A number of approaches to group psychotherapy, such as cognitive, cognitive–behavioral, problem-solving, and postmodern approaches, deviate both theoretically and technically from the long-term unstructured group psychotherapy approach that we have presented thus far in this volume. In this chapter, we first review the evidence for a developmental framework across theoretically diverse groups. We then turn our attention specifically to the structured group approach and describe such groups briefly, focusing on how they differ structurally in terms of content and process from the groups portrayed in chapters 5 and 6 of this volume. Next, we describe the relationship of group structure to stage development and present the research on stage development that is more germane to structured groups. Fourth, we make the argument that structured content does not preclude group development. A structured process may affect development depending on the degree and type of structure in the sessions. We indicate how structured group
therapies, cognitive and cognitive–behavioral groups in particular, can benefit from a developmental approach to group therapy. Fifth, we illustrate how our five-stage approach of group development can be beneficially infused into several different kinds of structured group therapies (e.g., a relaxation or an anger management group) and provide clinical vignettes from such groups to exemplify each stage. We demonstrate how the therapist was able to adhere to a particular model for the group while at the same time engaging in responses appropriate to the tasks required for that stage of development.

EVIDENCE FOR DEVELOPMENTAL POTENTIAL ACROSS TYPES OF GROUPS

Group developmental states have been studied most vigorously within the theoretical perspectives from which they were derived. Whether group developmental stages can be observed in groups beyond the theoretical frameworks in which they have traditionally been considered has been studied minimally. However, the applications of different models each lead to the creation of a particular type of session with certain characteristics. For example, some approaches are associated with highly structured sessions or sessions in which the leader has a very prominent role. Does group development occur in a wide range of groups with highly varying characteristics, or is it observable only under a narrow range of conditions? In other words, to what extent is group development better understood as precious or irrepressible?

Group developmental concepts were originally applied to groups that were unstructured, long-term, and characterized by a fair degree of stability in membership. Can group developmental phenomena be seen in groups that are structured, short-term, and changing in membership? Investigations on the occurrence of developmental phenomena on structured therapy groups are few. However, one relevant study was conducted by Stockton, Rohde, and Haughey (1992), who randomly assigned individuals presenting for treatment in a campus community counseling center to conditions in which they either received practice at the beginning of each session in the processes that would help members achieve their goals or did not receive training at the beginning of the session. The investigators used the short version of MacKenzie's (1983) Group Climate Questionnaire (GCQ–S) discussed in chapter 4 of this volume.

The investigations found that the group receiving the structure showed changes in members' engagement and avoidance scores that much more closely approximated the development trends suggested by most progressive stage models. As developmental theory predicts, conflict increased across initial sessions and then diminished, but this trend was similar for both experimental and control conditions. The investigators explained that the structure
helped the group to be more consistent and to avoid recycling through earlier stages. For this discussion, the important point is that group development can occur in structured sessions.

Some models of group psychotherapy assume a fairly short-term group experience. For example, groups run according to a cognitive–behavioral approach typically take place in 12 to 16 sessions. Can group development occur in this brief a time frame? Although the variable of time frame is examined in depth in chapter 9 in this volume, here it is sufficient to note that a brief group experience does not preclude group development. MacKenzie (1983) obtained patterns consistent with developmental theory on the GCQ–S for groups meeting across 35 sessions. These patterns were replicated by Brabender (1985, 1988) using the GCQ–S on seven groups meeting for 8 sessions each.

Can group development occur in a situation in which membership changes continuously? Although anecdotal evidence exists on the development of a group with a constantly changing membership (e.g., a description of support groups for terminally ill cancer patients by Kosoff, 2003), two formal studies pertinent to this question have been done. Schopler and Galinsky (1990) investigated 116 outpatient and inpatient groups covering a wide range of types, including skills training, psychoeducational, support, treatment, and assessment. The therapists, all highly experienced, rated the extent to which members of groups completed the formative tasks of the earliest development stage related to goals, bonds, roles, and norms. For example, a formative task with respect to goals was “Group purpose and/or goals are clear to most members” (Schopler & Galinsky, 1990, p. 438). They found that half of the groups were seen by the therapists as having completed the tasks of the early stages. Furthermore, the less the membership changed, the greater the number of tasks they completed. Hence, stable membership is the friend but not the sine qua non of group development. In an investigation of community meetings in a hospital in which new members entered and old members exited on an ongoing basis, McLees, Margo, Waterman, and Beeber (1992), using the GCQ–S, detected the presence of developmental patterns over the course of 12 weeks.

Extant evidence, though limited, suggests that group development is robust. Although it can be hindered by a wide variety of factors, group development appears to occur under highly varying conditions. For this reason, the application of any given theoretical model is unlikely to vitiate the possibility that developmental phenomena will be present. The question then arises what effect group development might have on the delivery of a given theoretical approach.

The phenomena of a given stage may interfere with the pursuit of group goals. For example, if the group is addressing authority issues at the same time in which they are asked to generate solutions to a particular member’s problem, members’ rebellious urges toward authority may manifest them-
themselves in their proffering solutions that are few in number or poor in quality. Conversely, the phenomena of a given stage may enhance the pursuit of group goals. For example, a group that has reached maturity and is capable of a deliberative decision-making process will be facilitated in performing the step of the interpersonal problem-solving model (for full description, see Brabender & Fallon, 1993) in which members determine among a range of solutions the preferable one.

To show the breadth of application of group developmental concepts, in this chapter and chapter 8 we present approaches that cover considerable theoretical terrain. In this chapter, theoretical approaches such as cognitive-behavioral therapy that have developed independently of developmentally oriented approaches are to be explored. In chapter 8, we focus on recently emerging theoretical frameworks that have a good deal of common ground with theoretical approaches that historically have been most closely associated with group developmental thinking. These more recent frameworks are labeled postmodern because, as we explain, they followed the abandonment of the epistemological assumption of modernity that human beings can know an objectively verifiable reality. These approaches may not only be enriched by a developmental perspective but also have a great deal to contribute to the understanding of group development and the therapist’s range of interventions for influencing group development. The particular models chosen are intended as illustrations of how group developmental thinking can be integrated beyond its theoretical homes to the benefit of the group members.

STRUCTURED GROUP PSYCHOTHERAPIES


The enormous array of groups can be reduced to five broad categories: (a) cognitive–behavioral groups, which use cognitive and behavioral techniques to change cognition; (b) behavioral groups, which focus primarily on changing particular behaviors that are environmentally maladaptive; (c) interpersonal problem-solving groups, which use a single model rigidly applied
to each individual's problem; (d) social skills groups, which concentrate on one social skill at a time, partitioning the skill into its behavioral components and behavioral role-playing and practicing with feedback; and (e) psychoeducational groups, which most often use the topical lecture format to educate a group.

In essence, these models emphasize examining and changing cognition, behavior, or both. They have clearly defined goals, focus on behavioral change, entail low to moderate levels of inference from behavior, and emphasize empirical outcome. Major efforts are focused either on disturbed or maladaptive behavioral patterns or the "mediational processes [which] give rise to maladaptive emotional states and behavior patterns" (Kendall & Bemis, 1983, p. 52).

In terms of technical interventions, this group of models differs from the unstructured group in the level of activity of the therapist, the amount of structure provided, the articulated use of behavioral techniques and strategies to accomplish individual goals, and thus the amount of interest and energy placed in interchanges between members. Each of these dimensions is discussed subsequently. Within each group, the dimensions can vary depending on problems to be tackled, goals to be accomplished, time allotted, and functional level of the participants. For example, in a group of day hospital patients, a small psychoeducational group may focus on the importance of medication compliance, alternating between leaders presenting and members being called on to share their experiences of noncompliance. In contrast, a psychoeducational group of executives learning stress management may use lecture, demonstration, and individual practice of specific techniques with little emphasis on sharing or social interaction. In both types of groups, active therapists, who limit content domain and use specific behavioral strategies, provide high levels of structure. The groups, however, differ on the amount of interpersonal exchange that is encouraged. Although the amount of structure introduced may vary from model to model, almost all models and their variations use considerably more structure than is present in the model presented in the previous chapters.

THE RELATIONSHIP OF GROUP STRUCTURE TO STAGE DEVELOPMENT

Most groups classified under the rubric of the cognitive and behavioral groups are more structured than the types of groups on which progressive stage models are based. Three features that relate to structure are more prevalent among the cognitive and behavioral groups. The first is that these groups are often homogeneous in psychopathology. For example, groups are formed on the basis of presence of anxiety (A. C. Page & Hooke, 2003), social phobia (Edwards & Kannan, 2006; Heimberg et al., 1990), panic (Lang & Craske,
2000), obsessive–compulsive disorder (Jacqueline & Margo, 2005), depression (Oei, Bullbeck, & Campbell, 2006), trauma (Pifalo, 2006), eating disorders (Radomile, 2000), sexual offenses (Beech & Hamilton-Giachritsis, 2005), schizophrenia (Bechdolf, Köhn, Knost, Pukrop, & Klosterkötter, 2005), bipolar disorder (Bauer & McBride, 2003), and substance abuse (Kaminer, Blitz, Burleson, Kadden, & Rounsaville, 1998). Therefore, the content that unfolds in groups is determined by the presence of a shared set of symptoms.

The second characteristic is that the majority of these groups have a high degree of structure. Often patients complete individualized questionnaires related to their symptoms at the beginning and end of each session. Then each patient is engaged in establishing an agenda for the session (or a stylized go-around) and works specifically on that agenda using identified techniques (e.g., mini-lectures, identifying the distorted cognition, identifying and following through on specific steps of problem solving, role-playing, guided imagery). Homework is assigned, and the group ends with session evaluation.

Last, emphasis is almost always on the individual outcome of a particular symptom, which is either internal (e.g., distorted cognitions) or behavioral (e.g., decreased phobic behavior). Because of this last feature, the many empirical studies examining participants in behavioral and cognitive–behavioral groups almost always have focused on symptom attenuation and rarely have included measures of group process. To date, only three studies using the behavioral or cognitive–behavioral group approach have included efforts to understand or measure group development or stages (Castonguay, Pincus, Agras, & Hines, 1998; Nickerson & Coleman, 2006; Tasca, Balfour, Ritchie, & Bissada, 2006).

Content and Process Structure and Group Development: A Review of the Research

Most research on group development has used models that were low in structure. Stages of development were most clearly established and consistent when these groups were also closed ended and time limited; context, task, time, degree of homogeneity, style of leadership, and theoretical model (MacKenzie, 1994a) also influenced developmental phenomena. Most of these factors involve some aspect of the dimension of structure. The unitary term structure, however, belies its bidimensional character. Groups can vary in structure for both content and process. The range of these two dimensions of structure needs to be delineated when considering its impact on development of group process.

Level of Structure: Content

Groups can range in content from highly structured to having little structure. Groups that convene to complete a task, discuss a certain topic, or
learn how to cope with a specific set of symptoms are likely to be highly structured. Most groups using cognitive, cognitive-behavioral, or behavioral models, being similarly focused on specific goals, are highly structured in terms of content (e.g., for posttraumatic stress disorder [PTSD], see J. G. Beck & Coffey, 2005; for social phobia, see Edwards & Kannan, 2006; for obsessive-compulsive disorder, see Jacqueline & Margo, 2005; for depression, see Oei et al., 2006; for auditory hallucinations, see Pinkham, Gloege, Flanagan, & Penn, 2004). When a group is homogeneous for symptoms, the group is educated in terms of the prevailing and accepted theory, taught methods for symptom reduction, and given specific instructions as to how theory and technique are applied in the group. Task and work groups, often seeking a specific outcome, are usually highly structured in terms of content. Psychotherapy groups with heterogeneous symptomatology have a medium-to-low range of structured content (Gersick, 1988; Yalom, 1995). Sensitivity training, laboratory training groups, and process groups have the lowest designated content structure. Many of these groups do not delimit what can be discussed in the group.

Whether the content of the group is highly structured, the existing empirical evidence suggests that either high or low structure will not necessarily limit developmental phenomena. MacKenzie, Dies, Coché, Rutan, and Stone (1987) studied both process groups (low in structured content) and special interest groups (groups formed around a specific, often academic, topic on group therapy and high in structured content) over the course of 14 hours of working together. They concluded that the two types of groups developed similarly; neither type of group showed a greater propensity for maturity. Wheelan, Murphy, Tsumura, and Kline (1998) have also provided evidence that ongoing groups with specific tasks appear developmentally similar to the MacKenzie et al. groups. In both studies, the more successful groups appear to have traversed the earlier stages of development. In the Wheelan, Murphy, et al. study, higher productivity was associated with reaching more mature phases.

**Level of Structure: Process**

Independent of content is the level of structure occurring in the process. In a group that is low in structure on this dimension, the leader may not have a set agenda for any of the sessions, although he or she may follow guidelines in the earlier sessions (e.g., introduce members to each other, review contract). The most extreme example of this is the training process groups available for group therapists at national group psychotherapy meetings (as was examined by MacKenzie et al., 1987). At the other extreme might be psychoeducational groups (Burlingame et al., 2007; Furr, 2000), Meichenbaum’s (1977) self-instructional training, and social skills training (Mueser et al., 1987). In the psychoeducational groups, lecture is the preferred format, often with some audience participation. In social skills train-
ing, almost every aspect of the group is preplanned; with therapist guidance and direct instruction, group members take turns with practice and role-playing, and specific structured feedback is provided by both therapist and group members. In these groups, agendas are set at each session; often, specific skills are taught, applied to the self, and then practiced in the group setting. Homework is assigned. These groups are highly structured in both content and process.

The central question is whether these latter groups also proceed through stages of development. Although the evidence is limited and we have to draw some inferences, we contend that it is the nature and degree of this structure that is likely to determine whether developmental processes will occur or perhaps even be enhanced.

A study by Sexton (1993) suggested developmental processes are not inhibited in groups designed with some explicit process structure. In this study, Norwegian patients and therapists completed symptom scales before each session. This was followed by verbal therapy, light aerobic exercise, group exercises, and brief discussion. Unfortunately, no information about what took place in the verbal part of the session is available. Although the developmental processes as defined by us and others were not measured as such in this study, therapist–patient processes were examined and were found to have differential effects depending on whether it was an early or later session. Patient outcome appeared related to the nature of the early therapist–patient relationship rather than the nature of that relationship later in the group. From this finding, we can infer that different processes are important depending on when they occur in group life and that the structured nature of this group did not inhibit group process from developing.

Type of Structure and Group Development

Several studies have examined where and what kind of structure might be helpful to the process of development. Lee and Bednar (1977) varied levels of structured exercises for self-disclosure, interpersonal feedback, and group confrontation in groups of university students. Groups participating in the highest level of structured exercises benefited the most in terms of producing behaviors most relevant to change (intensity and depth of communication). This trend was particularly evident for participants who were low in risk taking: With structured exercises, these participants were virtually identical to the high risk takers on relevant group behaviors—self-disclosure, interpersonal feedback, and confrontation. From this study, it appears that structuring the process is particularly helpful to those individuals who may be more reluctant to reveal themselves in group initially. These behaviors are relevant to the forwarding of group progression. However, the one caveat to this study is that increasing group structure decreased cohesion, a necessary component to stage development.
Using a similar methodology, Evensen and Bednar (1978) attempted to differentiate types of structure. Their study began with an initial period of behavioral practice, cognitive instruction, behavioral practice, and cognitive instruction or minimal structure. This was followed by a relatively unstructured period in which interpersonal feedback, self-disclosure, and group cohesion were measured. Contrary to the previous study, risk-averse participants did not benefit differentially from any type of initial structure: They still perceived risk to occur. Those with a high-risk disposition, however, benefited most from the behavioral practice, producing the most intense, appropriate, and in-depth interpersonal communication, and reported the highest level of group cohesion. In general an initial cognitive structure, which emphasizes verbal instructions about feedback, disclosure, the importance of it in group and resistance, has no impact on what occurs subsequently in the less structured sessions, and the combination of cognitive structure and behavioral practice has not added benefit over behavioral practice only in producing subsequent appropriate disclosure and feedback. It appears that at least initially, those with low-risk dispositions need to have continued structure to increase their level of self-disclosure and appropriate interpersonal feedback and perceived cohesion.

The previous studies used measurements that occurred in a single session. Results may differ as the group progresses. With these studies as background, Stockton et al. (1992) attempted to promote group progression by providing a structured exercise at the commencement of each of six weekly 2-hour groups designed to facilitate the occurrence of a particular phase of development (universalism, differentiation, and individuation). When compared with groups not given these low-risk structured exercises, the exercise groups had increased level of cohesion, more engagement, and less overall avoidance. The most significant finding was that conflict increased more and then significantly decreased compared with groups not using these structured exercises. Stockton et al. maintained that group development was enhanced as a result of increased consistency over the weeks and less revisiting of earlier developmental phenomena. Given that most of the group time was unstructured, it was unclear whether the positive findings were due to the content of the exercises, which primed the group and expedited it into a more productive working phase, or the initial structure.

Whether structuring the process aids the developmental progression may be dependent on the stage of the group. Kivlighan (1997) found that in those groups in which group leaders were judged by the group members to be more task oriented during the early sessions (i.e., more structured) and more relationship oriented during the later sessions (i.e., less structured), group members showed a reduction in their target symptoms at the conclusion of the group therapy. Conversely, leader task orientation late in group life and relationship orientation early in group life was unrelated to group member outcome.
Cognitive–Behavioral Therapy and Stage Development Research

Recent studies have focused more specifically on the question of whether group development can occur within particular structured approaches. Two studies have addressed the existence of group development in cognitive–behavioral group therapy—both studies involved the population of individuals with a binge-eating disorder. Castonguay, Pincus, Agras, and Hines (1998) followed 65 women over the course of 12-week manualized group treatment. Using a group version of the Therapy Session Report (Orlinsky & Howard, 1966), the investigators found that the members' progress through stages of development was associated with symptomatic improvement. Specifically, groups that showed high engagement at the beginning of the group and high conflict during the middle showed greater symptomatic change than groups that were lower on engagement at the beginning and lower on conflict during the midsessions. Specific limitations of this study are cited in chapter 4 of the current volume. However, the study does suggest that progressive stages may emerge in structured groups.

In a second and more recent study, Tasca et al. (2006) randomly assigned women meeting the criteria for binge-eating disorder to either cognitive–behavioral or psychodynamic–interpersonal groups with both groups meeting for 16 sessions. Adherence to treatment manuals was successful, and independent observers could distinguish the treatments from each other. Our interests are in the cognitive–behavioral model, and so the structure of those sessions is discussed in some detail. Goals of treatment included the diminution of dietary restrictions, exposure to a wider food range, reduction of inflexible food rules, improved body image, and fewer cognitive distortions specific to binge-eating disorder.

In the first of three phases of treatment, therapists sought to establish healthy and flexible eating habits by having clients complete a diary focused on eating and cognitions, which highlighted dysfunctional eating patterns and thinking. In the second phase, anxieties associated with control loss and eating were examined, and alternative cognitions and coping skills were introduced. Members focused on problem-solving strategies when situations might trigger a binge. The final stage addressed lifestyle strategies to weight loss and relapse prevention (Tasca et al., 2006).

The GCQ–S ratings provided evidence that a cognitive–behavioral model of group therapy will permit the development of group. However, the course of development may not be the same one that the psychodynamic–interpersonal model elicits. In the cognitive–behavioral group, a linear increase in engagement over the course of the group occurred. Avoidance, initially greater in the cognitive–behavioral model than in the psychodynamic model, decreased linearly over the life of the group, making it comparable to the psychodynamic model by termination. Conflict decreased over the course of the group and was also significantly less than in the psychodynamic model.
Thus, it appears that at least for this particular population, a group following a cognitive-behavioral model may display either a stage progression (as in Castonguay et al., 1998) or continuous change, but unlike a psychodynamic model, it will not occur in clearly demarcated stages and may not follow the same pattern of engagement, avoidance, and conflict.

In this cognitive-behavioral therapy, the therapists structured the early sessions by setting the agenda, teaching cognitive underpinnings of the disorder, and educating clients about healthy habits, which is not untypical for this model and lends itself to the perception that there is high avoidance, little conflict, and perhaps lower engagement than has been discussed in the model presented earlier. However, in this particular model, as therapy progressed, patients were encouraged to become more active with each other by developing problem-solving solutions and relapse prevention ideas, which are likely to result in increased engagement and decreased avoidance. With continued structure and emphasis on problem solving rather than interpersonal issues, conflict is less likely to occur.

Summary

The cognitive-behavioral group model involves a higher level of structure than does the more unstructured group on which group development theory and research have rested historically. Structure can be delineated into the dimensions of content and process. Structured content appears not to affect group development as we have previously delineated. Structured group processes may influence aspects of group development, depending on the degree and nature of the process. In the research reviewed, it is apparent that some structure may actually enhance group progression. Structured exercises placed at the beginning of a group and incorporating behavioral practice rather than didactic presentation seem to enhance group development and outcome for at least some group members. Initial attention to task and later emphasis on the relationship aspects of treatment are likely to result in the best outcomes. Those structured approaches that encourage member participation and responsibility and foster member-to-member interactions for at least some portion of the group time will likely allow for group progression. However, the type of progression may be influenced by the degree of structure imposed; the more structured the process, the less members will experience cohesion and the less they will permit conflict to erupt overtly.

How Cognitive and Behavioral Group Therapists Can Benefit From a Developmental Approach

The cognitive and behavioral approaches to treatment are fundamentally problem oriented and skill based. Symptom relief and amelioration of stress are accomplished by the teaching of individual skills, which enables modification of cognitions, behavior, or both. A perusal of the current litera-
ture in the use of the group format for cognitive and behavioral approaches indicates that many applications appear to use primarily an individual emphasis in a group setting and that the group setting is used for practical reasons (e.g., human resource limitations) rather than for the unique advantages that a group setting has to offer. Research studies testing the efficacy of group for a particular disorder rarely look at process variables. Outcome measures are almost exclusively focused on behavioral measurement of symptom amelioration. Manuals address the tasks and agenda of the group with little effort to provide a healthy group climate in which change can occur. With the notable exceptions of Rose (1977; Rose, Tollman, & Tallant, 1985), Gavin (1987), and Burlingame et al. (2007), cognitive and behavioral group therapists do not articulate the importance of norms, the development of cohesion, the usefulness of interpersonal learning and interaction, and the essential role that the therapist plays in fostering the use of these group resources (Brabender, Fallon, & Smolar, 2004).

All therapists have had groups in which members enthusiastically attend and work on their issues and finally leave when they have achieved some level of improvement. Then, in other groups, members never seem to engage, members drop out, group members only reluctantly work on issues that have brought them into treatment, and most do not accomplish their goals. In addition to individual variables, closer scrutiny often reveals that the groups that work well have reached a level of mature development, and the groups that do not are stuck in the earlier phases of group development. The significant difference between these types of groups is related to the process. The most compelling reason for group therapists to be familiar with group development and process is that over the range of types of groups, from work groups in schools, hospitals, and corporations to traditional group therapies, groups that achieve mature development have greater productivity (Wheelan, Murphy, et al., 1998), and members have better outcomes (e.g., MacKenzie et al., 1987; Tschuschke & MacKenzie, 1989).

Fostering initial opportunities for group members to discovery the commonalities of their experiences encourages individual hope, increases cohesion, and helps group members become more invested in the group. Increased connection to the group decreases group dropout rates, the first major impediment to recovery. Establishing the norm of member-to-member exchange, rather than merely therapist–client communications, even in a skill-based group may be necessary for some patients who struggle with anxiety around interpersonal connection (Tasca et al., 2006).

Many goals are more easily accomplished if the therapist enlists the aid of the group’s interpersonal resources. Such summoning allows for vicarious learning, permits natural practice of social skills, and fosters generalization of a newly learned skill when practice is done. It is an important thing for a group to learn when socioemotional activity is necessary even when it does not appear on task. Bales (1950) discovered that even task groups find it
necessary periodically to engage in socioemotional activity seemingly unrelat-
ed to that task at hand to function well.

Although most who have published on structured groups do not men-
tion development in their efficacy and outcome studies, recognition of the
importance of group climate among some cognitive and behavioral therpa-
sts who run groups has dawned (Gavin, 1987; Rose, 1977). This awareness
takes the form of an acknowledgment of the importance of cohesion (J. G.
Beck & Coffey, 2005; Beech & Fordham, 1997; Beech & Hamilton-
Giachritsis, 2005), instillation of hope (Beech & Hamilton-Giachritsis, 2005),
and open expression of feelings (Beech & Hamilton-Giachritsis, 2005). De-
spite this greater cognizance of group process, little guidance has been of-
fered for how such process can be tapped.

Understanding group development and applying that knowledge to
improve the functioning of group members dictates that therapists alter their
interventions depending on the group’s developmental stage. For example,
knowing when to encourage commonality or individuality rests on the matu-
rity of the group. An examination of two different sessions of a cognitive–
behavioral outpatient group whose members all have varying degrees of bul-
limia nervosa illustrates this point.

In the first session, members quietly await the therapist’s entrance. The
therapist begins by clarifying the nature of the group and provides infor-
mation regarding the frame and rules for participation. All members are
then invited to introduce themselves by giving their name and a brief
introduction about what has brought them to treatment, which may in-
clude a little about their background. During this exercise, the therapist
invites others to ask questions. As they make their introductions, the
therapist frequently comments on the similarities between members and
invites other members to notice them also. For instance, the similarity
between the hopelessness implicit in one member’s declared suicidality
and another member’s expression of despair over the never-ending cycle
of binge–guilt–purge are noticed and explicitly acknowledged. Common-
alities salient to the disorder (such as the wish to be thin, the futility of
dieting, the inability to control binging, feelings of guilt and shame, body
image distortions), similarities in age of onset, family environment, pre-
cipitating events, family and friends’ lack of understanding, and life cir-
mstances are underscored. As the exercise continues, each member
experiences the sense of being heard and a camaraderie with the other

In this group, the task of introducing each member is supplemented
with the therapist’s modeling of listening and underlining similarities be-
tween members and encouraging other members to do also. This is done to
highlight the universality of the group members’ circumstances and there-
Before the session begins, members are animated, discussing tidbits from their intervening week. They are passing around a fashion magazine and joking about who can wear which outfits. In the initial check-in, members report on their week and give an example from their weekly diary of a binging (or almost binging) incident. The therapist records each on a large flip chart with columns for environmental circumstances that surrounded the event, the dysfunctional thought(s), the emotion that followed, and how that then led to the binging. The first two of the eight members were able to provide a sequence. Tina had trouble formulating her sequence. She identified the binge and the precipitating circumstance. She was attending a wedding of a good friend. Although she was prudent in the number of hors d'oeuvres she ate, her last one was a large fried egg roll that she “slathered in” the sweet duck sauce. During the buffet dinner she went back for three large plates of food, several trips to the dessert station, and then two pieces of cake, after which she slipped into the bathroom and vomited. She recognized that she felt horrible and ashamed but was not able to identify the dysfunctional thoughts that preceded her binge. Janice suggested that perhaps Tina was feeling miserable because she was not married. Janice, now 35 and unmarried, believed that most of her binging would stop if she were able to find a male partner who would marry her.

The therapist expressed appreciation that Janice was able to add to the discussion, but she wondered if Janice had any evidence that marriage was an issue for Tina considering the fact Tina had recently extricated herself from an abusive marriage; had gone back to school; and had expressed interest in being on her own, traveling, and not being tied down. The therapist asked Janice and others to think of a question that might clarify how Tina did feel about attending the wedding. Janice then asked how Tina felt about going to this wedding. Tina was able to explain that she was not interested in getting married or having a long-term commitment at this point but felt the bride and “everyone around” was so much thinner than she was. Tina also thought that she would never be able to resist eating those delicious appetizers and therefore was doomed to being overweight. Tina then realized that these thoughts combined with her belief that eating that last appetizer would mean that she could never lose weight, so why bother to try? This dysfunctional thought led to hopelessness and a binge ensued.

After all members worked on their sequences, members were then asked to summarize their own sequence. Time remained for one member...
to work on ways to break the particular associative train. Rita volunteered with the anecdote of her binge after a fight with her sickly mother who wanted her to stay home instead of going out with friends; she offered one solution—to go out regardless of what her mother wanted. Two other members suggested other ways for Rita to break her pattern. Each was discussed, with other members being encouraged to give feedback on this solution in terms of the pros and cons of it working for Rita. Attention was paid to Rita’s unique circumstances—her mother’s real versus manipulated illness and Rita’s dependence on her. In a final go-around, members listed a cognitive distortion that they would be on guard for and its impact on them. The therapist commented on the number of different distortions and how each uniquely affects their behaviors around dieting and binging.

In this group, the therapist attempts to differentiate the antecedents and the cognitive distortions that contribute to binging behavior of each member. Similarity has already been previously established, and additional efforts to accentuate this aspect are not likely to augment members’ connections to each other. Members now need to focus more on their individual triggers and the sequences that follow, although types of cognitive distortions and ensuing emotions may overlap. Each member’s struggle to formulate his or her personal sequence can vicariously inform others of the struggle and despair in dealing with this disorder, but emphasis on the verbal articulation of these painful aspects is likely to disillusion group members and will not aid in the differentiation process. Differences among them should be noted so that each member can appreciate that he or she alone must accept responsibility for his or her symptoms and for finding the unique resolution for his or her behavior. When group members base their questions on their own particular circumstances (e.g., “I know what you mean because when that happens to me . . .”), rather than common ground, the therapist initially may intervene to articulate the differences between each member’s situation. With time and appropriate modeling, the therapist can request other members to help a member differentiate her own circumstances from that of others. As group members become competent in differentiating their own issues from others, the therapist should facilitate members in making these observations, rather than attempting to do all the work him- or herself. The latter is likely to stymie the individual members in learning these skills.

In these two group sessions, awareness of the group stage helps the therapist determine whether to encourage members to see the commonalities or the differences between them. When group members begin a group, isolation is high, and strategies to decrease the isolation should be prominent in the therapist’s repertoire. When members already experience an esprit de corps, individuating and learning to accept differences become important tasks for group members if they are to resolve their own difficulties. In the latter stages of a group, having group members actively participate in observing and com-
menting on others' circumstances allows for practice naturalistically and en-
courages generalization.

INTEGRATING THE FIVE-STAGE MODEL WITH
STRUCTURAL GROUP APPROACHES

The wide array of structural approaches makes it impossible to delineate how each kind of group might infuse group development principles into the group structure. We can give a sampling of what, where, and how strategies might be applied at the different stages of a group to several different types of group structure.

Stage 1: Formation and Engagement

The initial sessions of a structured group are often filled with the therapist's providing information about the nature of the group. Frequently, the therapist lectures to the group with little input from the members. When they do participate, the interchange takes the form of therapist–client–therapist–client (Rose, 1977). Although the initial structure may serve to reduce anxiety for those not originally involved in the exchange, if this is not soon replaced by encouragement from the therapist for client–client interactions, cohesiveness is hindered and interpersonal learning, a valuable resource unique to the group setting, is sacrificed. The next vignette shows how a structured six-session closed-ended stress management group might further develop cohesion and use interpersonal learning.

In the first session of a stress management group, information about the sessions, including what is to be accomplished in each, is discussed by the therapist. After answering questions, the therapist goes on to provide a model for understanding stress, factors affecting it, and the body's response to it. Participants are then asked to lie on the provided mats and are taken through a guided tense–relax pattern of the 16 muscle groups. At the end, a sheet listing the 16 muscle groups is provided for participants, and they are asked to practice this exercise twice a day over the next week.

We contrast this scenario with that of a group therapist who registers and analyzes information about the stages of development.

The first session begins with the therapist giving a brief introduction about the group and referring members to the handout that provides the same information and lists a brief summary of each of the sessions. She then asks members to introduce themselves and list one or two things that each finds stressful.

The therapist adds, "It does not have to be the most stressful circum-
stance in your life, but one that you happen to think about now. Let's
keep it to 20 words or less, as we have so much to cover. If someone else has already said it, you can add to it as they are talking.”

The therapist lists each on a flip chart. As each of the first participants introduces his or her stressful experience, the therapist provides a brief supportive comment. When general overlap occurs, the therapist makes the connection (e.g., “So, like John, you find work really stressful,” or “Judy, you, like Martha, also find making dinner with the kids clamoring for attention to be particularly stressful”). If the therapist observes nonverbal agreement, she comments, “I see you nodding—you can relate to this also? Did you want to add anything to what she is saying?” Once all have had a chance to speak, the therapist provides a brief introduction to a theory of stress and possible ways that it can affect one’s body, life, and relationships.

After entertaining questions, the therapist asks group members to use their mats, and the therapist goes through each of the different 16 muscle groups, with members first tensing then relaxing each group. They are given paper that lists each group and asked to practice this exercise twice a day. In addition, group members are given several 3-inch × 5-inch cards and asked to write for next time the ways in which they react to stress. They are told that these will be collected in the following session, read aloud anonymously, and organized into clusters of general categories.

In the second group described here, the therapist’s lecture component is briefer than in the first, and from the beginning, the therapist engages each group member, assisting participation. Members’ active involvement increases a connection to the group and fosters investment. The therapist also highlights commonalities among participants, asking each to add to the others’ input. The strategy of encouraging members to provide additional input about a particular stress promotes initial member-to-member interchange and permits members see the immediate relevancy of this group to their problems. Leaders who do not support member-to-member interactions often have groups that develop a less effective mode of operation (Karterud, 1988).

In the initial stages of a group, it is not necessary or even beneficial for members to share their lives or problems in great detail. Affiliations can begin to emerge even with superficial similarities. Some “cocktail talk” is necessary for a deeper relationship to ensue. In fact, some anxious individuals who prematurely disclose what they perceive to be highly personal may experience shame when reflecting back on their contributions in the group, creating the potential for premature termination. The group, unprepared for this level of disclosure, can be nonreactive or can respond in a way that is perceived as unhelpful or derogatory to the person who has disclosed. In groups in which a number of individuals have experienced similar traumas, premature disclosure of specific details of such an event may heighten anxiety, particularly in those members listening who had similar experiences. Thus, it is often necessary to carefully craft what will be revealed in the initial sessions. For example, J. G. Beck and Coffey (2005) worked with groups of par-
Participants who met criteria for PTSD after a motor vehicle accident. They found that setting norms for what and how information about each individual’s accident was shared was important for the successful management of their PTSD groups. These therapists advocate for greater emphasis on feelings and not on the actual circumstances of the accident. Structured groups are often better at adhering to this recommendation because therapists of such groups are accustomed to being in a didactic role and providing highly specific instructions. Moreover, participants come to expect this kind of guidance rather than feeling constrained by it.

Stage 2: Conflict and Rebellion

As mentioned in chapter 5 of this volume, Stage 2 occurs after the initial enthusiasm for the group has waned. Disappointment with the therapist’s offerings coincides with the realization of hard work looming ahead. The less directive the therapist is, the more pronounced this stage is likely to be. Thus, in a structured group in which the therapist has provided considerable direction and patients are actively participating and pursuing their assignments, this stage may take a more muted form. Most cognitive and behavioral therapists apply principles of the individual framework to the group setting so that if the conflicts and issues apparent in this stage do not appear as salient individual symptoms, member dissatisfaction will have little place in the therapy and will continue to be largely ignored in the literature. If the therapist does not heed the budding discontent and address it in some manner, it may lead to premature dropouts and often a nonproductive stalemate in work for some members.

This stage is characterized by the challenge of authority. The group therapist may become aware of its existence when a group member or members question norms and values set by the therapist. It can be manifested in the process of the group session, taking the form of acting out, as when group members are late, do not show up for sessions, do not pay their bill, or do not complete homework assignments. It can take a more passive form in the process as group members do not take much initiative with each other, seem satisfied only when the therapist has given an opinion on their issue, and express disappointment and frustration that they are not getting enough from the therapist. It can also be presented in the content as members express difficulties with bosses, parents, teachers, and others in authority.

Sometimes manifestations of this stage are viewed by the therapist as solely an individual’s problem. Rather than recognize the universality of the phenomenon, with the individual as a spokesperson for the group, the therapist perceives the problem as resident in the individual member whose challenges and hostility need to be contained, not explored. Viewed as an individual problem, the individual becomes a scapegoat of the group, a repository
for all members' negativity toward authority. Handled in this manner, group members perceive the danger in challenging authority.

The example that follows is the fourth session of a six-member traditional outpatient cognitive-behavioral group designed to work with mildly to moderately depressed individuals. In the first session, patients introduced themselves briefly. The therapist presented an overview of the group, had members complete the Beck Depression Inventory (A. T. Beck & Steer, 1987), and then introduced the method of mood monitoring (for a description of this technique, see White, 2000). Members were asked to rate their day thus far once a day for the next week. A brief introduction of the cognitive-behavioral theory of depression ended the first session. In the second session, members presented their findings, and group members collectively worked with observations of each patient. An activity-monitoring technique was introduced (Persons, 1989). Members were asked to continue monitoring their moods and to complete the activity monitoring for 1 day. The session ended with a review of the theory of depression. In the third session, one member, Joan, did not show up. Members again presented summaries of their mood ratings. Members were asked to make observations about the overall trends for each other. Activity monitoring was discussed and fine-tuned for more or less detail, and members were given the assignment to continue monitoring their moods each day and complete the activity log for 5 of the 7 days. The relationship of mood, activity, and depression was discussed and related to each of their situations. As the fourth session begins, Mary, Patrick, and Donna are present. Joan is again missing, as are John and Nancy. None of the absentees has provided an explanation prior to the group meeting. The therapist has a choice as to how to begin. The first vignette is the more typical.

The therapist waits approximately 7 minutes, allowing group members to chat and hoping that other members will arrive and that they might begin without interruption. As usual, she begins with an initial go-around in which results of the homework establish the agenda for each member. Patrick has not finished his homework and is questioned about the obstacles to its accomplishment. With only three present, this step is completed in less than 10 minutes, and they begin to work on their agendas. Two members arrive approximately 15 minutes late with apologies for traffic and unexpectedly having to work later than usual. The therapist summarizes the work they are currently addressing. The latecomers report on their homework and establish their agendas. The group continues with work on activity logs and mood monitoring.

Without some attention to the burgeoning resistance to the stated task, the therapist will have difficulty maintaining cohesion and preventing scapegoating. The next vignette presents an alternative the previous scenario.
The therapist begins on time even though there is some question as to whether waiting a few minutes might allow those coming late to join without interruption. Beginning on time sets the expectation and therapeutic frame clearly. The therapist opens with a question: “What are members' thoughts about the missing group members?” Doing so addresses the “elephant in the room,” allowing the members who are not present to remain a part of the group and their actions to be understood as originating from individual characteristics and common roots.

Mary expresses fear that Joan, the member missing for two sessions, may not be attending because when Joan said that it took her 2 hours to get to group by public transportation, Mary had offered Joan a ride when she discovered that they only lived a few miles from each other. Mary worries that this may have offended her in some way. Mary reasons that if she had not wanted to accept the ride, she would not have been able to say this directly and would have avoided the situation altogether.

Patrick reports that he could never renege on a commitment and so will see this through for the required 12 sessions but also sometimes feels resistance to coming to group. He reveals that he is somewhat disappointed that he is not getting better more quickly, did not complete his homework, and has been feeling more depressed this week. The therapist questions whether this disappointment has also made it difficult for Patrick to complete his homework—has he been questioning whether it is worth doing? He acknowledges that the exercise seems trivial. Donna says that she imagines that the missing members have gone to the beach; given the loveliness of the day, she wishes that she could join them.

When both latecomers enter, they are apologetic with appropriate explanations; John had to work later than he had anticipated, and Nancy complained of the traffic. The therapist thinks that their lateness could have been avoided with proper planning and prioritization, but she chooses not to articulate these thoughts. The therapist summarizes what Donna, Patrick, and Mary have said and asks for the latecomers' thoughts about their lateness and Joan's absence. John says that he finds himself thinking about other things when members review their homework and feels that it is the least important part of the session. John confesses that when he realized he would be late, he thought he would not miss much. Nancy jokes, “I wish I could have found someone to go to the beach with. Donna let’s you and me go next week if the weather is good instead of coming to group!”

The therapist summarizes the disappointment and frustration that the group members are feeling, as expressed by John and Patrick. She acknowledges that feeling better will take work and that at least some members were hoping that the therapist could and would do more to help. She also points out that each has his or her own underlying schema that is activated toward helpers and persons in authority such as herself and that each member reacts differently, such as by taking blame, feeling more depressed, or wanting to replace the group with a more enjoyable activity like going to the beach. She suggests that anticipation of attend-
ing group today may even have affected their mood ratings for yesterday and today. She also offers that as they review their homework and set the agenda for the day, they may wish to incorporate what they learned about their own mood and actions as they relate to the activity of attending the group. The group reviews their homework.

Although actual group events are seldom this blatant, there is usually more than one indication that the group is struggling with issues of authority; in this case, frustrations and disappointment toward the leader can be discerned. The manifestations presented here are common for depressed individuals, some of whom also may have a proclivity to act out their disappointments by avoidance or a counterdependent stance (e.g., going to the beach). In the first vignette, not completing homework is seen as an individual resistance, and lateness is taken at face value. In the second vignette, lateness, absence, and incomplete homework are considered part of a group phenomenon expressed by one or more members of the group. Although response to authority may be addressed as a group event in unstructured groups, within a cognitive–behavioral framework, it may be conceptualized as individuals' activated schemas, some of which could be dysfunctional. Appraisal of these events within the here-and-now framework of the group setting is likely to further generalization of the understanding of dysfunctional schemas to real-life situations rather than remain a purely intellectual endeavor.

If the group members already have some familiarity with the Automatic Thought Record, \(^1\) reactions can be listed on this record along with concomitant feelings and actions. At least some group members are likely to see these thoughts as dysfunctional and relate them to other current life situations such as reactions to parents, bosses, and other authority figures.

Depressed patients often are reluctant to acknowledge openly their frustration and anger often resulting in helplessness, passivity, and a worsening of depressed feelings. Although the previous example had individuals more likely to act out than to become passive and depressed, this may not be the case in some groups. Expression of anger and disappointment with authority figures such as the therapist may feel too dangerous for particular groups. Use of a structured exercise at the beginning of group may be helpful in bringing these feelings out in the open (Stockton et al., 1992).

Stage 3: Unity and Intimacy

As described in chapter 5 of this volume, this stage is characterized by increased cohesion, greater disclosure, and the pursuit of more intimate rela-

\(^1\)The Automatic Thought Record originated with Aaron T. Beck's therapeutic approach (A. T. Beck, Rush, Shaw, & Emery, 1979). It is a written chart kept by patients, initially taught in the session but often used as part of assigned homework, which identifies the situation and the immediate thoughts, feelings, and behaviors that occur. This document and the ensuing discussions of it during group help patients to identify triggering situations and modify dysfunctional thoughts (White, 2000).
relationships in the group. The dependence on and idealization of the therapist gives way to a more realistic view and use of the therapist's skills. The task of the therapist is to continue to foster member-to-member exchanges and to aid group members in achieving greater levels of disclosure; at the same time, she must help maintain the boundaries and assist members in recognizing that complete disclosure is not necessarily required for a deepened level of intimacy to occur.

This next example features a one-semester, time-limited outpatient group composed of male and female college students who have been diagnosed with social phobia. The 16-session group therapy is based on a model refined by Edwards and Kannan (2006) and uses a combination of systematic desensitization, exposure, psychoeducation, strategies for reducing self-focus, identifying and challenging cognitive distortions, and cognitive restructuring, all tools that have been known to be effective in attenuating social phobia (Edwards & Kannan, 2006). Excessive focusing on negative beliefs about the self heightens self-consciousness, which consumes energy and attention needed for accurate perception and responsiveness to social interchange. The idea is to disrupt excessive self-focusing and allow participants to discover and develop natural and spontaneous styles of interaction.

Sessions 1 through 5 were designed to help participants individually analyze their socially phobic behavior in terms of affected situations, assumptions and beliefs that make the individual vulnerable to phobic behavior, specific anxiety symptoms and the resulting self-focus, and behaviors used to protect the individual and mask the problem. During this early period, two of the six members dropped out. Although initially all group members displayed many overt symptoms of anxiety, said little to each other, and had little eye contact, the remaining members continued to attend, were diligent in completing assignments, and gradually appeared to display less overt anxiety. Cohesiveness increased along with acceptance and mutual support as each recognized the similarities of their difficulties. Beginning with Session 6, group members were encouraged to expose themselves to graded, gradually increasing anxiety-provoking situations (predetermined in prior group sessions) and to attempt to act without the safety of defensive behaviors. This was done with role-plays in the group and with homework between groups. These assignments were structured as experiments in which negative predictions are recorded in group prior to the activity.

The following vignette from Session 8 illustrates Stage 3 phenomena:

All four members arrived on time. Mary began reporting her experience of giving an oral presentation in class. She had predicted that classmates would be bored during her presentation and not pay attention. She thought they would think she was not very smart. As she went to the front of the class, she dropped her notes because she was physically shaking. A classmate helped her pick them up and said something about ev-
everyone being nervous. Mary acknowledged that she was nervous too. Mary reported that she did make it through the presentation but felt miserable afterward. The therapist encouraged the other members to explore Mary's underlying thoughts. Mary reported that even though she knew the classmate was trying to be supportive, she had some trouble shaking the idea that the girl said that to her because she was so pathetic. She also wished that she had not revealed that she was feeling nervous because revealing it may have highlighted it. It was not like "being here where we all know that we suffer from this disorder."

The leader commented on the difficulty of Mary's task, praised her for completing the assignment, and commented that she seemed uncomfortable disclosing what almost everyone in her situation was feeling even after someone else articulated it for her. She seemed to be struggling with what was an acceptable level of disclosure under the circumstances. Mark commented that he also could not tell what could and could not be said. He felt nervous and exposed. Dinah and Juan agreed.

Dinah was next, reporting on meeting with one of her male classmates for coffee. She reported that it had gone well as far as she was able to tell. She had dropped her safety behaviors of preparing questions so that she would never have to reveal anything about herself and did not move her hands around (to avoid the signs of shaking). Dinah was able to concentrate on what he was talking about and noticed things about his demeanor, such as clearing his throat many times, that suggested that he perhaps was also nervous. However, she could not shake the notion in her head that he was humoring her.

When Dinah explored this preoccupation with the group, she said that there were things about herself that she had not revealed to anyone in the group about her past, but she was sure that if the classmate knew and if the group knew, they would not find her acceptable, despite her newfound skills. Mary and Mark assured her that whatever was in her past would not influence the positive way they felt about her. Yet, Dinah was not persuaded, and she reported that delving into this area made her feel more anxious and alone. The therapist commented that Dinah appeared to regard the group as almost mandating her to reveal all, but no such stipulation from the group was evident. Revealing inner secrets and the pain attached to them required a certain comfort level for both her and the group or with whomever she chose to share.

Mark and Juan chose to attend a school function as their homework assignments. In the next session they reported that they had seen each other in the school cafeteria and decided to go to a party together instead. Mark was able to approach two girls and reported feeling great success, which he attributed to their work in group together. He said that he had kept in mind some of the comments that Mary and Dinah had given him the previous week and thanked the members for their support. Mark said knowing that he would have the group to talk this through helped him be willing to risk rejection. Juan had not been as successful. He picked out a girl he wished to approach but watched from
a corner of the room. He observed Mark and other guys “picking up” girls and wondered what he was missing. The meeting outside of group was an aberration from previous behavior, and socializing together had been discouraged from the beginning.

Although the therapist wanted to support their spontaneity and encourage group cohesion, this was an attempt to challenge previously established boundaries. The leader questioned what lead to the change in the previously assigned homework. Juan revealed that having Mark there initially alleviated his anxiety. Yet, when his efforts failed, it made Juan feel even worse. Dinah reminded the men of the rule not to socialize outside of the session. After a little more discussion, the leader set up a role-play in which Mary and Dinah gave Juan feedback on his behavior. The feedback was vague and overwhelmingly positive (“That was great!”).

The therapist encouraged them to be specific about what was great and include perhaps one specific thing that might be improved. Juan tried again and the second time, received comments about his casual and confident style. He said, “The group knows me in ways no one else ever will, and I know they just can’t say what a loser I am.” He reiterated the persistent belief mentioned in previous sessions that had they not known him, they too would pity him.

As is characteristic of this stage, members feel warmly toward each other, bonding around their perceived social failures. They desire to increase their closeness with each other yet manifest anxiety and struggle in relation to levels of appropriate disclosure both inside and outside the group, which is particularly true in a group like this one whose members are suffering with social anxieties. This tension was apparent when Mary spoke of her discomfort in sharing that she was nervous but was most poignantly displayed in Dinah’s conflict over revealing inner secrets. Part of Dinah’s distorted thinking centers around the blackness she feels about her previous traumas. At this stage of the group’s development, it is important for her to learn that she can be accepted and liked by the group and others without having to disclose everything.

Consistent with their mutual positive feelings, feedback to each other is both positive and vague—for example, when Mary and Dinah told Juan his role-play was great. The leader facilitates member-to-member exchange and feedback, rather than giving it herself, to increase member interdependence. However, she does intervene to ensure that the feedback will be specific and constructive. The demand on the therapist of structured therapies is to achieve specificity in feedback, and this element can be used to foster increased connection within the group.

A boundary violation (not uncommon in this phase) occurs when the two male members change their assignments and do their homework together. If the therapist does not acknowledge the violation and attempt to understand its place in their behavior, she too has colluded with them. For many cognitive and behavioral groups, outside connections are permitted. It is likely,
however, that boundary violations may occur in some other form for these groups, and the nature of legitimate outside interchanges should be spelled out from the beginning of the group so that violations are apparent and can be addressed.

Stage 4: Integration and Work

In this stage, group members struggle with issues around individuation both in terms of group process and the exploration of their individual issues. The push for the deepening of relationships among the members clashes with fears of intimacy. Successful negotiation of this stage helps participants continue their connectedness despite conflict and disappointment. Members also give and are able to receive specific feedback to and from each other, which enables behavior to change. The therapist must facilitate these processes by encouraging members to deal directly with each other.

An example of Stage 4 phenomena is provided by a closed-ended group of older caretaker adults who have been referred to a time-limited, 14-session, problem-solving group to help them deal with spouses or parents who require full-time caretaking because of medical conditions. Although those referred have not been given a diagnosis, many suffer from mild to moderate depression and have been judged by the medical team to be overwhelmed by the caretaking of their family member. The procedure uses the structured approach of identification and clarification of the problem, generating solutions, evaluation and selection of the solutions and methods of implementation, possible role-playing, and practice assignments (Spivack, Platt, & Shure, 1976). After evaluation and assessment of each individual using the Beck Depression Inventory (A. T. Beck & Steer, 1987), Dysfunctional Attitude Scale (Weissman, 1979), and an interview (Thompson et al., 2000), eight members started with the group. Following initial introductions and psychoeducation about the problem-solving model, members presented their chosen problems. This method enabled two to three problems to be discussed each session. Problems concerned managing the sick family member's needs, integrating other family responsibilities into the caretaking of the sick family member, and the conflict around care of the sick one and the member's individual needs. Initial problems were concretely presented and solved. With time, underlying conflicts concerning anger, guilt, anxiety, and responsibility became more apparent. We review a part of the 11th session:

The therapist announced that Janice and Monica left messages that they could not attend. Monica indicated that she could not get someone to stay with her husband because the person who had helped her in the past was no longer available, and she was requesting a change in the group’s meeting time. Sally jumped in, “I second this as the first problem that the group tackles today. I too have difficulty getting someone to stay with my mother at this particular time.”
The therapist agreed that this problem could be the first discussed, but before doing so wanted to check in with those who had discussed their problems last week to see if anyone had tried to implement his or her solution. Martha reported to the group that she had applied the work that she had done the previous week in group and was able to enlist the aid of her sister-in-law to stay with her husband for an afternoon while she got her hair done and then had lunch with an old friend. When she returned, she sensed that her sister-in-law was irritated, and Martha worked hard not to feel guilty, using what she has learned about her own dysfunctional thoughts. She expressed her gratefulness to the group and exclaimed that no one else understood her the way the group did and that she has never known such a wonderful group of caring people.

Chris said that she was unable to attempt the solution because she knew before she left that there really was no solution to her problem, even though the group had tried to provide one. The therapist suggested that time permitting, they could look at the failure in more detail because the group seemed unable to offer her a solution that worked for her. The group began discussing the problem of attendance and time. In identifying the parameters of the problem, most members found the time difficult; spouses and children were more available in the early evening.

Gail asked the group leader if it was possible to change the time because there seemed to be no point in discussing this further if time and date change were not possible. The group leader confirmed her willingness to change the time provided that everyone could be accommodated. Martha, Sally, Gail, and Karen generated a dozen solutions, some involving various time and day alternatives. They also included sharing lists of outside caretaker services and sitters and an alternating schedule of taking turns caring for others' family members.

The therapist noticed that Chris had not contributed and encouraged her, but she declined, saying that others had articulated the solutions. The therapist wondered if the entire problem had been identified. Was the availability of helpers the only problem related to attendance? That is, the group members were making certain assumptions about attendance based on their own positive feelings about the importance of the group. Martha, Sally, Gail, and Karen expressed surprise, reiterated their mutual feelings for each other, their sense of closeness based on their similarities, and their feelings of being helped by the group. The therapist cautioned, “But perhaps not everyone feels as if they have been helped. Chris said that we did not help her last week.”

Chris responded, “I knew last week when I left it was not going to work but did not want to dampen your enthusiasm that you found a good solution for me. It would have probably worked for others, but I guess my situation is different.”

The therapist remarked, “Perhaps we did not pursue the details of your perspective or explore in-depth your underlying schemas to understand how your struggles deviate from others’ struggles even when they appear like the same issues. We can pursue this a little later, but perhaps you can comment on your own feelings about coming to group.”
Chris commented that she sometimes felt left out. Others seemed to be so similar, and she felt different and wondered if she could be close to others despite this difference. The therapist then said, “Possibly attendance is part of the outcome of the larger problem for the group to tackle. Can differences among us on everything from concrete problems to more elusive issues of closeness be encouraged and accepted without sacrificing the positive feelings we have about each other and the group?”

Apparent in this vignette is the therapist’s empowering group members to take responsibility for a possible time or date change, the domain of the therapist in earlier sessions. This structured problem-solving group has progressed from the earlier solving of individual concrete problems (how to get relatives to help) to becoming more comfortable tackling group issues involving relatedness. With this development also comes a willingness to examine underlying resistances (e.g., dysfunctional thoughts and undergirding schemas). The therapist addresses this resistance when she asks the group if time is the entire problem with attendance, alluding to varying levels of enthusiasm and connectedness among group members. She highlights this conflict by contrasting the four enthusiastic members with Chris, who does not feel helped by the group’s work with her. The missing members are possibly in this latter subgroup, but without their presence, the therapist is reluctant to include them in this subgroup. Chris confirms her experience of difference and the question of intimacy with this difference. Attendance is then seen as only a small part of the larger issues of learning to accommodate and embrace differences. This more accepting attitude then allows for further individuation, an accomplishment particularly difficult for this group or any homogeneous group.

Related to this exploration and acceptance of difference is the therapist’s encouragement of specificity. In the vignette, the therapist requested that the group revisit the identification of the problem to expand their notion that difficult times and lack of caretakers lead to failed attendance. Later in the vignette, the therapist reformulated Chris’s perceived lack of help from the group as a failure to appreciate the way in which her problem may be different in spite of its apparent similarity to others’ problems. That is, the underlying dysfunctional thoughts and schemas producing her response may be different and need to be understood in specific detail before any adequate solutions might obtained.

Within the problem-solving framework, Chris’s presentation at this stage of the group can either be viewed from an individual or group perspective. Viewed individually, Chris’s “yes, but” response to the group suggestions can be seen as a problem requiring more specific exploration. Her characteristic stance can be discussed as a problem in isolation or as an interactional style requiring an understanding of the underlying dysfunctional thoughts and schemas that support this behavior. The task of the therapist is to help her distinguish her problem from other members’ problems that may appear simi-
lar. Her rejection of the solutions may also be an effort to decrease the closeness that the rest of the group appears to be pushing. Within a developmental framework, Chris's problem may be conceptualized as an individual response or challenge to the task at this stage of group development, which includes how to be connected without sacrificing individuality and ignoring difference. Chris's problem is representative of the group and its struggle to be close but respect individuality, which includes members' varying levels of comfort with both closeness and difference.

**Stage 5: Termination**

This final stage is demarcated by the visible end of the individual's tenure in the group. The three tasks of this stage are acknowledging and responding to the loss of the group and its members, evaluating what has been learned, and preparing for the future with awareness of what is still left to change. Time-limited structured groups are usually well engineered to deal with certain aspects of the termination process, particularly the latter two tasks. Inherent in the structure of the group are efforts to identify new skills learned, ascertain goals still remaining, and ensure a successful future by encouraging the generalization of skills acquired in the group to life outside the group. What is often not given adequate emphasis is the task of attending to the losses associated with group termination.

The following example illustrates some of the Stage 5 issues. In a 12-session anger management group designed for an outpatient mental health setting, the first 10 sessions help clients understand and identify their anger and aggression; identify the events and cues that trigger anger; develop a personal plan to control their anger, including learning progressive relaxation, cognitive restructuring, assertiveness training, and a model for conflict resolution; and learn how past family interactions around anger affect current behavior and emotion. The final 2 sessions involve review and consolidation of concepts of anger management and strategies learned and skills developed to control their aggression (Reilly, Shopshire, Durazzo, & Campbell, 2002). In preparing for termination, the therapist should note in the earlier sessions those clients for whom the events and cues triggering anger may include loss and abandonment. These individuals may have more difficulty as the group reaches its final sessions.

Within the model, it is predominantly in the last two sessions that we encourage the examination of termination. As an overall plan, we advise exploring loss more vigorously in Session 11, whereas efforts at consolidation and future plans should be the focus of Session 12.

In Session 11, basic concepts of anger management are reviewed and summarized. Homework (monitoring the level of anger on the anger meter on a scale of 1 to 10; identifying events that triggered anger and the physical,
behavioral, emotional, and cognitive cues associated with the anger-provoking event) is discussed. Strategies used to avoid reaching 10 on the anger meter are elucidated and reinforced as appropriate. However, references to loss may be indirect at best or otherwise avoided, a characteristic common to both structured and unstructured groups. Individual group members’ efforts to elude termination by group prolongation, a feature of many unstructured groups in termination, are likely to be suppressed by adherence to the original contract and specified format of the structured group. Likewise, attempts to avoid dealing with termination by distraction are usually limited because of the structured nature of the group session. What is likely to happen when issues of termination as defined in chapter 5 are introduced by group members is that they are seen as irrelevant to the specified task and so are likely to be ignored by the leader.

How might a therapist attuned to developmental stages and interested in addressing the task of dealing with loss intervene in Session 11? We have two suggestions that would not alter the basic structure of the session yet would allow for the acknowledgment of loss—loss of the former self, loss of the group as a support, and loss of individual members’ continuing impact on their lives.

First, we recommend that the therapist draw attention to the process of termination by reminding the participants at the beginning of Session 11 of the time left with a straightforward statement such as, “We have two more sessions together.” This simple statement calls attention to the time-limited nature of the group and reminds all that ending is near. The set of responses that follow the therapist’s remark, particularly if uncharacteristic of the members may signal a reaction to termination. For example, a member might joke, “and it could not happen any too soon.” Although this remark may seem irrelevant to the specific tasks at hand, the therapist’s response to these extraneous comments will encourage members to acknowledge their reaction to the termination as a reaction to loss and/or a defense against that loss. In Table 7.1, we present termination dialogue: some examples of member responses, their possible meaning in terms of termination, and suggested therapist responses.

Other members should be encouraged to join or disagree with these reactions. It is important that the therapist remember that termination is met usually with a mixture of reactions within each individual, whether he or she can voice both sides of the ambivalence. Even though only one member may give voice to a reaction, if time were available, most may be able to acknowledge each of the reactions.

Second, during the discussion of their homework, members may include loss events that trigger anger. After the triggers and cues are discussed, a parallel can be drawn between loss as a trigger event and the upcoming loss of the group. This brief vignette is informative.
<table>
<thead>
<tr>
<th>Group member response</th>
<th>Possible meaning related to termination</th>
<th>Possible therapist response</th>
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<tbody>
<tr>
<td>I am a new man. Not that my &quot;me&quot; was such a bad monster. [laughs] My old lady thanks you, and I thank you.</td>
<td>Grieving the loss of the old self, taking stock of behavior past and present.</td>
<td>So you can see all the changes that you have made over these last 11 sessions, and your wife notices also. It feels good. Yet I hear a little wistfulness about the old angry you. You feel like you will easily be able to find other things to do when group is over. Do others also have that feeling?</td>
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<tr>
<td>Who cares? It's not like we got nothing else to do with our time.</td>
<td>Devaluation of the group experience, denial of the group's importance.</td>
<td>It sounds like you feel that you will not be able to keep your anger down without us. How do you feel you will be without the group when it ends? You said “relief.” It was tough to get through this group—being confronted each week, having to do homework. Yet you came every time and gave it your all and made lots of changes in reducing your anger. What about that?</td>
</tr>
<tr>
<td>I can hardly believe that it's almost over. I don't know if I can keep the anger under wraps.</td>
<td>Denial of group's ending, fear and anxiety that gains will not be able to be maintained.</td>
<td>Joe did have his difficulties. Does anyone remember they once, too, got that angry? Could that have been any one of us on a really bad day? Ellie, you are right, Gina did do well in controlling how she expresses her anger, and the future is looking good. But I bet we all have some doubts about whether we're gonna be able to keep up the good work.</td>
</tr>
<tr>
<td>[in a joking tone] Yeah, and it will be a relief to be done with this.</td>
<td>Devaluation of the group's value.</td>
<td>Use of projective identification, a rejection of their angry selves, and a scapegoating of a single member. Idealization of the new self, denial of the fears of the future.</td>
</tr>
<tr>
<td>Yeah, things got much better after Joe left. He was too angry, and he was not gonna reform. [group nods in agreement]</td>
<td>Attempts at prolongation of the group as a way to preempt dealing with termination.</td>
<td>If we had another advanced anger management group we would not have to think about ending our work together and all that it means to each of us. What wouldn't we have to face?</td>
</tr>
<tr>
<td>Girl, [referring to another participant] you changed! You ain't never gonna be that angry again. Don't worry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an advanced anger management group we could join together?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Don has just completed telling the group that his anger meter reached 9, higher than in the previous 3 weeks. The event, a fight between him and his girlfriend, began with his sarcastic comment escalating to her threatening to leave the relationship. He explored the behavioral, physical, and emotional cues leading to the incident and reluctantly acknowledged his sensitivity to being abandoned by her but only in the context of it being so much work to replace her.

**Therapist:** Loss is really an emotional trigger even if it is only because it makes you mad that you have to put so much work into finding a replacement. It really "got to you" even more this week than in a while, despite the fact that you fight at least twice a week, and it most often ends with her threats, which thus far have been empty. Why did her threat to leave you bother you more this time?

**Don:** Don’t know. Now it seems pretty stupid, but I saw red that I hadn’t seen in a while. You know you just get used to something or someone, and it is pain in the butt and too much work to deal with the change.

**Therapist:** Losing your girl is an inconvenience, but it’s also a worry for you. But, perhaps you are facing another change that your conscious mind has not been thinking about but was triggered when your girl threatened to leave. You know the group is ending, and you’ve done a great job in using it to make big changes in the way you control your anger. Maybe you’re thinking that the group is really leaving you too.

**Don:** [laughs] These blockheads? I don’t know—maybe.

**Therapist:** Others have any connections to this for themselves?

At the same time that the therapist may want to remark on these references, the therapist is aware that this is a group of individuals who are acutely sensitive to self-image and particularly reactive to issues that may touch on personal shame. To acknowledge the meaning of a loss may be inconsistent with the self-image of being in control of one’s emotions and impervious to past and ongoing losses. Thus, the therapist needs to tread lightly, being careful about the language used. For instance, when Don perceived the loss of his girlfriend in terms of the work required to replace her, the therapist acknowledges where he is by using the word inconvenience but then goes on to insert worry as well.

As designed, the tasks of the final session include reviewing individual anger control plans; rating the usefulness of the various treatment components; and completing a final exercise that discusses topics such as anger management, how the strategies of individuals’ anger control plans aid in controlling anger, what areas of improvement are still needed, and how an-
control can be strengthened after the group has ended. Finally, a certificate of completion is awarded on completion. The focus is on what has been learned, what can still be acquired, and how can it be acquired.

To enhance the termination process, we suggest adding a question that focuses on the loss of the group—for example, “As you continue to use your anger control plans, what are the things about this group that have helped you, and what you will miss?” Allowing members to recognize the loss of the former self, the group as a whole, the therapist, and the individual members of the group will be a step in accomplishing this third previously ignored task. A second question to follow might be, “How will you make up for these losses?” These two questions will not alter the form and structure of the session but potentially will allow for the acknowledgment of the loss of the group, its members, and the support it provides.

As a final note, the therapist who conducts a structured group but desires to make use of the importance of the developmental approach will struggle to find the appropriate compromise between completing the tasks of the session and responding to members’ indirect and direct anxieties over the loss of the group and its support. To the same extent, however, that the therapist heeds the latter, he or she will do justice to the former.

Integrating Group Development Stages Into the Structured Therapy Model

Traditionally, the more structured models of group therapy have focused primarily on understanding and aiding the client by working with the individual in the group setting. Some have acknowledged the importance of cohesion, and a few have considered other group phenomena. However, at this time, only a small number of writers and researchers have taken group process seriously, even though understanding and cultivating group processes are not in conflict with the focus on individual outcome. In each of the vignettes presented in this chapter, the therapist successfully operates within the structured model but summons stage development theory to augment his or her decisions about when, how, and at what level to address particular individual concerns. With each model and with each group of clients, the stage may manifest slightly differently. Each vignette was specifically chosen because that model of group and type of patient would benefit from the infusion of stage theory with conceptualization of the individual’s problem. Our thesis is that all groups, structured or unstructured, must proceed through these stages of development if maximum benefit is to be gained from the group for each member.

We acknowledge that specific models and some types of patients may require technique modification. For example, the social phobia group, which illustrated Stage 3, is likely to have considerable difficulty with Stage 2 because any social interaction causes considerable anxiety. Thus, when dealing
with group members who have symptoms of social phobia, the work of Stage 2 may be done primarily by the therapist, who may actively titrate attenuated expression of dissension, conflict, and challenge to authority. In contrast, for bulimia sufferers, the work of Stage 2 and in particular the investigation of the negative feelings that typify this stage are absolutely essential for a good outcome (Castonguay et al., 1998).

HOW STRUCTURED GROUP MODELS CAN AUGMENT GROUP DEVELOPMENT

Those trained in the cognitive and behavioral traditions appreciate the importance of structure, which encourages high levels of specificity in articulating a group therapy model. Were these same therapists willing to regularly integrate the theory of development into their model, we would expect the same level of pith and precision in their presentation. There is good reason and empirical support for the efficacy of this incisiveness, and group therapists trained in an unstructured tradition could benefit from integrating some of this specificity into their technical armamentarium.

For example, high levels of structure can lead to fewer casualties at the initial stage of group, when dropout is most likely (Piper, Debbane, Garant, & Bienvenu, 1979). At the beginning of any group, members experience a certain amount of anxiety. This anxiety, as discussed earlier, is precipitated by not knowing what to expect. It is also instigated by the demand on members to forge interpersonal connections. Lack of participation increases the likelihood of dropout (Oei & Kazmierczak, 1997). Carefully constructed structured exercises, sometimes known as ice breakers, reduce this anticipatory anxiety; sanction a certain kind of connection; and, properly positioned, can aid in group development (Evensen & Bednar, 1978; Stockton et al., 1992). Having a repertoire of exercises designed to contain strong affects or evoke and increase awareness of unarticulated feelings may actually further group development and individual growth.

Sometimes, however, the anxiety is overwhelming, as is the case for patients with social phobia. The use of relaxation training and mindfulness, often a part of many structured approaches, can aid in the decrease of overwhelming anxiety, allowing members the energy to begin forming bonds. J. G. Beck and Coffey (2005) worked with patients with PTSD resulting from motor vehicle accidents. Patients driving to sessions were agitated and anxious, but mindfulness training at the beginning of each session helped decrease this intense anxiety.

Most structured models involve the formulation of an agenda for each session specifying what each member will accomplish in the session. Research has shown that agendas change over time (Kivlighan & Jauquet, 1990). With time, goals become more focused on the here and now and more interper-
sonal rather than intrapsychic. Although instituting articulated agendas may disrupt an unstructured group process, the leader's attention toward the implicit goals of the individual with efforts toward moving these in the direction of the interpersonal here and now is likely to help the progression to a mature phase.

Another contribution structured models can make is that their interventions use a language that is closer to accessible experience than more traditional unstructured models. For instance, we have found that patients are more willing to examine "automatic thoughts" than consider what may be in their "unconscious." Similarly, group development might be better fostered were psychotherapists able to talk where members live emotionally and cognitively. Vague interpretations foster distance from psychotherapeutic process (Yalom, 1995). Descriptions of schemas can be more incisive, closer to consciousness, and easier for group members to accept than some of the psychodynamic interpretations of unconscious conflicts or internalized images that therapists make.

Experience with high levels of specificity in feedback, the hallmark of the more structured models of group, is likely to aid the therapist in helping members formulate specific feedback to others, particularly when there is a tendency among members to provide more global and impressionistic comments in Stages 3 and 4. The shaping of the specificity is determined by the particular model used. For example, in social skills training, specific feedback is modeled initially by the therapist. As the group progresses, after a role-play, members are helped to formulate what went well. After this is exhausted, there is usually one person permitted to indicate what would improve the performance. Over time, members hone their observational skills and learn to give very detailed feedback.

SUMMARY

In this chapter, we have shown that the cognitive, cognitive-behavioral, and behavioral group models involve a higher level of structure in both content and process than do the more unstructured groups on which group development theory and research is based. Structured content does not preclude group development. A structured process may affect development, depending on the degree and type of structure in the sessions. In the research presented, some structure may foster group progression. Structured exercises and procedures at the commencement of group may encourage participation, decrease anxiety, and enhance group development. Structured approaches that can accommodate and encourage member-to-member interactions and cultivate responsibility for the group foster its progression. Vignettes for each of the stages of group development using structured models have been presented, and they have demonstrated that a therapist can adhere to the model.
and at the same time engage in responses that deal with the tasks required for that stage of development. Group therapists conducting unstructured groups could widen their therapeutic repertoire by learning from the techniques used in structural models to provide specificity and incisiveness to their interventions.