Evidence-Based Group Psychotherapy: Using AGPA's Practice Guidelines To Enhance Clinical Effectiveness

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Practice guidelines represent a useful approach to facilitate the delivery of evidence-based mental health care. In this article, we detail group psychotherapy practice guidelines developed by the American Group Psychotherapy Association (AGPA). Combining the research literature with expert consensus, the AGPA has created a resource that should prove useful for psychotherapists, administrators, and patients. We illustrate the guidelines through a series of clinical dilemmas and challenges. © 2008 Wiley Periodicals, Inc. J Clin Psychol: In Session 64:1238–1260, 2008.

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Having recently completed her graduate field placement, Jane was delighted to be offered a full-time position as a clinical social worker on the inpatient unit of the hospital at which she had trained. The unit was an acute care, general psychiatry unit with 26 beds and an average length of stay that was better and longer than many comparable institutions. Part of her responsibilities in her new post was to run a group therapy program for the inpatients on the unit. Having had some ambulatory group experience that she enjoyed, the prospect of leading the therapy groups quite excited her—until she actually began to lead the groups. After several weeks, she became frustrated and discouraged. Jane recognized that inpatient group therapy was by definition different than the outpatient models that she had practised. While Jane had read about inpatient groups and felt prepared to develop the program, she discovered that the groups were poorly attended, with often not more than two or

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three people reluctantly showing up. Patients would literally drag themselves into the group room for the 9 a.m. start. Once there, patients would often wander in and out and not infrequently would be called out by other staff members for tests or other interviews. Jane experienced a sense of being undervalued and even marginalized when she tried to increase group participation. She became particularly concerned when a colleague responded to her by calling the psychotherapy group, ''your group.'' Jane did not like that expression; it reflected her sense of isolation and lack of the group therapy's integration within the inpatient unit as a whole. She even began to wonder whether the rest of the staff had any investment in this group. Jane recognized that to have credibility in tackling this problem within a seemingly resistant clinical context, she would need to address this situation in an evidence-based fashion.

This vignette, likely a scenario familiar to many group practitioners, represents the challenge in developing and building a group therapy program. Frontline practitioners often face the questions, what is the best response to the clinical dilemma I am facing? Can I use research evidence to persuade colleagues to approach clinical problems more effectively? How can I be sure that my practice meets standards for evidence of effectiveness? What is the best way to ensure that my interventions are grounded in the knowledge of empirical literature and accrued clinical wisdom? How can I ensure that my clinical work does more than carry on the tradition of my earlier training? Can my therapy groups meet the increasing demands for accountability that the mental health environment demands?

These are some of the many questions that clinical practice guidelines (CPGs) address in general and that the American Group Psychotherapy Association's (AGPA's) *Clinical Practice Guidelines for Group Psychotherapy* (2007) answer specifically. The single source document was crafted through the process of a comprehensive review of the literature integrated with expert clinician consensus. Table 1 presents 10 key domains in the practice guidelines. The guidelines are intended to serve as a resource for practitioners, supervisors, teachers, administrators, and patients, by describing evidence–based group therapy practice. Throughout, we employ the definition of evidence-based practice as ''the integration of best research evidence with clinical expertise and client values'' (Institute of Medicine, 2001).

The AGPA Task Force that created these guidelines worked toward several objectives. The first was to produce practice guidelines for group therapy that would be practical, relevant, and flexible. Our approach would focus on group therapy broadly rather than articulate treatment guidelines more appropriate for a discrete model of intervention or for discrete clinical conditions. In this way, the CPGs reflect an effectiveness orientation that would be readily applicable within the real world of contemporary practice. The CPGs, similarly, would not manualize therapy nor set rigid standards for practice. Rather, it would serve to augment clinician judgment, recognizing that the practitioner has the fullest access to all clinically relevant information and that clinical judgment must be respected. It would be written in an aspirational rather than prescriptive tone. Noting the robust body of evidence for the effectiveness of group therapy broadly (Burlingame, MacKenzie, & Strauss, 2004), we emphasize group therapy that uses the group as the agent of change rather than simply the setting for treatment. This approach recognizes as well the centrality of common factors in group therapy and the essential role of the therapeutic relationship. The clinical practice guidelines are aimed at group psychotherapists across disciplines and settings.

Table 1
The AGPA Practice Guidelines for Group Psychotherapy

1. Creating successful therapy groups
   - i Starting well—Client referrals
   - ii Starting well—Administrative collaboration
2. Therapeutic factors and therapeutic mechanisms
   - i Mechanisms of change in group psychotherapy
   - ii The therapeutic factors
   - iii Cohesion—A core mechanism of change
   - iv Relationship of cohesion to other therapeutic factors
   - v Evidence-based principles related to group cohesion: Group structure, verbal interaction, emotional climate
   - vi Assessment of therapeutic mechanisms in clinical practice
3. Selection of clients
   - i Inclusion criteria
   - ii Exclusion criteria
   - iii Premature termination
   - iv Patient Selection Instruments
   - v Composition of therapy groups
4. Preparation and pre-group training
   - i Objectives of preparation: Establish the therapeutic alliance, reduce patient anxiety, provide information, consensus on treatment goals
   - ii Methods and procedures
   - iii Impact and benefits
5. Group development
   - i Models of group development and assumptions
   - ii Developmental stages
6. Group process
   - i The group as a social system
   - ii Work, therapeutic and anti-therapeutic processes
   - iii The group as a whole
   - iv Splits and subgroups
   - v The pair or couple
   - vi The individual and member roles
7. Therapist interventions
   - i Executive function
   - ii Caring
   - iii Emotional stimulation
   - iv Meaning attribution
   - v Fostering client self-awareness
   - vi Establishing group norms
   - vii Therapist transparency and use of self
8. Reducing adverse outcomes and the ethical practice of group psychotherapy
   - i Professional ethics
   - ii Group pressures
   - iii Record keeping
   - iv Confidentiality, boundaries and informed consent
   - v Dual relationships
   - vi Preventing adverse outcomes by monitoring treatment progress
9. Concurrent therapies
   - i Concurrent group and individual therapy
   - ii Combining group therapy and pharmacotherapy
   - iii Twelve step groups
10. Termination of group psychotherapy
   - i Unique aspects of termination in group therapy
   - ii Time-limited groups
   - iii Open-ended groups
   - iv Premature termination
   - v Ending therapy with personal satisfaction
   - vi A dilemma of the open-ended group
   - vii Ending rituals
   - viii Therapist departures

Through a review of the group therapy literature and the clinical expertise of the task force members, 10 essential group therapy domains were identified. The practice guidelines recognize that knowledge is evolving and that the positions articulated are not intended to be exclusive or an exhaustive statement. We similarly acknowledge the need to revise and update this document at regular intervals.

In this article, we review the content of the group therapy guidelines to introduce the content and scope of the document. Utilizing clinical vignettes from our experience as clinicians and educators, we illustrate the application of this CPG in the planning, development, implementation, and evaluation of group therapy.

Creating Successful Psychotherapy Groups

Let's return to Jane's situation and examine how the practice guideline section on creating successful psychotherapy groups offers information useful to Jane as she reflects on her difficulties. The guidelines provide the necessary support, credibility, and guidance she required to begin to modify the clinical situation she confronted. The CPGs underscore that Jane was really dealing with two groups: the group of patients she aimed to treat and the group of colleagues and administrators whose support for her work was essential but which had been previously ignored. For Jane to be successful, it will be necessary for her to understand and engage each group effectively. She recognized that she had been given responsibility for developing the group therapy program without much appreciation for the context in which that group was embedded and that without effectively engaging the larger milieu, the group therapy would fail (Cox, Ilfeld, Ilfeld, & Brennan, 2000). Jane soon recognized the importance of engaging the unit leadership in her plans. In beginning to do so, she recognized that there had been a long history in this environment of the groups being unimportant and viewed as perfunctory. There was accordingly no appreciation for the structural ingredients required for the group program to succeed.

Upon further review, Jane recognized that the larger group—the inpatient setting in which the therapy group resided—suffered from a lack of knowledge and a lack of positive expectations about group therapy. The phrase "your group" underscored for Jane the importance of integrating the group that she led on behalf of the unit into the life of the unit at large. This "other" group that Jane needed to engage was the larger inpatient staff and administration.

In response, Jane organized a series of meetings with the unit's leadership in which she spoke about the clinical importance of running effective group therapy and the need for the unit as a whole to take this on as a responsibility. Jane presented a comprehensive review of the literature on inpatient group therapy with regard to its efficacy. She explained the rationale and goals for group therapy and how she was prepared to modify the group to be consistent with goals that were achievable for a population of acutely ill patients in a short stay unit. She noted the strong evidence that inpatient group therapy needed to be quite structured, encourage mutual support, and mindful not to overstimulate participants. The group therapy sessions should focus on building communication skills and enhancing self care, be briefer, and meet more frequently than outpatient groups, ideally for 60 minutes five days a week (Yalom & Leszcz, 2005).

Jane requested and was given an opportunity to present this material to all team members so that they would have a better understanding of the work that she aimed to do. The ensuing discussion revealed that staff had certain biases and negative

expectations about the value of a talking therapy with their patients. Fortunately, with the support of the unit manager, Jane felt that she finally had an ally who could champion the work that she intended to do. Having engaged the larger group, Jane was guided by the practice guidelines to create the necessary conditions for success. Jane was successful in moving the group therapy time to later in the morning. Rather than the group starting just as patients were slowly waking up, still feeling sedated from their medication, shifting the group time just prior to lunch resulted in higher energy meetings. She also was effective in advocating for no interruptions in the group, requesting that her colleagues respect the time boundary of the group. She argued that it was not a reflection of the group being more important than individual counselling or diagnostic tests, but that if people were coming and going during the meeting it would discourage and demoralize the participants.

In response to this support, Jane committed to entering a brief summary of each group in the electronic medical record used by the unit so that all staff would quickly be able to read about their patient's participation in the psychotherapy group. She would also attempt to participate regularly in team meetings to integrate the information garnered from the group therapy into the team discussion. Jane's efforts proved to be very successful and, in short order, the unit staff took it upon themselves to mobilize patients to participate in the group therapy.

These changes proved effective and inpatient group therapy evolved from being a dispiriting drain of energy to an energized, meaningful, albeit focal therapeutic encounter. By embedding the inpatient group in the life of the unit as a whole, Jane secured the support of the unit as a whole to excellent effect for the therapy group.

Therapeutic Factors and Mechanisms

The following vignette demonstrates how the practice guidelines may be used to evaluate and understand an ongoing therapeutic process.

Joe is a psychologist who offers four therapy groups in his independent practice. He meets with a supervisor once a month to review his groups. Joe has always been energized by the complexity and intensity of the group process and the consultation helps him to keep his footing in doing the work.

Joe has a group which is ongoing and open ended. It is mixed gendered and includes members with heterogeneous problems and interpersonal styles. Joe came to his supervisor to review a dilemma. Joe told his consultant that the group had been stable with regular attendance and each of the individuals reported being more active in addressing conflicts outside group and that each of the sessions was emotionally interactive.

Joe thought the group would be a good fit for two new members; the group had room and he decided to bring them in. He mentioned to the group that he was inviting the new people and that he planned to have them join in the coming week. There were the usual questions about gender of the new people, but Joe said that he sensed some unease when he made the announcement. Some anxious anticipation about change was expressed and seemingly addressed. Joe proceeded to bring in the new members.

A month later, Joe came to his consultant perplexed. The two new people had joined his group. In the first session, both were greeted with polite and superficial hellos. Some brief interaction took place as the new members talked personally, telling how they became involved in the group and some of the issues in their life. Then the group members returned to an issue that had been ongoing in the group

over the past weeks. Joe sensed that the older members were uncomfortable with the new people, but there were no overt expressions of tension or rejection of the newcomers. In fact, the newcomers said that they enjoyed hearing the others talk but they felt lost in some of the story. A veteran member quickly reassured the new members and urged quiet patience—in time they would know what was happening. And others quickly came in to agree.

Joe shared with his consultant that he felt like he was in the middle. On the one hand, he felt involved with his old group members and the material that they were addressing was important. It was presented in a group short-hand that made it even more difficult for the new members to engage. On the other hand, he felt that the new people needed attention. Joe had worked with each individually for several months and he had told them how useful and rewarding participating in the group would be. Now, he felt worried that they would have a negative reaction to the group and question or withdraw their commitment to participate. Joe also said that in the following group session, the new members asked about what members did at the end of each group. A new member said that he saw several members start to talk in an animated fashion outside the building in a member's car after the last meeting, and he said he felt vaguely uncomfortable. He said that although he expected to be anxious during his first sessions, that had passed over time when he saw that the group members were similar to him; however, seeing the animated talk after the group ended made him uncomfortable again. He was puzzled and concerned about his experience in the group.

Joe wanted to talk in consultation about what could account for the group's behavior and to develop a plan to approach the work of the group in the next session.

The AGPA practice guidelines provide direction for Joe. For a therapy group to be effective, certain therapeutic mechanisms will typically operate, as noted in Table 1. While all mechanisms will not be present at all times, the factor described as cohesion has been shown to be the foundation for the other therapeutic factors. Cohesion is to group therapy as the relationship is to individual psychotherapy and in its absence the prospects for meaningful work are diminished. Cohesion is also a force prone to regression and can never be assumed—it must be actively maintained and nurtured. In its absence, there is little likelihood for activation of other therapeutic factors such as meaningful self-disclosure, interpersonal learning, or self-understanding.

Cohesion in a group can be understood from three structural perspectives: intrapersonal, intragroup, and interpersonal (Burlingame, Fuhriman, & Johnson, 2002). All three domains suffered in the changed composition and size of the group. In examining Joe's group, we see that the old-timers have a sense of belonging and allegiance to the group, but these do not yet encompass the new members to whom little attention is directed. We can also see that each member has a bond with the therapist and each other which permits the veteran group members to safely interact with one another. This, too, however appears diminished with some subtle and uncharacteristic expressions of criticism directed toward Joe. We also see that a phenomenon described as subgrouping has occurred along with negative feelings associated with perceived conflict. This is highlighted by the observation that the new member felt better sitting in the group hearing and seeing the others interact but reported that when he saw people outside the group talking, he felt vaguely ill at ease. To the psychotherapist, this unease communicates mistrust and alienation, which could lead to defensiveness and possible withdrawal.

Based on this analysis, Joe would be well advised to address the deteriorating cohesion in the group. He also was informed by the AGPA guidelines to think about adding empirical measures to track the group's cohesion, engagement, and overall climate. No meaningful group work could occur until the cohesion problem was remedied, and it would not self-repair without active intervention on his part. The guidelines suggested that his intervention attend to the intrapersonal, intragroup, and interpersonal aspects of cohesion and should include both a cognitive and affective component. The therapist could also consider communicating this in a manner that includes his own role in the development of the issue the group is facing.

How might Joe respond? It might unfold in the following fashion: "Our group has faced a challenge in the past few weeks. Although we are aware that meeting and working with new people is challenging, we seem to be doing things in the group that may be harmful, rather than helpful, to our newcomers trying to settle in and commit to the group. When I reflected on myself, I noted that I felt very good about our group and trusted that this would be a good place for the new individuals. But then I became aware, when we first came together, that the old group members felt close to one another and perhaps unconsciously emphasized their own closeness. For example, I remember Larry suggesting that our new members should be patient and watch, as if to say they should sit on the sidelines before joining. I would like to suggest that we recollect how we felt when I announced that I was inviting new members to join, and we might also recollect how each of us has felt in the past when we were expected to greet a newcomer that was not completely our idea. There may be some annoyance with me for making that decision and not giving the group time to digest this change. And I would also invite our newcomers to offer their thoughts and feelings about their experience in the group since they have joined. We all need to reflect upon the perspectives of both the new and the old and see how we can learn from what has occurred."

Another element can be understood from the point of view of group development (Wheelan, Davidson, & Tilin, 2003), as we discuss later in this article. When new members or change comes into an ongoing group, even the most mature group will revert to earlier developmental stages. This ongoing and trusting group has to return to dealing with trust and its relationship to the leader. The ongoing group trusted its leader, but bringing in two new people stimulated the individuals and the group to rework their relationships with one another, setting the stage for deeper self-disclosure, feedback, and interpersonal learning.

Selection of Patients

Paul was eager for group therapy because he attributed his chronic depression to interpersonal isolation and general loneliness. Paul's consultation for group psychotherapy, however, did not have the most auspicious beginning. Arriving for the session 30 minutes ahead of the scheduled time, Paul waited with great and mounting irritation. When the group therapist arrived at the time that had been arranged, Paul began by saying angrily that he was waiting and asked if the therapist realized that he had been waiting.

The group therapist felt irritated and defensive within literally a minute of meeting and experienced added frustration when Paul's response to the recommendation that they continue this discussion in the office rather than in the waiting room was resisted. Paul balked and saw no reason that they could not speak about this in the public waiting area before the consultation actually began.

The therapist quietly insisted, and they moved into the more private office. The therapist apologized for any role he had in the confusion about the starting time in the hope that it would lower Paul's hostility, even though the group therapist was certain of the correct starting time. Suggesting that they set the matter aside for the moment, the group therapist asked Paul what led him to seek group therapy.

Paul responded that he hoped group therapy could help. He has been depressed on and off for as long as he could recall, always longing for more social engagement and connection. He was productive at his job as an actuary but was "tired of eating lunch alone every day." He spoke with some self-awareness, noting that he can appear patronizing, loud in a way that makes him sound angry, and critical even when he is not. He complained, though, that others get away with way more than he does and it doesn't seem to damage their relationships. The most recent episode of depression followed the break-up with a girlfriend and his disappointment that there was no support forthcoming to him from family, colleagues, or friends.

A review of past treatment experiences showed that there were frequent starts and failures in therapy, usually as a result of some misunderstanding. He had a successful group experience recently in a structured stress reduction group. However, there was little interpersonal interaction. Paul added that in a less structured group in which he participated two years before, he quit after the first meeting because of critical feedback that was directed toward him.

Paul's parents divorced when he was 13 years old. He had one sibling, a much older sister who left home at the time of the divorce, leaving him alone with a great responsibility to care for his mother whom he found to be dependent, clingy, and incompetent in her caregiving toward him. He experienced his father as intensely critical and emotionally brutal in response to any failings that Paul demonstrated. Precision was highly valued by the father and was the only sure approach Paul could take to avoid rejection, criticism, and corporal punishment. He recognized that his father was quite a bully and that it had a negative impact on his own self-esteem growing up.

By this time in the consultation, the therapist had digested his initial feelings of antipathy and annoyance and saw that what happened in the waiting room was emblematic of the difficulties Paul generates. In fact, what occurred was a potential opportunity if it could be harnessed. With some caution, the therapist made that comment, questioning whether the tension they felt at the start of the meeting might reflect the kinds of difficulties Paul has, including anger, criticalness, and a lack of appreciation for his impact on people. Paul's response was not completely closed and, although not willing to embrace much personal responsibility, the therapist suggested that Paul seemed to engage negative interpersonal cycles around criticalness and blame and that group therapy might offer a way to break that cycle.

The group therapist suggested that they meet one more time before making a decision about coming into group therapy. Although a thorough history had already been obtained, the group therapist wanted to synthesize the information and try to determine whether Paul's entry into a group could be successful. Could he use an evidence-based approach to help make that determination?

In reviewing the group therapy guidelines, a number of significant concerns noted in the CPGs suggested that Paul was poorly suited for a dynamic, interpersonal group therapy. Paul presented a hostile, domineering style and demonstrated compromised interpersonal capacities (Joyce, McCallum, Piper, & Ogrodniczuk, 2000). He quickly became guarded, defensive, and blaming. There was also a history

of therapy failures including the abrupt termination from a prior group therapy. Although he had tolerated the structured, 12-session group, beyond learning some techniques to reduce stress, Paul had gained little with regard to interpersonal capacity. The therapist was also acutely aware of his own strong countertransference reaction to Paul, which is another cause for caution; on the positive side, he noted that over the course of the initial interview when more of Paul's story came to life, he was more settled with his negative reaction and could more readily understand Paul's struggles.

Favoring the decision of entry into group therapy were the clear elements related to Paul's need for treatment and that prominent interpersonal blind spots could be accessed effectively in group psychotherapy. There was no question that an interpersonal focus would be useful, and it would not be hard to collaboratively articulate clear goals for therapy. There might, however, be some disagreement around the tasks of therapy, which needed to be ascertained to determine how well Paul could engage the primary activities of group therapy. Additionally, Paul was conscientious and successful at work and this work ethic could be directed to the therapy.. The logistics for this group also worked very well for Paul. The clinic was near Paul's office, and he had flexibility with regard to his schedule.

Another consideration was that the group that Paul would be coming into was a mature group that had met for some time. It was cohesive and could both tolerate and benefit from someone with a more aggressive style. Through graduations of senior members, the group composition was unduly homogeneous for socially anxious and avoidant individuals. Although Paul would challenge the therapist and the group, there was a good chance that it would be worthwhile. Paul might overwhelm a newly formed group, but the therapist hoped that in this more stable and mature group Paul's difficulties could be encompassed (Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007). The group therapist also noted that Paul was quite motivated, so much so that he sought group therapy again after his prior failure. That motivation could be harnessed into a strong therapeutic alliance. Although Paul manifested several characteristics that predict premature termination, two axioms kept resonating in the group therapist's mind. He recalled, *the person who fails in one group therapy setting may be successful in another*, and *no failure means that one has avoided treating some higher risk people who might have benefited if they had been brought into the group*.

At the second pre-group meeting, the group therapist engaged Paul in a discussion about how group therapy could be useful and the requirements to make it as workable as possible. He predicted that Paul would find the group challenging and that his interpersonal style might evoke some critical feedback. He encouraged Paul to try to keep that feedback in context and look at it as an opportunity for growth rather than "here I go again." It would be important for the group members to understand from Paul why precision and being right was so significant to him that it clouded all other concerns about his relationships. The group therapist also encouraged Paul to make use of the techniques he learned in the stress reduction group to create more reflective space and reduce his tendency to react quickly and negatively. The group therapist was transparent in noting that any decision for treatment involves an evaluation of cost and benefit. On balance, he felt that the benefits would outweigh the cost in this instance, and it was for that reason that he recommended group therapy. He expressed hopefulness that this would occur in the group. Paul's reaction was constructive and positive. He was

convinced after leaving the first session that he would be turned down for group therapy, and he felt heartened by the group therapist's willingness to engage him in group therapy.

Preparation and Pre-group Training

The staff leading the therapy groups at a VA Hospital met to review the activities and effectiveness of their program. On the one hand, it was clear the program was effective and used empirically supported group methods to address the psychological trauma of returning war veterans. On the other hand, there was a very high attrition rate through the process of referral and entry into the program. Compounding this difficulty was a long waiting list of referrals. The size of the wait list often resulted in individuals being evaluated over the phone by an intake worker; they were asked a series of questions and then assigned to group therapy. Many patients did not follow through and a high percentage of those who did, dropped out after only a couple of meetings. Those who stuck with the treatment clearly benefited. The group leaders believed they were providing an effective treatment but they had to overcome the hurdle of engaging the patients more effectively and quickly. More intensive preparation for group therapy had been discussed from time to time within the program but had always been put off because of the cost of face-to-face preparation sessions done on an individual basis.

At the same time, it was evident that if there was a population that needed preparation, it was this population. Patients were variable in terms of their motivation: they were often in treatment with great ambivalence, or even active resistance, and mistrustful of authority.

The staff revisited preparation for group therapy through the lens of the AGPA practice guidelines. They underscored the need to approach preparation through the therapeutic alliance and to clarify the goals and tasks of therapy (Martin, Garske, & Davis, 2000). The CPGs underscored the need for pre-group preparation to be relevant, clear, articulate, and effective in communicating the ways in which this group program would work. Articulating the noted effectiveness of the group program would also bolster and synchronize positive expectations.

The staff's solution was to offer a brief series of pre-group therapy preparation groups. Where possible, these groups would be led by the group leaders that were conducting the more intensive groups so as to familiarize participants with the group leaders. It was hoped that this would increase the sense of personal connection and bond necessary to withstand the challenges that would emerge later in therapy. Using preparation groups, larger numbers of patients who were on the wait list could be seen more quickly and all would receive information and orientation with regard to how group therapy actually works. It also provided a supportive and containing environment while members were waiting for the next phase of treatment. The experiential component of the preparation group was coupled with verbal and written information regarding group therapy, with particular emphasis on the resistances and misgivings participants had historically shown toward group therapy. At the suggestion of one of the group leaders, they included in the written handouts a series of anonymous quotes from veterans who had participated in the active treatment. These comments served as a testimonial to the group that hopefully would encourage participation.

The written preparation also contained elements particularly relevant to those from ethnic and cultural minorities, particularly with regard to cultural prohibitions

against self-disclosure and emotional expression (Laroche & Maxie, 2003). In both the preparation groups and the handouts, group norms were articulated and reinforced, with particular attention paid toward confidentiality, reassuring participants that what they talked about in the group would be treated as confidential by the group leaders. It was expected that group participants would do the same.

The group therapists felt heartened in their plan, recognizing that the research on preparation concludes that individuals who are better prepared before entering into group therapy were more likely to attend and less likely to drop out prematurely, and the groups in which they participated were more likely to be marked by higher levels of cohesion, self-disclosure, and hopefulness about therapy (Piper & Ogrodniczuk, 2004). Keeping people in active treatment for a longer period of treatment could only be positive; certainly, early dropouts do not improve.

Group Development

Therapy groups develop in predictable stages. As we read in an earlier vignette describing Joe's struggle to maximize the group's use of therapeutic mechanisms, group development can progress or regress. It is a dynamic process influenced by many factors including the group's size and composition. Other group variables, such as the structure of the group (open or closed), time limited or open ended, as well as session frequency or duration may also come in to play.

Recognition of these developmental processes is essential in effective group leadership. They are important considerations even in structured, psychoeducational groups. The AGPA's CPGs note that abundant research documents a strong consensus for a multistage model of group development (Tuckman, 1965; Agazarian, 1999; Wheelan et al., 2003). The initial stage of forming the group addresses dependency and inclusion. Joe assumed that this stage had been worked through effectively in the past when he provided the initial norms and goals for the group. He underestimated how important it was for the group to work through this stage again with the addition of two new members.

The second or storming stage of group development is concerned with power/status and the resolution of these conflicts. It is helpful to the leader to be aware that the group members will probably argue or behave contentiously after an initial period of good will. When conflict emerges, the leader and group members frequently feel that they would like to flee from the situation or fight among one another. It can be helpful to anticipate differences and power conflict. In this scenario, two subgroups of people with different experiences with the leader might lead to conflicts with the leader.

Resolution of group conflicts will lead to the third stage of group development: the norming stage. A new level of trust is established based on conflict resolution rather than polite and superficial cooperation. The norming process begins as members develop a sense of the workability of the group.

In the fourth or performing stage, a mature and productive group process dominates. The group works together yet also highlights the individuality of its members.

The final stage of termination will involve a focus on separation along with preparation for the ending. This complex process will be reviewed in further detail in a section of its own.

In this vignette, Joe demonstrates how a therapist's understanding of group development may set the stage for continued therapeutic learning. The group is not failing; it is engaged in a predictable developmental process. Joe makes several helpful interventions. One, he acknowledges that the member's expression of concern is helpful in stimulating the members' reflection. This can be the first step in helping in each of the members see that they have their own responsibility to see and make sense of the process. Two, he uses the observation to describe the entire group's dilemma: this newly reforming group is composed of two subgroups with different histories and relationships to the leader that he has put together. Finally, the leader makes a transparent summary statement that includes both affective and cognitive components. The leader invites people to talk about the situation, which he will also do (role modeling), and he also lets people know that he is willing to examine his own behavior and responsibility.

Group Process

The psychotherapy group had been running continuously for many months. Many group therapist trainees would observe the group behind a one-way mirror—it was an important part of training. Patients in the group knew about the observation, and it was part of their preparation and consent to treatment. Observers knew to be discrete and were committed to maintaining the confidentiality of the participants in the group.

The group was in the midst of dealing with the departure of two senior and well-liked members of the group. There was a clear sense that the two group members who left had done meaningful work in the group and they had been leaders by virtue of their openness, authenticity, self-disclosure, and willingness to give feedback. A plan had been established to introduce two new members to the group in the imminent future.

Despite what appeared to be adequate time and attention paid toward working through the feelings of loss, ambivalence, and admiration of the departing members, the group therapist was taken aback by events in the next meeting. One member of the group began the session with a fair degree of upset. He stated that he saw some people entering the observation room. He was struck by how young they looked and described them as "children being let off the school bus." It made him feel quite uneasy. He noted that "these people see me and know me and I don't know them at all." He feared that he could encounter them socially and that he would feel vulnerable and exposed. Another member of the group picked up this line and added that she never liked the observers and resented the fact that the group was observed each week. She added that she felt exploited: "The students get a lot through observing the group and the members of the group received nothing in return." She mentioned that a couple of weeks ago she recalled seeing another woman in the washroom just prior to the beginning of the session and sensed that the woman was smirking at her in a dismissive fashion. A third member of the group picked up the theme and commented that he was also unhappy with the observers and shared the feelings of being mocked and exploited. He demanded that the process of observation stop immediately or, at the very least, the group members should close the drapes on the one-way mirror so that the observers would not be able to see them. Another member suggested that as an alternative, the observers should come into the group room, introduce themselves to the group, and sit quietly at the perimeter of the meeting.

The therapist, an experienced group leader who had felt pleased about this group's work, felt stunned by this powerful and negative cascade. He began to ask himself questions about why the group was feeling this intensity and why this felt like such a powerful issue now. There had been no change in the relationship with observers over time for many, many months. He found himself imagining closing the drapes and thinking for a moment that the group members had a legitimate point. He wondered whether there had been some breach of the group's sense of safety or integrity. Another jarring thought that passed through the group therapist's mind was a recollection of the way in which observers participated prior to audiovisual equipment. He recalled the era of silent recorders who would sit quietly around the margin of the group and take notes, and he wondered if perhaps that would be a good thing to do now.

Turning to the CPGs as a resource, the group therapist is reminded of the need to understand the multiple forces at play, in particular, that they had begun to mobilize him into thinking about action that he knew was not appropriate. The actions proposed would have been a poor *content* solution to a *process* problem. The risk of submitting to group pressure further alerted him to the regression at work. He began to speak to the group about his questions and about their strong reaction, offering that there was more here than met the eye, and that their strong reactions may be determined by multiple factors (Brown, 2003). He added with some transparency that he found himself feeling the concerns that they had generated in a profound way. He added that the group was dealing with things at two levels: the level of content and the level of the process. At one level, he added that he did not believe there had been any breach of integrity or confidentiality. He added that not only was observing the group highly valued by the trainees but also by him because of their feedback. The discussion after the group always deepened his understanding of the group and, in so doing, provided a return to the members of the group for the exposure they experienced.

The therapist then added that the group is expressing feelings of mistrust and suspicion and is wanting to change the ground rules in the group. It was as though they had shifted from working with trust to working against the group (Nitsun, 1996). He then went on to offer that he believed that an important factor in this process was the group's reaction to the graduation and loss of two important members. The departures shook them and led them to feel apprehensive about the future. He added that their concern about what was happening on the other side of the mirror may well have been overshadowed by their apprehension about what would happen on this side of the mirror going forward into the future.

He noted that the group members had, in fact, more influence on how the future of the group would take shape than they were assuming, even in the ways in which they oriented new members and brought them up to speed with regard to the ideal working of the group. The therapist added that he felt optimistic about achieving a good and productive fit with new members, but the group members would need to take responsibility to create and maintain the environment that they had found so helpful in the past.

Sharing his reactions and understanding seemed to lessen the group's distress almost immediately (Counselman, 2005). It was also important for the group to hear from the therapist that he too missed the members who had graduated. He added that over the course of the last few weeks and, in particular, over the course of today's meeting, he had a great number of reactions that he felt reflected on what the group experienced. He was pleased that he recognized the intensity of what he was feeling as information that he could use constructively.

Therapist Interventions

The following vignette is drawn from a novice therapist's initial efforts leading group therapy and demonstrates the complexity of group methods.

Julie came to her recently formed supervision group. The group includes five other trainees, and all are leading their first psychotherapy group. Some have already had several sessions with their treatment groups and supervision. Julie just led her first session and can barely wait to talk as she enters the room. She is bubbling with excitement as she describes the first two sessions she led. She reports that the first session was a breeze. Although she felt apprehensive about the members not talking, her initial fear was immediately put aside as the members all started to describe what led them to join the group. Julie told her supervision colleagues that everything was going so smoothly that she felt that she was working on auto pilot. The members were doing everything and about 40 minutes into the 90 minute session, one member, Sally, started to talk about what she described as a "family secret.' Julie encouraged this disclosure, thinking it would really get the group going.

After telling a long and complex tale of family intrigue and looking emotionally drained, the member looked up at the group as if asking for feedback. Julie said she felt caught up in the pathos of the story and was wondering how she could respond. But before she could speak, several in the group started to give opinions, some about the scariness of what they had heard and others offering critiques of the member who was telling the story. And then Julie reported a pall came over the group. The group became eerily quiet, and all of the energy that had been present at the start of the session seemed to leave the room. Julie said that she felt like all eyes were on her. She was preparing to give Sally feedback and acknowledge that it took courage for her to tell this part of her history when the Sally began to cry. She slowly said that she was having doubts about being in the group and that she did not feel that the other members knew how to respond to her. Julie noted that time was moving on and that there was little time left to review and discuss what had occurred. Julie then said that starting in a therapy group was a challenging experience for all in the group and that each person had their own fears and expectations. Julie acknowledged Sally's anger and frustration and that she might feel misunderstood. Julie then invited each person in the group to express their own feelings regarding the impact of the experience she disclosed. When each person said something, Julie said that she invited all to return the following week and that the group would continue to address what had happened.

Julie then said that she was shocked when two people did not return the following week: Sally, the woman who made the big disclosure and the woman who was critical of her behavior. Julie said that the group members spoke cautiously and politely to one another but she quietly feared that her group could fall apart. Julie then said that she wanted to hear what others in the supervision group thought about what she did. Before others could say anything, the supervisor intervened and offered the following statement: "Prior to anyone offering any critique of the material or transactions, it might be best for supervision group members to reflect on how they felt when they led their initial group therapy session." After each of the other trainees expressed how they felt in hearing what Julie had brought to the supervision, the supervisor asked Julie to talk about how she felt bringing this to the group and what her expectations were.

This vignette, both in the therapist's dilemma and in the supervisor's conduct of the supervision group, portrays many of the challenges that confront the new leader

of a therapy group. Every new group leader wonders what to do in the group and has a fear that he/she might do too much or too little. In this vignette, we see that the new therapist describes herself as being on auto pilot in the group and seems to assume that the talk and interaction of the group is helping the group to form and get started. Julie probably missed a series of opportunities to intervene and guide the group: the early social chit chat in the group, revealing a family secret, a barrage of reactions from group members, an emotional pall befalling the group, Sally stating that she did not feel safe, and then the efforts to finish the session. How can Julie be guided as a therapist to maximize her therapeutic effectiveness?

When leading a group, leaders must become aware of their unique role and become familiar with strategies and techniques which help them to discharge their professional responsibilities. AGPA's CPGs highlight several functions of the leader: Executive functioning, caring, emotional stimulation, meaning attribution, fostering client self awareness, establishing group norms, and therapist self disclosure/use of self (Lieberman, Miles, & Yalom, 1973; Yalom & Leszcz, 2005).

In reviewing Julie's work in the group, one can see inadequate therapist response in a number of ways. She failed to exercise executive functions typically related to establishing boundaries and ensuring that the group is a safe container. The most noteworthy situation arose in permitting Sally to tell the family secret without helping everyone to establish context and group rules. It was similarly important to help pace the disclosure of the "secret" to ensure that it would not be overwhelming. The third instance of inaction was not offering input when group members tendered spontaneous and critical reactions to the story. Because the group members have not formed a relationship with one another and have not developed a sense of how to offer feedback, this leads to development of mistrust and hurt.

It is also likely that in going into autopilot, Julie did not communicate or convey positive caring for the group or individual members. Being on autopilot could convey disengagement and foster distance between members, which permits people to offer critical opinions or express unmodulated affect. In providing care to the group, the leader serves as a role model to all.

The leader has responsibility for developing a climate of constructive emotional dialogue. Sometimes this means helping to move the interactions from the intellectual or cognitive to the emotional. But the converse is just as important as seen in this vignette in which emotional material appears to be produced prematurely with no structure and inadequate group containment. And when structure is offered by the therapist in the closing statement, it appears to be too little and too late.

Parallel to the emotional expression, the therapist attributed little or no meaning to the interactions of the members. The failure to attribute meaning to experience begins at the start of the session when the members begin to introduce themselves. While these interchanges can be useful in developing commonalities and shared concerns, the leader does nothing to acknowledge the need for the members to get to know one another and develop trust. There appears to be no orienting statement about ground rules or expectations.

And finally, the therapist was largely unaware that in the group setting, her passivity would be experienced and interpreted uniquely by each individual. The therapist missed an opportunity to be open, direct, and clear in how she is committed to help the group find meaning in each of their transactions. An early disclosure by the therapist about sensing the tension and excitement in the group, and that she

came with her own enthusiasm, could have set a different tone and helped people to move in different directions.

The conclusion of the vignette in which the supervisor asks the supervision group members to reflect on their own experience prior to offering a cognitive critique models in parallel a leader working to establish commonality, trust, and cohesion in the group. Rather than put Julie in a position of being criticized and perhaps shamed, all were first asked to identify with her setting the stage for thinking about what kind of feedback is most useful. The supervisor is thoughtful and judicious in quickly asking people to consider the feedback provided.

Reducing Adverse Outcomes and Promoting Ethical Practice

Do no harm is the universal precept that guides the provision of any psychotherapy. Group therapy, rooted in open expression of feelings and interaction between members, may stimulate an atmosphere in which members feel unsafe. In the following vignette, a co-therapy pair address in supervision their concerns and fears associated with working with potentially volatile emotions.

Two trainees, Larry and Linda, were starting their first psychotherapy group in a training clinic. They were accepting referrals from the training clinic and both were considering bringing some of their individual patients into the group. Both neophyte therapists, they were thoughtful people who took their work seriously and were sensitive to the needs of their individual patients. When they came to their first supervision session, they were filled with questions that barely masked their worries about working together and what could happen when they started their own treatment group.

The supervisor, sensing their concerns, decided to address directly their worries. First, the supervisor indicated that doing group work was challenging and the prospect of joining a group was scary for both the leaders and the members. The trainees expressed relief when the supervisor spoke, and they were engaged when the supervisor asked them to enumerate individually what was worrying them. Larry spoke first. He said that he was comfortable doing individual therapy and that he liked being in charge. He wondered how he could share responsibility with someone. While he knew Linda, they had never done any clinical work together and he did not know how he would respond to her therapeutic work. He wondered what he would do if he disagreed with her. When the supervisor asked him to elaborate, Larry said that expressing differences made him uncomfortable and that he might withdraw; he did not think that this would be helpful for him, Linda, or the group. The supervisor thanked Larry for his candor and then invited Linda to address her worries.

Linda began by saying that she was looking forward to working with Larry and, though she did not know him well, she respected his work. Her fear was different. She said that she had grown protective of her patients. Linda said that there was one fellow, in particular, about whom she was concerned. She and a former supervisor had discussed how group could be helpful to him. But he could be boisterous and loud. In individual therapy, he had talked about becoming involved in angry shouting matches, and she feared that he would offend or verbally attack group members. She also wondered how she could keep separate her knowledge of this fellow's behavior from the individual setting and react in a spontaneous though measured fashion and be helpful to both him and the others in the group.

To Linda's surprise, Larry quickly stated that he knew he could bring a different perspective to the situation, and she did not have to feel like she was totally alone in

modulating the patient's behavior or offering feedback to him or the group members.

The supervisor commented that it was good to see them both taking a stance of trying to be helpful to one another. The supervisor suggested that they were starting to work as a team and that it is helpful to establish a framework they both share. Together, co-therapists need to establish a structure to help both them and the members know the boundaries of the group. The supervisor also suggested that it would be helpful for the new co-therapists to meet alone to develop a plan to share the workload of leading the group, including record keeping, preparing prospective group members, and the like. The supervisor suggested that it would be helpful for them to begin learning each other's style to enhance their continued collaboration.

The vignette clearly portrays that implementing group psychotherapy is a complex endeavor with ethical challenges similar to but different than individual work (Brabender, 2006). Although all therapeutic work is rooted in maintaining privacy and building trust, the group format with increased numbers and a heterogeneous mix of clients require more planning and deliberation. In the vignette, the two leaders are confronted with these issues from the start.

The AGPA guidelines offer guidance and a format for dealing with these. The first principle is that therapists leading groups should be familiar with guidelines, federal and state statues, and case law related to practice (AGPA, 2002). The most salient are regulations related to privacy and confidentiality. Health professionals work within privileged communication laws and are required to maintain privacy. In all jurisdictions, except Illinois, this privilege is not accorded to group members. In starting the group, it is incumbent upon the leaders to help the members develop therapeutic trust and know the legal context in which the group functions. Informed consent documents may be useful to help understand group confidentiality and its limits (Beahrs & Gutheil, 2001). Also, it is useful to describe ways that members may discuss their experience in group with others and not identify members of the group.

A second principle of boundary maintenance in group therapy involves providing clear direction about extra group interaction. The group is not established to form a friendship network despite members' desires. All in the group are urged to bring chance extra group meetings to the group for discussion to ensure that the central relationships remain within the group. Co-therapists should explain to group members the nature of their professional relationship. They need to be aware that group members will have normal curiosity about the relationship and later in the group will have their own perceptions of how the two people work together, all of which can provide therapeutic grist for the mill.

Our new leaders are also concerned about working with potentially high-risk clients. Although the research is clear that group therapy is helpful for most, it is incumbent on the leader(s) to have a clear sense of the individual with whom they work. Developing a diagnosis and a treatment plan will be useful in tracking the individual's and group's therapeutic work. For example, a treatment plan will sensitize the leader to a client's acting out and also help the leader to consider how the process of the group can be helpful to the patient and to anticipate possible interventions.

In our vignette, Linda is concerned about the separation of individual and group therapy. Larry helpfully offers one solution in reminding his partner that his presence will help to provide a separation between her individual work and the work of the group. Leaders should also be aware of the importance of record keeping in tracking individual progress in the group. First, the professional note for group

therapy should not include any identifying material about other individuals. Two, the note should track the individual's response to the treatment format. Leadership includes power, status, and control functions (Leszcz, 2004). Leaders should be aware of their potential misuse; moreover, they should have tools to increase their awareness of these functions, such as personal reflection, co-leadership, supervision, consultation, and personal therapy. Potentially risky therapy behavior includes pressuring individuals to disclose prematurely or excessively or not intervening when a potentially damaging experience occurs between members. A common distortion in group therapy is for members to interpret the expectation to offer free communication and express all thoughts and feelings as license to say hurtful things; the leader(s) has a responsibility to intervene and help the group process such events. Ensuring that group pressure does not lead to scapegoating or member alienation is a key responsibility as well.

Concurrent Therapies

Phil, a man in his mid 50s, was referred for an assessment for group therapy. The patient was a university professor who sought treatment with a psychiatrist in response to the development of a depression after the death of his wife. The experience of grief led to significant depression exacerbated by social and interpersonal isolation. His wife had been the social connector in his life and, in her death, even his relationships with his children became perfunctory. In his individual therapy, he became deeply connected to a senior clinician, and it became clear in the consultation for group therapy that this treatment had been helpful. A certain degree of idealization of the therapist also played an important role in this. In addition to the psychodynamic-supportive individual therapy, Phil also began a course of antidepressants. Within a couple of months his mood was significantly better but the social isolation persisted. For this reason, he was referred for group therapy.

A group was forming and Phil was referred to it. The group was led by two senior residents who eagerly met with Phil for an assessment. Phil's story was sad and compelling and there was a clear reason for referral and participation in a group. The residents were apprehensive about working conjointly with a senior clinician who was to continue the individual treatment, but they were encouraged to do so by their supervisor, who had provided the original consultation regarding group therapy. They had obtained permission from Phil for communication with the individual therapist, recognizing that this would be essential for therapy to proceed meaningfully.

However, problems quickly arose in the group therapy. It soon became clear that Phil's interpersonal isolation was a result of a narcissistic and dismissive interpersonal style. Despite initial compassion, Phil quickly became a focus of critical feedback within the group. His response to the feedback was to complain about how well he felt in his individual treatment and how group therapy clearly was useless and ineffective. He added that this was no doubt a reflection of the inadequacy of the inexperienced leaders, an observation he assured them he would share with his esteemed individual therapist.

The residents were worried about the impact of Phil's criticalness on them and on the group. Although Phil continued to come to the group reliably, they began to dread the sessions. The supervisor encouraged them to communicate openly with Phil's individual therapist. The residents knew of this therapist's reputation and felt

insecure, doubting that they could have a substantive and open dialogue with him. They feared that they would have no credibility and that the individual therapist would take Phil's perspective to be accurate.

In supervision, the principles of conjoint treatment were discussed and reviewed as detailed in the AGPA guidelines. In many ways, this was an ideal treatment situation in that the group therapy would serve as a complement to the individual treatment (Kivlighan & Kivlighan, 2004). Phil's individual therapy had been insufficient in improving his interpersonal situation, and the group was intended to add the benefit of added therapeutic settings: maturational opportunities, transference objects, observers and interpreters, feedback, and communication skills. All of this, in fact, had taken place. The challenge was to encompass this effectively so that each of treatment formats was informing the other. The residents acknowledged that they had felt inhibited and less effective than normal because of the shadow of Phil's individual therapist in the room (Ulman, 2002).

What jumped out was the importance of the collaborative and mutually respectful relationship between group and individual therapists. The absence of that predicted failure. The group co-leaders felt encouraged to dialogue with their senior colleague—Phil's idealized therapist—to deal with their countertransference. They organized a meeting with the senior colleague and found him to be quite supportive of their work. They undertook to encourage Phil to speak in each setting about his experience in the other, entrusting him with the responsibility to bridge between the two and to articulate the differences in each of the formats that contributed to the idealization in one and the devaluation in the other. As the group therapists and individual therapist presented a consistent, mutually supportive, and integrated approach, Phil began to use the group more effectively.

For the first time, with his individual therapist's encouragement, Phil began to explore his idealization of his individual therapist in a way that led to him being more open to feedback from the group, interrupting a sequence that led to him idealizing and devaluing without looking at people in a more three-dimensional fashion. Although the responsibility for bridging between the individual and group therapy directly was ascribed to Phil, he also understood that the therapists were in regular communication and the right hand knew what the left hand was doing. His concerns about confidentiality were allayed with the statement that this communication in concurrent therapy was the practice standard. This framework enabled Phil to work constructively in the group therapy and develop a more realistic perspective on his relationship with his individual therapist. It also became a base for the exploration of other relationships in his life rather than relying only upon the safe haven of individual therapy.

Termination of Group Psychotherapy

The ending phase of group therapy is a unique and complex event due to the fact that multiple people are involved in the ending process and that each individual has a personal response to the departure. In the following vignette, two therapists who have been working with a group for a year address their reactions to ending with a departing member, and also address the fact that one therapist will be leaving while one will stay on with the group and be joined by a new co-leader.

After co-leading an open-ended group with Jennie for over a year, Jack is ending his training in several months. They came to supervision excited. Sam, a group member for almost 13 months, came to the last session and announced that he felt

ready to leave group. In the previous session after a member had finished talking about a recent crisis, Sam cautiously began to say that he had been thinking about leaving the group. The announcement shocked the group. One woman said that she was saddened. A man said that the decision seemed to come up quickly and that although Sam's personal changes were evident, he was stunned and did not know what to say. Over time, each person in the group said something, and the last person to speak, a woman, said that she was jealous of him. She was happy for Sam's progress, but she wondered if she would ever leave group. Although she saw changes in herself and she could point to some recent successes in her life, she did not know if she had the confidence to be on her own without the group support.

The supervisor encouraged Jack and Jennie to express their reactions to Sam and the rest of the group. He also asked how they responded to and intervened with Sam and the group members. Jack said that he was pleased for Sam; he had seen the decision coming and it was exciting to see the effect of the group on Sam. This was the first successful departure that Jack had experienced in the group. Previously, there had been sudden departures that caused havoc in the group. Jennie said that she shared Jack's reaction but found herself surprised at the different reactions of the members.

They both said that it was difficult to take charge of the session after Sam made his announcement. The room was filled with emotion, and each person was quick to jump in. Disappointment and later anger were expressed. Jack said that he finally found the room to offer an observation. He said that Sam had brought one of the most important messages to the group in its history; he said that Sam was taking more responsibility for himself, which was a part of his change in the therapy, and now he and the group had the opportunity to process his change and his departure. Jennie said that she piggybacked on Jack's comments and pointed out that each of the members had their own reaction to Sam and that it was important for the group to pay attention to these reactions. Before the session ended, Jack said that he thought the group needed to respect Sam's decision and that it would be helpful for Sam to set a date for his departure. That would permit Sam and the group to look back on their past together and for all to learn as much as possible from this goodbye.

This vignette highlights two challenging aspects of doing group therapy: the turmoil that may accompany terminations and the pleasure of participating in a successful therapy (Fieldsteel, 1996). The CPGs point out that it is best to view any termination as an essential phase of therapy that has its own unique processes and potential goals. In this light, some terminations—in particular, those that are premature—are disruptive because they have a negative impact on developing group trust and cohesion and also may demoralize the remaining members. When a premature termination occurs, it is the role of the leader(s) to help the group to process the departure as a learning experience and, in doing so, aid in the process of new entries into the group. Common reactions to these departures are as follows: blaming the group for not being welcoming enough, blaming the leader for inviting someone who was unsuitable, overanalyzing the motives of the departing member, questioning the value of group therapy, and apprehension of a contagious reaction that all will leave. The leader can help the group to learn that each member has a unique way of dealing with a perceived failure. And the leader can help the group to restore its own sense of integrity and recognize that is capable of coping with a negative experience.

In this vignette, the co-leaders helpfully set the stage for the departing member and the others to learn from the experience (Joyce, Piper, Ogrodniczuk, & Klein, 2007).

One, they ask Sam to set a date for the ending. This indicates that time should be set aside to focus on the departure. Occasionally, it is helpful for the therapists to offer a suggested set number of sessions for the ending process similar to reminding newcomers in the beginning of the group to take some time with the group to make their decision and commitment to continue with the therapy. Two, the group is reminded to respect the decision and to pay attention to their own reactions, communicating that the group should avoid quickly judging the correctness of the decision. And three, the therapists' comments emphasized that the group members can learn from their own reactions, including their style in leave takings and goodbyes, how they evaluate their own individual progress, or how the sense of support in the group stimulates dependence or independence.

In the remaining time with Sam, the AGPA guidelines suggest there are multiple tasks to consider. For example, Jack and Jennie will focus on reviewing and reinforcing change in Sam's behavior as well as the others. They will continue to establish a climate and encourage processes that help the members resolve conflicted aspects of their relationship with Sam.

As Jennie and Jack approach this ending, they are also are advised that groups frequently develop termination rituals (Shapiro & Ginsberg, 2002). For example, one member may bring refreshments or another member say something positive in the farewell process to the departing member. The leaders are also advised to develop their own format for saying goodbye. Using a ritual or format in the process both helps to manage the anxiety and facilitate continued processing of interpersonal reactions.

Finally, Jack's impending departure as a co-leader deserves comment. Since this is an ongoing group, likely in a training clinic, we assume that upon Jack's departure, Jennie will be receiving a new co-leader with the group continuing and taking in new members. First, we point out that the ground rules for the participation of the therapists should be provided to the group at the beginning of its formation and when new members are taken into the group. Within this context, Sam's departure will be preceding Jack's. While the main focus of the coming sessions will be on Sam, there should also be a reminder that a therapist departure is on the horizon and that the clinic/training program is in the process of determining a new co-leader to work with Jennie. Thoughtful management of Jack's departure include helping the individuals review their relationship, focusing on both positive and negative feelings, which they experienced in working with him. The group would also be directed to offer their reactions to how they saw Jack and Jennie work together. And finally they need to prepare for the new co-leader joining the group.

Clinical Issues and Summary

In this article, we focus on group therapy that uses the group as an agent of change. The work of group therapy is invariably complex. Three related dynamic elements are omnipresent in group therapy: the individual, the interactional/interpersonal, and the group as a whole. It is well recognized that interventions that have the power to be of help also have the power to harm. At any moment in a therapy group, the therapist is presented with multiple choices for focus and action. The contemporary practice of group therapy demands that therapists be guided in these clinical actions by empirical evidence and clinical wisdom. The AGPA's *Practice Guidelines for Group Psychotherapy* have been constructed to be an accessible and relevant resource to practitioners.

In this article, we provided clinical vignettes to illustrate how each of the 10 components of the guidelines may be used by therapists to plan, evaluate, modify, explicate, and monitor the treatment in an evidence-based fashion. Administrators may use these guidelines to support the development of group therapy programs. Patients seeking or participating in group therapy will also have a template to use in understanding the group therapy experience.

It is human nature to resist the external scrutiny or the imposition of restrictions. In that spirit, we note that the AGPA guidelines are aspirational rather than prescriptive. Most important, the guidelines are intended to enhance clinical effectiveness and augment therapist judgment rather than supplant that judgment.

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