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Therapeutic Factors: a Process Study of Small Group Psychotherapy

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By

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ABSTRACT

There is a need for structured research into the psychodynamic psychotherapies to strengthen evidence-based practice knowledge and communicate this knowledge to practitioners and funders. We know that group psychotherapy is effective, but many outcome assessment instruments fail to reflect process and individual experience. The current study used the Therapeutic Factors Questionnaire in an attempt to add to research knowledge of process.

In this exploratory study, twenty-two participants in small group psychotherapy at a day attendance therapeutic community rated eleven factors for perceived helpfulness in a modified version of Yalom's Therapeutic Factors Questionnaire, at five time points in the year. Therapists completed an identical version for each member, conveying what they thought each member had found most helpful in that period. Members who had been in the group for a year participated in a semi-structured interview, which was analysed using Interpretative Phenomenological Analysis. TFQ data was collated into three six-month phases dependent on length of time in the group. Admission data on individual clinical problems was coded by the researcher into nine categories.

Lower than expected numbers made the drawing of conclusions from the quantitative data impossible, though statistical analysis showed certain trends. However, interviews provided a particularly rich source of information, which also suggested that the TFQ trends were probably authentic. Two complete cases were explored in terms of the relationship between TFQ and interview results

CHAPTER 1. INTRODUCTION – PART 1

1.1 PREFACE

There is by now a wealth of evidence that group psychotherapy is clinically effective for a variety of patient populations, in a variety of settings. (Yalom, 1985; Roth and Fonagy, 1996; Greene, 2000; Pines and Schlapobersky, 2000) Our understanding of this most complex phenomenon has developed throughout the twentieth century as a result of clinical practice, research work and the interplay between them. This interplay has often been fraught, for clinicians worry that research intrudes on the therapeutic process and researchers mistrust the inference, lack of quantifiable evidence and theory driven nature of psychotherapy. (Coche & Dies, 1981; Dies, 1983; Clulow, Shmueli, Vincent and Evans, 2002) However, group psychotherapy is increasingly being seen as clinically and economically effective. The majority of studies have been focused on outcome, though more recently there has also been considerable interest in the process of group therapy. Typically, research now focuses on patient populations with complex psychopathology and may include measures of symptomatology and functioning. As clinical intervention has become more patient orientated, so has an awareness of our need to understand the patient's therapeutic experiences subjectively as well as objectively. [1]

Research on therapeutic factors and other definable aspects of the group process offers a structure in which to explore, define and draw tentative conclusions about what is most helpful and decisive in a therapeutic group. This forms the background of the current research. This study arises out of questions about *how and why* small group psychotherapy works. There are diverse ways of approaching these questions. The

[1] *The form of therapy under scrutiny here is psychoanalytically informed. In the literature, the terms 'therapy' and 'psychotherapy' are variously used by researchers to describe behavioural, cognitive-behavioural and counselling orientations.*

current research attempts a study of process, that is, "the fluid and dynamic fluctuation of emotion and experience, the business of relating and communicating and the change of association and inter-member responses." (Pines and Schlapobersky, 2000) It is based upon the Therapeutic Factor theories and related questionnaire of Irvin D. Yalom (1975/1985) and will review relevant research. This will be preceded by a brief account of the evolution of ideas about how groups function, with attention given to psychoanalytic views of group dynamics. It will be followed by a review of the conceptual underpinning of individual therapeutic factors and where available, the research related to each factor.

It has often been argued that the dynamic process of psychotherapeutic interaction can hardly be externalized sufficiently or reliably enough to meet the psychometric requirements of objective research. Indeed, the presence of research alters group process, and this influences research findings particularly powerfully in dynamic therapy. Moreover, many research studies of group psychotherapy do not reflect the practice of psychoanalytically oriented group therapy in self-motivated outpatient sessions. In the last decade, however, the demand for evidence-based practice has forced all forms of psychotherapy to struggle with the application of research methods, particularly in relation to outcome/effectiveness. (Roth and Fonagy, 1996; Chiesa and Fonagy, 1996) While many outcome studies have inevitably ignored the significance of process in therapy and use blunt measures of psychological experience, other studies have shown that there *are* imaginative ways to steer through the "methodological morass" (Yalom, 1985) of measuring process.

1.2 PSYCHOANALYSIS AND GROUP PSYCHOTHERAPY

Ideas about the theory and practice of group therapy developed largely out of the psychoanalytic milieu. This is particularly true of small group therapy in therapeutic communities, as both group process and the communities share some mutual origins. There are also wider applications since group analytic psychotherapy is widely practised both within the National Health Service and outside it. This section will very briefly consider the evolution of group therapy, in terms of those clinicians who have most influenced the small group therapy model experienced by participants in this research study.

For this reason, the important work of sociologists such as Kurt Lewin or Jacob Moreno is not considered here and neither are the many and varied approaches to group experience of cognitive or experiential proponents, though these too have made vital contributions to the field. Nor is attention given to cross-cultural anthropological studies of use of the group situation for a variety of purposes, though it is recognized that the concept of the group as a powerful medium for achievement and change is far from new.

Early Origins of Group Psychotherapy

The value of group psychotherapy has been recognized since the turn of the last century, when Joseph Pratt employed the group situation of the TB sanitorium for health-education purposes. (Pratt, 1917) A range of innovations followed, some of them unusual. For example, Cody Marsh, a psychiatrist related to Wild West Bill Cody, included tap dancing classes (an early form of dance therapy?) in his hospital regime, saying "By the crowd they have been broken, by the crowd they shall be healed." (Pines and Schlapobersky, 2000) A little later, Freud turned his attention to the group in 'Group

Psychology and the Analysis of the Ego' (Freud, 1921) and thus initiated a psychoanalytic interest in social group process in general.

Trigant Burrow, an American psychoanalyst, pioneered the use of groups and the term 'group analysis'. Initially, group therapy was based on Freudian analysis, with the therapist working in groups with each patient via the individual transference, but Burrow was perhaps the first to see that the conflicts and problems of groups are a product of the group as a whole, rather than a conglomeration of individual tensions. (Burrow, 1924)

This constituted a real shift of paradigm and laid the basis for those developments in Britain and America, during and after the Second World War, which led to the establishment of group psychotherapy as an accepted medium for therapy (Whiteley and Gordon, 1979). It also led, via the growth of an English school, to the rebirth of the therapeutic community concept first practised by Benjamin Tuke at the York Retreat in 1796. (Kennard, 1998)

Contemporary Underpinnings of Group Psychotherapy

A number of analysts have made lasting contributions to both the theory and practice of small group therapy. S.H. Foulkes had been a member of the Frankfurt Institute before he fled Nazi Germany and brought from his background a socially constructed Marxist view of psychoanalytic practice. He applied this creatively to group work at the Northfields Army Neurosis Unit, conceptualizing the network of interpersonal communications in the group as the *group matrix.* In his view, the group leader was part of the interpersonal interaction and other members could also make interpretations. This was therefore a more *interactive* model, but like Burrow, Foulkes treated the group as an

entity with its own dynamic process. (Whiteley and Gordon, 1979) After experimentation with various approaches, he identified a new meaning in the psychotherapeutic group, describing it as "reflective", its role being to impart insight into "both the profound and individual, the general and the universal turmoil of life". (Foulkes, 1946) Foulkes' understanding of group process, coupled with the similarly interactive models of the 'Ego Psychology" analysts such as Stack Sullivan, Horney and Fromm in America, has been most closely adopted by the Institute of Group Analysis and the Group Analytic Practice, the two major independent practitioner organizations in this country. The same two sources also profoundly influenced the later work of Irvin Yalom (1985), with which this study is closely associated.

A further influence in the development of small group psychotherapy came from W. Bion, whose work (1961) has been widely incorporated into the theory and practice of psychoanalytic group therapy in this country, though it is most closely followed by the Tavistock Clinic. Bion, like Burrow (op. cit.) used the group medium to explore 'here and now interactions' within the group. Coming from a Kleinian perspective, Bion identified the processes aroused by anxiety in the group as engendering "the psychotic group" as opposed to the task orientated "work group". The psychotic group process is active at an unconscious level and at this level the group may make a number of "basic assumptions", which are fluid defences against anxiety. These assumptions describe the dynamics of relating in the group to the leader or to other members and are all ways of avoiding the creative task of the group, which is lasting personal change. Bion placed more emphasis on the role of group leader than Foulkes.

1.3 EARLY THEORIES OF THERAPEUTIC FACTORS IN GROUPS

In order to attain a more objective understanding, some clinicians working with groups have attempted to make sense of the group process in terms of its elements or *factors*. After initial conceptual development, many of them attempted to apply these ideas to research. Unfortunately, much of the early research demonstrates more enthusiasm and imagination than methodological precision. In the last fifteen years there has been a move from vaguely defined and sometimes naïve approaches to more sophisticated and validated studies, often using the therapeutic factor *method* to study the totality of the group process. There follows a brief outline of the evolution of the therapeutic factor concept.

Therapeutic Factors

According to Yalom, whose "Theory and Practice of Group Psychotherapy" (1975; 1985)[2] was an extensive and highly influential account of groups, therapeutic factors in group therapy emanate from the interaction of patients, therapy and research. A useful definition is that of Bloch and Crouch (1985): "An element of group therapy that contributes to improvement in a patient's condition and is a function of the actions of the group therapist, the other group members and the patient himself." The factor concept represents a human cognitive attempt to categorise, though inevitably it has always been in danger of over-simplification and confusion, given the overlapping complexity of group dynamics.

Slavson (1979) had recognized this in describing five major factors as inseparable, and clearly non-exclusivity raises problems for research.

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[2] *First published in 1975. This study uses the fourth edition, 1985*

Table 1.1 Slavson's "Factors" (1954)

Transference
Catharsis
Insight
Reality Testing
Sublimation

Foulkes distinguished between analytic and supportive factors (1964) and suggested four supportive factors, which were incorporated into Yalom's later set of twelve.

Table 1. 2. Foulkes' "Factors" (1964)

Acceptance
Universality
Guidance
Vicarious Learning

The major conceptual turning point was marked by Corsini and Rosen berg (1955) in a systematic, non-psychoanalytic review of "the dynamics that lead to successful therapy". Believing that all clinical ideas about therapeutic factors were derived from clinical observation and therefore at least partly valid, they conducted a very extensive literature search, categorising various statements according to hypotheses about the group process. From this they refined nine therapeutic factors in three superordinate sets, which "captured the essence of group therapy" (Bloch and Crouch, 1985) and have influenced much subsequent group research.

Table 1.3. Therapeutic Factors, Corsini and Rosenberg (1955)

Acceptance	Emotional
Altruism	
Transference	
Intellectualisation	Intellectual
Spectator Therapy	
Universalisation	
Interaction	Actional
Reality Testing	
Ventilation	

The definitions of these factors seem imprecise and do not describe the hypothesized mechanisms by which they are assumed to be therapeutic, but they offered a basis for further research. An innovative study carried out by Berzon, Pious and Parson (1963) used Corsini and Rosenberg's classification and was the first where patients' own views were sought; they also introduced the "critical incident" measure, since patients were asked to choose from the events of each group session the one they thought "contributed most to them personally". (Berzon et al, 1963) However, it was Yalom who took the most significant step, " in an attempt to take the therapeutic process apart and put it together again". (Yalom, 1985)

1.4 YALOM AND RESEARCH INTO THERAPEUTIC FACTORS

1975 saw the first publication of Yalom's "Theory and Practice of Group Psychotherapy", an attempt to co-ordinate clinical observation and theoretical formulation in order to initiate a process of research. He had been particularly influenced by the psychoanalytic "Ego Psychology" school, which stressed the importance of interpersonal interaction. (Stack Sullivan, 1953; Horney, 1950; Fromm, 1947)

Yalom's own contribution to factor categorization was an emphasis on *interpersonal learning* as an intrinsic part of group experience. According to his perspective of personality as a product of relationships with significant others, Yalom added two factors entitled: "Interpersonal Learning-Input" (social feedback within the group) and "Interpersonal Learning-Output" (learning more acceptable ways of relating to others). These provided more specific and measurable definitions than Corsini's "Interaction". Incorporating modified versions of Corsini and Rosenberg's nine factors and Slavson's five, Yalom added another six. (See Table1. 4)

Table 1. 4 Yalom's therapeutic factors with modifications (1975)

Altruism	Catharsis
Group Cohesiveness	Identification
Universality	Family Reenactment *
Interpersonal Learning-Input *	Self-Understanding
Interpersonal Learning-Output *	Instillation of Hope *
Guidance *	Existential Factors *

* Factors added by Yalom

Other factors were given different names, or omitted. The existential factor was in keeping with the humanistic world-view of the time. Later, Yalom collapsed the two interpersonal factors into one. (Yalom, 1985) [3]

Much of the subsequent research used Yalom's factor categories (not always precisely), though it largely failed to examine their construct validity. The frequent use of a single instrument *could* have facilitated between-study comparison, but the large number of unreplicated studies, part experimental, part systematic and clinical and part isolated group studies mitigated against this. Given the variety of method and setting and presentation of results, it is difficult to make the comparative evaluations a true critical analysis requires and therefore a detailed attempt to evaluate these studies will be found in Appendix E, omitting pre-1970s research unless of particular relevance. The rationale for the particular choice of factors used in this study will be found in the Method section (P. 77).

1.5 BRIEF SUMMARY OF FACTOR RESEARCH

The research area is disparate and confusing. Rather than universally agreed "mechanisms for change", there would seem to be a whole range of factors and dimensions across an array of settings, diagnostic groups and types of group therapy. Virtually all descriptions of group psychotherapy process need qualification by population group, length of treatment, phase of group, therapeutic contexts and therapist style. (Dies, 1993) There has been minimal investment in empirical assessment of the

3 The studies of Yalom, Tinklenberg and Gilula (1970) and Bloch, Reibstein, Crouch ,Holroyd and Themen (1979) are described in Part II of the Introduction.

therapeutic factors themselves, which has detracted from the quality and conclusiveness of this field. (Dies, op.cit; Bednar and Kaul, 1994; Crouch, Bloch and Wanlass, 1994)

Nevertheless, commonalities emerge empirically. Patients/participants do regard certain factors as central or helpful to their group experience (Orlinsky and Howard, 1986), and some studies have demonstrated links between factors felt to be helpful and improvement on outcome instruments (Tschuschke and Dies, 1994, see Appendix E), though very few studies give much information about which *specific* interventions facilitate these experiences. Consistently, interpersonal interaction, catharsis, cohesiveness/ acceptance and self-understanding are seen as most helpful. (Rorbaugh and Bartels, 1975; Butler and Fuhriman, 1980; Yalom, 1985; Colijn et al., 1991; MacKenzie, 1987) These studies are reviewed in Part II of the Introduction.

It may be useful at this point to summarise findings which rank the therapeutic value of the various factors. (Table 1.5 is reproduced in Appendix E, with the review of the relevant research into individual factors).

Table 1.5 Factors considered to be most therapeutic by outpatient therapy group members, as ranked in each study.

Researchers	Most Therapeutic Factors
Yalom, Tinklenberg & Gilula (1970) (See Introduction, Part II)	Learning from Interpersonal Input Catharsis Cohesiveness Self-Understanding
Weiner (1974) (See Appendix E)	Interpersonal Input Catharsis Self-understanding Cohesiveness
Rorbaugh and Bartels (1975) (See Appendix E)	Catharsis Cohesiveness Interpersonal Input Self-Understanding
Bloch et al (1979) (See Introduction, Part II)	Self-Understanding Self-Disclosure Learning from Interpersonal Interaction
Butler & Fuhriman (1980) (See Appendix E)	Self-Understanding Universality Interpersonal Input Catharsis

Table 1.5 (cont.)

Butler & Fuhriman (1983)	Self-Understanding
(See Appendix E)	Catharsis
	Universality
	Cohesiveness
Colijn et al (1991) (See Appendix E)	Interpersonal learning
	Catharsis
	Self-Understanding
	Cohesion

In a review of twenty-three factor-based studies, MacKenzie grouped the above factors in a first cluster which he called "psychological working dimensions", a middle group of "non-specific morale-boosting categories", namely, hope, altruism, universality and interpersonal output (this does not seem non-specific) and a cluster consisting of guidance, family reenactment and, from the early research, identification. This last cluster may be considered less helpful, or simply have poor item content and be less likely to be reported. (Mackenzie, 1987)

As it became apparent that therapeutic factors could not be understood to exist in an objective and unmediated sense, the focus of research started to shift away from manipulation of factors in short-term non-clinical and personal growth groups. Interest in both short and long-term psychotherapy groups and in the mechanisms for change in the group-as-a-whole as well as in the individual dominate contemporary research. Greater methodological sophistication has been acquired and researchers are dealing with the complexity of linking concepts and measures, process and outcome.

Few studies have attempted to relate therapeutic factor ratings to outcome, so that we do not accurately know how factors are related to improvement and the research (described in Appendix E) which did examine this did not always make the links in terms of Yalom's factors. One reason for this lies in the pitfalls inherent in defining factors and the concepts which underpin them with enough precision to operationalise them. Consequently, there are weaknesses in establishing significant relationships between variable, process and outcome. Inexact relationships between factor concepts and measures employed in data collection also give rise to problems of validity in process research, the lack of distinctiveness between some factors being the most often cited.

This research is now reviewed in Part II of the Introduction.

INTRODUCTION: PART II

1.6 PREFACE

There has been a major shift in research focus from a variety of therapy and experiential groups to more specific aspects (eg., setting, disorder) of psychotherapy groups. The client population now is typically suffering from a neurotic complaint, or within a specific diagnostic category such as an eating disorder, substance misuse, bereavement, childhood abuse or personality disorder. In essence, the research focus is on diverse and "real" clinical groups, often including measures of symptomatology and/or functional levels.

Some aspects of the group process have attracted more attention than others. The literature suggests that length of time in the group and personality affect ratings of therapeutic factors and these are two salient features of research which will be reviewed in this section. (Part II, **1.8** and **1.9,** respectively) A further topic of interest in this study is divergence between therapist and patient perceptions of the patient's experiences of the group, and their comparative ratings of therapeutic factors. There has been interest in the impact of the "leader" on outcome and process, but much less on therapist/patient agreement. (Part II, **1.10**)

1.7 METHODOLOGICAL CONSIDERATIONS IN THERAPEUTIC FACTOR RESEARCH

Two models have served as major resources for the current research and will be described here in some detail, in relation to the methodological issues they raise.

Yalom's Study (1970) [4]

Basing his rationale on a belief in the primacy of interaction in human development, Yalom introduced the original Therapeutic Factors "questionnaire" for his 1970 study of twenty "successful" out-patients (success being determined by patients' self-ratings, independent ratings, therapists' evaluations and length of time in treatment exceeding eight months). (Yalom, 1975, 1985) The average duration of therapy was sixteen months. Twelve factors were represented by sixty items, Q-sorted by the subject and the total scores for each factor rank-ordered for helpfulness. It seems that the judgments by which "successful" patients were obtained for this sample were not inter-rated for reliability, the definitive instrument was constructed on the basis of recommendations by several group therapists and apart from the face validity this provided, it does not appear to have been validated. Not a good methodological start for an instrument which became so popular! Nevertheless, subsequent use has indicated reasonable reliability and construct validity, though many aspects of the latter have been open to debate.

The three factors perceived by patients as most helpful (or 'curative' in the early studies) were Interpersonal Learning–Input (feedback about one's own behaviour), Catharsis and Acceptance (Cohesion). Family Reenactment, Guidance and Identification were viewed as least helpful. This set of results has been broadly reflected in the entire body of work built upon this first study of outpatients, though not always precisely, given the wide range of sample populations and designs. It is possible that the salience of the interpersonal aspect was a function of the double number of relevant items (Weiner, 1974), of the fact that the therapists' approach emphasised the interpersonal and perhaps of the fact that outpatients who possess a fair degree of personal integration, and probably

[4] *This study was carried out by Yalom, Tinklenberg and Gilula (1970), but was not published. It is described in Yalom's "Theory & Practice of Group Psychotherapy" (1975; 1985)*

education, benefit most from this approach. (Maxmen, 1973; Leszcz, Yalom and Norden, 1985)

Yalom himself held that the "here and now" of group interaction was the most vital mechanism for change, although he acknowledged that past processes in the individual make an *a*historical process impossible. He believed that the therapeutic process must involve both intense emotional experience (Catharsis) *and* cognitive reformulations (Self-Understanding). Yalom hypothesized that the rating of factors perceived as most helpful would vary according to the group setting, individual differences among participants and the stage of group development. (Yalom, 1985)

Recently research has been carried out which has distinguished clearly between comparing the *helpfulness* of the various factors and assessing if they are *present* in the group. (Hastings-Vertino, Getty and Wooldridge, 1996; Lese and McNair-Semands, 2000b) Lese and McNair-Semands have highlighted the lack of an empirically driven instrument which assesses the presence of all Yalom's therapeutic factors in a group, and point out that most published scales are not investigated after their initial study. To this end, they modified Yalom's Therapeutic Factors Q-sort, deriving eleven scales which they piloted with a variety of college counselling and therapy groups, reducing a large number of items and newly phrasing them, to elicit information as to the presence of factors in the group process. They found a high degree of internal consistency and good test-retest reliability for all factors except the family reenactment scale. They found that, on the basis of participants' scores, many factors correlated significantly.

A major problem with Yalom's factor concept has indeed been overlapping or non-exclusivity of factors. If factors are not separate entities, then they cannot be independently related to outcome. Lese and McNair-Semands (op.cit.) discussed possible explanations, ranging from the possibility that the factors are meaningless, through suggestions that there were flaws in their own scale construction, that the factors are over-inclusive enough to negate differences between them, or that some "nest" inside certain others (See also Fuhriman, Drescher, Hanson, Henrie and Rybicki, 1986, P. 40) to a realistic notion that factors are distinct but may correlate because they are definitionally and realistically related. That is the view of this author. They suggested that rather than struggling to empirically distinguish factors, we study "the complex and interrelated nature of factors impacting group development".

The Study of Bloch, Reibstein, Crouch, Holroyd and Themen (1979)

Bloch and Crouch (1979, 1985), reviewing the literature, commented on the adherence to theory at the expense of structured research. Their own research and model was based on Yalom's factor dimensions, with adaptations. They excluded Family Reenactment and the Existential factor because, they asserted, these are based on particular theoretical positions rather than being universal and they suggested that the former is incorporated in Self-Understanding. They also distinguished between Catharsis (the release of feelings) and a new factor of Self-Disclosure (release of information), which have different therapeutic effects. They developed an alternative method of data collection, which had first been used by Berzon (Berzon, Pious and Farson, 1963) and has since been employed by other researchers. It is variously called 'the most helpful/important event' or 'the critical incident' method.

In a more qualitative attempt to reduce bias and intrusiveness and avoid the methodological problems related to structured interview methods, Bloch, Reibstein, Crouch, Holroyd and Themen (1979) asked thirty-three neurotic or mildly personality disordered outpatients in long-term psychotherapy to describe the Most (personally) Important Event in the last three sessions every three weeks for six months. A team of three therapists assigned these to a set of ten therapeutic factors based on those of Yalom as described above. Self-Understanding emerged as most important in over a third of cases, followed by Self-Disclosure (18%) and Learning from Interpersonal Interaction (13%), with Acceptance, Vicarious Learning and Instillation of Hope of intermediate importance to participants.

It seemed that Bloch et al.'s introduction of Self-Disclosure was perceptive, given the difference in ranking between this factor and Catharsis (second and ninth, respectively). It may be that the high rankings of Catharsis in studies using Yalom's factor method are due to the divulging of personal material, rather than emotional discharge.

This episodic method is creative in that it does not dictate to subjects a specific list of items, and thus reduces bias, but some processes in the group are not necessarily related to specific *events*, or less so than others and it conveys incomplete information. Assumptions are also made that a therapeutic factor is more valued the more often it is reported (Hastings-Vertino, Getty and Wooldridge, 1996; Landau, 1991) and that the whole therapeutic process is no more than the sum of events. In fact, it cannot be summarized in a series of "snapshots" and the fluidity of group dynamics is one of the problems which bedevils this research field. Bloch et al. believed their method to be unobtrusive (sometimes to the point where patients could not identify *anything* of

importance!), but a questionnaire privately completed would not appear to be any more intrusive.

The use of judges to assign each event to a factor distorts the unbiased, subjective perceptions which were sought by this study. Moreover, the only form of validity was face validity and although reliability and feasibility studies were performed, all three judges agreed in only 48% of cases. The minimum requirement for assignment of factors was 67% agreement, so it appears that this aspect of the study was not reliable. (Landau, 1991 – unreported by Bloch et al. in their 1979 paper.)

Judges found some factors to overlap (eg., Self-understanding and Learning from Interpersonal Interaction). Bloch et al. raised the inevitable issue of diffuse factors and suggested "including all those elements common to conventionally practised group therapy in the fewest possible factors". (Bloch et al., 1979) [5] All factor researchers face a choice between using a very large number of items in an attempt to establish precise exclusivity of factors, or constructing a questionnaire which is more accessible but possibly less accurate because factor-concepts overlap.

The Most Helpful Event/ Critical Incident Method has been popular with a number of researchers. To test the method, MacKenzie applied it over thirty to forty sessions with thirty-four members of four outpatient groups, whose members were diagnosed with neurotic complaints or mild to moderate personality disorders. Rankings of factors were made by clinicians trained in this method. They were similar to those of Bloch et al. (op. cit.), though MacKenzie's patients rated Catharsis and Vicarious Learning higher. There

[5] *For a full description of adaptation of Yalom's factors by Bloch et al. (1979) see Method section.*

were methodological problems in rating factors, due to overlap between Self-Understanding, Learning from Interaction and Vicarious Learning, all subsumed by MacKenzie under the heading of Psychological Learning. Self-Disclosure and Catharsis were often mixed, as for Yalom. Acceptance, Hope and Universality tended to 'move' together, subsumed under Morale-raising. The data was reanalysed using these three clusters. MacKenzie attributed the ensuing low rater agreement to the large number of items and raters. Despite clear instructions, general themes were often reported rather than specific incidents. He suggested that category definitions should facilitate more precise coding of the material. (MacKenzie, 1987)

However, MacKenzie rightly asserted that questionnaires have neglected negative experiences (only inferences can be drawn from low scores on questionnaires), whereas when using the Critical Incident method, these were often raised. (MacKenzie, 1987) He suggested that we need a developmental approach to group therapy, with systematic data collection.

While asking more specific research questions, Kivligan and Mullison (1988) (See below P. 45, 56) demonstrated similar findings to those of Bloch using the Most Helpful Event method. They categorized Bloch et al.'s factors in three superordinate groups, namely, cognitive, affective and behavioural, rather in the manner of Corsini and Rosenberg (1953) and essentially in line with contemporary cognitive-behavioral theory, which describes domains rather than characteristic processes. Both Kivligan and Mullison and MacKenzie were moving towards a new type of conceptual model, which involves examining over-arching concepts, often aspects of individual personality or stages of group development.

(It should be noted that the increasingly popular preference in the 1990s for studying time-limited or short-term groups is more suited to structured and cognitive –behavioural group work than to psychodynamic psychotherapy.)

Dies reviewed the Multi-Dimensional model of Burlingame, Fuhriman and Drescher (1984). He outlined the inevitable tangle in a psychotherapy group of individual, group and psychological variables, the problematic assumption of uniformity across groups and the lack of concrete definition of the group process, as well as the need to integrate measures of process and outcome. Burlingame et al. had suggested replicating research along four dimensions: Person (population, diagnostic category), Variable, Measurement and Time. Dies added the dimension Context to this, though did not define it. (Dies, 1985)

This model offered an organised structure for research design, though it does not appear to have been used empirically. However, their plea for the need to study the group more comprehensively, rather than to focus on parts of a model or process *has* been espoused in some of the recent research described below. With hindsight, it seems likely that group research was for some time influenced by classical approaches to individual psychotherapy, though the concept of the group-as-a-whole is by no means a new one in the psychoanalytic world. (See Part I)

From a different perspective, Lieberman, who had carried out therapeutic factor research with Yalom and others, explored the epistemological question of whether the philosophy (orientation) of a particular group dictates the language of the explanations offered. (Lieberman, 1986) He suggested that group system properties have a major influence on

the *type* of events or experiences found helpful, which is undoubtedly true. Similarly, if a therapist is trained to stress a particular factor, that factor is more likely to be reflected in the patient's values and gains. While there can never be absolutes in the study of human emotion and interaction, this notion challenges the validity of all conclusions about group process. To support this view, it would be necessary to establish whether and how initial expectations act as determinants of ratings of helpfulness of, for example, therapeutic factors. It would also be necessary to conduct a large-scale comparative study of differently orientated therapeutic groups, using the same design and measure and controlling for other variables, to test this premise, a daunting prospect.

Size of Sample

There have been marked improvements in the methodological criteria of group psychotherapy research, but it still remains problematic to set up a large enough study to compare multiple groups. It has been speculated that one would need one hundred and eighty groups, with fifty therapists and twelve thousand patients to carry out a comprehensive study with randomized controlled trials! (Kaul and Bednar, 1986). Even without going to such lengths, large sample groups require substantial resources and assembling even a single psychotherapy group can be a lengthy process.

Piper (1993) suggested that a large sample is particularly important where the very subjective "Most Important Event" method is used and felt that where the events, rather than the patients, are the sample, findings are given a different perspective, though one might argue that the therapeutic factor questionnaire equally employs participant evaluation of variables.

Piper also cited drop-out or change of therapist as a problem (Piper, 1993), but it is the clinical attrition of patients which would seem to be the most universal problem, with far-reaching implications both for research and for the effectiveness of *offering* therapy. Many determinants of patient attrition have been identified, including socio-economic status, psychological mindedness, diagnosis, educational level and social isolation. (Self, 2003) This affects much psychological research as well as clinical intervention, and is one argument in support of using qualitative methods in conjunction with quantitative methods, since sheer quantity is hard to obtain except in extensive studies.

Patient Population

Some unresolved questions arise in relation to the use of the same methodological approach – for, instance, the therapeutic factors method – with a very wide variety of populations. The problem with earlier research has been that researchers have not always been clear whether they were adopting the method *in order* to establish differences between patient populations, or simply trying to replicate findings and ignoring patient population differences. This leaves us uncertain whether variations are functions of the questionnaire, real effects or properties of the factor method.

Some relatively recent studies are still attempting to simply replicate Yalom's work, while others have used the therapeutic factor method to examine the properties of the Therapeutic Factors. An example comprising both is the work of Colijn, Hoencamp, Van Der Spek and Duivenvoorden (1991). This was a large-scale Dutch work which studied twenty-two inpatient and outpatient psychotherapy groups. Unfortunately, the questionnaire was executed before a randomly chosen session, which resulted in some patients having participated in two sessions and some in one hundred. (70% had

completed 20-40 sessions.) This seems completely to ignore the potential influence of time on the group and must have created disparities. They too found that Interpersonal Learning and Catharsis were considered most helpful, followed by Self-Understanding and Cohesion (Acceptance). Given the findings of previous research about length of time in the group influencing perceptions of helpfulness of factors, and considering the research which demonstrates intrinsic differences between in- and outpatient samples, it is remarkable that their overall results did reflect those of earlier research. Does this indicate that Yalom's work is robust enough to withstand the flaws described above?

It is clear that some effects have been consistently replicated, some supporting the validity of the method and others indicating ways in which different groups find the various factors helpful. For example, Piper's own conclusions from his review of research (op. cit.) were that outpatient groups tended to value psychological learning, while inpatients valued more factors related to morale-building. One could argue that, although comparison becomes difficult where research aims are not made explicit, generally consistent findings across different populations or designs indicate strength in the concepts and technique.

Relating Process to Outcome

While outcome research is not the topic under review, it is notable that we are still unsure as to whether the valuing of certain factors predicts or is even related to clinical improvement, since only a few studies have related the rating of therapeutic factors to outcome.

A significant deficit in those studies relating process variables to outcome is that these do not allow for the timing, quality or context of the variable (Dies, 1985; Piper, 1993), nor for the level of patient disorder. Some studies have made efforts to incorporate these aspects. (Burlingame and Fuhriman, 1986) The very complexity of the variables may produce a curvilinear or non-linear relationship, as for instance in the effects of level of self-disclosure. (Allen,1972; Morran, 1982, See Appendix E, pp.246/247 respectively) Correlational analyses of process outcome links have often been favoured, but it is always possible that unknown variables may be accounting for some of the relationships. This uncertainty is partly reduced by the use of more than one item per dimension in the rating scale, reinforcing the consistency of findings.

Some research has found that patients' perceptions of what was helpful in the group are not reliably related to individual change, though *therapists'* perceptions may demonstrate such correlations (Rorbaugh and Bartels, 1975))

Piper (1993) raised the issue of mediating variables, suggesting that in order to establish causal chains of action, we need to separately identify the characteristics of patients, relationships, therapists and the group, and consider the interaction of *all* of these. In this sense, it has been suggested that there are a) properties inherent in the individual's experience of the group (Insight, Catharsis), b) those specific to the experience with the therapist (Hope, Self-Disclosure), though these surely relate to the whole group experience, and c) others that are unique to the whole group (Reality-testing, Identification). (Fuhriman and Burlingame 1990) To elucidate these components has, however, always been the aim of researchers. The problem lies in finding reliable and replicable methods of doing this.

Measures

There is considerable variation in the detail of measures used in this research field, but to summarise, researchers have generally used either direct or scale measures. Direct measures involve using observers or raters of some kind. There is an assumption often made that this is more objective as observable behaviour is described and minimal inference is made about the subject's intention or internal state. (Both therapist and group members continuously make inferences about what is happening in the group.) However, the live observation used in some older studies clearly affects the group heavily as do other methods such as recording. Moreover, Lieberman's argument (op. cit.) is pertinent here, where group philosophy, too, will particularly influence the salience of what is observed and rated.

Scales, such as the Therapeutic Factor Questionnaire or other Likert scales, facilitate the combining of data across participants (or raters) and data points, but they assume equal intervals between rating points, which is statistically problematic and can give rise to ambiguous findings. The assumption that the summation of individual mean scores conveys information about the whole group raises problems in defining the meaning of group scores. (See Discussion section) Nor does this method address the "grey areas" between scales or dimensions, which may overlap. As indicated above, non-mutual exclusivity has been a problem in Yalom's therapeutic factors noted by numerous researchers, (Bloch and Crouch, 1979; Garfield and Bergin, 1986; Lese and Mcnair-Semands, 2000b) and many have struggled with the conceptual problems described above and more particularly with the methodological flaw constituted by non-exclusivity of therapeutic factors.

Properties of Therapeutic Factor Scales

Rorbaugh and Bartels (op.cit.) conducted a complex and influential study, questioning whether some factors are the *mechanisms* of change or the *conditions* for change. They used Yalom's Q-Sort factor method with seventy-two participants in thirteen groups, drawn from a variety of populations, and performed a Principal Components Analysis on the results. The first analysis produced eighteen clusters, but a second analysis revised the factors to fourteen, the rankings of which were similar to those of Yalom's study. Yalom had found that age, gender and time in therapy did not account for individual differences in ratings of therapeutic factors, whereas for Rorbaugh and Bartels, type of group, group size, time of testing and individual educational background appeared "to be somewhat more important in this respect than individual variables". Moreover, educational background and the valuing of 'relatedness' (similar to Cohesion) co-varied significantly. They suggested that a significant proportion of individual variation in perceptions of therapeutic factors can be accounted for empirically. The results of their multi-variate analysis showed that group characteristics and/or individual characteristics were significantly associated with thirteen of the fourteen item cluster scales. The individual differences which emerged were client group, not personality, traits, but the study does not appear to have attempted to elicit these. They concluded that some of Yalom's Therapeutic Questionnaire factors do have statistical as well as logical properties, though this study did not address internal consistency through item-scale correlations.

However, they also concluded that change processes defy definition or even description and that therefore measuring helpfulness of factors on the basis of evaluating *perceived* effects of Yalom's factors is of doubtful validity. We should refine and increase

specificity of particular factors to advance conceptual clarity and objectivity and combine subjective reports with objective observational methods.

Unfortunately, they did not publish any further work on this perennial dichotomy between subjectivity/objectivity. A related research problem, well summarized by Fonagy and Roth (1998), is essentially one of internal versus external validity. The former provides information about the extent to which causal relationships can be inferred between variables, but the most suitable techniques for this purpose may threaten the extent to which the inferred causality can be generally, that is, externally, validated.

This difficulty particularly affects the internalized and subtle process of psychotherapy groups and is compounded by another conceptual stumbling-block. MacKenzie asserted that " Much of the research is based on the *assumption* (author's italics) that the effects of therapeutic experience can be examined by studying patients' perceptions of process.....and that subsequent behaviour is highly influenced by the process of personalized meaning attribution". Effects in terms of outcome are indeed problematic, but in terms of individual experience, it is hard to see how we can avoid this assumption. He advocated strategies which might reveal the mediating variables, for instance, the Critical Incident method. (MacKenzie, 1987)

Fuhriman, Drescher, Hanson, Henrie and Rybicki (1986) studied the consistent rating of Insight (Self-understanding), Interpersonal Learning, Cohesion and Catharsis above other factors, feeling that this may indeed be because they actually are key factors or perhaps other factors "nest" in them due to the overlap of factors. Equally, they may be necessary or sufficient conditions for change as well as effects of change. Alternatively, they may

simply carry the most valid or reliable items. From two principal components analyses, they identified five clusters:

1. A Cohesion scale - including all five of Yalom's items.
2. A Catharsis scale - all five items plus two from Interpersonal Learning.
3. An Insight scale - four out of Yalom's five items.
4. Two Interpersonal Learning items.
5. One Insight and one Interpersonal item.

They succeeded in obtaining (the first) four factors whose construct definitions and items did not overlap and suggest that interpersonal items may have been dispersed because they occur in an interpersonal *context,* which Yalom and others believe to be the core aspect of group therapy and therefore the wording of *all* items tends to acknowledge the process of activity with others. It could also be the case that it is more difficult to express the psychology of items in this factor – they depend on behaviour more than some more purely psychological, internal, factors.

Some researchers carrying out this type of study have started to develop new instruments based on therapeutic factors in the hope that these can be universally used in more cumulative research. Stone, Lewis and Beck (1994) modified the factors in a large-scale study of forty professional life growth groups. They administered a very abbreviated form of Yalom's questionnaire (fourteen, shortened, items). No pilot study was conducted to establish the validity of the new instrument, which was also given a very different slant, towards addressing career issues. Factor analysis yielded three superordinate categories, the strongest of which comprised Yalom's core elements. Given

the radical alterations to the questionnaire it seems that either unidentified variables were at work, or Yalom's method is one which is widely generalisable.

Hastings-Vertino, Getty and Wooldridge (1996) have been developing the Therapeutic Interaction Factors scale to measure the extent to which some of Yalom's factors are actually present in the group. They stress the need to examine the relationships between factors and outcomes objectively, rather than employ the patient's subjective view of the experience, moving their work into the arena of outcome studies whilst still exploring process. The issue of objective observational research versus subjective measures was hotly debated in the 1970s and Rorbaugh and Bartels (op. cit.) had found that participants' perceptions of helpfulness of factors were not necessarily related to independently measurable behaviours. Rater observation using one set of scales can more reliably facilitate comparisons between studies. However, the patient's contribution is vital to understanding how the group process helps and the authors themselves query whether even factors measured by observational tools correspond to the factors actually related to therapeutic outcome.

Another embryonic scale is that of Budman, Soldz, Demby, Davis and Merry (1993), though their Individual Group Member Interpersonal Process Scale (IGIPS) is concerned more with the measurement of group member behaviour. They used it in a twelve-patient group study of Cohesiveness, where it demonstrated that various observed participant behaviours were related to group Cohesion. The IGIPS measures, statement by statement, behavioural process dimensions hypothesized to be related to positive outcome (eg., "demonstrates self-awareness", "discloses personal material", "expresses affect"). The researchers felt hopeful that it could examine the intricacies of therapy group processes

and is "generic", in that it can be used appropriately with group therapies of varying orientations. Ratings were made by non-participants on each "burst of speech" of more than two words and details of, for example, agency, length of segment, focus etc. were recorded. Measures could thus be analysed for patient, group or session, and sequence can also be examined. This approach is multi-faceted and comprehensive, but requires fairly extensive resources.

A Multi-Dimensional Rating System has been attempted by Kivligan, Multon and Brossart (1996), using the Bloch et al. based Critical Incident method with two hundred and four growth group and seventy-four counselling group participants. A measure was also used which incorporated items from the Therapeutic Factors (Bloch et al., 1979), Categories of Good Moments (Mahrer and Nadler, 1986) and the Taxonomy of Helpful Impacts (Elliot, 1985). Principal Components Analysis revealed four factors which accounted for fifty-nine percent of the variance, namely: Emotional Awareness (Insight), Relationship Climate, Other Self Focus and Problem-Solving Behaviour.

Other methods of data collection have been attempted but apparently not successfully developed. Sampling employs a random cross-sectional approach, which has not been able to record fluctuations in sessions or to capture development of group or individual processes. (Garfield and Bergin, 1994) Sequential analysis is attracting some attention in group therapy research as it tracks which therapist interventions lead to which patient reactions, but it does not elucidate *how* a particular experience or interpretation leads to change neither does it provide links with outcome variables. Only immediate effects can be determined, which makes it inadequate for all but the most superficial of group approaches.

It has been said that many researchers develop measures for a study, which are never used again, though this is by no means entirely true, and that we should build on the past to allow replication. (Garfield and Bergin, 1990) In practice, with the focus on more incorporative aspects of the group process, there has been an interest in measures of the therapeutic alliance and/or group cohesiveness. (Budman et al., 1989; MacKenzie, 1981) Rather than continuing to struggle with the old methodological problems, researchers have moved the focus. This inevitably presents new problems, many of them very similar because they are intrinsic to the process of group psychotherapy.

1.8. LENGTH OF TIME IN THE GROUP / STAGE OF DEVELOPMENT

Some research into these variables confounds the length of time in the group with the *group's* developmental points. The two are not necessarily synonymous and a frequent turnover of patients in a slow-open group makes it impossible to assume that individual development parallels that of the group.

Butler and Fuhriman (1983) conducted an extensive (twenty-three outpatient groups) study of Level of Functioning and Time in treatment, examining outpatients' ratings of Yalom's TFQ at three time points (six months, seven months to two years and two years plus) in a cross-sectional and longitudinal design. (For a summary of time-orientated therapeutic factor studies, see Table 1.6, P.51) Cohesiveness, Self-Understanding and Interpersonal Learning Input /Output were rated significantly differently by patients at different time-points, but were all valued more highly the longer the patient had participated. Social experimentation also increased with time, presumably as a function of cohesion and confidence. Multi-variate analysis showed no significant interaction

effect between patient level of functioning and length of time in the group on any of the twelve factors, or overall. However, all results were mediated by High and Low levels of patient functioning and unsurprisingly, the four factors which accounted for most of the of the total effect of level of functioning were those found to most typically differentiate between more and less able clinical populations. (Catharsis, Self-Understanding and Interpersonal Learning Input and Output)

MacKenzie (1987) developed a Group Climate Questionnaire based on his model of group development. In his view, the first task of any treatment group is member acceptance and engagement. Yalom, however, had assumed it to be the need for orientation and the search for meaning – the sharing of experience led to a sense of universality of experience and thence to mutual understanding. On a more basic note, he also thought that the early group is concerned with individual struggle for survival and the establishing of boundaries. (Yalom, 1985)

The second stage of group development according to MacKenzie is one of differentiation, that is, recognition of differences between members, with fluctuating polarisations, rebellion against the group or group leader, anger, conflict and striving for dominance. Dies notes in his review (1993) that while there are multiple models of group development there is general agreement about the first two phases – though Yalom and MacKenzie clearly differed with regard to the important first stage tasks. In fact, it is striking that these stages mirror developmental models of infantile development. (Mahler, 1965; Hinshelwood,1994; Winnicott, 1965) If the first two stages are successfully negotiated, they are followed by the growth of individuation, emotional intimacy and mutuality within the group.

Kivligan and Mullisson (1988), however, found rather different outcomes to Yalom's in an exploratory study of participants in eleven week long counselling groups, using the critical incident method and the CLOIT behavioural assessment instrument. (See below, P.58) Universality was valued in the early weeks and Learning from Interpersonal Interaction achieved salience later, apparently doubling in perceived importance across the two temporal halves of the group. Hope and Guidance were valued late rather than early, surprisingly, and Acceptance (highly valued), Altruism, Self-Disclosure and Self-Understanding were stable across time. Yalom's hypothesis that the relative importance of factors would vary as a function of length of time in group was thus upheld, with some commonalities with the study of Butler and Fuhriman (op cit.), but the researchers rightly assert that Yalom does not propose a formulation of *development* which would enable clear connections to be made with the relative value of therapeutic factors. They do not discuss the fact that eleven weeks is a very short period in which to measure such variance, particularly since Yalom developed the TFQ scales with a group whose average length of stay was sixteen months. They concluded that there is a need for a more sophisticated model which incorporates ratings of factors with stages of group development, which Yalom did not do.

Subsequently, in a methodologically sophisticated and thoughtful study, Kivligan and Goldfine (1991) examined ratings of factors as a function of time, using the Yalom based therapeutic factor method of Bloch et al. (1979) and also the first three stages of MacKenzies's Group Climate Questionnaire (MacKenzie, 1983) to study the stages of group development. Mackenzie describes these as Engaged, Differentiation and Individuation. They found similar rankings to the Bloch et al. (1979) study (correlation between therapeutic factor rankings of the two studies: $r = .73$) and suggested that

although their sample was drawn from thirteen week long growth groups, findings were similar to clinical groups along several dimensions, thus supporting Yalom's hypothesis across different samples. The fact that the same "stages" occur in roughly the same order despite very different time spans might suggest that group members and therapists adjust in some way to knowing the length of time the group will run, which is curious, given that certain intrapersonal processes are known to be resolved in a long-term psychotherapy group only with time and personal struggle. However, the short life-span of their group suggests a different patient population.

Five out of the ten factors showed a significant and predicted relationship with stage of group and Hope and Guidance were again valued less in the early stages, as was Universality in this case. Catharsis was valued throughout and highly in the later Individuation stage, suggesting that personal exploration might develop with time and confidence in the group. Acceptance was highly valued in the first and third stage – perhaps where individual commitment and later exploration of personal issues predominated. The other five factors showed no relationship with stage of group. The researchers suggested that a more complex stage model might elicit these, but acknowledged that the use of such models would require more reliable methods of stage definition. Again, the time span may have been too short to engender or trace reliable and meaningful changes. It may also be the case that different subjective experiences are articulated according to whether the group member is tested/reflects on the most recent experiences or reviews the whole time in the group on its termination, when some over-arching "rearrangement" may take place in the mind.

In the view of this author, this study exemplifies some of the ways in which exploratory psychological justifications or possibilities can *always* be found for results, even though these justifications may be contradictory across studies. This phenomenon is particularly striking in this area of research. The reasons lie in the large numbers and subtleties of variables in a highly complex psychological process, but unfortunately, they have often deflected attention from the ways in which variability of findings is very likely to be a function of methodology.

In a fine-grained piece of research focussing on Cohesiveness which cannot be fully described here, Budman et al. (1993) used two scales developed by themselves, the Community Health Plan Cohesiveness Scale and the IGIPS (see above, P.41) with twelve fifteen-week long groups. They selected thirty-nine segments of recording for analysis, of an intentionally wide-ranging nature, though this does not eliminate the bias intrinsic to any form of selection.

They found that particular patient *behaviours* as defined by the IGIPS and considered to relate to Cohesiveness varied at different stages of the group. At the beginning, the number of patient statements showed a significant relationship to Cohesiveness, becoming even stronger in the middle and disappearing later in the group. Cohesiveness correlated most powerfully to "sentiment quality" in the middle phase. Self-Disclosure was significantly related to Cohesiveness only early in the group. Discussion of self bore no relationship, though discussion of *others* was evidently the decisive element as it was significantly related early on.

In the first stage, the percentage of statements focussed on the therapist showed a strong negative correlation with Cohesiveness, dropped in the middle phase and partly recovered towards the end, still in a negative correlation.

Budman et al. suggested that that the IGIPS may be more sensitive to components of cohesion in the early stages as it characterised "good" (more cohesive) process more easily at that point. It is also possible that as the group proceeds, different forms of interaction may be associated with Cohesiveness, so that we cannot simply assert that it is greater or less at a given stage. They acknowledge that even what is considered "good" interaction varies with stage of group. Cohesiveness may be a function of "a very different array of interactions" and they advise that both research judgments and therapist approaches need to be phase specific. They caution against making global statements about cohesion which blur important phase dependent clinical distinctions. This could hold true for all the factors.

The researchers comment on their previous research on Cohesiveness and therapeutic change, suggesting that this set of detailed findings may have implications for outcome as well as process. This study underlines the sheer complexity of the research area precisely because it is detailed and thoughtful.

The above findings are challenged by two studies. Landau (1991) found no significant relationship between length of time in the group and importance of factors when factors were considered *jointly*. He used both Yalom's Therapeutic Factors questionnaire and Bloch et al.'s Most Important Event method to explore length of time and stage of personal development in the group, which he categorized in four different stages. Data

was collected on three occasions from forty-two outpatients in five slow-open groups. Rankings were high for Self-Disclosure, but not for Self-Understanding and Learning from Interaction, as had been hypothesised. When factors were considered separately, only two out of the ten factors were significantly affected by time in the group (Self-Disclosure and Instillation of Hope). Participants rated factors over four *stages* of development similarly, but therapists differentiated between stages of development. Therapists felt that participants in the early stage valued Guidance significantly more, and Acceptance was thought to be least valued during the 'Dissatisfaction' stage and most during the 'Resolution' stage.

Secondly, McNair-Semands and Lese (2000) hypothesized that the strength of factors simply increases over time. A study of fifteen therapy or support groups of college students supported their hypothesis, significantly for the factors Universality, Instillation of Hope, Imparting of Information (Self-Disclosure), Recapitulation of the Family, Cohesiveness and Catharsis. Their hypothesis was apparently based on their clinical experience with such groups, so the results may not be surprising, but since they run counter to much previous work, issues of generalisability arise. Importantly, like Hastings-Vertino et al. (op.cit.) they were examining *presence* of therapeutic factors, rather than helpfulness. One might conclude that if a factor is felt to be more present, it is viewed as more important, though not necessarily more helpful. However, there is a shading of "important" and "valued" and "helpful" as well as "present", which may or may not be problematic, as no one has clarified differences between these terms. For instance, does "helpful" equate to "important" if this description is made soon after an emotional or disturbing experience?

Summary

Comparing the above studies, we find that Acceptance is important across time, though group Cohesiveness may vary, but has generally been found to be important early. Self-Understanding is consistently valued early and Catharsis and Self-Disclosure are fairly stable across time, though varying between studies. Some aspect of socialization (Learning from Interpersonal Interaction or Vicarious Learning) features both early and late. The salience of Hope and Guidance late in both the Kivligan studies but not elsewhere suggests that it could be a function of their method. However, it could describe hope for life after the group rather than hope for alleviation of distress and an awareness of the help in self-directing that the group has given. All these factors, and particularly the first six can accurately be described as "conditions for change" and therefore would need to be paramount early in the group.

These findings not only provide valuable information about group process, they also offer pointers to those aspects which should be especially considered, supported and encouraged by group leaders. There may be "ideal levels" of process variables such as therapeutic factors which change over the life of the group. (Burlingame, Fuhriman and Johnson, 2004) Clinicians should focus on encouraging group support, acceptance and attendance in the early stages (Dies, 1993) rather than immediately trying to foster insight or mutuality.

Table 1.6

Most valued Therapeutic factors by Length of Time in Group

	Early	Late
Butler & Fuhriman, 1983	Cohesion	
	Self-Understanding	
	Interpersonal Learning–Output/ Input	
Kivligan & Mullison, 1988	Universality	Learning from
		Interpers.Interaction
		Hope & Guidance
	Acceptance, Self-Understanding	Stable over Time
	& Self-Disclosure	"
	Altruism	"
Kivligan& Goldfine, 1991	Self-understanding, Acceptance	Hope & Guidance
	& Vicarious Learning	Universality
	Catharsis	Catharsis
Bloch et al., 1979	Self-Understanding	
	Acceptance	
	Vicarious Learning	
McNair-Semands & Lese, 2000	All scores increased over Time.	
	Universality, Hope, Imparting information (Self-Disc.),	
	Cohesiveness, Catharsis and Recapitulation of the family	
	reached significance.	

1.9 DIFFERENCES IN SAMPLE POPULATIONS AND INDIVIDUAL DIFFERENCES

Sample populations

Some researchers have regarded differences between sample populations as the prime variable to be explored. Maxmen (1973) studied one hundred hospital inpatients in very short-term daily groups using Yalom's Therapeutic factors Q-sort method and found marked differences between his Yalom based hypotheses and his own patients' ratings of the helpfulness of curative (therapeutic factors). He suggested that since hospitalized patients often feel stigmatized and "at the end of the road" they value Hope and Universality highly, discovering in the group that others have similar adverse experiences and that some may have recuperated.

Equally, the surprising salience of Cohesion in such short-term groups may be explained by the fact that the groups met daily and were in each other's company almost eighteen hours a day and in fact became noticeably more tolerant of each other through being accepted within the group. Lastly, Altruism was highly valued, perhaps as a temporary emotional boost to the self- esteem which results from belonging and sharing within the group. Since then, many studies have demonstrated similar differences between in- and outpatient groups. (Leszcz, Yalom and Norden, 1985; Butler and Fuhriman, 1989; Gonzalez de Chavez Gutierrez, Ducaju and Fraile, 2000) It has been one of the strongest research findings in this field, though there is often conflation of inpatient samples with patients suffering from mental illness. This may be a function of the rarity in 1970s and 80s America of finding identified personality disordered patients in mental health institutions.

Significant differences between in- and outpatient preferences have been found on particular factors, namely: Cohesiveness/Acceptance, Interpersonal Learning, Family Reenactment, Catharsis, Guidance, Self-Understanding and Universality. Butler and Fuhriman identified these differences in their 1980 study of both kinds of patient groups, but included Identification rather than Catharsis or Guidance. Their review of the literature on curative factors found that seven outpatient groups drawn from several different sources all showed remarkably consistent values.

Butler and Fuhriman's 1983 study described above (P.43) also examined levels of patient functioning in order to test Yalom's hypothesis about individual differences, dividing participants into those having moderate or slight difficulties in functioning. They found that Catharsis, Self-Understanding, Interpersonal Learning Input and Output were rated significantly more highly by the higher functioning group, thus reflecting the findings with most outpatient or personal growth groups. These factors are strongly related to the capacity of group members to cope with personal anxiety. They noted that social experimentation increased with time in one group as Cohesion developed and facilitated a safe and containing environment. Higher functioning patients appear to value "an atmosphere of demand" more highly. Perhaps less psychologically robust members do value the same experiences, but they are less reinforcing because of the greater anxiety involved for them.

Leszcz, Yalom and Norden (1985) published results from a more complex study of fifty-one inpatients, exploring differences between inpatient groups and between patients who valued group therapy highly and those who did not. As in other findings, the latter sample valued Hope and Advice (Guidance) most and Self-understanding much less, also rating

Altruism low. The researchers felt that this was a reflection of the early state of the inpatient groups and the patients' traits, though Maxmen's patients had in fact also valued Altruism. A group of personality disordered and affectively disordered patients valued the psychotherapy groups most, while patients with a mental illness thought alternative kinds of group most helpful.

However, Marcovitz and Smith (1983) found that thirty in-patients in a study of group therapy valued Catharsis above all factors and rated Self-Understanding and Interpersonal Learning fourth, similarly to Butler and Fuhriman's study and in Yalom's original work. Hope was of only moderate importance. They attributed these similarities to therapist approach, their group being psychodynamic like Yalom's, whereas Maxmen's was behavioural. This is yet another instance of an important variable confounding replication. It also points to a certain tautology in the findings for many inpatient groups, since the rationale for Maxmen's more behavioural approach was that it was more suited to psychiatric patients whose ego-structure is fragile.

Further reinforcing the necessity of adapting group orientation to the needs and abilities of specific patient populations and individuals, a study of patients suffering from loss found a significant relationship between "psychological mindedness" in group members and incidence of both staying and working in the group. (Piper and McCallum, 1992)

Macaskill's work (1982) demonstrates the difficulties of interpreting results without reference to what may be very specific and crucial variations in sample group. He studied a group of eight patients with Borderline Personality Disorder. They completed self-reports with a Yes-No answer scale and one item only for each of Yalom's factors,

though there are good conceptual and methodological reasons for not drastically reducing this instrument. Self-Understanding was valued most, followed by Hope, Catharsis and the Existential Factor. Acceptance was rated low, as were the interpersonal categories – perhaps a reflection of the narcissistic core of the disorder. Macaskill plausibly surmises that the sessions served almost as individual therapy in the first year and interaction was perceived as critical and threatening. Perhaps hope would be important to people who had endured the hopelessness of early trauma, but Acceptance might challenge the narcissistic injuries of these patients and threaten them with loss of ego-boundaries. Thus we cannot assume that, while some outpatient groups include patients with a degree of various personality disorders, the group process of *more* specific and severely affected clinical groups will be characterized by typical outpatient experiences of helpfulness. However, given that we know that the items which compose Yalom's factors do not in all cases describe a unitary factor, one cannot be clear about the constructs which McCaskill was measuring with single items.

This author has not found factorial research in therapy groups in therapeutic communities, who have other foci of research. However, a study at the Henderson Hospital, originating from concerns about the lack of relationship between progress in hospital and after discharge, adopted the Most Important Event technique and found that half of these were perceived to take place in small therapy groups and half in daily community living outside the group. Staff members (including therapists) figured little in these events, but patients who established a relationship with a key staff figure showed greater improvement. (Whitely and Collis, 1973)

Individual Differences

Yalom's second hypothesis has attracted less attention than comparisons between patient population groups, perhaps because of the particular intricacies of studying this aspect. He suggested, following Stack Sullivan (1953), that individuals will perceive and interact with others in ways that maintain their interactive style or problems and that the group process can influence this positively. However, the ways in which the individual perceives the group experience will be influenced by both these and other aspects of their personality. He also suggested that patients' views are inevitably distorted by their therapist's approach, and Lieberman has presented a more sophisticated argument in this vein. (Lieberman, 1983. See P.33)

There is a problem of homogeneity of sample. This may create skewed findings in real-life clinical groups, which are assembled to comprise similar pathologies and experiences, or like-minded individuals. A study of thirteen therapy and human relations groups, which were considerably varied in terms of sample composition found that personal characteristics did account for some of the variance in ratings of therapeutic factors for helpfulness, but group variables were more decisive. (Rorbaugh and Bartels, op. cit.) They found that the more educated members valued relatedness (similar to Cohesion) more highly.

Affiliativeness

Believing that previous research into therapeutic factors and group development had been too simplistic in the light of current understanding of the stage and fluidity of group development, Kivligan and Mullison (1988) used Kiesler's theoretical model of interpersonal behaviour and attitude. Kiesler's Checklist of Interpersonal Transactions

(CLOIT) classifies individual differences along the dimensions of Affiliativeness – a more interactional interpersonal style versus a reflective style, and Dominance – Submissiveness. In the study of eighteen student participants in eleven week counselling groups described above, Kivligan and Mulisson (op. cit.) employed the CLOIT together with Bloch et al.'s Most Helpful Event method and demonstrated partial support for Yalom's hypothesis of individual differences. Those participants who were more affiliative emphasized Self-Understanding, whereas those who were less so valued Self-Discovery, Learning from Interpersonal Interaction and Altruism most. There were no significant factorial differences on the Dominance scale. If participation in group psychotherapy is viewed as a personal journey, this would suggest that affiliative patients start from an advanced position in terms of insight.

Filak, Abeles and Norquist (1986) also found that outpatients in twenty-four session groups, when rated as "successful" by both self and therapist, were significantly more affiliative before and after therapy than less "successful" clients. Seventy-two per cent of the affiliative group were "successful", as opposed to thirty-eight percent of the less affiliative. Again, there were no significant differences on the control dimension.

Kivligan and Goldfine (1991) then used a similar approach in their 1991 study with thirty-six growth group members and concluded from this that participants defined as Affiliative emphasised 'cognitive' therapeutic factors such as Self-Understanding and Vicarious Learning. Non-affiliative members placed greater value on behavioural factors. (Learning from Interpersonal Actions, Altruism). Participants categorized as "Friendly-Submissive" and "Hostile-Dominant" reported more incidents of perceived Acceptance than "Friendly-Dominant" or "Hostile-Submissive". The researchers felt that the group

gave Hostile-Dominant members a chance not to push others away and therefore Acceptance was valued, while the Friendly-Submissive members entered the group ready and able to elicit Acceptance.

It appears likely, that within a group, affiliativeness or the ability to relate to others should be closely related to individual improvement, in the same way that personal reflectivity has usually been understood to be a requisite for successful individual psychotherapy. A comparative study found that on four dimensions of session impact, Relationship-Climate and Self-Other Focus were rated significantly higher by group participants, and Emotional Awareness/Insight and Problem Definition ratings were higher for participants in individual treatment. (Holmes, Kivligan and Dennis, 2000)

There are clearly many other possible dimensions and ways of classifying personal characteristics. Shaughnessy and Kivligan (1995) reversed the usual direction of factor research and used client perceptions of therapeutic factors to define client typologies. They did this by asking college students taking part in groups to complete a critical incident form based on Bloch et al.'s (op. cit.) ten factors after *each* session. They identified four types of responders: Broad-spectrum, Self-reflective, Other-directed and Affective. Where these kinds of personality attributes seem to be increasingly attracting attention, therapeutic factors are typically being used to explore the attributes and their implications, rather than constituting the object of research.

Mcnair-Semands and Lese (2000), working on Yalom's 'group as social microcosm' assertion that people will perceive others in ways that maintain their interpersonal problems, found that participants self-rating as unassertive and "too responsible" for

others perceived the group as significantly higher in altruism than those who self-rated as more dominant, who perceived altruism, imitative behaviour, socialization and interpersonal learning as less present earlier in the group. Later, the more dominant participants were less likely to perceive the group as instilling hope, reenacting family dynamics and ennabling imitative behaviour. These findings concur with clinical thinking – people who (need to) control others may be more psychologically defended and less able to allow the degree of vulnerability needed to form attachments, or to listen and learn from others.

1.10 THERAPIST AND PATIENT DIVERGENCE

The potential for differences in therapist and patient perceptions and possible changes in these over time has not been of prime interest to many researchers, yet is surely revealing and possibly influential in treatment. Burlingame, Fuhriman and Johnson (2004) point to the reliance on client self-report alone as a limitation of therapeutic factor methodology which may fail to capture the complexity of the therapeutic process. Bloch and Reibstein (1980) examined this aspect in their 1979 study. In thirty-eight percent of cases the therapist recorded for the patient Most Helpful Events characterised by Self-Understanding, Learning from Interaction, Self-Disclosure and Acceptance. Patients recorded Self-Understanding in thirty-seven per cent of Events, followed by Self-Disclosure and Learning from Interaction, but also Instillation of Hope and Vicarious Learning. Other factors were infrequently selected by both groups.

Despite the degree of convergence in these results, Bloch and Reibstein (op.cit.) found that therapists and patients appeared to hold generally divergent views. Therapists

emphasized behavioural and objective factors and patients cognitive, subjective ones. Many factors encompass both. Self-Understanding, for example, includes both events where something is reflected back to the patient *and* internal self-analysis. Bloch et al. pointed out that, like Yalom, their theoretical approach may lead them to stress some aspects of the group process more than others. (See also Lieberman, 1983)

Dies conceptualizes group process differently for therapists when he says that therapists move back and forth between their conceptualization of client behaviour and group process on the one hand and the "data base" of what clients do within and outside the group on the other. (Dies, 1983)

Schaffer and Dreyer (1982) explored divergence in a short-term crisis unit based on Social Learning Theory, though they did not use Yalom's model. They found a moderate degree of stability in patient/therapist perceptions over the eight-day period, but very little convergence. Staff felt that being able to express one's feelings, modelling on other members and behavioural experimentation were most important in encounter groups, whereas patients regarded Self-Understanding and Self-Responsibility more highly. The experimenters point to the possible interaction of personality and outcome in determining perceptions of therapeutic mechanisms. A more likely explanation might lie in the training of staff in behavioural methods.

Landau's study (1991), described above, examined therapist-patient divergence, finding that therapists allocated participants to the early "orientation" stage three times more often, whilst they were less likely to place participants in the "Dissatisfaction" stage.

Therapists also differentiated between relative presence of some factors in the differentiation stage of development, whereas participants did not.

In a broad-ranging innovation and study of the transition of a psychiatric unit in Greece to psychodynamic and therapeutic principles, Pappas, Yannitsi and Liannos (1997) found that both staff and patients rated Acceptance most highly, followed by Learning from Interpersonal Interaction and Universality, but the last two were doubly stressed by staff, lending support to the view that therapists value observable, behavioural change. This study employed ranking methods using very simple questionnaires they had devised. Bloch and Reibstein (1980), however, suggested that because the critical incident method was subjective, it was inherently biased against the observer and that this could explain why therapists had appeared to emphasise more (observable) behavioural factors in their own study.

Finally, Maxmen(1973) referred to the notion that therapists offer a role model for patients as a "charming theory". He pointed out that what patients want is to be like their own healthy selves!

Despite the paucity of research on this aspect of group process some interesting questions present themselves. To what extent are patient ratings of factors influenced by therapist style and orientation? Therapy is unavoidably a value-laden process, but we do not have much information on how these values influence what patients find most helpful in group psychotherapy. Theoretical distinctions can be made between therapists' personal values and therapeutic values intrinsic to their orientation, though clearly these merge. However, from a practical and clinical outcome perspective, comparisons of patients treated by

therapy with people not in treatment tend to produce much larger effect sizes than comparisons between groups all receiving treatment with therapists of different orientations, indicating the value of the relationship rather than therapist orientation.

Though there are studies of personal therapist variables and outcome in therapy, there is no body of research on how or if therapist personality attributes affect process and ratings of helpfulness of factors. Had there been, there would probably have been greater interest in divergence of patient and therapist perceptions. It would also be of value to understand whether therapists' perceptions are related solely to individual change, as for patients, or whether they are more influenced by their knowledge of group process.

1.11 EMERGING RESEARCH QUESTIONS [6]

Process

It might be thought that previous factor based research has demonstrated problems of application of theory to practice which should lead us away from the notion that we can ever satisfactorily establish what the various elements of group psychotherapy are. Nevertheless, the commonalities which *have* been found legitimate this approach as a way of understanding participants' experience in the group in a communicable way. This constitutes the rationale for choosing Yalom's therapeutic factor method to address the question "What aspects of group experience are most helpful?" in this study. The psychoanalytic method of understanding groups may have greater facility in terms of exploring both depth and breadth in post-session supervision, but requires complex and

[6] *Research questions and hypotheses are formally stated in the Method section.*

lengthy research methodology. The episodic method was not favoured because of its selectivity and inability to convey the "whole picture". Methodology can be devised using more than one measure in order to achieve a balance of objectivity and subjectivity, and simultaneously provide information about construct validity which is lacking in much of the earlier factor based research.

Length of Time

Clinical experience has frequently led the author to think about the impact of time on the unfolding of therapy, and the literature reviewed (See above and Table 1.6) indicates that time has a major influence on the therapeutic process in terms of what is most helpful/important at various time points. It seems constructive to try to elucidate this in a slow-open analytic group, as so much of the research has chosen to examine structured set time groups. However, this inevitably poses a specific problem of structuring and collating data, which is addressed in the Method section.

Individual Variables

It may well be that the impact of personality traits and organisation, or of clinical presentation, is subordinate to other group-as-a-whole processes, such as length of time in the group, leader attributes, setting, homogeneity or slow-open as opposed to closed groups. This is a methodologically complex area. If we examine personality organisation, for example, we would be likely to find that at different stages of therapy different personal attributes become salient. Moreover, there would be a need to differentiate between the development of the whole group and the individual, which, it seems, would be extremely difficult if not impossible. The more recent literature suggests that researchers have favoured individual variables which are mainly socially oriented traits.

However, since the current study springs from clinical concerns and in order to avoid some of these problems, it seems apposite to examine the variety of clinical features presented by the participants, such as relationship difficulties and the non-experience of a loving relationship in childhood, childhood abuse of all kinds, anxiety, substance misuse etc. How do these impact on the individual's experience of group psychotherapy and is their impact more or less powerful than that of other variables?

Therapist and patient agreement

The issue of shared perceptions between patients and therapists is under-addressed. Therapists may assume that their patients see their experience in the same way, or they may be aware that patients cannot fully understand their own process until certain points of resolution are reached, or there may indeed be similar perceptions. These inter-relationships may change as time passes in the group and as a result of the sharing of a common therapeutic task. The literature is not particularly instructive in this case, so it was decided to research this theme.

Using the Therapeutic Factors Questionnaire in parallel for both patients and therapists would also address the criticism that relying solely on patient generated data lacks objectivity.

Sample population

This research arose out of clinical interest in the struggles and achievements of people suffering from severe neurotic and mild to moderate personality disorders in group psychotherapy. It therefore differs from most of the research reviewed above. For this reason, and because Yalom's Therapeutic Factors Questionnaire was modified, a pilot

study was conducted to validate the questionnaire, thus attempting to address the flaws of many of the earlier studies (See Appendix E. P.231), which failed to view different populations as a separate variable, or altered the questionnaire without a pilot study.

The aim of this research is to identify those aspects of group psychotherapy which are experienced as most helpful in this sample group, and to use this knowledge to improve practice. It is also hoped in the course of the study to examine the properties of the Therapeutic Factors Questionnaire.

CHAPTER II: QUANTITATIVE METHODOLOGY

2.1 INTRODUCTION

Since the aim of this research was to elicit and explore the most helpful processes of small group psychotherapy, a descriptive design was favoured. Descriptive or exploratory studies are particularly appropriate where the research topic seeks to investigate complex human experience or where the research area is disordered or contradictory. (Barker, Pistrang and Elliot, 1994) Both these conditions pertain to Therapeutic Factors research, as it appears that quantitative research into individual factors in the 1970s onwards was carried out before sufficient descriptive exploration had been undertaken. Moreover, Yalom's own Therapeutic Factors Questionnaire (YTFQ) does not appear to have been systematically validated or standardized by him (Yalom, 1975) and partly for this reason, his original questionnaire has not been used here, though it underpins the whole study.

An attempt was made in this study to consolidate his approach. To this end, a new and modified version of the TFQ was devised by the researcher and a small Pilot study was carried out in order to evaluate the reliability and validity of the modified TFQ (MTFQ). The MTFQ was thus used as a structured way of describing those factors helpful in the group process and it was hoped to obtain data about the properties of the MTFQ. The research was carried out in a Therapeutic Community setting using a quite homogenous population.

2.2 DESIGN OF STUDY

The design of the main study was determined by research questions about the relationship between helpfulness of factors and particular variables. More precisely, it has been

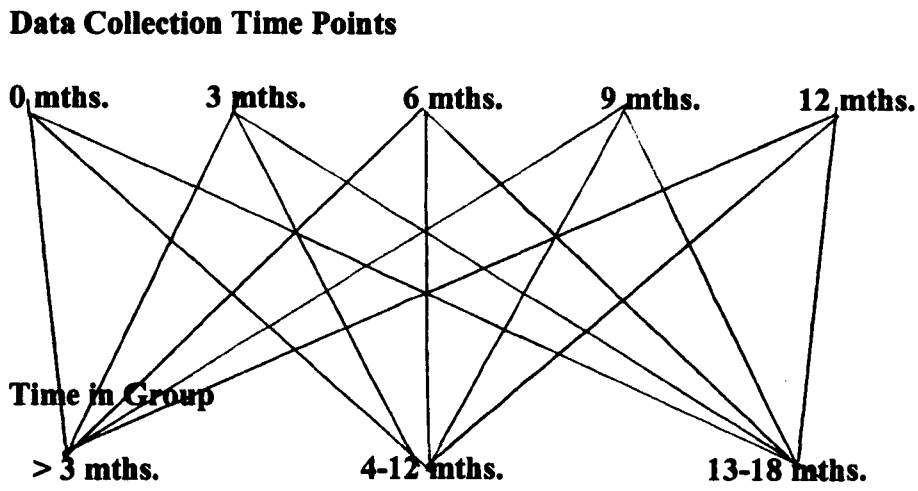
suggested that the **length of time in the group** may have an effect on the rated helpfulness of factors (Butler and Fuhriman, 1980, 1983; Kivligan and Mullison, 1988; Kivligan and Goldfine, 1991) To this end a *cross-sectional and longitudinal repeated measures* design was adopted to elicit changes in the ratings of individual participants over time.

Modified Therapeutic Factors Questionnaire Data was collected at five time-points over a year *solely* to increase numbers through inclusion of new members of the community over the study period. Data was grouped at each point into one of three phases determined by the length of time members had been in the group:

1. **<3 months**
2. **4 – 12 months**
3. **13 – 18 months**

Firstly, the progress of each member through each time phase was tracked to ensure that no participant completed an MTFQ twice in the same phase, but only when they had moved from one to another. Apart from the first phase, where the MTFQ nearest to admission was used, the questionnaire nearest to the mid-phase was selected for analysis.

Fig.2. 1 Research Design



Secondly, **individual variables** may influence the factors which participants find helpful/therapeutic in groups. (Macaskill, 1982; Butler and Fuhriman, 1983; Kivligan and Goldfine, 1991) The Therapeutic Community participating in this study employed several assessment instruments (CORE, RSCQ and an Admission Questionnaire) on a once only basis on the individual member's admission. This provided admission data on individual clinical presentations, which was used in conjunction with MTFQ scores to explore the relationships of individual variables to ratings of helpfulness of factors.

Thirdly, it was considered constructive to explore agreement between members' and therapists' perceptions. There is some evidence that therapists stress or value more observable, behavioural change. (Bloch and Reibstein, 1980; Pappas, Yannitsi and Liannos, 1997) To this end, the therapists were asked at the same five time points to rate the factors on the MTFQ which *they* thought the members of their group had found most helpful. This was done *blind* and neither therapists nor members had any knowledge of each other's questionnaires.

Fourth, the repeated measures design facilitated the analysis of agreement over time. In this way, it was possible to explore questions about the effect of shared experience of the group on member/therapist differences of perceptions of helpfulness.

Research Question 1

Impact of Length of Time in group on Therapeutic Factor Scores

Does the length of time spent in the group affect ratings of helpfulness of therapeutic factors?

Hypothesis 1

Research Hypothesis

MTFQ factor scores will vary according to the length of time spent in the group.

Null Hypothesis

MTFQ scores will not vary according to the length of time spent in the group.

Analysis

MTFQ data collected at the five time-points provided the full data set for analysis, length of time in the group being the independent variable and factor scores the dependent variable. The data was divided into three time spans, or phases, and mean group MTFQ scores were derived for each phase from individual mean factor scores. A Wilcoxon Signed Ranks Test was performed to examine change of direction over time between each two time-points of paired data on factor scores. Patient generated individual mean scores were explored in detail in order to understand how the total group mean for each factor was constituted. It proved inappropriate to use a one-way Analysis of Variance, as

the lower numbers than anticipated and irregular distribution of data suggested that the data would not meet the requirements of parametric tests. Findings were subsequently explored in the light of responses in the Semi-Structured Interview.

Research Question 2

Impact of Member Variables on Therapeutic Factor Scores

Do individual member variables influence ratings of helpfulness of therapeutic factors?

Hypothesis 2

Research Hypothesis

MTFQ factor scores will vary significantly in relation to individual member variables.

Null Hypothesis

Variance in TFQ scores will not be significantly related to individual member scores.

Analysis

Relationships between individual member variables, as evidenced by the Admission Questionnaire data, were examined using Mann-Whitney U Tests for two independent samples, and where appropriate, Kruskal-Wallis H Tests for several independent samples. Individual variables from the admission data were the independent variables and MTFQ scores the dependent variables. Some of these results were also explored in relation to individual responses in the interviews.

Research Question 3

Agreement of Member and Therapist Therapeutic Factor Scores

Do group members' and therapists' perceptions of helpfulness of factors show agreement?

Hypothesis 3

Research Hypothesis

Matched member and therapist scores will co-vary significantly.

Null Hypothesis

Matched member and therapist MTFQ scores will not co-vary significantly.

Analysis

Streiner and Norman (1995) advise that a perfect correlation may be obtained with scores which follow identical intervals but are quite different. In order to cancel out this possibility, the data set of MTFQ scores was manipulated. Pearson's product-moment coefficient was then used to derive an intra-class correlation coefficient which indicated levels of agreement between members' and therapists' scores on each factor in each phase

Research Question 4

Change over time in agreement of Member and Therapist scores

Does the length of time spent in the group by members affect agreement of member and therapist scores?

Hypothesis 4.

Research Hypothesis

Significant co-variance of member and therapist MTFQ scores will demonstrate change which will be attributable to the member's length of time in the group.

Null Hypothesis

There will be no significant co-variance in member and therapist MTFQ scores which can be attributed to the member's length of time in the group.

Analysis

The table of intra-class correlation coefficients for each phase was examined for variations between member and therapist MTFQ scores across the three phases, and these relationships explored both in terms of agreement of individual scores and agreement of ranking of factors by the whole patient sample with the whole therapist sample.

2.3. SETTING AND PARTICIPANTS

The setting for this study was a daily attendance Therapeutic Community (W.T.C.). There are eighteen places for members and a range of qualified staff. As is customary in such communities, the dividing lines between disciplines are blurred, so that almost all staff become therapists at some level. Members are referred via General Practitioners and psychiatrists and enter through an assessment process which involves joining a three to six month pre-admission therapeutic group. The implications for this research study of the selection process are a) that the members are both self-selected and selected by the whole community and b) that they all have disorders of attachment which profoundly

affect their relationships, but are able to achieve a degree of stability sufficient to enable them to be outpatients.

In keeping with the ideology and practice of the therapeutic community, the day is structured around the joint Community Meeting, rota-ed work (for planning, meal preparation, gardening, etc.) and twice weekly small therapy groups.

The therapy groups

The members of the community are distributed between three slow-open groups, with care taken to choose the "right" group for each member. Numbers may be affected by discharge and delay in new admissions. Each group is co-led by two therapists and all work within a psychodynamic framework, but have slightly different training backgrounds. The similarities in methods of working were asserted by the therapists to be greater than the differences in style and orientation. The average age of the therapists was forty-five years and they were all female.

The length of stay in the community is generally eighteen months in its entirety, but a member may leave or be asked to leave at any time, for specific reasons. (Substance abuse, non-attendance, criminal offending, personal reasons etc.)

There is a member support system arranged for after-hours whereby more stable members volunteer to offer support to a distressed individual for a specific night. Otherwise, relationships outside the community are discouraged.

Potentially, the sample was the whole community, with all members having the option of being included.

Data Collection and Recruitment

The data collection period spanned almost a year from 7.01.02. to 3.12.02. This was driven by the need to obtain sufficient numbers for statistical analysis.

2.4. MEASURES

2.4.1. Pilot Study: Modified Therapeutic Factors Questionnaire

A small trial was carried out to test the reliability and validity of the MTFQ in the following way. In order to avoid contaminating the participants in the main study, eighty ex-members of the Therapeutic Community were contacted postally by the Community secretary, in October, 2002. A letter of invitation and description of this part of the research was accompanied by consent forms (Appendix B). Nine replies were received in the following two weeks. The invitation was then sent out again (November, 2002) to all non-respondents and seven more consents were received, totalling sixteen. A response rate of 20% is low, but may be accounted for by some ex-members having moved address since they left. It is impossible to know the percentage who did receive letters and also likely, though unknown, that the respondents were on the whole the most recent members. There is no data on responders and non-responders, other than that they had been WTC members and had taken part in small therapy groups. The first Modified Therapeutic Factor Questionnaires were sent to all ex-Therapeutic Community

participants in the pilot study on 28. 01. 03. The second batch was sent on 5.02.03. Returns were prompt.

It was considered that a sample size of thirty would be necessary to meet the requirements of statistical analysis. The Research and Development section of the Institute of Group Analysis was therefore approached as all trainees undertake small group therapy. Letters and consent forms were sent as above in mid-February to twenty-four trainees. Twelve agreed to take part, a response rate of 50%. The first MTFQ was sent on 25.04.03. and the second on 3.05.03. Nine complete sets of questionnaires were received. Others were received too late to use.

A further group of outpatients was contacted by the IGA in September and letters of invitation sent to the six members. Five consented, a response rate of 77%. Questionnaires were sent on 10.10.03. and 18.10.03. and returned appropriately.

There is no background information on these participants. There were no exclusion criteria other than their own consent and the sole requirement that they should be, or have been, members of a small therapy group, in order for the MTFQ to be relevant to their experience.

Questionnaire Construction

The Modified Therapeutic Factors Questionnaire (MFTQ, Appendix D) was based on Yalom's Twelve Factor, Sixty Item 'Therapeutic Factors Questionnaire' (TFQ, Yalom, 1975, Appendix D), but also closely follows the formulation of Bloch, Reibstein, Crouch, Holroyd and Themen (1979). There are five items in each factor. The item with

the lowest face validity or most complex syntax in each factor was omitted, leaving a total of eleven factors and forty-four items. The "Existential Factor" was omitted because it was closely related to the humanistic growth movement of 1970s America and may not be viewed as relevant by individuals suffering from emotional disorders in early 21st. century England. Responses were rated on a five-point Likert scale where each point was given a numerical value of 1-5 to produce subscale scores and facilitate statistical analysis of ratings. The numerical values were treated as continuous interval measures, as is usual when dealing with Likert scales, though it is acknowledged that the regularity of such intervals is not established. The order of items was randomised. (See also Table 2.1, below)

Following the Pilot study, six "weak" items were omitted, leaving eleven factors and thirty-eight items. Weak items were considered to be those with the lowest Alphas statistic in the Item Total Correlation. (See below, P. 82, for description of these)

Some factor labels were revised following the work of Bloch et al. (1979), namely:

Learning from (Interpersonal) Interaction approximates Yalom's **Interpersonal Learning (Output).**

His **Self-Understanding** and **Learning from Interpersonal Interaction-Input** were combined in a factor of **Self-Understanding** closely related to insight.

Group Cohesiveness was revised and redefined as **Acceptance**, considered to be a more reliable and unitary concept, as discussed. (See Appendix E)

Yalom's **Identification** became the more comprehensive factor **Vicarious Learning**.

Bloch et al.'s **Self-Disclosure** factor was added in order to examine its relationship with other factors and because there is a suggestion in the literature that Yalom's Catharsis in fact comprises both aspects of "unloading" and the imparting of personal information. (See Introduction, P.29)

Bloch et al. discarded **Family Reenactment** because they though it was subsumed under Self-Understanding. It was decided to retain this factor out of clinical interest and because it seemed relevant to this sample.

Some individual items were slightly revised with the intention of providing a more consistent portrayal of the factor and achieving greater specificity and content validity. For example, Yalom's "Belonging to and being accepted by the group" combines two experiences in one item and became "Feeling I am accepted by the group".

Table 2.1 Revised Factors of T.F.Q.

Acceptance
Altruism
Catharsis
Family Reenactment
Guidance
Instillation of Hope
Learning from Interpersonal Interaction
Self-Disclosure
Self-Understanding
Vicarious Learning
Universality

Data was collated from the five-point Likert scale TFQ responses of the pairs of questionnaires and analysed using SPSS for Windows, Version 11.5.

Descriptive statistics were obtained.

2.4.2 Analysis for Reliability

Table 2.2 Therapeutic Factors Questionnaire: Reliability Statistics by Intra-Class Correlation of Time 1 to Time 2

Overall Reliability	**.953**
Acceptance	.849
Altruism	.870
Catharsis	.785
Guidance	.926
Instillation of Hope	.820
Learning from Interaction	.670
Family reenactment	.795
Self-Disclosure	.772
Self-understanding	.574
Vicarious Learning	.744
Universality	1.0

Initially, Cronbach's Alpha statistic was used as a measure of test-retest reliability, producing good (between .7 and .9) reliability levels, but Streiner and Norman (1995) caution against the use of this test, asserting that a high number of items can produce deceptively high reliabilities. On the advice of the statistician, an intra-class correlation coefficient was calculated (Table 2.2), as recommended by Streiner and Norman, the 'classes' being the two time-points. The intra-class correlation controls

for the fact that Pearson's Product-moment coefficient can produce a perfect correlation without perfect agreement. Therefore, the data was manipulated by adding the Time 2 data to Time 1 data and vice versa and then carrying out a Pearson's test.

2.4.3. Analysis for Validity

Table 2.3 Therapeutic Factors Questionnaire

Alpha Statistics for internal consistency, by factor, after deletion of "weak" items.

Acceptance	.85
Altruism	.82
Catharsis	.80
Guidance	.92
Instillation of Hope	.88
Learning from Interaction	.77
Family Reenactment	.86
Self-Discovery	.83
Self-Understanding	.79
Vicarious Learning	.81
Universality	.79

1.Face validity

Despite the original lack of validation, one could conclude that Yalom's Therapeutic Factors Questionnaire has relatively good face validity, as evidenced by the frequency

and variety of ways in which it has been used. It is also underpinned by the more rigorously researched qualitative work of Bloch and Crouch (1985), Rorbaugh and Bartels (1975) and others reviewed above.

2. Construct validity

1. Cronbach's Alpha Statistic (See Table 2.3) can provide a measure of internal consistency for interval data. This was explored through the Item Total Correlation Alpha Statistic for test and retest separately. In six factors the mean of both test and retest fell below .65. One item in each factor was identified as contributing little to the construct and therefore deleted. These items were from the factors:

Altruism	Learning from Interpersonal Interaction
Family Reenactment	Self-Understanding
Instillation of Hope	Vicarious Learning

There were, therefore, three items in each of these six factors and four in each of the remaining five factors.

2. (This test was first carried out unsuccessfully – some participants failing to notice that items could be classified in one category only - during the Pilot study. It could not be repeated in time to incorporate changes to four items which might thus have been revised, but has been included here because it does suggest good construct validity of the MTFQ.)

Independent organisation of MTFQ items into therapeutic factor categories.

The revised MTFQ was circulated to twenty second-year clinical psychology trainees, together with a questionnaire requiring them to place each MTFQ item in the most

appropriate therapeutic factor category. (See Appendix D: Categorising Therapeutic Factors) Each item could be placed in only one category, and a brief definition was given of each factor.

Nine trainees responded. Results were classified according to whether the categorization was correct or incorrect. (Six factors have three items and five have four items.)

Table 2.4 Correctly and incorrectly categorized therapeutic factors

	Correct	Incorrect
Acceptance	28	8
Altruism	22	5
Catharsis	23	13
Family Reenactment	27	0
Guidance	34	2
Instillation of Hope	25	2
Learning from Interaction	19	8
Self-Disclosure	23	13
Self-Understanding	26	1
Vicarious Learning	23	4
Universality	36	0

The thirteen incorrect items in Catharsis and Self-Disclosure represent a perfect crossover. The literature suggests that these two factors are inter-related.

There were five incorrect responses to the second item in Acceptance – "Revealing embarrassing things about myself and still being accepted by the group". This item was

mis-placed either in Learning from Interaction or Self-Disclosure, both of which are possible interpretations. The item was closely based on one of Yalom's items, but is possibly not exclusive enough in its phrasing, despite the presence of the word "accepted".

The second item in Learning from Interaction, "Learning about the way I come across to other group members", was mis-placed in six cases in Self-Understanding, again not unreasonably.

These instances exemplify the non-exclusivity of this questionnaire method, but the fact that there were so few apparently ambiguous items indicates that the items did largely succeed in accessing the factors under scrutiny and suggests that therefore the MTFQ had reasonable construct validity.

2.4. 4. Measures for Main Study

Main Study only - Patient and Therapist versions of MTFQ

There were two versions of the Therapeutic Factors Questionnaire (MTFQ), one for the member and one to enable the therapist to convey what she thought the member had found most helpful. They differed only in the use of pronouns. This was to facilitate testing for agreement in member and therapist perceptions, and for changes in this over time.

From Admission Data of Therapeutic Community

The Core Outcomes in Routine Evaluation (CORE) (Appendix D.)

This is a clinical tool developed by the Leeds Psychological Therapies Research Centre as a means of assessing changes in symptomatic levels over time in a range of populations. The thirty-four items measure global distress (symptomatology) via scores on four domains, which represent "core" components of patients' distress. These are: Subjective Well-being, Symptoms, Functioning and Risk/Harm. It has undergone trials with clinical and non-clinical populations. In tests of internal consistency, all dimensions obtained alphas of .70 or more.

During the year of the study, data was collected from the admission CORE of each participant, and overall scores and severity ratings were entered into the body of data.

The Robson Self-Concept Questionnaire (RSCQ) (Appendix D.)

The RSCQ (Robson, 1988, 1989) has been developed to conceptualise and quantify different aspects of self-esteem. It has been standardised on non-patient norms as well as with a number of clinical populations, including psychotherapy referrals in the district and population under study.

It has five subscales:

Attractiveness/Approval by others

Competence/ Efficiency

Containment/ Worthiness/ Significance

The Value of Existence.

Autonomous Self-regard

Means and Standard Deviations are provided for a variety of patient populations, but reliability data is not available. Overall scores and severity ratings had been assigned by the community and were entered into the data set.

The Admission Questionnaire (Appendix D.)

This is a patient-completed instrument developed by the therapeutic community themselves. The data is in simple categorical format and provides a wide range of demographic and trauma-related information. For the purposes of the study, the following variables were selected and assigned numerical values:

Gender

Significant Trauma (Victim or witness)

Educational Qualifications

Experience of a "warm, confiding relationship"

Current psychiatric problems (These were coded by the researcher into nine categories)

2.5 MAIN STUDY:PROCEDURE AND RECRUITMENT

Following a lengthy process of negotiation with the therapists concerning detailed therapeutic and ethical considerations and following completion of the Pilot Study, an open meeting was held to describe the study. Some anxieties were raised about confidentiality and some members were so immersed in the group process that they felt it strange to be asked to complete a questionnaire individually. All members were given an envelope containing an introductory letter inviting them to participate and two Consent Forms. All envelopes and papers were numbered with a personal number allocated by the participant and held by the liaising therapist. The number of consenting members at the start of the study was twelve out of fifteen – a response rate of 80%. One became ill and left the study. All but one of the twelve *new* members who joined the Community after commencement of the study consented, providing another eleven participants, and totalling twenty-two in all.

Procedure

On the first day of the study, members were given the MTFQ in an envelope and asked to return it a week later. Members had suggested this time lapse themselves, saying that it would allow them to complete the questionnaire on a "stable" day, which would not distort their real perceptions. At the same time, the therapists were each given MTFQs to complete for each member of their small group. All envelopes and papers carried the personal number and in the case of the therapist MTFQ, also the therapist's signature. This procedure was repeated at three, six, nine and twelve months into the study, totalling five repeats.

2.6 ETHICAL CONSIDERATIONS

(These considerations applied equally to the qualitative methodology described below.)

Ethical approval for the piloting of the TFQ and for the main study was sought and obtained from West Berkshire Local Research and Ethics Committee. Ethical approval for the involvement of the Institute of Group Analysis (a private charity) was covered by its own Ethics Committee.

Owing to the year's delay obtaining results for the pilot study of the MTFQ, the therapeutic staff had changed completely by the commencement of the main study. A process of negotiation with the original small group therapists had revealed some concerns.

These were as follows:

1. A previous experience had occurred where it seems they felt they had been "used' for research and then discarded, with no gain for the community. They were reassured that this project was envisaged as a joint undertaking and that should it be possible to publish, they would be invited to contribute or co-author. Each member or therapist would be given or sent a written description of the findings.

2. Therapists were rightly protective of their clients. There was concern that members should not experience any pressure, therefore members' participation was kept to a minimum and admission data collected by the community was used. This meant that the use of any psychometric assessment of personality had to be ruled out. (This had been part of the admission data when the project was first discussed.) The MTFQ was considered relatively non-intrusive and is a non-pathology based method of collecting data.

3. The researcher voiced concerns that the members would have anxieties about confidentiality, fearing the therapists might know their responses. To this end, a simple numerical coding system with envelopes was used. In the interview, the researcher was aware only of the member's number. Therapists had no contact with members' completed MTFQs, other than the liaising therapist, who collected the sealed envelopes and returned them to the researcher.

Therapists were reassured that their work would not be open to scrutiny and that the research was not using methods which would facilitate this.

On commencement of the main study, the new therapists voiced very few concerns, feeling that since agreement had already been reached they were willing to continue.

After the completion of the study, an account of the study and its findings was sent to all participant members of the community. A more detailed account was sent to the therapists. A visit to discuss the research with the community was arranged.

CHAPTER TWO-B: QUANTITATIVE RESULTS

2.B.1: INTRODUCTION

The study had aimed to examine the experience of being in a slow-open therapy group through use of a modified version of Yalom's Therapeutic Factors Questionnaire, and thus to acquire a better understanding of the questionnaire's properties. Disappointingly, the data did not facilitate this, owing to low numbers and homogeneity of sample response, which skewed the data.

The total data set consisted of the three sets of members' TFQ scores which had been collected into the three six-month phases. Scores, in interval data, indicated which factors participants found most helpful, to facilitate analysis of ratings of helpfulness of factors in relation to Length of Time in the group. There was a parallel set of therapists' TFQ data, indicating the therapist's assessment of what the member found helpful, and a correlational analysis of agreement between patients and therapists over time was applied to this. Data defining a number of socio-demographic details, presenting clinical problems and scores on the CORE and RSCQ psychometric instruments, facilitated an analysis of ratings of helpfulness of factors in relation to the individual characteristics of participants. The data collection period lasted from 1.7.2004 to 1.7.2005. Twenty-two therapeutic community members participated, distributed over three phases as shown in Table 2.B.1

Table 2.B.1 Distribution of completed questionnaires over three phases of the study.

Phase			Number of completed MTFQs
One	0 – 6	months	15
Two	7 – 12	months	14
Three	13 – 18	months	8

There were twenty-two participants in the whole study, but this is not reflected in Table 2.B.1 because participants entered Phases Two and Three continuously at numerous points throughout the data collection period.

10 participants moved from phase one to phase two *during* the study.

6 participants moved from phase two to three *during* the study.

2 participants moved from phase one to two to three *during* the study.

It will be seen from the Table 2.B.1 that the organization of data into three phases dependent on how long the individual had been in the group, as described in the method section, (P.67) enabled analysis over time, but meant that the third phase was always likely to be smaller, and this was particularly the case where the data collection period lasted only one year. This was exacerbated by three premature discharges. Only two participants were present throughout and appear in all three phases. This made analysis of the structure of TFQ scores across all three phases impossible.

2.B.2: PROBLEMS PRESENTED BY SAMPLE NUMBERS

In practice, small numbers, particularly in phase three, made analysis of the data set as described above proved quite inadequate to draw any conclusions in response to the research questions. Based on throughput figures for the five years prior to the study,

roughly thirty participants were expected (in itself not a large number), but because the community was never full, this did not happen. There *were* discernable trends, which may be noted in Tables 2.B.2 and 2.B.3 below, and although therapist scores did not always match closely those of individuals, there was a move towards closeness of overall ranking, as in Table E.1.14. (Appendix) The four factors which *appeared* to be consistently most helpful over the whole study were Acceptance, Catharsis, Learning from Interaction and Self-Disclosure. Family Reenactment and Self-Understanding were the two factors which showed clear increases in scores through the course of the year. The Instillation of Hope and a sense of Universality seemed very important at the start of the group and much less so later.

Unfortunately, although the data was explored very thoroughly, the fact remained that numbers were simply too small for a sophisticated analysis, or indeed, to be able to make any claims about helpfulness of factors in the group process or about the properties of the Therapeutic Factor Questionnaire. Numbers were particularly low when split two ways in the analysis of individual variables, and the correlational analysis of patient/therapist scores was untenable because it was also based on means produced for the overall ratings of factors.

Further tables are, however, shown in the Appendix to convey the potential trends referred to above. Tables E.1.11.to E.1.14. (Appendix) may be perused to further explore the structure of the TFQ data in terms of findings. Descriptive details of the sample may be found in Section E.1.1 of the Appendix.

2.B.3 A STUDY OF TWO CASES

In the light of the revealing descriptive data conveyed by interview material, it was decided to explore the TFQ data sets of the two cases which spanned all three phases, in relation to their interview material.

These two participants had very different personalities, which was reflected in individual scores, and would support the notion that personality affects group experience and engagement. Case Number One was a professional woman in her forties, who had been increasingly breaking down in for at least five years prior to admission to the community as a result of a painful upbringing. She had ceased to work, and had wished to enter treatment in the community for some time, but they had insisted that she first address her alcohol problem in intensive rehabilitation treatment. Having done this meant that she came to therapy already very engaged and having plucked up considerable courage to tackle her long-standing disorders.

Case number 5 was a man in his mid- thirties who suffered from an equally difficult background and profound social anxiety, and had stopped work in order to engage on the eighteen months long daily community programme. Speaking in the group was very frightening for him, so that he was also drawing on reserves of courage, but did not start as far along the therapeutic journey as Case 1. This is reflected in the marked difference in their ratings of helpfulness of Instillation of Hope throughout.

Table 2.B.2 Case Number One (F.)

Mean scores on three phases of Therapeutic Factor Questionnaire: Patient and Therapist *

Therapeutic Factor	Patient	*Therapist*	Patient	*Therapist*	Patient	*Therapist*
Acceptance	**4.8**	*(4.8)*	**5**	*(5)*	**4.8**	*(4.7)*
Altruism	**5**	*(4)*	**5**	*(3.3)*	**4.3**	*(4.3)*
Catharsis	**4.2**	*(5)*	**5**	*(4.2)*	**5**	*(5)*
Fam. Reenactment	**4.7**	*(4)*	**5**	*(4.7)*	**5**	*(4.3)*
Guidance	**4.2**	*(2)*	**4.5**	*(4.5)*	**4**	*(4.2)*
Instillation of Hope	**4.7**	*(4.7)*	**4.3**	*(4.3)*	**5**	*(4)*
Learn from Inter.	**4**	*(3.7)*	**4**	*(4)*	**4.7**	*(4.7)*
Self-Disclosure	**4.8**	*(4.2)*	**4.5**	*(4.5)*	**5**	*(5)*
Self-Understand.	**4**	*(5)*	**4**	*(4)*	**4.7**	*(4.3)*
Vicarious Learning	**3.7**	*(4.3)*	**4.3**	*(4.3)*	**4.7**	*(4.3)*
Universality	**5**	*(4.5)*	**5**	*(5)*	**5**	*(4.2)*

* Means are used because the number of items per factor varied between three or four.

It will be seen that F. tended to rate helpfulness of factors quite highly throughout (her scores were among the highest ratings of participants). Scores of 4 to 5 convey that she found the factors "A little helpful" or "Very helpful" respectively. Even the low score of 3.7 for Vicarious Learning in the first phase rose to 4.7 by the end. One might conclude that this participant was simply very enthusiastic or demonstrating an agreement set pattern of responses, but interview material (See below) refutes this. Interestingly, it was this group member who asked that they be allocated a whole week to complete the questionnaire in order to avoid responding in an unstable emotional state. This suggests that she was aware of the emotional and mood changes involved in treatment (she also

mentioned a bi-polar disorder), but it could mean that she *wanted* to give only positive responses. Again, the interview was too varied in its narrative content to support this.

More specifically, her sense of the helpfulness of Acceptance and Universality was high from the start. It is perhaps not surprising that a sociable, articulate woman would be predisposed to access and facilitate the sharing of experiences which leads to universality, but her experience of acceptance was surprising and challenging for her. She had found entry into the group *"frightening and intimidating"* because she *"didn't understand what was going on"*, but they were accepting of her.

...that was quite a new experience...amazing, if I'm honest.

That can be a scary thing, to know what to do with that, to know that something I've believed of myself wasn't true.

It should be noted that although there seems to be some variation between and within Catharsis and Self-Disclosure, the difference between, for example, 4.8 (19) and 4.5 (18) represents a difference of only one point on one item. There is a little more difference between Catharsis and Self-Disclosure in the first phase which suggests that perhaps F. found it more helpful (easier?) to disclose verbally at first, and this led her to a deeper emotional experience in phase two. In interview, she verbalized and self-disclosed very fluently.

...at times I talk an awful lot...I think I'm supportive.

At that time (the turbulent working phase in the literature) she was also preoccupied with, and finding meaningful, Family Reenactment. In her TFQ scores, understanding of

herself and her internal world was rated as less helpful than some other factors (See also Discussion, Self-Understanding), but increased in parallel to the Family Reenactment scores. She described how learning in the group helped in actual situations when she saw her family, but also:

...at a more bizarre level, which is all the transference...it's rife with me...so, people are representing my mother or my brothers, yes...and one of the small group therapists I have an official maternal transference with...it's all to do with what went on with my mum, which is fascinating and painful at the same time.

M. seemed to have absorbed the analytic ideology to good advantage. Her interview accessed many common themes in a very articulate and emotionally direct way.

Learning from Interaction scores were the same as those for Self-Understanding, increasing in the third phase in exactly the same way. Like all interviewees, she described instances where she found she had learned to react differently in the group, though was unsure whether this would generalize outwards. She was learning to experience her emotions (this would seem to represent a combination of factors, and may be an outcome).

I didn't really experience my emotions much before I came here. ...I almost had a sense that if I cried - I was going to be punished, and that has gone, which is an important thing to go.

Despite the rather lower Learning from Interaction score, learning seemed to be the thrust of F.'s progress.

It's more for me to know what's wrong...and not know how to change things, and the group helps me with that ...things get repaired while I'm here.

She spoke of a *profound* experience of change, of becoming able *"to see all the bits of me...and to accept them, even the bad bits, and put the two (bi-polar) bits together...so I could have evil thoughts and whatever, but I don't have to act on them.* (Author's emphasis.) In object relation terms, it seems that containment by the group had fostered an experience of the good object, which enabled self-containment.

Therapists generally scored lower than patients, but in this case, many scores are close. They seemed to disagree that she had found Guidance helpful in the first phase, and thought she had found Altruism less helpful, than she did. It is possible, since this can be expressed as an observable behaviour, that they were making a judgement about how altruistic she had actually been. There is no precise reference to this in interview.

It seems that F. was a person who entered fully into the experience of group work and was very able to use the process. At the one-year point, she could say:
I can comfort myself, which I didn't, and I can let other people comfort me, which I couldn't...And I know what to do with my two-year old, because of other people showing me what to do, and other people around me.

Like the other members, she had concerns about how she would manage outside, especially regarding making new friends, but with six months till the end, she seemed to have already experienced internal shifts which could support and enable her in her life.

F. had process issues too numerous to describe here, and it would seem that the further she took these, the less the process was focused on the given therapeutic factors, and more on aspects of change in the internal and external worlds which constitute the essence of psychoanalytic exploration. She has, however, in her interview, described many primary process themes and experiences in the group which are a necessary condition for change in any therapy which aims to address damaged attachment and narcissism. Her descriptions have an immediacy and subjective reality which was truly informative.

Table 2.B.3 Case Number Two (M.)

Mean scores on three phases of Therapeutic Factor Questionnaire: Patient and Therapist

Therapeutic Factor	**Patient**	*Therapist*	**Patient**	*Therapist*	**Patient**	*Therapist*
Acceptance	**4**	*(4)*	**4**	*(3.8)*	**3**	*(4.2)*
Altruism	**4.7**	*(4.7)*	**4**	*(4.3)*	**3.3**	*(3.3)*
Catharsis	**3.5**	*(3.2)*	**3**	*(2.8)*	**2.8**	*(4)*
Fam. Reenactment	**3**	*(2.7)*	**2.7**	*(3.7)*	**2.7**	*(2.7)*
Guidance	**3.5**	*(3.2)*	**3.3**	*(2.2)*	**2.8**	*(2)*
Instillation of Hope	**3**	*(3)*	**3**	*(2.7)*	**3**	*(4)*
Learn from Inter.	**3.7**	*(3.7)*	**4.3**	*(2.7)*	**3**	*(4)*
Self-Disclosure	**4**	*(4)*	**3.5**	*(4)*	**3**	*(4)*
Self-Understand.	**3.7**	*(3.7)*	**3.3**	*(2.7)*	**3**	*(4)*
Vicarious Learning	**3.5**	*(3.7)*	**3.3**	*(2)*	**3**	*(4)*
Universality	**4.2**	*(3.5)*	**3.5**	*(4)*	**3**	*(4)*

M. produced the lowest overall scores in the whole sample. Having suffered problems of low self-worth, depression with suicide attempts and acute social anxiety for many years, he must have needed a great deal of courage to enter the community and endure the daily anxieties of such a demanding group situation. He also had an alcohol problem, which he had been dealing with by avoiding social situations where he would be tempted (or need alcohol to make them bearable), and so had become increasingly isolated.

...it was very nerve-wracking for me...and still is...It almost prevented me from coming, and staying, because of the anxiety about speaking in groups.

In interview, one had a sense of remoteness, and that although he made a number of perceptive comments, he was always *holding back.*

I'm not really an angry person...as I've said, I've only had one occasion to express that.

(Noticeably unusual in this treatment setting)

Low self-esteem was also apparent, and the researcher wondered about a certain degree of negativism in relation to himself and the rest of the world, though he described positive gains. It was obvious that despite good intentions, he was struggling even to be in the interview. It seemed that this affected his ability to self-disclose in the group and in the interview.

(In response to a question about increased self-esteem)

...Probably not. The core belief probably isn't, but a lot of that is to do with feeling inadequate, ***not being able to speak in relation to the group****... there are more moments, I think, of feeling quite good about myself, but I don't know whether that's just come from*

sort of having contact with people everyday, and not just being sat at home all day dwelling on things...

M. described a very isolated social situation, and what he calls the "structure" of the community seemed to mean for him simply being within something, and one felt that he needed a very great deal of "holding" in the Winnicottian sense before being able to progress, although he mentioned *"having been (unsuccessfully) through different types of therapy".*

Having contact through the day, with people, I actually feel more comfortable now staying in on my own (in the evenings)

M. scored Family Reenactment as neither helpful nor unhelpful. Whilst he said he didn't find that he was reminded of others by people in the group as much as some members were, some emotional experiences were evocative.

It's only things like, if a confrontation's building within the group – that kind of reminds me of childhood and sort of escalation of confrontation...I do tend to react a little bit.

Curiously, he did not endorse items in the TFQ which refer to precisely to this kind of experience.

Though negativism is largely inseparable from a hopeless or depressive state, one suspects that in the group he may have been fairly impervious to help from others, which would have frustrated them. This is, of course, inferred. The therapists obviously felt that he found learning from the example of others (Vicarious Learning) and Guidance less helpful than he felt he did. In the third phase, against their usual trend, they mainly scored

helpfulness of factors higher for him than he did. This could mean that they were not quite as sensitive to his distress or negativism as they might have been, but it is equally likely that in his state of mind, and beset more than most by fear for the future, his rating style inclined to under-rate helpfulness.

M. found Self-Disclosure very difficult and *less* helpful as time went on, which seems to refer to disillusionment with the whole therapeutic process. However, he also referred to the painful experience of feeling narcissistically shamed and exposed, in response to a question about "old problems" and relationships.

I've spoken about certain things and events...after I have spoken, I feel quite sort of, humiliated...just by my own sort of ...I think people do try, but I'm aware that people can look at me, and I do often look afraid, in the group and – people often leave me alone, because they think I'm crying.

He was never clear in interview as to whether he found the Instillation of Hope useful, and given his difficulties in telling his story, it would have been difficult for him to have a Cathartic experience. The only score which increased in the second phase was for helpfulness of Learning from Interaction, though the therapists evidently did not think he found this helpful. Again, this could mean that they did not observe him trying to make use of it.

He found Altruism quite helpful at first, and this was not due to a self-effacing trait, but a response to items which spoke of being able to help others and support them, and of feeling important in their lives, which consequently provided feedback for him.

I like to think I give quite a sort of reasoned and good feedback to people.

... 'cos I know how important it is for other people to say to me, yes, I understand what you were talking about...so I don't get this distorted view, that my thoughts are totally irrational and nobody else could understand.

Ironically, this experience can only be found this powerfully in the group situation he found so difficult.

The sense of being someone who mattered, which for him seemed to be close to Acceptance, evaded him as the group progressed, according to TFQ scores, though this is not so clear in interview, supporting the view about response set above.

I don't recall <u>not</u> feeling accepted – any feelings of being out of place, I think, were purely mine...I'm now an older member of the group, it's still this problem of meeting new people and forming new relationships.

...if there have been things I've really needed to speak about, then I've tried to...I've always felt the group welcomed that...

Initially, he seemed to have found a sense of Universality.

But being able to speak about them (fears) with other people and listen to their own experiences, I realise I'm not the only one who feels irrational feelings...that in itself has helped.

M. understood that the group did not provide structured guidance, but in relation to the therapists, he thought that:

I'm not sure what I expected...probably the therapists in that situation to be kind of vocal, provocative and driving the group, whereas actually the group drives itself...so it's quite an unusual experience, to discover that.

His expectations may have been founded on previous therapeutic experience, or on the dynamics of his family of origin.

Summing up his pathway through the group, M. thought that it had been *"a real up and down time in terms of how integrated or connected I felt in the group. There were times like I lost my voice, then at nine months, I had a review* (one-to-one) *expressed how I felt ...about myself and being in the group – and it did seem to get better. Now, I've gone back into a quiet mode, haven't I? I guess coming up to the year, I'm two-thirds of the way through, so I need to ask for help...*

His interview highlighted the main problem areas, but conveyed that he thought he had made some gains despite his fears within the group and for his future after treatment. This could not have been concluded from the TFQ results. It may be that M. offers a good illustration of ways in which a structured questionnaire cannot access subtleties of experience. Negative experiences can offer equally good pointers as to how we should conduct groups to maximum benefit for participants, and which problems may arise. In particular, what people bring to the group at the beginning, in terms of personality and pathology may be of crucial importance.

These were two very different people, both having suffered early emotional damage, but one was able to grasp the chance for reparation, however painful, and however self-

destructive she may have been, and the other seems almost to have used all his internal strength in just being in the group and may be too fragile to be able to use the experience after it ends. They illustrate the difference as well as commonality of the group experience for different individuals. There may also be a question of whether or not one comes to the process at just the right time-point.

Therapist' ratings of helpfulness have been tabled and mentioned, but not explored, as therapists were not interviewed. However, Table E.1.14. (P. 207) shows a gradual move towards overall agreement, allowing for the inconclusivity of data described above.

CHAPTER THREE: QUALITATIVE METHODOLOGY

3.1 INTRODUCTION

In relation to the TFQ, it was felt that the reduction of outcomes to a series of scores would not capture the subtleties of a very complex entity. A **Semi-Structured Interview** was carried out on the date when each member had been in the group twelve months, to provide a thematic qualitative measure which would allow more undirected exploration and also facilitate comparison with ratings of factors. This recorded data was analysed and transcribed by means of Interpretative Phenomenological Analysis in order to elicit emerging themes. (Smith, 1995; Smith, Jarman and Osborn, 1999; Smith, 2003; Smith and Osborn, 2003) This method was chosen since, on the one hand, "Access depends on, and is complicated by, the researcher's own conceptions" (this study approached the area with certain factorial concepts about the process of group psychotherapy), but at the same time, "the researcher is trying to make sense of the participants trying to make sense of their world" (the researcher was exploring and trying to make sense of the individual member's experience of those factorial concepts). (Smith and Osborn, 1997) It is recognized that the starting point in this study was not completely open-ended. This part of the research will be considered further in the Discussion section.

A further reason for using an interview technique was to compare the findings of the quantitative and qualitative results in order to ascertain if Yalom's modified Therapeutic Factors questionnaire was supported by the findings of the open-ended interviews. This was to some extent a circular process, since the broad areas for discussion and the prompts used in the interview were based on the Therapeutic Factors Questionnaire, but

this did not detract from the value of information about the individual's subjective experience.

Attention was therefore also given to themes related to the research questions, in terms of helpfulness of therapeutic factors, and also in relation to different time-points.

Epistemological Statement

It was hoped to provide an interactive balance between the positivist stance, which seeks to widen our understanding of psychological processes through hypothesis-testing empiricism, and qualitative methods, which are capable of accessing the rich variety of ways in which individuals construct their internal and external worlds.

The Semi-Structured Interview was administered one year from the participant's admission date. Interviews lasted from twenty-five to forty-five minutes, the majority lasting thirty to thirty-five minutes. They were recorded on to audiotape with full consent. It was made clear that members could complete the TFQ without the interview if they so wished. Owing to the premature departure from the community of three of the original eleven members who would have reached the one-year point during the study, eight interviews were carried out.

3.2 ANALYSIS OF INTERVIEWS

In accordance with the methodology of I.P.A., all interviews were first transcribed.

1. The first interview was perused and points of interest, descriptions and brief summaries of the content of each interviewee's responses were annotated in the left-hand margin, as in example 1.

Example 1

Good that could share some issues and work on them together.	...initially I liked that the people who wanted...who seemed to have some of the same issues to me and we could talk about them and to work through ...things	

2. In the right-hand margin, "emerging theme titles" (Smith, 1999) or conceptualizations of the essence of what was in the text and in the left-hand margin were recorded. The interview was then studied again and these themes modified.

Example 2

Others: I can show emotions and be understood.	...the good bit was other people...knowing I could complain, or cry or get angry, and other people would have some idea of – where I was coming from. A lot of it *was* just getting out of the old routine, and coming somewhere every day and being with people is something I haven't been for a long time...the bad thing...at first, everybody was a stranger – could tell they were shy, so it was quite hard to let your guard down enough to – er - trust.	**Being understood despite outbursts. Isolation, goodness of others. Difficulty of trusting.**
Out of isolation to be with others		
Strangers in group, Shyness and trust		

3. This process was repeated for each of the eight interviews.
4. A list of theme titles for each interviewee was then separately drawn up and this facilitated "clustering" of thematic material for the whole set.

Example 3

Case Number 8. ** Themes which appear more than twice in this interview.

Being understood **

Problem of trust, letting defences down

Uncertainty, ambivalence

Self-judgment/harsh superego**

Others: valued, group supporting you, pleasure of relating**

Sharing usually helpful

Value of talking, pleasure in talking**

Fear coping won't last outside**

Learning expressing negative emotion is alright**

Anxiety and Hope – about starting , about talking & self-disclosure**, about fears, about future

Group enabling: resolution, grieving for father** (central for her), comfort and confidence, containment after social isolation** permission to act

Shame over self, acceptance by group>self-acceptance

Change in self - effects change in relation to family. *"...the actual relationships haven't changed, but how I feel about them has"*

Evocation of family themes reworked in group, Inclusion/Exclusion

Facilitating role of therapists

Change: from silence to talking, to laughter, narrative listened to sympathetically

Someone there for her

What's me, what's the group? Change in her role – new girl to responsible mother, accepted. Closeness despite change in members

Time – difficult at half-way point, panic about progress and end of group

Variation in ease of group experience>ability to talk or not

5. Subsidiary categories were listed and referred back to the text to check their accuracy. This became easier with each new interview analysed, since although there was rather a large number of categories, many of the same themes emerged repeatedly. It may be seen that the categories (lower level themes) listed below are moving very close to the final higher level themes.

Example 4

Case Number 8

1) Anxiety& hope at start, Uncertainty/ambivalence Problem of trust, letting defences down

2) Talking: value of, pleasure in, anxiety over self-disclosure, variation in ease of group experience > ability to talk or not

3) Acceptance by group > self-acceptance

4) Shame over self, harsh superego, being understood > experience of good object, expression of negative emotion acceptable, narrative listened to sympathetically

5) Group enabling: resolution, (esp. facilitation of grieving) containment after social isolation giving of comfort, confidence

6) Self-change > change in relation to family *(the actual relationships haven't changed, but how I feel about them has)* Evocation and reworking of family themes in group, eg. Inclusion/Exclusion

7) Facilitation role of therapists

8) Change: in her role, new girl to responsible 'mother', from silence to talking, to laughter, what's me, what's the group?

9) Others: value of, supporting you, pleasure of relating to, someone there for me, sharing usually helpful

10) Time: variation in ease of group experience, difficulty of halfway point, fear coping won't last outside, panic about progress and ending.

These clusters were not numbered in order of importance, and some themes overlapped in some points. As the analysis progressed to the final formulation, some details which were personal to a participant were subsumed in the general themes. In addition, the *relative* importance of a specific sub-category to the participant was not revealed here.

6. Higher level themes were established and tabled. This process is one of interaction between the understanding of the interviewer and the expressed experience of the interviewee. This is explored further below.
7. Interviewee excerpts were derived from the texts to illustrate the themes and categories.

Finally, the interviews were examined to identify therapeutic factors in the text and these were ranked in order of the number of references to them in the interviews. This procedure follows the work of Smith and Osborn (2003).

3.3 IMPACT OF THE INTERVIEWER ON THE DATA

The interviewer is acknowledged in qualitative methodology to be an integral part of the interactive narrative. Clearly, the selection of prompts based mainly on therapeutic factors, and entirely on what interested the researcher, deviated from the purity of the I.P.A. method. It is, however, felt that minimal prompts would have been needed to help the participants engage in the interview process. The structure of prompts according to progression of time (anxieties about beginning, acceptance and universality, moving through self-disclosure to self-understanding and family issues, and then to anxieties about the ending) seemed a naturalistic basis for thinking about the therapeutic journey.

This selection was based on intuition, therapeutic experience and on the therapeutic factor literature.

The researcher had a particular interest in Family Reenactment, derived from psychoanalytic training and from extensive work with personality disordered patients. The literature fails to reflect the realities of therapeutic work, perhaps because many of the client groups were directed at non-pathological personal growth, though it seems likely that painful family experiences will always surface in psychotherapy groups. It could be that though this was only one of the topics, the researcher's interest communicated itself to interviewees, though two of them had not found it helpful. The intensity of some of their references to family dynamics and evocation in the group was so emotional as to make it doubtful that it was merely a response to the researcher's interests.

A second interest in time as a curative process, in terms of Time as a powerful agent of resolution and change, elicited a variety of responses, ranging from descriptions of time-based variations in the unfolding emotional experience of the group, to a minority view that it had not played a role. For the participants, the half-way interview at nine months was prime, in that the very fact of it confronted them with anxieties about the ending. The researcher's notion that the major therapeutic work would not start until about six months into the group was partly borne out. Interviewees described how anxiety, particularly about speaking, and feeling accepted were crucial at the beginning, though this seemed to cover a time span of roughly three months. There was a long period of "up and down" struggle and challenge, which seems to correspond to clinical theories and experience, then at the year's point, some of them conveyed a certain pleasure at perceived change in

themselves, whilst acknowledging how far they had yet to go. Time can be seen as curative not only through its sheer passing, but through its interaction with dynamic personal change, so that some events in the therapeutic group need to happen at the "right time" in order for internal processes to evolve and crystallize.

Thirdly, the interviewees used some the researcher's words, in response to prompts, notably in the first prompt, where they described entry into the group as a "relief" and/or "nerve-wracking". A lesser example was where they described acting or "reacting differently now", in response to a prompt based on Learning from Interaction which used these words. They then went on to describe their experience in unusually vivid terms, rather than stick with the offered language, but it cannot be denied that the concepts and language they used were to some extent the researcher's. It is hard to see how this could have been avoided.

There is an interesting deviation from this in some interviewees' descriptions of primary process. Containment, good and bad self, transference mothers, being understood, good objects, and some resolution of these processes which was new, though still precarious, were salient in five out of eight interviews. It is not surprising that this should be conveyed after a year in analytic style groups, but the researcher, whilst psychoanalytically trained, gave no prompts relating to these dynamic structures, so her orientation should not have influenced responses in this way. Moreover, these parts of the narratives were the most powerful and emotionally authentic, and did not have the tone of an acquired ideology. This would seem to indicate autonomy of thought in the responses.

A particular problem for the researcher as a psychoanalytic psychotherapist lay in maintaining a detached interviewer stance when confronted by rich analytic material. Sometimes, just reflecting participant's last words elicited a revealing response, or a torrent of words. Although no interpretations were given, it is very likely that non-verbal communication of a certain kind (the kind to which they were used on the part of their therapists) had some effect on their responses. However, one cannot help but feel that similar responses would have been obtained by other interviewers, judging by the participants' eagerness to talk about their personal journeys.

3.4 THE IMPACT OF THE INTERVIEW PROCESS ON THE RESEARCHER

Initial worries that the interviews would be perceived as intrusive were largely dispelled. The participants conveyed no sense that they felt obliged to engage, but were remarkably ready to "open up". That they would do this for a stranger was quite humbling. They had been through such difficult experiences in their lives, drawn on reserves of hope and courage to come to the community, and to touch painful processes yet again in these interviews of their own free will commanded respect. Moments of visible distress on their part left the interviewer feeling frustrated and helpless, as only the most minimal interventions were acceptable within the framework of the research. However, everybody continued and nobody left the room! One man confused the interview with the therapeutic situation, started to "unload" at length and had to be gently stopped and reminded that the researcher could not fulfill that role. There was a circular interaction between a sympathetic interest on the part of the researcher and their openness and willingness to be thoughtful in the presence of the interviewer, which further elicited the interviewer's interest and sympathy.

It was fascinating to hear in such a direct manner what it is like to be a member of a therapeutic group and to gain an insight into how therapists are seen. When therapists take an individual into therapy, they take on a whole universe of experience in the shape of one person. This is an enormous responsibility and it was rewarding to hear how the curative process can and does work as we hope that it will. Unfortunately, not always: the man described in the Results section as Case Number Two seemed sadly remote and too defended to fully engage in the process. One is left wondering how they have all fared now they have left the community, and hopeful that the gains they were so clearly making can be consolidated. It was strange to gain such personal insights into their internal lives and not know their names. It was an encounter that could probably never have been obtained outside of a research framework, and one can only be grateful for the opportunity.

CHAPTER THREE-B: QUALITATIVE RESULTS

3.B.1. INTRODUCTION

Semi-structured interviews were carried out with the eight participants who reached the point of a year's attendance in the groups and analysed using Interpretative Phenomenological Analysis. (See Method section) Interviews lasted between thirty and forty–five minutes. The contents of the interviews were explored and themes elicited were also linked to the results of the MTFQ in two cases. (See below)

These findings were extremely rich and comprehensive. The members had been in an intensively therapeutic environment for a year, engaged in a constant process of introspective *and* interactive self- exploration, of which the twice–weekly group sessions were the most concentrated manifestation. Many of them came to the community with significant distress. Several spoke of the "profundity" of the experience. In these circumstances, it is not surprising that there emerged a large number of themes. However, there was marked homogeneity of experience, only two people having individual issues unreflected by others.

Seven super-ordinate themes emerged, comprising large clusters of direct experiential themes.

Table 3.B.1. Sub-Categories and Themes identified by the analysis

Themes	Sub-Categories
GROUP-AS-A-WHOLE	Reparation, Cure & Redemption, Personal Investment
(The Process)	Validity of type of treatment Personal Investment Containment, Structure, Social Contact
	Safety & Stability Support vs. Rough-and-Tumble
	Facilitation of Verbalisation > "Dealing with things" > Change
	Acceptance, Feeling Understood, Inclusion/Exclusion,
	New Experiences Challenging previous Beliefs
THE VALUE OF OTHERS	Value of presence of Others
	Sharing, Guidance and Feedback Contribution to Group
	Emotional Closeness, Respect, Encouragement
	Awareness of Interpersonal Processes, New Perspectives
THERAPISTS	Stable Carers and Facilitators Giving Reflection and Gentle Guidance Remote and Controlling, Arousing Curiosity
GAINS	Anxiety
(in Clinical Presentation)	Depression
	Anger
	Self-Esteem
	Changes in Behaviour

THE FAMILY	**Evocation** **Greater Understanding of Family** **Resolution**
THE JOURNEY	**Development of Role (in Group),** **Increased Rationality and Self- Understanding** **Primary process: Regression, Integration,** **Core-Self Development,** **Internalisation of Good Object** **Creative Thinking** **The Emotional Journey:** **Reflection and Survival**
TIME	**The Beginning: Ambivalence** **and Uncertainty** **The Middle: Generalising Gains** **& the Need To Do More** **Towards the End** **Time Patterns** **Time Needed**

Description of Themes

First Theme

"Group-as –a –whole" The group was perceived by members in many ways, some expressive of its composition or very existence, but most relating to group process.

Second Theme

Value of others This describes the interactive experience of doing this work together with other people, very largely a positive experience, though sometimes confusing or fraught.

Third theme

Therapists Members' perceptions of therapists varied, but were generally positive. Clearly, several themes were strongly influenced by individual transference, but there was more concurrence than variation.

Fourth Theme

Gains This theme comprises quite clearly defined changes in clinical presentations, as experienced and described by participants.

Fifth Theme

The Family This was a particularly powerful theme for many participants, comprising the emotional re-experience of past adverse familial events and their sequelae in a new setting where different experiences were achieved.

Sixth Theme

The Journey: Self-Actualising Growth These issues reflected personal development experienced as result of group therapy.

Seventh Theme

Time This theme identifies the role of time in the group process, both in terms of structured time-points or changes and the recuperative value of the passing of time in the group.

3.B.2. THE INTERVIEWS

First Theme

Group-as-a-whole

The very existence of the group[8] was valued. It was seen as a container of anxieties, of growing self-understanding, of the potential for personal development and as a **reparative, curative** pathway through problems. For some it was **redemptive,** a new type of (longed for) cure that was more **valid** than others.

...I'd been trying for years to get it...and nobody really wanted to listen...so I did feel a sense of relief when I finally got here.

I'd been trying for thirty years to get...and nobody really listened.

I do get depressed quite a lot...especially a few months ago, and I did find that by the end of the day in the group, those feelings had lifted – so that worked – in the group.

...but it's not like, left at that level (of self-confrontation and understanding) it's that things get ***repaired*** *while I'm here, things that have been wrong all my life. They get made right, so it can be quite challenging.*

The group is the container of great **personal investment** in coming to the community, not only by members not working, perhaps going on benefits and finding the therapeutic day absorbed all of their energy *("the day here is consuming"),* but also in their

[8] *"The group" refers to the entity in this section. Interviewees came from three actual groups.(See Method: Setting and Participants)*

willingness to undertake emotional challenge, pain and risk in the groups and the hope underlying this.

I think, I was always hopeful that sorting my problems out would be the end result –but, having been through different types of therapy, I was kind of like, not taking it for granted that it would be, some kind of magic cure or magic solution...

...I needed group therapy rather than one to one...and...so it felt like a real chance at last of getting what I needed.

I've been wanting to come for ages. I've been wanting to do something, I mean it's been years for me...I'd had to be working up to come here for some time, 'cos I'd had an alcohol problem . I'd had to go to Rehab., basically,...so it took a heck of a lot of effort...

For others, the group could be a **container** of anxiety or distress and offer comfort and for some the group offered **structure** and **social contact** to what may have previously been an unstructured and isolated life, though the structure of a slow-open group could also be problematic, in that the composition changes. (See below.)

Yeah, been a couple of times where I've, I wouldn't normally have turned up, but now I do...it'll be like, if someone's really rattled my cage, more often than not I can actually say that...instead of getting annoyed for a week, then coming back, for them to try and work it out.

So it was, you know, it was like a comfort to know that I was somewhere I could start working on things.

I must have made progress, because I'm in a community, I'm a member of something, and at least it feels I've got help at the other end of the 'phone...

I mean, the main thing it's provided me with, which I probably desperately needed, was structure and contact every day...and as such it's helped...

(Same participant)... it's kind of difficult, 'cos the group is – constantly changing itself, and even though I'm now an older member of the group, it's still this problem of meeting new people and forming new relationships, even though you may have your core ones with people who have been here for quite some time.

Generally the group was seen as a **safe and stable** place, and, particularly, as **supportive**, though there could be different experiences, indicative of the **rough and tumble** of group life.

The good bit was, knowing I could...complain, or cry or, get angry and other people would have some idea of where I was coming from.

I've always felt that the group welcomed that, when I have been able to speak.

...sort of intimidating, 'cos, didn't understand what was going on – what was being said to me a lot of the time – and ***why*** *it was being said to me...*

Yes, they can be... very attacking. ***... the group doesn't spoonfeed you*** *... It can be quite a brutal experience, so you've really got...you don't talk about everything like you would in individual work, so...you've got to fight your way in ...and sort of...juggle, wrestle a bit.*

I didn't think I was able to speak in the group. I felt didn't have permission to speak and I shouldn't really be there...

A major feature of their experience was of the group as **facilitator /ennabler** of **verbalization** (a particularly threatening and relieving experience) and of **dealing with** things, which leads to **change.**

Yeah, they sort of encouraged me to talk and to sort of open up a bit and I gradually got to trust them...Yeah, I definitely could talk or give feedback now where I wasn't able to before.

I feel much more able to express myself in the group than I did at first.
(How did you overcome that? [the anxiety of speaking in groups])
Really just by persisting – I still don't find it easy, speaking in the group, at all.
They tried (to help me) – they do try, a lot of the time, but it's pretty difficult.

I still get nervous about what I say and whether it's O.K. or not, but it is a lot stronger and I'm not the same, afraid of what people will think of me...

(Change)

...it's more for me to know what's wrong and not to know what to do about it, not to know how to ***change*** *things, and the group helps me with that – supports me with* ***that*** *and encourages me.*

...Well, I was very angry, completely fell apart – just...kind of lost myself, and the same comment...happened again this week, and I was able to tell myself, that's her problem, and I haven't, you know, I'm fine.

We all sort of support each other and help each other and... talk about it really, so things aren't sort of left up in the air, they're sort of talked about, discussed and feelings are aired.

I'm much more ready to come out and say "Look, sorry, I didn't understand, explain it a bit further"...

Acceptance, feeling understood and inclusion/exclusion

Most group members had issues about the all-important question of **acceptance** and a sense of **belonging.** Generally, it had either been felt to be there from the start, or it had grown, but some members had ambivalent experiences. Some were aware that their own emotional reactions mitigated against it being easy to feel accepted. **Feeling understood** was a related matter.

Not immediately (felt accepted), though I think it was quite obvious they were accepting of me, which in itself was a quite a new experience, for me to actually feel that... (it was) amazing if I'm honest.
It's hard to give an answer to that (a question about acceptance), because to a large extent that is part of my issues, in that I do feel isolated...

I knew...that it was a community, but for me to be part of anything was really difficult. I felt sort of accepted, but I found there was a very, very close-knit group formed

...and I found that I wasn't really one of those...those...people... and it did make a difference.

They were very welcoming in the group, but I guess...it did take a little bit of time to feel accepted.

I felt very understood. I felt like – I was very kind of regressed when I came in – small and tearful, and I didn't feel that was, you know, allowed... what was hard was that everything seemed to hurt.

Some days, I've felt very much part of something and some days I've felt very on the outside.

...but that's what felt good, is that, yeah, I did feel part of something, which I needed to.

...so much was going on when I first started that I was literally missed, for about a month or so after I first started, then I was noticed...it was pointless me being there for the first month, to be honest...there wasn't any help, 'cos people were – busy, with other things, it was very difficult.

Despite and because of the experience of isolation, including within the family of origin for one member, the related sense of **inclusion/exclusion** in the group could be keenly felt.

That it was a community...to me, to be actually part of anything was really difficult.

I still feel isolated, but I'm more able to talk about my feelings of isolation and feel that in some way they're being addressed.

Some days I've felt very much part of something and some days I've felt very on the outside...up to my own mental brain waves, really.

There are times when I feel ostracised by everybody and feel that other people are being more supported than you.

Clearly many aspects of the group process and situation were **new experiences** for members. This could involve a change in perception of others, in feeling accepted and acceptable (see above), or for some, a definite **challenge to their previous beliefs about themselves.**

....they were accepting of me, which was quite a new experience...it was scary – I mean it still is now, sometimes, if I think about it...

...perhaps - because of the isolation – my life I've tended to lead – those people who haven't fitted, pretty closely, with my ideals and chosen attitudes and things, I've tended to avoid them. Here, you don't have that luxury – it's very kind of non-judgmental, this place. We're all here because we feel whatever we've done in the past hasn't worked for us...and some of them have endured awful things and some have done awful things – but you don't judge.

...even now at times that can be – a scary thing, to know that something I've believed of myself wasn't true. You know, that I was the one with all the problems, that sort of thing – you know, I believed I couldn't be accepted later on, that was the hard part.

It can be quite challenging sometimes, there are parts of me that I think are O.K. – they're not helpful to me and I'll talk about them...

Second Theme

The Value of Others

The essence of group work, that is, sharing working together with other people and the interchange with them, was highly valued by people whose childhood experience of others had often been very adverse. Sometimes fraught, and almost surprising for some, it could be experienced as a real pleasure.

The sheer **presence** of others was **valued** as reassuring or containing.

I liked the idea of being in a group with people who are there sort of every day, and I needed that ongoing support...

...felt like kind people – just, having kind people around...who looked after me!

Many aspects of emotional and information **sharing, shared guidance and feedback** were perceived as helping, though also challenging. (Unsurprisingly in analytic groups, guidance was understood not to be directive.) However, members had varied perceptions, again mediated by their own personal processes, of the value of their **contributions.**

Sharing

...initially I liked that the people who I wanted...who seemed to have some of the same issues to me and we could talk about them and to work through things.

It's nice to hear other people having similar problems than me, especially now.

...feeling quite confident and good about myself, but – y'know, I don't know whether that's just come from sort of having contact with people every day, and not just being at home all the time dwelling on things...

There are lots of times when I recognize, you know, yes, I've been there and I've felt like that and, I think it's useful to say to people then.

In some ways that's been quite frightening (sharing her problems), I'd always tell myself that I was being silly, and then when you hear that other people have the same – bad stuff - it actually made it more real – I couldn't tell myself it was nothing, 'cos other people felt it as well – so for a while it made it more frightening to me, I didn't want to - go there. But now, I feel stronger, I think it's valuable – 'specially when you see people who have come through it – people who've been in a really bad place and are stronger, that helps me a lot – I think, I know they were there, and now they're better.

...but being able to speak about them to other people and listen to their own experiences as well, I realize that I'm not the only one with irrational feelings.

Shared Guidance

you know...(Guidance)... is not as directed as that, it's more, a subconscious process in them.

I don't think it's advice or guidance because people will give you feedback, but it isn't "you should do this" or " you should go in this direction", or whatever, it is really that people tend to speak from their own perspective, and offer, perhaps, an alternative view to one that you thought, and then it's really up to you to guide yourself using that information.

Feedback

If I've had a similar experience or whatever, I will give that person feedback about it, 'cos I know, from my own point of view, how important it is for other people to say to me, yes, I understand what you were talking about...

...that is good feedback, you can't always see it yourself...

I talk quite a bit...I think they see me as being quite honest...some people find that I get straight to the core of things...

...and now, I do like listening to other people and giving them feedback and perhaps be careful not to say too much, 'cos – we're all itching to say something about it!

Contributions

I don't contribute a great deal... It feels to me that the women come here with a much better instinctive grasp of this kind of work than I have – and I feel that I struggle...I don't think I trust my own judgments very well...that they're worth very much.

I think a lot of my qualities and things I had to offer were not actually talked about very much.

I don't actually feel most of the time I give any thing they actually want.

I say quite a lot and I always have...I hope that...I think I've been very open, I needed to be, 'cos I was in pieces when I came, there was no way I was going to get me to be – closed off – so I have been open... and I think that might be helpful to the group.

Think what's nice now is that the people that are coming, I know what they feel, so I can help them persevere, and that's nice...It's nice that they listen to me and try to understand, really.

I'm more of a listener than speaker, when I do speak, I hope that what I say, is noticed...if somebody's got a difficulty, I speak to the person ...I think I do contribute, I just don't know how, other people are more better at being able to tell me than the other way round.

It seems possible that despite feedback, low self-esteem may leave some members unaware how much they do contribute.

Others in the group were seen to provide containment in a closer, more relational way than the group-as-a-whole. **Emotional closeness, respect and encouragement** provided safety, though there could be times when the group felt attacking or unwelcoming (see also above).

Emotional closeness, respect and encouragement

I was able to say how I was feeling and get help with it and they just understood and – just were near me really.

...although the people have changed, it's the whole, general, feeling of – closeness, hasn't really changed. We have been more open in our small groups than we can be in the large group. That, that sense hasn't really changed.

The other members, I was quite scared of them, it just felt like school, and these – I was a little insignificant thing at school and (they were) the big people, and that's how it felt in the group.

Clearly some people find changes in group composition harder than others.

Interpersonal experiences could lead to an **awareness of interpersonal processes** – the essence of social interaction. Only one person voiced this directly, but several members were involved in trying to puzzle out the nature of these – **is it me, or is it the group?** Acquiring understanding of this may also reflect a maturational process, moving towards greater individuation. It also expresses an awareness of the group as composed of the sum total of its members, while simultaneously having a dynamic of its own. With these developments in experience and insight into the group, came **new perspectives.**

New Perspectives

I think I'm more aware of sort of interpersonal processes than I once was.

...being my own entity rather than trying to identify with other people...and merge with other people.

I have to be careful that it's really about them, and separate myself from them.

...very supportive...and helped me see things in different lights that may be I didn't think about before.

I never used to think that there was anything wrong (with my family), I used to think that, you know, it was just me – and now I realize that it isn't me.

Third theme

Therapists

Perceptions of the therapists and their role varied, though were mainly positive. Both negative and positive views appeared to be heavily imbued with transference issues. It

was clear to members that this was a non-directive therapist style, though two people felt therapists might be cleverly controlling or manipulating the course of the session.

Therapists were experienced as **carers** (containers of the child at the centre) and **facilitators**, giving **reflection and "gentle guidance"**, providing **stability** and aspects of the primary process good mother. They could also be **remote, controlling** and **arousing curiosity** or suspicion, perhaps the bad mother, giving and taking away attention and understanding.

Stable carers and facilitators

I think that generally, whatever they're doing for me is more caring than what I had in the past ...I mean, the way I see it, is I can be in the middle, doing all sorts of things, and they'll be standing firm around me...

...and one of the small group therapists and I have an official maternal transference, so most of the stuff I work out with her...

(staying steady) ...other than me, it's the therapists.

Well to me, the therapists have always been absolutely crucial, and I've had to really learn to trust other members as much as I rely on the therapists – they're just mummies, some more than others, and, I was very, very dependent on them, and it's only gradually now I've got a more adult relationship with them, but they can still set me back in the thick of them being mummy.

Giving reflection and gentle guidance

I look on them as being – in a place like this – I look on them as being a cross between a sort of a – referee, and somebody who gives gentle guidance. Seems to be an art almost to step back, let the community carry on, just keep things on track if necessary, but, bring things back to the real world...I think the therapists' art, it's a good one, is knowing when to keep out of the way.

Capturing the essence of therapy, the same member adds:

In a sense, it almost feels as if – the members, what they're trying to do is become their own therapists.

I sometimes think they probably reflect back to the client...to the community members, what they're doing...

You'd have to listen very carefully or read between the lines to understand what they're on about sometimes. Now and again they're actually direct, but it's very rare.

Remote or controlling, arousing curiosity

They...sort of have quite a remote stance and look at just the trouble spots here and there and don't have any involvement with anybody else, it seems. There are some people who appear very friendly, but I think that they sometimes try to say certain things to certain people.

Sometimes, I keep on – to ask what they're doing...I'm a bit curious.

You can see what they do, especially if you've been there a while, you can tell that they say particular things that bring somebody else in before you start going on to speak... They literally shut you up and get someone else to speak, which does get annoying. ... Now and again, you can tell they have an agenda, but you don't know who it is they've got the agenda with, until...I think that the worst thing is, that sometimes when you do speak, they literally coax you to speak, where they want someone else, they forget about you. I suppose sometimes they really don't understand and they don't care that they don't understand.

Fourth Theme

Gains (in Clinical Presentations)

There was clear awareness of gains in specific areas identified by the interview schedule, namely: **anxiety, depression, anger, self-esteem** and **behaviour change.** Depressive anxiety in various forms was described by six of the eight members and difficulty with anger was a major and common issue, either because it could not easily be expressed or even felt, or, less often, because it was hard to control. There was both uncertainty and hope (See below, **Anxiety about the ending)** about the possibility of self- esteem generalizing to outside the group and community, and one person felt her new-found confidence was not reflected by the group's confidence in her.

Anxiety

I'm less anxious than I was, in part that's because I must've made progress, partly because I'm a member of a community...and at least it feels I've got help at the other end of the 'phone.

I still...(coping with fears in the group)...I still get very nervous about what I say, but it is a lot stronger, and I'm not so afraid of what people will think of me, I'm not so afraid of it as I was.

I think possibly not getting anxious about some things and I was very aware of people's reactions to me... and thinking it was all to do with what I did...and now I've begun to separate a bit.

Depression

I don't get as depressed as I used to, but...how much of that is real changes on my part and how much of it is due to the fact that should I need help, I can get it...it's hard to say.

I feel generally that my mood has gone – a bit - up from how it used to be. I don't get such prolonged periods, of, being low.

...since I've been here, I've had the odd day when I feel depressed here – and I come in, and it's obvious what's happening, and it'll get sorted – and it's a total reaction to what's happening to me.

Anger

I've been very aware of how – a lot of my life, I think, I've been really, really angry and not been aware of it – and that's caused the mania or the depression.

...the occasion when I actually got angry and I got angry with one of the therapists ...I was actually able to say, what it was that angered me, how it made me feel...I don't see it as, like, some other people do, are happy to feel anger quite frequently, I know I don't.

Yeah, it was one of my pet subjects, that I never really wanted to get angry with anybody – that's a lot easier now. Sometimes it gets a bit out of control when I'm angry about every thing, but I can still talk about it and it doesn't push people away – or if it does, it's only temporary – so, I'm beginning to learn that anger's O.K.

At least I've got more understanding now and I've got less anger than I did.

Self-Esteem

The core belief probably isn't (improved)...There are more moments, I think, of feeling quite good and quite confident about myself, but – you know, I don't know whether that's just come from, sort of having contact with people every day...

So, yeah, I have more self-confidence here, but a lot of it's to do with the comfort of other people I know I trust...

I've got more confidence. I think the problem is, the group has less confidence in me, it doesn't have any confidence in me...and I've got more now.

If, I say, as happened the other day – I'll ask a question and I don't get a straight answer, I don't get the information I need, I'm much more ready to come out and say "Look, I'm

sorry, I didn't understand, explain it a bit further." So I suppose in a sense, it's assertiveness.

Behaviour Change

I'd like to be able to live it rather than just theorise about it here.

Well, there's been times when people have been quite forceful with me, and I've just taken it, rather than over reacted to it – or if someone's upset me, if I can't say it on the spot, I might say it in the next session.

And it wasn't very long ago...somebody in the group envied the competence I was showing in the group and that really touched an old nerve – I'm not allowed to be – competent, and I completely fell apart – just, lost myself, and the same comment, more or less, happened this week and I was able to tell myself, that's her problem, and I haven't, I'm fine.

Fifth Theme

The Family

This was a salient and poignant theme for most members, and so has been given a separate entity, though there are certainly commonalities with other themes. It is also a therapeutic factor which has been seen as problematic in the research literature, having low ratings of value/helpfulness, which challenges clinical experience. However, it *was* a strongly expressed issue emerging through interview.

Group material related to the family aroused **evocation**, often of fears, though the group process could bring **greater understanding**. A major difficulty was **resolution** of family trauma, in that redress usually seemed to be only partly achievable, whether because of family members' continuing dynamics, or because they had died.

Evocation

It has brought up several memories...not all that good...my most difficult relationship reminded me of how I reacted to somebody like as...as a child, I couldn't really explain...I just had this vague sort of feeling about what the relationship felt like...and I'm re-experiencing that.

...certain dynamics with in the group have made me feel like I feel at home. I tend to feel excluded from my mother and sister at home and... there's been instances when there's been a close friendship between two people here and I felt excluded.

Greater Understanding

It's only things like...if a confrontation's building within the group – that kind of reminds me of childhood sort of escalation of confrontation, so, that's one situation where I tend to react a little bit.

The actual relationships haven't changed – how I feel about them has – and how I understand them has dramatically. I never used to think there was anything wrong with my family, I used to think that, you know, it was just me – and now I realize it isn't just me. It hasn't changed the actual dynamics of my family...but I do feel different.

Yes...my family life, my upbringing, has been very unfortunate, I suppose everybody here could say the same... I had quite a good understanding of things, the dynamics of the situation, when I came here, I think being here has helped me understand them a bit better.

Resolution

It feels like that's what it has all been about (family relationships) – and it's been really painful...It's, facing up to the way I became and feel because of my early childhood, which was absolutely traumatic, and I didn't want to know...I just wanted, like, "You've got an illness, have some drugs, you'll be fine" – and to actually have to face my childhood, it's very painful.

...I didn't see any thing other than, my mother was perfect – so that's really helped. But it's still part of me and it's still alive.

...there's two sides to that. One is the real, practical side...because we've all got different problems and I'm the one who ended up being labelled as the one with the problem – we have to talk as a group, we talk about what I should do...But then there's the side, which is, probably at a more bizarre level, which is all the transference...it's rife with me...so, people are representing my mother, or my brothers, yes...it's to do with what went on with my mum, and so on...which is fascinating and painful at the same time.

And it's nothing really I can do anything about as most of my relatives are now dead and those few I have got left, to be honest, I think the relationships are beyond repair...

...with my relationship with my mother, it has, I think (helped with relationships). ...and sort of helping quite a bit being my own entity rather than trying to identify with other people...

Yeah, it has (helped with family problems). ...Hard to describe how the group helps me, s'pose – you start talk 'bout one thing, and then, take you to something, without you realizing though – they do help, very hard to describe how, but they do ...some of my problems aren't due to my past, they're due to my xxx, and the group aren't able to help me with that problem.

Sixth Theme

The Journey: Self-Actualising Growth

This theme forms a direct link between the opening theme and personal growth acknowledged to be a consequence of the pervasive experience of the group-as-a-whole. The sense of a journey undergone was expressed clearly in members' views on finding their place in the group, in **development of role** and personal psychological shifts towards **greater rationality and self-understanding.** These occurred as a result of **primary process** maturation: **regression** and the **integration** of split-off parts of the self, strengthening of the **core self,** and some sense of the **internalisation** of **good objects,** which had been lost in childhood. These psychic processes represent **repair** (See First Theme) and growth, which was also expressed by the two male members in **creative thinking** about life after the group. For some, there was **reflection** on their achievements and **survival.**

Development of Role

... it was difficult to talk, as well, 'cos.....if there's eight people there... ...it's difficult to know when to take your turn. (Later in group) I do talk a lot – at times I talk an awful lot...sometimes liven things up, I think I'm supportive.

(feeling more part of something) Yes, I do, but it...to some extent that's because I know the ropes now and because I've been here 12 months, I've sort of moved up the ranks...I'm one of the old hands.

*...and it's about knowing how to put that across...***being different and yet still valid.**
I think it's helped me that people could let me give to them as well. ...I didn't dare give anything to anybody when I first came – I thought – I thought I'd be completely inadequate and now I feel like, people will accept me, give me feedback more, hugs or comfort...so that's made me kind of stronger.

I never used to say very much, just listen a lot. It was very hard for me to talk – I started talking a lot in the last three or four months ... but I tend to be the person that other people will call if they need help and – that does kind of make me feel, well, I must be doing something O.K. ...now I'm the most senior member, so there have been changes...

Yeah, I kind of feel responsibility now as the oldest member...my own sense of responsibility's changed.

Increased Rationality and Self - Understanding

It's making me much more aware of what my underlying issues really are...of what it is that affects me adversely. And in some kind of way, I'm chipping away at it.

At the moment, I have a physical response to most things, rather than to, you know, to rationalize it... Before I came here, I used to intellectualise everything. And I can't, I've had lots of things here that I can't express.

(my fears) I think if any do come out, then – they probably sound perfectly irrational, but I know they're probably quite logical fears...I realize I'm not the only one who feels irrational feelings, that in itself has helped.

...I was always talking from my needy place, and now I'm much more able to talk adult to adult with people than I was before.

Primary process issues

I was very kind of regressed when I came in – small and tearful...in the group now, people want to hang on to my stronger self, so I find that people are...acknowledging that more, which is helpful, but...it's quite difficult when the needy bit comes up, y'know, to get the balance between being the stronger self and getting the nurturing...

I think it's helped in the group people seeing different parts of me and acknowledging them, saying O.K., yeah, that bit of you's O.K., bring it here...

...and I was kind of flooded with what I think is emotional memories, and my body – emotions...I had emotional memories of being a baby...and I could visualize myself being

in a pram, I don't know, it's more feelings – they weren't, I couldn't, it's just like very early stuff or something.

...so I did the big, strong "I know everything " act, and that was a total sham, 'cos I was falling apart inside, and I did fall apart and I've come here now and I'm getting all the bits sort of put together...it's quite painful really...it's quite profound, really ...it's difficult to explain, 'cos I've changed a lot...and people have noticed...

I mean, one of the things that's really pronounced for me, is that I think I can now cope with myself when I feel I'm regressing. I can comfort myself, which I didn't, and I can let other people comfort me, which I couldn't. And I know what to do with my two-year old. ...my diagnosis is bi-polar...what I was told (here) needed to be done about that in the sense of putting the two bits together...what my process is, is to see all the bits of me and to accept(them), even the bad bits, 'cos that's been really hard for me to do, to accept that there are bits of me that aren't very pleasant...and deciding what to do with them, so I could have evil thoughts but I don't have to act on them.

(describing "a very peculiar experience") ...I'd become two people, one of whom was observing the other from a distance – and it felt alright, it felt safe – and one of whom is going to look after the other...I don't know where I'm going to go with it, but it felt valuable and I don't think I'd have gone through that if I hadn't been here...and thinking "this bloke's alright, my god, the things he's done with his life, the things he's achieved".

...I was very aware of other peoples' reactions to me ... and thinking that it was all to do with what I did ... and now I've begun to separate a bit.

Other things, it's helped me, but I'm not quite all the way there yet – hopefully I'll get further along and maybe grasp it properly – but even if I don't, I've got more understanding of myself than I used to have.

Oh, I have nasty thoughts about people, and I'm starting to explore that and verbalise some of them – it's O.K. to do so – but my vindictive side isn't pleasant, but it is there and I'm acknowledging it...

Creative Thinking

I want to finish off the old cottage I'm working on and sell it...and I can move somewhere where I can feel more part of a community, ...a few holidays with my wife, and hopefully go back to university and do some future business.

For me, ideally, I'd like to do something totally away from what I was doing, which was xxxx. I'd like to do something creative, or working with people, or teaching, or something like that.

The Emotional Journey: Reflection and Survival

I've only really been doing well in the last few months...I didn't know how to. I didn't really understand how to – but, it was my own doing.

Yes, I think because I have a lot to go through, just ordinary having fun can be quite difficult.

I often think this is so tough, but when I talk about it and I think how I was, I've actually come a long way.

Seventh Theme

Time: beginning and ending

Specific and shared experiences emerged relating to the difficulties of beginning and finishing. The **beginning** was characterised, predictably, by intense **ambivalent anxiety and uncertainty**, about how one would be received, bring personal problems to the group and even manage to speak. (See also above, First Theme) A flutter of panic was sometimes experienced at the **nine-months, halfway mark**, and as the end approached, uncertainty and anxiety returned, this time characterised for some by worries about **whether their gains would generalise** to life outside the community – will I survive without my therapist? – and by worry about the social isolation which had been a feature of some of their lives before the community. A common theme **towards the end** was the **need to do more**, to somehow work harder, before leaving. Some members were conscious of a simple need for the passing of time to resolve and heal conflicts.

The Beginning

Very frightening – sort of intimidating, 'cos – didn't understand what was going on...

It was nerve-wracking because I had no idea what to expect, really...I felt to some extent I was pitching myself into the unknown, but also it was a relief....it was quite obvious they were accepting of me...amazing if I'm honest...scary.

When I started here, I almost had a sense that if I cried I was going to be - punished, and that has gone...

It was very nerve-wracking for me, and still is...It almost prevented me from coming, and - staying because of the anxiety about speaking in groups

It was absolutely terrifying – but – it was a relief as well. It was a feeling of, this is the place I need to be, where I can get help, but very, very scary as well.

It was a relief to get out of the house, actually, talking was very difficult, very nerve-wracking, very scary – but being with people that had some idea was a relief.

...because I was the new member – I found it alternating between feeling as though they were trying to look after me, and help me – and feeling as though because I was new, I didn't have any right to say anything yet.

Middle

...it was bang on the nine months, actually, I cracked up...and then we...I...hit all these negative feelings, like anger, fear, ugh – a massive void, the whole lot, and it was really, really hard to keep going.

...then at nine months I had a review, just expressed how I felt – about myself, about being in the group – and it did seem to get better, until xxx...(Time of Year)

It was very hard around eight – nine months. I was very conscious of being half-way through at nine months and sort of starting to panic...

Yeah, very panicky about being half-way through, and had I done enough already and had I wasted time ...in preparation for that (nine month review) I was thinking about what's happened these nine months.

Towards the End

I still don't think that – out there I'm better. A lot of it's just knowing what...to expect, so I'm a bit more comfortable. So, yeah, I have more self- confidence here, but a lot of it's to do with other people I know I trust.

I guess coming up to the year ...I kind of thought, I'm two-thirds of the way through it now, so I need to – ask for help, to try and change things.

In some very real sense I feel that at the end of time here there's a void waiting for me...an I have very great apprehensions about becoming old...When I actually leave this place will be the end of xxx next year, so I'll have to put up not only with leaving but also with God knows what awful weather.

I'm still pretty socially isolated – something I'm starting to work on...I've little social contact (my friends) don't live locally...that is a worry, that I do need – 'cos I leave in six months, so I do need to pick that up, 'cos I don't particularly want to end up going to mental health drop-in centres...if I could avoid doing that, go to places with everybody else, it would be of more benefit to me. I'll get stuck for what to do with, social life,' cos I lost a lot of friends...it's almost like living in a new area.

I do find relationships confusing. That's one of the things that worries me, is that I've only got six months to go, and – will I be able to make it to the summer? A mass of confusions and self-doubt.

It's difficult because I actually had to cut back on my social life...because of, you know, the temptations of drinking, so, not wanting to interfere with the, sort of, therapy side of things.

Time

Time patterns had been experienced as fluctuations, both in personal difficulty and in the way different kinds of help had been important at different times. Most members felt there was not a phase- linked pattern, rather a constant "up and down" in ease or struggle. Half of them did point to the simple **need for** and value of **Time** itself, in order to experience and resolve their needs of the group.

the amounts of work, what's gone on, has been, constant.

Then after about two weeks, I felt a period of fairly steady decline, then the general trend seemed to be upwards, but now I'm going through another sort of period of uncertainty

It's been a real up and down time, in terms of how integrated or connected I felt in the group. The first three months was very difficult, and it got a bit easier – and towards my nine months it got a bit more difficult again

Sometimes they can provide (different help at different times) I just say, oh yes I can agree with that, or I've shared that experience. Sometimes we go up and give physical support to...people who are in distress...

I think...the last couple of months have been most useful...I got a lot of help in the beginning, but it's people trying to make things nice for you...and then that tapers off and then most people get to know you really well and it gets more fundamental sort of support.

It really does vary...every now and then, I'll go back to that place, and I can't say anything, I can't talk. So, yes, sometimes it gets harder, sometimes it gets easier, it doesn't seem to be any sort of pattern.

It varies really, it depends on what experiences are around in any given situation, really...

Time needed

...if I let myself believe everything that people say...but I'm still...I still don't let myself believe everything, totally.

...I guess it did take time to feel accepted...

It took quite a while to begin with...to bring sad feelings to the group...and then not all of them, but most I think.

My mum died about four years ago, and it still affects me...I think that's gonna take a lot of time, 'cos I was ill for a year, maybe two or three years after it.

(the group have helped)...being...giving me the time to talk about it and having plenty of opportunities...

I've been here, it's given me the courage to do that (grieve for her father) and that was a huge milestone. It's helped me with that. Other things, it's helped with, but I'm not quite all the way there yet – hopefully I'll get further along and maybe grasp it properly...

3.B.3. IDENTIFICATION OF THERAPEUTIC FACTORS IN INTERVIEW MATERIAL

Interviews were re-examined to identify references to the eleven therapeutic factors. It is clear that some factors were well represented in interview, whilst others rarely appeared. Two points should be borne in mind. Firstly, although every effort was made to include *all* references to factors, this was not a precise art (there is clearly considerable potential overlapping in the quotes above) and it was not possible to exclude inference. Secondly, mentioning or describing a factor does not necessarily convey information about how *helpful* it was found.

A number of references - to Acceptance, for example - were negative. There were twenty-five references to negative experiences overall, though these were often descriptive of a particular stage related to a theme or factor, and Yalom's questionnaire does not directly comprise negative experiences of the group process.

Table 3.B.2. Ranking of Therapeutic Factors by number of references to factors in Interview

Therapeutic Factor	Number interview references	Rank by Refer.s
Acceptance	38	3
Altruism	26	5
Catharsis	12	9
Family Reenact.	15	7
Guidance	6	11
Instil. Of Hope	20	6
LIA.	42	2
Self-Disclosure	27	4
Self-Underst.	48	1
Vicarious Learning	9	10
Universality	13	8

In accordance with Yalom's theories of group psychotherapy and with findings in early research with outpatient groups, Self Understanding and Learning from Interaction occupy the highest ranks in the interview material, though in the MTFQ Self-Understanding is ranked in eighth place, progressing to sixth. Interview material suggests reasons for this may have more to do with non-compartmentalisation of this factor by group members than with specific questionnaire items, as in the example below, which refers to self-understanding without conceptualizing it as such.

...Probably the first nine months I was ...a needy baby, basically, and something traumatic happened to me and since then I've gradually found my stronger self and what happens in the group now is that...people are acknowledging my stronger self more, which is helpful, but then it gets quite difficult when the needy bit comes up... trying to get the balance between being the stronger self and the nurturing, it's quite difficult.

Self-Disclosure does not have the primacy in interviews that it does in the questionnaires. This may because it was apparent from interview that the question of "speaking" (about oneself), was crucial initially and then taken for granted as the group progressed. Participants may have rated it highly in the questionnaire while not necessarily focusing on it per se in interview. (See example below) Ranking of Catharsis showed the expected links with Self-Disclosure only in the first two phases of the MTFQ.

Example

There are parts of me that I think are O.K....they're not helpful to me and I'll talk about them – that doesn't happen very often...it's more for me to know what's wrong and not to know what to do about it...and the group helps me with that, supports me with that and encourages me.

Acceptance occupied a ranking of 2 – 4 in both interview and questionnaire and was clearly an enabling and sensitive experience. Altruism showed variation between phases, becoming more helpful as the group progressed, and ranked fifth in numbers of references in interview, if interpreted to include experiences of support given or received and the helpfulness of empathizing with another's pain by speaking of one's own similar adverse experiences.

The MTFQ results gave Instillation of Hope and Universality primacy in phase one, which then dropped to ranks of eighth for Universality and ten and eleven for Hope. This is perhaps why Hope ranked mid-way in numbers of references in interview. It was conveyed clearly initially in the sometimes intense personal investment in coming to the community, but decreased in importance as therapy became established. MTFQ data indicated that Guidance was more helpful in the beginning and middle, but it was the least mentioned in interview, despite a prompt which referred directly to it.

Family Reenactment increased strikingly in helpfulness, according to questionnaire data, but was referred to only moderately in interview. This is partly because there was a section of the interview schedule devoted to it, and it was not mentioned often elsewhere. However, this is a good example of the difference between number of references and helpfulness, as it can be seen from the quotes that this was an intense and valuable aspect of the group process

3.B.4. EXAMPLES OF REFERENCES TO THERAPEUTIC FACTORS IN INTERVIEW

Acceptance

I don't recall not feeling accepted – any feelings of being out of place, I think – were purely mine, I think. It wasn't to do with any kind of response I got from people – it was just my – lack of feeling comfortable in groups.

Felt it was accepted that's the state I was in...and that really helped...people supporting and not disapproving, you know...

Altruism

Sometimes we go up and give physical support to people who are in distress...I suppose you know about the system?

I've certainly changed in that I'm more reluctant to speak myself until I know that everyone else is O.K.

Catharsis

The good bit was, knowing I could...complain, or cry or, get angry and other people would have some idea of where I was coming from.

I didn't really experience my emotions much before I came here.

...things aren't sort of left up in the air, they're sort of talked about, discussed and feelings are aired.

Family Reenactment

It's only things like...if a confrontation's building within the group – that kind of reminds me of childhood sort of escalation of confrontation, so, that's one situation where I tend to react a little bit.

The actual relationships haven't changed – how I feel about them has – and how I understand them has dramatically.

Guidance

you know...(Guidance)... is not as directed as that, it's more, a subconscious process in them.

I think some of the community members do (give guidance), but they're usually the ones who take on the leadership role.

Instillation of Hope

...I needed group therapy rather than one to one...and...so it felt like a real chance of getting what I needed.

So...I'm more hopeful that if I can't do it, then, there are things that I can do.

Learning from Interaction

Yeah, been a couple of times where I've, I wouldn't normally have turned up, but now I do...it'll be like, if someone's really rattled my cage, more often than not I can actually say that...instead of getting annoyed for a week, then coming back, for them to try and work it out.

If I've had a similar experience or whatever, I will give that person feedback about it, 'cos I know, from my own point of view, how important it is for other people to say to me, yes, I understand what you were talking about...

Self-Disclosure

Yeah, they sort of encouraged me to talk and to sort of open up a bit and I gradually got to trust them...

Dunno if I could cope with them (my fears) if I wasn't here – but because I can talk about them, they don't...

Self-Understanding

...being my own entity rather than trying to identify with other people...and merge with other people.

It's...more, just helped me to see things differently or understand more, or even...to not worry so much that they're unresolved and to carry on.

Vicarious Learning

...but through a process of interaction it highlights your own strengths – so you can utilise those. Highlights your weaknesses, so you can work on those.

'Cos I've changed a lot and people have noticed that.

Universality

...initially I liked that the people who I wanted...who seemed to have some of the same issues to me and we could talk about them and to work through things.

There are lots of times when I recognize, you know, yes, I've been there and I've felt like that and, I think it's useful to say to people then.

Inevitably, there was overlap in material, both in terms of various quotes encompassing more than one theme and in terms of describing therapeutic factors. This is a function of the inter-connectedness of human dynamics, and while it is a phenomenon which has bedevilled research into the psychotherapeutic group, it also simply reflects reality.

Example containing multiple factors

I think I've been very open – there was no way I was going to get me to be closed off – and I think that might be helpful to the group.

This could refer to Altruism, Vicarious Learning (for other group members) and Universality.

Summary

The dual research objectives of providing a broader exploration of group experience and of ascertaining whether interview material supports the questionnaire ratings of helpfulness of factors were realised through using semi-structured interviews and thematic analysis. The results will be examined in the Discussion section.

CHAPTER FOUR: DISCUSSION

4.1 INTRODUCTION

The results of the quantitative part of this study were disappointing, in that no findings could be demonstrated for the helpfulness of the Therapeutic Factors Questionnaire, nor for its properties, due to the unexpectedly low sample numbers. They were also exciting and rewarding in that the interview material presented a rich source of subjective participant information about the experience of being in a small therapy group. This consisted not only of data about what was helpful, but a continuous narrative about the unfolding of the process.

It is generally possible to suggest realistic potential explanations for psychological research findings. This is particularly the case where the research field is complex and unclear, as it was here. The literature has produced examples of contradictory findings where convincing interpretations have been made for both results. This may always be possible where many variables are involved in a constantly fluctuating process and where studies are rarely replicated precisely. An advantage of the qualitative method used here is that the material speaks for itself and reliance on the interpretation of the researcher to attribute meaning (for example, to statistical findings) is minimised. However, the researcher plays an interactive role in determining the content of the material produced.

4.2 THE FACTORS

Interview material indicates quite strongly that most factors were helpful for most participants, rather than suggesting dividing lines between problems and personalities. Commonality rather than specificity appeared to be an over-arching theme. Perusal of

clinical problems (Table E.1.3.) shows that this was an homogenous group. This raises a question about process and individual variables. Is the basic psychological and emotional process the same for mixed presentations? The literature on therapeutic factors would suggest that different factors are found helpful for different presentations and that there is possibly a different process. (Maxmen, 1973; Macaskill, 1982) Comprehensive group analytic theories such as Bion's, for example, describe common processes, but there is not yet enough research based material within group analysis to elaborate such theories in terms of presentation or helpfulness of the experience.

The agreement of therapist and patient ratings of helpfulness could only be studied in two individual cases, where the therapists tended to rate helpfulness of factors lower overall, though in generally similar patterns to patients. The exceptions are detailed in the results section. (2.B.3., P.92) Therapists were not interviewed.

Most interviewees found **Acceptance** to be helpful, from the start of the group experience, despite, or including, difficulties reported in interview data. McKenzie's model (1987) suggests that acceptance and engagement are initially crucial, though engagement also *depends* on acceptance. The interview material indicated that for these participants it was not only helpful, but a mixed and possibly fraught experience at the beginning. Acceptance was related in interview material to feeling understood and feeling included or excluded, and perhaps to some degree to Core-Self development and thus to acceptance of self. Containment and structure were also loosely related, in that they provided a space where one could be accepted. Acceptance by the group was invariably a prerequisite for finding the courage to self-disclose.

Interviews supported Yalom's view that the sharing of experience leads to a sense of universality, though not with his related notion that the *first* task of the group is the search for meaning. (Introduction, P.44) Later, when members largely felt they *had* been accepted, it was clearly still important, but perhaps a more comfortable and familiar experience. Ratings of the value or helpfulness of Acceptance/Cohesiveness over time have been quite consistently high in the literature, either staying stable over time (Kivligan and Mullison, 1988) or being of most importance in the early stages. (Kivligan and Goldfine, 1991; Bloch et al., 1979) Research findings as to its importance later in the group have been varied. Acceptance has also emerged very strongly from the literature as a crucial factor in group psychotherapy, parallel to the increased value attributed to unconditional regard in the Rogerian counselling movement. It decreased in popularity as the closely allied Cohesion/Cohesiveness became a focus of research.

It would seem to the author that both these are features of group experience, the one individually orientated and the other a function of the group-as-a-whole, and that both are relevant, but if the spotlight is on individual experience, Acceptance may be a "cleaner" concept for research purposes. The importance of creating a sense of Acceptance in the therapeutic situation is well-known and researched. Participants in this group both desired it and found it difficult at first, but this did not diminish its helpfulness in their eyes.

Altruism figured rather little in interview. It may or may not have been related to the awareness of interpersonal processes. Examples of altruism were mentioned in interview, but not often directly, requiring some degree of inference or interpretation. Interviewees found the group to be mutually supportive to a high degree, which *implies* altruism, but it may not have been conceptualised by them in this way. Yalom's items refer to the *giving*

of altruistic acts, rather than the receiving, and one wonders if it is reasonable to expect individuals suffering emotional distress to find giving this kind of generosity helpful, particularly in the first phase. It may be that this factor is of less cultural interest now than it was in 1960s/70s America.

Self-Disclosure was conceptualized as "speaking" or "talking". Telling the group about oneself and feeling "able to speak", especially the "bad bits", were major issues presented in the interviews, though the factor ranked fourth in number of interview references. The expressed anxieties accompanying discussion of this factor were mentioned much less in the context of the middle and end of the group, suggesting that the anxieties had subsided.

For most participants this experience seemed to gradually become easier as they felt more accepted by the group and became more able to explore their problems, suggesting a quite powerful dependence of Self-Disclosure on Acceptance. Bloch et al. (1979) distinguished between **Catharsis**, which describes an expressive unburdening of emotional material and Self-Disclosure, which refers more to the imparting of information. Yalom felt that the two are so closely related that they could be one factor. Catharsis is a factor which is more salient in the early research, and not as much discussed in the psychotherapeutic world as it once was. In interview, interpreting most references to Catharsis involved some degree of inference.

It may have been that information about the cathartic relief of disclosure was embedded in responses to a prompt in interview as to whether entry into the group was a *relief,* though this was assumed to refer to a more general experience. It appears that members

had an ongoing narrative about how they *felt* in the group, and catharsis was subsumed under this. Related to this process were interview sub-categories like facilitation of verbalisation, which led to "dealing with things", which brought about change. Lieberman, Yalom and Miles (1973) found that increased Self-Disclosure brought improvement in insight (See Appendix E.2., P. 225) There were instances of "speaking" being related to development of role and to sharing, guidance and feedback.

The interviews conveyed a very accurate understanding of the lack of directive **Guidance** in an analytic psychotherapy group, but according to interview responses, the perspectives other members conveyed *were* valued and the two generally most highly rated items for Guidance in the TFQ both concerned advice given by other group members.

In interview material, **Universality**, sharing and feeling "not alone in having my type of problem" was a relief and perhaps a comfort, but was not a subcategory which elicited the same flood of responses as some other factor related prompts. Butler and Fuhriman (1983) suggested that this factor stays fairly constant, whereas McNair-Semands and Lese (2000) found that Universality, Self-Disclosure and Hope increased in "presence" over time. In interview, sharing and self-disclosing facilitated or were related to Universality, and this factor also seemed to be loosely related to emotional closeness and encouragement.

Instillation of Hope ranked sixth in interview and the references were mainly in the context of starting the group. It appeared, however, from the degree of personal investment expressed that the Instillation of Hope was vital initially, with a particular

hope that the group could repair and cure, though this decreased subsequently. If most participants found the group as helpful and curative as they said they did, then it is likely that the *need* for hope would decrease or that it might be simply taken for granted.

There is little research literature on this factor, but the findings of Gauron (1977) and Yalom, Houts and Newell (1967) regarding the advantages of pre-group preparation may be relevant here. All therapeutic community members attend a pre-admission group one afternoon per week, for three to six months. This may have intensified the degree of personal investment and raised hopes that this intervention was valid and could be helpful to them.

Family Reenactment was certainly a powerful experience for most interviewees and clearly related to evocation and to greater understanding of family. It was also related to a degree of resolution of family problems. It played a part in facilitating increased rationality and self-understanding, and perhaps led to valuing the presence of others more. Equally, participants' positive experience of "significant" others in the group may have facilitated the transferential working through of family conflict.

Even allowing for the fact that there was an interview question asked about family experience and the group, many of the responses were full of intensity. Most members felt that the group had evoked family dynamics, and by helping the participant to see the problem more systemically, had enabled them to be relatively free of the sick role. Despite this and the prompt about the family in the interview schedule, the number of references to it placed it at seventh place.

It was evidently one of the most difficult and painful aspects for most participants, but clinical experience suggests that family issues, like childhood abuse, are often not brought, or brought fully, to therapy for some time, and therefore Family Reenactment might not be an ongoing factor like Self-Disclosure, Acceptance or Learning from Interaction. It is of interest that no participant brought the topic into the interviews other than tangentially until the prompt question was asked. It seems likely from perusal of clinical notes that many of the experiences of abuse were family related. The departure from general findings of the literature in relation to Family Reenactment may be a feature of this sample, which demonstrated high levels of distress and traumatisation.

In the current study Family Reenactment fared better than in many other studies. Bloch et al. (1979) omitted it since they thought that it had produced typically low values because it was subsumed under Self-Understanding. In this study, **Self-Understanding** produced the greatest number of references in interviews and was clearly of great importance. Much of what was said about family issues was indeed expressed in terms of greater understanding of self and family, but conversely, the understanding of self was not restricted to family matters. The perspective of Weiner (1974) was that a forced choice questionnaire cannot access the change in the unconscious which is the start of self-understanding but which may be expressed as discomfort.

Insight is not necessarily understood by clients in the same way as clinicians use it, and equally, it seems that one cannot assume to know precisely what Self-Understanding meant to participants. They described many experiences of gaining understanding without using the word at all. This may be an effect of the word not being used in prompts, to encourage open exploration, as it was felt that the factor is a particularly

complex one. Self-Understanding may be an aggregate of a number of intuitions, emotions and cognitive restructuring. Feeling and being understood were as important as self-understanding to these participants.

As in most therapeutic factor research, **Learning from Interaction** appeared to be highly valued in interview material, ranking second in number of references. It seems to have been closely related to Self-Understanding, in that participants expressed the learning and insight gaining process as one, though again, the word "learn" was little used.

There was not a prompt related to this factor in the interview schedule, but members described many learning experiences, particularly in terms of behaviour change and in relation to mood, anger or self-esteem. Clearly, all the sub-categories in the theme "Value of Others" would have facilitated this, which in turn, helped to lead to clearly described improvements (Gains) in clinical problems, including behaviour change. For Yalom, this was of the essence. It is hard to disagree with the idea that the group is a socially interactive forum where learning and change can take place through new and different experiences, but the emergence of this factor in so much research, including the current study, also lends credence to his approach.

Vicarious Learning was ranked only tenth in interviews. There were very few references to having learned through another member's example. There was an experience of sharing information about oneself and finding commonalities, which led to feedback and "feeling understood", and to the group tolerating or reflecting maladaptive behaviour or emotional reactions, which could then lead to change. In other words, this was part of the whole process of the group rather than a discrete experience.

It seems likely that some factors changed little in value over time, though this could not be precisely deduced from the interviews, while others, like Family Reenactment and Self-Disclosure were increasingly valued or found easier as the group progressed.

4.3 PROBLEMS OF METHODOLOGY ENCOUNTERED IN THIS STUDY

Non-exclusivity of factors

As has been noted, a major problem with this area of research is posed by the non-exclusivity of therapeutic factors. It is unlikely that a comprehensive taxonomy could be devised where this would not be the case. Some high inter-correlations of factors can occur, and these can even vary considerably between phases. They may realistically make sense. Acceptance may show a strong relationship to Self-Disclosure, because it facilitates the latter. Learning from Interaction enables Self-Understanding and Self-Understanding facilitates an improved quality of interaction in the group. Catharsis may precede and then be subordinate to Self-Disclosure. The Instillation of Hope and the depathologising effect of Universality may overlap, and so on. In addition, some factors represent external phenomena, some internal and some both. The difficulty is not in accepting that this is so, but that it raises the question "What are we actually measuring, and what are we seeing in the results?" perhaps more pointedly than in connection with single symptom measurement, such as depression. This intricacy has in turn created great difficulty for researchers attempting to relate factors to outcome.

The interviews made it very clear that this interweaving of process factors simply has to be accepted as expressive of the dynamic life of the group, as it is in life outside the group.

In the TFQ some items may not have quite captured the essence of the factor. This is easier to do in some cases than in others. This was apparent in the Pilot study, where trainees were asked to categorise questionnaire items into therapeutic factors. Altruism may not have been conveyed in a way that was relevant and meaningful to the group members. Sometimes even the presence of a key word which gives a clue to the appropriate items-factor category, did not ensure accurate categorization, though clearly a key word alone cannot sum up the essence of a factor. In the case of Acceptance "Revealing embarrassing things about myself and still being accepted by the group" was not highly rated as helpful, though it was described in interview ("the bad bits") and it was also a source of error in categorisation, despite the use of the word "accepted". Similarly, two thirds of trainees did not categorise "Learning how I come across to the group" in Learning from Interaction, even though the word "learning" appeared. If these effects were found, either internal consistency may not have been as good as tests suggested, or alternatively, one cannot rely on conveying the meaning of a therapeutic factor to unknown individuals.

Problems of sample size

The small numbers encountered in this group disabled the study. To obtain reasonable numbers from such a group, it would have been necessary to run the study for three years, perhaps stopping the new intake during the last year, which would have balanced the size of the phases. It was unfortunate and unforeseeable that the groups were not filled, since

numbers had been maintained in previous years. Unfortunately, these problems characterise much small-scale clinical research.

Feasibility of Measures

The use of quantitative methods in a process study is problematic. In general, there are difficulties in applying quantitative methods to data in this kind of research, as the data structures may be irregular, as in this study, and the dual problems of small sample groups and attrition frequently affect the viability of statistical tests and therefore research findings, as they did here. There is a further question which may be asked concerning the *meaning* of numerical data in relation to dynamic processes, and in this respect, even had numbers been sufficient, the communication of subjectivity which the interview method allowed was vastly superior in conveying the individual's experience of the group. However, this kind of data does not lend itself to pinning down variations in process and it is not easily conveyed to or accepted by monitors of clinical governance and funders of services.

4.6 CONCLUSION AND RECOMMENDATIONS

The study aimed to explore process in small outpatient psychotherapy groups, and to produce a coherent narrative of experience for the individual and thus for the group as a whole. This was achieved. It also aimed to test the effectiveness of a modified Therapeutic Factors Questionnaire, and this proved impossible.

Recommendations for Future Research

This work may be considered to have contributed to the research field by illuminating a process which enables us to look at the helpfulness of different aspects of group therapy

in particular populations. It therefore has potential for defining the needs of particular populations in group psychotherapy. In this case, it has indicated specific process variables in a highly symptomatic sample in a therapeutic community. The improved understanding this generates may have implications for therapist training. This research indicates that individual variation is to some extent overtaken by trends which are general to the group, but it is also important to understand what individuals bring to a group initially.

It is not possible on the basis of this study to make statements about the validity of the Therapeutic Factors Questionnaire, which does not detract from the method's usefulness, but the factor concept was reflected in semi-structured interviews. A direction for future research might be:

a) To further our understanding of experience in the group and replicate these findings within similar clinical populations.

b) It would be particularly useful to explore the impact of the initial stages of the group. Not all group members are as highly motivated as the groups under scrutiny here, and we need more understanding of the problems of engagement and acceptance at the beginning. This might help us pre-empt some of the attrition common to many psychologist- and psychotherapist- run groups. Perhaps an exploratory interview similar to the current format could effectively differentiate between the clinical and emotional needs, and possibly personality attributes, of a variety of populations and individuals.

c) Yalom did not incorporate negative experiences into his questionnaire, which are only inferred by low scores, but interviewees described a number of these, and they are

revealing as to which aspects of experience therapists might need to be especially sensitive. It seems crucial to consider these too. It is apparent from interviews that positive and negative experiences of factors are not necessarily opposed – for instance, an initially negative experience of Acceptance could make its evolution into a positive one particularly creative.

Summary

Experience of helpfulness in the group

It was not possible from interviews and thematic analysis to establish with any rigour that factors were more or less helpful over time, but interview material suggested that there was a process which unfolded and that there were particular difficulties as well as resolutions where time made a difference to what the individual found helpful. The tendency to find factors increasingly helpful as time passes has been found elsewhere in studies as far apart in time as those of Butler and Fuhriman in 1983 and McNair-Semands and Lese in 2000.

More specifically, some factors were important to participants right across the phases, notably Acceptance and Learning from Interaction. Family Reenactment, Self-Disclosure and Self-Understanding increased in helpfulness over time, which suggests that a containing and accepting environment enabled group members to disclose and confront difficulties in front of and together with other people.

Conversely, a group atmosphere which is not facilitative in this way can be ineffective or even adverse, and therapists are crucial in *holding* the group while allowing it to apparently flow in whatever direction emerges. Patients became aware that this happened

and even admired what was termed the therapists' art in "keeping out of the way" while containing all that arose in the group.

The value for these often traumatised survivors of being able to recall and relive past experiences in their families, whether through a transference to the therapist or through interaction with other group members, was considerable. There was a connection with Learning from Interaction which was clearest in relation to interaction with others. There seemed to be a crucial interplay of Family Reenactment, Self-Understanding and Learning from Interaction in relation to the original sources of distress, which underpinned the slow development of Self-Understanding. This surely is the essence of group therapy - "dealing with things" through eliciting information, facilitating comprehension of the previously incomprehensible and slowly evolving new ways of being in relationship to people.

The interviews indirectly highlighted precisely the difficulties of research into dynamic group therapy, in that they conveyed beautifully the power and fluidity of a psychotherapy group. The interview/thematic analysis method proved extremely effective in accessing the subjective experience of the group. It balanced the quantitative data and fulfilled one of the hoped for objectives of the study, in that the emergence of common themes enabled the researcher to describe something of the complexity of group process and interaction, as well as support most of the (albeit inconclusive) questionnaire findings.

Generally, the most clinically meaningful findings of this study were that the passing of time spent in the group has more effect on personal experience than do individual clinical

symptoms, and that there is a constant interplay between individual and group–as-a-whole processes. In dynamic terms, this means that the group can successfully contain diverse presentations and diverse psychological processes. Moreover, therapists may be possibly be increasingly attuned to the experience of the group-as-a-whole over time, apparently more than to individual experience. In dynamic terms, they treat the group as a whole unit with a life of its own and interpret on this basis.

Carrying out this exploratory research proved rewarding and instructive, despite initial misgivings that the research background might be too full of contradictions and the conceptual field too indefinable to elicit coherent results. It has, in fact, proved possible to "paint a picture" of the *process* of group psychotherapy within a specific population, and with minimal interference in the subtle intricacies of that process.

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APPENDICES A to E

APPENDIX A Ethics agreement

West Berkshire Local Research and Ethics Committee:

Responses to application form

Letter of approval of proposal

Letter of agreement from Winterbourne Therapeutic Community

WEST BERKSHIRE LOCAL RESEARCH ETHICS COMMITTEE

RESPONSES TO APPLICATION FORM

1. **TITLE OF PROJECT**

   Therapeutic factors in small group psychotherapy: a study of process.

2. **SPONSORS OF PROJECT** N.A.

3. **INVESTIGATORS** See Application form for details.

4. **PLACE WHERE RESEARCH WILL BE CONDUCTED**

   Winterbourne Therapeutic Community/ W. Berkshire Psychotherapy Service.

   53-55, Argyle Rd., Reading RG1 7YL

   The Community admits members who have somewhat disordered or traumatised personalities or pervasive difficulties in their relationships.

5. **PROPOSED DURATION OF RESEARCH**

   September 2002 to September 2003

6. **PURPOSE OF PROJECT**

   It seeks to explore and identify those aspects of small group therapy which are considered most therapeutic by group members and therapists. The concerns in this research are with what actually happens in therapy, but the study may lead to development of process sensitive measures.

7. **SCIENTIFIC BACKGROUND**

   Previous studies (1970s onwards) have been enlightening, but often flawed and inconclusive. Evidence Based practice and the demands of Clinical Governance require that we demonstrate *how* therapies work. Publication is intended in a professional journal on completion of the project.

8. **DESIGN OF STUDY**

   A mainly within-groups cross-sectional design, which by use of repeated measures also facilitates a longitudinal analysis of change over time. Also a correlational study of member/ therapist agreement.

9. **SIZE OF STUDY**

This is an exploratory study in a naturalistic setting, observing process in all participants. Subjects have been selected as suitable for group therapy by treating clinicians. Since this is not a comparative study of treatment approaches, we are not looking primarily for effect size. However, for a power of .80 and at a significance level of .05, Cohen (Cohen, 1992) suggests a sample size of 52, where there are three groups for analysis and a medium effect size. The administration of 5 x repeated measures means that if only 18 members take part over one year, there will be 90 sets of results for analysis in the main study. For Factor Analysis, these will be combined with data from the 30 TFQs of the pilot study.

10. **ANALYSIS OF INFORMATION**

Data will be analysed as determined by the questions to be answered, by Analysis of Variance (See attached Proposal)

Test-retest reliability of the questionnaire will be established using Cronbach's Alpha.

11. **RECRUITMENT OF SUBJECTS**

Pilot study 30 ex-members of W.T.C. will be recruited by post to test questionnaire reliability.

Main study A potential 30 members of W.T.C. will be approached through distribution of letters and will have the opportunity to discuss the project with staff and researchers.

In both studies, there will be a mixed gender age range of 18 - 65 years. There will also be three therapists taking part.

12. **ARRANGEMENTS FOR MONITORING SERIOUS ADVERSE EVENTS**

Members have ample opportunity to discuss any problems with staff.

13. **DETAILS OF PROCEDURES**

Completion of repeated-measures 44-item Therapeutic Factors Questionnaire during study period. (See attached Proposal)

One semi-structured half-hour interview.

A & B not applicable

C Access to clinical records would be required by Judith Levi, Consultant Clinical

Psychologist.

D Questionnaires See attached Appendices

REFERENCES: CORE: Barkham, Evans, Margison, Mcgrath, Mellor-Clark, Milne and Connell. 1998. J. of Mental Health,7, 1, 35 - 47

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TFQ Devised and to be piloted for study.

CONFIDENTIALITY of information - all data will be kept in locked files by Judith Levi. On completion of project it will be returned to W.T.C. and held in locked files for five years.

14. NA

15. INFORMED CONSENT OF PATIENT OR SUBJECT

a) In both the Pilot and Main studies participants will receive an invitation/information letter from the researcher, accompanied by two Consent forms and signatures witnessed. Contact details are included.
In the Main study there will be opportunity for discussion at Winterbourne House.

b) Subjects will be given two weeks to consider, discuss participation.

16. PATIENT INFORMATION SHEET See attached

17. CONSENT OF OTHERS

This has been obtained through an extended process of negotiation with the therapists and has involved a day-long visit to Winterbourne House, discussion with Dr. Haigh and therapists and Clinical Researcher, provision of further information and exchange of ideas with therapists through memos.

18. INVOLVEMENT OF NON-RESEARCH STAFF

As above

19. INFORMATION FOR GENERAL PRACTITIONER

Probably not applicable.

20. NA

21. NA

22. NA

23. For signature of Supervisor, see Application Form

24. DECLARATION OF PRINCIPAL INVESTIGATOR

    See Application Form.g

25. For counter-signature of Head of Department, see Application Form.

WEST BERKSHIRE

LOCAL RESEARCH ETHICS COMMITTEE

Tel: 0118 982 2900
Fax: 0118 9601218
Email: rasheeda.azam@berkshire.nhs.uk

57/59 Bath Road
Reading
Berkshire RG30 2BA

Please quote this number on all correspondence: REC/67/02

13 February 2003

Ms Judith Levi
15 Martingale Close
Cambridge
CB4 3TA

Dear Ms Levi,

Title: Therapeutic factors in small group psychotherapy: a study of process

The West Berkshire Local Research Ethics Committee further reviewed your application on Tuesday 11th February 2003.

The members of the Committee present agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you the favourable opinion of the committee on the understanding that you will follow the conditions set out below:

Conditions

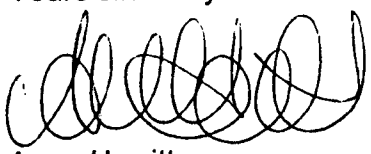
- You do not recruit any research subjects within a research site unless favourable opinion has been obtained from the relevant REC
- You do not undertake this research in an NHS organisation until the relevant NHS management approval has been gained as set out in the *Framework for Research Governance in Health and Social Care.*
- You do not deviate from, or make changes to, the protocol without prior written approval of the REC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases the REC should be informed within seven days of the implementation of this change.
- You complete and return the standard progress report from to the REC one-year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within three months of completion.
- If you decided to terminate this research prematurely you send a report to this REC within 15 days, indicating the reason for the early termination.

- You advise the REC of any unusual or unexpected results that raise questions about the safety of the research.

The project must be started within three years of the date on which REC approval is given.

With kind regards

Yours sincerely



Anna Howitt
LREC Administrator

Encs:
List of members present

Berkshire Healthcare NHS

NHS Trust

WEST BERKSHIRE PSYCHOTHERAPY SERVICE
Winterbourne House
53 - 55 Argyle Road
Reading RG1 7YL

Telephone: 0118 956 1250
Facsimile: 0118 956 1251

RH/SR/

18 February, 2002

Judith Levi

Dear Judith

Thanks for your memo about your proposed study. I am very much in favour of it, and see it as a sensitive and appropriate piece of research for our service.

Because of the time pressure we are aware that our therapy staff are under, Jane Knowles and I have both agreed that therapists who participate in this study should be able to have an extra days annual leave per year as some recompense for the time they will need to spend on it.

I hope this is helpful.

Yours sincerely

Dr Rex Haigh
Consultant Psychotherapist

cc Melanie Bowden, Libby Holloway, Margaret Hutton, Pat O'Connell, Mary-Beth Primmer, Gary Winship

APPENDIX B – Pilot Study

Letter of invitation (to ex- members of therapeutic community)

Follow-up letter to invitation

Consent form – Pilot

Letter accompanying questionnaire

Letter of invitation (to IGA. Trainees / members of psychotherapy group)

Follow-up letter to psychotherapy group members

Letter to above, accompanying questionnaire

Letter of invitation to clinical psychology trainees for factor categorizing exercise

"Categorising therapeutic factors" sheet for trainees

Winterbourne Therapeutic Community

53 - 55, Argyle Rd.,

READING, RG1 7YL

21. 10. 02.

A Research Study: "Therapeutic factors in small group psychotherapy: a study of process."

Dear Ex-member of Winterbourne TC.,

A study is taking place at the Winterbourne Therapeutic Community into what is most helpful in the experience of being in small group psychotherapy. This is based on previous research, and it is hoped that it may help us to understand better how therapy works and how we can use it to the best advantage. This study is supervised by the University of Hull and has been reviewed by West Berkshire Local Research Ethics Committee.

YOU ARE NOT BEING ASKED TO TAKE PART IN THE STUDY, ONLY TO TAKE PART IN A TRIAL RUN OF THE QUESTIONNAIRE BEING USED IN ORDER TO ASSESS HOW RELIABLE AND VALID IT IS.

To this end, I should be very grateful if you would consider completing this questionnaire. You would be sent one to complete and return in a stamped addressed envelope, and sent a second one a week later to complete and return. The questionnaire is about issues related to being in group therapy. It should take no more than about 20 minutes to complete.

If you do decide to take part in this trial run of the Therapeutic Factors Questionnaire and this should raise any issues, or if you wish to know more about the study, please feel free to contact:

Clinical Researcher

Winterbourne Therapeutic Community

53 - 55, Argyle Road,

Reading, RG1 7YL TEL: 0118 - 956-1250

or myself - Judith Levi - via Mary-Beth Primmer at the above address.

Anyone taking part in this trial will be given a numerical code and all information will be treated with complete confidence. The questionnaires will be held by the researcher and eventually destroyed.

If you are willing to take part, could you sign **both** enclosed Consent Forms and return one in the stamped addressed envelope and keep one yourself. The forms should both be witnessed, and this can be done by anyone.

Thank you for your interest.

Judith Levi

Yours Sincerely,

JUDITH LEVI BA (Hons.) MSc. C. Psychol.
CONSULTANT CLINICAL PSYCHOLOGIST
PSYCHOTHERAPIST

Berkshire Healthcare NHS

NHS Trust

Winterbourne Therapeutic Community

53 - 55, Argyle Rd.,

READING, RG1 7YL

21. 11. 02.

Dear Ex- member of Winterbourne T.C.,

You may recall a letter asking if you would be willing to take part in helping with a piece of research into small group therapy. There has been quite a good response so far, but we still need a greater number in order to start the research study.

We are aware that often people approached are happy to take part in research, but forget or mislay the information. In case this has happened, I am sending you a fresh copy, and should be very grateful for your help.

If, however, you simply did not wish to take part, then please excuse this second contact.

Yours Faithfully,

Judith Levi

JUDITH LEVI

CONSULTANT CLINICAL PSYCHOLOGIST

PSYCHOTHERAPIST

cf|P

CONSENT FORM

Therapeutic factors in small group psychotherapy: a process study.

Please complete, circling Yes or No as appopriate

Have you read the Invitation and Information letter? Yes | No

Have you been able to ask questions about the study and the task if you wished? Yes | No

If so, are you satisfied with the answers to your questions? Yes | No

Do you consider that you have received enough information to decide whether to take part in the task? Yes | No

Do you understand that your choice to take part in the completion of the questionnaire is entirely free? Yes | No

Signed:_____ Date:_____

Name (Please Print)_____

Berkshire Healthcare NHS

NHS Trust

Winterbourne House

53 - 55, Argyle Rd.,

Reading RG1 7YL

10. 2. 03.

Dear Participant,

Thank you very much for agreeing to participate in our research on small group therapy. Here is the first of the two questionnaires. You will receive the second a week later. Could you please try to ensure as far as possible that you complete the two questionnaires with a week in between?

The questionnaire asks you to say how helpful each item was for you. Simply tick or cross in the appropriate box. You will see that all envelopes and sheets are numbered at the bottom right-hand corner - this is to protect your confidentiality.

I hope you enjoy completing the questionnaire. As before, please contact Mary-Beth Primmer at the Winterbourne address with any queries.

With many thanks,

Yours Sincerely,

JUDITH LEVI

CONSULTANT CLINICAL PSYCHOLOGIST

THE UNIVERSITY OF HULL
DEPARTMENT OF CLINICAL PSYCHOLOGY

SCHOOL OF MEDICINE • HULL HU6 7RX • UNITED KINGDOM
TELEPHONE 01482 465476 • FACSIMILE 01482 466155 • E-MAIL S.Clement@hull.ac.uk

MS SUE CLEMENT BSocSc(HONS) MSc DipClinPsy
SENIOR LECTURER

20. 03. 03.

A Research Study: "Therapeutic factors in small group psychotherapy: a study of process."

Dear Group Member,

A study is taking place at the Winterbourne Therapeutic Community in Reading into what is most helpful in the experience of being in small group psychotherapy. This is based on previous research (Yalom, Bloch and Crouch, etc.) and it is hoped that it may help us to understand better *how* therapy works and how we can use it to the best advantage. This study is supervised by the University of Hull and has been accepted by West Berkshire Local Research Ethics Committee. Unfortunately, I do not yet have sufficient numbers to make statistical analysis of the questionnaire I have developed viable.

YOU ARE NOT BEING ASKED TO TAKE PART IN THE STUDY, ONLY TO TAKE PART IN A TRIAL RUN OF THE QUESTIONNAIRE BEING USED IN ORDER TO ASSESS HOW RELIABLE AND VALID IT IS.

To this end, I should be very grateful if you would consider completing this questionnaire. You would be sent one to complete and return in a stamped addressed envelope, and sent a second one a week later to complete and return. The questionnaire is about issues related to being in group therapy. It should take no more than about 20 minutes to complete.

Anyone taking part in this trial will be given a numerical code and all information will be treated with complete confidence. The questionnaires will be held by the researcher and eventually destroyed.

If you are willing to take part, could you sign both enclosed Consent Forms and return one in the stamped addressed envelope and keep one yourself.

If you do decide to take part in this trial run of the Therapeutic Factors Questionnaire and

If you do decide to take part in this trial run of the Therapeutic Factors Questionnaire and this should raise any issues, or if you wish to know more about the study, please feel free to contact me on the address below. If I am not available, please leave a message with Reception, and I will contact you.

Thank you for your interest.

Yours Sincerely,

JUDITH LEVI BA (Hons.) MSc. C. Psychol.

CONSULTANT CLINICAL PSYCHOLOGIST

PSYCHOTHERAPIST

Redford Lodge Hospital

15, Church Street,

Edmonton, N9 9DY

0208-956-1234

Berkshire Healthcare NHS

NHS Trust

14.7.03.

Dear Participant,

Thank you very much for agreeing to participate in our research on small group therapy. Here is the first of the two questionnaires. You will receive the second a week later. Could you please try to ensure as far as possible that you complete the two questionnaires with a week in between?

The questionnaire asks you to say how helpful each item was for you. Simply tick or cross in the appropriate box. You will see that all envelopes and sheets are numbered at the bottom right-hand corner - this is to protect your confidentiality.

I hope you enjoy completing the questionnaire.

With many thanks,

Yours Sincerely,

JUDITH LEVI

CONSULTANT CLINICAL PSYCHOLOGIST

THE UNIVERSITY OF HULL
DEPARTMENT OF CLINICAL PSYCHOLOGY

SCHOOL OF MEDICINE • HULL HU6 7RX • UNITED KINGDOM
TELEPHONE 01482 465476 • FACSIMILE 01482 466155 • E-MAIL S.Clement@hull.ac.uk

MS SUE CLEMENT BSocSc(HONS) MSc DipClinPsy
SENIOR LECTURER

October 5, 2003

Dear Group Member,

Please find enclosed a copy of the questionnaire mentioned in the letter you recently had about research into small group therapy. This is so that you can see exactly what is involved before you decide whether to participate or not. THIS IS NOT INTENDED TO PUT ANY PRESSURE ON YOU TO PARTICIPATE, but if you do decide to do so, could you please try to return this questionnaire (the first of two copies) within a week to ten days?

There is also another Consent Form, in case the first one should be mislaid.

With many thanks for your time,

Yours Sincerely,

JUDITH LEVI

CONSULTANT CLINICAL PSYCHOLOGIST

THE UNIVERSITY OF HULL
DEPARTMENT OF CLINICAL PSYCHOLOGY

SCHOOL OF MEDICINE • HULL HU6 7RX • UNITED KINGDOM
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MS SUE CLEMENT BSocSc(Hons) MSc DipClinPsy
SENIOR LECTURER

30. 3. 05.

"Therapeutic Factors in Small Group Psychotherapy": a process study.

Dear Colleague,

A study is taking place at the Winterbourne Therapeutic Community in Reading into what is most helpful in the experience of being in small group therapy. This study is supervised by the West Berkshire Local Research and Ethics Committee.

A Therapeutic Factors Questionnaire has been devised for participants in the study to rate items describing various aspects of the therapeutic process, which are then subsumed under dimensions, for the purpose of statistical analysis. In order to provide back-up to tests of construct validity in the piloting of this questionnaire, it would be useful to know if there is consensus on the concepts underlying the factors.

To this end, I should be grateful if you would consider grouping the items on the enclosed questionnaire, according to the instructions on the response sheet. Please return the sheet in the envelope provided.

Thank you very much for your time and interest.

Yours Faithfully,

Judith Levi

JUDITH LEVI

CONSULTANT CLINICAL PSYCHOLOGIST

THE SCHOOL OF MEDICINE IS PART OF THE FACULTY OF HEALTH
PROFESSOR MICHAEL WANG BSc(Hons) MSc PhD CPsychol FBPsS • HEAD OF DEPARTMENT • DIRECT LINE 01482 465416
DR SONIA GATZANIS HDipEd BA BA(Hons) MA MPhil PhD CPsychol AFBPsS • SENIOR LECTURER AND DEPUTY DIRECTOR
DIRECT LINE 01482 465423
MS BEVERLEY J LEAK BA(Hons) • ADMINISTRATOR • DIRECT LINE 01482 465933
MS SUE CLEMENT BSocSc(Hons) MSc DipClinPsy •SENIOR LECTURER • DIRECT LINE 01482 465476
DR ESME MONIZ-COOK BSc(Hons) DipClinPsy CPsychol AFBPsS • SENIOR LECTURER • DIRECT LINE 01482 466036/328807
DR PETER OAKES BA(Hons) DipPsych PsyD CPsychol • LECTURER • DIRECT LINE 01482 466035
DR DON KENDRICK BA(Hons) DipPsychol PhD CPsychol FBPsS • EMERITUS READER • DIRECT LINE 01482 466037
DR JAC EMPSON BA(Hons) PhD CPsychol • HONORARY SENIOR FELLOW
PROFESSOR M HOGHUGHI BA(Hons) PhD FBPsS • HONORARY CLINICAL PROFESSOR

CATEGORISING THERAPEUTIC FACTORS

Please group items of the questionnaire under the heading you think most appropriate.

EG. **Universality**

3, 20, 17, 38

Please do not complete the questionnaire!

Each item may be entered in one category only, even if they appear to overlap.

Acceptance – A sense of belonging in the group, feeling emotionally comfortable with the group and part of it.

Altruism – Feeling that it is possible to help other people in the group and that this makes one feel of value.

Catharsis – The expression of feelings which have previously been difficult or impossible to release, and the relief which comes from this.

Family Reenactment – Re-experiencing with group members or therapist ways of reacting and relating which stem from old family conflicts and learned behaviour, and being able to recognise and question this.

Guidance – Receiving helpful information and/or advice from therapists and other group members.

Instillation of Hope – Feeling optimistic about the group's potential for help, seeing that other members have progressed or are improving.

Learning from Interpersonal Actions – trying out new and potentially positive ways of expressing oneself and relating to other group members, clarifiying one's relationship with them.

Self-Disclosure – Revealing and sharing personal information, including that which may be embarrassing or painful.

Self-Understanding – Learning something important about one's behaviour, assumptions or fantasies, how one "comes across" to other group members, and why one behaves as one does. Insight.

Vicarious Learning – Experiencing something of value for oneself through observing the in-group experiences of other group members, identifying with them, and/or finding models in positive behaviours of members and therapist.

Universality – Recognising that one is not alone because one's problems are not unique and that others share similar experiences and feelings.

APPENDIX C – Main Study

Letter of invitation and explanation

Patient information sheet (as required by Ethics Committee)

Consent form – Main Study, members

Consent form – Main Study, therapists

Berkshire Healthcare NHS

NHS Trust

March 22nd., 2004

Winterbourne Therapeutic Community
53 – 55, Argyle Rd.,
Reading, RG1 7YL

The Study: Therapeutic factors in small group psychotherapy: a process study

Dear member of WTC,

You are being invited to take part in a research study. Before you decide, it is important that you understand why the research is being done and what it will involve. Please consider the following information and decide whether you wish to take part or not. Thank you for reading this.

Purpose of the study

The present project, based at the University of Hull, is trying to understand what are the most helpful experiences in group therapy. We should also like to know if there are changes in this according to how long a member has been in the group and if there are differences in the ways members and therapists see things. The study will last one year.

Why am I being approached and how do I take part?

All members of WTC. are being approached, since you are all in an ideal position to give this feedback. If you do decide to take part, I will need your signed consent.

What you will be asked to do.

1. You will be asked to complete one questionnaire, the Therapeutic Factors Questionnaire. This has 44 items and you are asked to rate how helpful they have been. You will be asked to do this when the study starts (April) and again after 3, 6, 9, and 12 months. It should be completed in private and should take about 20 minutes at most.
2. When you have been in the community 12 months (or more for some people at the beginning of the project), you will be asked to take part in an informal interview with the researcher, Judith Levi. This will be in private, recorded and last about half an hour. It will explore similar experiences to the questionnaire, but will enable you to discuss it more freely.

Confidentiality: Who will know the results?

All personal information given when you take part will be confidential to this researcher (Judith Levi). Neither your therapist nor other staff will be aware of your responses, during or after the study. The results will be presented on overall terms, not individual ones. All questionnaires will be held by the researcher in a locked file.. At the end of the study they will be held in locked files at WTC. until destroyed.

The recording of the interview is simply to provide an accurate memory of what was said, to enable the researcher to analyse it. All tapes will be destroyed when they are transcribed (to paper) by the researcher and the transcripts will be in her possession till end of the study.They will then also pass to WTC. and be destroyed after five years.

Information and confidentiality

If at any time you need more information or want to discuss concerns about the research, or if you feel upset because of something the research has raised (we hope this is unlikely) please feel free to discuss it with the community staff. If you wish , you can ask Claire King or other staff to contact the researcher, who will be happy to talk to you. If you have complaints we shall be happy to address these directly, as well as through the usual channels. If you decide not to take part, this will in no way affect your treatment or relationships with staff. You may withdraw at any time.

While there is no immediately obvious personal benefit from taking part, you may well find that it makes you think about what it is like for you being in the group. We hope very much that in a small way this research will contribute to the effectiveness of group psychotherapy in general.

Publication

It is hoped to publish a summary of the results in a professional journal in collaboration with some of the Winterbourne staff. You will not be identified in any way. Should we be successful in publishing, you will be sent a copy o the article.

If you would like to take part, could you complete the two Consent forms, keeping one for yourself. The witnesses may be members of WTC. as well as anyone outside it.

Please return one copy in the S.A.E. provided. I should be grateful if you could do this within the next 10 days, which will give you time to think about it if you wish.

I aim to distribute the first questionnaire (TFQ) just after Easter.

With thanks for your time,

Yours Sincerely,

Judith Levi

JUDITH LEVI
CONSULTANT CLINICAL PSYCHOLOGIST
PSYCHOTHERAPIST

PATIENT INFORMATION SHEET

Following your kind consent to take part in the Research Study:

Therapeutic factors in small group Psychotherapy,

Here is an information sheet to remind you about what will happen

What you will be asked to do.

1. You are asked to fill in this questionnaire. It has 44 items and you are asked to rate how much each one is true for you on a scale of 1-5. You will be asked to do this again after 3, 6, 9, and 12 months. Could you please make sure that you complete it in private, in the sense of not collaborating with anyone for answers? It should not take long to do.
2. When you have been in the Community for 12 months, you will be approached to take part in an informal, face-to-face interview with the researcher, Judith Levi. This will be private, recorded and last roughly half an hour. It will give you a chance to explore the experiences identified on the questionnaire in free discussion.

Confidentiality

All information given by you will be confidential to this researcher. **Neither your therapist nor other staff will be aware of your responses, during or after the study.** The results will not be discussed in individual terms and your name will at no point be disclosed. The recording of the interview is simply to provide an accurate memory of what was said, in order to analyse it. Tapes will then be destroyed.

If at any time you want moreinformation or wish to discuss the research, please ask Claire King, who can contact me if necessary and I can then discuss it with you.

JUDITH LEVI
CONSULTANT CLINICAL PSYCHOLOGIST
PSYCHOTHERAPIST

April 2004

CONSENT FORM

Therapeutic factors in small group psychotherapy: a process study.

Please complete, circling Yes or No as appropriate.

Have you read the Invitation for patients, the Patient Info. Sheet and and the Research Proposal? Yes| No

Have you been part of an ongoing process of negotiation and clarification as to the requirements and implications of this study? Yes | No

Are you satisfied with the outcome of this? Yes | No

Do you feel you have received enough information about the study to make your decision? Yes | No

If you have chosen to speak to someone, who was this? Dr.|Mr.|Ms._____

Do you understand that you are free to decline entry into the study ? Yes| No

You are free to withdraw from the study at any time.

Signed:_____ Date:_____

Name (Please Print)_____

Witnessed by:_____ Date:_____

Name of Witness (Please Print)_____

APPENDIX D – Questionnaires

Therapeutic Community Admission Questionnaire

Clinical Outcomes in Routine Evaluation (CORE)

CORE – Means for patient and non-patient populations

Robson Self-Concept Questionnaire (RSCQ)

RSCQ – Norms for various populations

The Most Therapeutic Factors - Modified Therapeutic Factors Questionnaire (MTFQ), for patients

The Most Therapeutic Factors – MTFQ for therapists

MTFQ Item Sort by Dimension Post Pilot revision

MTFQ Items by Factor Post Pilot revision

Semi-Structured Interview Schedule

Resources for MTFQ

Yalom's sixty item Q-sort (TFQ) (*From The Theory and Practice of Group Psychotherapy, Yalom, 1985, pp74 – 80)*

A Method for the study of Group Psychotherapy (*From Bloch, Reibstein, Crouch, Holroyd and Themen, 1979, pp 262 – 263)*

Strictly Confidential

WEST BERKSHIRE PSYCHOTHERAPY SERVICE

Winterbourne House
53-55 Argyle Road
Reading
Berkshire RG1 7YL

Telephone: 0118-956-1250
Fascimile: 0118-956-1251

Record Number:

A. Current Problems

1. Please prioritise the problems you are currently experiencing (in order of difficulty), and rate the problem according to the severity of distress on the following scale.

   [1] No problem
   [2] Slight problem
   [3] Problem causes some difficulty
   [4] Problem causes serious difficulty
   [5] Severe problem

Problem
Length of time the problem has been experienced
Severity of distress [rated on above scale].....1.....2.....3.....4.....5

Problem
Length of time the problem has been experienced
Severity of distress [rated on above scale].....1.....2.....3.....4.....5

Problem
Length of time the problem has been experienced
Severity of distress [rated on above scale].....1.....2.....3.....4.....5

B. Early Life and Relationships

2 Please give some information about your family of origin.

Relation	Name	Age now or at death	If not now living your own age when he/she died	Occupation
Mother				
Father				

Details of your step-parents [if appropriate] brothers and sisters and yourself in order of age. Include any other important people in your childhood.

3 Did your mother have any miscarriages or any termination of pregnancies on medical grounds? How old were you when this happened?

4 What was your religion of upbringing [if any]

5 Adoptive Status (tick one box):

[1] Never adopted, fostered or in care for long periods ☐
[2] Adopted before age 1 ☐
[3] Adopted after age 1 ☐
[4] Fostered long term before age 1 ☐
[5] Fostered long term after age 1 ☐
[6] Fostered or in care for long periods ☐

---

6 Your family of upbringing (up to when you were 18) *(tick one option only)*

[1] Parents together at home ☐
[2] Parents apart (at some point) ☐
[3] New parental situation following original parental separation. ☐

---

7 Please describe any losses, major upsets or separations, briefly

Aged 0-5	Aged 5-12	Aged 12-20

Significant traumas

8 Have you ever been a victim or a witness of a major accident, assault, disaster etc?

[1] Victim Yes ☐ No ☐
[2] Witness Yes ☐ No ☐

If yes, please specify if you wish

---

9 If yes, was it

[1]	in childhood	☐
[2]	within the past year	☐
[3]	one to five years ago	☐
[4]	over five years ago	☐

---

10 Have you ever suffered physical or sexual abuse?

[1] Physical abuse	Yes	☐	No	☐	Unsure	☐
[2] Sexual abuse	Yes	☐	No	☐	Unsure	☐

If yes, please specify, if you wish

---

11 If yes, was it

[1]	in childhood	☐
[2]	within the past year	☐
[3]	one to five years ago	☐
[4]	over five years ago	☐

---

12 Have you ever experienced neglect, deprivation or emotional abuse?

[1] Neglect	Yes	☐	No	☐	Unsure	☐
[2] Deprivation	Yes	☐	No	☐	Unsure	☐
[3] Emotional abuse	Yes	☐	No	☐	Unsure	☐

If yes, please specify, if you wish

---

13 If yes, was it

[1]	in childhood	☐
[2]	within the past year	☐
[3]	one to five years ago	☐
[4]	over five years ago	☐

---

14 Have you ever experienced a warm confiding mutually-enhancing relationship?

[1] childhood [yes] [no]
[2] adult [yes] [no]

---

15 History of past significant relationships
Who are or have been the significant people in your life?

What was the relationship (eg child/parent, friends, lovers, partners, pets etc)	How long were you in that relationship	On-going

---

16 How do you feel about your family?

C Education and Work

17 Please describe what your experience of school was like.

---

18 Qualifications:

[1]	none	☐
[2]	G.C.S.E./'O' level	☐
[3]	'A' level or equivalent	☐
[4]	Degree or professional qualification	☐
[5]	Currently a student	☐

---

19 Are you considering any further education or training?

---

20 Employment situation (Please tick one option)

[1]	Employed	☐
[2]	Self-employed	☐
[3]	Unemployed	☐
[4]	House-worker	☐
[5]	Student	☐
[6]	Retired	☐

21

Past Work History	Description of Job	Reason for Leaving

D Past Problems and Treatment

22 Have you had any previous help for emotional or psychiatric problems?If yes, then please complete the following:

	Please tick	What was this for?	Date and Duration
In-patient psychiatric service			
Out-patient or community psychiatric service			
Psychotherapy or counselling			
GP			
Other agencies, e.g. marriage guidance, social services			

23 Have you ever been treated with medication for these problems? If yes, please specify which drugs you have taken, when and for how long.

24 What medication are you presently taking (if any)?

25 Have you ever attempted to take your own life, or harm yourself? If yes, please specify if you wish

Family Psychiatric History

26 Has any member of your family had treatment for a psychiatric illness? If yes, please specify if you wish.

---

27 Is there any history of suicide in your family? If yes, please specify if you wish

---

Previous Medical History

28 Have you had any serious medical or surgical condition requiring treatment? Please give your age when it happened and brief details of diagnosis and treatment.

E **Current Situation**

29 Current Living situation (please circle one option)

- [1] Homeless ☐
- [2] With family of origin ☐
- [3] On own ☐
- [4] With a partner ☐
- [5] With a partner and children ☐
- [6] On own with children ☐
- [7] In a shared household ☐
- [8] Institutional residence eg college, nurses home etc ☐

---

30 Do you have any children? If you have, how old are they?

---

31 Do any other children live in your home apart from your own?

---

32 Do you experience any difficulties in your relationships with your own children or any other children?

---

33 Have you (or if male, your partner) had a miscarriage or termination of pregnancy? How old were you?

---

34 Have you suffered the loss of a significant relationship (tick one or more as appropriate)

[1] within the past year ☐
[2] one to five years ago ☐
[3] over five years ago ☐

---

35 Could you describe any eating problems you have ever had?
This includes severe dieting or overeating, recurrent vomiting, purging or worries about your weight

---

36 Are you worried you may be abusing any substance or drug at the present time? If yes, please specify

---

37 Do you have any specific sexual problems or difficulties in your sexual relationships? If so, please try to describe them.

---

38 Do you drink alcohol? If so, how much each week and in what circumstances (eg alone or in company)? Do you feel in control of your drinking or are you sometimes worried about it?

---

39 Do you smoke? If so, how many per day?

---

40 What aspects of your life give you satisfaction?

---

41 In choosing goals that you would like to achieve what would be the three most important ones for you?

a] ----------

b] ----------

c] ----------

---

42 What do you like and dislike about yourself?

---

43 What would you like to change?

---

44 Do you see your present problems as

[1] a crisis in an otherwise normal life ☐
[2] a chronic situation that has continued for many years ☐
[3] part of long-term difficulties you have had since childhood ☐
[4] other (please describe) ☐

---

45 Please add anything else that you would like to say at the moment.

Thank you for completing this questionnaire.

CLINICAL OUTCOMES in ROUTINE EVALUATION (F)

Site ID

letters only / numbers only

Client ID

letters only / numbers only / numbers only

Sub codes

D D / M M / Y Y

Date form given

Age

Male

Female

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1 I have felt terribly alone and isolated	0	1	2	3	4	F
2 I have felt tense, anxious or nervous	0	1	2	3	4	P
3 I have felt I have someone to turn to for support when needed	4	3	2	1	0	F
4 I have felt O.K. about myself	4	3	2	1	0	W
5 I have felt totally lacking in energy and enthusiasm	0	1	2	3	4	P
6 I have been physically violent to others	0	1	2	3	4	R
7 I have felt able to cope when things go wrong	4	3	2	1	0	F
8 I have been troubled by aches, pains or other physical problems	0	1	2	3	4	P
9 I have thought of hurting myself	0	1	2	3	4	R
10 Talking to people has felt too much for me	0	1	2	3	4	F
11 Tension and anxiety have prevented me doing important things	0	1	2	3	4	P
12 I have been happy with the things I have done.	4	3	2	1	0	F
13 I have been disturbed by unwanted thoughts and feelings	0	1	2	3	4	P
14 I have felt like crying	0	1	2	3	4	W

Please turn over

Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most of all the time	OFFICE USE ONLY
15 I have felt panic or terror	0	1	2	3	4	P
16 I made plans to end my life	0	1	2	3	4	R
17 I have felt overwhelmed by my problems	0	1	2	3	4	W
18 I have had difficulty getting to sleep or staying asleep	0	1	2	3	4	P
19 I have felt warmth or affection for someone	4	3	2	1	0	F
20 My problems have been impossible to put to one side	0	1	2	3	4	P
21 I have been able to do most things I needed to	4	3	2	1	0	F
22 I have threatened or intimidated another person	0	1	2	3	4	R
23 I have felt despairing or hopeless	0	1	2	3	4	P
24 I have thought it would be better if I were dead	0	1	2	3	4	R
25 I have felt criticised by other people	0	1	2	3	4	F
26 I have thought I have no friends	0	1	2	3	4	F
27 I have felt unhappy	0	1	2	3	4	P
28 Unwanted images or memories have been distressing me	0	1	2	3	4	P
29 I have been irritable when with other people	0	1	2	3	4	F
30 I have thought I am to blame for my problems and difficulties	0	1	2	3	4	P
31 I have felt optimistic about my future	4	3	2	1	0	W
32 I have achieved the things I wanted to	4	3	2	1	0	F
33 I have felt humiliated or shamed by other people	0	1	2	3	4	F
34 I have hurt myself physically or taken dangerous risks with my health	0	1	2	3	4	R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

	(W)	(P)	(F)	(R)	All items	All minus R
Total Scores						
Mean Scores (Total score for each dimension divided by number of items completed in that dimension)						

Gender Differences

In the non-patient sample, women (M=0.68; SD=.45) scored higher than men (M=0.62; SD=.44) Interestingly, in the patient sample this was reversed men scored higher (M=1.85; SD=.76) than women (M=1.68; SD=.77).

Table 5 Comparison by Gender of CORE Outcome Measure total mean scores for patient and non-patient populations

Population	N	Mean	SD
Patient Population	**121**	**1.72**	**.76**
Male	31	1.85	.76
Female	90	1.68	.77
Non -Patient Population	**231**	**.66**	**.71**
Male	75	.62	.72
Female	156	.68	.70

Age Differences

A one way ANOVA showed no significant differences in the mean total score between age groups. The data suggests therefore that there is no correlation between age and the total score of the core measure.

Table 6 - Comparison by age ranges of CORE Outcome Measure total mean scores for patient and non-patient populations

	Patient Population (n=117)			Non-Patient Population (n=230)		
Age Range	**N**	**Mean**	**Std Dev**	**N**	**Mean**	**Std Dev**
20 and under	6	1.40	.62	32	.64	.42
21-30	32	1.75	.82	61	.66	.38
31-40	38	1.81	.68	65	.72	.47
41-50	28	1.69	.86	39	.64	.41
51-60	11	1.72	.84	25	.55	.41
61-70	0			8	.41	.13
71-80	2	1.12	.54	0		

Stability/Sensitivity to Change

An interim analysis of one-week test-retest stability in a patient sample (n=27) showed good evidence of stability of scores (r=.81) with considerable change on item scores. These findings suggest that the scale is likely to show the necessary combination of stability in non-clinical samples and longer term sensitivity to change in clinical samples. Further work into the stability and sensitivity to change of the CORE Outcome Measure is being carried out in the next phase of the research.

Name: Date:

The following are statements about yourself.
Indicate how much you agree or disagree with each.

		Completely Disagree			Disagree		Agree		Completely agree	Reverse score
1.	I have control over my own life	0	1	2	3	4	5	6	7	
2.	I'm easy to like	0	1	2	3	4	5	6	7	
3.	I never feel down in the dumps for very long	0	1	2	3	4	5	6	7	
4.	I can never seem to achieve anything worthwhile	0	1	2	3	4	5	6	7	
5.	There are lots of things I'd change about myself if I could	0	1	2	3	4	5	6	7	
6.	I am not embarrassed to let people know my opinions	0	1	2	3	4	5	6	7	
7.	I don't care what happens to me	0	1	2	3	4	5	6	7	
8.	I seem to be very unlucky	0	1	2	3	4	5	6	7	
9.	Most people find me reasonably attractive	0	1	2	3	4	5	6	7	
10.	I'm glad I'm who I am	0	1	2	3	4	5	6	7	
11.	Most people would take advantage of me if they could	0	1	2	3	4	5	6	7	
12.	I am a reliable person	0	1	2	3	4	5	6	7	
13.	It would be boring if I talked about myself	0	1	2	3	4	5	6	7	
14.	When I'm successful there's usually a lot of luck involved	0	1	2	3	4	5	6	7	
15.	I have a pleasant personality	0	1	2	3	4	5	6	7	
16.	If a task is difficult that just makes me more determined	0	1	2	3	4	5	6	7	
17.	I often feel humiliated	0	1	2	3	4	5	6	7	
18.	I can usually make up my mind and stick to it	0	1	2	3	4	5	6	7	
19.	Everyone else seems much more confident and contented than me	0	1	2	3	4	5	6	7	
20.	Even when I quite enjoy myself there doesn't seem much purpose to it all	0	1	2	3	4	5	6	7	
21.	I often worry about what other people are thinking about me	0	1	2	3	4	5	6	7	
22.	There's a lot of truth in the saying: "What will be, will be"	0	1	2	3	4	5	6	7	
23.	I look awful these days	0	1	2	3	4	5	6	7	
24.	If I really try I can overcome most of my problems	0	1	2	3	4	5	6	7	
25.	It's pretty tough to be me	0	1	2	3	4	5	6	7	
26.	I feel emotionally mature	0	1	2	3	4	5	6	7	
27.	When people criticise me I often feel helpless and second rate	0	1	2	3	4	5	6	7	
28.	When progress is difficult, I often find myself thinking it's just not worth the effort	0	1	2	3	4	5	6	7	
29.	I can like myself even when others don't	0	1	2	3	4	5	6	7	
30.	Those who know me well are fond of me	0	1	2	3	4	5	6	7	

Please note: Some scores need to be reversed (see above). This is a technical point related to questionnaire construction

Robson Self-Concept Questionnaire

Devised by Phil Robson (Department of Addictive Behaviours, Warneford Hospital, Oxford); not copyrighted and freely available. Phil Robson is interested to hear who is using it, and what for. Developed to enumerate self-concept, and five subscales.

POSITIVE QUESTIONS (Scores as marked) 1, 2, 3, 6, 9, 10, 12, 15, 16, 18, 24, 26, 29, 30
FOR ALL OTHER QUESTIONS, SCORES ARE REVERSED (e.g. 7=0; 0=7; 2=5)

FACTORS:	"ATTRACTIVENESS, APPROVAL BY OTHERS"	2, 9, 15, 23, 30
	"CONTENTMENT, WORTHINESS, SIGNIFICANCE"	5, 13, 17, 19, 21, 27
	"AUTONOMOUS SELF-REGARD"	3, 6, 10, 24, 29
	"COMPETENCE, SELF EFFICACY"	1, 12, 16, 18, 26, 28
	"THE VALUE OF EXISTENCE"	4, 7, 8, 11, 20, 25

	mean	sd	n
Non-patient norms (Oxford - whole sample)	140	20.0	151
Non-patient norms (Oxford -Male)	141	19.5	61
Non-patient norms (Oxford - female)	139	20.5	88
Clinical populations:			
Adult psychiatric OP (consecutive series)	112	24.5	50
Heroin dependent pts (currently abstinent)	108	29.3	55
Alcohol dependant pts (currently abstinent)	108	34.8	20
Generalised anxiety disorder pts (DSM III)	106	25.9	61
Psychotherapy referrals - Oxford (Consecutive series)	100	24.1	47
Psychotherapy referrals - Birmingham (Consecutive series)	95	24.6	50
Psychotherapy referrals - Reading (Consecutive series)	91	27.7	143

References:

Robson, P.J. (1988) Self-Esteem - A Psychiatric View. British Journal of Psychiatry 153, 6-15.

Robson, P.J. (1989) Development of a new self-report questionnaire to measure self-esteem. Psychological Medicine, 19, 513-518.

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POSITIVE QUESTIONS (Scores as marked) 1, 2, 3, 6, 9, 10, 12, 15, 16, 18, 24, 26, 29, 30
FOR ALL OTHER QUESTIONS, SCORES ARE REVERSED (e.g. 7=0; 0=7; 2=5)

FACTORS:	"ATTRACTIVENESS, APPROVAL BY OTHERS"	2, 9, 15, 23, 30
	"CONTENTMENT, WORTHINESS, SIGNIFICANCE"	5, 13, 17, 19, 21, 27
	"AUTONOMOUS SELF-REGARD"	3, 6, 10, 24, 29
	"COMPETENCE, SELF EFFICACY"	1, 12, 16, 18, 26, 28
	"THE VALUE OF EXISTENCE"	4, 7, 8, 11, 20, 25

	mean	sd	n
Non-patient norms (Oxford - whole sample)	140	20.0	151
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THE MOST THERAPEUTIC FACTORS

What do you think has been most helpful in the small therapy groups?
Please tick according to whether the item was: Very helpful, a Little Helpful, Neither, Not Very helpful, Unhelpful For You.

	Very helpful	A Little helpful	Neither	Not very helpful	UN-helpful
1. Feeling I am accepted by the group.					
2. Learning how to express my feelings.					
3. Revealing embarrassing things about my self and still being accepted by the group.					
4. Group members giving good advice.					
5. Helping others and being important in their lives.					
6. Group members advising me what to do.					
7. Finding the courage to share private information, even though it's painful.					
8. Feeling that I can give more of value now.					
9. Sometimes I almost relive past family experiences in the group.					
10. Giving support and reassurance to others has given me more self-respect.					
11. Discovering that I am not alone in having "bad" thoughts or feelings.					

	Very helpful	A little helpful	Neither	Not very helpful	UN-helpful
12. Seeing something positive in another member's attitude or behaviour and trying to be like that.					
13. Being able to unload.					
14. Being able to develop an honest relationship with other members.					
15. Being part of something.					
16. Finding that I am not alone in having my type of problem.					
17. Learning why I think and feel the way I do.					
18. Finding that others had backgrounds as difficult or unhappy as mine.					
19. Learning from the group that I react to some situations unrealistically.					
20. The therapist advising me what to do.					
21. Learning about the way I come across to other members.					
22. Working out my difficulties with someone in the group.					
23. Observing how someone else on the group is helped in a way that I can learn from.					

	Very helpful	A little helpful	Neither	Not very helpful	UN-helpful
24. Finding that others had problems similar to their's.					
25. Belonging to a group of people who understand and accept them.					
26. Being able to say both positive and negative things about other group members.					
27. Knowing the group had helped others with similar problems.					
28. Revealing information about their thoughts or problems.					
29. Becoming able to talk about things.					
30. Feeling that the group might offer a solution to their problems.					
31. Being able to talk about things they find difficult.					
32. Someone in the group making definite suggestions about a life problem.					
33. The group helps understand things that happened in their family.					
34. Being able to vent their feelings in the group.					

	Very helpful	A little helpful	Neither	Not very helpful	UN-helpful
35. Being encouraged by seeing others improve.					
36. Being in the group helps them understand ways of relating they learned in their family.					
37. Discovering and accepting previously unknown or unacceptable parts of themself.					
38. Being able to benefit from the experience of another group member because they can identify with them.					

Therapists
Please sign.

THE MOST THERAPEUTIC FACTORS

What do you think has been most helpful in the small therapy groups?
Please tick according to whether the item was: Very helpful, a Little Helpful, Neither, Not Very helpful, Unhelpful For You.

	Very helpful	A Little helpful	Neither	Not very helpful	UN-helpful
1. Feeling they are accepted by the group.					
2. Learning how to express their feelings.					
3. Revealing embarrassing things about themself and still being accepted by the group.					
4. Group members giving good advice.					
5. Helping others and being important in their lives.					
6. Group members advising them what to do.					
7. Finding the courage to share private information, even though it's painful.					
8. Feeling that they can give more of value now.					
9. Sometimes they almost relive past family experiences in the group.					
10. Giving support and reassurance to others has given them more self-respect.					
11. Discovering that they am not alone in having "bad" thoughts or feelings.					

	Very helpful	A little helpful	Neither	Not very helpful	UN-helpful
12. Seeing something positive in another member's attitude or behaviour and trying to be like that.					
13. Being able to unload.					
14. Being able to develop an honest relationship with other members.					
15. Being part of something.					
16. Finding that they are not alone in having their type of problem.					
17. Learning why they think and feel the way they do.					
18. Finding that others had backgrounds as difficult or unhappy as theirs.					
19. Learning from the group that they react to some situations unrealistically.					
20. The therapist advising them what to do.					
21. Learning about the way they come across to other members.					
22. Working out their difficulties with someone in the group.					
23. Observing how someone else on the group is helped in a way that they can learn from.					

	Very helpful	A little helpful	Neither	Not very helpful	UN-helpful
24. Finding that others had problems similar to mine.					
25. Belonging to a group of people who understand and accept me.					
26. Being able to say both positive and negative things about other group members.					
27. Knowing the group had helped others with similar problems.					
28. Revealing information about my thoughts or problems.					
29. Becoming able to talk about things.					
30. Feeling that the group might offer a solution to my problems.					
31. Being able to talk about things I find difficult.					
32. Someone in the group making definite suggestions about a life problem.					
33. The group helps understand things that happened in my family.					
34. Being able to vent my feelings in the group.					
35. Being encouraged by seeing others improve.					

	Very helpful	A little helpful	Neither	Not very helpful	UN-helpful
36. Being in the group helps me understand ways of relating I learned in my family.					
37. Discovering and accepting previously unknown or unacceptable parts of myself.					
38. Being able to benefit from the experience of another group member because I can identify with them.					

M T F Q Item Sort by Dimension Post Pilot revision

Acceptance	**1 3 15 25**
Altruism	**5 8 10**
Catharsis	**2 13 26 34**
Family Reenactment	**9 33 36**
Guidance	**4 6 20 32**
Instillation of Hope	**27 30 35**
Learning from Interpersonal Interaction	**14 21 22**
Self-Disclosure	**7 28 29 31**
Self-Understanding	**17 19 37**
Vicarious Learning	**12 23 38**
Universality	**1 16 18 24**

Item No.	Item
Acceptance	
1.	Feeling I am accepted by the group.
3.	Revealing embarrassing things about myself and still being accepted by the group.
15.	Being part of something.
25.	Belonging to a group of people who understand and accept me.
Altruism	
5.	Helping others and being important in their lives
8.	Feeling that I can give more of value now.
10.	Giving support and reassurance to others has given me more self-respect
Catharsis	
2.	Learning how to express my feelings.
13.	Being able to unload.
26.	Being able to say both positive and negative things about group members
34.	Being able to vent my feelings in the group.
Family Reenactment	
9.	Sometimes I almost relive family experiences in the group.
33.	The group helps understand things that happened in my family.

36. Being in the group helps me understand ways of relating I learned in my family.

Guidance

4. Group giving good advice.
6. Group members advising me what to do.
20. The therapist advising me what to do.
32. Someone in the group making definite suggestions about a life problem.

Instillation of Hope

27. Knowing the group had helped people with similar problems.
30. Feeling the group might offer a solution to my problems.
35. Being encouraged by seeing others improve.

Learning from Interpersonal Interaction

14. Being able to develop an honest relation ship with others.
21. Learning about the way I come across to other members.
22. Working out my difficulties with the group.

Self-Disclosure

7. Finding the courage to share personal information, even though it's painful.
28. Revealing information about my thoughts or problems.
29. Becoming able to talk about things.
31. Being able to talk about things I find difficult.

Self-Understanding

17. Learning why I think and feel the way I do.

19. Learning from the group that I react to some situations unrealistically.

37. Discovering and accepting previously unacceptable parts of myself.

Vicarious Learning

12. Seeing something positive in another member's behaviour or attitude and trying to be like that.

23. Observing how someone else in the group is helped in a way that I can learn from them.

38. Being able to benefit from the experience of another group member because I can learn from them.

Universality

34. Discovering that I am not alone in having "bad" thoughts or feelings.

15. Finding that I am not alone in having my type of problem.

18. Finding that others had backgrounds as difficult or as unhappy as mine.

24. Finding that others had problems similar to mine.

SEMI-STRUCTURED INTERVIEW SCHEDULE

1. If you think back to when you started in the group, how did it feel then?
   Prompts.....difficult at first, nerve-racking, a relief, what was good/bad about it then? Did you feel accepted, supported, a sense being part of something?
   (Likely Factors) Accept, Insthope, Univ.

2. What do you feel you get out of it, or in what ways has the group been helpful for you?

2.a. **Prompts**.....feel more able to relate or talk to people, more able to cope with fears, deal with anger.....depressed feelings and losses.

(Factors) LIA, Viclearn, Selfunst.

2.b. **Prompts** .....feel easier in self-confidence/self-esteem, reassurance from sharing problems.

(Factors) Accept, Selfdisc,

2.c. **Prompts** .....become more outgoing, social life, want to work, friends, a future.

(Factors) Insthope, LIA, Viclearn

2.d. **Prompts**.....has it helped deal with old problems and relationships/relationships in the family?

(Factors) Famact, Selfunst, Cathars

3. What do you think the other members might gain from your being in the group?

Prompts.....feel you contribute, do you say much in the group or are you mostly listening,, maybe you give examples from your own experience, share a joke, someone's painful story, you can be supportive.

(Factors) Altruism, Viclearn, Univ, Guidance

4. Can you tell me about any new experiences you've had in the group?
   Prompts.....something you haven't done/said before, noticed you reacted differently, brought back memories, pleasant/painful, that was a good or bad thing?
   (Factors) Cathars, Famact, Selfunst, Selfdisc, LIA

4. Have you any thoughts about the role therapists play? Or equally, the role the other members play?
   Prompts.....Who gives advice or guidance? Which matters more, do you think?
   (Factors) Guidance, Viclearn, Selfunst, LIA, Altruism

5. Has the group provided different kinds of help/experiences at different times?
   Prompts.....what things were different at the beginning, after a while, how did it change for you, eg., struggled more in middle of the 12 months.
   (Factors) All possible

JL, 2.3.04.

These two small studies deal with only the early stages of group therapy (less than fifteen meetings); yet their findings are consistent with many studies that followed.

I. Yalom, J. Tinklenberg, and M. Gilula studied the therapeutic factors in twenty successful long-term group therapy patients.[7] The investigators asked twenty group therapists to select their most successful patients. These therapists led groups of middle-class outpatients who had neurotic or characterologic problems. These subjects had been in therapy a minimum of eight months and had recently terminated or were about to terminate group therapy.[8] The range of duration of therapy was eight months to twenty-two months; the mean duration was sixteen months. All twenty subjects completed a therapeutic factor Q-sort and were interviewed by the team of three investigators.

Twelve categories of therapeutic factors were constructed from the sources outlined throughout this book,* and five items describing each category were written, making a total of sixty items, which are listed in table 4.1. Each item was typed on a 3 × 5 card; the patient was given the stack of random cards and asked to place a specified number of cards into seven piles labeled in the following manner:

1. Most helpful to me in the group (2 cards)
2. Extremely helpful (6 cards)
3. Very helpful (12 cards)
4. Helpful (20 cards)
5. Barely helpful (12 cards)
6. Less helpful (6 cards)
7. Least helpful to me in the group (2 cards).[9]

*The list of sixty therapeutic factor items passed through several versions and was circulated among many senior group therapists for suggestions, additions, or deletions. Some of the items are nearly identical, but it was necessary methodologically to have the same number of items representing each category. The twelve categories are: altruism; group cohesiveness; universality; interpersonal learning, "input"; interpersonal learning, "output"; guidance; catharsis; identification; family re-enactment; self-understanding; instillation of hope; existential factors. They are not quite identical to those described in this book; we attempted, unsuccessfully, to divide interpersonal learning into two parts —input and output. One category, "self-understanding," was included to permit examination of the importance of derepression and genetic insight. The therapeutic factor Q-sort was meant to be an exploratory instrument constructed, as I described, *a priori* on the basis of clinical intuition (my own and that of other experienced clinicians); it was not posited as a finely calibrated research instrument. It has been used in so much subsequent research that much discussion has arisen about construct validity and test-retest reliability. By and large, test-retest reliability has proven to be good; factor analytic studies have yielded varied results: some studies showing only fair, others good, item to individual scale correlations.[10] The most comprehensive factor analytic study provided fourteen item clusters that bore considerable resemblance to my twelve original therapeutic factor categories.[11]

Following the Q-sort, which took approximately thirty to forty-five minutes, each patient was interviewed for an hour by the three investigators. Their reasons for their choice of the most and least helpful items were reviewed, and a series of other areas relevant to therapeutic factors was discussed (for example, other, nonprofessional therapeutic influences in the patients' lives, critical events in therapy, goal changes, timing of improvement, therapeutic factors in their own words).

RESULTS

A sixty-item, seven-pile Q-sort for twenty subjects makes for complex data. Perhaps the clearest way to consider the results is a simple rank ordering of the sixty items.* Turn again to the list of sixty items (table 4.1). The number after each item represents its rank order. Thus, item 48 ("discovering and accepting previously unknown or unacceptable parts of myself") was considered the most important therapeutic factor by the consensus of patients; item 38 ("adopting mannerisms or style of another group member") the least important; and so on. ("g" denotes a tie.)

The ten items deemed most helpful to the patients were (in the order of importance):

48. Discovering and accepting previously unknown or unacceptable parts of myself.
35. Being able to say what was bothering me instead of holding it in.
18. Other members honestly telling me what they think of me.
34. Learning how to express my feelings.
16. The group's teaching me about the type of impression I make on others.
32. Expressing negative and/or positive feelings toward another member.
60. Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others.
17. Learning how I come across to others.
37. Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.
22. Feeling more trustful of groups and of other people.

Note that seven of the first eight items represent some form of catharsis or of insight. I again use "insight" in the broadest sense; the items, for the most part, reflect the first level of insight (gaining an objective perspective of one's interpersonal behavior) described in chapter 2. This remarkable finding lends considerable weight to the principle, also described in chapter 2, *that therapy is a dual process consisting*

*Arrived at by ranking the sum of the twenty pile placements for each item.

TABLE 4.1

Therapeutic Factors
Categories and Rankings of the Sixty Individual Items

		RANK ORDER (THE LOWER THE RANK ORDER, THE HIGHER THE ITEM IS VALUED BY THE PATIENT)
1. Altruism	1. Helping others has given me more self-respect.	40 T*
	2. Putting others' needs ahead of mine.	52 T
	3. Forgetting myself and thinking of helping others.	37 T
	4. Giving part of myself to others.	17
	5. Helping others and being important in their lives.	33 T
2. Group Cohesiveness	6. Belonging to and being accepted by a group.	16
	7. Continued close contact with other people.	20 T
	8. Revealing embarrassing things about myself and still being accepted by the group.	11 T
	9. Feeling alone no longer.	37 T
	10. Belonging to a group of people who understood and accepted me.	20 T
3. Universality	11. Learning I'm not the only one with my type of problem; "We're all in the same boat."	45 T
	12. Seeing that I was just as well off as others.	25 T
	13. Learning that others have some of the same "bad" thoughts and feelings I do.	40 T
	14. Learning that others had parents and backgrounds as unhappy or mixed up as mine.	31 T
	15. Learning that I'm not very different from other people gave me a "welcome to the human race" feeling.	33 T

*"T" denotes a tie.

TABLE 4.1 *(continued)*

		RANK ORDER (THE LOWER THE RANK ORDER, THE HIGHER THE ITEM IS VALUED BY THE PATIENT)
4. Interpersonal Learning—Input	16. The group's teaching me about the type of impression I make on others.	5 T
	17. Learning how I come across to others.	8
	18. Other members honestly telling me what they think of me.	3
	19. Group members pointing out some of my habits or mannerisms that annoy other people.	18 T
	20. Learning that I sometimes confuse people by not saying what I really think.	13 T
5. Interpersonal Learning—Output	21. Improving my skills in getting along with people.	25 T
	22. Feeling more trustful of groups and of other people.	10
	23. Learning about the way I related to the other group members.	13 T
	24. The group's giving me an opportunity to learn to approach others.	27 T
	25. Working out my difficulties with one particular member in the group.	33 T
6. Guidance	26. The doctor's suggesting or advising something for me to do.	27 T
	27. Group members suggesting or advising something for me to do.	55
	28. Group members telling me what to do.	56
	29. Someone in the group giving definite suggestions about a life problem.	48 T
	30. Group members advising me to behave differently with an important person in my life.	52 T

TABLE 4.1 *(continued)*

		RANK ORDER (THE LOWER THE RANK ORDER, THE HIGHER THE ITEM IS VALUED BY THE PATIENT)
7. Catharsis	31. Getting things off my chest.	31 T
	32. Expressing negative and/or positive feelings toward another member.	5 T
	33. Expressing negative and/or positive feelings toward the group leader.	18 T
	34. Learning how to express my feelings.	4
	35. Being able to say what was bothering me instead of holding it in.	2
8. Identification	36. Trying to be like someone in the group who was better adjusted than I.	58
	37. Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.	8
	38. Adopting mannerisms or the style of another group member.	59
	39. Admiring and behaving like my therapist.	57
	40. Finding someone in the group I could pattern myself after.	60
9. Family Re-enactment	41. Being in the group was, in a sense, like reliving and understanding my life in the family in which I grew up.	51
	42. Being in the group somehow helped me to understand old hang-ups that I had in the past with my parents, brothers, sisters, or other important people.	30

TABLE 4.1 *(continued)*

		RANK ORDER (THE LOWER THE RANK ORDER, THE HIGHER THE ITEM IS VALUED BY THE PATIENT)
Family Re-enactment *(continued)*	43. Being in the group was, in a sense, like being in a family, only this time a more accepting and understanding family.	44
	44. Being in the group somehow helped me to understand how I grew up in my family.	45 T
	45. The group was something like my family—some members or the therapists being like my parents and others being like my relatives. Through the group experience I understand my past relationships with my parents and relatives (brothers, sisters, etc.).	48 T
10. Self-Understanding	46. Learning that I have likes or dislikes for a person for reasons which may have little to do with the person and more to do with my hang-ups or experiences with other people in my past.	15
	47. Learning why I think and feel the way I do (that is, learning some of the causes and sources of my problems).	11 T
	48. Discovering and accepting previously unknown or unacceptable parts of myself.	1
	49. Learning that I react to some people or situations unrealistically (with feelings that somehow belong to earlier periods in my life).	20 T
	50. Learning that how I feel and behave today is related to my childhood and development (there are reasons in my early life why I am as I am).	50

TABLE 4.1 *(continued)*

		RANK ORDER (THE LOWER THE RANK ORDER, THE HIGHER THE ITEM IS VALUED BY THE PATIENT)
11. Instillation of Hope	51. Seeing others getting better was inspiring to me.	42 T
	52. Knowing others had solved problems similar to mine.	37 T
	53. Seeing that others had solved problems similar to mine.	33 T
	54. Seeing that other group members improved encouraged me.	27 T
	55. Knowing that the group had helped others with problems like mine encouraged me.	45 T
12. Existential Factors	56. Recognizing that life is at times unfair and unjust.	54
	57. Recognizing that ultimately there is no escape from some of life's pain and from death.	42 T
	58. Recognizing that no matter how close I get to other people, I must still face life alone.	23 T
	59. Facing the basic issues of my life and death, and thus living my life more honestly and being less caught up in trivialities.	23 T
	60. Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others.	5 T

emotional experience and of reflection upon that experience. More about this later.

The administration of scoring of a sixty-item Q-sort is so laborious that most researchers have subsequently used an abbreviated version —generally one that asks a patient to rank the twelve therapeutic factor categories (rather than sixty individual items). However, two studies replicate the sixty-item Q-sort study and report remarkably similar findings. S. Freedman and J. Hurley studied twenty-eight subjects in three fifty-one-hour sensitivity-training groups on four college cam-

TABLE 4.2

Most Valued Therapeutic Factors: Outpatient Groups

STUDY	POPULATION	FACTORS VALUED MOST HIGHLY
Yalom, et al., 1968[a]	Outpatients N = 20	Interpersonal learning (input) Catharsis Cohesiveness Self-understanding
Weiner, 1974[b]	Outpatients, short- and long-term N = 19	Interpersonal learning (input + output) Cohesiveness Self-understanding Catharsis
Rohrbaugh and Bartels, 1975[c]	9 therapy groups 4 personal growth groups N = 72	Catharis Cohesiveness Interpersonal learning (input) Self-understanding
Butler and Fuhriman, 1980[d]	Community mental health center outpatients N = 68	Self-understanding Universality Interpersonal Learning (input) Catharsis
Mower, 1980[e]	Community counseling service clients N = 25	Interpersonal learning (input) Self-understanding Universality Catharsis
Flora-Tostado, 1981[f]	Community mental health center outpatients N = 42	Catharsis Self-understanding Hope Universality
Butler and Fuhriman, 1983[g]	Community mental health center outpatients N = 91	Self-understanding Catharsis Universality Cohesiveness
Long and Cope, 1980[h]	Residential treatment center for felons N = 12	Catharsis Cohesiveness Interpersonal learning (input) Interpersonal learning (output)
Leszcz, Yalom, and Norden, 1985[i]	Private practice outpatient groups N = 34	Interpersonal learning Self-understanding Catharsis Vicarious learning

a. I. Yalom, J. Tinklenberg, and M. Gilula, "Curative Factors in Group Therapy," unpublished study, 1968.
b. M. Weiner, "Genetic versus Interpersonal Insight," *International Journal of Group Psychotherapy* 24 (1974): 230–37.
c. M. Rohrbaugh and B. Bartels, "Participants' Perceptions of 'Curative Factors' in Therapy and Growth Groups," *Small Group Behavior* 6 (4 [November 1975]): 430–56.
d. T. Butler and A. Fuhriman, "Patient Perspective on the Curative Process: A Comparison of Day Treatment and Outpatient Psychotherapy Groups," *Small Group Behavior* 11 (4 [November 1980]): 371–88.
e. R. K. Mower (1980), cited in T. Butler and A. Fuhriman, "Level of Functioning and Length of Time in Treatment: Variables Influencing Patients' Therapeutic Experience in Group Therapy," *International Journal of Group Psychotherapy* 33 (1983): 495–524.
f. J. Flora-Tostado, "Patient and Therapist Agreement of Curative Factors in Group Psychotherapy," *Dissertation*

Catharsis

The basis of catharsis is emotional *release*, i.e. the ventilation of feelings, either positive or negative, and about either life events or other group members, which brings some measure of *relief*.

This factor operates when the patient:

— releases feelings (leading to relief) within the
— group — either of past or here-and-now material.
— expresses feelings, such as anger, affection, sorrow, and grief, (leading to relief) which have been previously difficult or impossible to release.

Self-Disclosure

The basis of self-disclosure is the act of revealing personal information to the group. It differs from *catharsis* which concerns the release of feelings and from *learning from interpersonal actions* which concerns the attempt to relate adaptively and constructively to other group members.

This factor operates when the patient:

— reveals information, about either his life outside the group or his past, or his feared, embarrassing, or worrisome problems, or his fantasies, which he regards as private and personal.
— reveals and shares personal information even though such revealing and sharing may be difficult or painful.

Learning from Interpersonal Actions

The basis of this factor is the *attempt* to relate *constructively* and *adaptively* within the group, either by initiating some behaviour or responding to other group members. More important than how the group members react is the patient's effort to relate constructively and adaptively.*

This factor operates when the patient:

— tries out new, potentially positive ways of *initiating behaviour* with other group members. These ways can include:
  — expressing oneself to other group members to clarify one's relationship with them.
  — making an explicit, overt effort to develop a more honest and open relationship with other group members.
  — expressing oneself in a more constructively assertive fashion.
  — expressing oneself to achieve closeness with other group members.
— tries out new, potentially positive ways of *responding to* other group members:
  — e.g. with increased sensitivity or with appropriate acceptance of criticism.

* (See *self-disclosure* to note differences between *catharsis*, *self-disclosure* and *learning from interpersonal actions*; see also *altruism* to note differences between it and *learning from interpersonal actions*).

Universality

This factor operates when the patient:

— recognises that his problems are not unique to him.
— perceives that other group members have similar problems and feelings and this reduces his sense of uniqueness.
— experiences the sense that he is not alone with his feelings and problems.

Acceptance

This factor operates when the patient:

— feels a sense of belonging, warmth, friendliness and comfort in the group.
— feels valued by other group members.
— values the support that the group offers to him.
— feels cared for, supported, understood and accepted by other group members.
— feels unconditionally accepted and supported even when he reveals something about himself which he has previously regarded as unacceptable.

Altruism

The basis of altruism is that the patient *can feel better* about himself, and/or *learn something positive*, about himself, through helping other group members. Altruism differs from *learning from interpersonal actions* in that in his efforts to help other group members, the patient improves his self-image because he learns that he can be of value to them. Although *learning from interpersonal actions* may involve altruistic behaviour, the therapeutic value lies in the patient's actions rather than in their effect on his self-image.

This factor operates when the patient:

— offers support, reassurance, suggestions or comments to help other group members.
— shares similar problems for the purpose of helping other group members.
— feels needed and helpful.
— can forget about himself in favour of another group member.
— recognises that he wants to do something for another group member.

Guidance

This factor operates when the patient:

— receives useful information and instruction from the therapist about mental health, mental illness or general (*not* personal) psychodynamics.

— receives explicit advice, suggestions, guidance about his problems from either the therapist or the other patients.

Self-Understanding

The basis of self-understanding is that the patient learns something important about himself. This can come about as a result of feedback (direct or indirect) and interpretation from other group members, both patients and the therapist.

This factor operates when the patient:

— learns something important about his behaviour or assumptions or motivations or fantasies or unconscious thoughts.

— learns how he comes across to the other members of the group.

— learns why he behaves the way he does and how he got to be the way he is.

— learns more clearly the nature of his problems.

Vicarious Learning

The basis of vicarious learning is that the patient experiences something of value for himself through the observation of other group members, including the therapist.

This factor operates when the patient:

— benefits by observing the therapy experience of another patient.

— identifies with another group member to the extent that the patient benefits himself from the other member's therapy experiences.

— recognises some positive aspect of the behaviour of the therapist, or of other patients, to imitate.

— can find models in the positive behaviour of other group members (including the therapist) toward which he can strive.

Instillation of Hope

The basis of instillation of hope is that the patient gains a sense of optimism about his progress, or potential for progress, through his treatment in group therapy. It differs from *vicarious learning* in which the patient sees *how* other group members improve. In *instillation of hope* the patient sees *that* other group members improve.

This factor operates when the patient:

— sees that other group members have improved or are improving.

— sees that the group can be of help to its members in working towards their goals.

— feels optimistic about the group's potential for help. e.g. 'I am hopeful that, or feel that, the the group will help me; I can see that the group is taking me somewhere'.

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APPENDIX E – Further Information - Addenda to the thesis

E.1 Further Information

E.2 Review of Therapeutic Factor research, by Factor

APPENDIX E.: FURTHER INFORMATION

E.1.1. SOCIAL AND CLINICAL DEMOGRAPHICS OF SAMPLE

Information regarding gender, experience of significant trauma, education, experience of a "warm, mutually enhancing relationship" and scores on the CORE and RSCQ clinical instruments (See Method and below) was derived entirely from the admission assessments of members prior to entry. This information was completed by members themselves, in the Admission Form and the clinical questionnaires. (Appendix D). Access to this information was provided to the researcher and entered on the SPSS file.

Gender

There were 19 women and 3 men in the study. In Phase Three there were only two men. This represents the distribution of gender in the whole community at that time.

Education

Seven members of the sample had completed education at secondary level. Of these, six had G.C.S.E.s and one had A-levels. Ten participants had degrees or equivalent. Only four had no qualifications. There was one missing case.

Table E.1.1. Education completed by participants.

Qualification	Number
None	4
G.C.S.E.	6
A-Level	1
Degree or Diploma	10
Missing	

"Warm, mutually-enhancing relationship"

Participants rated themselves according to whether they had experienced such a relationship in childhood, in adulthood or not at all. Only four participants out of the whole sample had experienced this kind of relationship in childhood, ten in adulthood and six not at all

Table E.1.2. "Warm, mutually enhancing relationship

Relationship	Number
In childhood	4
In adulthood	10
Not at all	6
Missing	2

Clinical Problems

Information regarding psychological problems had been collected on admission. This was coded by the researcher into nine categories.

Table E.1.3. Distribution of Clinical problems

Identified Problem	Number *		
	Fem.	M	All
Major Relationship difficulties	14	3	17
Depression	14	3	17
Anxiety	15	1	16
Self-Esteem	18	2	20
Childhood Abuse, Sexual	9	1	10
Physical	9	1	10
Emotional & Neglect	11	2	13
Substance Misuse	7	1	8
Eating Disorder	11	2	13

* 'Number' is out of a total sample of 22

Multiple problems

All participants had more than one clinical problem. Particularly pervasive in this study was the presence of depression and anxiety, often, but not always, concurrent with childhood abuse or trauma. Fifty-nine per cent in this largely female sample had an eating disorder (one male), also often in relation to childhood abuse. Sixteen participants had suffered a form of childhood abuse, twelve of them experiencing multiple forms of abuse. Not surprisingly, all but two participants suffered from low self-esteem. (See Table 3.4)

Table E.1.4. Frequencies of Multiple Pathology

Number of identified problems	Number out of 22
Members with 3	2
Members with 4	3
Members with 5	5
Members with 6	4
Members with 7	6
Members with 8	2

Clinical Outcomes in Routine Evaluation (CORE)

CORE scores are presented for participants. These are based on a numerical index, which represents the *total score* on all items of the CORE, divided by the *number of items*. (Mean Score)

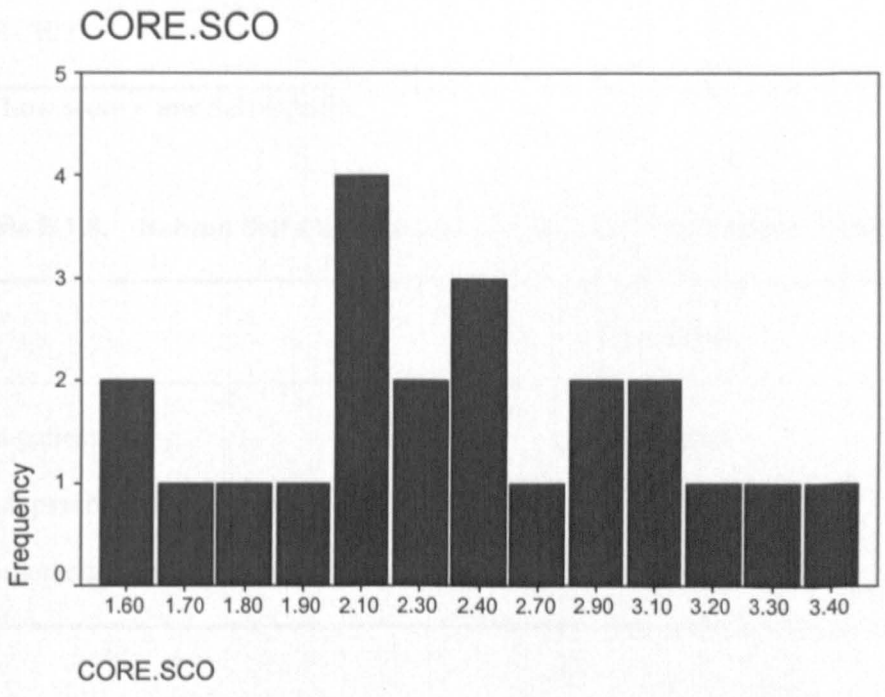
Table E.1.5. CORE - Distribution of mean scores (High score = high symptom level)

Score	No. of Members with scores of:	Percentage
1.6 - 2	5	23
2 - 2.5	9	40
2.6 - 3	3	14
3 - 3.4	5	23

Table E.1.6. Patient and non-patient norms for CORE (Connell, Barkham, Evans, Margison, McGrath and Milne, 1997)

	Number	Mean score	S.D.
Patient Population	121	1.72	.76
Non-patient Population	231	.66	.71

Figure E.1.1. CORE: Distribution of mean scores



Mean CORE scores in this sample ranged from 1.6 to 3.4. 40% of participants had scores of 2 – 2.5, representing the predominant level of self-evaluated distress. The fact that the scores of five people fell in the 3-3.4 range suggests that almost a quarter of participants were experiencing a very high degree of self-evaluated distress on entry into the community.

The above scores are typical of this highly symptomatic population. Recent CORE scores for the first five entrants to a sister unit were 2.1, 2.8, 3.1, 3.2 and 3.4. (Haigh R., Personal communication)

Table E.1.7. Robson Self-Concept Questionnaire – Distribution of mean scores

Score *	Number	Percentage
49 - 60	8	36
61 - 80	7	32
81 – 100	3	14
101 – 127	4	18

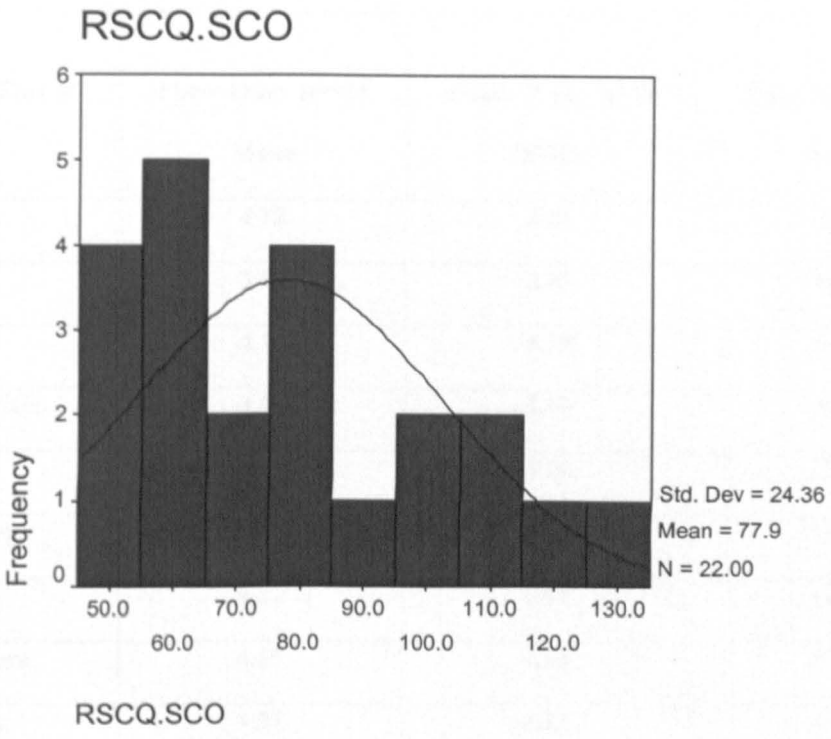
* Low score = low Self-Esteem

Table E.1.8. Robson Self-Concept Questionnaire (RSCQ): Norms (Robson, P. J., 1989)

	Raw Score
Non-patients	140 points
Adult psychiatric outpatients	112 points
Psychotherapy referrals (same district as study)	91 points

RSCQ scores in this sample ranged from 49 – 127. It can be seen by reference to the norms that this sample did not reach adult outpatient levels of self-esteem/self-concept, indicating generally very low self-esteem within this population.

Figure E.1.2. RSCQ: Distribution of mean scores



E.1.2. Differences in Therapeutic Factor Scores over Time

In relation to Research Question One as to whether length of time in the group is reflected in MTFQ scores, individual and group mean scores were computed from each MTFQ data set for patient generated and therapist generated mean scores.

Table E.1.9. Total mean MTFQ scores for patients' ratings of helpfulness over three phases

Therapeutic Factor	Phase One: n=15 Mean	Phase Two: n=14 Mean	Phase Three: n=8 Mean
Acceptance	4.12	4.21	4.46
Altruism	3.93	3.95	4.08
Catharsis	4.15	4.25	4.25
Family Reenact.	3.91	4.10	4.45
Guidance	4.10	4.10	3.72
Instil. Of Hope	4.31	3.92	3.83
LIA.	4.27	4.35	4.33
Self-Disclosure	4.15	4.33	4.53
Self-Underst.	4.07	4.33	4.30
Vicarious Learn.	3.98	4.00	3.91
Universality	4.30	4.05	4.16

Table E.1.10. Total mean MTFQ scores for therapists' ratings of helpfulness over three phases.

Therapeutic Factor	Phase One n=15 Mean	Phase Two n=14 Mean	Phase Three n=8 Mean
Acceptance	4.02	4.27	4.28
Altruism	3.84	3.81	4.08
Catharsis	3.98	4.00	4.28
Family Reenactment	3.20	3.95	4.16
Guidance	3.23	3.18	3.25
Instil. Of Hope	4.31	3.43	3.83
LIA.	4.11	3.88	4.12
Self-Disclosure	3.95	4.16	4.50
Self-Understanding	3.66	3.83	4.08
Vicarious Learn.	3.73	3.02	3.87
Universality	3.88	3.95	3.91

E.1.3. INDIVIDUAL VARIABLES

The purpose of this study was exploratory but it is, however, acknowledged that some of these findings are not only not statistically significant, but involve such small numbers that they cannot convey a definitive basis for drawing conclusions, and the have therefore not been represented. Mann-Whitney and Kruskal-Wallis Tests for independent samples were used to explore relationships between socio-demographic and clinical variables.

The study was particularly hampered by small numbers in phase three. This meant that in some instances there was only one, or more often, only two cases carrying some degree of significance. In some instances, there was no marked pattern of results, in others a very

equal distribution, and in one case, all participants bore the same problem, so there was no differentiation.

The 'presence' of clinical problems referred to a time-point just before admission to the community. Interview material suggested that the same clinical issues tended to remain throughout, though often showing some, or considerable, improvement.

E.1.4. THERAPIST/ PATIENT AGREEMENT IN RATINGS OF HELPFULNESS, OVER TIME

Intra-class correlation coefficients were used to explore agreement in ratings of helpfulness of therapeutic factors. Variations in individual scores were masked in this way. Tables presented here represent an attempt to elucidate this point.

Table E.1.11. Intra-Class Correlations of therapist and member scores by phase, based on total mean scores

Therapeutic Factor	Phase One	Phase Two	Phase Three
Acceptance	.362	.565**	-.180
Altruism	.219	-.206	1.000**
Catharsis	.224	.414*	.373
Family Reenact.	- .097	.352	. 649 **
Guidance	.320	.046	.090
Instil. Of Hope	.584**	.413 *	.485
Learn. from Interact.	.339	-.255	.373
Self-Disclosure	- .094	.019	.155
Self-Underst.	.049	.045	-.147
Vicarious Learn.	-.016	-.067	-.470
Universality	-.312	.404 *	.143

** Significant at p< 0.001 level
* Significant at p< 0.005 level

Table E.1.12. Differences in mean score between patients and therapists, for each phase. (Derived from total mean scores)

Therap. Factor	Phase One	Phase Two	Phase Three
Acceptance	.10	.06*	.18
Altruism	.09	.14	0
Catharsis	.17	.25	-.03*
Family Reenact.	.71	.15	.29
Guidance	.87	.92	.47
Instil. Of Hope	0	.49	0
Learn from Interact.	.16	.47	.21
Self-Disclosure	.20	.17	.03
Self-Understand.	.41	.50	.22
Vicarious Learn.	.25	.98	.04
Universality	.42	.10	.25
Total difference	**3.38**	**4.23**	**1.72**

*Signifies that the therapists' scores were the higher ones.

Table E.1.12. shows that, whilst patient and therapist scores seemed to be rather more divergent in the middle of the group, when there was most score variation on the part of patients, by the last phase the overall differences were, on average, halved. This apparent contradiction between Tables E.1.11. and E.1.12. arises because the former is based on a correlation coefficient and the latter on total mean scores, thus giving different *kinds* of information.

Table E.1.13. Comparison of changes in therapist and patient therapeutic factor scores from phase one to phase three. (Derived from total mean scores)

Therapeutic factor	Patient score change	Therapist score change
Acceptance	0.34	0.26
Altruism	0.15	0.24
Catharsis	0.10	0.30
Family Reenactment	0.52	0.96
Guidance	–0.38	0.02
Instillation of Hope	–0.48	–0.48
Learn. From Interaction	0.06	0.01
Self-Disclosure	0.38	0.55
Self-Understanding	0.23	0.42
Vicarious Learning	–0.07	0.14
Universality	–0.14	0.03

Table E.1.14. MTFQ ranking of Therapeutic Factors by patients and therapists, according to total mean scores.

Phase One		Phase Two		Phase Three	
Patients	Therapists	Patients	Therapists	Patients	Therapists
Hope	Hope	LIA	Acceptance .	Self-Discl.	Self-Discl.
Univers.	LIA	Self-Discl.	Self-Discl	Acceptance	Acceptance
LIA*	Acceptance	Self Underst	Catharsis	Fam Reenact	Catharsis
Catharsis	Catharsis	Catharsis	Fam.Reenact.	LIA	Fam.Reenact.
Self-Discl.	Self-Discl.	Acceptance	Univers.	Self-Underst	LIA
Acceptance	Univers.	Fam Reenact	LIA	Catharsis	Self-Underst.
Guidance	Altruism	Guidance	Self-Underst.	Univers.	Altruism
Self-Underst	Vic. Learn	Univers.	Altruism	Altruism	Univers.
Vic. Learn.	Self-Underst	Vic. Learn	Hope	Vic. Learn	Vic. Learn.
Altruism	. Guidance	Altruism	Guidance	Hope	Hope
Fam Reenact	Fam Reenact	Hope	Vic.Learn.	Guidance	Guidance

*LIA Learning from Interaction

Ties

In phase one: Catharsis and Self-Disclosure for patients.

In phase two: Self-Disclosure and Self-Understanding, Family Reenactment and Guidance for patients. Family Reenactment and Universality for therapists.

In phase three: Acceptance and Catharsis, Self-Understanding and Altruism for therapists.

E.2 REVIEW OF THERAPEUTIC FACTOR RESEARCH BY FACTOR

This section will define each factor as used in the current study and review the clinical research pertaining to it.

E.2.1. Acceptance

Theory of Acceptance and Cohesiveness

Acceptance is by far the most cited therapeutic mechanism, referring to the human need to belong to a relationship or group, but despite its clinical popularity, Acceptance as a therapeutic factor has been conflated with group cohesiveness. Cohesiveness can be seen as a process which is constantly in flux. (Bednar and Kaul, 1978) Yalom distinguishes between Acceptance – the sense of being understood – and Cohesiveness, which he sees as a "determinant and effect of inter-member acceptance" and a precondition for other therapeutic factors. (Yalom, 1985) Similarly, Bloch and Crouch (1975) believe Cohesiveness to be a 'condition for change', (See their definition of therapeutic factors, above), which perhaps parallels the importance of the therapeutic alliance in individual therapy, while others have also suggested that *affective integration* promotes self-disclosure and consequently positive interpersonal interaction. (Tschuschke and Dies, 1994)

Cohesiveness is not necessarily creative. A group can use its cohesion to avoid therapeutic change, as in Bion's basic assumption *pairing* group, (Bion, 1961) though the research fails to deal with this. Similarly, an angry group may *feel* uncohesive but in fact be cohesive enough to contain the conflict.

Bloch and Crouch (1975) stress the support from the group for the individual implicit in Acceptance and suggest that it can be clearly evident as a therapeutic factor operating in relation to specific group events. The concept of group cohesiveness is both multi-dimensional and multi-directional, so that it would appear that the use of Acceptance for research purposes offers greater specificity,[9] though it may be of less import for whole group based research.

Research

Acceptance

Studies of patient ratings of all Yalom's therapeutic factors have variously found acceptance to be highly valued (Lieberman, Yalom and Miles, 1973; Colijn, Hoencamp, Snijders, Van Der Speck and Duivenvoorden, 1991) or of intermediate importance (Bloch, Reibstein, Crouch, Holroyd and Themen, 1979), across a wide variety of different patient groups and measures. However, Bloch and Reibstein, in a review of their own study, suggest that the lower ranking of Acceptance they found may be related to the fact that their's was a repeated measures study and perhaps Acceptance is a "cumulative feeling more easily elicited when patients review their entire group experience." They add that Berzon et al (1983), using a similar method, also reported low rating of Acceptance, whereas studies where measures were obtained only once (Maxmen, 1973; Yalom, 1975) rated it highly. (Bloch and Reibstein, 1980)

Cohesiveness

[9] *Cohesion (Cohesiveness) are often used interchangeably in this area of research. Terms are used as per study described. The present author takes a particular view on this factor. (See Method section)*

"There is little cohesion in the cohesion research!" (Bednar and Kaul, 1978) Bednar and Kaul pointed to flawed designs, disparate population groups and the methods used to 'measure' cohesiveness, criticising the assumption that different methods could yield equivalent results. Whilst increasingly attracting research attention, both definition and operationalisation of cohesiveness have varied widely. (Drescher, Burlingame and Fuhriman, 1985; Mudrack, 1989) This has led to a lack of correspondence between concept and measures. Reliable methods of representing cohesiveness as a whole group factor have remained elusive, making it difficult to integrate research findings. For example, a study examining the construct validity of Yalom's factors found responses on his group cohesiveness factor unrelated to scores on a measure of group cohesiveness describing "attraction to the group". (Rorbaugh and Bartels, 1975) They concluded, as have many others, that cohesiveness is not a unitary construct.

Cohesion, Compatibility and Improvement

Yalom, Houts and Zimberg (1970) conducted an exploratory study with the aim of identifying predictors of improvement in group therapy. They measured a number of variables over a year in newly formed outpatient groups from a unitary population, using a design with repeated measures plus one semi-structured interview. Cohesion correlated positively with self-ratings of improvement, though not when interviewer ratings were included. However, "popularity in the group", closer to acceptance, correlated significantly with both self and interviewer ratings on all outcome measures, reinforcing the view that acceptance may be the more robust and unitary concept. In addition, the disparity between self-ratings and interviewer ratings points to a gap between patients' subjective and objective experience of the group.

Promotion of cohesive style

Liberman (1970) experimented effectively with therapist strategies to promote cohesive style. Arguing that the distribution of affection (loosely, and very debatably, defined as a similar factor to Cohesiveness) is central to group function, he set up two groups where the therapist in the experimental group was trained to reinforce patient statements which reflected Cohesiveness. He had some success in demonstrating that therapist strategies can foster Cohesiveness. Hurst similarly demonstrated that a caring style of leadership was related to increased Cohesiveness, positive outcome and attitudinal change in a study of adolescent self-awareness groups. (Hurst, 1978) These are aspects of the therapist-patient relationship which are largely taken for granted today, when the focus is on the group as a whole entity in which the individual may or may not feel accepted.

Phase of group and Cohesiveness

Later research has increasingly identified the phase or length of time in the group as a major variable and Cohesion has been found to play a differential phase-based role. Using an established Group Cohesion Scale with twelve short-term outpatient psychotherapy groups, Budman, Soldz, Demby, Davis and Merry (1993) found that individual participant behaviours related to cohesion varied with the length of time the group had run.

Summary and Conclusion

Group cohesiveness is both cause and effect and has been found empirically to enhance both process and outcome (Dies, 1993), whereas acceptance is a more uni-directional

factor. Cohesiveness has attracted contemporary research, which has approached it as a more comprehensive element, and in relation to other aspects of group function. For example, a significant relationship between self-disclosure and cohesiveness has been found (See 'Self-Disclosure', below and Introduction)

In an attempt to clarify a very diffuse area, Drescher, Burlingame and Fuhriman (1985) suggested that the meaning of cohesion varies significantly according to four critical dimensions: person, variable function (as antecedent or response), measurement strategy and time and proposed using a multi-dimensional research model based on these dimensions. Dies (1985) cautioned against asking individuals to rate their own experience of cohesiveness and then averaging these scores to provide a measure of whole-group cohesion.

E.2.2 Altruism

Theory

Altruism can be defined as a need or impulse of the individual to act in such a way as to be of value to others. It may have a biological basis, as for example, in maternal selflessness, but it can be observed from childhood in human beings as a reasoned urge, which is regarded as a commendable moral value. (Piaget, 1932; Kohlberg, 1968) As a therapeutic factor, it is a "cognitive dimension, ie., a self-evaluative quality inherent in placing another person's needs ahead of one's own". (Bloch and Crouch, 1985) Clinical observation has suggested that it is unique to the group situation and a beneficial feature of group therapy, which boosts self-esteem and enables the participant to learn something about his/herself. (Fuhriman and Burlingame, 1990)

Research

However, there appears to be almost no research literature on altruism in therapy groups. Killilea, in a review of the self-help literature, found altruism to be one of seven properties that typify self-help groups (Killilea, 1976). There is no research to suggest that this necessarily so in therapy groups and it may therefore be a factor which is difficult to measure.

E.2.3 Catharsis

Theory

It is well known that the concept of catharsis originated with Aristotle, though its meaning in the context of Greek tragedy is rather different from the sense given to it by Breuer and Freud. (Freud, 1911) It has come to mean an outpouring of emotion (Corsini and Rosenberg, op. cit.) which facilitates a healing awareness. Yalom (1985) believed it to be crucial in the interpersonal framework, stressing the need for open expression *and* cognitive assimilation to make sense of the revelation. Bloch and Crouch (op. cit.) suggest that the items of Yalom's Therapeutic Factor Questionnaire conflate it with Self-Disclosure. They assert that it is possible to understand the latter factor as a learned skill, expressing feelings towards therapist and peers which bring some relief.

Research

Effects of Catharsis

There is a paucity of research findings in this area. Haer (1968) conducted a comparative study with two psychoanalytic groups where the expression of feelings was encouraged

by the therapist in the experimental group. Taped sessions were coded for frequency of angry expression and aggressive responses. The latter were found to decline after angry ventilation of feelings. Haer therefore concluded that emotional discharge can indeed affect patterns of interaction, but lacked evidence that it is therapeutic. Liberman (1970), working from a more behavioural stance, compared two groups, where the therapist in the experimental group promoted the expression of hostility towards himself. The increase in expressed hostility was unrelated to improvement in symptoms or personality change. Clearly the latter study was so manipulated that it is doubtful if it could reflect the clinical situation and the two studies observed different factors - ventilation of feelings and expression of hostility are hardly synonymous.

Similarly, in the Stanford study of group experience in seventeen college encounter groups, Lieberman, Yalom and Miles (1973) found that despite catharsis being ranked third most helpful factor out of thirteen, there were no significant differences between the three outcome categories related to increased insight which could be shown to derive from catharsis. (Participants completed a "most important event" questionnaire on several occasions.) They conclude that "there is no evidence that expressivity per se is specifically associated with differences in individual growth". However, criteria differed from those used in Liberman's study, (op. cit.) and symptomatic improvement does not always occur with insight. In this study, aggressive ventilation actually increased negative outcomes.

Summary and Conclusion

The interest in the inconclusive study of catharsis per se has been subsumed by more cognitive factors, but one would support Yalom's (op.cit.) view that emotional expression

is a necessary aspect of group culture. Alternatively, emotional expression might be considered a *medium* for other factors, rather than a factor in itself.

E.2.4 Family Reenactment

Theory

This factor embodies those aspects of the group interactive process which express and relive for the individual past experiences within the family setting. These have played a part in forming personality, motivate the individual's behaviour and shape her/his expectations and interpretations of others' actions.

Research

Yalom and others included this factor in their research and practice (Yalom, 1985), but it has not yielded research results which suggest that it is valued by group members, being rated consistently low in helpfulness. (Butler and Fuhriman, 1980; Colijn et al, 1991; Rorbaugh and Bartels, 1975; Yalom, 1985) This would seem to run counter to clinical experience and to theoretical and empirical approaches to understanding the construction of personality. One possible reason for this is that while clinicians may understand that the process of re-experience and new understanding is occurring, according to our conceptual framework, participants may not perceive the process in this way. However, Tschuschke and Dies (1994), in their study of two long-term analytic groups, found it to be one of five factors associated with clinical improvement. It may be that the methodology used has been unable to access this factor, though the fact that it appears to

be more salient in longer-term groups suggests that this could be an artefact of group-phase development.

Wheeler, O'Malley, Waldo, Murphey and Blank (1992) conducted a study with a group of incest survivors, using therapeutic factor methodology with fairly typical results, the most valued therapeutic factors being Catharsis, Self-Understanding, the Existential Factor and Cohesiveness, in that order. Using both Yalom's Q-Sort method and Bloch et al's critical incident technique, they compared their findings in a closed, time-limited survivors' group to those of Bonney, Randall and Cleveland (1986) with an open, two-year long survivors' group in which Therapeutic Factors were ranked. The group studied by Bonney et al found a marked relationship between Family Reenactment and experiences in the group (Family Reenactment × Self-Understanding, Cohesiveness, and Catharsis), and factors most valued were Self-Understanding, Cohesiveness, Family Reenactment and Catharsis, in that order. This differs from the findings of Wheeler et al. and from the 1983 review of Butler and Fuhriman (1983) which had found that personal growth and therapy groups most valued Self-Understanding, Catharsis and Interpersonal Learning.

Wheeler et al. also compared their results with those of the original study of Yalom, Gilula and Tinklenburg (1970). They found a correlation of .78 between their own group results and Yalom's in ratings of helpfulness of therapeutic factors, but only a .55 correlation of most valued factors between the survivors' groups of Bonney et al. and Wheeler et al. (op. cit.) This suggests that either it is Yalom's questionnaire which fails to access this factor, or that a longer-term, open group is needed to facilitate disclosure of this painful area, which is the view of Wheeler et al.

Summary and Conclusions

Yalom's items seem fairly unambiguous. Perhaps they are difficult for some participants to answer affirmatively. Yalom himself suggested that although this may be a pervasive factor, it may operate at a different level of awareness from more explicit factors. Moreover, Bloch et al. (op. cit.) seem to have considered it redundant, since they argued that learning about early family relationships through transference in groups is a type of self-understanding and should therefore be subsumed under this factor. Landau points out that we are making an assumption that patients identify a specific cause for their problems. (Landau, 1991) However, patients are heard in group sessions to make these connections. There is apparently no other therapeutic factor research which can offer insight into this puzzling finding.

E.2.5 Guidance

Theory

Guidance is the imparting of information and the giving of direct advice. It has been given lower priority than some other factors in group psychotherapy and many dynamic therapists would consider that although advice and guidance occur naturally within the group, the deliberate offering of direct advice deprives the individual of self-discovery.

Research

This theme is picked up in the research, where Maxmen (1978) successfully devised a model for lower-functioning Inpatients, which stressed the containing and didactic elements of the process. Yalom's research findings support this. (Leszcz, Yalom and

Norden, 1985) Yalom et al concluded like Maxmen that inpatients in groups value different factors from outpatients, though the distinction between groups was conflated with diagnosis. The inpatient groups in Maxmen's study were suffering from mental illness, which has been found to respond more successfully to structure (Yalom, 1983), whereas participants in Yalom's groups had neurotic or mild personality disorders and were cognitively and emotionally more contained.

Flowers (1979) found in an experimental study with small groups of detained sex-offenders, that both the offering of alternatives and detailed instructions were more beneficial than simple advice, but this observed benefit was not tested and the population group was atypical. However, a study of groups in eight two-hour workshops also found that those groups who had received specific behavioural advice showed improved cohesiveness and greater self-disclosure and feedback, as rated by participants and independent judges. (Bednar and Battersby, 1976)

Therapist Promotion of Guidance

A potentially useful related area which may have relevance because of its implications for the promotion of Hope is that of pre-therapy training. Rabin (1970) reviewed and categorized a number of methods and a later study (Gauron, Steinmark and Gersh, 1977) used one of them, the "intake-group" method, with a "here-and-now" approach. He found improved understanding of therapy and of the learning process, lessening of anxiety and increase in hope. Unfortunately, these were not measured. However, D'Augelli and Chinski (1974), working with twelve small groups of students and using a cross-over design, demonstrated that pre-training led to higher levels of personal discussion.

Similarly, a controlled study with outpatients, using a systematic talk to promote the therapy group (Yalom, Houts and Newell, 1967) was able to demonstrate that the preparatory session was effective in fostering faith in treatment and encouraging interaction within the group.

Summary and Conclusion

The research again divides into studies which were well designed and executed, but limited by their "laboratory" setting (Flowers, op.cit.), and clinical or personal growth studies which demonstrated loose methods or confounded variables. (Rabin, 1970; Gauron et al., 1977)

This factor can more easily be operationalised and is therefore potentially easier to research than some other factors. However, this research has impacted more usefully on the psycho-educational field and "lower functioning groups" than on group psychotherapy.

E.2.6 Instillation of Hope

Theory

"A therapeutic factor whereby the patient gains a sense of optimism about his.....potential for progress through his actual experience in the therapy group". (Bloch and Crouch, op cit.) They note that the distinctive aspect in the group context is that hope includes the role of peers as well as the therapist. However, Yalom views hope as a therapeutic factor in group specific terms, where the group provides the opportunity for the individual to see that one or more of his/her peers with similar problems is gaining

from the group. This differs from Vicarious Learning in that the patient sees *that* problems can be addressed, rather than *how* they are addressed.

There is virtually no literature on Hope as a therapeutic factor in Yalom's sense. A very recent study by Littrell (2005) of clinicians working with schizophrenic patients asked them to describe their experiences of rendering hope. Among the dominant themes which emerged were optimism (that is, ongoing hope from clinicians despite relapses), the establishment of realistic treatment goals, perseverance and the therapeutic relationship, the stability of which was considered fundamental for the instillation of hope.

The research on pre-therapy training discussed above (Guidance) suggests that hope is a reasonable factor for therapists to promote in this or other ways, and that it could be researched.

E.2.7 Learning from Interpersonal Interaction

Theory

This factor *can* be seen as a condition for change, but it is primarily a therapeutic factor which is amenable to being measured and observed. It could be described as the raison d'etre of the group and the therapeutic community.

From the beginning, Corsini and Rosenberg (1963) included "transference to others" as well as to the therapist in their list of factors. The ego psychologists Horney, Sullivan and Fromm (op. cit.) had all stressed interpersonal dynamics, and learning from interpersonal interaction became in Yalom's schema the most important aspect of group therapy.

(Yalom, 1985) As a factor, it equates Yalom's 'Interpersonal Learning – Output'. Bloch and Crouch (1985) stress its behavioural quality and offer the definition: "The attempt to relate *constructively and adaptively* in the group by imitation or by responding to group members". The self-modification of behaviour is its essence and may include both various kinds of expressive response and overt behavioural attempts to relate to others. They note a potential overlap with Altruism, Catharsis and Self-Disclosure, but not the inevitable overlap with Self-understanding.

There are numerous theories. Psychoanalytically, "Interaction is only a preliminary to the loosening of defensive armour." (Slavson, 1966) Alternaltively, Stein saw that as the transference splits up and goes towards each group member and the therapist, group tensions can arise and cause members to 'act out' with each other (Stein, 1970). In Yalom's (1985) rather more cognitive-behavioural perspective, the peer group takes priority. His "dynamic interactional " is based on the premise (Sullivan, 1953) that psychological symptoms originate in disturbed relationships. The group is seen as a social microcosm and offers a corrective emotional experience where the patient feels safe to take the risk of expressing strong emotion and can reflect on it, which leads to improved interpersonal relating. More precisely, feedback from others may label and reduce dysfunctional behaviours by facilitating insight into how those behaviours affect others. (Rothke, 1989)

Research

Much of the theoretical argument on this factor now seems outdated, as we now assume interaction to be the most powerful social element in group activity. There was less

empirical exploration than theory and this tended to avoid examining the links between interaction and outcome.

The Therapist's Role in Interaction

Heckel, Froelich and Salzberg (1962) found a significant association between the therapist's redirection (of comments to the therapist back to the group) and the level of interaction between group members. Another constructed study (Salzburg, 1962) demonstrated that therapist silence encouraged greater patient interaction and vice versa. He also found that redirecting increased interaction, though this did not affect the content of the response. These were useful findings in terms of running the group, but constructed studies inevitably alter the group.

Grosz and Wright (1967) studied stability in a slow-open group beset by admissions and discharges and found, unsurprisingly, that periods of stability increased the number of patient interactions. Despite the fluctuations in the group, the average *number* of interactions per patient increased from twelve to one hundred and four over a six-month period. There were no therapist effects, but they suggest that therapists over time inculcate a norm of interaction, which becomes accepted by the group and communicated to new members. Later work has raised the question of how the concepts and language of a particular group determine patients' articulation of their experience (Lieberman, 1983), and how those aspects of the process which the therapist is trained to stress are likely to be reflected in patient values and gains. (Chiesa and Fonagy, 1996) It should also be noted that although a high number of interactions may suggest a lively group, this says nothing about the content and whether or not learning takes place.

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In a rare early study of interaction and outcome, Swarr and Ewing demonstrated significantly positive change in the first ten sessions in the areas of, for example, self-esteem and anxiety. Other problems, among them interpersonal consequence, showed improvement only after six months, which may have been a function of the early growth of self-esteem and also of the norm to which Grosz and Wright (op. cit.) refer. It is also relevant to theories of evolution of the group as a whole. (Swarr and Ewing, 1977)

Summary and Conclusion

For a factor regarded as so central to the group process, interpersonal interaction has received disappointingly little attention. Since it is expressed as overt behaviour, it is amenable to operationalisation and measurement in terms of frequency, duration, intensity, timing and reciprocity, all of which might have enriched our limited understanding of causal links in group process.

E.2.8 Self-Disclosure

Theory

Self-disclosure in group psychotherapy refers to the revealing of information about personal life experience: past and present, in fantasy, dreams and the "here and now" in the group. A single dramatic revelation is rare and complete self-revelation is not required. The therapeutic aim is that this should embody a constructive and honest shift in attitude through self-examination. There may be intense expression of emotion and this "cathartic" factor may *accompany* the sharing of information, rather than be conflated with it, as Bloch and Crouch suggest (Bloch and Crouch, 1985).

Jourard (1971) similarly suggested that self-disclosure facilitates self-awareness and emotional growth and both he and Cozby (1973) posited a curvilinear relationship between the degree of self-disclosure and psychological health. Discriminant self-disclosure is a prerequisite for intimacy and necessary for the development of relationships. (Yalom, 1985) It can occur only in a social context, where its acceptance provides a reward (Thibaut and Kelly, 1959) and conversely Lieberman notes that it is the sense of acceptance by others which facilitates self-disclosure. (Lieberman, 1980)

Research

Self-Disclosure and Cohesiveness

Many studies point to a positive relationship between self-disclosure and cohesiveness. (Query, 1970; Johnson and Ridener, 1974) Cohesiveness in these studies refers to group cohesion rather than acceptance and it is not surprising that self-disclosure is linked to a factor that can be seen as a condition for personal change.

Possible relationships between self-disclosure and others of Yalom's therapeutic factors have not been researched. In addition to catharsis and acceptance, there may be particular links with self-understanding and vicarious learning, both related to the acquisition of insight.

Self-Disclosure and Relationships

Examining the effect of general group processes on self-disclosure, one finds from laboratory studies that we reveal more to those to whom we are attracted and have a preference for those from whom we receive personal information. (Worthy, 1969; Certner, 1973) Allen argued that because of the power of reciprocity in this factor, in a

group those who can risk self-disclosure will do so and others will follow in a benign cycle. (Allen, 1974) A curvilinear relationship has been found between self-disclosure and facilitative relationships (Morran, 1982) and between self-disclosure and social desirability scores, suggesting that those with the highest need for social approval might regard self-disclosure as a threat to acceptance by the group. Clearly, there are subtle interconnections between acceptance by the group and the risk-taking of self- revelation.

Self-Disclosure and Outcome

If personal insight is a generally accepted aim of therapy, then self-disclosure should contribute to this by facilitating self-awareness. The findings of Strassberg, Roback and Anchor (1975) of a negative correlation between self-disclosure and progress, as rated by patients, are complex and equivocal. The Stanford encounter group study of Lieberman, Yalom and Miles (1973) found that in the early sessions, students who gained either more, or less, insight reported similar rates of self-disclosure, but in later sessions, greater self-disclosure was associated with improved insight. This may again be related to cohesiveness or acceptance by the group. It appears that for understanding to occur, reciprocal support, reflection and clarification are needed.

Self-exploration and a willingness to talk about problems *together with* a sense of responsibility was found to be significantly related to clinical improvement in a review by Orlinsky and Howard (1986), as were expressiveness and openness. In addition to likely difficulties in defining and measuring a sense of responsibility, it is not clear whether the studies reviewed actually identified the proportion of the variance due to these characteristics.

Summary and Conclusion

It is hard to see how interaction or insight can occur *without* self-disclosure at some level. This theoretical and empirical link indicates interdependence of factors. Despite being one of the most observable behavioural factors, the research has not addressed simple building blocks of self-disclosure such as duration, frequency and most importantly, timing.

E.2.9 Self-Understanding

Theory

Often called insight this factor has attracted considerable attention, but has proved particularly difficult to externalize and measure. Yalom stresses that it relates to the process of self-*discovery* of which the behavioural component is *acting* on new insight (Interpersonal Learning-Output). Interpersonal Learning-Input *brings* insight through learning from the group what others think.[10] However, Bloch and Crouch argued that the latter could be appropriately subsumed under Self-Understanding and Yalom's Output is equivalent to their Learning from Interpersonal Interaction. (1985)

Insight seems easy to recognize, but is notoriously hard to define. There had been earlier wrangling over this phenomenon, with analysts like Wolfson (1975) and Slavson (1979) insisting on the primacy of historical or aetiological insight, which they held was engendered by transference. They thought the group diluted the transference. Foulkes, however, perceived transference to be both horizontal (between peers) and vertical (patient-therapist). (Foulkes, 1964)

[10] *The literature uses the terms Self-Understanding and Insight interchangeably.*

Yalom (1985), basing his work on Stack Sullivan's interpersonal model (op. cit.), was also critical of these analysts' emphasis on transference and claimed there was no evidence to support it. He did not discount unconscious processes, but believed that the individual constructs his/her own psychological past present and future. Weiner (1974) critically pointed out that there are twice as many items in the Therapeutic Factors Questionnaire concerning interpersonal learning as for any other factor, which loads the instrument to support Yalom's theory. He also suggests that a 'forced-choice' questionnaire cannot reflect changes in the unconscious mind, which may be experienced at the time only as discomfort. This would support the concurrent use of qualitative methods.

Weiner's own research (1974) concluded that, except for Interpersonal Learning-Input, factors ranked most highly by patients in group therapy equalled those *expected* by them. Unfortunately, Weiner combines the assessment of I.L.-Input with I.L.-Output though the latter cannot be experienced until the group commences. Moreover, his view that the TFQ is overloaded in this direction is not supported by the fact that Interpersonal Learning-*Input* frequently ranks among the first three or four most valued factors, but not I.L.-*Output*.

Relevant to Weiner's argument is Malan's follow-up study of group psychotherapy (1974). Malan's complex findings led him to suggest that psychodynamic gains are less externalisable than symptomatic gains, which can in fact mislead research findings, this being one of the greatest problems in all psychodynamic psychotherapy research.

Unfortunately, these and other very real and pertinent issues revolving round the translation of theoretical definitions to reliable methodology were not the major focus of research at that time.

Research

Self-Understanding and Change

Several studies have explored the relationship of insight/self-understanding to clinical change. Meichenbaum's well-constructed comparative study of three controlled group intervention types (desensitisation, insight or a combination of the two) found that some group approaches can be beneficial without insight. Where there was specific anxiety, desensitization brought improvement, but where the anxiety was diffuse, desensitization *plus* insight were necessary. (Meichenbaum, Gilmore and Fedoravicius, 1971)

Studies comparing interactional groups with insight-orientated groups (Roback, 1972) concluded that insight was not crucial for behavioural change in psychotherapy. It is not clear whether these two elements can be separated in a psychotherapeutic group and design and assessment instruments were of poor quality. Roback found that a combined interactional and insight group was most effective, but conclusions appear to have been based on unsubstantiated assumptions. Moreover, the subjects were chronic schizophrenic patients, whose therapeutic requirements have been found to differ markedly from others. (Yalom, Lescsz and Norden, 1985; Maxmen, 1973)

Psychological-mindedness has been found to be more helpful in insight-orientated groups than in others, though in a small and non-clinical sample measured by self-report only. (Abramovitz and Abramovitz, 1974) It was also found that "here-and-now"

interpretations in the group were more helpful than those related to the past. Ranking methods suggested that a combined approach group (insight plus interaction) was consistently superior. (Abramovitz and Jackson, 1974) This has simple face validity and reinforces the view that they are therapeutically inseparable.

Self-Understanding and Feedback

Jacobs, Jacobs and Gatz (1973) studied process rather than outcome, basing their work on the commonsense assumption that feedback is an important aid to self-understanding. It is of interest that positive feedback had the greatest impact and was most credible to the recipient. There was a suggestion that positive behavioural feedback was enhanced by combining it with positive emotional feedback and that negative is best given *after* positive and best when not supported by negative emotional feedback, all of which makes sound clinical sense, though unfortunately neither the population nor the methods were clinical. The Stanford encounter group project found no significant differences between "learners, non-learners and negative outcome members" in the number of times feedback was cited as being helpful. However, feedback was rated as the most helpful factor by participants overall. (Lieberman, Yalom and Miles, 1973).

Bloch and Crouch (1985) distinguish between interpretation and the role of feedback, in that in feedback there are no inferences. They also distinguish between behavioural feedback and that which conveys an emotional reaction to the individual, as in the study of Jacobs et al. (op. cit.) Clearly there must be a cognitive process of understanding to put it to use, hence the findings of psychological-mindedness above. (Abramovitz, op.cit.) They found the timing of feedback to be of crucial importance in their research study.

Summary and Conclusion

This factor is generally seen as pivotal to clinical change, and therefore both a mechanism and a consequence of change. It appears possible for behavioural change of a limited kind to take place in the group setting without insight.

E.2.10 Vicarious Learning

Theory

Little attention has been paid to this factor, which is a kind of learning possible in group rather than individual therapy, and more observable than some of the other factors. Bloch and Crouch (op. cit.) adapted it from Yalom's Identification, which essentially describes imitation. They define it as *both* the imitation of qualities in others deemed desirable by the observer *and* learning that stems from identification with another patient's specific experience in therapy, making this a less unitary factor and overlapping with universality.

Research

Jeske (1973) found clinical improvement on self-report correlated positively with identification, but the experiment (not untypically for some methods of the time) was so intrusive, requiring each patient in the group to press a buzzer each time they felt they identified with a fellow patient, as to radically alter the experience of the group! In a short-term and very structured social skills group with psychiatric outpatients, modelling was found to be more effective than guided discussion (Falloon, 1981).

The view that patients value learning from or imitating the therapist was not supported by Pappas, Yannitsi and Liakos (1996) who carried out a project introducing a therapeutic community approach to a psychiatric ward in Greece and found that the measure

"learning from the example of the therapist" was endorsed significantly negatively by most patients, which salutary finding could be a lesson to us all!

Summary and Conclusion

This factor has attracted little interest, even though it lends itself to observation.

E.2.11 Universality

Theory

Universality refers to the awareness that problems are not unique to oneself and that there can be a particular dialogue with others who have similar experiences. It appears to be experienced most at the beginning of therapy and is felt implicitly rather than articulated, say Bloch and Crouch (op. cit.), though personal clinical experience would suggest that it *is* articulated. From the start of thinking about groups it has been given great importance, both for its capacity to reduce the patient's sense of isolation with her/his problems and because the shared recognition of problems enables the patient to think about them more objectively. (Wender, 1936; Corsini and Rosenberg, 1963; Foulkes, 1964) To these benefits, Foulkes added the lessening of anxiety and guilt. Lieberman (1980) points out that the self-help group is actually organised around the aim of maximizing universality to provide support and that this also brings relief from a stigmatizing image. Despite this, the concept has not attracted interest within the therapeutic factors research field. Universality could, however, be seen as a *condition* for the facilitation of the Instillation of Hope and for Vicarious Learning.

Table 1.5 (Reproduced from Introduction) Factors considered to be most therapeutic by outpatient therapy group members, as ranked per study.

Researchers	Most Therapeutic Factors
Yalom, Tinklenberg & Gilula (1970) (See Introduction, Part 2)	Learning from Interpersonal Input Catharsis Cohesiveness Self-Understanding
Weiner (1974)	Interpersonal Input Catharsis Self-understanding Cohesiveness
Rorbaugh and Bartels (1975)	Catharsis Cohesiveness Interpersonal Input Self-Understanding
Bloch et al (1979) (See Introduction, Part 2)	Self-Understanding Self-Disclosure Learning from Interpersonal Interaction
Butler & Fuhriman (1980)	Self-Understanding Universality Interpersonal Input Catharsis

Table 1.5 (cont.)

Butler & Fuhriman (1983)	Self-Understanding
	Catharsis
	Universality
	Cohesiveness
Colijn et al (1991)	Interpersonal Learning
	Catharsis
	Self-Understanding
	Cohesion