaum & Patterson, 1995). Described as "quasi-therapeutic sensitivity groups in which authenticity, openness, confrontation, and encounter were encouraged," Rosenbaum and Patterson note that the "emphasis was on facing one another and honest expression of feelings" (p.179). Important contributions to the encounter movement came from: William Schutz, who advocated physical and non-verbal methods of interaction; George Bach, Paul Bindrim and Fred Stoller, who were pioneers of the "Marathon group" movement whereby group members spend numerous hours or even days in extended therapy sessions; Carl Rogers, who introduced the idea of therapist self-disclosure; Eric Berne, who devised the theory and method of "transactional analysis," a variant of psychoanalytic group work; and Fritz Perls, the originator of Gestalt therapy. Other influential figures in this period include: Wilfred Bion, who was in charge of group therapy at the Tavistock Clinic in London; S. H. Foulkes, who founded the journal *Group Analysis*; and Irvin Yalom, whose (1970) *Theory and Practice of Group Psychotherapy* is still widely considered to be the seminal work on group therapeutic processes.

Currently, there are a variety of theoretical and procedural approaches to group psychotherapy and authors differentiate these approaches in various ways. For example, while Brabender (2002) suggests that there are four basic models of group psychotherapy (interpersonal, psychodynamic, cognitive-behavioral, and interpersonal problem-solving

models), Bednar and Kaul (1994) argue for eleven different kinds of groups, including insight-oriented, group desensitization, encounter, group transactional analysis, Marathon, Rogerian, Gestalt, leaderless, cognitive, and behavioral. George and Dustin (1998) divide groups into two categories, "growth groups" and "psychotherapy groups." To distinguish them from growth groups, George and Dustin suggest that psychotherapy groups are less geared toward healthy individuals seeking further growth, are more aimed toward restructuring of the personality and/or alleviating symptoms, and use in-depth exploration of past events and unconscious factors to help participants work through unresolved issues and achieve insight.

<div align="center">Brief Overview of Group Therapy Research</div>

As the practice of group therapy has become more and more prevalent, the body of group therapy research has grown. Corsini (1957) notes that between 1906 and 1930 only 34 books, articles, and dissertations were published on the subject of group therapy. However, in the next 25 years the number of publications regarding group therapy increased from each five-year period to the next, with 20, 69, 203, 536, and 879 publications, respectively. Rosenbaum and Patterson (1995) point out that, in 1995, the rate of publication in the area of group psychotherapy was approximately 300 books, articles, and theses per year.

A number of authors have reviewed group therapy research and have concluded that group therapy, on the whole, "works" (Bednar & Kaul, 1994; Brabender, 2002; Corsini, 1957). In a comprehensive review of group psychotherapy research, Barlow, Burlingame and Fuhriman (2000) conclude that, "with few exceptions… the general

conclusion to be drawn from approximately 730 studies that span almost three decades is that the group format consistently produced positive effects with a number of disorders using a variety of treatment modalities" (p.122). While many in the field are convinced that group therapy works, therapists and researchers of different theoretical backgrounds use diverse concepts and terminology to define the "working" group. Although creating a universal definition of "working" psychotherapy may not be possible, dialogue around this issue may provide fruitful ground for future research. Throughout the course of this text, I use a range of expressions to point toward working group therapy, such as "healing," "therapeutic gains," and "improvement of client difficulties." My hope is that readers from a wide range of backgrounds will be able to find a point of resonance, a way to connect with the notion that group therapy helps clients.

The overwhelming evidence that group psychotherapy is helpful begs the question: what is it about group psychotherapy that helps people? A number of authors have attempted to extricate and explicate the "therapeutic factors" at work in group psychotherapy (e.g. Corsini & Rosenberg, 1955; Yalom, 1970). These classifications of therapeutic factors have, in turn, spawned a large body of empirical research, the majority of which attempt to determine the factors' therapeutic value to group participants. Most of these studies rank order the therapeutic factors in terms of relative importance, given a particular therapeutic modality, therapeutic setting, client population, or group developmental stage (Kivlighan & Mullison, 1988).

Rationale for the Present Study

Given that so much research exists on group therapy and, in particular, on what it is about group therapy that helps clients, it is alarming to discover that clinicians rarely use research findings to inform their clinical practice (Barlow, 1981). This phenomenon is widely referred to as the "research-practice gap." When considered seriously, the field's overall consensus that a research-practice gap has existed for some time is quite distressing. In a field such as astronomy, one can perhaps more easily imagine an unproblematic research-practice gap, as research may be oriented exclusively toward understanding rather than facilitating change. However in a field such as psychotherapy, it is more difficult to justify a gap between research and practice. Although one might expect to find some research oriented toward understanding without regard for practical application, one would expect clinicians to find at least some of the research on how group therapy works to be helpful in improving client care. Otherwise one can't help but suspect that researchers, clinicians, or both are pursuing their work in isolation, lacking information that would increase the quality of both treatment and theory.

Such widespread agreement about the research-practice gap begs the question: Why? Are therapists negligent in reading up-to-date literature that is pertinent to their work? Are researchers publishing articles that are inaccessible to practicing clinicians? Is there a lack of communication between researchers and clinicians about what research questions are worth pursuing? Extending beyond questions of why the research-practice gap exists, a question of potentially greater importance emerges: What can be done to bridge this gap? Given that numerous group therapy researchers express interest in (or

believe that they are) generating clinically useful outcomes, how can this goal be accomplished?

Based on my review of group therapeutic factor research, explored more deeply in Chapter II, I believe that the research-practice gap exists, at least in part, because many studies fail to meet group therapists' needs. For the most part, existing studies fail to explore how therapeutic factors may be harnessed (Schleidlinger, 1997), how therapist variables affect therapeutic factors' impact (Barlow et al., 2000), and how therapeutic factors are related to client outcome. Further, research methodologies tend to rely heavily on client report, which may or may not accurately reflect the course of therapy (Morgan et al., 1999; Tschuschke & Dies, 1994), while focusing exclusively on impressions at the end of treatment (Bloch and Crouch, 1985). They also tend to utilize measurement tools that may be biased (Lese & MacNair-Semands, 2000) and unreliable (Greene, 2003).

These impressions motivated me to tackle the gap between group therapy researchers and practitioners by involving therapists in generating clinically relevant research questions and developing research methodologies that are well suited to these questions. I approached this goal by bringing together a group of therapists in a focus group, where they discussed their notions of how group therapy works, their experiences with group therapy research, and their ideas about research questions and methods that would address their needs. I also gave them the opportunity to discuss struggles and challenges they face in practice, as well as areas in which they wish to grow; I anticipated that their responses would stimulate my thinking about potentially useful research topics

and methods. In Chapter III I provide a rationale for, and description of, the focus group method I used for this study, as well my phenomenological method of data analysis.

The results of the study, provided in Chapter IV and discussed in the context of relevant literature in Chapter V, point toward numerous ways in which researchers can work toward closing the research-practice gap. Interestingly, participants in the present study expressed feeling enlivened and enriched following the focus group discussion, suggesting that involving clinicians in research endeavors may benefit clinicians directly while increasing the relevance of group therapy research. I hope that the present study will serve to inspire further collaboration between researchers and group therapists, whereby each can gain the valuable experience of having something to offer, while benefiting from the other's expertise.

CHAPTER 2: REVIEW OF LITERATURE

Those who study and practice psychotherapy devote the bulk of their working hours to helping others with psychological difficulties, in hopes of decreasing problematic feelings, thoughts, and behavior while improving quality of life. However, for many in the field of psychotherapy, to be able to help others in distress is not a satisfying end point in itself. We also want to know why we are helpful and we are always looking for ways to improve standards of care. Put another way, and with particular reference to group therapy, it is not enough to know that group therapy is helpful; we strive to understand why group therapy benefits clients and how those benefits can be maximized.

Many researchers who are concerned with these matters investigate what has been termed "therapeutic factors." Beginning around the middle of the 20th century, researchers began to search, using both empirical methods and clinical experience as guides, for the underlying mechanisms behind effective group therapy. Once an acceptable classification system was devised, researchers began to study therapeutic factors in varying contexts and with diverse populations, in hopes of further delineating what is most helpful, when, where, and with whom.

In the literature review that follows, I begin with an overview of the canonical texts on group therapeutic factor classification. I explain how efforts toward classification culminated in Irvin Yalom's classification system (Yalom, 1970), now widely recognized and accepted within the group therapy community. Next, I describe the existing research on Yalom's therapeutic factors, including studies that explore the relative value of factors depending on treatment setting, treatment modality, client

population, and group developmental stage. In the section thereafter, I outline the major

criticisms of existing research that have been voiced by clinical authors and researchers,

and I provide samples of existing research that exemplify these criticisms. Next, I

describe researchers' attempts to address criticisms of group therapeutic factor research,

and I provide a context within which these criticisms can be integrated: a gap between

research and practice. This context provides the rationale for the present study, as well as

its aim to make a contribution toward improved quality of group therapy research.

Identification and Classification of Therapeutic Factors

Corsini and Rosenberg's (1955) attempt to classify group therapeutic factors is

widely recognized as the first seminal work on this topic (Berzon, Pious, & Farson, 1963;

Bloch & Crouch, 1985; Bloch & Reibstein, 1980). Bloch and Crouch note that, until

Corsini and Rosenberg, most authors who wrote about group therapeutic factors used a

theoretical focus and wrote exclusively from their own experience, rather than seeking

outside or empirical support. For example, Taylor (1950, p.996) provides the following

theoretical account of what constitutes a therapeutic factor: "any agency which is

potentially capable of producing such changes in the personality of a patient that an

alleviation or cure of clinical symptoms may result." Based on his own clinical

experience, Taylor adds that therapeutic factors consist of both "field forces" that affect

all group members collectively, such as attachment to the leader, as well as "interpersonal

relations," such as popularity within the group. Although clinicians like Taylor may have

pointed toward broadly applicable understandings of the group therapy process, without

corroboration from outside sources, their theories were never widely adopted.

Bloch and Crouch (1985) maintain that Corsini and Rosenberg made the first attempt to "produce a unifying classification of the therapeutic elements at the core of the group process and shared by therapists whatever their orientation" (p.10). In order to examine existing group therapy literature for expressions of group dynamics, Corsini and Rosenberg (1955) reviewed 300 articles, which they claimed comprised one fourth of the entire literature on group therapy. They abstracted statements from these articles that appeared to indicate "dynamics," rather than "results." After eliminating "duplicates" they arrived at a list of 160 items. Each statement was written on a card and the cards were clustered under themes. They arrived at ten classes of mechanisms, including: acceptance, altruism, universalisation, intellectualization, reality testing, transference, interaction, spectator therapy, ventilation, and miscellaneous.

Corsini and Rosenberg's (1955) study marked a significant paradigm shift in the field of group psychotherapy. Their attempts to discern the threads that unify helpful approaches to group therapy represented the first documented efforts to delineate what we now would call "group therapeutic factors." For the first time, a classification system was derived from a broad base of clinical experience and authorship, yielding findings that were widely applicable. Following the work of Corsini and Rosenberg, numerous researchers began to study client perspectives on what makes group therapy helpful (Berzon et al., 1963). These studies reflected the field's growing interest in using empirical methods to explore the inner workings of psychotherapy, in the service of improved clinical services. When viewed from this perspective, Corsini and Rosenberg were true pioneers in the area of psychotherapy process and outcomes research.

Irvin Yalom's (1970) publication of *The Theory and Practice of Group Psychotherapy* represents the second milestone in group therapeutic factor research and is often cited as the singularly seminal work in the field (Butler & Fuhriman, 1983a; Fuhriman, Drescher, Hanson, Henrie, & Rybicki, 1986; Kivlighan & Holmes, 2004; Kivlighan & Mullison, 1988; Lese & MacNair-Semands, 2000; MacNair-Semands & Lese, 2000; Rohrbaugh & Bartels, 1975).

In the second edition of *The Theory and Practice of Group Psychotherapy*, in which Yalom (1975) refines and expands concepts from the first edition, he describes group "curative factors" within an interpersonal conceptualization of psychotherapy. He claims that this conceptualization was primarily influenced by Harry Stack Sullivan's interpersonal theory of psychiatry. According to Yalom, Sullivan believed that the personality as a whole is almost entirely the product of social interaction. Consequently, Sullivan defined "mental disorders" in terms of disturbed interpersonal relations and he understood psychiatry to be the study of processes that occur between people. Goldman (1957) wrote that, according to Sullivan, the only significant difference between patients and other people is that patients overuse particular relational dynamics that were developed early in life to cope with patients' childhood relationships. Goldman claims that the therapy group is an ideal place for patients to recognize "patterns of interpersonal reaction as a prelude to learning their historical perspective and eventually changing [their] behavior" (p.391).

Yalom's (1975) theory of group psychotherapy draws upon Sullivan's interpersonal theory of psychiatry. Yalom claims that:

A freely interactive group, with few structural restrictions, will, in time,

develop into a social microcosm of the participant members. I mean by

this that, given enough time, every patient will begin to be himself, to

interact with the group members as he interacts with others in his social

sphere, to create in the group the same interpersonal universe which he has

always inhabited. In other words, patients will begin to display their

maladaptive interpersonal behavior in the group; there is no need for them

to describe their pathology – they will sooner or later act it out before the

group's eyes. (p.29)

Through feedback and self-observation in the group, members have the opportunity to

appreciate the nature of their interpersonal behavior, including how it affects themselves

and others, and then have the opportunity to try new ways of relating within the group

context.

Yalom (1975) delineates eleven curative factors that contribute to client progress

in group therapy, some of which represent mechanisms of change while others represent

conditions for change. He explains that the curative factors were derived from his own

clinical experience, the experience of other therapists, the views of "successfully" treated

group patients, and systematic research. As a caveat to his classification system, Yalom

reminds us that he presents the therapeutic factors, for the sake of clarity, "as separate

entities when in fact they are intricately interdependent" (p.70). These eleven factors

include: instillation of hope, universality, imparting of information, altruism, corrective

recapitulation of the primary family group, development of socialization techniques,

imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential

factors.[1] Yalom indicates, however, that he uses a slightly different twelve-factor system

when researching the curative factors, using an instrument he devised called the Q-Sort.

For the Q-Sort, Yalom uses different names for "imparting of information" and "imitative

behavior," preferring "guidance" and "identification," respectively. He also removes

"interpersonal learning" and "development of socialization techniques" and creates three

alternative factors, including: interpersonal input, interpersonal output, and self-

understanding.[2]

Some other authors have posited other lists of therapeutic factors (for example,

Bednar & Kaul, 1994; Berzon et al., 1963; Bloch & Crouch, 1985; Bloch, Reibstein,

Crouch, Holroyd, & Themen, 1979) and such alternative factor systems have also been

explored through research (for example, Biancosino et al., 2004; Shechtman & Gluk,

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[1] As Yalom (1975) indicates, the curative factors are not truly separate entities, and as will become apparent later in this review, there are no clear, distinct, and widely accepted definitions for the curative factors. To give the reader a general idea, however, I provide the following brief definitions based on my own understanding of Yalom's text:
Instillation of hope: assisting clients in developing the belief that they are capable of making progress in problem areas through participating in group therapy
Universality: clients finding that they are not alone because others can relate to their difficulties
Imparting of information: didactic instruction about psychological topics, as well as advice about life problems (offered by the therapist or other group members)
Corrective recapitulation of the primary family group: emergence of clients' family dynamics within the therapy group, with opportunities to explore thoughts and feelings and try out new ways of relating
Development of socialization techniques: learning social skills through methods such as role playing or receiving feedback about one's maladaptive behavior
Imitative behavior: clients imitating adaptive behaviors of the therapist or other group members
Interpersonal learning: clients' displays of maladaptive behavior, followed by self-examination and feedback from others, providing insight into how behavior impacts self and others; and provision of opportunities to try out new, more adaptive ways of relating, eventually carrying over into outside relationships
Group cohesiveness: the attractiveness of the group to group members
Catharsis: expression of emotion
Existential factors: recognizing the limitations and difficulties common to all human beings, and learning to take responsibility for one's choices

[2] As before, the following brief definitions are based on my own understanding of Yalom's (1975) text:
Interpersonal input: gaining insight into how one's behavior impacts others
Interpersonal output: learning how one relates, increasing trust, and improving social skills inside and outside the group
Self-understanding: discovering and accepting parts of oneself and recognizing historical sources of thoughts, feelings, and patterns of relating

2005; Thornton, 2004). However, Lese and MacNair-Semands (2000) point out that

"Yalom's classification of the therapeutic factors in therapy groups has been the most

widely adopted version of this popular concept" (p.303).

Existing Research on Group Therapeutic Factors

Although various methods have been used to study group therapeutic factors (e.g.

Freundlich, 1976; Kellerman, 1985; Lese & MacNair-Semands, 2000; Tschuschke &

Dies, 1994), Kivlighan and Mullison (1988) and Fuhriman et al. (1986) note that most

studies use either Yalom's Q-Sort or some variant of this instrument. Yalom's Q-Sort is

composed of 60 cards, on each of which is a statement intended to reflect one of his

twelve curative factors; there are five cards for each factor (Yalom, 1975). Participants

are instructed to make a normal distribution of the cards, in which two cards are chosen

as "most helpful to me in the group," six cards are chosen as "extremely helpful," twelve

cards are chosen as "very helpful," twenty cards are chosen as "helpful," twelve cards are

chosen as "barely helpful," six cards are chosen as "less helpful," and two cards are

chosen as "least helpful to me in the group" (p.77-78).

Another common method for accessing client perceptions of helpful therapeutic

factors is the "Critical Incident Questionnaire" (Bloch et al., 1979). This method, since it

is not dependent on Yalom's theory, can be used in therapeutic factor studies regardless

of whether or not they are based on Yalom's model. MacKenzie (1987) presents a

version of this instrument, which is commonly given to participants directly following a

group therapy session:

Please describe briefly the event that was most personally important to

you during today's session. This might be something that involved you

directly, or something that happened between other members, but made

you think about yourself. Explain what it was about the event that made it

important for you personally. (p.81)

Trained clinicians are then asked to place each "critical incident" in a pre-determined

category, one for each therapeutic factor.

Kivlighan and Mullison (1988) point out that much of the research emanating

from Yalom's theory focuses on client perceptions of which therapeutic factors were

helpful, in relation to type of therapy group. Some studies, for example, explore which

factors seem to be most helpful depending on whether the treatment setting is inpatient or

outpatient (Chase & Kelly, 1993; Goldberg, McNiel, & Binder 1988; McLeod & Ryan,

1993). Other studies focus on particular therapeutic modalities, such as psychodrama

(Kellerman, 1987), music therapy (Goldberg, McNiel, & Binder, 1988) and, more

recently, e-groups (Chen, Lin, & Bai, 2004). Butler and Fuhriman (1983a) point out that,

in addition to therapeutic factor comparisons based on treatment characteristics, a large

number of studies explore which factors are most valued by differing client populations.

Examples of target populations include: alcoholics (Feeney & Dranger, 1976), incest

victims (Bonney et al., 1986), drug-addicted patients (Campbell & Page, 1993), self-

destructive women (Cooper & Milton, 2003), divorced participants (Oygard, 2001), and

men who batter (Roy, Turcotte, Montminy, & Lindsay, 2005).

The results of studies examining the perceived benefits of therapeutic factors,

depending on client population, treatment setting, and treatment modality, are too

extensive and varied to be summarized here. What is significant for this literature review, however, is the nature of the results, which often take the following form: "The three factors considered to be most useful by the [schizophrenic] patients in the Acute [inpatient] Unit group were instillation of hope, cohesiveness, and altruism, in that order" (de Chavez et al., 2000, p.259). Such results reflect client perspectives on what is most helpful, given a particular treatment setting, diagnostic group and/or treatment modality.

One comprehensive study, completed by Rohrbaugh and Bartels (1975), compared 13 different groups using Yalom's Q-Sort. The groups varied with respect to type (e.g. growth, therapy), leader orientations (e.g. dynamic, rational-emotive, interactional), member populations (e.g. alcoholics, counseling graduate students, mixed), "age" of the group, and time of evaluation (e.g. after, during). Rohrbaugh's and Bartels' results indicated that "characteristics of groups and/or their members *do* account for at least some variation in perceptions of the various change mechanisms" (p.449). Another of their most significant conclusions, however, was that "participants' perceptions of curative factors in therapy and growth groups are complex and not easily dimensionalized" (p.453). This result made it difficult to state definitive conclusions about which factors were perceived by particular groups to be most beneficial.

Another vein of therapeutic factors research explores Yalom's (1975) assertion that the importance of therapeutic factors change depending on the group's "developmental level." There is general agreement among researchers that a therapy group moves through stages, from introductions and testing the waters, toward greater cohesion, empathy and support, and eventually into honest feedback, emergence of conflict, and exploration of differences; authors differ, however, on the number and

specific characteristics of group developmental levels (Bernard & MacKenzie, 1994; Brabender, 2002; Corsini, 1957; Poey, 1985). A number of researchers have found supporting evidence for the notion that therapeutic factors change in value over time (Butler & Fuhriman, 1983b; MacKenzie, 1987; MacNair-Semands & Lese, 2000; Tschuschke & Dies,1994). Kivlighan and Mullison (1988) found that the overall importance of therapeutic factors increased over the course of therapy.

In summary, most studies on Yalom's group therapeutic factors have used either a Critical Incident Questionnaire or some version of Yalom's Q-Sort in order to assess the factors' relative importance to group participants. The majority of these studies have rank ordered the therapeutic factors, in terms of relative importance, given a particular therapeutic modality, therapeutic setting, client population, or group developmental stage. Despite the great number of existing research studies, however, there is not yet consensus about which therapeutic factors are most helpful for particular client populations, in particular treatment settings, using particular treatment modalities, or at particular stages of group development. It is also true, however, that for all the (ever increasing) research studies, it is hard to find information that is applicable to groups outside of the homogenous, clearly demarcated, or otherwise 'controlled' populations so sought after by researchers. Group therapists in private practice, university, community mental health, or other institutions often work with heterogeneous groups, where old members leave and new members join during the course of treatment. Such group therapists will have trouble finding up to date research relevant to their work.

Critique of Existing Research on Group Therapeutic Factors

The most fundamental criticism voiced against existing group therapeutic factor research is that the therapeutic factors are poorly conceptualized and lack clear definitions (Bloch & Crouch, 1985; Dies, 1997; Lara, Navarro, Acevedo, & Berenzon, 2004; MacKenzie, 1987). MacKenzie suggests that unclear definitions may be reflected in poor item content on Q-Sort cards or derived questionnaires. For example, Marcovitz and Smith (1983) point out that items such as "discovering previously unknown parts of myself" and "learning about current feelings related to the past" are too different to be listed under the same factor, self-understanding. Stone, Lewis, and Beck (1994) performed a factor analytic study of a Q-Sort based questionnaire and found that interpersonal learning (input), catharsis, and existentiality loaded inconsistently across two of the factors. Yalom himself (1975) includes "receiving interpersonal feedback" as part of both "learning socialization techniques" and "interpersonal learning."

One symptom of poor factor definitions is the fact that different authors may use different names for the same factors, while at other times they may use the same names for different factors. As described above, at times Yalom (1975) uses "interpersonal learning (input)" and "interpersonal learning (output)" to indicate two different factors, whereas at other times he subsumes both of these factors under "interpersonal learning." To make matters even more confusing, Bloch et al. (1979) introduced a system for classifying group therapeutic factors that uses some of the same terms Yalom uses, but with different definitions. For example, they use the term "learning from interpersonal actions" to describe what Yalom called "interpersonal learning (output)," and they combine Yalom's "interpersonal learning (input)" and "self-understanding" under the

name "self-understanding" (Bloch & Crouch, 1985). Some researchers cite both Bloch and Yalom in their publications (de Chavez et al., 2000; Kivlighan & Mullison, 1988), making it difficult for readers to determine what is meant when authors use terminology common to both systems. Bednar and Kaul (1994) sum up these issues when they say that the "modal investigation seems to be an attempt to establish empirical relationships between events that are barely described, defined, and measured" (p.640).

A second aspect of research on group therapeutic factors that has received considerable criticism is research methodology. One questionable aspect of popular methodology is its heavy reliance on client report (Tschuschke & Dies, 1994). As numerous authors indicate, client reports may not accurately reflect what has taken place in therapy (Morgan et al., 1999; Rohrbaugh & Bartels, 1975). As Barlow et al. (2000) put it, "multiple sources and methods for measuring these change mechanisms are still missing generally. The majority of studies use only client report…" (p.130). Although some exceptions exist (such as Bloch & Reibstein, 1980; Bonney et al., 1986; Goldberg et al., 1988; Morgan, Ferrell, & Winterowd, 1999), therapist perspectives are included very infrequently in therapeutic factor research (MacKenzie,1987). By giving priority to client accounts of what is helpful, researchers overlook the clinical expertise that group therapists can offer when evaluating the differential importance of therapeutic factors. Goldberg et al. (1988), for example, questioned "severely disturbed" patients, most of whom had psychotic disorders, who had only been in group therapy for five to eight sessions, in groups with high rates of patient turnover. These hardly seem like the ideal conditions for a group climate to evolve. Further, by relying exclusively on reports from

"severely disturbed" patients, the researchers may not have obtained complete or accurate pictures of what occurred in therapy.

A variety of authors criticize Yalom's Q-Sort, suggesting that it lacks important items (Kellerman, 1987), is unfairly biased toward interpersonal learning (Lese & MacNair-Semands, 2000), is cumbersome and "somewhat unreliable" (Greene, 2003) and does not, as mentioned above, represent "independent" dimensions (Butler & Fuhriman, 1983a). Rohrbaugh and Bartels (1975) mention that short forms of the Q-Sort are especially problematic, since single items chosen for each factor may not be adequately representative. Goldberg et al. (1988), for example, used a short form of Yalom's Q-Sort with only one item per factor, and patients had to do a forced ordering from "most" to "least" helpful. Although such abridged measures may simplify data analysis, such simplification may detract from research participants' ability to adequately communicate what they found to be helpful in therapy.

Another methodological problem apparent in existing studies is the "forced choice" aspect of the "Critical Incident Questionnaire;" raters are told to look at each incident as a whole and select "only one factor which best [represents] the emphasis of the 'event'" (Bloch et al., 1979). This runs counter to the commonly acknowledged overlap and/or inseparability of the therapeutic factors. It also opposes the common sense notion that a description of human experience, particularly one chosen for its personal significance, cannot be captured in a single word or phrase. Jones, Herrick, and York (2004) conducted a study in which the "forced choice" aspect of the Critical Incident Questionnaire is clearly problematic. For example, the statement "I liked communication with the youth," (p.753) made by a participant in an intergenerational

group, was labeled "development of social skills," a label that is a stretch at best; further, the authors concluded from such statements that participants "successfully mastered" several of Yalom's therapeutic factors, seeming to misunderstand the therapeutic factor concept.

In addition to those who highlight problems with factor definitions and research methods, some critics emphasize a third problem area with respect to group therapeutic factor research. These authors indicate that important topics are neglected in the bulk of existing research, topics which may impede applicability to clinical practice. For example, Schleidlinger (1997) says that we need to explore how therapeutic factors promote clinical improvement. Indeed, while some exceptions exist (Lese & MacNair-Semands, 2000; Rohrbaugh & Bartels, 1975) the most commonly cited research gap is the failure to link group therapeutic factors to client outcome (Bloch & Crouch, 1985; Greene, 2003; MacKenzie, 1987; Roy et al., 2005; Tschuschke & Dies, 1994). In essence, these authors highlight the fact that knowing which therapeutic factors are perceived as helpful does not necessarily translate into which factors actually contribute to clients' progress in therapy.

Other authors emphasize the importance of understanding not only which therapeutic factors are helpful, but what therapeutic factors look like in action and how group therapists can increase the impact of therapeutic factors in their clinical work. Schleidlinger (1997), for example, recommends that we explore how and under what circumstances therapeutic factors can be harnessed, while Tschuschke and Dies (1994) suggest that we need detailed process analyses of patients in group therapy.

A number of authors (for example Barlow et al., 2000; McLeod & Ryan, 1993) comment that therapeutic factor research has paid insufficient attention to therapist variables, while Kivlighan and Mullison (1988), and Butler and Fuhriman (1983b) indicate that there is insufficient research on client individual difference variables. These authors draw attention to the fact that clients who share a particular diagnosis, like therapists who share a particular approach to psychotherapy, may still differ on dimensions that significantly affect the therapeutic process; similarly, clients with different diagnoses, like therapists with different approaches to therapy, may still have important similarities. For example, Shechtman and Perl-Dekel (2000) compared two groups with different treatment approaches, but had the same therapists run both groups with the same participants; it would be extremely difficult in such a design to differentiate the therapeutic factors operating in one group from those operating in the other. By lumping together diverse clients and practitioners, researchers may overlook important personal variables that influence the relative impact of therapeutic factors.

To summarize, there are three main areas in which critics of existing group therapeutic factor research focus their attention: difficulties in identifying, defining, and differentiating therapeutic factors; methodological weaknesses, such as over-reliance on client report as well as questionable reliability and validity of the Q-Sort and Critical Incident Questionnaire; and neglected topics that are relevant to group therapy in practice, such as therapeutic factors' relation to client outcome, how therapeutic factors appear in practice, how therapeutic factors can be harnessed, and the influence of therapist and client variables on the impact of therapeutic factors.

Given these three clusters of problems, it is perhaps not surprising that Kivlighan and Holmes (2004) observe that, despite the plethora of studies exploring the relative value of group therapeutic factors with respect to different client populations and treatment settings, there is little evidence of consistent differences across groups and settings. They conclude that the result is "a literature composed of contradictory and atheoretical findings that has added little to the practice and theory of group counseling" (p.26).

It is important to acknowledge, however, that these criticisms are complex and not easy to remedy. All classification systems, by definition, simplify complex data and are susceptible to critique for their inability to capture the complexity of the phenomena they seek to classify. Similarly, all testing instruments are vulnerable to criticism regarding reliability and validity. Finally, because research into the human sciences is always expanding and discovering new topics for exploration, one can never expect the literature to cover all relevant topics and produce completely satisfying results. The purpose of this critique, therefore, is not to condemn what has gone before but, rather, to examine where we can go from here. In the next section, I describe several researchers' attempts to address the criticisms outlined above.

What Can Be Done? A Reply to Criticisms of Existing Research

Some of the authors who have responded to the criticisms outlined above have focused on problematic factor definitions, others on methodological weaknesses, and still others on needed research topics. Given evident difficulties in identifying, defining, and distinguishing between group therapeutic factors, a number of authors have called for

clearer factor definitions (Bednar & Kaul, 1994; Bloch et al., 1979; Butler & Fuhriman, 1983a; MacKenzie, 1987). Fuhriman et al. (1986) conducted a factor analytic study "focused on seeking a clearer definition of the four curative factors – cohesion, catharsis, interpersonal learning, and insight – through the development of a revised curative factors instrument" (p.189). They report "some success," but (as noted above) conclude that the curative factors may not, in fact, represent distinct entities.

Rather than continue efforts to define and distinguish therapeutic factors, some authors suggest we acknowledge the fact that therapeutic factors overlap considerably and may be inseparable (Butler & Fuhriman, 1983a; Dies, 1997; Kivlighan & Holmes, 2004; Scheidlinger, 1997; Tschuschke & Dies; 1994). Lese and MacNair-Semands (2000) suggest that all or some of the factors "could be seen as so overly inclusive that significant differences between them are negated" (312).

Others have gone further, suggesting that the factors are confused and difficult to differentiate because some or all of them are permeated by a common contextual background, which might be called "interpersonal learning." Fuhriman et al. (1986) completed a factor analytic study of Yalom's Q-Sort and found that "items from the a priori interpersonal scale were the only items in the factoring that were spread across three of the five factors" and that "perhaps the time has come to drop 'interpersonal' as a curative factor and recognize that all curative factors occur in an interpersonal context" (p.198). Rohrbaugh and Bartels (1975) suggest that "interpersonal learning… is an extremely broad rubric which could incorporate processes such as identification, 'insight,' and altruism" (p.454). Yalom himself (1975) admits that the factors are interdependent. The central importance of "interpersonal learning," in particular, is

evident in Yalom's references to Sullivan's interpersonal theory of psychiatry and his indication that interpersonal learning is "a broad and complex curative factor" (p.19).

Other authors attempt to remedy problems in existing research by focusing on methodological change. MacKenzie (1987) suggests that we need instruments that, unlike existing options, code general themes in addition to specific incidents, and are suitable for a wider variety of treatment approaches (e.g. directive). Lese and MacNair-Semands (2000) designed a new instrument called the "Therapeutic Factors Inventory." They found, however, that their scales were highly correlated with one another, like those in Yalom's Q-Sort. They also note that further research on the instrument's construct and criteria-related validity is needed before the instrument can be confidently applied to Yalom's theory.

Finally, in recent years, some researchers have begun to address critics' claims that practice-related topics have been neglected in group therapy research. Wanlass, Moreno, and Thomson (2005), for example, elicited therapist perspectives on what was helpful to group members and found that therapists and their clients emphasized different therapeutic factors. They conclude that involving therapists in research on therapeutic factors allows for a more comprehensive view of the group experience.

Pan and Lin (2004) explored the relationship between leader behaviors and participants' reported importance of therapeutic factors. They found, for eight out of twelve therapeutic factors, that "the more positively leader behaviors were perceived by the members, the more such therapeutic factors could be experienced" (p.191). In other words, therapist behaviors had a significant impact on what clients perceived to be helpful. Pan and Lin conclude by commenting that the relationship between therapeutic

factors and group effectiveness, the most often-cited gap in therapeutic factor research, might be enhanced through the use of qualitative research methods, such as in-depth interviewing.

Although criticisms of group therapeutic factor research, along with proposed remedies, can be summarized in three broad categories (i.e. factor definitions, methodology, and research topics) there are risks in doing so. If we envision three distinct areas of difficulty, we run the risk of improving one problem while sustaining another. For example, if we focus on creating better tools without revamping the factor system, we may encounter the same problem Lese and MacNair-Semands (2000) encountered: just as strong correlations between factors as we find using the Q-Sort. If we focus on creating clearer, better-defined factors, we run the risk of losing clinical relevance and further obscuring the complexity of the group therapy experience. Finally, if we include previously lacking research topics, such as the relation between therapeutic factors and client outcomes, without revising our research methods, we will continue to increase a corpus of knowledge that is founded upon widely questioned concepts and methods.

As an alternative to addressing the criticisms of group therapeutic factor research in a piecemeal fashion, I contend that all three clusters of problems can be understood within the context of one larger issue: a gap between research and practice. To gain a feeling for this larger context, consider the following questions in light of the criticisms outlined above: If researchers find that a specific population, in a specific therapeutic setting, perceives one factor to be more helpful than another, how can therapists put that knowledge into practice? Can client reports be viewed as accurate? And if they are, how

do their perceptions of helpfulness relate to outcome? If therapeutic factors are inseparable in practice, how is it useful to practitioners to know which "particular factor" is most valued by clients? And finally, given that the factors are inseparable, poorly defined, and not demonstrably related to therapist or outcome variables, why do researchers continue to "measure" them with instruments that are so often deemed insufficient?

These questions point toward a lack of adequate dialogue between researchers and clinicians. The "researcher-practitioner gap" has been documented by a number of authors (Barlow, 1981; Druss, 2005; Goldfried & Wolfe, 1996; Greenberg, 1994; Kernberg & Clarkin, 1994; Stricker, 1992). As explicated by Goldfried and Wolfe, this term refers to the fact that, "although therapists and researchers often begin with similar professional training, they eventually end up living and working in very different worlds" (p.1007). Barlow points out that, in particular, clinicians report that they rarely use research findings to inform their clinical practice.

Authors from a wide range of related fields in the human sciences, where research-practice gaps have been observed, offer a range of explanations. Some suggest that existing research is, in itself, unproblematic. Such authors indicate that to close the research-practice gap is to get clinicians to make use of existing research. Within the medical field, McGrath, Lawrence and Richardson (2004) place this responsibility on researchers, urging them to translate findings "into messages that are easier for practitioners to access, comprehend, and incorporate" (p.374). Within the field of psychotherapy, Narud, Mykletun, and Dahl (2005) place this responsibility on practitioners. They state that "experienced therapists frequently deviate from

recommendations offered by guidelines and experts' statements" (p.190), suggesting that practicing clinicians neglect their responsibility to apply research outcomes.

Other authors suggest that, in order to bridge the research-practice gap, research methodologies and questions need to change. Tally, Strupp, and Butler (1994) suggest that alternate research methodologies ought to be employed, and Safran and Muran (1994) propose that qualitative methods be used, particularly those oriented toward discovery. Edelson (1994) remarks that "one reason for the difficulty of translating research findings into clinical practice follows from differences in the interests clinical researchers and clinical practitioners pursue. The questions that psychotherapy research is eager to address are not the questions in which a psychotherapist qua practitioner is most interested" (p.60). Elliott and Morrow-Bradley (1994) corroborate this sentiment. They cite an example from their own research, in which therapists were presented with a list of the researchers' "favorite research topics" and asked what they were interested in studying. Their response was: "None of the above" (p.133). Consequently, Elliot and Morrow-Bradley suggest that "researchers who want their research to be attended to by therapists should find out what therapists are interested in knowing about" (p.136).

As a psychologist-in-training, I resonate with the explanations offered by Edelson (1994) and by Elliott and Morrow-Bradley (1994). Although it is true that research articles may be difficult to follow at times, I typically find that I can grasp the results of a study by reading the abstract and discussion. Further, as a trainee, I do not have the luxury of neglecting my responsibility to read current research. To the contrary, during my graduate training I have read a multitude of research articles on group therapeutic factors, yet I cannot think of one that I apply to my work as a group therapist.

Over and beyond the concerns I have about the accuracy of the Q-Sort and the Critical Incident Questionnaire, the questions explored and the results obtained by group therapy researchers simply seem to lack relevance to my clinical work. The populations, treatment settings, and therapeutic modalities are so specific that they do not seem to apply to the groups I facilitate. In my experience, psychotherapy and client change is too complex to be captured in a selection of discrete factors. Further, without the inclusion of therapist traits, therapist perspectives, and outcome correlates, it is difficult to imagine how rankings of therapeutic factors could actually be used to improve clinical practice. It does appear, at times, that researchers and clinicians inhabit two different worlds.

Druss (2005) echoes these sentiments when he insists that we can close the gap between research and practice only when we succeed in closing the gap between researchers and clinical practitioners. Sullivan et al. (2005) provide an inspiring example of a study that does just this. They explain that clinical interventions developed by researchers alone are rarely sustained in clinical practice either because they lack relevance to clinical practice or because they are difficult to apply to "real world" settings. Conversely, they suggest that collaboration with clinicians in the development of research projects increases clinical relevance, clinician investment, and potential sustainability of clinical application. Toward this end, Sullivan et al. developed a partnership program through which services researchers could assist practicing clinicians in researching interventions of their own design, attempting, whenever possible, to involve clinicians with little or no research experience. Although this study is still underway and, therefore, its outcomes uncertain, it promises to make a vital contribution toward bridging the gap between researchers and practitioners.

In a similar vein, I designed the present study with an eye toward decreasing the "researcher-practitioner" gap. Through the process of completing this literature review, I came to believe that difficulties in existing therapeutic factor research, including those related to therapeutic factor definitions, research topics, and research methodologies, are symptoms of this greater problem. To a group therapist and psychologist-in-training, the problem of a research-practice gap is a significant one. I wish to be an effective group therapist and do not want efforts made by researchers to improve clinical practice to be in vain. To the contrary, I would like to be able to apply the results of psychotherapy research to my clinical work, in service of my clients' improved quality of life. With these values in mind, I developed a research study that involved practicing clinicians in research, research that was specifically oriented toward developing research questions and methodologies that are relevant to group therapists. In the next chapter, I describe the methods I chose to pursue this goal, explain why the methods I chose were appropriate to the topic at hand, and describe in detail the procedures I followed in light of my chosen methodology.

CHAPTER III: METHOD AND PROCEDURES

In Chapter II, I reviewed the literature that explores those aspects of group therapy that are considered helpful to clients, paying particular attention to the seminal classification of such factors by Irvin Yalom (1975). I demonstrated that the vast majority of research into therapeutic factors examines which factors are perceived by clients to be helpful, depending on treatment modality, treatment setting, client population, or group developmental stage. Next, I reviewed the central criticisms that have been voiced with respect to existing research on therapeutic factors, most notably that therapeutic factors are poorly defined, or possibly inseparable, and that trying to divide the therapeutic process into discrete factors obscures research findings. Additionally, others pointed out that there is too heavy a reliance on client report, and that the instruments used to measure clients' perceptions of what is helpful are too simplistic, unreliable, and do not adequately capture clients' experience. Finally, some suggested that existing research lacks clinical relevance, particularly with respect to a neglect of topics such as: the influence of therapist and client individual variables on the impact of therapeutic factors; how therapeutic factors appear and can be cultivated in clinical practice; and the relationship between therapeutic factors and client outcomes.

I linked these criticisms together by couching them within the larger context of a gap between research and clinical practice. Various explanations have been offered for the research-practice gap, including researchers' failure to describe results in accessible language and clinicians' neglecting to read up-to-date research. However I proposed that the most compelling explanation, in my view, is the apparent lack of communication

between researchers and clinicians about which research questions and methods would best address clinically relevant issues.

My dual role as clinician-researcher, offering access to both worlds, provides the context for my perspective. While I have read and comprehended many research articles regarding therapeutic factors in group therapy, I find that they are difficult to apply to clinical practice. The notion that specific kinds of clients in particular kinds of treatment groups perceive certain discrete factors as more helpful than others seems too simplified and too remote from clinical realities to inform my clinical work. In real therapy groups, client diagnoses are often diverse, rather than homogenous. Therapy groups include therapists, who may draw from multiple approaches, implement distinct approaches in idiosyncratic ways, and formulate ideas, in an ongoing way, about what they can do or say to be helpful as the therapy hour proceeds. The therapeutic process is complex and multifaceted; at any given moment, multiple interpersonal events may be occurring between group members and the therapist, all of which are perceived differently by unique participants. Existing popular methods for exploring what makes group therapy "work" are simply not able to capture this complexity, inherent to group therapy in practice. As Hoshmand and Martin (1995) put it, "Humans and the context in which we reside may be too varied to permit tightly prescriptive applications of the findings generated by research on practice" (p.63).

In the present study, therefore, I tackled the gap between researchers and practitioners by actively involving practicing clinicians in the development of research questions that are relevant to their practice and research methods that would be appropriate to their questions. The purpose of the study was: (1) to learn from group

therapists how they believe group therapy "works" and, based on their responses, to evaluate the assertion that there are problems with the current therapeutic factor system; (2) to learn from group therapists what role research does or does not play in their practice and, through comparison to the extant literature, to evaluate the claim that a research-practice gap exists; (3) to learn from group therapists about their struggles as well as areas of desired improvement and, based on an analysis of these responses, to theorize and propose research questions and methodologies that would best address their concerns; and (4) to give group therapists an opportunity to voice their own ideas about research questions and methodologies that would address their concerns and to explore similarities and differences between their ideas and my own.

In order to invite the complexity and richness of the group therapy experience to emerge in my research findings, I decided to use qualitative methods of inquiry. In the next section I provide a rationale for choosing qualitative methods for the present study, and particularly focus group theory, which underpins the procedures I used to collect my data. I then describe the phenomenological method of data analysis and explain why I deemed it appropriate to my research questions. The basic theory of qualitative data analysis software, which I used to simplify and augment my analysis, is briefly outlined. Following a short description of a pilot study I conducted in order to fine tune my method, I describe in detail the procedures used in the present study.

Methods

Choosing an appropriate method for the present study was an important part of my research process, particularly in light of the methodological critique provided in

Chapter II and summarized above. In *Research as Praxis: Lessons from Programmatic Research in Therapeutic Psychology*, Hoshmand and Martin (1995) describe the philosophical issues that are at stake when choosing research methods. For example, the methods of empirical science that emerged during the 19th century and continue to dominate contemporary scientific research are founded upon the philosophical view that absolute truths exist and that "objective," scientific methods provide knowledge of reality. This philosophical tradition is known, broadly speaking, as positivism. In contrast, the constructionist tradition, growing in recognition over the past few decades, is founded upon the notion that human beings construct meanings and "truths." As a result, knowledge is always relative to its cultural and historical contexts.

Hoshmand and Martin (1995) point out that "psychological science, in striving for scientific status, has adopted a positivistic model of knowledge for most of its history" (p.12). As noted above, positivistic philosophy relies on the assumption that absolute truths exist and are ascertainable. From this perspective, when the context of a phenomenon is diminished, including the person of the researcher, the phenomenon itself can be accessed and revealed most accurately. Methods of natural science are often adopted in light of a positivistic approach, as they emphasize manipulation of discrete variables within a controlled context, elimination of variation between participants grouped under a common label, and conceptualization and presentation of results as increasingly approaching objective reality. When we observe the bulk of existing research on group therapeutic factors, the underlying assumptions of positivistic science are apparent; researchers assume that there exist therapeutic factors that are most beneficial to clients, depending on variables such as diagnosis and treatment setting, and

that these factors can be discerned through scientific inquiry (e.g. correlating client-constructed Q-Sorts with a list of therapeutic factors).

However the methods used to explore group therapeutic factors, as noted in the literature review, yield findings that clinical practitioners rarely find useful. Hoshmand and Martin (1995) echo this sentiment, when they state that positivistic methodological preferences result in clinicians' "dissatisfaction with experimental research and [with] the relationship of psychological science to practice" (p.12). Frank (1987) agrees that the methods of science, which typically involve manipulating quantitative data (e.g. rank-ordering therapeutic factors), are ill-suited to address the meanings and values inherent to psychotherapy. Indeed, he claims that "the oft-lamented failure of [traditional scientific methods] to influence psychotherapeutic practice may reflect the irrelevance of this type of science to psychotherapy" (p.300).

As noted in the literature review, several authors have suggested that qualitative methods may be helpful in addressing problems with existing group therapeutic factor research (Pan and Lin, 2004; Safran and Muran, 1994). Hoshmand and Martin (1995) point out that most qualitative methods stand in contrast to those founded upon positivism, in that they approach research topics more holistically and take context into account. Because qualitative inquiry is directed toward understanding lived experiences, Hoshmand and Martin indicate that "the inquiry process tends to be open and adapted to the realities of naturalistic contexts" (p.14). McLeod (2000) suggests that qualitative methods, when used in psychotherapy research, are "grounded in a willingness to accept diversity, or even ambiguity, rather than being wedded to a 'horse race' mentality in which the therapy with the highest gain score is the winner" (p.122).

While it may be tempting to assume that qualitative methods are inherently more open-ended and holistic, that they invite diversity and ambiguity, and that they honor the contextual nature of meaning, this is by no means always the case. Although many qualitative methods do share constructionist philosophical roots, including a sense of context (including researcher and participants) as integral to the construction of meaning, there remains great diversity among qualitative methods, some drawing upon positivistic assumptions. In particular, qualitative methods differ in terms of how data is collected, how it is interpreted, and what purpose the results serve. For example, when qualitative researchers attempt to ascertain the "essence" of a human experience by finding common elements among multiple accounts, they rely upon the positivistic assumption that an objective reality exists and can be revealed. When I discuss phenomenological theory below I will further explicate how positivistic assumptions and constructionist assumptions can support (at least) two different versions of phenomenological analysis.

Having earned a Certificate in Interpretive and Qualitative Research, my experience with, knowledge of, and affinity for qualitative methods was already present when I embarked on the present study. I resonated with the sentiments offered by critics of existing therapeutic factor research, suggesting that qualitative methods might help to remedy the research-practice gap. However my choice of qualitative methods was not a simple one; I recognized the need to select, from a myriad of options, methods that would be appropriate to my research topic, while supporting (and gaining support from) my constructionist orientation toward research. I believed that using qualitative methods founded upon a constructionist philosophy was integral to avoiding the pitfalls of existing research, much of which is founded on positivistic assumptions.

In *Psychology as a Human Science*, Giorgi (1970) provides a language for considering how a researcher's philosophical orientation, topic of inquiry, and research methods inform and shape one another. He uses the term "approach" to describe the researcher's fundamental viewpoint toward human beings and toward the world. Approach includes philosophical assumptions, including those regarding the phenomena researchers study, whether or not those assumptions are recognized or made explicit by the researcher. Giorgi differentiates approach from both content and method, where content refers to what the researcher studies and method refers to how the researcher goes about studying this content. Giorgi insists that approach, content, and method are inextricably interwoven, that "there is a constant dialogue among the approach, the method, and the content of the phenomenon that is being studied" (p.127). Giorgi suggests that if one of these three arenas is given priority over the others, the other two remain present, lurking implicitly, untapped for the wisdom they have to offer the research endeavor.

In my own contemplation of Giorgi's (1970) dialogue between approach, method, and content, numerous analogies emerged to illustrate its critical importance. Take, for example, the raising of a child. Assumptions about parenting, including those about childhood, adulthood, communication, morality, and relationships, impact the methods parents use to raise their child and, by this means, shape the child who emerges over the years. The qualities of the child, in turn, determine which parenting practices will be most effective; as a result, the child's personality may impact the practices parents choose and, ultimately, their philosophical orientation toward parenting. Unfortunately, this ideal of ongoing dialogue between approach, method, and content (which, in this

analogy, are parenting philosophy, practices used, and the person of the child) is not always achieved. Parents use practices learned from their own parents (e.g. corporal punishment), while advocating a parenting philosophy that is inconsistent with these practices. Parents use one set of parenting strategies with all of their children, without taking into account which are most effective with each unique child. In such cases approach, method, and content are all present but, without dialogue between them, parenting is less informed and therefore less effective.

With respect to the present study, I strove to develop a method in dialogue with both content and approach. The content consisted of human phenomena: group therapists' perceptions of how group therapy works; their thoughts and feelings about group therapy research; the challenges they face in practice; and areas in which they would like to improve as clinicians. This content impacted my choice of methods in several ways. Because the focus of the study was group therapists, I believed it was important to involve them directly in the research. With group therapy as my overarching research topic, an interactive group-oriented method for data collection seemed more appropriate than surveys, written protocols, or even individual interviews. Ultimately, I decided to study the group therapist experiences listed above by involving practicing clinicians in a facilitated group discussion. Interested primarily in what participants thought and felt, I chose to focus on the content of participants' speech, rather than their styles of communication or dynamics between participants. In the sections below, I will describe these methods – focus group facilitation and phenomenological data analysis – in greater detail.

My approach also had an impact on my choice of methods, some of which I can make explicit and some of which is necessarily beyond the scope of my awareness. In terms of philosophical assumptions, I do not believe that human phenomena can be observed objectively, encapsulated and labeled without losing significant aspects of their meaning, or explained in terms of absolute truths. In contrast, I believe that human phenomena are infused with meanings by the contexts within which they emerge. Consequently, the socio-cultural context and the researcher's personal background shape what can and will be known about a research topic. To engage in research with this approach, described above as constructionist, implies that researchers may (and, at times, ought to) speak in the first person and explain their thought processes. A constructionist approach also supports choosing methods for data collection and analysis that open possibilities rather than narrow possibilities, as well as conceptualizing and presenting results as interpretations rather than as absolute truths. Throughout this and the following chapters, reflecting on my own thought processes, offering results as interpretations, and discussing results in the context of our cultural milieu, embody the constructionist approach that informs the present study.

In the next three sections, I will describe in more detail the qualitative methods I chose for the present study, including a focus group approach to data collection, a phenomenological approach to data interpretation, and the use of qualitative research software to simplify and enhance data analysis. By maintaining an open inner dialogue, I was able to use these methods in ways that honored my constructionist approach, as well as the humanity of the phenomena under study.

Focus Group Theory

I chose to pursue the research questions listed above (i.e. whether or not problems exist in the existing therapeutic factor system, whether or not a research-practice gap exists with respect to group therapists, what group therapists experience as struggles and areas of desired improvement, and what research questions and methods would address group therapists' needs) through a "focus group" format. Focus groups, which were initially called "focus interviews," became popular after World War II (Stewart & Shamdasani, 1990). In particular, they were used by social scientists who noted the limits of close-ended questions with predetermined responses (Krueger, 1994). According to Kitzinger and Barbour (1999), focus groups have become increasingly important in academic research: "Over the last few years there has been a three-fold increase in the number of focus group studies in academic journals" (p.1).

Focus groups typically have somewhere between 4 and 12 participants (Kitzinger & Barbour, 1999; Krueger, 1994; Morgan, 1998; Stewart & Shamdasani, 1990; Wilkinson, 2003). According to Krueger, participants are often chosen because they have certain characteristics in common that relate to the topic of the focus group. Stewart and Shamdasani state that participants "discuss a particular topic under the direction of a moderator who promotes interaction and assures that the discussion remains on the topic of interest" (p.10). Wilkinson indicates that the moderator typically comes prepared with a set of questions to guide the discussion, while Krueger adds that an effective moderator creates a permissive, non-threatening environment. Kitzinger and Barbour suggest that the moderator encourage participants to talk to one another, ask questions, exchange stories and comment on one another's ideas.

Wilkinson (2003) notes that focus group interviews are typically recorded and transcribed, although transcription may be more or less detailed. Most commonly, focus group data is interpreted by way of content or thematic analysis, either by hand or with the assistance of a computer program.

A variety of benefits of focus groups have been noted. Stewart and Shamdasani (1990) point out that a focus group provides a rich body of data that is produced in participants' own words, with a minimum of "forced responses." Focus groups allow the researcher to interact directly with the participants and are conducive to asking and answering follow-up questions. Morgan (1998) notes that focus groups share several strengths common to all qualitative approaches: they are conducive to exploration and discovery; they provide context and depth (e.g. background of participants); and they draw upon participants' interest in understanding one another, so the process is inherently geared toward understanding, interpretation, and meaning. Further, Morgan remarks that focus groups can be moderated by a researcher who does not necessarily know a great deal about the topic; participants can be relied upon to provide further direction.

Stewart and Shamdasani (1990) suggest that focus groups are preferable to individual interviews, because members can react to one another and build upon one another's responses; this creates a "synergistic effect," where ideas are produced that might not have been uncovered in individual interviews. Krueger (1994) concurs that focus groups tap into the natural human tendency to develop ideas and projects in interaction with one another. Stewart and Shamdasani say that participants are more likely to be candid in a focus group than an individual interview, because they soon realize that the researcher's attention is on the group rather than the individual and that

they will not be identified with their particular comments. Further, participants are not required to answer every question; they can choose to respond when they are genuinely inspired to respond. Once they are arranged, focus groups are also more convenient than individual interviews. Kitzinger and Barbour (1999) add that the focus group format allows the researcher to see how different views are expressed, reacted to, and changed through social interaction.

The focus group format appears to be particularly well suited to bridge the gap between research and practice for numerous reasons. As Morgan (1998) puts it, "Focus groups are fundamentally a way of listening to people and learning from them. Focus groups create lines of communication" (p.9). In what he calls "problem identification" focus groups, "instead of directing the groups to talk about a predetermined agenda, the research team is trying to learn what matters most to the participants" (p.13). Stewart and Shamdasani (1990) note that focus groups are especially good for stimulating new ideas, creative concepts, and "generating research hypotheses that can be submitted to further research" (p.15). Kitzinger and Barbour (1999) concur. They suggest that "the method is particularly useful for allowing participants to generate their own questions, frames, and concepts and to pursue their own priorities on their own terms, in their own vocabulary" (p.5).

Loneck and Way (1997) provide an excellent example of using focus groups to bridge the gap between research and practice. Loneck and Way conducted focus groups with clinicians who work with dual-diagnosis clients in order to refine "research questions, formulate hypotheses, and select appropriate research methods" (p.108). Loneck and Way contend that the study served to increase the clinical relevance of future

research endeavors and to engender clinical interest and investment in those endeavors. I decided to use the focus group format with group psychotherapists, in hopes that it would yield equally fruitful outcomes.

Phenomenological Theory

According to Giorgi and Giorgi (2003a), phenomenology began as a distinct philosophy in 1970, when Edmund Husserl's (1900) publication of *Logical Investigations* was first published in English. Numerous major philosophers took up the phenomenological philosophy of Husserl during the 20th century, developing a number of research methods founded upon its assumptions and principles. Although specific procedures may vary, phenomenological research methods are oriented toward gaining understandings of particular phenomena. Toward this aim, "a situation is sought in which individuals have first-hand experiences that they can describe as they actually took place in their life. The aim is to capture as closely as possible the way in which the phenomenon is experienced within the context in which the experience takes place" (Giorgi & Giorgi, 2003b, p.27). The specifics of how a researcher analyses a description of an experience, as well as the goals of the analysis, vary depending on the particular researcher who takes up the phenomenological approach and the philosophical assumptions of that researcher.

For example, Giorgi and Giorgi (2003a) state that the goal of phenomenological inquiry is to discern the essence of an experience, suggesting that their approach, unlike many approaches to qualitative research, relies upon the positivistic notion that objective reality exists and can be ascertained. In terms of procedure, they recommend a four step process. First, the researcher reads the description (or the transcription of a description)

for a sense of the whole. Next, the researcher attempts to bracket prior knowledge of the

experience being studied and to observe what is presented, with the understanding that

the researcher's perception may not completely or accurately represent the experience

under study. The researcher re-reads the description, marking each occasion where

meaning appears to shift with respect to the phenomenon of interest, and dissecting the

narrative into "meaning units." Next the researcher attempts to articulate the essence of

the meaning units in language that captures their psychological significance. Finally, the

researcher examines the psychological meanings to discover what is truly essential about

them, and "describes the most invariant, connected meanings belonging to the

experience, and that is the general structure" (p.253) of the phenomenon under study.

Smith and Osborn (2003) present an alternative phenomenological approach,

which they call "interpretive phenomenological analysis." In this approach, Smith and

Osborn take a constructionist approach to phenomenology, placing emphasis on the

socially embedded nature of participants' and researchers' perspectives. They also

suggest that researchers may benefit from considering what might convey without

describing it directly. The procedure Smith and Osborn use holds much in common with

Giorgi and Giorgi's (2003a) approach. The researcher reads the description or transcript

a number of times, noting in the margin what is interesting or significant about the

content. Next the researcher transforms these initial notes into concise themes, which

may involve psychological terminology, aiming to capture the meaning of what was said.

The researcher lists the emergent themes and looks for connections between them,

generating clusters of themes, while regularly consulting with the original transcript to

make sure that the themes and connections are appropriate to the data. A table of themes

is created, in which clusters are presented together and given a name. In writing up the results of the study, the themes are explained, nuanced, and illustrated with verbatim extracts from the transcript. They recommend taking special care to differentiate between the participants' words and the researcher's interpretations, and to link results to the extant literature. In contrast to Giorgi and Giorgi, Smith and Osborn do not suggest seeking a general or essential structure.

Because I wished to gain understandings of my participants' experience as group therapists (with respect to how group therapy works and how research might more adequately address their needs), I chose to use a phenomenological method for data analysis, a method that seeks to interpret the content of participants' speech. As noted above, my philosophical orientation leans away from positivism and toward constructionism; I believe that knowledge and meaning are human creations and that they are inseparable from the contexts in which they emerge. Although exploring the ways in which psychological knowledge is constructed was not the goal of the present study, it was important to me to invite diversity and conflict among participants, to acknowledge ambiguity and uncertainty in participants' accounts, and to acknowledge my own role, as researcher, in the data analysis. The notion of pursuing a general structure, or essence, of the group therapist experience ran counter to these goals. In light of my philosophical orientation, I developed a phenomenological method very similar to that used by Smith and Osborn (2003). The details of my method are outlined in the Procedures section below.

Data Analysis Software

My initial reactions to the idea of qualitative research software included both skepticism and curiosity. However curiosity took center stage when Qualrus (2002), a specific qualitative research software package, was first described to me by a fellow qualitative researcher. She suggested that Qualrus is to Microsoft Word as Microsoft Word is to a typewriter. In other words, Qualrus makes organizing and analyzing a large quantity of data much easier than it would be with a simple word processor. The software does not interpret qualitative data; rather, it provides tools to assist the researcher in keeping track of interpretations and linking them to the original data. I decided to use Qualrus based on this understanding, as well as my hope that skills in using qualitative research software would prove useful in the future.

Qualrus allows a researcher to create "codes," delineate segments of a transcript (segments may be distinct, overlapping, or embedded), and assign one or more code to each segment. For example, one could code an entire comment made by Participant A with the code "A" and code part of that comment, which revealed a view Participant A held about research, with the code "about research." Qualrus offers the researcher multiple ways of searching through a transcript to search for segments and code them. For example, one could search for segments that contain the word "research" and label them with the code "about research." One could then search for segments that have the code "about research," divide these segments into two "stacks" (represented visually as cards laid out on a table), and label one stack "research weakness" and the other "research strength." Once codes are created and applied, the researcher can create links between codes. For example, the researcher could create a link called "is an example of"

and use it to link the code "utilizes case examples" to "research strength." In light of my choice to use phenomenological approach similar to that proposed by Smith and Osborne (2003), I believed that Qualrus would simplify the process of labeling themes and exploring their relations. I describe Qualrus's coding and linking functions in greater detail, with examples from my data analysis, in the Procedures section below.

In addition to its coding and linking functions, Qualrus provides a number of advanced tools the researcher can use once codes and links are in place. Although I developed my research procedures with an eye toward using Qualrus's advanced tools, in the end I decided to limit my use to its coding and linking functions. My decision to abandon Qualrus's advanced functions exemplifies Giorgi's (1970) notion of dialogue between approach, method, and content. While the coding and linking functions seemed to facilitate organization immensely, I found that the advanced tools were confusing, did not add much to my existing impressions and interpretations, and seemed to separate me too much from the original data. In particular, the tools created distance between me and the content I was seeking to interpret by requiring me to manipulate codes, apart from the original data. Further, the tools were conducive to quoting statistical probabilities, rather than to owning and articulating my evolving understandings. When experimenting with the tools, I found myself inclined to manipulate Qualrus into generating (seemingly independently and objectively) the interpretations I was already developing. The phenomena under study and the context of the research, including myself as researcher, seemed to be slipping away. Thus I abandoned the advanced functions of Qualrus in attempts to align my method more closely with the approach and content of my research.

In summary, I chose to pursue my research questions using qualitative methods grounded in constructionist philosophy; such a stance supported reflexivity around the research process as well as interpreting results for their usefulness, rather than expecting results to reveal absolute truths. In particular, I decided use a focus group format for data collection and phenomenological methods of data analysis, with the help of qualitative research software. I believed these methods would allow me to explore the richness and depth of group therapists' perspectives, while allowing for potential ambiguity and uncertainty.

I decided to conduct a pilot study in order to refine my research methods. Having completed multiple courses in qualitative research, I already had experience using phenomenological methods to analyze qualitative data. At the time of my pilot, however, I had never put together or facilitated a focus group. In the following section, I describe the pilot study I conducted in order to put focus group theory into practice and increase my ability to compose and facilitate a fruitful discussion.

Pilot Study

In order to fine-tune my method for the present study I conducted a pilot study with Institutional Review Board (IRB) approval. Based on my review of the literature (e.g. Kitzinger & Barbour, 1999; Krueger, 1994; Morgan, 1998; Stewart & Shamdasani, 1990; Wilkinson, 2003), I created a topic guide (see Appendix A) composed of four broad sets of questions, designed to address my research questions (i.e. how group therapy "works," what role research does or does not play in group therapists' practice, struggles and areas of desired learning, and ideas about research questions and

methodologies that would address group therapists' needs). I estimated that two hours would be a reasonable amount of time to discuss these questions and that having between four and twelve participants would provide sufficient balance between diversity and space for all participants to share. I anticipated that the University of Duquesne Psychology Clinic would provide a quiet and confidential atmosphere.

Through the pilot study, I hoped to find out whether my chosen duration and location were suitable for the study, whether the number of participants was conducive to a lively discussion where each participant was able to contribute, and whether the focus group topic guide did, in fact, inspire discussion among participants. I also anticipated that the pilot study would give me an opportunity to test out recording equipment and to practice my role as facilitator. In other words, I was more interested in the process than the content of the pilot study discussion, insofar as it could inform my method in the present study. Rather than orient myself toward analyzing themes from the discussion, I planned to observe what seemed to facilitate versus interfere with a flowing discussion, and to elicit feedback from participants, following the discussion, regarding any aspects of the focus group that they thought could be improved.

Being a graduate student in Duquesne University's doctoral program in clinical psychology, I had ready access to a large number of practicing individual therapists. Because the purpose of the pilot study was to refine my method, rather than explore my research questions, I decided to simplify recruitment by inviting individual therapists, rather than group therapists, to participate. I altered the language in my topic guide accordingly (e.g. by replacing "group therapy" with "psychotherapy"). I sent an email (see Appendix B) to fellow graduate students on October 27, 2005, describing the pilot

study and inviting them to participate. Six recipients responded and agreed to participate in the pilot study, which took place from 4pm until 6pm on November 13, 2005. Before the focus group discussion, we reviewed the consent form (see Appendix C) carefully and all participants signed two copies, one for me and one for their own records. During the study I noted anything that I thought would increase participation and engage participants more deeply in exploring my research questions. Following the discussion I took notes on participants' feedback.

From the pilot study, first and foremost, I gained newfound excitement for my research study. By the time I conducted the pilot study, I had become relatively exhausted from reviewing literature, planning methodology, receiving feedback and making revisions. My excitement about the project had dampened and I suffered from periodic doubts about whether the project was interesting or worthwhile. The pilot study, however, reignited my inspiration. The conversation was lively, very interesting to me, and appeared to engage participants about issues they were eager to explore. Following the discussion, participants expressed that the experience was enjoyable and stimulating. I felt renewed confidence that involving clinicians in research is a worthwhile endeavor.

The pilot study also helped me fine-tune my method in several ways. Based on participant feedback, I decided to extend the duration of the discussion from two hours to two and a half hours and to include a short break. For the pilot study, I gave participants the topic guide on the day of the focus group discussion, but my experience during the pilot and feedback from participants convinced me that participants would benefit from time to consider the discussion questions in advance. For the present study, I decided to give participants a summary of discussion topics at the time of recruitment.

Following the pilot study, I made a number of revisions to the topic guide. Based on both participants' feedback and my own observations, I determined that the length and complexity of the topic guide were somewhat overwhelming to participants. I simplified the guide so that, rather than having four sections with three or four questions each, it had only three sections with two questions each (see Appendix D). However, in order to retain the nuances of the original topic guide, I transformed it into a facilitator guide that I could use during the discussion to prompt follow-up questions (see Appendix E). When creating the facilitator guide, I expanded the original topic guide slightly by providing multiple ways to ask the same question, depending on what kinds of phrasing inspired more participation. For example, the original question "How would you describe your approach to psychotherapy?" was supplemented by several additional questions, including: "What are some of your theoretical influences?" and "What is the purpose(s) or goal(s) of group therapy?"

Finally, the pilot study provided insight into how I could be a more effective facilitator. During the pilot discussion, I found myself trying to make sure I heard every answer from every person to every question. I felt nervous that I might miss something, that participants might be thinking things they didn't have a chance to say, or that the wording of my questions might not elicit all of my participants' ideas. Toward the end of the discussion, I realized that my efforts to elicit every possible response were fruitless and my fears about failing were unnecessary because, in its very nature, qualitative research designs such as interpretive phenomenology, when built upon constructionist philosophical assumptions, tend toward opening rather than enclosing possibilities. In other words, I recognized my desire to arrive at a comprehensive set of understandings

and conclusions, yet I also recognized that this desire was founded on positivist assumptions about the nature of knowledge and that its fulfillment was antithetical to the theoretical underpinnings of my research.   I wrote myself a note to read before conducting my dissertation study: "Focus on quality vs. quantity of responses. Remember there's not enough time (nor would it be possible) to hear every idea participants have about each question.   Rather than push to answer all questions completely, explore given responses more fully."

Overall, the pilot study was helpful in refining my procedures for the present study, with respect to the focus group discussion. I lengthened the time for discussion and decided to provide participants with a summary of discussion topics in advance of the study. I simplified the topic guide and created a facilitator guide, to avoid overwhelming participants with too many questions while retaining the option to ask complex follow-up questions. I found that having six participants struck a nice balance between diversity of perspectives and time for everyone to share, and that the Duquesne Psychology Clinic provided a quiet and confidential environment for the discussion. My enthusiasm for and confidence in the present study increased. Finally, I experienced how important it was for me, as facilitator, to welcome the rich complexity inherent to qualitative research and to remember that the goal of my research is to open possibilities, rather than uncover and encapsulate absolute truths.

Procedure: The Present Study

Focus Group Topic Guide

As described above I created a topic guide for the present study (Appendix D) composed of three broad sets of questions, designed to address my research questions. For myself, I created an in-depth facilitator guide, with follow-up questions and alternative wordings underneath each general question, to aid in facilitation of the discussion (Appendix E).

The purpose of the first set of questions, in which participants were asked to describe their approaches to therapy and how group therapy "works," was twofold. First, it offered an opportunity to find out who the participants were, in terms of the theoretical and practical threads that guided their work. Participants' responses could then provide a context within which to understand their contributions to later topics. Second, participant responses could be compared and contrasted with findings from the literature review, which indicated problems with the current therapeutic factor system. If participant responses supported findings from the literature review, they could be analyzed to reveal particular weaknesses and point toward possible alternatives.

The second and third sets of questions were both directed toward learning how group therapy research might better address needs of practicing clinicians. The second set of questions was designed to help me generate ideas for potential research endeavors, based on challenges group therapists face as well as areas in which they would like to improve or grow. The third set of questions allowed participants to discuss the role research did or did not play in their practice, how they made sense of this, and how they believed research could be more helpful. I anticipated that responses would help me

evaluate the notion that there is a research-practice gap in the field of group

psychotherapy. Further, I hoped that by positioning the questions in this order,

participants would share their challenges and areas of desired improvement without first

considering these with respect to research, allowing me the space to interpret their earlier

responses, generate research ideas, and then compare their research ideas with my own.

Participants

My goal was to recruit between 4 and 6 participants with diverse approaches to

group therapy in order to give depth and richness to the data, as well as to support wide

applicability of the findings. I wished to find participants with at least 30 hours direct

experience facilitating groups, to maintain the "internal validity" of the study. In order to

recruit participants, I first placed advertisements in both the Pennsylvania Psychological

Association newsletter and the Greater Pittsburgh Psychological Association newsletter

(Appendix F). After two months, during which I did not receive a single email

expressing interest, I solicited help from colleagues, friends, and professors. I sent them

an email, asking them to tell group therapists they knew about my study and to ask those

who were interested if I could contact them (Appendix G).

Seven colleagues, friends and professors responded with contact information for

eight group therapists who were interested in learning more about the study. All but two

of the contacts came from unique referral sources, and the two who were referred by the

same person worked in different practices and had never facilitated groups together. One

of the contacts had studied clinical psychology at Duquesne University, while the others

all came from different training institutions. This gave me reason to believe that they

would each provide a unique perspective, supporting my goal of bringing together a

diverse group. I called seven of them and emailed one, who indicated that she preferred to communicate via email. I approached all contacts with the understanding that, as long as they had at least 30 hours of direct experience leading therapy groups, I would invite them to participate.

Upon contact, I introduced myself and confirmed that the potential participant was interested in learning more about my study. I described the focus group format, the required time commitment, and the location of the study. I gave the potential participant an overview of the focus group topic guide, emphasizing my interest in learning about: challenges participants face in their practice of group therapy; areas participants would like to learn or grow as group therapists; and participants' experiences – helpful and/or unhelpful – with group therapy research. I told the potential participant that I had conducted a pilot study with individual therapists, who had found the experience to be rewarding.

If the potential participant was still interested, I explained that the study would be audio- and video-taped, that identities of participants and any clients they discussed would be protected by means of letter designations, and that a summary of findings would be mailed to all interested participants. The video-taping was described to participants as a back-up for transcription purposes; in particular, I planned to use the video tapes whenever the audio recordings were difficult to understand, as well as for parts of the discussion that occurred while replacing audio tapes. I answered any further questions the potential participant had about the study. For people who indicated they would like to participate, I asked how much experience they had facilitating therapy groups. I asked when they were available to participate and told them I would contact

them within two weeks with a date and time for the study. I welcomed them to contact me in the meantime with any questions or concerns that might arise.

Out of the eight group therapists I contacted, one indicated that he was not interested in participating but would be willing to participate as a favor to the colleague who referred him. He and I agreed that I would contact him if I was not able to find at least four other participants. One male and six female group therapists, however, agreed to participate in my study, so that contacting the therapist who was not interested was unnecessary. All contacts may indeed have been motivated, in part, by a desire to help the friend who referred them, yet every therapist who agreed to participate stated that he or she was interested in the study and looked forward to participating. All participants had facilitated therapy groups for at least four and a half years, so there was no need to exclude anyone from the study.

Once I found these seven participants, I contacted them by email to thank them for agreeing to participate, inform them of the date and time of the focus group discussion, and review the basics of the study (Appendix H). All participants confirmed that they were available on the time and date. One week before the date of the study, I emailed participants to thank them again, remind them of the time and date of the study, and send them directions to the focus group location (Appendix I). I also asked them each to fill out a short form with basic information about their backgrounds with respect to group therapy (Appendix J). This basic information is summarized in the Results chapter, to provide context for the results. Again, I welcomed them to contact me with any questions or concerns.

Focus Group Discussion

With the approval of the Duquesne University Internal Review Board, I recruited an undergraduate assistant from the psychology department, Marisa Romani, to assist with technical and logistical aspects of the focus group discussion, as well as transcription. Marisa did not know any of the participants ahead of time and we had a detailed conversation about confidentiality, after which she signed an affidavit of confidentiality (Appendix K).

The focus group discussion was held at a University Psychology Clinic at 2:15pm on Sunday April 30, 2006. All students and faculty who use the Clinic agreed not to enter the clinic during the hours of the study and signs were placed on the front doors indicating that confidential research was in progress. When participants arrived, coffee, water, nuts and cookies were available on a small table surrounded by a semi-circle of comfortable chairs. Once everyone had arrived, I thanked everyone for coming, introduced myself and my undergraduate assistant, and explained briefly that the goal of the study was to decrease the "gap" between researchers and practicing group therapists by involving group therapists in research. I went through the consent form with participants (Appendix L), highlighting the overall description of the research, the description of participants' involvement, their right to withdraw at any time, confidentiality, and possible risks of participation. I answered any questions participants had and reminded them to contact me, my dissertation chairperson, or the Duquesne University IRB representative (listed on the consent form) with any questions or concerns.

Following signatures, I collected Participant Information Sheets and reminded participants that I would be making a donation of $20 to a charity of each of their choice and that I would send all interested participants a summary of the study's results. I passed out copies of the participant topic guide for our discussion (Appendix D) retaining my more detailed guide to assist with facilitation (Appendix E). I emphasized that they were encouraged to discuss the questions with one another, to question one another, and to comment upon one another's contributions. I explained that we would begin with the first cluster of questions, but from there the discussion could flow from one cluster to another; I would come back to questions that had not been addressed later in the discussion. I then explained my role as facilitator: involving quieter participants, asking follow-up questions, and keeping track of time. I told participants that they would have an opportunity, at the end of the discussion, to reflect upon their experience of participating.

The focus group discussion lasted approximately two and a half hours, minus a fifteen minute break. Following the discussion, Marisa and I locked the video and audio recordings, along with the consent forms and participant information sheets, in a toolbox. I gave Marisa the only key to the toolbox, which was locked in a graduate student office at the Duquesne Psychology Clinic.

Data Transcription

The transcription of the focus group occurred in several stages. First, Marisa created a draft, over the course of several weeks, using a session room at the Duquesne Psychology Clinic to ensure confidentiality. During initial transcription sessions, Marisa listened to audio recordings of the focus group discussion and typed up a draft as she

listened, stopping and rewinding as needed. She saved the draft to disk after each session, which was locked inside the toolbox with the recordings and participant forms. Once Marisa completed an initial draft, she reviewed the video recordings in order to fill in gaps, improve accuracy, and confirm which comments were made by which participant. When this draft was complete, I copied Marisa's disk, I obtained the toolbox with key from her, and Marisa destroyed her copy of the draft.

After obtaining the draft from Marisa, I read through it to refresh my memory of the focus group discussion and gain a general sense of areas where she may have had difficulty. On a second read-through, I listened to the audio tape, rewinding and replaying as needed, to improve the accuracy of the transcription, fill in gaps, and alter any identifying information. From that point forward, I kept the disk with the original draft in the toolbox and saved the de-identified draft to my home computer and to a backup CD. Then I edited the transcript while watching the video, looking in particular to confirm who spoke when. I added, in parentheses, several non-verbal indicators, including: "some laughs" (two or three participants); "many laughs" (four or more participants); "few nods" (two or three participants); and "many nods" (four or more participants). Finally, I edited the transcript for grammatical accuracy.

Data Analysis

As described above in the Methods section, I used an approach to data analysis very similar to Smith and Osborn's (2003) "interpretive phenomenological analysis." By the time the transcription was completed, I had read it approximately four times and had a good sense of its overall flow and central themes. Smith and Osborn suggest that the next step involves noting in the margins what is interesting or significant about the

content of the transcript, based on the research questions under study.   In a similar vein, I went through the transcript closely and jotted down, in a separate document, topics discussed by participants. These notes served as an initial stage for summarizing what participants seemed to be saying, particularly with respect to my research questions. As I listed topics, I attempted to stay close to participants' language; in many cases I simply extracted a centrally important phrase from a particular participant's comment. The document grew, as I moved through the transcript without regard for conciseness or coherence, into a long list of over a hundred phrases (Appendix N).

According to Smith and Osborn (2003), the next step of interpretive phenomenological analysis involves transforming initial notes into concise themes that aim to capture the meaning of what was said. Before generating themes, I decided in advance to use words that expressed my own understanding of participant comments, rather than attempt to classify comments in terms of Yalom's therapeutic factors. I believed that this would allow me to approach the data with the mental freshness necessary to contemplate questions such as: How easy or difficult is it to classify qualitative data, including comments about how group therapy works, into discrete categories? How often do comments regarding "how group therapy works" appear to reflect more than one concept? How do group therapists conceptualize the therapeutic process? Is there a context within which therapeutic factors can be understood as aspects of, or perspectives on, a larger whole? After exploring my own interpretation of the data, I planned to examine it in terms of Yalom's factors, in order to evaluate the issues raised by my literature review.

Examining my long list of topics from the transcript, I attempted to cluster them under concise themes that captured their overarching subject matters, while keeping in mind my research questions. By moving back and forth between the list of topics and my research questions, I arrived at eleven concise themes to use in coding participant comments. In order to capture participant comments about how group therapy works, my first research question, I created four themes: Therapist Role – what therapists do to help clients; Client Need – client needs that group therapy aims to address; Client Struggle – client difficulties that emerge in group therapy; and Client Role – responsibilities clients have with respect to their group treatment. To delineate participants' comments about whether or not research is useful to them in practice, I created two themes: Research Positive – positive experiences using research; and Research Negative – shortcomings or limitations of group therapy research. In order to capture participants' comments about their struggles and areas of desired improvement, I created four themes: Therapist Struggle – areas in which participants struggle as clinicians; Therapist Need – things participants indicated they need in order to feel good about their work and practice effectively; Therapist Benefit – things participants experience as positively impacting their work; and Therapist Question – questions participants seemed to believe were relevant to improved practice. Finally, I created a theme called Research Topics – comments about explicit research topics or methods that participants indicated would be clinically helpful.

At this point, I loaded the transcript into Qualrus to facilitate my analysis. I will describe in detail the procedures I followed using Qualrus, providing examples from my transcript. Following this description, I will provide a visual aide to further illustrate the

process. I began by delineating each participant utterance as a segment and coding it with a letter, A through G, to indicate who had spoken. Then I went through the transcript thoroughly and coded segments of the transcript using the eleven broad themes listed above (Therapist Role, Client Need, Client Struggle, Client Role, Research Positive, Research Negative, Therapist Struggle, Therapist Need, Therapist Benefit, Therapist Question, and Research Topics). While many segments only fell under one broad theme, others reflected more than one. For example, the following comment seemed to reflect a need that is shared by therapists and clients:

> And we're lacking in community so much that a group is extraordinary. It's like, one of the few times people can come together consistently and care. And that in itself is powerful, even just, you know, when they're coming and going, you know, and walking each other to their cars. (Few nods) I mean, I just think we're starving for connection.

The participant seemed to be expressing a need for connection that is shared by clients and therapists alike. Based on both the content and the context of this segment, I coded it with both Therapist Need and Client Need.

Once I had coded the entire transcript with these eleven broad themes, I progressed into a stage of analysis that Smith and Osborn (2003) describe as using psychological language to capture the meaning of participant comments. I examined each broad theme and refined it into more specific themes using Qualrus's Stack function. For example, using Qualrus I generated a list of all segments of the data that I had coded with the theme Client Need. I read through the list of segments carefully and created a "stack" for each specific client need (e.g. support, reduced shame, insight)

described by participants. I constructed these specific themes in dialogue with the data; they were shaped by participants' words, my own background in clinical psychology, and my desire to make meaningful sense of the data in relation to my research questions.

Because Qualrus allows any given segment to be placed in more than one stack, a complex statement could be labeled with more than one specific theme. For example, the following comment seems to reflect clients' need to receive support, as well as their need to voice the unsaid:

> Whatever they're experiencing at the time gets supported, you know,
>
> particularly when you notice that the body language isn't matching what's
>
> being said, or something like that. So they're invited to share what's really
>
> going on. And then they put that piece out there and then the group doesn't
>
> run away or attack them.

Such a comment could be placed in two stacks, one labeled Receiving Support and the other Voicing the Unsaid. After using the Stack function, this comment would be labeled with three codes: Receiving Support, Voicing the Unsaid, and Client Need.

Next I used Qualrus's Link function to create a relationship called "is an instance of" that I could posit between each specific theme and the broad theme within which it was subsumed. For the purposes of this study, these links served to keep my data organized. For example, I used "is an instance of" to link each specific client need to the broad theme Client Need. In the example above, Receiving Support and Voicing the Unsaid were linked by "is an instance of" to Client Need.

Combining the Link function with the Stack function, Qualrus allowed me to use a particular specific theme to refine more than one broad category. For example, I used a

stack called Increasing Self-Acceptance to refine both Therapist Need and Client Need. I put the following segment, initially coded with Client Need, into the Increasing Self-Acceptance stack:

> The work around healing shame really drives so much of the work I do professionally, overall, in terms of helping people to come to a place of acceptance for where they are right now and how their behaviors make perfect sense - finding the "no wonder" in what's going on. And so, kind of overall, I'm very Rogerian in that respect.

The next segment, initially coded with Therapist Need, also seemed appropriate for the Increasing Self-Acceptance stack: "feeling that we're competent… even though we may not be perfect." In other words, while each of these segments was coded with a different broad theme, they share the specific theme Increasing Self-Acceptance. In this case, Increasing Self-Acceptance is linked by "is an instance of" to both Client Need and Therapist Need.

To summarize, Qualrus facilitated my coding the data with specific themes that exemplified the broader themes under investigation. The coding function provided a simple way to transform my reactions to the transcript into themes and label segments accordingly. The linking function served as a way to organize my thoughts and obtain a visual picture of how I envisioned themes in relation to one another. Thanks to Qualrus, rather than shuffle stacks of paper or perform complicated searches on Word documents, I was able to navigate through my data with relative ease. I provide a conceptual map of how two segments (used as examples above) were coded with Qualrus in Figure 1.

Unbroken lines connect the segments to specific themes with which they were coded using the Stack function in Qualrus. Although each segment was actually coded with
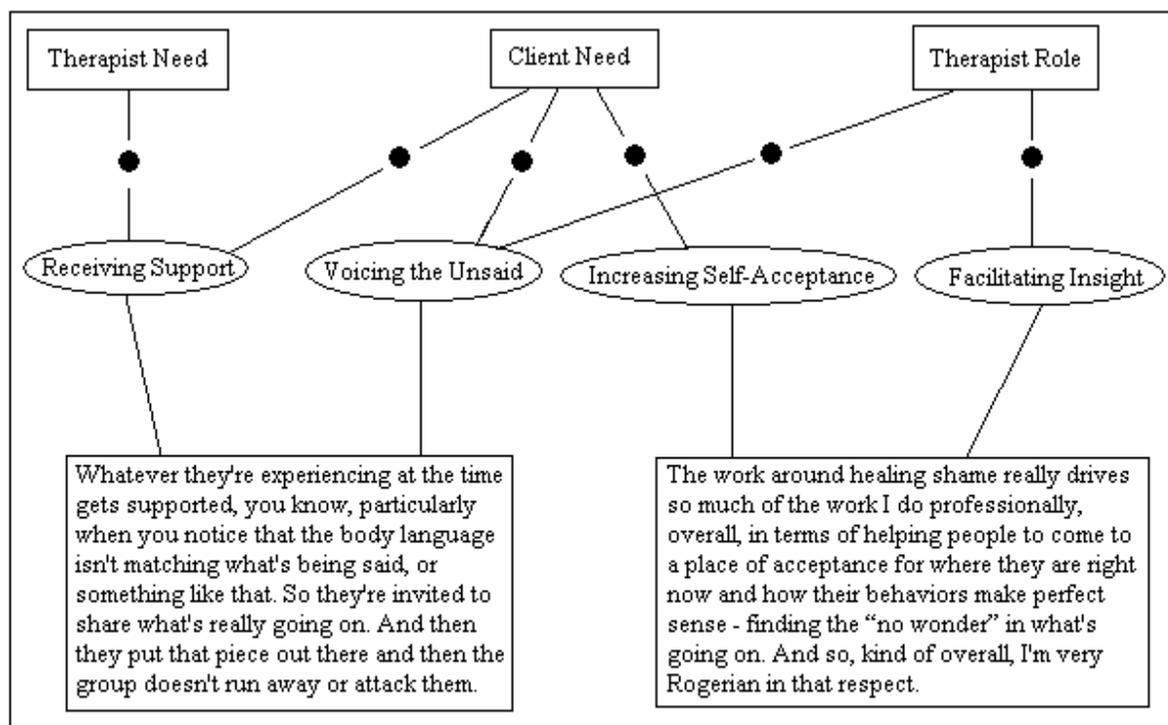
Figure 1: Conceptual Map of Qualrus Codes and Links

more than two codes, only two are provided for the sake of simplicity. Lines bisected with a filled circle represent the link "is an instance of," connecting specific themes to the broader themes they exemplify. Once coded in Qualrus, a segment can never be viewed without the themes with which it has been coded; conversely, every code is easily traced to every segment to which it has been assigned. As a result, when analyzing the transcript using Qualrus, I was always close to the original data. With Qualrus, checking to make sure that codes were appropriate to their corresponding segments was an (almost unavoidable) part of the analytic process.

In the next chapter, I describe the results I obtained using the procedures described in this chapter. I followed the recommendations of Smith and Osborn (2003)

and created several tables of themes, each of which contains results pertinent to a

particular research question. Following each table, the themes are explained, nuanced,

and illustrated with verbatim extracts from the transcript. This form of presentation

allows the reader to differentiate easily between the participants' words and my own

interpretations. The final product is a collection of results that were co-created by

participants and researcher, shaped by our unique clinical perspectives as well as our

strivings to articulate meaningful answers to the research questions under study.

CHAPTER IV: RESULTS

To reiterate briefly, in this study I attempted to learn from group therapists how they believe group therapy works and, based on their perspectives, to evaluate the notion that the current therapeutic factor system is problematic. I also hoped to learn from group therapists what role research plays in their practice and, by this means, evaluate the claim that a research-practice gap exists. Finally, based on group therapists' struggles, their areas of desired improvement, and their ideas about potentially useful research topics, I hoped to generate clinically relevant research questions and methodologies in service of closing the research-practice gap.

In this chapter I present the results of the present study in three sections, each oriented toward one of the study's overarching goals (i.e. to evaluate the claim that there are problems with the existing therapeutic factor system, to evaluate the claim that there is a research-practice gap in the field of group therapy, and to generate clinically relevant research questions and methodologies). In each section, I follow the recommendations of Smith and Osborn (2003) by providing a table of themes used to code the transcript of the focus group discussion and then by explaining and illustrating themes with verbatim excerpts from the transcript.

The first section presents results regarding how participants believe group therapy works, organized under four broad themes: Therapist Role – what therapists do to help clients; Client Need – client needs that group therapy aims to address; Client Struggle – client difficulties that emerge in group therapy; and Client Role – responsibilities clients have with respect to their group treatment. The second section provides results related to participants' experience with group therapy literature, organized under two broad themes:

Research Positive – positive experiences using research; and Research Negative –
shortcomings or limitations of group therapy research. The third section includes results
with respect to group therapists' struggles and needs, organized under four broad themes:
Therapist Struggle – areas in which participants struggle as clinicians; Therapist Need –
things participants indicated they need in order to feel good about their work and practice
effectively; Therapist Benefit – things participants experience as positively impacting
their work; and Therapist Question – questions participants seemed to believe were
relevant to improved practice. The third section also includes specific themes coded as
Research Topics – participants' ideas about clinically useful research questions and
methods.

<center>How Does Group Therapy Work?</center>

In theory, Yalom's (1975) group therapeutic factors reflect the aspects of group
therapy that contribute to client improvement. In other words, therapeutic factors ought
to describe how group therapy "works," or what it is about group therapy that is helpful
to clients. However, critics suggest that the therapeutic factors overlap considerably and
may be impossible to differentiate. If one cannot identify or measure distinct group
therapeutic factors, then research that examines the relative impact of individual factors is
flawed in its basic assumptions. Indeed a number of researchers, including myself,
perceive this to be a significant problem that interferes with the applicability of group
therapy research to clinical practice.

In order to evaluate the notion that the existing group therapeutic factor system is
limited in its relevance to practice-oriented research, I asked group therapists to describe

how they believe group therapy works. I anticipated that participant responses would

support the notion that effective group therapy is too complex to be understood as the

product of distinct, interacting factors. Table 1 includes a list of specific themes I created

Client Struggle	Client Need
- Being Defensive - Being Honest - Developing Insight - Developing Trust - Financial Strain - Gaining Empathy - Isolation - Lack of Knowledge - Limits and Boundaries - Looking at Oneself - Past Trauma - Resolving Conflict Effectively - Self-Acceptance - Shame - Taking Risks - Voicing the Unsaid	- Healing Relationships (Honest, Supportive, Accepting, Compassionate, Committed) - To Feel Understood/Similar To Others - A Self-Aware Therapist - Affordable Therapy - Feedback - Increased Self-Acceptance - Individualized Treatment - Information and Skills - Insight - Reduced Shame - Safety - Support - The Right Group - To Learn To Resolve Conflict Effectively - To Take Risks - To Voice the Unsaid
Client Role	**Therapist Role**
- Being Honest - Creating and Enforcing Rules - Developing Trust - Gaining Empathy - Looking at "Here and Now" - Looking at Oneself - Practicing Relating - Providing Acceptance - Providing Feedback - Providing Support - Receiving Acceptance - Receiving Feedback - Receiving Support - Role Playing - Taking Risks - Witnessing and Helping	- Balancing Needs - Creating and Enforcing Rules - Empathic Listening - Ensuring Safety - Facilitating Insight - Fostering Honesty - Guiding and Focusing Sessions - Looking at "Here and Now" - Making Clients Comfortable - Modeling - Providing and Encouraging Support - Providing and Fostering Acceptance - Providing Information and Skills - Resolving Conflict Effectively - Voicing the Unsaid

Table 1: Client Struggles, Client Needs, Client Role and Therapist Role

to differentiate among various Client Struggles, Client Needs, Client Roles, and Therapist Roles, the broad categories I used to organize participant comments about the group therapy process. In the following paragraphs, I explain the themes and illustrate them with excerpts from the focus group discussion transcript.

Clients who come for group therapy struggle in various areas, and many of these struggles emerge within the context of the group. "How therapy works" involves addressing and overcoming some of these struggles, many of which may not represent clients' initial reasons for seeking therapy. For example, participants noted that many clients experience shame and have difficulty accepting themselves, either as a result of past trauma or due to lack of knowledge about psychological problems and their sources. In the following excerpt, a participant describes how shame and struggles with self-acceptance emerged in a group where the majority of clients identified as homosexual:

> There sometimes is someone who's the scapegoat… and, you know, if
> she's a little bit different, or maybe a lot different (many nods) from the
> group norm that has been established, then…. Straight woman became the
> scapegoat. (Laughs) Yeah, and then people could see their own
> internalized homophobia.

Clients' shame may decrease and their self-acceptance may increase when they speak honestly about difficult feelings or experiences and find that others remain supportive and accepting of them. One participant explained that it is therapeutic when clients realize: "If I share that, you're not going to leave. You're not going to abandon me. We can get through it." Clients may also benefit from hearing that others understand or can relate to their problems. One participant said:

I think it gives an opportunity for people to see themselves as 'the same as,' as opposed to 'different,' because so many people feel that they're different, they're unique. You know, 'You don't understand me.' And in group, they have that benefit of that universality, of seeing themselves in the other (many nods) and oftentimes can have compassion for the other, and in turn starts to, you know create that compassion for self. (Many nods)

One participant added that information about sources of psychological problems (e.g. biological, historical) can serve to reduce clients' shame and self-blame.

However taking the risk to share difficult feelings, painful past experiences, and previously concealed parts of oneself is not easy for clients. Clients may have difficulty trusting others enough to be honest and vulnerable in the group and they may have built up defenses against integrating supportive and/or challenging feedback. As one participant put it, clients have difficulty "developing a sense of trust in oneself but also trust in others to be able to take those risks to talk, to be real… to not have that false self." Clients may also have anger and resentment from past relationships that make it difficult to gain empathy for other clients.

In order to facilitate clients' sharing difficult feelings and experiences, therapists take care to create a supportive and accepting environment, in which clients feel safe to be honest. For many participants, cultivating a safe environment involves creating rules and boundaries, sometimes in collaboration with group members. One participant distinguished between rules that are not open for debate, such as preserving confidentiality, and others that are best left to the group to negotiate. He described a

situation in which the group as a whole decided to ask several members to leave, because they continued to engage in risky behaviors and seemed not to be engaging in or benefiting from therapy. As he explained it, "It was actually the group that made that decision but I allowed it to happen. So I, you know…. You're sort of in tune with your group. You know what's going on." Participants voiced diverse opinions about whether or not it's helpful to instantiate rules about client relationships outside the group; the intensity and length of participants' discussion on this point seemed to reflect their shared appreciation for how relationships outside the group may impact client experiences in group, sometimes in helpful and other times in problematic ways.

Another way in which therapists cultivate a safe, supportive environment is by listening attentively to their clients' needs so that everyone feels heard, and by guiding sessions to balance needs of different group members. One participant said that she uses a check-in at the beginning of group for this purpose:

In the check-in they say what they'd like to work on, if anything, or….
And so I think it's really important to tend to at least getting that
addressed, (few nods) getting people's needs addressed. And I don't mean
taking care of everybody's feelings, but just really paying attention to see
that everyone gets - who wants to - gets attended to, and that no one gets
lost and reenacts something that, well, they didn't work with.

Indeed listening is only one of many ways in which therapists attempt to provide their clients with relational experiences they may not have had in the past. Put another way, therapists try to avoid recreating experiences that have negatively impacted clients.

Throughout the group process, therapists direct clients' attention to the "here and now" when appropriate, encouraging clients to voice things that are difficult to share and facilitating or modeling effective conflict resolution. One participant, for example, described a time when she forgot about the particular needs of a group member when changing their meeting night. This participant focused on the client's feelings in the "here and now" and encouraged her to speak openly about feeling hurt. In turn, the therapist modeled both empathy and responsibility by apologizing to the group member: "I was in the wrong and it was the first time anyone in her life had ever said, 'You're right. I blew it and I'm sorry.' And so it was just amazing, the transformation, just because I said…. I told the truth and said I was sorry."

In the "here and now," therapists also provide feedback to clients about their styles of relating that emerge during group sessions, particularly when these styles are maladaptive. Group members can also offer feedback to other members, providing more opportunities for insight. One participant described a situation in which a group member learned about his style of relating by examining a behavior that elicited confrontation from another group member:

> One nice thing that can happen, though, in that kind of situation is that this confrontation happens in the group and what's happening is one person is responding to this person the way anyone would…. You can actually work on the issue in, sort of, a safe, transparent way, where it's all right out, you know, and it's not all clean, but at least you can do it. (Few nods)

Some of the maladaptive behavior that group members display may reflect social

isolation and a lack of social skills. Once problematic patterns are made transparent,

clients profit from practicing new ways of relating, particularly when conflict arises.

One participant commented, "I've often said to people in my group, it's the person you're

prickly with you're going to learn the most from." This comment was followed by many

nods and sounds of agreement from group. Another participant commented, "You know,

they get to practice with people who are safe."

In addition to attending to feelings, behavior, and issues that emerge in the "here

and now," role playing is another potential venue for exploring feelings and practicing

new ways of relating. One participant described a role-play in which one group member

played herself and another group member played an abusive mother. Not only did the

first group member benefit from confronting her mother figure in a way she was unable

to do previously but, as another participant pointed out, the client who played the abusive

mother likely benefited as well. As he put it:

> It's amazing too to take on the perpetrator or, you know, the bad mother in
>
> a way that becomes humanized… Because if you're being something,
>
> you're still human, so you're not just bad. You know, it's so much more
>
> complicated now.

Safety of group members remained a paramount concern for the participant who

facilitated this role play. As she put it:

> I wouldn't have done it if I didn't think she could have handled it, and she
>
> had lots of support; she had other group members sitting behind her, you

know, supporting her back. And I would check in with her and, of course, facilitated that process.

Beyond the benefits clients reap from others' presence, support, feedback, and acceptance, they also benefit from providing these same things to other group members. One participant noted how valuable clients' feedback can be, particularly when they share similar struggles:

> I think that we are experts of our own pathologies that we can't see in ourselves but it's easier to see in the other (few nods). And so if you get, you know, like, for instance, a bunch of sex offenders in a room, they're going to call each other on stuff.

Another participant highlighted how therapeutic it can be for clients to feel they are helping one another: "They get to participate in the healing process, which in turn is self-healing." Even witnessing fellow clients' group experiences can be therapeutic for group members. As one participant stated: "I think one of the beauties of group is that people get to benefit from each other's work and they get to bear witness to…. They have witnesses to their work: loving, supportive - most of the time - witnesses."

As clients share difficult experiences, receive and provide support and feedback, and experiment with new, more adaptive ways of relating, a trusting community grows among group members:

> It's really the only community that you can come to and be… receive feedback, receive support, be confronted and yet safe, and be able to get angry and still come back, and have to not just leave (few nods) like we do… we all do in our real relationships. (Few laughs)

As a result, clients are increasingly able to take the risks that lead to personal and interpersonal growth. They develop "healing relationships" with the therapist and with other clients, relationships characterized by commitment, compassion, feeling understood, honesty, support, acceptance, and open communication.

According to participants, therapists are best able to cultivate this rare, healing community when they are aware of their own difficulties and blind spots. One participant summed this up when she said,

> I think doing your own work, whether it be going to therapy, you know, paying attention to your own process with your clients, you know, whether it be individual or couples or group… but to be mindful of that piece and be able to say, 'These are the areas I need to work on. These are my blind spots.'

Multiple participants agreed that participating as a client in therapy and/or consulting with colleagues about personal issues that are triggered during group helps them to prevent their own issues from negatively impacting the group process. One participant added that participating as a client in group therapy increased his empathy for group members: "Just the experience of being a client in a group and how defended you are…. And it's so easy to be defensive (many nods)."

Overall I was struck by participants' emphasis, throughout their depictions of what makes group therapy helpful, on the power of interpersonal relationships. Again and again, participants referred to relationships – among group members as well as between group members and the therapist – as integral to group therapeutic work. One participant stated: "As we have all said here, that is what really heals: the relationship."

Another participant commented that research underscores the important role healing relationships play in psychotherapy: "And yet, overall, you know, the one thing I always go back to is, what B said, is really always supported in research: that it is the therapeutic nature of the relationship."

In retrospect, when I examined the codes I created in attempts to capture Client Struggles, Client Needs, Client Role and Therapist Role, I was struck by the fact that nearly all the specific themes both create and depend upon a foundation of healing therapeutic relationships. Even lack of knowledge and financial strain, seemingly individual struggles, are rendered interpersonal by therapists' providing information and skills, and making affordable therapy available. In sum, most of what participants indicated is helpful about group therapy seemed to reflect the powerful role relationships play in healing and growth. In the Discussion Chapter, I explore how this pervasive theme of healing relationships informs my research questions.

<center>Research-Practice Gap in Group Psychotherapy</center>

According to the literature, many psychotherapists do not use the results of research to inform their clinical work. Numerous explanations have been offered, including the inaccessibility of research language for non-researchers, the failure of clinicians to keep up with current research, and the failure of research to provide practice-relevant results. In order to examine the group therapy research-practice gap, I asked participants to tell me about their experiences, both positive and negative, with group therapy research. I anticipated that I would find support for the notion that a research-

practice gap exists, as well as some ideas about why the gap exists and how it can be reduced.

Participant comments about the usefulness of group therapy research literature varied from "I think research is very important and there are a lot of benefits from it" to "I don't find empirical or even qualitative research that useful." The fact that such diverse opinions were expressed and explored suggests that participants felt comfortable, by this rather late point in the focus group, articulating both positive and negative experiences with group therapy research. Based on my interpretation of participant comments, I coded 23 positive comments about research and 32 negative comments. The positive comments seemed to fall under six overarching themes, while the negative comments seemed to fall under five overarching themes. Table 2 summarizes these results.

Research Positive	Research Negative
• Research confirms that the therapeutic relationship is foundational • Research validates what group therapists already do and think • Research finds short, simple ways of helping • Research may reduce clients' self-blame • Research energizes group therapists • Research has potential for social action	• Most interesting questions are raised at end of articles and left unanswered • Cost and time needed to access and read research is prohibitive • Population or treatment studied is too specific to be relevant to practice • Research may reduce acceptable and reimbursable treatment options • Group therapist cannot be "standardized" for research

Table 2: Research Positive and Research Negative Themes

In terms of positive experiences with research, several participants indicated that research stimulates their enthusiasm for group therapy and increases their confidence in their work. One participant stated, "I mean I love it when I read an article and I love it when I go to a conference. It seems great, I'm excited, and it definitely helps my therapy." Some participants expressed that research supports what they already think and do. One

participant commented, "A lot of times it happens that it's validating for what's already going… how I'm already thinking about things. (Few nods) Sometimes it's useful to be able to say, you know, 'Research does say that….'" Another participant responded, "Many times when I read journal articles, it does just kind of validate what I already know after years of seeing patients. (Few nods) And you're right, A, it just kind of makes you feel like, 'Yeah, I was right.'" As noted in the section above, participants also stated that research supports their belief that the therapeutic nature of the relationship is integral to client gains.

In a similar vein, one participant valued research that demonstrates how effective group therapy can be: "The research in sex offender therapy especially says that group therapy is the best modality (few nods)." Research's potential to advocate for group therapy was, indeed, the liveliest topic discussed by participants when asked about positive experiences with research. However because most comments described research's *potential* for social action, rather than research's history of social action, I will save the remainder of these remarks for the next section, where I present participants' ideas about research topics that would address their needs.

Beyond research's capacity to energize group therapists and support what they already do and believe, participants only made a few comments about research outcomes that they find helpful. One participant said that she reads research for information that can reduce client's self-blame:

And I actually… I do a lot of reading. Not on groups, but I do a lot of
reading on eating disorders. I get journals and I find that kind of research
helpful to the client… I mean, to me as a therapist but also to the clients,

because it can help them therapeutically. You can talk to them about the

medical component of the eating disorder. (Many nods) You can talk to

them about medication and neurotransmitters and, you know, and all these

sort of things so there's not so much self blame.

Another participant commented that research can be helpful in finding shorter, simpler

ways of helping clients: "So there are treatments like DBT or a twelve-week group that,

at the end, you measure… did you get structured interview before and after. And if there

was some benefit, you know, I'm all for that." She implied, however, that these shorter,

simpler treatments provide a compromise between no treatment and more helpful

treatments: "If it's between not giving anything to the patient and being able for them to

have that, I'm like, 'Of course.'"

Of all the negative research themes listed in Table 3, two were discussed only

briefly. One participant suggested that the most interesting questions are raised at end of

articles and left unanswered, while another participant said that the cost and time needed

to access and read research limit his motivation. Three themes, however, were discussed

more extensively during the focus group discussion. First, participants claimed that the

population and/or treatment under study is often far too specific to be relevant to their

practice. One participant expressed concern that research studies neglect patients who do

not fit neatly into diagnostic categories:

The other piece about research that is very difficult sometimes is that

patients don't fit models and… or boxes. And because of research… we're

starting to be pushed into, sort of, tracks. And, you know, different clinics

are starting to move in the perspective of, 'If you have this diagnosis

you're going to that group….' But what about the patients who don't fit

one particular piece of it?

Another participant pointed out that therapists end up giving diagnoses in order to gain

reimbursement from insurance companies, and that this interferes with effective

application of research findings:

What happens is you're going to get paid for a certain diagnosis and not

for another one. (Few nods) So what you do is you just give the diagnosis

they want. So it completely flaws whatever they're looking for in the first

place.

To clarify, I asked "So do you mean that, basically, if you're giving a person a diagnosis

for that reason, then they might not even fit into the treatment that research shows is

[effective]….?" (Many nods) The participant replied, "Right."

Participants also had an extended discussion about their fear that research poses a

threat to their practice. If they can't find a research study to endorse what they do, if they

don't know how to do research themselves, or if their approaches to therapy are difficult

to study, their services may be considered invalid and un-reimbursable by insurance

companies. One participant stated:

Now I'm hearing more about, 'Oh, we can't do that because that's not

evidence based.' (Few nods) And I think it's bringing to group therapists -

or to anybody who's doing psychodynamic work or that doesn't have a lot

of research - some challenges in terms of how, you know, to prove to

people… because managed care is controlling everything…. I think that's

where we need the research because we need to defend what we're, you

know, doing and we need to prove it to someone, although we all know it

works. But for other people we need to prove it so that it continues. But at

the same time, when you don't get the results of that study just because it's

so difficult to do the research, then you're also limiting all of these patients

from getting what they need. (Few nods)

Four of the seven participants explicitly expressed concern about their lack of outcomes

data supporting their work, as well as desire to learn about and document the impact of

their services. As one participant put it, "It would be really nice to have a little research

team follow behind and just like crank it out to me every now and then." I will explore

this topic further in the next section, with respect to Therapist Needs.

Finally, four out of seven participants made comments reflecting the impossibility

of standardizing the group therapist component of a group in order to conduct a research

study. As one participant stated:

One of the limitations of research is that we are… or… we are the service.

It's our person-hood. (Few nods) It is our humanity. And regardless of

how much we try to, you know, standardize, the human element can not be

removed. And if you remove it, you remove the most healing component.

So I think that's something that research constantly bumps ups against.

Another participant echoed the centrality of human connection to effective group therapy:

And that's what our philosophy is because, you know, it's really the

human-ness that connects people and it's not about your… you know, your

body size or what, behaviorally, you're doing. It's really about what are

you struggling with underneath and how that makes people connect.

One participant illustrated how trying to eliminate the person of the therapist interferes with practical applications of research findings. She stated that she uses DBT, an evidence-based treatment, but has no way of knowing whether or not she is doing it effectively; she and a different group therapist might provide the same treatment in very different ways.

In summary, participants indicated that they appreciate research for inspiring them, validating what they already do, providing information about symptom etiology that can reduce clients' self-blame, and generating shorter, simpler ways of helping clients. On the other side, participants expressed concern that research tends to study specific diagnostic categories, which may neglect a significant percentage of clientele and drive therapists to make inaccurate diagnoses in order to obtain reimbursement. They also expressed fear that their own approaches to therapy will become obsolete if they are not studied and supported by research. It is notable that none of the participants indicated that they use research to learn new therapeutic techniques or to determine how to work with particular client populations.

Group Therapist Challenges, Areas of Desired Learning, and Research Topics

As I described in Chapters II and III, some authors suggest that a lack of clinical relevance explains the research-practice gap in the field of psychotherapy. Based on a literature review and my clinical experience, I argued that this explanation has merit and is worth addressing. In order to help me generate research questions and methods that would, in fact, possess clinical relevance, I asked group therapists to describe their

challenges and areas of desired learning. I also asked participants to tell me how research

could better address their needs, in terms of research topics or methods.

Table 3 includes the following broad themes, oriented toward generating

clinically relevant research questions and methods: Therapist Struggle – areas in which

Therapist Struggles

- Assessing Outcomes
- Balancing Member Needs
- Becoming Self-Aware
- Creating and Enforcing Rules
- Dealing With Difficult Clients
- Dealing with Managed Care
- Diagnostic Categories
- Ensuring Safety
- Financial Strain
- Finding the Right Group for Members
- Finding Time and Self-Discipline to Seeking Out Training
- Fostering Honesty
- Guiding and Focusing Sessions
- Isolation
- Maintaining Confidence
- Making Clients Comfortable
- Providing and Fostering Acceptance
- Resolving Conflict Effectively
- Social Devaluation of Group
- Determining One's Resistances
- Decided When Clients are Ready for Termination

Therapist Benefits

- Consultation with Other Therapists
- Having a Co-Leader
- Peer Support
- Remembering Their Love for Group Therapy
- Talking About the Power Group Therapy
- Talking About the Privilege of Leading Groups

Therapist Questions

- Am I doing evidence-based practice (e.g. DBT) in a way that's effective?
- Are clients honest on therapy feedback questionnaires?
- Are my feelings a good judge of how effective my therapy is?
- Do clients believe therapy feedback questionnaires are truly anonymous?
- How can I obtain outcomes data about my own practice?
- Is the way clients appear to feel about me a good indicator of how useful my therapy is to them?
- What is helpful about my therapy? How is it helpful?
- What makes my individual work effective and how can I measure it?

Research Topics

- Cost-Effectiveness of Group Therapy
- Overall Effectiveness of Group Therapy
- Client-Therapist Match
- Spirituality and Psychotherapy
- Case Studies

Therapist Needs

- Advocacy
- Confidence
- Connection/Intimacy
- Feedback
- Information and Skills
- Safety
- Self-Acceptance
- Self-Awareness
- Support
- To Remember Their Love for Group
- To Take Risks

Table 3: Research Topics and Therapist Struggles, Questions, Needs, and Benefits

participants struggle as clinicians; Therapist Need – things participants indicated they need in order to feel good about their work and practice effectively; Therapist Benefit – things participants experience as positively impacting their work; and Therapist Question – questions participants seemed to believe were relevant to improved practice. Finally, I include a broad theme called Research Topics – direct comments about research topics or methods that participants indicated would be clinically helpful.

Most of the Therapist Struggles correlate with fulfilling the Therapist Role and addressing the Client Needs outlined in Table 1. For example, group therapists are expected to balance needs of members, create and enforce rules, ensure safety of group members, foster honesty, guide and focus sessions, make clients comfortable, provide and foster acceptance, resolve conflict effectively, become self-aware (e.g. of one's own resistances), find the right group for clients with diverse needs, and provide healing relationships for difficult clients. The multiple roles a therapist is required to play in order to meet clients' needs may be challenging for group therapists. For example, in the following comment a participant explains how difficult it can be to balance needs and ensure safety of all clients, when some clients are less vocal about what they need:

> I think it's really important to [make sure] that no one gets lost and reenacts something that, well, they didn't work with. But sometimes I don't know. If I don't know about it, I can't…. So that's a big challenge to me… is to just not get caught up in someone who might be more dramatic or more articulate or expressive.

Another participant commented on the challenge of resolving conflict between difficult clients:

I have a number of people that have Axis II, you know, personality

disorders and some are fairly severe. And so managing that when you

have multiple people getting triggered and helping them to have, you

know… helping to facilitate effective conflict resolution really is a

struggle. (Few nods)

As noted above, participants had a lengthy discussion about their struggles with respect to

creating and enforcing rules in the group, particularly those that pertain to relationships

outside the group. One participant stated:

In particular, you know… working with LGBT, you know…. They really

have a hard time, you know, because a lot of times they're very isolated

and they have a very difficult time forming social support. And so, you

know, "Why can't this be my social support?" You know, and then so,

you know, you answer the question and the group answers the question.

In sum, the majority of Therapist Struggles simply reflect the challenges inherent to

meeting group leader responsibilities.

Therapists also struggle with diagnostic categories, social devaluation of group,

and dealing with managed care, all of which relate to Therapists' Need for advocacy.

Participants explained that: insurance companies reimburse them for certain diagnoses

and not for others; managed care often limits clients to an insufficient number of sessions

per year; and managed care combines individual and group therapy benefits, despite the

fact that group therapy is less expensive than individual therapy. Participants suggested

that research might be able to advocate for continued or expanded benefits. One

participant stated: "If research convinced managed care that this would be cost effective

for them, it would be very helpful." Another participant expressed frustration that research seems to be the only way to convince insurance companies, large treatment providers, and the general public, that group therapy is worthwhile:

> I've already seen it here at the facility where I work. The only way that I can get, like, things to happen…. Like, I bring a paper or something and I say, 'Can I do family therapy? Please, look there is a paper here.' (Many laughs) And it's the only way that people will start listening to me and start opening doors. And it's very sad that that's where we are, but that's where we are.

A couple of other participants expressed similar frustrations and indicated their wish that researchers would advocate for the survival of group therapy.

A majority of participants communicated their desire to learn how to research their own practices and/or improve their own outcomes assessments. The Therapist Questions listed in Table 2 articulate this desire in diverse ways. While one participant asked, "So, you know, DBT is an evidence-based treatment but am I doing it in a way that's effective?" another participant wondered about client feedback questionnaires: "You know, if it's anonymous, do they trust that it's anonymous? (Few nods) If it's not anonymous are they, you know, are they filling it out honestly?" Another participant stated, "I think that what would be most helpful to me would be to be able to, in some way, have documented the results of being in group for a certain length of time." To clarify I asked, "From your own groups, you mean?" and she replied, "Mm hmm. It would be so helpful because, you know, I have a subjective assessment of what I see and it's remarkable. It's miraculous in some cases. But it's anecdotal and it's subjective." In

general, participants seemed to desire improved skills and resources to document their own outcomes, both to improve their own practice and to advocate for its continuance.

Beyond the potential research has to advocate for group therapy as a worthwhile modality and to assist clinicians in researching their own practice, one participant had several ideas for research topics that would be relevant to her work. She expressed interest in research that would explore spirituality and psychotherapy, the body-mind connection, and therapist-client match. With respect to methods, this participant stated: "I think studying clinicians a lot of times would be more useful, as the research, than studying clients (few nods)." With an eye toward research methods and forms of presentation that are helpful to clinicians, three participants indicated that they prefer the *Psychotherapy Networker* to other journals, because the articles: are practice-based; involve dialogues between practitioners; focus on case studies; provide summaries of current research; and are accessible to clients.

Perhaps the most interesting surprise I encountered in the data was the similarity between Therapist Struggles and Client Struggles, and between Therapist Needs and Client Needs. For example, group therapists struggle with isolation and lacking confidence, much like the clients with whom they work. One participant commented on how difficult it is to run groups in an agency where group therapy is neither well-understood nor viewed as a particularly valuable treatment modality:

I mean, it's a great opportunity but it's hard work… and then not having other colleagues at the agency who enjoy group, you know… feeling isolated in that way. (Group nods) You know, where you really…. I really don't have anyone else to go to, to get support and talk about, you

know, what's going on. And this feeling, 'Oh conflict, oh,' you know,

rather than being supportive (few nods). This means we have some

cohesion here, you know, and they're willing to take these risks. And so

having people understand group work at the agency….

Five out of the six other participants nodded in agreement.

Three participants spoke openly about their lapses in confidence, a topic not easily broached among a group of professionals. Although some participants expressed the belief that finding time and self-discipline to seek out training would improve their confidence, other participants urged them to cultivate confidence in themselves despite not having "all the answers." One participant stated: "You just want to know everything and you want to think you're supposed to have the answer. And after a while you just realize, like, that's not it." Two other participants voiced agreement, while another pointed out that paying for her own trainings is a financial strain. Later, one participant discussed her feelings of self-doubt: "I think sometimes I struggle with the other side, like, that even though I'm not at *this* place, I still have something of value to offer today." A participant with more group experience responded, "Which, on the other side, is feeling that we're competent… even though we may not be perfect. (Many nods) You know, and that just being competent doesn't equal failure. You know, that it's something in and of itself."

Also like clients, therapists need feedback in order to develop self-awareness, or insight. As on participant put it:

I'm still blind and I am, you know, lost, in that I don't have a co-facilitator

and I'm not in peer support. So, I know from my experience working with

other people that there are some people I must be not jiving with well,

because you can see that in someone else.

Like clients, therapists need safety in order to take risks. Ironically, one participant commented on the appearance of this phenomenon in our focus group discussion: "Everyone wants to talk, you know, and it's always safer to talk about something if you're holding something," to which another participant responded, "Like us (holding up topic guide)." Like clients, therapists need greater self-acceptance: "When you get to the point where you just open to making mistakes and talking about that and just saying… you know, and processing that, and it's okay, you know?"

Finally, and perhaps most importantly, group therapists need supportive relationships, just like clients do. One participant commented:

I do have a consultation group I go to once month, but it's just…. It's a rich environment and, because of busy schedules with kids and work and everything else, that for me personally it feels really enriching to do this and it taps into a need that I have.

The preeminence of therapists' need for support is perhaps most evident when one notes that every single member of the focus group expressed a desire to continue consulting with other participants. One participant stated:

I feel very grateful to have met you all and I do hope that, perhaps, there will be some more conversation about consultation or peer supervision (few nods), because I don't have a lot of group therapists, you know, in my circle right now. And I really could use that.

In fact, some participated in the study with explicit hopes of creating supportive connections with other group therapists. During our introductions, one participant stated, "I hope that I can also make a network here and be able to get a little bit more exposure and possible mentoring." Several participants explained that consulting with other group therapists reminded them how much they love leading groups. One participant stated: "It has helped me to get all excited about doing a group again. (Many nods) And also it has helped me just to know again how much I love doing groups." Another added, "I just feel like so energized and supported." Finally, one participant said she was reminded of what a privilege it is to lead therapy groups:

> I can feel the excitement and the charge around when I talk about working with groups and remembering just how powerful it was and is, and just how… just what a privilege it is to be able to walk alongside people when they're in such a vulnerable and scary place.

Many participants nodded in agreement.

It wasn't until I was coding the transcript using Qualrus that similarities between participants and clients stood out for me. Participants, however, highlighted their similarities with clients long before I noticed their similarities in the data. As one participant put it:

> I was in a process group for a couple of years and that…. It was very helpful. You know, it really becomes like… what I do in my work is who I am. (Few nods) You know what I mean? And there, I really do feel that I am the same as, you know, the people in the group.

Another participant put it more succinctly when she stated, "I always say to my clients, 'The only difference between you and me is I have wheels on my chair' (many laughs)."

In summary, when asked to describe their struggles as group therapists, participants noted that many of their responsibilities, such as maintaining safety of group members, balancing needs, and resolving conflict, could be challenging at times. Group therapists also struggle with the possibility that research on specific treatments for specific diagnoses will lead managed care and large-scale providers to believe that alternative approaches (e.g. group therapy for heterogeneous clientele) are ineffective.

Despite fears that research may threaten their viability as clinicians, participants also perceived research as a potential ally if it advocates for continued group therapy benefits and assists them in determining the effectiveness of their own practices. In addition, one participant expressed interest in research on spirituality, body-mind connection, and client-therapist match. Numerous participants indicated that they prefer the *Psychotherapy Networker* to other publications, because the articles are concise, accessible, practice-based, and case-oriented, and because the *Networker* includes viewpoints of diverse practitioners.

Unexpectedly, participants shared a number of needs and struggles that resembled those they described with respect to clients. Like their clients, participants struggle with isolation, self-acceptance and confidence, reflecting their needs for support, safe people with whom to share difficulties, and constructive feedback. Overall, participants said that they enjoyed participating in the present study, particularly because it provided a confidential venue where they could forge supportive connections with fellow group therapists. They expressed renewed enthusiasm for facilitating therapy groups and

optimism about continued consultation with other participants. In the next chapter, I will

revisit the literature on group therapeutic factors in light of my results.

CHAPTER V: DISCUSSION

Group psychotherapy has existed within the field of psychology for approximately one hundred years and research has continually supported the notion that groups help clients improve in areas of difficulty. Beginning around the middle of the 20th century, researchers began to search for the factors at work in effective group therapy. Currently, the most widely accepted system of therapeutic factors remains that which Irvin Yalom put forth in his 1970 publication of *The Theory and Practice of Group Psychotherapy.* Since then, numerous researchers have studied Yalom's therapeutic factors in varying contexts and with diverse populations, in order to determine which factors are most helpful to whom and under what conditions.

In reviewing the literature that explores the relative value of group therapeutic factors, I documented and illustrated a number of criticisms that have been voiced with respect to this body of research. In particular, I highlighted: difficulties in identifying, defining, and differentiating the therapeutic factors; methodological weaknesses, such as over-reliance on client report and potentially inadequate measurement instruments; and neglected topics that are relevant to practice, such as therapeutic factors' relation to client outcome, how therapeutic factors appear and can be enhanced in practice, and the impact of therapist and client variables on therapeutic factors. I conceptualized all of these problem areas as part of the well-documented gap between psychotherapy researchers and practitioners and I argued that involving group therapists in the development of practice-relevant research questions and methods would serve to reduce this gap.

Before addressing the research-practice gap and attempting to forge a bridge, I first needed to evaluate the claim that this gap does, in fact, exist in the field of group

therapy. Indeed, none of the participants in the present study indicated that they use group therapy research to learn new therapeutic techniques or to alter their approaches with clients. This absence strongly supported the notion that a research-practice gap exists in the field of group psychotherapy, providing the evidence I needed to pursue the remaining goals of my study.

In order to address the research-practice gap, I designed the present study with several objectives. I wished to evaluate the notion that there are problems with existing methods for studying what is helpful about group therapy, to clarify what is problematic about these methods and consider how they impact the field of group therapy, and to involve group therapists in generating research questions and methods that would help us, as researchers, move beyond the limitations of our current approaches in order to meet the needs of practicing clinicians. In service of these goals, I organized and facilitated a focus group discussion among experienced group therapists, where they had a chance to describe how they believe group therapy works, challenges of being a group therapist, areas of desired learning, experiences with group therapy research, and ideas about research questions and methods that would address their needs. I used a phenomenological method of data analysis, rooted in a constructionist research philosophy, to generate themes from the focus group discussion that addressed my research goals.

In Chapter IV I provided the results of the present study in three sections: the first for participants' ideas about how group therapy works; the second for participants' experiences with group therapy research; and the third for group therapists' challenges, questions, needs, and ideas for practice-relevant research. In this chapter, I integrate

these results and discuss their implications in two sections. First I explore problematic aspects of current, dominant approaches to group therapy research, including the notion of therapeutic factors as a guiding force, attempts to eliminate the person of the therapist, and specificity with respect to diagnosis and treatment approaches. I conceptualize these features of current research methods as belonging to a research paradigm borrowed from the natural sciences. I consider how a positivistic, scientific research paradigm, despite its appeal, may negatively impact the field of group psychotherapy and contribute to the research-practice gap. In the second section, I explore ideas for how researchers may approach group therapy differently, in order to address the shortcomings of dominant approaches while increasing research's relevance to practice. I conclude with a summary of the present study and its implications for future research.

Limitations of Dominant Group Therapy Research Methods

Based on my literature review and the results of this study, numerous limitations of dominant approaches to group therapy research appear to stem from the scientific paradigm within which they operate. Therapeutic factors, seemingly distinct and quantifiable variables, are studied in place of the therapist, the client, and the healing relationships they forge. This paradigm may be popular because it simplifies research design, while communicating that psychological research outcomes deserve the same credence our culture gives to scientific discoveries.

However, the problem with studying therapy groups within a scientific paradigm is that, at its very foundation, this paradigm is inappropriate to the topic under study. The scientific method was designed to study objects that can be controlled and manipulated,

and whose impact can be discerned and predicted. Human beings and the complex ways in which they relate, however, cannot be defined in terms of discrete variables. Human beings have thoughts, feelings, desires, and fears. They are socially, culturally and historically embedded in contexts that permeate their beings and lend meanings to the world around them. To study human phenomena as though they have the same ontological status as objects means, necessarily, to overlook a vast portion of their meaning and significance. While emphasizing cause and effect between isolated variables, the natural scientific paradigm cannot honor the complexity, ambiguity, and nuance of the human encounters that comprise group therapy. Not surprisingly, research findings generated within such a research paradigm are bound to be at best simplistic, at worst inaccurate, and in any case difficult if not impossible to apply in real world settings.

In the first three sections that follow, I consider three central themes from the results of the present study that reflect this discord between research paradigm and topic of inquiry. First, I explore the notion that therapeutic factors are not, in fact, distinguishable and that there is, in addition, something ineffable about the group therapy process. Second I consider the phenomenon whereby researchers attempt to eliminate or reduce the impact of the therapist on research outcomes. Third I discuss researchers' tendency, in psychotherapy research, to study the effects of specific treatments on clients with particular diagnoses. In each section I integrate participant concerns with my own, infusing the discussion with support, where appropriate, from relevant literature.

In the fourth section, I tie the first three sections together by considering how studying therapeutic factors, neglecting the person of the therapist, and focusing on

specific treatments and client diagnoses can all be conceptualized as part of a movement toward empirically supported treatments (EST's) in the field of psychotherapy, a movement that espouses the assumptions of the natural scientific paradigm. I examine the implications of this research paradigm, as it contributes to the research-practice gap and potentially hinders our capacity to provide quality client care.

Therapeutic Factors Cannot be Distinguished and Quantified

Overall, I found that the majority of comments made by participants, with respect to how group therapy works, reflected more than one concept or "therapeutic factor." My frequent sense that segments warranted more than one code supported my impression that therapeutic factors are not easily distinguished from one another, but tend to overlap and intertwine with one another.

As Yalom (1975) states quite directly, group therapeutic factors are not truly distinct from one another, yet the most common approaches to researching group therapeutic factors involve dividing qualitative data into discrete categories, one for each factor. On the surface, it is easy to find segments from my transcript that seem to reflect one of Yalom's particular therapeutic factors. Consider, for example, the following statement:

> In group last week one of the members, who's older, disclosed that she had
> a teenage daughter and the youngest member of the group is 20…. She
> [the youngest member] was all uncomfortable and everything and the
> other people in the group noticed. So we processed all of that because she
> was having a real reaction to having a mother figure in the group.

If I were using the Critical Incident Questionnaire to classify this incident, I would most likely classify it as "the corrective recapitulation of the primary family group." However, if the above statement is placed in context, classification becomes much more difficult. The participant quoted above continued:

> And to be able to talk about that… which brought up a lot of pain for her about her mother not being available to her. So you know, it's along those same kinds of lines, that it's not always - maybe that's sort of your second question (to facilitator) - it's not always even to be supported. It can sometimes even be that hard feelings come out and conflict can come up in group, which ultimately we try to resolve. But, you know, it can also be something that teaches people more about themselves and what's inside them that they wouldn't be able to get with a therapist or, you know, a friend or something.

This addendum suggests that others of Yalom's therapeutic factors, including catharsis, insight, development of socialization techniques, and interpersonal learning, would also apply to the incident described. In my own coding scheme, I used the following themes to describe the Client Roles involved in the segment above: voicing the unsaid, being honest, resolving conflict, receiving feedback, providing feedback, and looking at oneself. Whether it is labeled using Yalom's factors or using the themes I created, this segment, like many others, resists confinement to one category alone.

Other segments, rather than seeming to reflect multiple therapeutic factors, don't fit neatly into any of the therapeutic factor categories. For example, four out of seven

participants referred to a "group energy" that members experience and that shifts over time. One participant explicitly stated that this energy is difficult to label:

> I just wanted to add one additional piece in addition to the perspectives and the community and the other things that have been said. It's that, energetically, there's an experience. And we don't really have language for that, you know, or we don't talk about that a lot. But energetically there's something that happens. (Few nods) Part of it's that pressure, but there's also, just…. You feel something in the room. (Few nods) And so it's easier for… for clients to identify that, and I think that's really useful. And so the experience itself gives, you know, a feedback of sorts. It's inspirational.

I experienced difficulty finding a name for this theme and ultimately decided not to name it, but rather to use it here as an illustration. Within Yalom's system, this segment could be construed as "instillation of hope" or "group cohesiveness," although neither of these labels captures the ineffability of what this participant described. Strupp (1989) states this point well when he notes that "a human relationship, which psychotherapy basically is, will always encompass ineffable elements" (p.717). Research studies in which therapeutic factors are assumed to be distinct from one another, ranked-ordered, and correlated with outcomes measures, are unable to capture these ineffable aspects of the therapeutic relationship.

My difficulty identifying, classifying, and differentiating themes, similar to the difficulties reported by critics of therapeutic factor research, supports the notion that therapeutic factors are not separable, nor can one construct the group therapeutic process

by summing factors like ingredients in a recipe. However, it is understandable that we are tempted to divide the group process into distinct variables, when one considers the values espoused by the natural scientific paradigm, so often adopted by researchers in the field of psychology. From such an epistemological starting point, causal relationships between variables are sought after as the ultimate form of knowledge and truth, and correlations between variables are an acceptable second, especially when experimentation is not possible. When it comes to group therapy research, some critics suggest that measuring therapeutic factors' comparative significance ought to be replaced with correlating therapeutic factors with outcomes variables. In such suggestions we find the implicit assumption that the closer we come to approximating the scientific method, the more academic credibility we attain.

However if therapeutic factors cannot, in light of human experiential reality, be differentiated and quantified, attempts to use natural scientific methods will necessarily generate questionable results. In requiring us to artificially break down human phenomena into discrete components, this paradigm distorts our research topic from the very start. In terms of group therapy, the Q-Sort and Critical Incident Questionnaire distort the topic under study by attempting to classify and study parts of a whole that cannot be understood except holistically. If what we study in the laboratory differs so significantly from the lived group therapy experience, results will necessarily be difficult or impossible to apply to group therapy in practice.

Researchers' Neglecting the Person of the Therapist

Participants expressed concern that psychotherapy research studies often attempt to standardize or "eliminate the variable" of the therapist. Numerous authors have voiced

similar concerns (e.g. Lambert and Bergin, 1994; Norcross, 2002; Orlinsky et al., 1999; Vermeersch, 2006). Vermeersch (2006) emphasizes that therapists are, indeed, often treated as confounding variables in psychotherapy research:

> Outcome research in the last decade has extensively focused on the effects
> of specific treatments for specific disorders, so-called clinical trails.
> Researchers employing this methodology typically eliminate the
> individual therapist as an important factor in client outcome (p.1158)

Norcross points out the discrepancy between this common practice of attempting to reduce the therapist's impact on treatment and the contrasting evidence that the therapist, in context of relationship, is vital to therapeutic gains:

> Although efficacy research has gone to considerable lengths to eliminate
> the individual therapist as a variable that might account for patient
> improvement, the inescapable fact is that the therapist as a person is a
> central agent of change (p.4)

Attempting to reduce or eliminate therapists' impact on outcomes is even more counterintuitive given that, according to Lambert and Bergin, different therapists offering the same treatment have demonstrated significantly divergent therapeutic results. While some claim that divergent results may be due to low treatment integrity (the extent to which a treatment is implemented as intended), Perepletchikova's and Kazdin's (2005) literature review suggests that treatment integrity may be less correlated with outcomes than many researchers presume. They suggest that therapist and client characteristics may influence, or be confounded with, treatment integrity in outcomes studies.

To try to eliminate the therapist's impact from group therapy research is to assume that techniques are mechanical, objectively distinct and demarcated, and can be performed in the same way by any therapist. Researchers may find themselves attracted to this way of thinking because it simplifies the research process as it simultaneously accrues from an objective and positivistic epistemological essentialism. Techniques are more conducive to quantification and measurement, so necessary to natural scientific methods, than are the human beings studied in psychological research. If we assume that the therapist can be eliminated from group therapy research, we are saved the burden of contemplating one of the most complex aspects of that which we wish to understand. Assuming that techniques operate independently may also facilitate the creation of treatment manuals, increasingly popular in academic circles and desirable to managed care companies. As hard as we may try, however, "techniques cannot be separated from the human encounter" (Lambert & Bergin, 1994, p.167).

When we attempt to eliminate or reduce the impact of the therapist on outcomes studies we negatively impact the field of group therapy in several ways. Similar to dividing the group therapy process into distinct therapeutic factors, disregarding the person of the therapist creates research conditions that do not accurately reflect group therapy in practice. Findings are likely to be distorted and difficult to apply in real world settings. Further, researchers who focus on technique in order to develop treatment manuals may create the perception that adequate training consists of teaching trainees to access and implement appropriate resources. The quality of client care is bound to suffer if training emphasizes manualized techniques, while neglecting the skills, sensitivity, and

interpersonal attunement trainees need to develop in order to cultivate relationships that foster healing.

Researchers' Emphasis on Specific Treatments and Diagnoses

Participants also voiced concern about the specificity of research treatments and populations. My literature review supported the notion that psychotherapy research tends toward considerable specificity, as most research studies on group therapeutic factors examined their relative value given particular client populations. Norcross (2002) echoes this observation: "Most practice guidelines and evidence-based compilations unintentionally reduce our clients to a static diagnosis or problem" (p.5). This phenomenon is distressing in light of participants' indications that few clients fit neatly into diagnostic categories, as well as research indicating that categorical diagnoses may not be very reliable (Heumann & Morey, 1990, p.498). Howard, Orlinsky and Leuger (1994) make an even stronger statement about the limitations of our widely accepted diagnostic system: "The DSM-III-R diagnostic system has not been very useful for categorizing patients, it being more or less arbitrary and seemingly ever changing" (p.5).

If diagnostic categories fail to capture the complexity and uniqueness of the typical client who comes for treatment, if they are regularly altered by the psychological and psychiatric community, and if they tend to be unreliable forms of case conceptualization, why are they used so often by psychotherapy researchers? As noted in the section above, to reduce is to simplify; and the simplified rule is the cornerstone of naturalistic epistemology. Relying upon diagnostic categories, much like neglecting the person of the therapist or dividing the group process into discrete therapeutic factors, appears to eliminate the complexity and ambiguity inherent to human phenomena. When

reduced to categories, human beings are transformed into objects that are more easily examined with scientific research methods. Further, when a pool of potential research participants is streamlined, so that all those invited to participate in a study are extremely similar to one another, treatment effect sizes are likely to be larger. In other words, similar participants are likely to respond similarly to a particular treatment. Larger effect sizes translate into better likelihood of publication, often a strong motivator when developing a research project.

Despite its appeal for researchers, however, it appears that excessive research specificity, with respect to treatment and population, negatively impacts the field of group therapy in multiple ways. Participants expressed concern that clients who do not fit into diagnostic "boxes" may be underserved or that therapists may assign inappropriate diagnoses, corresponding to inappropriate treatment guidelines, in order to maintain reimbursement from insurance companies. Norcross (2002) agrees that "practice guidelines and EST [empirically supported treatment] lists do little for those psychotherapists whose patients and theoretical conceptualizations do not fall into discrete disorders" (p.6). Therapists who work with clients who do not fit strict diagnostic criteria find little research to assist them in their work, and clients who elude diagnostic categories are either unable to obtain treatment or are treated with approaches that are not necessarily appropriate to their difficulties. In either case, by virtue of neglecting the complexity and uniqueness of the typical client who comes for therapy, research that focuses on specific treatments for specific populations may inadvertently reduce the quality of client care.

The EST Movement and the Natural Scientific Paradigm

I contend that group therapy researchers' attempts to divide and quantify therapeutic factors, reduce the impact of the person of the therapist, and increase specificity with respect to treatment modality or client population, can all be viewed within the context of a larger, philosophical and epistemological issue: choice of research paradigm. By working within the natural scientific paradigm, psychological researchers may seek to obtain the academic and cultural credibility granted to natural science researchers. This credibility, however, is obtained by artificially reducing complex human phenomena to discrete variables that fail to capture their complexity and their humanity. The movement toward empirically supported treatments (EST's) provides a powerful view into the controversies that emerge when the scientific research paradigm clashes with the phenomenon under study, in this case group psychotherapy. In particular, the EST movement highlights the role research plays in portraying particular therapeutic approaches as valid for particular disorders, and therefore worthy of reimbursement by insurance companies and managed care. Within a cultural context where research holds such power, therapeutic approaches that are not easily researched, have not yet been researched, are not readily standardized, or are not oriented toward specific diagnoses, may become extinct due to lack of funding.

In 1995 the Task Force on Promotion and Dissemination of Psychological Procedures (Task Force) of the Clinical Psychology Division of the American Psychological Association first put forth a list of what they called empirically validated treatments (Chambless & Ollendick, 2001). In this report, the Task Force published criteria that they used to evaluate treatments, as well as a preliminary list of 25 treatments

that met these criteria. Among other criteria, in order to be considered a "well-established treatment," a treatment needed to demonstrate efficacy in comparison to at least one other treatment in multiple scientific experiments. Treatments that were "probably efficacious" needed to meet slightly looser guidelines, but still needed to demonstrate efficacy in at least one scientific experiment. The term empirically validated treatment (EVT) was later changed to empirically supported treatment (EST), which continues to be used today.

Chambless and Ollendick (2001) review numerous controversies that surround EST's. First and foremost, in accordance with participant concerns, they state that "much contention stems from guild or economic concerns that the EST findings… will be misused by managed care companies to disenfranchise practitioners of psychotherapies that are not so designated" (p.697). They claim, however, that the strongest arguments posed against the use of EST's is lacking evidence that EST's are beneficial when applied in ordinary clinical settings, with ordinary clients, outside the rigid confinements of a scientific experiment. They note that EST's tend to be evaluated solely in terms of reducing client symptoms, an insufficient measure of what some therapies aim to accomplish. Finally, they point out that a treatment's failing to meet Task Force criteria, does not translate into a treatment's being inefficacious.

Henry (1998) further explores controversies around the EVT/EST movement, focusing on its detrimental effects on the field of psychotherapy. Henry points out that the emphasis EVT's place on diagnosis, rather than on the individual person who seeks therapy, de-emphasizes the interpersonal relationship between client and therapist, so often linked to positive outcome. He suggests that the EVT approach furthers the idea

that techniques, rather than therapists, are what render therapy helpful, a notion that has

received much criticism and opposing evidence over the years. In these ways, Henry

echoes concerns I voiced with respect to neglecting the person of the therapist. As

participants suggested, Henry also notes that the EVT movement may promote the belief

that treatments not on the list are not efficacious, despite the fact that this is an inaccurate

deduction. He points out that some approaches to therapy are more conducive to

experimental design than others. "Nonetheless," he states, "it would be reasonable from

the standpoint of a consumer or third-party payer to increasingly look askance at

therapies that were not on the list" (p.130). He acknowledges that this may serve to

narrow the range of treatments deemed acceptable to managed care, excluding treatments

that are less mechanical or prescribed in nature.

These authors (Chambless and Ollendick, 2001; Henry, 1998) provide a context

within which we can understand participants' concerns about existing group therapy

research. When researchers attempt to reduce or eliminate the impact of the therapist on

outcomes research, and when they limit studies to specific diagnoses and to treatments

conducive to the scientific method and EST criteria, they contribute to a movement that

threatens to reduce viable treatment options. Participants in the present study struggle

with the possibility that research will lead those in power to believe that the approaches

they use are ineffective.

Indeed, numerous authors indicate that group therapy is often presented and

perceived as a "second rate" treatment (e.g. Fenster & Colah, 1991; Fieldsteel & Joyce,

2005; Piper & Joice, 1996). Participants expressed worry that they do not have sufficient

evidence to convince their employers, managed care providers, and insurance companies

that group therapy is worthwhile. Many participants indicated that they do not know how to collect outcomes data in order to assess their effectiveness and generate the kinds of empirical support necessary to attain EST status. Participant concerns are understandable, considering that "mental health funding sources and managed care organizations are demanding counselor accountability as a requisite for funding" (Leibert, 2006, p.108).

The scientific paradigm underlying EST research requires researchers to sacrifice depth and intricacy of understanding, in exchange for simplicity and academic credibility. In the end, the reduction necessitated by scientific research design distracts us from the person of the therapist, the humanity of our clients, and the complexity and richness of the human therapeutic encounter. We are left with empirically supported treatments that may not be beneficial in real life treatment settings, while helpful approaches that do not meet EST criteria risk extinction due to lack of funding. Within a field devoted to serving those in psychological distress, our obligation to support all therapies that effectively serve clients may motivate our search for new research methods.

<div align="center">Addressing Limitations of Current Group Therapy Research</div>

In the sections above, I discussed several limitations of current group therapy research that emerged in the present study. In particular, I examined the notion that therapeutic factor research artificially breaks the group process down into isolated components that fail to capture the complexity and humanness of the group therapy experience. I also discussed the trend whereby researchers downplay the person of the therapist and the person of the client, in exchange for categorical variables more

amenable to natural scientific research design. I conceptualized these limitations as symptoms of a general movement toward empirically supported treatments (EST's), a movement that encourages researchers to study psychotherapy within the research paradigm of natural science.

I noted that the scientific research paradigm holds appeal for numerous reasons, including its seeming ability to simplify the research process and its capacity to generate outcomes (e.g. causation or correlation between variables) that are viewed as credible within our particular cultural and historical context. Despite its appeal, however, I argued that the scientific paradigm is inappropriate to the study of group psychotherapy, as it necessarily obscures the complexity, ineffability, and humanity inherent to the group process. When human phenomena are studied with methods appropriate to objects, results are bound to be limited in terms of real-world applicability. Particularly distressing is the potential such research holds to reduce clients' treatment options and limit funding for effective therapists.

In the following sections, I explore three potential directions in which researchers may wish to move, in order to deepen our understanding of the group therapy process in service of improved client care, and in order to close the gap between research and practice: therapeutic relationships as a context for healing, qualitative research methods, and action research.

Therapeutic Relationships as a Context for Healing

If therapeutic factors cannot be identified and distinguished discretely, what does this imply for the tables of themes and the descriptive narratives I provided in Chapter IV? From a constructionist perspective, these results must be viewed as one among many

potential forms in which the group therapy process may be organized and depicted. Rather than presuming that results reflect absolute truths about distinct mechanisms of change, themes and meanings must be understood as co-constructed between researcher and participants; had I worked with a different group of participants or had a different researcher facilitated the study, different themes may have emerged. This does not mean that the results lack grounding in "reality;" to the contrary, the results reveal the meanings that practitioners and I generated regarding their lived experience of facilitating therapy groups. By using these results to open possibilities, rather than attempt to encapsulate understandings, we can recognize their value while honoring their contextual nature.

One possibility that emerged for me, in contemplating the results of the present study, was the notion that group therapeutic factors are inseparable aspects of a greater context, which I conceptualize as "healing relationships." As I stated in Chapter IV, participants referred again and again to relationships among group members, as well as between group members and the therapist, as central to what makes group therapy helpful. The same is true for the majority of Yalom's therapeutic factors. In theory, it may be possible for catharsis and existential factors to help an individual in isolation. However the remaining factors, including instillation of hope, universality, imparting of information, altruism, the corrective recapitulation of the primary family group, development of socialization techniques, imitative behavior, interpersonal learning, and group cohesiveness, simply cannot exist outside of an interpersonal context.

The centrality of relationship to client change implies that therapeutic techniques, such as fostering honesty or promoting group cohesion, cannot be conceptualized as

distinct from the relationships within which they occur. It appears that if we are to

understand the group therapy process, our research methods must shift not only in

philosophical orientation and design, but also in focus. Rather than placing emphasis on

therapeutic factors, seemingly disembodied forces at work in group therapy, we must

shift our emphasis to the group itself, including the nature and quality of group members'

relationships.

As participants noted, there is a great deal of support for the notion that the

therapeutic relationship between therapist and client is central to therapeutic change (e.g.

Antoniou & Blom, 2006; Norcross, 2002; Strupp, 1989). As Strupp puts it, "Research

has sharply etched the overriding significance of the interpersonal relationship between

patient and therapist as the vehicle for therapeutic change" (p.723). Evidence that the

therapeutic relationship is integral to client improvement has inspired some

psychotherapy researchers to shift emphasis, away from techniques and treatment

approaches, toward the therapeutic relationship and the person of the therapist.

Numerous authors suggest that research focus more on whether and how

therapists can strengthen their relationships with clients. Crits-Christoph, Gibbons and

Hearon (2006), for example, recommend research on: approaches to therapy tailored

toward clients who have difficulty forming a positive alliance with a therapist; whether or

not therapists can be trained to improve their alliances with clients; identifying therapists

who need training on alliance-building; and provision of ongoing feedback to therapists

regarding the quality of their alliances with clients.

Consistent findings about the importance of the therapeutic relationship motivated

John C. Norcross of the APA Division of Psychotherapy to commission a Task Force in

1999 to research, identify, describe, and publish the relational qualities that support client progress in psychotherapy (Norcross, 2002). The Task Force's systematic research culminated in the 2002 publication of *Psychotherapy Relationships That Work*, which includes contributions from a wide range of authors. For example Burlingame, Fuhriman, and Johnson (2002), based on their review of the literature, suggest that facilitating group members' emotional expression and facilitating the responsiveness of others to that expression promotes group cohesion, often conceptualized as the group equivalent of therapeutic alliance. Throughout the text, some authors describe various aspects of helpful therapy relationships, while others (e.g. Beutler, Moleiro & Talebi, 2002) explain how one can customize the therapeutic relationship to the individual client.

Some authors, considering the importance of the therapeutic relationship, suggest that researchers put more energy into studying psychotherapists. Crits-Cristoph and Mintz (1991) suggest that studying effective versus ineffective therapists may shed light on how psychotherapy works and how to best train emerging therapists. Critz-Cristoph et al. (2006) suggest that researchers could improve client care by providing ongoing feedback to therapists regarding the quality of their alliances with clients. Okiishi et al. (2006) conducted a study in which providing therapists with feedback in order to improve client care was a central goal.

One striking aspect of this research, as well as recommendations for future research, is that most of it pertains to the dyadic relationship between client and therapist, typically situated in individual therapy. Based on results of this study, however, as well as my own experience facilitating therapy groups, relationships in group therapy are much different than they are in individual therapy. First, the relationship between client

and therapist is significantly different. Time and attention from the therapist are shared with other clients, and clients observe the therapist interacting with other clients in ways that differ from their own interactions. In groups with co-leaders, clients forge unique relationships with each therapist, relationships that are impacted by clients' past experiences and current perceptions, as well as each therapist's cultural background, personality, and leadership style.

In addition to the ways in which therapist-client relationships differ in groups from those in individual therapy, clients also form relationships with one another in group therapy. Yalom and others (e.g. Burlingame et al., 2002) suggest that group cohesion is "the analogue of 'relationship' in individual therapy" (Yalom, 1975, p.45). This concept, however, defined by Yalom as "the resultant of all the forces acting on all the members to remain in the group, or more simply the attractiveness of a group for its members" (p.46) appears to be insufficient to capture all the contributions group members make toward one another's progress.

Participants described numerous ways in which clients contribute toward one another's progress. Clients may interact very differently with one another than they do with their therapists, as they tend to perceive less of a power differential. They may compete with one another for leaders' attention, express anger toward one another, or develop close friendships. They may challenge each other in ways they might not with the therapist, and they may offer each other support by sharing experiences of a more personal nature than those a therapist would share. All of these types of relating offer opportunities for healing that are not present in individual therapy.

Further research on therapeutic relationships, as they appear uniquely in group therapy, would build upon existing evidence that the therapeutic relationship is integral to client improvement, while honoring the distinctive ways in which relationship fosters healing in a group setting. By moving away from disembodied therapeutic factors, such as imparting of information or universality, researchers may be able to see the group process from a broader vantage point, a vantage point that does not obscure the holistic relationships within which therapeutic phenomena occur.

Given that effective group therapists seem to be able to cultivate healing relationships with and among clients, research focusing on the person of the therapist would also benefit the field of group therapy in numerous ways. Such research would facilitate a training approach that emphasizes trainees' psychological and interpersonal development rather than disembodied techniques, admittedly a more complex, demanding, and time-consuming endeavor but one that more adequately honors the relational context within which effective psychotherapy occurs. Clinicians would be more likely to perceive such research as relevant to clinical practice and, in particular, to the therapeutic relationships they attempt to cultivate in the groups they lead. Participants in the present study, for example, indicated that becoming aware of their blind spots and personal biases was integral to effective group facilitation. Research exploring the role therapists' self-awareness plays in the group therapy process would engage clinicians in both research and self-reflection, thereby increasing the relevance of research to practice while improving client care.

Hand in hand with the recognition that therapists are much more than variables to be eliminated or controlled, goes the recognition that clients cannot be reduced to discrete

categories either. Researchers who approach group therapy research with the guiding assumption that clients are, like all human beings, complex and unique would generate findings that are more compatible with clinical work in practice. By studying heterogeneous therapy groups, researchers may find that therapists who are flexible, and able to assess the diverse needs of their clients and the changing needs of a group, are more effective than those who adhere strictly to a treatment designed for a particular diagnosis. By studying therapists who use a variety of techniques and approaches during the course of treatment, researchers may find that therapeutic relationships emerge more significantly as integral to therapeutic change. In particular, therapist and client qualities that nurture healing relationships within the group, such as self-awareness and sensitive attunement, may come more clearly into view when they are no longer hidden behind techniques and treatment manuals.

In summary, although the results of this study support the notion that studying therapeutic factors using current methods is problematic in numerous ways, they also suggest that group therapy can be studied more fruitfully if approached from a different angle. As an alternative to separating group work into distinct therapeutic factors, therapeutic factors may be conceptualized as interwoven aspects of healing relationships. Group therapists appear to foster a special kind of community in which these therapeutic relationships emerge. By modeling and encouraging honesty, support, empathic listening, acceptance, self-awareness, communication skills, and effective conflict resolution, group therapists provide the ground upon which clients may forge different kinds of relationships than they have in their outside lives. A community emerges in which clients may increase their awareness of self and other, disrupt patterns of thinking

and relating that sustain emotional suffering, and practice more adaptive ways of relating. When we conceptualize the therapy group as a healing community, providing previously lacking relationship opportunities, we gain a richer understanding of how group therapy works – richer than is possible when we attempt to break the therapy process down into parts. Furthermore, whether we view ourselves as therapists, researchers, or simply as fellow human beings, we may find that the importance of community resonates across many other contexts of our lives, particularly when we reflect upon our greatest sources of suffering, comfort, and joy.

By responding to the question of how group therapy works with a particular conceptualization of community, one in which therapeutic relationships are cultivated, I echo the conclusion reached by Fuhriman et al. (1986), that "perhaps the time has come to drop 'interpersonal' as a curative factor and recognize that all curative factors occur in an interpersonal context" (p.198). Research that explores aspects of relationship that are unique to a group environment would deepen our understanding of the healing relationships that are consistently associated with positive outcomes. Further research on how therapeutic relationships can be cultivated and enhanced may be especially helpful to practicing clinicians.

Qualitative Research Methods

Another way in which group therapy researchers can improve the quality and applicability of their work is by shifting their ontological assumptions regarding the subject of inquiry, along with the epistemological and methodological implications of these assumptions. Widely accepted, positivistic, research methods approach psychological phenomena as though they can be understood in the same way as the

phenomena of natural science; qualitative methods, to the contrary, recognize that knowledge about human beings is different in its fundamental nature from knowledge about objects, therefore requiring different research methods. While the former seek to manipulate discrete, isolated variables in order to make predictions in a controlled environment, the latter seek to understand human experience, which is always complex, meaning-laden, and embedded in culture.

Qualitative approaches, particularly those situated within a constructionist philosophical paradigm, invite the rich description than enhances understanding of human experience in ways that positivistic, quantitative approaches cannot. Rather than reduce interpersonal phenomena to discrete categories, qualitative approaches open up phenomena so that our perspectives expand. By starting with something which we already understand to some degree (e.g. a client, a group), these approaches invite us to explore and describe, deepening existing understandings and opening possibilities for new understandings.

When it comes to studying interpersonal relationships, as in group therapy research, particular qualitative approaches may be desirable for different purposes. Ethnography is especially well-suited to describing the richness of a group culture, while discourse analysis is particularly helpful when considering the multiple meanings and effects created through human language. Interpretive phenomenology may be useful when considering the meanings of particular phenomena, such as support or challenge, in the natural language of group participants. For those qualities of group therapy that are difficult to capture in language, innovative qualitative research approaches, such as those involving film, performance, or poetry, offer opportunities to explore and communicate

the ineffable. While some phenomena will always resist communication, these methods reach, despite inevitable limitations, toward the unsaid.

Using qualitative research approaches, however, that are constructionist rather than positivistic in nature, is not an uncomplicated choice in our particular cultural and historical context. It requires resisting pressure, within the field of academic psychology, to construct human experience in a way that is conducive to scientific experimentation. It requires tolerating ambiguity and uncertainty, recognizing the fact that human reality is immensely complex, and choosing to honor that complexity despite temptations to simplify, explain and predict. In essence, using qualitative research approaches requires making a fundamental epistemological shift from the mainstream in order to expand and deepen our understanding of human phenomena. By using methods that are more appropriate to human endeavor of group therapy, researchers will likely generate findings that are more applicable to everyday clinical practice.

Action Research

A third option for researchers who wish to increase the clinical relevance of group therapy research and bridge the gap between research and practice is to engage in what is often called action research. In essence, action research refers to research endeavors in which participants benefit directly from participation. Participants in the present study, for example, left with renewed enthusiasm about group work, as well as contact information for group therapists with whom they could consult in the future. There are numerous ways in which researchers can bridge the research-practice gap through action research, including collaboration with clinicians on outcomes studies, creation of guides

to facilitate clinicians' research, and bringing together group therapists to study their group processes in the contexts of therapy or peer supervision.

The first type of action research I wish to suggest is collaboration between researchers and clinicians around documenting clinical outcomes. Given that group therapists are required to provide evidence in support of their clinical work and given that participants indicated they do not have the skills or resources to perform such research but would like to learn how, this option for action research emerges center stage.

Morris, Gawinski, and Goanning (1994) suggest that researchers and practitioners are beginning to question the idea that researchers can study psychotherapy more "objectively" than practitioners. As they put it: "The notion that the work of the therapist and the work of the researcher must be kept separate and distinct in a clinical research setting now appears questionable" (p.25). They review a research study in which therapists and researchers were assigned mutually exclusive tasks, yet over the course of the project both parties discovered an overlapping of roles. The research study became increasingly infused with curiosity regarding the roles both therapists and researchers can play in co-creating meanings.

Howard et al. (1994) collaborated with clinicians on a research endeavor designed to provide clinicians with feedback about their work. They describe their attempts to render the study as naturalistic as possible: "We do not directly interfere with the treatment episode of any patient, assign patients to therapists, limit the number of sessions, or tell therapists how to conduct their sessions" (p.6). The authors claim that therapists welcomed the feedback provided by the researchers and found that it enhanced their clinical work.

Whiston (1996) points out that many therapists, like those in the present study, do not have the training to evaluate their effectiveness, yet, as noted above, they are increasingly required to document that their services are both helpful and cost-effective. Researchers can serve as activists by helping practitioners learn how to use research software and educating them about qualitative research options. Whiston notes that researchers stand to benefit from collaboration as much as do clinicians. In particular, she points out that clinicians can assist in developing practice-relevant research questions and that they can provide field-based data to enrich our understanding of psychotherapy. Given that numerous participants indicated that they prefer to read articles that are concise, accessible, practice-based, case-oriented, and inclusive of practitioners' perspectives, clinicians can provide useful feedback to researchers regarding how to present results in ways that will be accessible to and valued by practitioners.

A second, related form of action research available to group therapy researchers consists of writing articles and creating guides that assist practitioners in conducting their own research. Numerous researchers have already begun to move in this direction. Cleary and Freeman (2005), for example, put together a guide that encourages nursing staff to identify their own learning goals and provides the structure to pursue them. Among other things, their guide leads practitioners through identifying a research question, conducting a literature review, designing methods, collecting and analyzing data, and writing up results. They anticipate that the guide will provide practitioners with skills needed to undertake self-directed learning and assess their clinical effectiveness, thereby enhancing practitioners' confidence and improving client care. In their own words, the authors aim to "demystify, clarify, and promote research while recognizing the

importance of experiential learning" (p.204). They also anticipate increased quality and relevance of research endeavors due to stronger links between research and practice.

Hauri, Sanborn, Corson, and Violette published the *Handbook for Beginning Mental Health Researchers* in 1998, a text that provides beginning researchers with guidelines to facilitate various parts of the research process (e.g. reviewing literature, analyzing results). The authors go further in assisting new researchers, by exploring philosophical questions that arise during the research process, such as why mental health research is valuable, ethical issues that arise in mental health research, and the importance of choosing methods that are appropriate to one's research questions.

Kazdin (1994) suggests that clinical assessment is a methodology well-suited to clinical practice because its goals are different from those of a typical research study. Whereas the latter is concerned with demonstrating causal relationships between variables and isolating the impact of individual variables, the former is concerned with assessing, evaluating, and demonstrating therapeutic change. He claims that "systematic ongoing assessment can improve our understanding of relations between treatment and change and provide information for immediate benefit of the client" (p.19). To clinicians, he suggests that traditional assessment tools can be supplemented with individualized assessment tools, co-created by client and therapist to address each therapeutic goal. To researchers, Kazdin recommends further development and testing of assessment tools that are specifically designed to be used in clinical settings.

Some authors consider potential pitfalls of clinicians completing their own outcomes research. Sandahl and Wilberg (2006) point out that clients are sensitive to their therapists' needs and may wish to reward them with reports of positive outcome.

Kazdin (1993) cites research suggesting that clinicians inaccurately perceive correlations or causal relationships between phenomena, portray overconfidence in their inferences, and demonstrate biases toward evidence that supports their own perceptions. Leibert (2006) points out that clients are not reliable reporters, because they have invested time, energy, and money into treatment and are therefore invested in positive outcomes. Therapists are not entirely reliable either, because they do not wish to fail and because good results may affect whether or not they will obtain future contracts with an HMO.

Despite its limitations, taking on the dual role of researcher-clinician has evident benefits. As Strupp (1989) puts it, "Although I have greatly profited from the investigation of others, nothing is as convincing as one's own experience" (p.717). In other words, clinicians will be more likely to take outcomes data to heart and adjust their approaches with clients accordingly if they are involved and invested in the research process. Sandahl and Wilberg (2006) elaborate on the benefits of conducting one's own research, stating that "a number of clinical researchers, including the authors of this article, are of the opinion that research in itself has a therapeutic effect" (p.403). Indeed, participants in the present study indicated that they felt supported and energized as a consequence of participation.

Whether researchers choose to collaborate with clinicians or to provide clinicians with research aides, clinicians will benefit from documenting the outcomes of their clinical work, thereby generating the evidence necessary to maintain funding. Clients stand to benefit from adjustments therapists make in light of outcomes data. Finally, researchers will benefit from access to real world therapy groups, where they can study

the group process in a naturalistic setting and generate findings that are applicable to practice.

Results of the present study suggest that group therapists struggle in other areas, beyond documenting the efficacy of their work; in considering these struggles, a third option for action research emerges. As I noted in Chapter IV, participants indicated that many of the responsibilities inherent to group facilitation can be challenging. McCarley (1975), a psychiatrist with experience leading groups composed of group therapists, claims that: "the notion that the role of the psychotherapist carries special stresses is a truism that we all acknowledge" (p.221). Schroder and Davis (2004) agree that working as a therapist has inherent difficulties. They note, however, that therapist difficulties are often neglected in both clinical and research literature and, when therapists' difficulties and needs are left unaddressed, they may reduce motivation and enthusiasm for clinical work. Ross, Altmaier, and Russell (1989) state that "research has indicated that persons in occupations that involve providing services to others are especially susceptible to burnout" (p.464), which may involve emotional drain, as well as negative feelings about oneself, work, life, and others.

Beyond difficulties inherent to group facilitation, participants identified with numerous client difficulties, including struggles with isolation and self-doubt, as well as needs for support, community, and constructive feedback. Such striking similarities between participant and client difficulties inspired me to investigate literature pertaining to "parallel process." While parallel process is defined differently by various authors (e.g. Altfeld, 1999; DeLucia, Bowman & Bowman, 1989; McNeill & Worthen, 1989; Morrissey & Tribe, 2001; Mothersole, 1999) the basic idea is that parallel process occurs

when dynamics between a supervisor and therapist are similar to dynamics between the same therapist and his or her client(s). Although my role in the present study was focus group facilitator rather than supervisor, my questions about challenges and areas of desired improvement overlap with topics typically explored in group supervision.

Different authors have suggested diverse explanations for why parallel processes occur (e.g. DeLucia, Bowman & Bowman, 1989; McNeill & Worthen, 1989; Morrissey & Tribe, 2001; Mothersole, 1999). The explanation that resonated most with my own sensibilities, however, was that put for by Altfeld (1999):

> [Harry Stack] Sullivan's (1953) oft-quoted dictum, 'We are all simply
> more human than otherwise' seems relevant to the issue under discussion,
> as it reminds us of our commonalities, the many existential issues all
> people experience that allow one to understand in others the many joyful
> and painful experiences with which life regularly confronts us. (p.252)

As four out of seven participants commented, therapists, like clients, are human. All human beings struggle to develop self-awareness, to take risks in relation to others, to cultivate healthy relationships, and to gain confidence and self-acceptance. It follows that therapists and clients alike, particularly when in a similar situation (e.g. a group), would experience and express similar difficulties and needs. Indeed, I believe that it is our very ability to empathize with client difficulties that provides a foundation for understanding, support, and effective intervention.

I believe that a third form of action research would serve to support group therapists in coping with these personal and professional stresses that emerge in the context of their clinical work. Participants in the present study suggested that pursuing

their own psychotherapy, as well as consultation with other clinicians, benefits them both personally and professionally. Numerous authors support these notions (e.g. Altfeld, 1999; Counselman & Weber, 2004; Kline, 1972; McCarley, 1975). In light of this literature, I will discuss how bringing together group therapists in therapy and/or peer supervision groups may benefit therapists and their clients, while providing a new venue for researchers to examine group processes.

There is evidence that group therapy can be particularly helpful in addressing the needs of practicing group therapists. McCarley (1975), for example, who has facilitated process-oriented groups composed of group therapists at the American Group Psychotherapy Association's (AGPA) annual institute, notes that participants benefited from recognizing and accepting their own need to be cared for. He also suggests that therapists' participation in group therapy may benefit not only therapists, but their clients as well. In his experience, "the opportunity to reexplore their feelings periodically in the supportive, therapeutic atmosphere of a group can be very desirable, not only for the therapist's personal comfort but so that he can function better in his role with his patients" (p.224). He adds that the therapist's self, so integral to psychotherapeutic work, "has to be adequately cared for to function well" (p.224). Kline (1972) describes the benefits gained by eight psychoanalytically oriented, experienced group therapists who participated in a leaderless group for approximately one and a half years. He claims that group members were gradually able to develop trust in and accept help from one another, reduce their isolation, and make progress in areas of personal defensiveness.

In addition to participating in group therapy, participating in peer supervision groups has also proved helpful to practicing group therapists. Counselman and Weber

(2004), for example, suggest that peer supervision groups are attractive to therapists for numerous reasons, including "the need for additional training, the isolating effects of private practice, the stress of the current health care climate, and the emotional intensity of clinical work" (p.127). They note that peer supervision groups offer acceptance and belonging, opportunities to help others, and a context for receiving constructive feedback. Further, the non-evaluative atmosphere may increase clinicians' willingness to take risks in sharing difficulties, while hearing others share their struggles may decrease participants' shame around their own areas of struggle. Ross, Altmaier, and Russell (1989) found that counseling center staff with a network of people who shared their interests and concerns experienced less emotional exhaustion than those without such a network. Altfeld (1999) points out that "much of what goes on in the experiential supervisory group is not unlike the kinds of events one pays attention to and attempts to stimulate in therapy groups" (p.249), such as focusing on members' styles of relating to one another. By attending to their own and others' experiences in a peer supervisory group, therapists may learn new ways to cultivate healing group processes in the groups they facilitate.

Bringing group therapists together, whether in therapy groups or supervision groups, stands to benefit researchers as well as clinicians. As one participant suggested, studying therapy groups composed of group therapists might provide useful insight into complex, psychologically sophisticated forms of resistance. The field would also benefit from researchers' examining how peer supervision groups cultivate personal and professional growth. Such research would serve to increase our understanding of group therapists' struggles and how group therapists are able to help one another, while serving

to create communities among clinicians, thereby addressing clinicians' collegial needs and improving quality of care.

Although the present study did not involve psychotherapy or formal peer supervision, participants did share clinical difficulties, personal struggles, and their experiences of the group process. They indicated that the discussion rejuvenated their enthusiasm for group work and that the confidential venue of the focus group provided opportunities to forge supportive connections with fellow group therapists. Indeed, all participants expressed interest in continued contact with other participants, some in creating a consultation group. As researcher/facilitator, I benefited from participating in the study as well. Participants helped me to flesh out what is problematic about existing group therapy research, and to consider how research can better address their needs. I left the focus group feeling energized, and inspired to persist in facilitating dialogue between practitioners and researchers. I left with conviction that a wide range of topics relevant to group psychotherapy can be explored when a group of clinicians are brought together. For example, a group of experienced clinicians could shed light on issues such as client-therapist match and client readiness for termination, both topics suggested by participants in the present study. The present study, therefore, may provide a glimpse into the fruits born of action research in the field of group therapy.

The examples provided above indicate how different kinds of action research may support and advocate for clinicians' needs. Researchers may collaborate with clinicians in developing research studies that evaluate the effectiveness of psychotherapy in practice. They may also work toward developing assessment tools and research guides to assist clinicians in performing their own outcomes research. Finally, researchers may

bring together group therapists to study their group processes in therapy or peer supervision groups. Researchers may find that they benefit from pursuing such endeavors, in that new directions for research emerge, research outcomes become more practice-relevant, and results are increasingly valued and utilized by practitioners. Researchers may also gain satisfaction from providing direct benefit to the clinicians who participate in their studies.

Summary and Conclusions

The present study began with a review of literature concerning the therapeutic factors presumed to be at work in effective group therapy. As a group therapist in training, I was motivated by my desire to understand the group therapeutic process and to increase my ability to effectively serve the clients with whom I work. However I found that group therapeutic factor research was difficult to apply to clinical practice for numerous reasons, which I conceptualized as symptoms of a gap between group therapy researchers and clinicians. In hopes of building a bridge, I brought together seven group therapists to discuss their notions of the group therapy process, their experiences with group therapy research, and their needs, struggles, and areas of desired learning. Using qualitative methods of analysis I interpreted this focus group discussion, with any eye toward themes that would reveal practice-relevant research questions and methodologies.

I found that the participants in my study offered support for my initial impressions: therapeutic factor research does not capture the complexity or human quality of the group therapy encounter and group therapy research, on the whole, has not been useful to them in clinical practice. I learned that participants felt threatened by

dominant research methods, such as those espoused by the EST movement, which rely upon the assumptions inherent to natural science. They expressed a desire for research that advocates for group therapy as it actually appears in clinical practice, research that honors the humanity of the people involved and the healing relationships they forge.

In light of the experiences, thoughts, and feelings described by participants, I explored the limitations of current research methods and their potentially negative impact on the field of group therapy. In response to the difficulties and needs expressed by participants, I considered alternatives to dominant methods of inquiry, with an eye toward benefits available to clinicians, clients, and researchers. I offered numerous suggestions for directions in which group therapy researchers can move in order to decrease the research-practice gap.

By studying therapeutic relationships between clients and therapist, as well as relationships among clients in groups, researchers can deepen our understanding of the healing relationships that are consistently associated with positive outcomes. Research on the person of the therapist and on how effective therapists cultivate therapeutic relationships may be particularly helpful to practicing clinicians. Researchers may wish to move away from research designs that emphasize techniques and diagnostic categories, toward designs that honor the complexity of psychotherapy as it appears in actual clinical settings. In particular, qualitative methods rooted in a constructionist philosophy may be more appropriate to the subject under study than methods borrowed from the natural sciences.

Researchers may also wish to engage in action research, benefiting clinicians directly while gaining access to group processes as they occur in practice. In developing

outcomes studies with practicing clinicians, researchers can help evaluate the effectiveness of existing psychotherapy approaches. By developing assessment tools and research guides, researchers can assist clinicians in conducting their own outcomes research. Finally, by studying group therapists in therapy or peer supervision groups, researchers can learn more about the person of the therapist, the group therapy process, and how clinicians may contribute to one another's personal and professional development.

Efforts toward new research methodologies stand to benefit the field of group therapy in numerous ways. They may provide researchers with new vantage points from which to study group therapeutic processes, generating conceptualizations that are able to hold the complexity, ambiguity, and nuance inherent to human phenomena. New research methods may assist clinicians in documenting the outcomes of their clinical work, and in creating connections for support and feedback. Perhaps most importantly, alternative research methods may benefit clients, as we gain deeper, richer understandings of the healing relationships that found effective group therapy, and as we assist therapists in cultivating and enhancing these relationships. By reducing the research-practice gap, new approaches to group therapy research will bring us closer to our goal of providing quality treatment for the clients we serve.

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APPENDIX A

Pilot Study Topic Guide

<u>Ice Breaker:</u> What do you value about practicing psychotherapy?

<u>1. Approaches to Therapy</u>
- How would you describe your approach to psychotherapy?
- What is your role?
  What are your clients' roles?
- What makes it 'work' when it does work (for you or in general)?

<u>2. Challenges and Directions</u>
- What keeps therapy from 'working' when it doesn't work (for you or in general)?
- What are some of the challenges of being a therapist (for you or in general)?
- What are some areas you'd like to improve your understanding?
- What are some areas you'd like to improve your practice?

<u>3. Existing Psychotherapy Therapy Research</u>
- What experiences have you had with psychotherapy research?
- How has or hasn't it impacted your understanding?
- How has or hasn't it impacted your practice?

<u>4. New Directions for Research</u>
- How can psychotherapy research be more helpful to you?
- What questions might it explore?
- What outcomes might it provide?
- What methods might be appropriate?

APPENDIX B:

Pilot Study Recruitment Email

Dear colleagues,

I would like to invite you to participate in a pilot study for my dissertation research. The pilot study will consists of one two-hour focus group discussion, in which I will facilitate a discussion about certain aspects of your practice of psychotherapy.   The discussion will take place in the Duquesne University Psychology Clinic at a time that is convenient for all interested participants. I hope to involve between four and twelve participants.   I will provide light refreshments during the discussion.

During the discussion, I will ask that you disguise the identities of any clients you describe in clinical examples.   I will make video and audio recordings of the discussion and then I will transcribe the dialogue, further disguising your clients' identities as well as your own. All recordings will be kept in a locked cabinet to which only I have access and will be destroyed within 5 years of the study.   I will use the transcripts to aide in the fine tuning of my dissertation method. I will also retain the transcripts for potential further analysis, and may use the results in future presentations or publications.

In order to show my appreciation for your participation, I will host a vegan dinner at my apartment following the focus group.

Please email me back if you have interest in participating or have any questions about the study. Once I hear from you I will email you back to coordinate around dates and times.

Thank you!

Sincerely,
Mandy Schleifer

APPENDIX C

Pilot Study Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title: Bridging the Gap between Research and Practice: Psychotherapists Contribute to the Development of Clinically Relevant Research Questions and Methodologies: Dissertation Pilot

Investigator: Mandy Schleifer, M.A.
                            Doctoral Student in Duquesne University's Clinical Psychology Program
                            212 South Winebiddle Street Apt. 8
                            Pittsburgh, PA 15224
                            (412) 478-4955
                            MandyRae123@gmail.com

Advisor: Dr. Connie Fischer, Duquesne University
                            (412) 396-5073

Purpose: This study will consists of a focus group composed of four to twelve individual psychotherapists who work in the Duquesne University Psychology Clinic. In this study, various aspects of psychotherapy practice and research will be discussed. The aim of the study is to fine tune the method for the researcher's dissertation proposal, in which group therapists will explore similar questions. The ultimate goal of the dissertation project is to help bridge the gap between research and practice with respect to psychotherapy.

Your Participation: The focus group discussion will take place in the Duquesne University Psychology Clinic for approximately two hours. In the focus group discussion, participants will be asked to discuss a number of questions related to their practice of psychotherapy, including struggles and areas of desired learning or improvement. The role research does (or does not) play in therapists' practice will also be discussed. Participants will be encouraged to converse with one another, question one another, and comment upon one another's thoughts.

Risks and Benefits:	Participants may enjoy the opportunity to participate in a discussion with other practitioners about group therapy practice. Participants may also benefit from contributing to researchers' understandings of what issues are relevant to practitioners. The risks of this study will not be more than what participants would expect in the events of everyday life.
Compensation:	In appreciation for participation, a vegan dinner will be provided at the researcher's home following the focus group discussion.
Confidentiality:	Participants are asked to disguise the identities of any clients they may discuss during the focus group. The focus group discussion will be recorded using both audio and video equipment. These recordings will be locked in a cabinet to which only the researcher has access and will be destroyed within five years of the focus group. The identities of clients will be further disguised during transcription of the data, which will be performed personally by the researcher. All identifying information about participants will be disguised during transcription as well. The transcript, excerpts of the transcript, and interpretations of the transcript may be used for future publications or presentations.
Right to Withdraw:	Participants have the right to withdraw from the study or to withdraw their data provided in the discussion at any time and for any reason. There is no signature required to withdraw from the study.
Summary of Results:	Upon request, a summary of the results of this study will be provided to the participants.
Voluntary Consent:	I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I |

may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412-396-6326). I also understand that I may contact the researcher, Mandy Schleifer (412-478-4955), or the researcher's advisor, Dr. Connie Fischer (412-396-5073) with any questions or concerns.

Signatures:

_____   _____

Participant's Signature   Date

_____   _____

Researcher's Signature   Date

Participant Topic Guide

Focus Group Topic Guide

How Group Therapy Helps People
- What makes group therapy "work" when it does work?
- How would you describe your approach to group therapy?

Challenges and Directions
- What are some of the challenges of being a group therapist?
- What do you think would make you a better group therapist?

Group Therapy Research
- What experiences have you had with group therapy research?
- How could group therapy research be more helpful to you?

APPENDIX E

Facilitator Topic Guide

<u>Approaches to Therapy</u>

1. <u>What makes group therapy "work" when it does work (for you or in general)?</u>
   - What is the healing process?
   - What is it about (your approach to) group therapy that seems to help clients?

2. <u>How would you describe your approach to group therapy?</u>
   - What are some of your theoretical influences?
   - What is the purpose(s) or goal(s) of group therapy?
   - What is your role as therapist?
   - What are clients' roles?

<u>Challenges and Directions</u>

1. <u>What are some of the challenges of being a group therapist (for you or in general)?</u>
   - What do you struggle with in your practice?
   - Where do you feel unsure of yourself or in need of guidance?

2. <u>What do you think would make you a better group therapist?</u>
   - What are some things you wish you knew better how to do or handle?
   - In what ways would you like to improve your understanding of group therapy, of your clients, or of the therapeutic process?

<u>Existing Group Therapy Research</u>

1. <u>What experiences have you had with group therapy research?</u>
   - How has or hasn't it impacted your understanding or practice of group therapy?

2. <u>If it's been helpful, what about it has been helpful?</u>
   - What do you value about existing group therapy research?
   - What are some of the strengths of existing group therapy research?

3. <u>If it hasn't been helpful, why do you think this is so?</u>
   - What are some of the weaknesses of existing group therapy research?
   - What has been more helpful than research in developing your abilities as a group therapist?

<u>New Directions for Research</u>

1. <u>How can group therapy research be more helpful to you?</u>
   - What questions might it explore?
   - What outcomes might it provide?
   - What methods might be appropriate?

APPENDIX F

Participant Recruitment Advertisement

Do you facilitate therapy groups? Take this opportunity to network with colleagues,

engage in stimulating discussion, and make a valuable contribution to the field! I am a

graduate student in the Duquesne University doctoral program in clinical psychology,

interested in learning from group therapists about the challenges of group therapy, areas

they would like to improve understanding or practice, and how research could best

address their needs. The study will consist of a one-time, 2½-hour focus group in spring

2005 in Pittsburgh, PA. In appreciation for your participation, a $20 donation will be

made in your name to a charity of your choice. Refreshments will be provided and child

care can be arranged. Please email Mandy at mandyrae123@gmail.com for more

information.

APPENDIX G

Email to Colleagues, Friends, and Professors

Dear (Colleague, Friend, or Professor Name),

I'm emailing in hopes that you might be able to help me. I'm at the stage of my dissertation where I'm trying to find participants and I'm wondering if you might know someone in the Pittsburgh area who'd be interested in participating. I'm looking for therapists who have experience leading groups to participate in a one-time (2 1/2 hour) focus group discussion. In my pilot study, participants (individual therapists) really enjoyed the experience - they felt it was a great opportunity to network with colleagues, engage in stimulating discussion about various aspects of being a therapist, and make a valuable contribution to the field. In the actual study, I will make a $20 donation to a charity of each participant's choice, as a token of my appreciation for their participation. I'm hoping to do the study in late April, but the date/time is completely flexible, depending on what works best for interested participants.

Do you know any therapists who have experience running groups? If so, it would be a great favor to me if you were willing to tell her/him about my study and find out if it would be alright for me to call her/him to talk more about it. I would also be glad to talk to you more about it before you approach anyone, if you'd like more information. Please let me know what you think.

Great thanks,

Mandy

APPENDIX H

First Email to Participants

Hello everyone,

I welcome and thank all of you who are interested in participating in my group therapy study!   I think we have a very diverse and interesting group and I'm quite

looking forward to meeting all of you in person. I'm going to review the basics of the

study and share the time I've found that seems to be convenient for everyone; I hope to

hear that you're all still interested and available to participate.

Sunday April 30 from 2:30-5pm seems to be a time that works for everyone. I would ask

that everyone shoot for arriving at 2:15pm, so we have time to get settled and go over the

consent form before starting our discussion. We'll have some light refreshments during

the discussion and we'll take a 15 minute break about half way through. About a week

before the study, I'll send an email to everyone with directions to the Duquesne

University Psychology Clinic and information about parking.

In order to get to know each other a little bit, we'll start by talking about each person's

experience leading therapy groups, including what you each feel is helpful to clients

about group therapy. Then we'll discuss some of the challenges you face in your practice,

as well as areas where you might like to learn or grow as a group therapist.

Finally, we'll talk about how research has - or hasn't - been helpful to you in your work

leading groups.

How does all of this sound? Please email me back and let me know if the date and time work for you, and whether you have any questions for me. Again, thank you so much for your interest! I look forward to hearing from you.

Sincerely,

Mandy Schleifer

APPENDIX I

Second Email to Participants

Hi everyone,

I'm getting excited about the approaching study and was glad to hear that April 30 from 2:15pm to 5pm works for everyone. In total, there will be 7 participants (plus myself) in our discussion. I greatly appreciate your willingness to participate and I hope it will be an enjoyable and rewarding experience.

Attached to this email are directions to campus and parking information, as well as a map of campus. I've also attached a short "information sheet." This sheet asks for some basic info about your background/experience with group therapy. It would be a great help to me if you could fill out the form and either email it back to me or bring it to the focus group discussion.

Please don't hesitate to call me (412-478-4955) or email me if you have any questions or concerns between now and April 30. I look forward to meeting you soon!

Thanks,

Mandy Schleifer

APPENDIX J

Participant Information Sheet

<u>Dissertation Study: Bridging the Gap Between Research and Practice</u>

1. First Name _____

2. Address (if you would like a summary of themes and results from the study):

   _____

   _____

   _____

3. Degree(s)/License(s): _____

4. I have _____ (years/months) experience leading therapy groups.

5. Types of therapy groups I have facilitated include: _____

   _____

   _____

6. How would you describe your group therapy approach, style or orientation?

   _____

   _____

   _____

   _____

   _____

   _____

7. As a token of appreciation for my participation, Mandy Schleifer can make a $20

   donation to the following charity: _____

APPENDIX K

Affidavit of Confidentiality

After having discussed with Mandy Schleifer the privacy and confidentiality issues

associated with her dissertation study, I, _____,

give my assurance that I will not disclose any information obtained during my

observation or transcription of the focus group discussion.

_____   _____

Signature   Date

_____   _____

Witness Signature   Date

APPENDIX L

Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title:	Bridging the Gap between Research and Practice: Involving Group Therapists in the Development of Clinically Relevant Research Questions and Methodologies
Investigator:	Mandy Schleifer, M.A. Doctoral Student in Duquesne University's Clinical Psychology Program 212 South Winebiddle Street Apt. 8 Pittsburgh, PA 15224 (412) 478-4955 MandyRae123@gmail.com
Assistant:	An undergraduate psychology student from Duquesne University will be present during the focus group discussion in order to help with refreshments and recording equipment. The same undergraduate student will aid with transcription of recorded data. The student will sign an affidavit of confidentiality to protect the privacy of participants and any clients they may discuss.
Advisor:	Dr. Leswin Laubscher, Duquesne University (412) 396-6520
Purpose:	This study will consists of a focus group composed of four to six group psychotherapists. In this study, various aspects of psychotherapy practice and research will be discussed. The aim of the study is to learn from group therapists about the challenges they face, as well as areas in which they wish to learn and improve their practice, in order to generate research questions and methodologies that would address these clinical concerns. The ultimate goal of the project is to help bridge the gap between research and practice with respect to group psychotherapy.
Your Participation:	The focus group discussion will take place in the Duquesne University Psychology Clinic for

approximately two and a half hours. In the focus group discussion, participants will be asked to discuss a number of questions related to their practice of group psychotherapy, including struggles and areas of desired learning or improvement. The role research does (or does not) play in therapists' practice will also be discussed. Participants will be encouraged to converse with one another, question one another, and comment upon one another's thoughts.

Risks and Benefits:	Participants may enjoy the opportunity to participate in a discussion with other practitioners about group therapy practice. Participants may also benefit from contributing to researchers' understandings of what issues are relevant to practitioners. The risks of this study will not be more than what participants would expect in the events of everyday life.
Compensation:	In appreciation for participation, $20 will be donated in the name of each participant to a charity of his or her choosing.
Confidentiality:	Participants are asked to disguise the identities of any clients they may discuss during the focus group. The focus group discussion will be recorded using both audio and video equipment. These recordings will be locked in a cabinet to which only the researcher has access and will be destroyed within five years of the focus group. The identities of clients will be further disguised during transcription of the data, which will be performed by the researcher and the undergraduate assistant. All identifying information about participants will be disguised during transcription as well. The transcript, excerpts of the transcript, and interpretations of the transcript may be used for future publications or presentations.
Right to Withdraw:	Participants have the right to withdraw from the study or to withdraw their data provided in the discussion at any time and for any reason. There is no signature required to withdraw from the study.

Summary of Results: Upon request, a summary of the results of this study will be provided to the participants.

Voluntary Consent: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412-396-6326). I also understand that I may contact the researcher, Mandy Schleifer (412-478-4955), or the researcher's advisor, Dr. Leswin Laubscher (412-396-6520) with any questions or concerns.

Signatures:

_____   _____

Participant's Signature   Date

_____   _____

Researcher's Signature   Date

APPENDIX M

Focus Group Transcription

Mandy: First of all, I just want to thank everybody for being here. I am so thrilled to see all of you and meet you all in person. You know, it was neat meeting you all over the phone, but to actually see your faces and meet you in person is great. I've been looking forward to this for a long time and, like I said before, I'm just so grateful to all of you for helping me out. This is, you know, something I really appreciate, especially considering how beautiful it is outside today – that you're giving me your afternoon. So I hope it will be rewarding for you as well. But I just can't say enough how grateful I am that you're here. So, I'm Mandy, as you all know I guess and, like I mentioned earlier, I just finished up my fourth year here at Duquesne and I'm kind of heading into the dissertation phase and then I'll be doing my internship the following year, so I'll be here in Pittsburgh this year working on this. And I got, I think, some of your addresses and I'll get the rest of them later if you're interested in my mailing you kind of a summary of what I end up coming up with from all of this. It may not be until eight or nine months from now that I, you know, get it all together and everything, but I will definitely do that. So, I guess I just wanted to also share that I'm really interested in group therapy and that's why I put this together. I haven't done a lot of group therapy myself; most of my training here has been doing individual therapy so it's something that I really want to pursue in my internship and I also really wanted to do my dissertation about group therapy. So that was kind of what motivated me to start researching group therapy and put together a study. And what ended up happening when I started researching group therapy is I ended up feeling, and kind of finding, something that's pretty often cited, I guess, called the "research practice gap," (few nods) or, you know, the fact that a lot of times practicing clinicians are not all that involved in research. So I really wanted to do a study where people who actually do group therapy were actually part of the research. So that's kind of what brought us here today, together. So, sort of part of the goal of my study is to contribute to a lot of the efforts out there to bridge that gap by involving therapists more in research. So, I guess what we'll do first is we'll look through the consent form together and just go through the details of it and if anyone has any questions or anything we can talk about them. Then what we'll do is we'll talk for about an hour or so and then we'll take a break, and then we'll talk for about another hour or so. So if you could just take two of these. One of them is for you to keep and one is to give back to me. You can just pass them around.

A: Did you say two?

M: Yeah, and then one you get to take home.

B: Do we have to sign it?

M: Yeah, but if you want to wait until we read through it, that's fine.

B: Oh, okay (laughs).

M: In case I ask you to sign your life away there. (Many laughs)

D: You never know….

M: But yeah, I'm going to pass around a pen.

B: A great thing: we had to go to the hospital a lot with one of our kids and my wife Francis would read those things at the hospital and just cross off, like, huge amounts of it and then sign it and you can do that. (Many laughs) No videotaping…. (Many laughs)

M: Yeah, I guess we already have the videotape going so hopefully that part.... (Many laughs)

B: And that's fine. It's just when you go to the hospital, you basically allow them to kill you and videotape the process. (Few laughs)

M: So, on the front of this you've got my name, and the address and phone number here, and my e-mail address, which most of you have already. (Everyone looks through consent form as M summarizes.) But if anything were to come up, you know, in the next couple weeks or today or anytime and you wanted to contact me, please feel free. As it says here, I have an undergraduate assistant – well actually she's graduating in a week so pretty much a graduate assistant. She's going to help out with the recording today and also with transcription. We had a long conversation about confidentiality and all that and she's familiar with that as well. So we'll be taking care to, I think I'm jumping ahead, but to disguise not only all of your identities but also any clients that you might mention during our discussion. But I also ask that you, if you do mention a client… to disguise that person so that we have, kind of, a double disguise there. My advisor is Dr. Leswin Laubscher. He's a faculty member here and he can also be contacted with any questions. Okay, the purpose of the study, the focus group…. We ended up with seven, which I'm delighted about. We're going to talk about various aspects of psychotherapy practice and research. And the aim of the study is to learn from group therapists about the challenges they face, as well as areas that they wish to learn and improve their practice, in order to generate research questions and methodologies that would address these clinical concerns. The ultimate goal of the project is to help bridge the gap between research and practice. So your participation is about two and a half hours here. I'll be passing out a topic guide that has the questions that I mentioned to most of you on the phone and that I just mentioned now. So we'll be talking about areas of struggle or areas of desired learning that any of you have, as well as the role that research does or doesn't play in your practice: what you find helpful, what you don't find helpful, that kind of thing. And you'll be encouraged to talk to each other, so I really want to encourage, you know, you to ask each other questions or make comments on anything each other say. It's really a discussion for all of you. I might jump in here and there and ask follow up questions and things like that, but I certainly want to encourage as much discussion as possible. As far as risks and benefits, there shouldn't be any risks with this study other than those you

would encounter in everyday life. Hopefully you'll benefit by not only contributing to the study, but also getting to know each other. As I mentioned, I'll be making a twenty dollar donation to a charity of each of your choice; I know some of you have already told me where you'd like me to donate that. Confidentiality, I kind of already touched on. We are recording, you know, the discussion with video and audio. They will be kept in a locked box which I have in the back. Only I have a key to it and Marisa will also have a key, and I'll be destroying them within five years of the study. So, I may use the transcript for future publications or presentations, but all of your identifying information will be taken out before that would happen – not only your names but anything that could identify you. You have the right to withdraw at any time if you decide that you'd like to, and like I said I would send out a summary to everyone. So that pretty much covers that. Does anybody have any questions about anything on the consent form? Thanks. So you can keep the one copy for yourself.

F: So you would only be using the transcript, not the video itself?

M: Right. I would never use the video or the audio in any presentation or demonstration, anything like that. Those would be only…. The only two people who would ever listen to or view those would be me and Marisa. I guess possibly my dissertation director, but besides that, it would just be the transcript that I would use, which would already have identifying information taken out of it. Good question.

D: I actually thought that, I don't know how people feel about it, like if we could get a copy of the video. Because I actually thought it would be a good teaching tool, but depending on how people feel about sharing that.

M: Yeah, I won't be doing that for this study, but it could be an interesting thing to do for another study. But for this it will just be confidential. But I could see how that would be interesting to do that for another project.

F: What is today?

M: The 30th.

F: I should know that.

M: I have this date burned in my mind (laughs). (Many laughs)

A: I dated mine the 29th.

M: Oh yeah? Okay, well hopefully, I think it should still be valid. (Many laughs) I think I forgot to mention that, not only can you contact me or my dissertation director, but you're also welcome to contact the IRB, the Internal Review Board, that reviews research, if you have any questions. And that number is…. I believe it's on the consent form.

B: Yeah.

M: Okay. Alright, excellent. And the next thing was I had asked everyone to fill out a short information sheet and I think two of you gave it to me today and two of you e-mailed it to me.

B: I haven't.

M: Okay, do you have that?

B: (Nods "no")

M: Okay, I'll just give this to you and you can fill it out after.

B: Okay great.

M: Is there anybody… (Turns to D) You've got yours? Okay. Can I get that from you?

D: Mine's blank too.

M: Oh, you haven't filled it out. Okay, you can do that after too. And then I guess…is that everyone? Except yours…

A: I e-mailed mine.

M: Okay, and then I got yours. Okay, so great. Alright, so I guess I'll go ahead and pass out the topic guide and hopefully this should all sound familiar from the conversations that we had over e-mail and the phone. And before we start actually talking about it, I'll just sort of breeze through kind of what my role is and how we'll do things. I'll let you take a glance through it first. (Everyone looks at topic guide) Thanks. So basically we've got kind of three clusters of questions here. The first one is sort of a way to get to know each other and just kind of get a sense of where each of you is coming from, in terms of how you think about group therapy or, you know, what kind of therapy you've done. And this first question here… partly just to get to know each other, but also for me to get a sense from you of what do you think is helpful about group therapy and, you know, how come you think therapy helps clients, what makes it work. And the reason I use that term…. A lot of, I guess, studies say, "Well, studies show that group therapy works. It helps people." But how come it works? And I'm just kind of curious to learn what each of you think is helpful to your clients, or in general. Then the second section is kind of the crux of the study, which I mentioned to most of you over the phone or e-mail. I'm curious about, you know, what some of the challenges are that you've faced in your own practice or that you think in general group therapists face. What are some of the difficult things about doing group therapy? And kind of a corollary to that: what do you think would make you a better group therapist? What do you think…. What are some ways you might like to learn or grow as a group therapist? So those kind of go together in a way. And the third section is about group therapy research. I'm curious about what

experiences you've had. Maybe some of you use it, maybe some of you don't. I'm curious to learn about both. So, you know, if you use it, I'm curious, you know, what's helpful about it? What research do you find more helpful than others? If you don't use it, you know, maybe, if you've had some experiences that weren't so helpful that turned you off to it, I'm curious to learn about that. Really anything you can share with me. And then this last question: how maybe it could be more useful or more helpful.
So I was thinking that we could start with this first sort of cluster, just to kind of get to know each other. But then, from there, we can kind of jump around. It doesn't necessarily have to go in a linear order, but I will probably at some point try to make sure we cover all of it. So I might pop in here and there and kind of bring things back to one of these questions. But other than that, like I said, I really encourage you all to kind of bounce off of each other and comment on whatever you hear from each other, ask each other questions or anything. If I notice that anyone seems particularly quiet, I might try to involve you because I want to hear from everyone. So I might do that also. I'll be keeping track of time just to make sure we, you know, have a chance to talk about everything. When we have about ten minutes left, I'll probably, at the very end…. We'll have a chance to just kind of talk about what it was like participating in the study, and any closing thoughts you have that you want to share that we didn't get to. So, any questions before we start? (Pause, silence)

I guess we could just say our names, although we have nametags, just to kind of introduce…. I'm Mandy

A: I'm Alice

B: Bob

C: Carla

D: Diane

E: Emily

F: Felicia

G: Gail

M: Okay, so why don't we start off with this first question. What do you feel is helpful about group therapy? Or, what makes group therapy work? (pause) And I guess I should add, I think, you know, we have a very diverse group here. So, from what I've heard from you, you run very different kinds of groups and have very different kinds of training. So that's great. I love the diversity and I'm curious, you know…. For some of you, it might be…. You might have a very different answer from someone else based on what kind of groups you do, so I welcome that.

F: Mandy, do you think it might be helpful to talk a little bit about what we do first, to sort of get a sense of…

M: Yeah, sure, why don't we get a little tiny…that's a great idea, just a little blurb about what you do.

A: Should I start?

M: Sure. (Few laughs)

A: I work at, is it okay for me to identify where I work, or you don't want any identifying information?

M: You can, I'll take it out.

A: Okay. (Many laughs) I'm female… (more laughter)… O blood type (more laughter). I work part time at a counseling center and also I have a private practice with one office in the city and one in the outskirts. The group…. I run various forms of group. I run a lesbian coming-out group, a lesbian support group, a personal growth group for LGBT, various therapeutic art and play groups, a group for healing shame – I've run several of those for a couple of years now. And I also do work in addiction, so I've run an early recovery group that I put together and an assessment group, also with the idea of making loving choices in terms of recovery or deciding whether or not someone has a problem. The type of…. My approach…. My mentor at the counseling center where I work was a Gestalt trained therapist, so I think that's certainly part of my orientation in terms of a "here and now" focus. The work around healing shame really drives so much of the work I do professionally, overall, in terms of helping people to come to a place of acceptance for where they are right now and how their behaviors make perfect sense – finding the "no wonder" in what's going on. And so, kind of overall, I'm very Rogerian in that respect. And, I think that's probably enough for now.

D: Can we ask questions? The "healing shame" group, what's the background?

A: I had given them all flyers (points to other participants and laughs).

D: Oh, okay.

A: The group for healing shame is**….** What do you mean by "what's the background?"

D: Is it a process group?

A: It's a process group.

D: I guess, like, the theory, or it's just…. You developed this and it's just called that way in the program.

A: I developed it based on some work, actually, I did with another clinician, whom some of you know. (Few nods) The format for the group is we start with the sound of a soft bell and we meditate for five minutes with an intention that's solicited from the group. Then we move into whether there's any unfinished business. We resolve that, and then people say "yes," "no," or "maybe," in terms of whether or not they'd like some group time to talk about a triggering experience, or some current shame that they're struggling with, or any other kind of struggle or victory that they're having in their lives that they need to share to be present or want feedback on. And then once we know what's in the room then we move to either an experiential exercise that highlights compassion or the experience of shame or self-hate in a safe way, such as feeling someone talking above you or someone… or sitting in a chair and having someone talk at you – that sort of thing. That's one example of an experiential exercise… or a reading that might be provocative, but very short, on compassion or shame or self-hate. We just have a discussion on the reading and then we move to individual sharing and then the group has an opportunity to give feedback. If there's someone else who gets triggered in the process then we resolve that, and kind of tree from there. Whatever we resolve then… we move to the next person who had a "yes" and wanted to share time, until we run out of time. So that's the format for my group.

B: I've done quite a few groups but for a long time my specialty has been with sex offenders. And they're mostly male and I do two typical kinds of groups. One is an intro group where you have topics like thinking errors, cognitive distortions, or normative sexual development, or sexual abuse and the after effects of that. And then a process group which is much more open ended and has to do with whatever is going on in someone's life. So it could just be something that's happening like someone finding out at work that you're a sex offender or it could be you talking to your mom…. It could be anything. And I've also worked in prisons. Right now I'm working outpatient, which I like a lot more because it is very oppressive to go in prisons. So that's pretty much my context. I've also done survivor groups for people who have been sexually abused, but in fact that was a long time ago. I haven't really had a group like that in a while.

E: Do you do this with an agency or in private practice?

B: I worked at one community mental health center for years. (Few nods) And then a group of us started a non-profit and got picked up by a different community mental health center, one that was part of a hospital system. And then I left that group and now am in private practice with a colleague. (Few nods)

F: What part of the city?

B: We're in, right where Street 1 and Street 2 intersect.

F: Oh, okay.

B: The X Building

D: Do you see adults and adolescents, or…?

B: I see adults and adolescents, and actually children, but mostly adults. Right now I'm taking on a lot more children because it seems like no one else is. But really I've mostly worked with adults. But right now I'm seeing kids 9 or 10 years old and some adolescents.

D: Who are, uh….

B: Who are offenders, right. And of course almost all those kids have been sexually abused themselves so they're just repeating what happened to them.

F: Individual work as well?

B: Individual and group, right.

F: Do they have to be in both at the same time?

B: They don't have to be, but that's the ideal situation. For a lot of people, if they don't have insurance, the group is nice in that you pay $35 for an hour and a half and they can afford that. And many of these people are just working for minimum wage.

C: Yeah.

B: But what we want is individual and group therapy and I think that combination is great.

F: Yeah.

B: But the research in sex offender therapy especially says that group therapy is the best modality (few nods). And I think that's true myself, even though personally I'd want both. But if you had to pick one or the other, I'd say go with group therapy.

D: Can you share about it?

B: I think it… well I mean, just quickly, it…

D: Well, I don't want to, uh….

(Group makes jumbled interjections, including something like "Get to that afterwards" and "Yeah")

D: Okay, okay.

M: Well actually that does tie in with my question about what makes group therapy helpful.

B: Well we can get to…. We'll let everyone introduce quickly….

M: Okay, and then we'll just take off from there.

C: I've done groups over the years for women, and I've done actually some men's groups, but for the past several years I've been more focusing on doing groups with women with eating disorders. Actually I'm starting an adolescent group this summer. But in the past two years, I've done it for women probably like college aged – 20, 21 – to, I think someone in the group is 46. So it's pretty much adult females with eating disorders. So, that, yeah, that's really…. And I'm co-facilitating it with another therapist from the area. She and I do that together. We find it works out well to have two therapists, just given the intensity of the work that we're doing. (Few nods)

D: So, I'm still in training. I finished my adult psychiatry residency training in New York and I moved here to do my child fellowship at a local psychiatric hospital. So I just arrived in town last June. And so my experience has been primarily in the area of adults. I've worked in state hospitals in New York running process groups, I've done DBT adult, I've done DBT adolescents, and I developed, like, a CBT-oriented trauma survivor group for adult females, survivors of childhood trauma. And I am one of those psychiatrists who really believes in therapy and who really wants to be trained in all the possible modalities. And I'm hoping that part of the reason why I'm kind of bonding to Mandy and why I'm here today was because I was not finding it here in town, group therapy, at least in terms of what was offered. I hope that I can also make a network here and be able to get a little bit more exposure and possible mentoring.

E: I'm in private practice. I'm trained as a Gestalt therapist. I have about five years of post-masters training in Gestalt therapy and then a lot of hours in supervision and consultation around Gestalt, so that's the modality for the groups that I do. I'm currently not doing a group. It's been about a year and a half since I did two groups of women's personal growth therapy groups. I attempted with a colleague a long time, several years back, to do a co-ed group, and we just couldn't get any men; we got one gay man who was interested (few laughs) and so I decided that I love working with women and the universe keeps sending me women, so that's just fine with me. I was doing two process groups, personal growth groups, simultaneously for a long time: one for eight years and one for five years. And they both started to dwindle and I merged them into one group and I did that for a couple of years. And about a year and a half ago, or two years ago, I moved my office from town out to a nearby suburb and terminated that group. And I'm going to start up another group. I'm going to spend a day a week at a friend's therapist office in town, so I'm going to start up another group, a women's therapy group, Gestalt. And I just love doing groups. I also work with individuals and couples in my practice, but doing groups is my favorite. I just really love it. It's very exciting to me.

M: Thanks.

F: I'm Felicia and I'm a social worker, and I have a small private practice. I'm in a suburb of town. I used to work at a local psychiatric hospital for eight years or something and I started doing groups there. I was in inpatient doing inpatient psychotherapy groups. And so for the last few years – and I got interested in DBT at the psychiatric hospital and went through a number of trainings and such – and so for the past few years in my private practice I've been doing a DBT skills group. And I'm also…. Sort of at the same time, I was becoming more interested in yoga and became a yoga instructor and decided that I would try expanding the typical five minute mindfulness of a DBT skills group into, like, a 45 minute yoga. And so that's what I've been doing most recently and that's been really exciting. And I've also, this past year…. I did a DBT skills group at a local high school… so, using DBT skills with adolescents. And I'd never really worked with adolescents that much before so that was nerve-racking and exciting. (Few laughs) It just seems like that's kind of like the direction that I'm going. I do some…. I have, like, one or two slots, so I see a little bit of, you know, individual. I have one couple, I have a few individuals, but it seems like the group stuff is, you know, my passion basically.

G: I'm so jealous. Everyone's doing groups. I haven't done groups in two years. (Many laughs) I'm Gail and I work at a behavioral health practice, which is a large private practice. So the majority of our patients are insurance and insurance and group don't always work out. But most recently I've done women's process groups focusing on relationships. Usually the women are going through a divorce or contemplating divorce; that's kind of, as you say (looks to E), what the universe sends you. And prior to that, I've done more, kind of, experiential groups with couples: communications skills, time-limited kinds of things. And prior to that, I was working with adolescents – that was before my own kids became adolescents – and worked with young teen offenders and their parents. That was an interesting group. So I'm getting inspired to try and do groups again. (Few laughs) I'm going to try and do something about it.

F: It's cool to hear what other people are doing.

M: That was great. I'm glad you suggested that, just to kind of get a sense of everyone. So, if we can start with this question about what is helpful about group therapy or what you feel helps clients when you do groups…. Another way of putting that might be: what is… what's healing about group therapy for clients?

C: Well I think that, in a sort of a nutshell, that… the relationship piece of the groups… the fact that often people who are struggling with whatever affliction, whether it be a mood disorder or an addiction or an eating disorder… that there's often isolation. Or they've had a history of difficulties in relationships or a history of abuse or something that's kept them from relating in an optimal way to other people. So I see groups as a way, in a safe environment, for people to enter, take risks, learn more about themselves, learn how to relate to other people, without it being scary and overwhelming. So, I see it really as a… in a relational (few nods)…. And that's how I work too, in more of a relational type of way, that…. It helps them to learn about themselves, even to work through past historical pieces of their, of trauma or depression, so they can have a healing experience through that.

B: Just to tie in with that quickly too, I think that we are experts of our own pathologies that we can't see in ourselves but it's easier to see in the other (few nods). And so if you get, you know, like, for instance, a bunch of sex offenders in a room, they're going to call each other on stuff that a therapist might not see or if they did see, they might not be able to be heard. Where if you hear it from another person who is just, you know…. It's more like, "Hey I know what you're doing." It's going to happen; they're going to accept it. (Few nods) And the communication will happen. It's very powerful in a way that…. You might be in a fight for six months in individual therapy and that can just happen in group therapy from one client to another. (Many nods)

E: Sort of piggybacking on that, I think one of the beauties of group is that people get to benefit from each other's work and they get to bear witness to…. They have witnesses to their work: loving, supportive – most of the time – witnesses. (Few nods) And they get to participate in the healing process, which in turn is self-healing, as you said. I think often of an example of…. I had…. I was…. I did a group…. In one of my groups, a woman was sitting and doing this with her nails (makes a clicking sounds with her nails). And its being a Gestalt group, I certainly paid attention to that. And this other woman was just, like, doing this (shifts in her seat) and she said, "Would you please stop that?" (Few laughs) "My mother did that all the time and my mother was really abusive and it just really triggers me." And so right then and there, we did a piece of work. The woman with the nails was the mother and, you know, it was all…. And they did such a beautiful…. And it was healing for both of them, not just the woman who had the mother. (Few nods)

M: Can you say more about when you say "a piece of work"? Just elaborate on what it is?

E: They role played, mother/daughter. And the woman who was reactive was able to just say to her what she hadn't been able to say, really confront her and be angry with her. And the other woman was in the role. And I wouldn't have done it if I didn't think she could have handled it, and she had lots of support; she had other group members sitting behind her, you know, supporting her back. And I would check in with her and, of course, facilitated that process. And the woman who reacted moved to another level with that and healed that piece. You know, later on that same woman with the fingernails was doing this (clicks her nail again) and the other woman was sitting next to her and she just (places her hand on the hand of the participant next to her)… "It's alright, it's alright." (Many laughs) This was about a year later of course. (More laughter)

F: You mean like, "It's okay that you're doing this."

E: Yeah, "It's alright." (More laughter) "I see that you're doing this and it's alright. I'll leave you alone this time." (Many laughs) That's the beauty of group that cannot happen in individual work. Of course the people don't have the benefit of the time that they have in individual (few nods), but, so it's always nice if they have an individual session to take

some of the stuff to that gets stirred up, because you can't address everything that gets stirred up. (Few nods)

D: I'm wondering if, what you're saying – "It's alright" – also meant, like, "Mom, I forgave you," you know? "It's alright."

E: I think what she was saying is, "I'm through with you. I got through that." You know, "You can get away with it now."

B: "And I won't be triggered." It's amazing too to take on the perpetrator or, you know, the bad mother….

E: Yeah.

B: …in a way that becomes humanized, because if you're being something, you're still human…

E: That's right. (Few nods)

B: …so you're not just bad. You know, it's so much more complicated now.

E: That woman otherwise might have gone through the rest of her life going crazy when somebody did this (click her nails).

B: Right. (Few others voice agreement)

E: It's a really small example, but powerful.

A: Related to your – oh sorry (to E for speaking over her briefly) – related to your comment, you know, I think it gives an opportunity for people to see themselves as "the same as," as opposed to "different," because so many people feel that they're different, they're unique. You know, "You don't understand me." And in group, they have that benefit of that universality, of seeing themselves in the other (many nods) and oftentimes can have compassion for the other, and in turn starts to, you know create that compassion for self. (Many nods) Because we are, we really are far more similar than we are different.

D: That's right.

B: And we're lacking in community so much that a group is extraordinary. It's like, one of the few times people can come together consistently and care. And that in itself is powerful, even just, you know, when they're coming and going, you know, and walking each other to their cars. (Few nods) I mean, I just think we're starving for connection.

C: Right, right.

F: We're approaching honesty with people. You know, we're not just, "How are you?", "Fine," or trying to just always appear, you know, "together." (Few nods)

B: Yeah, absolutely.

C: Yeah, that idea of trust. You know, that developing a sense of trust in oneself but also trust in others to be able to take those risks to talk, to be real, to not have that false self. (Many nods)

G: To take risks with somebody other than the therapist.

C: Exactly.

G: And I think that's part of the power, is that "These are people just like me. I thought I was alone and only my therapist really got me (many nods and sounds of agreement from group) and then all these people who are just like me get it." You know, it's like this…. It's wonderful to watch.

B: In a group therapy, I mean, I'm just part of the group that might direct a little bit. (Many nods) They're doing all the work.

C: Yeah.

B: I mean, that's what's so nice about it.

G: Oh yeah, I do group at the end of the day.

(Much laughter from the group)

A: I think it took practice. You know, they get to practice with people who are safe, with the safety of someone that they… who is there, and practice that confronting, which is, you know, I think, you know…. A lot of times it's easy for people to be supportive even if they're not really feeling it in here (points to heart). (Many nods) And they get to really find out what really is in here and to… and, "If I share that, you're not going to leave. You're not going to abandon me. We can get through it." (Many nods) You know, that working through something is really very powerful.

M: When you say "what's in here" (points to heart) you mean something that might not be supportive? It might be more confrontational, or something else?

A: Whatever they're experiencing at the time gets supported, you know, particularly when you notice that the body language isn't matching what's being said, or something like that. So they're invited to share what's really going on. And then they put that piece out there and then the group doesn't run away or attack them.

C: Yeah along those lines of what you were talking about with the fingernails, in group last week one of the members who's older disclosed that she had a teenage daughter and the youngest member of the group is 20. And her body language…. She drank her water…. She was all uncomfortable and everything and the other people in the group noticed. So we processed all of that because she was having a real reaction to having a mother figure in the group. And to be able to talk about that… which brought up a lot of pain for her about her mother not being available to her. So you know, it's along those same kinds of lines, that it's not always – maybe that's sort of your second question (to M) – it's not always even to be supported. It can sometimes even be that hard feelings come out and conflict can come up in group, which ultimately we try to resolve. But, you know, it can also be something that teaches people more about themselves and what's inside them that they wouldn't be able to get with a therapist or, you know, a friend or something.

E: I've often said to people in my group, it's the person you're prickly with you're going to learn the most from. (Many nods and sounds of agreement from group)

A: Absolutely.

E: It's not the warm and fuzzy relationships you make that you're going to get something from. (Many nods)

F: You know, I want to write that down, that's a good line. (Group laughter)

E: It's very true.

F: Yeah. Oh, absolutely.

G: Yeah, in my groups I've had women whose husbands are having affairs, in group with women who are having affairs with married men. *There's* some interactions…. (Laughter, many nods, and sounds of agreement from group) You get to kind of see the other side's story. (Sounds of agreement from group)

B: In a lot of the process groups I run…. They're ongoing for, you know, years. I mean, one group I'm in right now has been going on for five years and some people have been in it for five years, some people come and go. But because of that you get sort of a…. We try to keep it light. Humor is used a lot, which I think it makes everything much easier. (Few nods) And at the same time though, you get this sense where you can call someone, let's say, who's very defensive, always acts like the clown. And so it sort of can be like…. Everyone's like, "Okay, you're doing that and that's okay." And then that will be said for a while. And then eventually it will be like, "Well what's really going on?" (Few nods) And somehow just that dynamic in a group is great, where everyone knows what's happening. And, you know, I might be the one who first said "That's…. He's just putting that on." But then everyone's like, "Oh okay, okay, okay." And then eventually…. And then that…. So that person now knows "Everyone knows I'm just

putting on a show, but it's what I do." And then eventually he can just get beyond that, which is just great. (Many nods)

E: Yeah.

B: You know, I somehow think that can only happen…. It can, of course, happen in individual therapy, but it's more powerful in group because it's a community. It's not just my therapist (few nods), my expert therapist. (Few laughs)

D: I like a lot of the sound of the words that are being brought up, like, about power and…. I actually had an amazing experience this last… was it February? …at the American Group Psychotherapy Association meeting. I have…. As part of my training I had been in therapy but it had always been in individual therapy. And I participated in a process group in my first year of residency, but it was, like, very short and it really didn't work and we sort of stopped it. In that meeting, I went to one of the workshops that…. I thought I was going for a workshop, but it ended up being an experiential combined… experiential and a workshop. (Group laughter) And it was on children and adolescents, so we all sort of regressed to our own issues from childhood. (Few laughs) And it was only two days and I left that group feeling I had done more work in two days than what had taken like three years of individual therapy. (Few nods) And it was scary and at the same time it was fascinating to me, so I cannot describe it. It's like taking individual therapy but putting it, like, under all this pressure, like a pressure… you know, cooker. And I think that's the main… like, one of the things that is more fascinating to me about group therapy: how strong and powerful. And we think about it, there's like, Bob mentioned, community, but it's really the only community that you can come to and be… receive feedback, receive support, be confronted and yet safe, and be able to get angry and still come back, and have to not just leave (few nods) like we do… we all do in our real relationships. (Few laughs)

B: Or pretend you're not angry.

D: Exactly, or pretend that you're…. You have to deal with it. You have to stay there. And even when you feel like leaving, the group is going to call you on it to pull you back in. So you can't escape, sort of. And I think even it's easier to leave even individual therapy than to leave group therapy (few nods) because you need to come and terminate it and you're going to be called on it. And so I just think it's amazing.

B: And it's not just you and the professional. It's you and these other people like you. (Many nods)

D: Exactly.

E: That's the bearing witness.

B: Yeah.

E: It really is. It really is.

M: Well in the interest of time, if anyone wants to add anything before we shift…. I'm thinking we'll shift to the next question about challenges of group therapy. But before we do that, is there anything anybody felt they wanted to add about what's helpful about group therapy?

A: I just wanted to add one additional piece in addition to the perspectives and the community and the other things that have been said. It's that, energetically, there's an experience. And we don't really have language for that, you know, or we don't talk about that a lot. But energetically there's something that happens. (Few nods) Part of it's that pressure, but there's also, just…. You feel something in the room. (Few nods) And so it's easier for… for clients to identify that, and I think that's really useful. And so the experience itself gives, you know, a feedback of sorts. It's inspirational.

E: And if there isn't an energy…. Then there are times, especially in the beginning, when people hold back. You know, they don't trust, they don't know each other. (Few nods) So, when there… when it's flat, when the energy is flat, a great question that I just always love to ask, to stir it up, is, you know, "What's not being said right now?" (Few nods)

A: Exactly.

E: You know, "What is not being said?" And people really respond to that and get their toes in the water, and the energy shifts. (Few nods) You can feel it in groups. You can feel it when the energy shifts from flat to high, or the reverse. What just happened here? (Few nods) Somebody got scared or something is not being said, usually.

A: There's a white elephant here.

E: Exactly.

A: Yeah

F: And I think just sort of an obvious point is that you can reach more people in one hour… (Many nods)

A: Yes.

E: That's right.

F: …than in individual.

D: In our managed care era, it's most effective, really, (few laughs) to find ways to be able to keep treating our patients, and even with the limitations we are given. (Few nods)

M: Okay, well if any thoughts, you know, come up over the rest of the discussion, feel free to throw them in there. But I guess for now, we can talk a little bit about what some of the challenges are that you've experienced as a group therapist. What's difficult about doing group therapy? Or what are some obstacles or challenges that you've faced… some things you've maybe struggled with or that you just think, in general, are difficult about doing group therapy… or challenging?

F: I know for me when, being in private practice and then making the decision to start a group…. That was just scary in and of itself to, kind of, like, put it out there. Would anybody come? You know, would I get any referrals? (Few nods) I'm not a big marketer kind of person, so…. And because my group is set up the way it is, you know, eight week modules, and then you can sign on for the next module or not…. So, just that… kind of getting it started, putting the word out, getting referrals – that sort of thing. Any eight weeks, I'm not sure, you know…. Will I have anyone there or not? So, it's just stressful.

B: I think that there's always challenges. I can think of some of my personal ones, but for most people who haven't been a group leader the biggest scary thing is just getting in a group, because it's just terrifying. But once you do it, you find out it's not that bad at all. And the only way you can find that out is by being thrown into the group, you know, probably with some other facilitator.

M: Do you mean, haven't been in a group as a participant or as a group leader?

B: No, just like, you know, when you first…individual therapy seems like it's so much more…. You can control it. You've got your room. It's okay. (Many laughs) In group therapy, you don't know what's going to happen. Just like couples therapy, is a whole…. It's like, whoa!

(Lots of laughter)

G: There's lots of people in a room with couples therapy!

E: I think couples is by far the hardest.

B: Hardest, oh I agree.

A: That's actually my favorite.

C?: It's my favorite too.

B: What did she say? (Group laughter) Don't say anything…. (More laughter) But for me, I guess some of the biggest struggles being a group therapist would be, you know, if some issue of your own is happening and you know it's happening (few nods) and you don't want that energy to get out in the group. So usually I think that can be prevented by talking to someone about it, you know, some colleague or something. But I think most

people don't get into group therapy because they're just afraid about groups and what's going to happen because you can't control it. But once you're in a group, it's so rewarding. I always learn from my groups, always. (Many nods) I completely learn every group. You know, I come out enlightened, and I don't completely from every individual session. It's just different.

E: I think that another challenge is, for me… is making sure no one gets lost. (Few nods) Tending to… as I don't work with a co-therapist, and so…. You know, just paying attention to everyone's needs. And usually, in the groups that I've done, I have a… there's a quick check-in. And in the check-in they say what they'd like to work on, if anything, or…. And so I think it's really important to tend to at least getting that addressed, (few nods) getting people's needs addressed. And I don't mean taking care of everybody's feelings, but just really paying attention to see that everyone gets – who wants to – gets attended to, and that no one gets lost and reenacts something that, well, they didn't work with. But sometimes I don't know. If I don't know about it, I can't…. So that's a big challenge to me… is to just not get caught up in someone who might be more dramatic or more articulate or expressive, but to….

G: Or just demanding more attention.

E: Paying, right, paying attention to the balance. So, that's a challenge.

F: How many people work with co-facilitators?

C: I do that.

B: I have.

A: I have.

C: Right now I do, but….

F: It's so nice.

A: Interns.

G: It's a luxury. It really is a luxury, because somebody can be watching the group as the other one is, perhaps, addressing the group, or… you know, you can bounce off each other. (Few nods)

C: And you can process later.

F: Yes, exactly.

C: That's what's amazing is, sort of, "Did you notice that?" and checking in with each other around that, you know.

B: The one…

G: In couples groups we did a lot of modeling. You know, my co-therapist and I used to, kind of, set up fights (many laughs, few nods) and have disagreements, and resolve it in appropriate ways.

B: And that's so interesting, too… you know, pros and cons. I mean, what can happen with, I imagine, a woman with all women or a man with all men? Certain energy can happen, certain things can be said, and certain dynamics will happen (many nods) that will not happen if a woman's not in the room. Right? So there is good things and bad things about that. To me, ideally, you would have a man and a woman co-facilitator, especially with sex offenders. (Few nods) And it's amazing how different that is. It makes a lot of people a lot more defensive. But at the same time it allows, definitely, for certain things to be addressed that wouldn't be otherwise. And certain things are going to be repressed that wouldn't be otherwise. (Few nods)

C: Yeah, an extreme example of that was…. Years ago, I was running a men's domestic violence group, co-facilitating it with a man. And I was pregnant and I was getting increasingly more pregnant as the group went along. (Group laughter) And it was very interesting to see…

B: Oh wow.

C: … some of the counter transference and some of the issues, I mean, which I won't get into. But just, uh….

B: Right.

C: But I would agree that that was one of my pieces that I was thinking of, in terms of the challenges. And it may be the nature of the group that I'm working with right now, because most of the clients have been dealing with pretty long-term eating disordered issues and they're chronic, and some of them…. You know, it's a real struggle. And to take care of… you know, making sure that each one of them has a voice and is able to express themselves in the group and that they're safe when they leave…. (Few nods) Really, that's a piece too, because there will be times where a client will come back and say, "Oh yeah, I left the group and this is what I did." And you know, maybe in hindsight, maybe, with my co-facilitator, I can say, "Oh yeah, we knew she was struggling, but we had no idea to what extent." So that piece is there. The other thing, and again it may be specific to the population that I'm working with, which…. They deal with lots of significant depression, abuse issues, even self-injury stuff. But a sense of negativity can come over the group, where the tone and a certain amount of energy can be… that they jump into sort of this hopelessness pit where nothing's going to change. It's bad. And then, even there's a…. You try as co-facilitators to try move the energy to a different place, but sometimes it's…. You're moving it and then it goes right back into it. (Few nods) So sometimes that can be a struggle, in terms of trying to be therapeutic

instead of you know, educating…. The clients are educating themselves in a negative way. Like, "Well restricting is a really good thing. And we should talk about how great that is (few laughs) and how that helps me function in my daily life. And when I eat, I can't function at all." That's the tone of the message. And not only is it triggering, it's incredibly hopeless. And so I think that that can be… that, sort of, group effort in that direction sometimes can, you know…. Obviously the group…. You're trying to work through that and talk about it and move away from that, but sometimes that energy level doesn't always move in that direction, so that that's…. I can see sometimes, like, the bandwagon kind of effect that goes on, so….

A: Kind of to bring it back to some of the administrative stuff that we struggle with is doing groups in an agency setting. You know, there's this desire to – particularly, like, on the drug and alcohol side – to have a group that's always available. And so you kind of want an open group. (Few nods) But then, you know, with people that are coming in and they're in early recovery…. They really need the stability, you know, of a closed group. And so, struggling with that, open/closed, you know…. (Few nods) So finally we went to an eight-week thing and people can join up through the second week and then after that it's closed. (Few nods) You know, if you need a group you're going to have to wait. With some of the shame healing groups, again, you know, monitoring that… the door, in terms of when people are coming in. And is it… whether it's a good time or not, that can be a struggle. The, more clinically, when you have…. I have a number of people that have Axis II, you know, personality disorders and some are fairly severe. And so managing that when you have multiple people getting triggered and helping them to have, you know… helping to facilitate effective conflict resolution really is a struggle. (Few nods) And so, you know, trying to provide the environment where the conflict can happen because that's, the group's at that stage…. And yet you don't want the fire to get out of control. (Few nods) And so, you know, walking that line is sometimes a challenge, particularly without a co-facilitator.

F: And you want everything to sort of wrap up neatly within, you know, the time frame.

A: And it doesn't, yeah. Sometimes it just doesn't happen. And that's hard. (Few nods)

M: It reminds me of what, I think, you were saying about people leaving the group feeling safe. (Many nods)

B: One nice thing that can happen, though, in that kind of situation is that this confrontation happens in the group and what's happening is one person is responding to this person the way anyone would. They're just nerve-racking. But it doesn't have to be you, the therapist.

A: Yes.

B: And so they're doing the response, and then you…. "Alright, everyone back up. Now let's see what happened here." Which, again, is great, instead of, you know, working with a borderline or something where you're always having to be contained and

trying not to get evoked. You can actually work on the issue in, sort of, a safe, transparent way, where it's all right out, you know, and it's not all clean, but at least you can do it. (Few nods)

A: Yeah, and when it stays at that level, that's great. What some of the problems that I've run into is when you then have two, also, who have pretty significant Axis II issues…

B: Right.

A: … and they're aligned with this one. So anything anyone says that's contradictory, you know, to being supportive 110% of this person, then becomes more fire. (Few nods) You know, so, you know, so you have all these pieces going on.

E: That's when I pull out and go to the group level, you know, and say, "Okay, what's happening here?" (Many nods) Because often times, I've…. And this is challenging too, and it's similar to what you were saying, is that there sometimes is someone who's the scapegoat…

A: Absolutely.

E: … and, you know, if she's a little bit different, or maybe a lot different (many nods) from the group norm that has been established, then….

B: Problem child.

E: Yeah, the problem child.

A: Straight woman became the scapegoat. (Laughs) Yeah, and then people could see their own internalized homophobia: "I'm not ashamed of being gay. This isn't about homophobia." So it's really, really….

E: Exactly.

B: Right.

A: I mean, it's a great opportunity but it's hard work, and then not having other colleagues at the agency who enjoy group, you know… feeling isolated in that way. (Group nods) You know, where you really…. I really don't have anyone else to go to, to get support and talk about, you know, what's going on. And this feeling, "Oh conflict, oh," you know, rather than being supportive (few nods). This means we have some cohesion here, you know, and they're willing to take these risks. And so having people understand group work at the agency….

M: I saw about five nods when you said that.

A: Well, it's hard.

D: What do people feel like gets, sort of, in the way…. What are the challenges of getting a co-leader or co-facilitator in private… in your own…?

B: Money. That's the biggest thing. I mean, you've got to split it. Because, I mean, it was great at the community health center where I most recently worked. We were in a situation where we could always have a male and a female co-facilitator, but in private practice, you know…. There's different contexts where you can get an intern or something where you're not… and that's great. But other than that, I think people don't do it purely just because of monetary reasons, I would think.

C: Scheduling is a bitch. You know, trying to find two therapists who have an hour and a half, like, pretty much two hours allowed when you… meeting… getting there…. You know, that is so difficult.

E: In that regard, it's just easier. It's just easier to just go do my group.

M: I have kind of a follow up question for you, Felicia, because you mentioned the co-facilitator challenge earlier. And I wondered if you were saying that it's challenging to run a group without a co-facilitator, or were you talking more about the challenge of finding a co-facilitator?

F: I think running it without one.

M: Okay.

F: Just like what people are mentioning… just the support that you have with somebody else in the room, whether it's, you know, sort of, clinically, like you were saying… somebody to watch when somebody else is presenting, so to speak. (Few nods) Like, in DBT it's a little bit different because it's more didactic. It's more like, "Okay, I have sort of an agenda to describe these skills to you." So not only am I trying to, kind of, think about what's going on for people, but I also am sort of self conscious about my, sort of, performance piece in that. But, like in the DBT group that I run in the school, the teacher of the students – they're in an alternative-ed program – she's in the room and we also have an intern in the room. And, even though they're not really co-facilitators because they're mainly – they're almost like group participants – they're mainly observing and kind of participating, it's just so delightful after they leave to be able to talk to people, talk to someone about what just happened. (Few nods) It's very validating to have somebody else in the room. (Few nods)

B: On the other hand, it also can be threatening to have someone come into your group that you've just been doing, because now it's this other observer and you're in your safety zone and so forth. One thing I found forever is the standard, is that we never allow women into our sex offender groups. Most sex offenders who are adjudicated are men, and most of the women sex offenders have been sexually abused. Many sex offenders

have been sexually abused but, um, just because of the way, you know, mental health is working, I was in a situation where these women were coming to the group and, philosophically, we never would have let this happen. It was like, "Oh my god, this is really weird." It was fantastic, just great. (Few laughs) I mean, it just was great. It was like everyone was thinking, "Oh, we can't do this, ever, and it's the most wrong thing to do, and they're going to be traumatized." And this was an intro group so it was more didactic and so forth. And we had a transsexual and two young females in their twenties and then mostly young and middle aged men, but the dynamic was amazing, just amazing. Then, also in my internship, that same thing was with an anorexic group… that men shouldn't go to this group. It should just be run by female facilitators. And I was like, "I really want to be in this group. I really want to be in this group." And again, apparently, it wasn't as disruptive as everyone thought, and it was, in fact, positive. (Few nods) So there are certain things that we just get in our heads… "Oh we just can't do this." (Sounds of agreement from group) It's just our bullshit. (Group laughter)

D: You know that kind of, that kind of…. It's very interesting. And probably we can talk about it more when we move on to the research piece. But I find that, as much as I respect and it's so important to have research, there's also the flip side to that…. that many times, if it's not evidence based, now, with what we're… with the type of mental health that we're practicing, it's interpreted as "it doesn't work." So it's really bringing some limitations, especially into therapy, which is something that we're so committed… in terms of research… because it's really difficult to do the research. So I'm really glad that you're bringing that up because sometimes it's also…. Now I'm hearing more about, "Oh, we can't do that because that's not evidence based." (Few nods) And I think it's bringing to group therapists – or to anybody who's doing psychodynamic work or that doesn't have a lot of research – some challenges in terms of how, you know, to prove to people…. because managed care is controlling everything. And instead of going that way, it's like, how do we…? I think that's where we need the research because we need to defend what we're, you know, doing and we need to prove it to someone, although we all know it works. But for other people we need to prove it so that it continues.   But at the same time, when you don't get the results of that study just because it's so difficult to do the research, then you're also limiting all of these patients from getting what they need. (Few nods)

B: And that whole issue is so complicated because what is "healthy" and what's "getting better?" I mean, basically the whole idea is people should go to work. And so if that's the idea we should just be on good drugs and just go to work and shut up. I mean, that would be the best thing for managed healthcare. (Few laughs)

M: I wonder…. I just want to ask a couple little follow up questions. You (to F) had mentioned your kind of groups are a bit more didactic and you talked about… and you (to B) mentioned some of yours are too, and… just thinking about what some of the challenges might be of those kind of groups, since so far we've heard more about kind of the challenges of a process oriented group.

F: I think one big challenge of a didactic group is that, like, in DBT it's all about bringing them back to skills, bringing them back to skills. So there's not a lot of space for really going deep into any one particular thing. (Few nods)

D: It's un-processy. (Many laughs)

F: Yeah it's very un-processy. I mean, there's some opportunity to talk about yourself, as long as you are talking about how you tried skills and they worked or they didn't work. So, like, a big piece in DBT, if you're doing a DBT skills group, is people are supposed to be in individual therapy. So you can always sort of fall back on, "Yeah you should talk to your individual therapist more about that." (Few nods) So that's challenging. I think people, once they're in a group setting, often really want to keep going and keep talking and keep talking and other people want to support them and you have to really balance that in this type of group.

B: The way I do it is the project is purely just to make people comfortable. All I really want to do is get people talking. But of course they're going to be more comfortable if you give handouts and "We're going to go over this." (Many nods) You know what I mean? So it's… you know, and I'm really just trying to get them used to being in therapy, in a group. So I'm just trying to get them to talk. (Few nods)

M: Do you find that that's a challenge, getting people comfortable with being in a group?

B: I'm sure it is, but I'm certainly used to it now. You know, you just are yourself and, you know, you're talking about something interesting. And everyone wants to talk, you know, and it's always safer to talk about something if you're holding something. (Laughter from group)

F: Like us (holds up topic guide). (Few laughs)

B: Yeah, right.

C: Takes us back to the school days where you would answer questions on a piece of paper. (Group laughter)

M: You've been quiet over there (to G). I wonder if you have any thoughts about – I know that you said it's been a couple years, but – what some of the challenges are that you remember from your experience….

G: I think, you know, as Bob said, he's used to it, but… I think getting people comfortable the first session. So, and I think, making sure it's a safe environment. People come in and they're scared people are going to be critical of them or they're not going to relate to anyone. (Few nods) And I think in women's groups, especially, a lot of the women are hesitant to come in to group because they're afraid they're going to take everyone's problems as their own. 'Cause that's their big issue, you know, their

codependency with other people. (Many laughs, few nods) Heard that before, huh? (Many laughs) And, kind of, making sure that the group and the therapist and the participants themselves pay attention to that… that they don't take on everybody else's problems inappropriately. (Few nods)

E: As an avoidance to their own. (Few nods)

G: Right. Which is really what it's all about.

A: I don't know what you said, but it reminded me of another challenge, which is: people wanting to have relationships outside of the group. (Few nods)

G: Oh yes, I've had a couple of bad experiences with that.

A: You know, and so that can be…. I mean, essentially I'm powerless.

E: Do you mean "relationship" relationships?

A: Both, you know.

E: Yeah.

G: Do you have rules that you…?

A: Mm hmm.

G: I mean, I did too and somebody just flagrantly blew them out of the water and she had to leave group.

A: In particular, you know… working with LGBT, you know…. They really have a hard time, you know, because a lot of times they're very isolated and they have a very difficult time forming social support. And so, you know, "Why can't this be my social support?" You know, and then so, you know, you answer the question and the group answers the question. And, you know…. But there's a myth that "The intimacy that I experience in this safe place, I can take outside of here and it can be the same and I will have this always." (Many nods) And so, you know, so I think that's a challenge, more for the participants, really, than… I don't have to manage it.

E: Well, in fact, that intimacy cannot happen without a vulnerability (few nods) and without a willingness to risk and to be seen. You know what have I told groups…. And I've had groups where absolutely nobody got in touch with anybody outside of group and I've had groups where they became best friends. And what I have said…. I haven't had any rules. I started out, I think, with a rule, but I let it go, because, I said, "It's grist for the mill. (Few nods) It's easier if you don't have a relationship outside of… a friendship outside of here. It's easier, but…."

B: Um, the tape recorder just stopped.

E: … "that's entirely up to you, and we'll work with whatever you bring in."

M: Oh, thank you. I guess the tape needs to be switched. (Reaches down and flips tape)

A: Yeah, I have, as kind of a guideline…. There's a caution. You know, there's a prohibition against starting a sexual relationship….

E: Oh, yeah.

A: But there, you know, there's a caution you know, around….

G: Didn't you find that people would do the work that should have been done in group with their other relationship outside?

A: That would start, if people….

G: Yeah.

A: … were sharing secrets.

E: (Nods "no") When there's conflict, they bring it in and say, "Okay, let's start here."

A: Depends on the level of functioning.

E: Yeah, it does.

A: Doing groups with lower functioning people, you know…. That doesn't happen.

E: Yeah, I work with pretty high functioning people.

B: I like what you said about the rule because, if…. The grist for the mill thing is good because we've tried to control that before and then that's just a whole nother level of, you know…. (Few nods)

F: Right.

A?: Authority. (Sounds of agreement from group)

C: And power. And, you know, if there's a rule you break it, you know?

(Much laughter from group)

E: We're not here to control their personal lives, but it will complicate it.

B: Right, right. But, with that stance, it's more likely it will come into the group instead of just being this secret with all this energy and, you know…. (Few nods, some sounds of agreement)

E: Oh I've had many pieces of work in the group between people who started to be friends "out there" and it didn't quite work, and it broke down, and one wouldn't speak to the other (few nods)… yet they're still in group. (Few laughs)

*** There's about a 2-3 second bit here that is unintelligible***

D: I've always wondered with that because I trained, sort of, with that initial rule. It was not until I did DBT groups that…. It actually has the opposite…. Like, we encourage, with the adolescents, that they can share their skills and have relationships outside as long as anything they speak of, you know, comes to group. And I always wondered if actually telling them, "No you can't do that," actually doesn't give them, like, more motivation to do it…like the whole oppositional…. (Many nods and sounds of agreement from the group)

B: Adolescents for sure.

G: Absolutely.

D: And even adults. Like, how many.…

B: We're all adolescents.

D: Yeah, we all have our issues with authority, you know, so….

(Garbled voices from participants, mixed with laughter)

M: Well I think we'll just take a couple more minutes and then we'll take a break. So, before we take a break, is there anything anybody wants to add about any challenges that have popped to mind?

G: I think I'd like to know what other people do about the whole rules thing because, to me, it was always about safety issues for women coming to the group, and what the expectations were. And it wasn't that I was setting myself up as an authority so much as the group monitored each other and decided on the rules, so to speak. I'm not sure if that's….

B: Well, I mean, I agree. If someone breaks confidentiality, for instance…. (Few nods) It's happened and there's a group vote and they're voted out of the group. And it's a traumatic thing and people deal with that. (Many nods)

G: Right.

B: Or another…. Two different people just kept on doing risky behaviors… and over a long time with lots of encouragement, so it's just demoralizing to the group. And at a certain point it just naturally comes up, like "What are we going to do here?" And they've been, sort of, voted out of the group. (Few nods) What I really was referring to is: if you try to hyper-control, like, for instance, what's going to go on outside of that group, then that's – I think, and I've tried it – self defeating. We did have things, you know…. No sex. We never thought we'd have to say it. Like, confidentiality, you know you're going to say that, but, "Alright, no sex between group members and this is why." (Few nods) But it's like, if that happens, it's better just to…. We'll deal with that, because otherwise it's just sort of one of these things where you're just telling people not to tell you. (Few nods) You know? But then there's certain things that…. A rule's a rule. Like, if someone is making group members feel unsafe, (many nods) they're not welcome in the group. Or if they're just sort of demoralizing the group by continually doing risky behaviors and not listening…. The two people in this five-year group have been kicked out of the group for that. But, basically, eventually the group just gets so frustrated…. And it's a sad thing, but it's sort of like…. It ends up, "That person's in individual therapy. They might even go into another group, but we just couldn't help that person in this group."

G: So was it the group that made that decision or you as the therapist?

B: It was actually the group that made that decision but I allowed it to happen. So I, you know. You're sort of in tune with your group. You know what's going on, I mean, and you're also aware of this, sort of, this…. Both these people, sort of, were the "problem children." So a lot of times, like, all the energy would be going on… like, "Oh they're screwing up," instead of people dealing with their own issues. (Many nods) So that also is a disruption because someone is just being a poster child for screwing up every week. "I want to be the center of attention today." (Many nods, few laughs)

G: And then they get all the attention week after week.

B: So I'm not saying "no rules." I'm just saying there's some things that I've learned I just can't control and it's better just to, sort of, have it be like, "If something goes on out there it is going to be more complicated, but bring it into the group," (few nods) opposed to, which we had done before, like, actual rules, which I think just sort of shut people up.

G: I think it warrants saying, you know, the difference between being a support group and a process group, right? (Few nods)

M: So I just wanted to ask… just make sure… if there's anything else anyone wanted to add about any challenges that they've experienced as a group therapist, or anything they find challenging….

D: I think, coming from a trainee level still, just that it's getting more difficult to get training. And it has to do with the whole, also, managed care. We're kind of holding out waiting more for process groups and, sort of, mentorship. So I'm concerned about group

therapy in some states or cities just not existing, or not being readily available… or where everything – at least in psychiatry training – everything else that is being given importance and is being taken away from other things….

M: Is there something you wanted to say (to A)?

A: On the addiction front, running an assessment group – where you have some people that are in early recovery, that are clean, and you have people that are using – again, you know, you can have a rule that if you use you can't come to group…. People just aren't going to tell you. You can't… obviously you can't have somebody coming high to group – we haven't really had trouble with that – but, you know, what are the consequences of use? You know, and things like that, at the group level. And so we're currently struggling right now because I have a group that's mixed (few nods). You know, two people that…. One's trying to do moderation, one who's still using, like, once every three weeks, and then the rest of the group is clean and sober. So there's a norm of, you know, of sobriety but because they're so new in sobriety it's very difficult for them to have people that are using in their presence. So do we separate the groups? (Few nods) You know, it's hard. And then numbers become a problem, so you're back to the administrative, you know, concerns. (Many nods)

C: I deal with that issue with this eating disorder group, because… in terms of type, type of eating disorder, you know. (Few nods) I'm doing clients struggling with anorexia versus clients who are maybe binging and purging, and then there's compulsive overeating, and how to… to put different clients in a group, not only behaviorally but also body image and those kinds of triggers. (Many nods)

A: Yeah.

C: So that… that can be challenging. Not to mention, you know – because eating disorders, you know, you can use the addiction model with that – the phase of recovery with that as well… in terms of someone who is in a later stage and really trying to improve the quality of their life versus someone who is just in the depths of behaviors and really struggling. (Few nods)

B: Just to add to that, with sex offenders we purposely have many different types all in the same group instead of separating them. So you've got your rapist, your pedophile, your exhibitionist, and they're just very…. They're very different but, bottom line, they're more similar than different. (Few nods) Even though, you know, the way they're manifesting is very different…. But really they're great for each other. (Few nods)

C: And that's what our philosophy is because, you know, it's really the human-ness that connects people and it's not about your… you know, your body size or what, behaviorally, you're doing. It's really about what are you struggling with underneath and how that makes people connect. So I agree with that.

M: Well this has been very interesting for me so far. I guess we'll…. Why don't we take a ten minute break and then we'll come back and talk about a few of these questions.

M: Alright, let's go ahead and get started. I want to make sure we get out of here at 5, so I just want to make sure we have enough time before 5 o'clock hits. (Turns on tape recorder) Okay, so kind of piggybacking on the last question we talked about, about challenges of being a group therapist…. I'm wondering about areas where you think you could grow as a therapist or things you'd like to learn more. What would make you a better therapist?

F: I always feel like I need tons more training and then…. But then there's, sort of, the dilemma – well, my personal dilemma – about paying for it. (Many laughs) You know, like, working at the psychiatric hospital where I used to work, training was always available and there was never this issue of paying for your own training and I…. (Few nods) So that's, like, a struggle for me, and just… having it be available. And so there's the training thing and then there's, sort of, seeking out my own support around it, so… finding other people that I can organize with. (Few nods) Like, I have a peer supervision group that a few of therapists that are in private practice kind of put together. So I find that incredibly important.

M: Is there any – when you think about trainings – anything in particular that you feel would be helpful?

F: Well, like, right now my thing is DBT, so I always want…. I would always like more DBT trainings. Working with adolescents – Diane and I were just talking about this – there's, like, one guy who's the adolescent DBT guy and there's a training in June. So can I finagle to get the school to pay for me to go? The other issue is that they don't offer state CEUs for social workers and so, you know… kind of working with that. I'm pretty sure I could probably get it approved, but I have to figure out all the paperwork to apply to have this training approved, so….

B: Just go with no paperwork. (Many laughs)

F: Just go ahead and… just go, just show up, like when you jump into a race and you don't really have a number. (Many laughs)

C: Yeah.

A: I'm not asking for CEU's. (Few laughs)

C: Exactly, I promise not to learn anything! (Few laughs)

B: I'm sure if you go up and ask they'll be alright. (Few laughs)

F: Yeah, sure. That's a funny thing to think about.

D: Hey, maybe for creativity…. (Few laughs)

M: Well, what are some of your other thoughts about areas where you'd like to grow, or learn, or improve as a group therapist?

D: I think, for me, especially being in group therapy or if I'm going to continue practice in group therapy, I would love to at least be in one year of group therapy, because being in individual therapy has really made a difference. So I think that would be something that it would be ideal for all of us to do... (something unintelligible).

B: I agree. At my graduate training institution you had to be in a group. I was very defensive, probably like most people – you know, very safe for, you know, half, at least half the session – and then had that experience of… where, you know, you suddenly started actually opening up and being vulnerable (few nods) and just how powerful it is. But having just the experience of being a client in a group and how defended you are…. And it's so easy to be defensive (many nods). You know, you do whatever you do. And then you don't get anything out of it, of course. It's just this thing that you have to go to… and then how different it is once you actually use the group and open up. So I agree. I mean, if we could all be in a group that… you would learn a lot from that perspective, for sure. (Many nods)

D: And I always wondered…. I would love, actually, to be in a group that is a process group of therapists themselves because I'm sure that the resistances are another level. (Many laughs)

B: Oh yeah, yeah.

G: (Jokingly) Why would you say that?

D: I wonder then, you know, what it is that we become resistant to?

B: Right.

D: What do you say? Like… "Oh no, I've opened up already. I've been in therapy for years."

G: I always say to my clients, "The only difference between you and me is I have wheels on my chair (many laughs). That makes me the expert."

E: In Gestalt therapy it said that resistance is where the work is. (Many nods) That's the place. That's that contact, that boundary.

M: Do you feel like it would help you as a therapist to know more what your own resistances are?

E: Sure. (Many nods)

D: And why do we resist? What are the fears? What are the…. I just don't know how the patients are feeling, because it's so overwhelming when you're on the other side.

A: I was in a process group for a couple of years and that…. It was very helpful. You know, it really becomes like… what I do in my work is who I am. (Few nods) You know what I mean? And there, I really do feel that I am the same as, you know, the people in the group. And so, that…. And getting…. And being able to say, you know, and identify when I'm triggered, you know, is really very useful. Sometimes it's useful to find out what's going… in terms of what's going on with the client, particularly on an individual level and, you know… (something unintelligible). But, you know, I think that's really important. (Few nods) I'm more…. I'm in the process of setting up a peer supervision group but, again, these aren't people that do group. And so I was kind of hopeful that one of the things that might come out of this group might be, you know, the ability to form a peer supervision group related to group, (few nods) because we are kind of hidden. There are those of us who advertise but, in terms of actually knowing each other, it's a different matter.

D: I second that idea.

B: I'd be interested. I mean obviously we all have our… just blind spots that we can't see because of who we are. And that's been real obvious to me working with other…. Often I've been the therapist and then someone younger is coming in. And usually when you're younger just getting in, you want to control everything and you want to know what you're doing. And part of the luxury of having been a facilitator for a long time is I'm not worried about that now. I'm just going with the flow and just being myself. But of course I'm still blind and I am, you know, lost, in that I don't have a co-facilitator and I'm not in peer support. So, I know from my experience working with other people that there are some people I must be not jiving with well, because you can see that in someone else. (Many nods) Like, you know, they're getting into, you know, sparring or they're getting judgmental. And you can see the client react and I'm sure I do that, but I'm blind to it. (Many nods) You know, so I don't know. So it would be great. Just by talking about it, I think it's more likely you'll figure out when you're doing it. But the whole thing you're talking about – just, sort of, wanting to know and so forth – I think that's so much a function of just getting into it. Because you just want to know everything and you want to think you're supposed to have the answer. And after a while you just realize, like, that's not it. (Few laughs)

A: That's not what it's about. (Many laughs)

E: The more groups I do, the less I know. (Many laughs, many nods)

F: And that is part of having experience, right? So sometimes at the beginning there might be a little bit of, sort of, false confidence…. (Many nods)

B: You need that! Oh you need that!

F: And then even, like, you know, I've been in it for a little while but, like, the more I learn the more I realize I have to learn. And I guess it's…. In a way it's a little bit like feeding a bottomless pit, you know? (Few laughs) You'll probably never….

B: When you get to the point where you just open to making mistakes…

F: Yeah.

B: …and talking about that and just saying… you know, and processing that, and it's okay, you know? And you always have next week. You know it's not like everything has to happen right now or it's going to be resolved right now. (Many nods) And you are going to make mistakes and hurt people's feeling at times, and hopefully you'll notice that and say what happened. (Few nods)

F: And those are the times where it would be so helpful to have a co-facilitator, someone to talk about that stuff with. (Many nods)

E: There was one time in group where – I don't need to get into exactly what, but – I had ignored someone. I just missed it. I missed it completely and this was somebody I really cared for. I really…. Not that I would have wanted to do that with anyone, but I encouraged her to confront me and let me know. We stood in the middle of the group and I invited her to say everything to me that she was unhappy with, just really confront me with everything. (Few nods, few laughs) And she did. This was something that was very hard for this woman to do. She just couldn't bear to hurt anyone's feelings, and so here she was with me and in that dilemma. And she told me all the ways in which I had hurt her by neglecting…. You know, there was something about…. I think it was about…. I was changing the night of the group. This was when I was merging the two groups. And I was all caught up in doing it the right way and doing it this… and I dropped her out. And she had said what her needs were and her childcare problems and I just completely dropped it out, and she told me everything that… and it was so hard for her. And she was crying and I said, "You're absolutely right. I'm sorry I did that," and "I'm really sorry. I would never hurt you intentionally, never." And it was what I would have said, of course, because I was wrong. I was in the wrong and it was the first time anyone in her life had ever said, "You're right. I blew it and I'm sorry." And so it was just amazing, the transformation, just because I said…. I told the truth and said I was sorry. (Few nods)

B: And there probably was something about her that that always happens to her.

E: Yes, exactly, it is. (Many laughs)

C: Right.

E: We got to that later. (Many laughs) Not that night.

C: (Jokingly) I'm sorry, but…. (Many laughs)

B: No, but… but you offered a different….

E: (Jokingly) How is this a pattern for you? (Many laughs) No, I saved that one. But just the… just something you said about just being yourself, being… I mean, because obviously everyone is watching you to model certain behaviors that are very scary. (Few nods) And it wasn't hard for me to say "I'm sorry" because it was the truth. I didn't have to…. I was…. She had been in the group for a few years and it was a pretty seasoned group of people. And so…. But I think I would have said…. I'd like to think I would have said the same thing had it been with newer people and, you know….

F: Was it hard at all for you at all to hear that? Or were you very….

E: Yeah, no, it was hard for me to have that role in it. Well no, it was hard for me…. It was painful. It wasn't…. My ego didn't suffer from it because I knew I had blown it with her. And I think it's so important that our human-ness comes through. (Many nods) I mean, I don't want to be in a role. Obviously we have to be in a role for a lot of it, but when it comes to…. I mean, if I want people to be vulnerable so that we can develop more and more intimacy, then I've got to be willing to do it too when the occasion calls for it.

C: I certainly think that reading helps. Going to trainings help. Having supervision and consultation…. But I think doing your own work, whether it be going to therapy, you know, paying attention to your own process with your clients, you know, whether it be individual or couples or group… but to be mindful of that piece and be able to say, "These are the areas I need to work on. These are my blind spots." (Few nods) I don't think any research is going to tell you that.

E: No, that's right.

C: You know, or any… because maybe a good supervisor you've worked with a long period of time who knows you, that you've been vulnerable enough with…. But I think it's that, sort of, life work and hopefully…. And if you, you know…. I've been in and out of therapy, you know, and from my own therapy… trying to enhance my own quality of life so I can be more present for my clients. I feel like that's…. That feels like the most important piece for me, personally.

E: A long time ago in graduate school I remember one of my professors said, "You can only take a client as far as you've come." And boy did that stick with me. And, you know, I think it's so important to continue the work on myself. (Many nods)

M: Well, kind of, piggybacking on what you said, it's kind of a good segue into research and what any of you have found helpful about research as well as, maybe, some of its limitations. I'm curious to hear.

A: Some of the things I get frustrated with are…. I'll really be…. At one point, you know, I was, you know, I had all kinds of memberships and memberships in specializations and all kinds of things. (Few nods) And over time, you know, the benefit of those really became difficult to justify… the renewal. You know, when I get my *Group Work* journal or whatever…. (Few laughs and something muffled)

A: What's that?

C: You get your checkbook out…. (Many laughs)

A: You know, and I'd look through and, you know, and the articles…. A lot of times the questions raised at the end of the article were the ones I was hoping would be answered. (Many laughs, few nods)

G: Good point.

A: You know, "We really encourage more study on this." I'm like, "Yeah, please tell me…." Or the generalizability doesn't quite fit because they're studying such a specific population sometimes. (Few nods) But I don't find… you know, like, some of the…. One of the most valuable things I've read most recently was about schemas related to spirituality. And I saw it in…. In the research article they were talking about, you know, when people experience sexual assault and trauma, that you know their schemas are shattered. And it was just validating to see that language that I had already been using for so long. (Few nods) You know, how safety in the world gets shattered. And so a lot of times it happens that it's validating for what's already going… how I'm already thinking about things. (Few nods) Sometimes it's useful to be able to say, you know, "Research does say that…." I find the *Psychotherapy Networker* much more useful than any journal I've ever gotten (few nods), just because it's much more practice-based. And I don't find empirical or even qualitative research that useful.

M: When you say it's more practice-based, can you say more what you mean about…?

A: It's clinicians talking about what they're doing and, you know, a lot of times they're case studies. And then people will comment on the case study and a lot of times they're critical, you know, or they're confrontive of the author. And then the original author gets to respond back. And so it's like having a consult and then, you know…. So you get to hear some of the dialogue between practitioners. Or they're talking about mind, body, you know, spirit connection. Or they'll just have little blurbs, you know, about, you know, the studies or the research that are going on. But you don't have to read the whole article. (Few laughs, many nods) You know what I mean? You just get the snippets of what's valuable, you know?

B: And that's one thing: often you just don't have time or you don't make the time.

A: Yeah.

F: Yeah.

B: I mean I love it when I read an article and I love it when I go to a conference. It seems great, I'm excited, and it definitely helps my therapy. But usually I'm just living my life and going to work. So it's not that there's…. There's probably information out there right now that I would love to… that's meaningful and so forth, but I just don't make or find the time to look at it. One thing that Diane said was that, of course, they're going to think it's helpful if we can make a case that this is cost efficient and that that's where managed healthcare is going. And I think it is. And from what we were talking about before, one thing I think is the most important, probably with any client but particularly with sex offenders, is simply being human and treating the other people as fellow human beings. (Many nods) And no doubt about it, to me, that's the most therapeutic thing in the world. It doesn't matter what else I might learn or what technique or anything, just being present and being real – that's the most important thing (few nods) and that's what they're going to respond to. And that might even be, sometimes, me getting prickly. I mean, but the whole point is that I'm not rejecting you. And I can disagree with you and care for you at the same time. And I like you. You know, I pretty much just like my clients and that's therapeutic. (Few nods) You know, but I think there's a lot I can always learn. But so much of that's just my own discipline problems more than what might be out there. I imagine there's a lot out there that I'm missing.

C: Sure.

D: I think there's certainly pros and cons… I mean, benefits to research and pros and cons about it, just across the spectrum. It would make a case for us to, again, get reimbursement for it and try to advocate so that it continues. And at the same time, it is limiting to some extent because of how we're living. Like, the other thing, the other piece about research that is very difficult sometimes is that patients don't fit models and… or boxes. And because of research, or the mental health that we're living, there's some… or…. We're starting to be pushed into, sort of, tracks. And, you know, different clinics are starting to move in the perspective of, "If you have this diagnosis you're going to that group. If you have this diagnosis…." But what about the patients who don't fit one particular piece of it? And so, I think it's always wonderful, research. My concern is what it's being used for (few nods) and when it's not… when it's accepted as the absolute truth. And all that's just, you know, we are…. As you were commenting, kind of, I think many people who have been doing clinical work for many years have the answers already that research is bringing up, just because of their experience. They've seen it. They know. We just know it works. And the anecdotes… you just know. But again, because of how we're living and, sort of, the financial issues that are motivating our health system, we're kind of forced into that. And it is very concerning for me, because I'm seeing…. I was, you know, coming from New York, where it is more psychotherapy-

oriented. I came here and I've seen some amazing differences that are really scary for me.

B: Like for instance?

D: For example – and this is good this is confidential (few laughs) – at the hospital where I'm doing my fellowship, it's a research, you know, institution and I did come here because, to some extent, I do want to learn research and I believe in research. But when I got here, it was really scary to see that the way the clinics are run are so specialized that it doesn't…. Patients are discharged from this clinic, like…. If they have an eating disorder and they get therapy for twelve weeks then that's it. And you're discharged and you're sent to this other service or this other clinic, because now you only have depression; you don't have the eating disorder any more. (Many laughs) And then you go there for twelve other weeks, and all the sudden you get discharged to a different clinic. Or if you have problems at home, in the case of the children, you get wraparound services for eight months. But then, for me, as understanding long-term therapy and that model, when just that team is starting to develop a relationship with that family…. Because, how long does it take? I mean, in eight months it's done. And so the treatment has to finish and then they come back to me. And next time that I refer them, I'm going to refer them to another wraparound services next year. It's going be a different team and meanwhile it's a revolving door and it's like, all these boxes….

B: And the family gets exhausted. (Sounds of agreement from the group)

D: And everybody…. And there has nothing…. No one….

E: (Something unintelligible) …confused.

D: Exactly, not even one single constant, you know, figure in the life of that patient that…. As we have all said here, that is what really heals: the relationship.

M: And you think that the research, kind of, feeds into that, kind of, "Okay, this program for this period of time, then this program"…? (Many nods)

B: A grant for this, a grant for that.

M: Right, right.

A: And yet, overall, you know, the one thing I always go back to is, what Bob said, is really always supported in research: that it is the therapeutic nature of the relationship. It's that person that's being, you know, empathic, non-judgmental. (Few nods) You know, unconditionally give positive regard.

B: And the worst thing is what she's describing.

A: Absolutely.

B: It's the worst. You're just redoing it.

A: You're cut off.

B: It's just the repetition. It's happening again and again.

D: I found it's more traumatizing….

B: Oh, it's terrible.

D: …because if you – especially with the kids – because if you didn't have that constant figure in your childhood, and you're coming to me and I can't follow you for more than twelve weeks…. (Many nods)

B: That's sick.

D: …whenever… when, finally I was starting to get just the tip of the iceberg, to start getting a relationship with you, boom it's gone.

B: Which is probably worse – that's what's so terrible about it.

D: It's re-traumatizing.

C: It's just reenacting what happened.

A: It might be useful to know that, you know, in a private setting or, you know, even in an agency setting, getting an authorization for the work that we're doing is not a problem.

D: Really? Oh that's wonderful.

A: I mean, you have so many sessions per year. I mean, that's a function of the cost of healthcare in America, you know. But yeah, it's really not…. It really isn't a problem, you know, for today, you know.

M: If I could just jump in…. The three of you have been a little quieter over there just now, and I want to make sure there's space for, you know, divergent opinions also. Maybe…. I'm not sure if you're sitting over there thinking, "Well I actually like research." Or maybe not (many laughs), but I'm curious to hear what you're thinking over there.

G: I was actually thinking that Alice was saying everything I was thinking.

M: Oh, okay.

G: Which is: many times when I read journal articles, it does just kind of validate what I already know after years of seeing patients. (Few nods) And you're right, Alice, it just kind of makes you feel like, "Yeah, I was right." But then, as you say, there's some questions at the end that they haven't answered.

M: What kinds of – for either of you – what kinds of questions at the end do you find, like, "Well, that would be really interesting if someone actually either researched or wrote about that"…? I don't know if…. You can sit with that for a moment if you want, if anything pops to mind.

A: Well this particular one, you know, again had to do with spirituality and, you know, how… looking at how clinicians actually integrate spirituality. The article seemed to say that, you know, clinicians are hesitant and tentative to integrate spirituality. But I think spirituality is infused in therapy; you can't separate it. You know, it's a matter of language. It's a matter of semantics. (Few nods) And so, you know, actually talking to people in terms of what they're actually doing, I think…. So I think…. So that's, you know, like, in that particular case, is, you know, "What are people doing? How are clinicians thinking in terms of their work?"…I think is useful. I think studying clinicians a lot of times would be more useful, as the research, than studying clients. (Few nods)

G: That's right.

M: That kind of actually feeds right into my next question which is…. And I want to give the two of you (to E and F) the chance, also, if there's anything you wanted to add.

E: No that's fine.

F: This isn't exactly on that, but just in terms of research, like…. So, the group that I do at the high school…. I would really like to somehow gather some data about that. (Many nods) You know, DBT is being used with lots of different populations but, as far as I know, it hasn't been in, like, public schools yet. (Few nods) And I would really like to see where I can go with that. But that presents certain challenges. You know, I'm not a PhD student, I don't have an IRB at an institution to go through and, like, how do you do that? (Few nods) I talked to…. I went to this education grant-makers meeting and, you know, it's challenging because it's an expensive, or a wealthy, school district. Just… so there's that thing about research. And then it also, sort of, brings up the question about what makes what we are doing as individuals effective, and how do we know, and how do we measure whether it's effective. And I know, like, in social work school they suggested that you always be collecting data, doing sort of personal outcome stuff, which I have never really done. And my only… my only, like, way of deciding if something's been effective or not, partly, is, like, my own internal feelings about it. You know and, like, does that really translate to it being effective?

B: Right, right. And that is one of the things about our work: it's so rewarding, but it's not like building a house or planting trees. I mean you never really know. (Many nods)

F: Right, right, right, right. And we can have a sense of, you know, the therapeutic relationship and how our clients sort of feel about us. But is that even a good indicator that what we're doing is, you know, useful to them in some way? So I do, sort of, struggle on that issue, you know. So, you know, DBT is an evidence-based treatment but am I doing it in a way that's effective? (Few nods) 'Cause, you know, we could all be doing cognitive therapy or we could all be doing whatever, but are our outcome's going to fit with the research? (Few nods)

M: (To C) I thought you were about to jump in…

C: I was going to say…. It's actually a thought I had before, in terms of how I use research, because it seems like we're talking about, sort of… we… our reading articles that are going to help us with our clinical work. And I actually… I do a lot of reading. Not on groups, but I do a lot of reading on eating disorders. I get journals and I find that kind of research helpful to the client… I mean, to me as a therapist but also to the clients, because it can help them therapeutically. You can talk to them about the medical component of the eating disorder. (Many nods) You can talk to them about medication and neurotransmitters and, you know, and all these sort of things so there's not so much self blame. You know, it's all about "the fault that I have an eating disorder." You know, you can talk about, you know, some of the genetic studies that are being done on eating disorders, you know… all that kind of stuff that I think is really helpful to the clients, in terms of them understanding the whole… the complexity of what they're dealing with. So that kind of stuff I think can be helpful therapeutically.

A: Yeah, I've copied things from the *Networker* and given it to my clients.

C: Uh huh, yeah.

F: Yeah, they're very accessible articles.

M: (To D) I think I might have cut you off there. Were you about to say something?

D: That, just to clarify again… that I think research is very important and there are a lot of benefits from it… not to, you know, ignore that. I think when it's just taken as the absolute truth, that's when it becomes a problem. And one of the most, sort of, useful things about research is that it helps us also change public policy and be able to advocate. And that is something that, unfortunately again, at a macro-spectrum, we can't do, like, without having the evidence, because we need to go to the insurances, we need to go to politicians. And they're going to ask for that data (few nods) and it needs to be quantified and it needs to be…. So in that sense, and also because, you know, funds are limited and what not, I think research does try to find, sort of, simpler, shorter answers on ways of helping. So there are treatments like DBT or a twelve-week group that, at the end, you measure… did you get structured interview before and after. And if there was some benefit, you know, I'm all for that. If it's between not giving anything to the patient and being able for them to have that, I'm like, "Of course." When it becomes a

problem is when it, then, is used only…. It has to be that way… or we're not finding ways around to, sort of, combine the relationship with the treatment. So….

B: And another way of, I think, saying what you're saying, is: what happens is you're going to get paid for a certain diagnosis and not for another one. (Few nods) So what you do is you just give the diagnosis they want. So it completely flaws whatever they're looking for in the first place. (Few nods) You know, "Adjustment Disorder… well, okay."

M: So do you mean that, basically, if you're giving a person a diagnosis for that reason, then they might not even fit into the treatment that research shows is…. (Many nods)

B: Right.

M: Right.

B: And that's pretty much always the game.

M: Just to, kind of, build on a couple of comments, it sounds…. My last question here, "How could group therapy research be more helpful" …I heard a few things. One is it could be helpful in the sense of kind of giving some evidence, or providing some sort of backing, for what people are already doing, to kind of, you know, give it some credibility. (Few nods) Another thing you mentioned was hearing from clinicians about what they actually use and how it's helpful… little snippets from their experience. (Few nods) You mentioned, I guess, as a practicing clinician, "How can I, sort of, research what I'm doing myself and figure out, you know, is it helpful?" I'm wondering if, either building on those or any other ideas about how research could be more helpful… Or what kind of research you think would be more helpful than what's out there right now…?

A: I think doing things around client… clinician-client match, that that might be useful. (Few nods) Things you could study are perhaps the relationship and the components of that and how…. You know, we've done stuff around couples and what makes, you know, couples work (few nods) you know… maybe, you know, something along… using a similar model might be useful… because I think one of the limitations of research is that we are… or… we are the service. It's our person-hood. (Few nods) It is our humanity. And regardless of how much we try to, you know, standardize, the human element can not be removed. And if you remove it, you remove the most healing component. So I think that's something that research constantly bumps ups against. But I've wondered, too, in terms of, like, the groups I lead around healing shame, I really would like to have some outcome data to support what's already, what I've already seen happen. (Many nods) You know, because I've seen, you know, clients that used to have, you know, psychotic, you know, thoughts, you know, realize it's their own projection, you know? (Few nods) I mean, so, I mean people can, you know, be transformed, you know. Now is that just, you know, an anomaly or…. You know? (Few nods) So it's hard.

E: I think that what would be most helpful to me would be to be able to, in some way, have documented the results of being in group for a certain length of time. (Few nods) At least a year it would have to be, I imagine.

M: From your own groups, you mean?

E: Mm hmm. It would be so helpful because, you know, I have a subjective assessment of what I see and it's remarkable. It's miraculous in some cases. But it's anecdotal and it's subjective (few nods) and it would be really nice to have a little research team follow behind and just like crank it out to me every now and then, (many laughs) just so that I could….

M: Do you think it would also be helpful… not only for your own practice but to read, say, another clinician's, sort of, exploration of how helpful their research was? I mean their….

E: Sure, sure. (Few nods)

F: And what is it really about any individual case that you have that was helpful. You know, how do you really sort of tease that apart? You know, maybe I'm using cognitive therapy, but is that really it or is it, you know, being empathic or, you know, active listening or, you know, what element of it? (Many nods) Can you even tease that apart?

E: You mean and isolate one thing?

F: Yeah

C: There are some therapists, that – I don't do it because of that time issue – but that send out, you know, surveys or questionnaires and get feedback. But then there's that whole dynamic of, you know, is this the client…. You know, if it's anonymous, do they trust that it's anonymous? (Few nods) If it's not anonymous are they, you know, are they filling it out honestly? But there would be a sense…. At least it would be… it would be, sort of, a subjective piece, but there would be some level of feedback to that.

E: I actually did that, you know, in the beginning when I was first starting groups. And I actually did that when I was into, sort of, controlling how well I was doing. (Many laughs) Forget it. (More laughs). But they just kept doing group. That was my indication that they really liked what they were getting.

C: And not to mention, like, often times when you're… because I…. When I run this group we do have openings and closing. Sometimes it's eight weeks… it's ten weeks…. It depends on what the schedule looks like, really. And so we will have a closing group where people will say, "Oh it was helpful for this reason." But it's always like, "Oh it was so helpful…." You know? And you're like, what else? How? (Few nods, few laughs)

E: I always asked what wasn't helpful.

C: Oh yeah, and we say that too, but, you know…. You know, one person had said it would be helpful if there were fewer people and at the time there was five people in the group (many laughs), and I was like, "Well, did you want a group or do you want individual therapy?" Individual therapy with two therapists! (Few laughs) And so, yeah, I mean, I…. But it's…. That piece would be helpful.

D: I think, for me, the most crucial piece of getting more research in group therapy – because we have… we are very limited, actually, especially in process groups, just because it is so difficult to quantify a relationship, like we have all said – it's just knowing that if we don't start doing it, just because of how the system is working, it's going to start disappearing, like it's already…. So it's like, "If you cannot fight the enemy, you have to join it." And so, for me, as a future researcher, one of the reasons why I decided I need to be trained in research and I need to go out there and do my thing is because if somebody doesn't do it, then those of us who really believe and have seen the effect of a long-term therapy relationship…. We are going to start losing that. So in order to advocate and in order…. I've already seen it here at the facility where I work. The only way that I can get, like, things to happen…. Like, I bring a paper or something and I say, "Can I do family therapy? Please, look there is a paper here." (Many laughs) And it's the only way that people will start listening to me and start opening doors. And it's very sad that that's where we are, but that's were we are. And so we need to, sort of, work around ways to then try to get the support that we need, thinking of patients that, unfortunately, cannot come to private practice or… because if not, managed care is just going to control things in some other direction.

M: I think what I'd like to do now, just for a few minutes before we, kind of, close up, is just give everyone a chance to check in. If there's anything that's, kind of, been on your mind that you haven't had a chance to say yet about any of these questions…. If not, that's fine too, but if there's anything kind of lingering that you want to share before we finish…. And then we'll just take a few minutes just to talk about what this experience was like. So….

D: I actually had a question…. I would like to get the feedback from all of the experts here, in terms of, also, that, sort of, piece of research, and what not…. How do you know, like, when a patient is ready to end their therapy? Because the other thing that is out there a lot now, because of the evidence-based, time-limited, is the conception that long-term therapy creates dependent people, that people become dependent on therapy. And that's also one of those things that I'm struggling with, in terms of trying to….

M: Well I think what I'd like to do, if it's alright with you – because I think that's a great question and I'm glad you mentioned it, 'cause it sounds like it is, kind of, a challenge – is just to hold off the responses 'til after, since we only have about five minutes.

D: Okay sure.

M: But I'm glad you mentioned it anyway, because it sounds like that is one of the challenges. But I guess…. Does anybody else have any thoughts that they'd like to share?

G: I was just going to say that research could probably be helpful in convincing managed care that group therapy would be cost effective. (Many nods) Because I know in the health insurance company where I used to work, where they had in-house mental health, it used to be that if people attended group, it was only half the benefit that they used up (few nods), instead of the whole benefit. Now with managed care, whether you're doing group or you're doing individual, it's twenty sessions a year. (Few nods)

A: Which sucks. (Few laughs) In laymen's terms, it sucks.

G: Because even if I think it would be very therapeutic for somebody to be in group, they have twenty visits and, you know, they have to stretch that out for the whole year sometimes. So if research convinced managed care that this would be cost effective for them, it would be very helpful.

A: And they're only paying half the amount anyway, so it doesn't make any sense.

B: Unless you're trying to save money. (Few laughs)

G: And that's the bottom line.

M: Any other closing thoughts, or….

D: I was just thinking, as people – we were answering the "What would make you a better group therapist?" – as I was listening to everyone, that just… sort of… it comes down to knowing that you always… making sure that you always remind yourself that you are in the learning and growing process until you, sort of, die, and never becoming too convinced that you're, you know, already you're there, you know it all, and you have grown the most that you can (few nods), because it sounds like all of you have, in some way or another, just mentioned that you learn from each group, that you learn, that you grow as a person, that… so, reminding ourselves about that every day. (Many nods)

E: Just stay teachable.

A: Which is the definition of humility.

G: I think our patients remind us of that.

F: And I think sometimes I struggle with the other side, like, that even though I'm not at *this* place, I still have something of value to offer today. (Many nods) You know, like, I'm really teachable. (Many laughs) But, even though I don't know it all yet, that there's… that that's still the case.

D: But that's dialectic in itself.

F: Yeah.

A: Which, on the other side, is feeling that we're competent…

F: Yes, exactly.

A: … even though we may not be perfect. (Many nods) You know, and that just being confident doesn't equal failure. You know, that it's something in and of itself. (Many nods)

F: Yes, perfectly stated.

M: Well, on that note, just a quick moment for any reflections on what it was like to participate in this discussion today. I know I can say, for me, it was really great. I loved hearing from all of you and you each had something unique to offer. And so I'm glad each and every one of you was able to make it here. What was it like for any of you?

E: It's been good for me. It has helped me to get all excited about doing a group again. (Many nods) And also it has helped me just to know again how much I love doing groups. (Few nods) And, you know, I can feel the excitement and the charge around when I talk about working with groups and remembering just how powerful it was and is, and just how… just what a privilege it is to be able to walk alongside people (many nods) when they're in such a vulnerable and scary place. And it's just…. you know, to have their trust…. I don't know. That's all part of it for me.

B: I think that's a great word: privilege, (Many nods) because it's sort of like a gift. You're being given a gift.

E: It truly is.

D: I think it's been fabulous and I just want to thank you for inviting me and thank all of you for the sharing. And I just feel like so energized and supported, I think. And I just… again, speaks for how wonderful it would be to have peer support and to… because I think we have the privilege of, you know, being there for patients, and give and also getting back, and yet sometimes we can also get burned out, many times because of the system. I always think that the easiest part of my career is the clients and patients. (Few laughs, few nods)

G: Oh, yes.

D: The difficult part is dealing with the rest. So it was just a fabulous experience.

C: Yeah, I mean, I felt like just listening to everybody was great on many levels… on an intellectual level, but also, you know, noticing this is a group (few nods) and we're all

talking. It's not, you know, necessarily a process group where we're revealing thoughts and deep issues or anything. But, it actually reminds me, on a more personal note, the need…. I do have a consultation group I go to once month, but it's just…. It's a rich environment and, because of busy schedules with kids and work and everything else, that for me personally it feels really enriching to do this and it taps into a need that I have. (Few nods)

M: Something that I didn't think about until it got closer to the study was the fact that I was bringing together a group of group therapists (Few laughs) and that, even though it's not, you know… the topic isn't something extremely personal, it is still somewhat personal (many nods), because I've asked you all to share about some of your challenges and areas you'd like to grow. And that is somewhat vulnerable. And I'm glad that you've been able to, kind of, connect with each other and find some support, just like you were talking about for your clients.

E: Are we allowed to have a relationship outside of group? (Many laughs)

D: (Jokingly) The group ends here!

F: Yeah, I definitely leave feeling like I don't want it to end, and like I would like to get to know everybody more. I think there's just, like, a wealth of experience here. And also just, like, on a professional level, it's just so helpful to know people who are doing this, like, even in terms of referring and things like that. (Many nods) And, like, my… the wheels are already spinning and I'm thinking, "You should change your Ph.D. topic to, like, an ongoing group for group therapists." (Few nods, many laughs) I guess I just want to give you the feedback, Mandy, that I just feel like, from the beginning throughout, that the way that you have handled this… like getting everybody together and making people feel comfortable, and just even how you facilitated the group, and drawing people in, and summarizing and…. It just shows a real skill level in you. (Few nods)

M: Thank you.

F: So I just wanted to give you that feedback. And I just really appreciated being here.

M: Thank you. I'm really glad.

A: Me too. I appreciated the way that you approached this. And even from the initial phone call, you know, I really felt good about participating today (few nods) and today wasn't a disappointment in any way. I feel very grateful to have met you all and I do hope that, perhaps, there will be some more conversation about consultation or peer supervision (few nods), because I don't have a lot of group therapists, you know, in my circle right now. And I really could use that. So thank you.

M: Well I guess what I'd like to offer, then, since it's five, is we'll stop for now and if anybody wants to just stay here and hang out for ten, fifteen minutes, I'll be just, kind of, cleaning things up (few nods)… and I have to be out of here by about five thirty. But

then if anybody…. I'll send out an e-mail, but if any of you would like to, sort of, be on an e-mail list… and I can distribute it…. I'll elicit that in my e-mail (many nods), so no one's pressured and, you know, you can let me know if you'd like to be in contact with each other and that way I can distribute that. (Many nods)

A: You could leave phone numbers and addresses for those (gestures to B who does not use email)…. (Many laughs)

M: Well, I can call and see if he'd like to have his phone number on that. Thank you everyone, again.

(Simultaneous thanks voiced by participants)

M: And I will be in touch, you know, with a summary, as well as just an e-mail.

C: Take your time. (Few laughs)

APPENDIX N

Initial Analysis of Themes

<u>What makes group therapy work?</u>
Cultivating self-acceptance
Being accepted by other group members
Reducing shame
Insight into why one developed a behavior
Insight into why something affects one in a certain way
Resolving unfinished business
Sharing struggles and victories with others
Experiential exercises that elicit difficult feelings in a safe environment
Feedback from others
Psycho-education
It's more affordable
You can reach more people in one hour
Take risks (safe)
Get insight into self (safe)
Learn how to relate to other people (safe)
Feel less isolated, others care
"Work through" historical problems
Group members call each other on things a therapist might not see
Group members may accept confrontation from member they wouldn't from therapist
Having supportive witnesses
Being a witness
Contributing to someone else's healing
Role play characters in a past conflicted relationship
Role play the "bad guy" and develop empathy
Group members elicit feelings/relationship conflicts from the past/present
Hear the "other side's story" from members w/opposite relationship problems
Express (words, feelings) one has needed to express but never did, saying the unsaid
Resolve conflict between group members in a productive way
Universality, others are like you
Compassion for others becomes compassion for self
Relating honestly – taking risks to be real, being authentic
Giving/getting negative feedback or sharing difficult things and not being abandoned or attacked
Developing trust in others
Group therapy provides things individual can't (-)
Group members provide things the therapist can't
Noticing discrepancy between body language and words
Humor
Calling someone out on their defenses/not being real
It's harder to run out on group than individual

"Energy" in the room
Modeling (with a co-facilitator) scary/difficult behaviors
Group members respond the way anyone in person's environment would
Can work on issues when they arise between group members
Make people comfortable and get them talking, use handouts
Therapist willing to be wrong and admit mistakes
Developing intimacy
Therapist willing to be vulnerable, open him/herself
Being present for clients
Just being human, treating others as human beings, and being real
Disagreeing without rejecting
Liking one's clients
Works best when combined with individual work
Works best with two facilitators

Therapist Needs
Need for confidentiality to voice challenges/concerns
Mentorship/training, especially process groups and training for psychiatrists
Networking – Not having a community – being isolated as a group therapist
No support for therapies that aren't "evidence based" – need to prove/defend value
Quantified evidence for what we're doing
Availability/affordability of trainings
Getting CEU's approved
Being in group therapy (being vulnerable, opening up, seeing one's defensiveness –
learning what it's like to be a client)
Discovering one's own resistances
Identify one's triggers
Peer supervision
Learning one's blind spots
Learning clients one doesn't click with
Learning to trust oneself, let go of control, to "not know" the answers
Being open to making mistakes
Developing confidence
Doing one's individual therapy to be mindful of areas one needs to work on, blind spots
Staying open to learning, staying teachable
Remembering one has something to offer

Therapist Challenges
Insurance
Limited time for group members
Starting/marketing a group, getting referrals
Being scared to have less control (than in individual)
When your own issue comes up in the group
Making sure no one gets lost/attending to everyone's needs
Making sure people feel safe when they leave – not knowing a quiet member was
struggling greatly

Difficulty doing research on some kinds of therapy
Balancing vocal members with quieter members, making sure everyone has a voice
Not reenacting past painful experiences
Gender of therapist vs. clients
Negativity/hopeless attitude coming over group
Negative peer pressure
Patients triggering each other (to do problematic behaviors)
Open vs. closed group
Timing for adding group members
Facilitating environment where conflict can occur without its getting out of control
Wishing things could wrap up neatly within the time frame
Handling Axis II patients
Scapegoats
Financial strain, schedule difficulties of getting a co-leader
Running without a co-leader – missing support
Having someone join as co-leader – vulnerability of being observed
Feeling self-conscious about one's "performance"
Norms that prevent opportunities (e.g. no women in sex offender group)
Definitions of health
Bringing back to skills – prohibits going deeply into things
Getting people comfortable enough to share (fear of criticism, taking on others' problems)
Making sure patients don't avoid their own problems by focusing on others
Handling relationships outside the group
Whether/what to have as group rules
Dealing with broken confidentiality
Keeping/terminating people who are not progressing, making others feel unsafe, persisting in risky behaviors
Mixing members of different levels of difficulty (e.g. addiction, eating d/o)
Heterogeneity vs. homogeneity
Knowing whether what one is doing as a therapist is helpful
When is a patient ready to terminate?
Session limits

Research: Weaknesses
It can't tell you your weaknesses/blind spots
It's hard to do for some kinds of therapies
Cost of memberships/journals
Questions raised at end left unanswered
Not generalizable
No time
Pushes particular diagnoses toward particular tx, but people don't fit into boxes
Can be accepted as the absolute truth
Disorders are simplified
Treatments are too specialized

Clients are bumped from one tx to the next – revolving door, hurts the relationship piece, retraumatizing

Even if a tx is evidence-based, each clinician may do it differently – how to know if he/she is doing it effectively?

Ignoring the relationship aspect of the tx

Diagnoses given to justify insurance coverage – indicated tx may not be appropriate

Standardization cannot get rid of the personhood of therapist – if you remove it, you remove the most healing element

Getting clients to feel anonymous and be honest

Need a paper to justify anything

Research: Strengths
Validates what one already believes/does

Psychotherapy Networker – practice based, case studies, critical peer review/dialogue, mind-body-spirit connection, blurbs without the whole article

Could make a case that group therapy is cost-efficient

Advocate for group therapy

Reading about disorders for psycho-education for patients

Does find simpler ways of helping people

Research Ideas
Integrating spirituality

Studying clinicians rather than clients – what are they doing? How are they thinking about their work?

Clinicians need money and training on how to measure their own efficacy/outcomes

Interested in reading others' outcomes too

Client-clinician match

The therapeutic relationship and its components

How to figure out what's helpful in an individual case

Convince managed care that group therapy is cost-effective

Advocate for what we know works – get evidence

What Focus Group Experience Was Like
Excited about doing groups

Motivated to do groups

Reminded why love it

Reminded of the privilege of doing it

Reminded of need for support from/connection with other group therapists

Wanting to continue contact – referrals, peer supervision, consultation

Grateful for meeting each other

Appreciated my facilitation, making everyone comfortable, drawing people in, summarizing