THE RELATIONSHIP OF GROUP RESEARCH AND CURRENT PRACTICES IN GROUP COUNSELLING AND THERAPY IN METRO TORONTO

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Abstract

One hundred and sixty-five practicing group leaders in the Metropolitan Toronto area were interviewed using a questionnaire designed to explore the correspondence between current group counselling and what the research literature suggests. Responses were discussed under four headings: 1) pretherapy considerations, 2) group leader orientation, 3) outcome evaluation and, 4) size and open/closed issues.

Group leaders were found to be aware of and concerned with many issues of current concern to researchers and theoreticians. All of the group leaders were able to specify goals for change and report methods of evaluating outcome although there was an excessive reliance on subjective instruments (verbal and written self-reports). Seventy-five per cent of the group leaders reported that the research literature had minimal relevance or no relevance to clinical practice. Some current findings from the research on group practices are discussed.

Résumé

On a interviewé 165 chefs de groupe qui travaillent dans la région métropolitaine de Toronto. Pour ce faire, on a utilisé un questionnaire conçu pour explorer le rapport entre la consultation en groupe courante et ce que la littérature suggère. On discute les résultats de quatre façons: 1) les considérations pré-thérapeutiques, 2) l'orientation du chef de groupe, 3) l'évaluation du résultat, 4) la grandeur et les questions ouvertes/fermées.

On a trouvé que les chefs de groupe accordaient beaucoup d'attention et d'importance aux problèmes actuels qui réclament les énergies des chercheurs et des théoriciens. Tous les chefs de groupe étaient capables de donner des buts au changement et d'exposer les méthodes employées pour évaluer les résultats, quoiqu'on avait trop recours aux moyens subjectifs (rapports personnels oraux et écrits). Soixante-quinze pour cent des chefs de groupe ont indiqué que la recherche contribue peu ou aucunement au travail accompli en clinique. Enfin, on discute certains résultats courants de recherches effectuées sur les démarches utilisées avec des groupes.

The practice of group counselling has burgeoned in recent years and group practices are now applied in a wide variety of academic, institutional and social settings with almost every conceivable kind of client. Yalom (1975) discusses the proliferation of groups in his region of the country and reports ". . . a bewildering array . . ." of group practices.

Similarly, research investigations of group counselling have increased in recent years although it is often not known to what extent those principles uncovered in the laboratory are being applied in clinical practice. Furthermore, theoretical expositions on group therapy are relatively rare in the literature and are often ambiguous, contradictory and difficult to subject to experimental study. As yet no clear conception of what group therapy is or how it is practiced has emerged.

Gazda (1971) speaks of a theoretical and methodological void in the field of group counselling which arises from the confused state of current theory and the application of new and relatively unresearched practices. He reviewed 145 studies published between 1938 and 1970 and found only 15 related to process variables in group psychotherapy. Of those fifteen ". . . few provided guidelines which group counsellors could apply to their practice" (p. 213). Gazda (1971) concludes that many problems in the clinical practice of group counselling or therapy may be attributed to the fact that the ". . . research literature conveys very little guidance to the

practitioner who must decide his position from among a number of competing theoretical positions" (p. 211). Gazda (1971) quotes Moreno's (1960) statement of the two great problems in group practice ". . . waiting for a solution: (1) the definition of professional standards of performance and skill and (2) a code of professional ethics" (pp. 263-264). He points out that little has changed in the last 10 years.

Hansen, Warner and Smith (1976), referring to the rapid growth of the group movement, say that the major problems in the practice of group counselling ". . . involve the use of the group process by untrained leaders and the assumption that a 'good' individual counsellor is automatically a 'good' group counsellor" (p. 1). They further suggest that "the state of the art of group practice probably precludes general and universally applicable answers . . ." (p. 434), to many issues of central importance to leaders. Confronted with an array of information from group members, the leader needs some structure to organize that information. Hansen et al. (1976) present 12 principles that are based on a synthesis of many different models in an attempt to provide group leaders with a ". . . broad framework with which to develop their own eclectic position". They do not consider these "conceptual" models as perfect but only as "general guidelines".

Thus, it can be readily seen (Gazda, 1971; Hansen, et al., 1976) that the question of what group therapy is and how it should be practiced is far from being settled. For a comprehensive review of recent empirical research in group psychotherapy and counselling the reader may refer to Bednar and Lawlis (1971), Grunebaum (1975) and Lieberman (1976).

Is there a close correspondence between what the research literature suggests and group practices in Metropolitan Toronto? To help answer this question, and others, a survey study was conducted consisting of group counsellors and therapists in the Metropolitan Toronto area.

METHOD

In order to explore the question of how group therapy or counselling is currently practiced, interviews were held with 165 practicing group leaders in the Metropolitan Toronto area. Group leaders were interviewed by graduate students enrolled in a group counselling course taught by the senior author at the Ontario Institute for Studies in Education between 1973 and 1976. Group leaders were selected primarily on the basis of availability, willingness to cooperate and being known by the interviewer.

The actual procedure required students to arrange to interview the group leaders personally; follow a standard set of 12 interview questions designed by the senior author and record the responses to these questions. The questions asked were as follows:

1. Do you give any instructions to the client before entering the group?
2. What is the optimal number of clients you care to work with?
3. How do you conceptualize the role of the group leader?
4. What criteria do you use to evaluate a client's progress in the group?
5. What are the advantages of doing counselling or therapy in groups as opposed to individual counselling or therapy?
6. Are your groups open or closed? Why?
7. What particular theory, if any, has influenced your approach in doing counselling or therapy in groups?
8. Has the research on group dynamics or small group behavior had any relevance for you in doing therapy or counselling in groups? If so, how?
9. What criteria do you use for accepting or rejecting clients when forming a group?
10. Are there any rules for the group to follow?
11. What goals do you hope to achieve by conducting counselling or therapy in a group?
12. How long have you been conducting counselling or therapy in groups?

RESULTS

The total number of group leaders interviewed were 165 but 43 were rejected on the basis of incomplete or unusable data. The remaining 122 group leaders' responses to each of the eleven questions were coded and percentages in each code were calculated (See Table I). Two questions are not reflected in Table I (Questions 9 and 12). Only percentages were given for Question 12 which dealt with number of years experience in conducting groups and the response code for Question 9 which was too long to put in a table. Thus the results of Question 9 (criteria used for accepting or rejecting clients) are as follows: (1) criteria for rejection was psychiatric pathology (37%); disruptive acting out (10%); leader assessment interview (13%); individual therapy needed (14%); not meeting group goal (10%), lack of commitment (6%); no rejection criteria (10%); and (2) the criteria for acceptance was goal specific commitment (38%); leader assessment interview (20%); high motivation, strong ego (17%); voluntary presentation i.e. "want help" (15%); agency referral

(8.5%); and those in touch with reality (1%). The responses to questions with "How", "What", or "Why" are referred to in the discussion.

Of the total number of group leaders 68% were male and 31% were female. The group leaders' educational specialization included psychology, psychiatry, theology, education, social work, sociology, and nursing. The level of education attained was: Ph.D. = 22%, M.D. = 16%, M.A.[M.Ed. = 35% and B.A. = 27%. The number of years of experience (question 12) ranged from less than one year to more than 20 years with a mean of 4.2 years. The settings for group practice included private practice (7%), psychiatric facility (29%), agency (21%), high school (30%), and university (5%).

DISCUSSION

Discussion of the responses to the interview questionnaire are subsumed under four general headings based on similarity and ease of comparison with current research. These four areas are: 1) Pretherapy considerations, 2) Group leader orientation, 3) Outcome evaluation, 4) Size and open-closed issues.

1) Pretherapy considerations:

The results of questions 1, 5, 9 and 10 will be discussed in this section.

When group leaders were asked if they gave any pretherapy instructions 83% responded positively. A brief summary of recent research on this issue will serve to justify the positive response to this question. Pretherapy training and instruction is currently an active area of research in group therapy. Hoehn-Sarie, Frank, Imber, Nash, Stone, and Battle (1964) suggested that group therapy is more successful if clients receive an introduction to some of the principles of group dynamics. Although they did not present empirical research they felt that the success was due to the client knowing what to expect. Truax, Shapiro and Wargo (1968) compared groups with and without pretherapy training using Q-sort measures as outcome criteria and found that the pretrained groups made positive changes on all five self-concept measures while the groups without pretraining regressed on four of the five measures. Studies by Yalom, Peters, Sheldon & Rand, (1967) present similar evidence in that pretherapy training had a positive effect on group processes, i.e. group cohesion and task concentration, which are considered necessary predecessors of behavioral change (see also Hansen et al., 1976). Bednar and Lawlis (1971), concluded that clarifying client role expectations, modeling desired client behavior patterns and providing a framework should be a prerequisite to group therapy.

In response to the question about the presence of rules for the group to follow, 91.5% responded that there are rules. The rules most often stated were; no physical violence, confidentiality, regular attendance, honesty and courtesy. What is possibly more surprising than the high positive response is that some group leaders stated that they specified no rules. One psychiatrist stated ". . . I would never lay out a set of explicit rules at the beginning". Rules and boundaries were found to be critical by Yalom and Rand (1966) and Goldstein, Heller and Sechrest (1966).

When asked about their view concerning the advantages of groups the Toronto group replied that feedback of peers (37%) and real life simulation (19%) were two principle advantages of the group method. Another principal advantage was efficiency and economy of time (28.5%). Some specific comments were: the group was a more natural setting to practice interpersonal skills, the group provided an opportunity for clients to see others with common problems and groups contributed to the prevention of feelings of isolation and abandonment. However, some group leaders suggested that the advantages depended on the nature of the clients' problems. Research studies on the advantages and disadvantages of group therapy or counselling are contradictory and are often based only on clinical impressions and single group studies. Several studies (Novick, 1965; Sommers, Schaeffer, Leiss, Gerber, Bray, Fundrella, Olsen, & Tomkins, 1966) report no significant difference in outcome with group and individual therapy or counselling. Bednar and Lawlis (1971) conclude that group therapy or counselling is not that effective with psychotic patients and this conclusion is supported by studies on phobias (Geldar, Marks & Wolff, 1967) and not supported by studies with discharged schizophrenics (O'Brien, Hamm, Ray, Pierce, Luborsky, & Mintz, 1972; Schwartz, Myers, & Astrachan, 1973).

The majority of studies concerning acceptance/rejection criteria indicates that group composition is important and that such variables as age, sex, occupation, personality traits and intelligence are powerful determinants of group behavior and group cohesiveness (Grunebaum, 1976; Yalom, 1975; Yalom & Rand, 1966; Bednar & Lawlis, 1971). Most researchers agree that some kind of assessment is necessary in deciding whether to accept or reject group members. Consistent with this conclusion, the Toronto group leaders contained only 10% who had no rejection criteria. The most often cited criterion for rejection was psychiatric pathology (cited nearly three times as often as any other criterion).

When the group leaders were asked what criterion they used for acceptance, more than half said goal

Table I

A Summary Of Group Leaders Responses To Inverview Questions In Percentages

Interview Questions	Response Code	Percentages
1. Instructions to Client:	No Instructions	17.0
	Yes Instructions	83.0
2. Optimal Number of Clients for the Group:	3 - 5	3.5
	6 - 8	44.0
	9 - 12	41.5
	13+	11.0
3. Conceptualization of Role of Leader:	Non-directive	6.5
	Directive	16.5
	Facilitator (supportive only)	56.5
	Eclectic (situationally determined)	16.5
	Model	3.5
4. Criteria Used to Evaluate Client's Progress:	Subjective (self-report)	87.5
	Objective (tests, questionnaires)	1.0
	Subjective and Objective	11.5
5. Advantages of Group Over Individual Counselling:	Efficiency/economy	28.5
	Feedback of Peers	37.0
	Real Life Simulation	20.0
	Commonality of Situations and Problems	13.5
6. Groups Open or Closed:	Open	26.0
	Closed	52.0
	Both	22.0
7. Theoretical Approaches that Influenced You:	Dynamic (Freud, Maslow, Rogers, Perls)	44.0
	Eclectic (whatever works)	33.0
	Behavioral (Skinner, Glasser)	12.5
	Cognitive (Ellis)	1.5
	Other (unidentified)	9.0
8. Relevance of Research in Group Dynamics and Small Group Behavior:	Yes	26.0
	No Relevance	31.0
	Minimal Relevance	43.0
10. Rules for Group:	Yes	91.5
	No	8.5
11. Hoped for Outcome:	Behavioral Change	24.5
	Attitude Change	56.0
	Behavioral and Attitude Change	19.5

specific commitment or high motivation (55%). None of the leaders used any assessment or diagnostic instruments in accepting or rejecting clients and only 17% held an assessment interview. This would seem to indicate that although most group leaders had some specific acceptance or rejection criteria, most of them did not apply these criteria in any systematic fashion. For those who utilized an assessment interview, this assessment was for an intake evaluation.

2) Group leader orientation:

The results of questions 3, 7 and 8 are discussed.

It has been suggested that how the group leader sees his assets and limitations is an important factor in affecting group cohesion, group limits and therapeutic progress (Bednar & Lawlis, 1971). For example, it has been found that authoritarian leadership can be harmful under some circumstances (Grunebaum, 1976); that personality characteristics of group leaders can directly affect treatment outcome (MacLennon, 1976); that similarity of cognitive style between patient and leader has a facilitative effect on group treatment (McLochlin, 1972) and that group therapy or counselling casualities are related to leader personality and techniques (Lieberman, Yalom, and Miles, 1973).

The Toronto group leaders saw the role of the leader as being non-directive (6.5%), directive (16.5%), a facilitator (56.5%) and as a model (3.5%). The remaining group leaders (16.5%) saw the role as situationally determined and eclectic. From the research, it would seem to be advantageous to be able to use a variety of roles and techniques depending on the composition and goals of the group (Bednar and Lawlis, 1971).

A closely related question was what theory influenced the leaders approaches. It is interesting to note that many leaders had to be pressed before they would answer this question, i.e. many initial responses revealed a resistance to any kind of theory. This is consistent with an editorial by Loeser (1951) 25 years ago in which he spoke of a "wide disregard" for a "frame of reference". Indeed, Lieberman et al. (1973) stated that theory has little influence but added that leader behavior is critical.

When asked what relevance research has for the practice of group therapy or counselling 74% of the Toronto leaders replied that it had minimal (43%) or no relevance (31%). Those group leaders who said the research was not relevant stated that they considered discussions with colleagues and their own experiences more relevant. Of the 26% who thought research was relevant the reasons most often given were that research provided good, up to date, information on what was happening in the field and that they learned new techniques.

These results may seem less unreasonable when one considers the dearth of experimental research in this area. Frank (1975) and Lieberman (1976) surveyed ten years of literature reviews in major group therapy journals and found only 7% of the articles were research studies, i.e. they contained some kind of quantitative analysis of the data. He concluded that empirical research has little impact on treatment and that this is at least partially due to the lack of experimental sophistication in the reviewed studies. Indeed, a practicing group leader would have to read a great deal of material in order to come across a clinically relevant empirical study. Unfortunately we had no way of knowing whether or not they had read or were familiar with the research literature.

3) Outcome evaluation:

The results of questions 4 and 11 are discussed.

The Toronto group leaders were asked what criteria they used to evaluate progress in group therapy or counselling. An overwhelming majority (87.5%) stated that they used only subjective data (i.e. client self-report, either verbal or written); "I ask them . . . why should they lie to me?", "I have them write a few paragraphs on their experience in the group". The interpersonal functioning of the group members seemed to be the main criterion of evaluation. Such things as how well the client relates to the group, contributions to group feeling, control, willingness to leave hospital, dressing more neatly and use of the groups resources were mentioned. There was no mention, by those therapists, of the use of psychological tests, rating scales, follow-up after treatment or any type of quantitative assessment. Only 11.5% of the group leaders used a combination of subjective and objective evaluation and one leader used objective evaluation alone.

Although it may be reasonable to assume that clients will not "lie" about their group therapy experience, it is likely that they will not always tell the truth. Garfield, Praeger and Bergin (1971) reported that clients', therapists' and supervisors' ratings were often in conflict and tended to overestimate change in the positive direction. Bednar and Lawlis (1971) have said, "It can hardly be considered that a patient's feelings of satisfaction . . . can be considered either a major goal of the procedure or evidence of its success. People tend to be remarkably well satisfied with fortune tellers . . ." (p. 821).

The problem of outcome evaluation is extremely important and is probably the most actively researched area in group therapy at the present time. Researchers employing clinical outcome designs have used the Minnesota Multiphasic Personality Inventory, Q-Sort, Manifest Anxiety Scale, Edwards Personal Preference Scale, Rorschach, Mirror Training and a wide variety of other assessment scales (Lieberman, 1976). Outcome measures can be used by leaders to assess their relative effectiveness with different techniques and clients (Apelle, 1974; Lieberman, et al., 1973; Truax, 1971; Yalom et al., 1967).

It is interesting to note that, although most of the group leaders surveyed (87.5%) employed only subjective evaluation measures, they were very specific about what they hoped to achieve. Many thought at great length and spoke carefully in answering this question. Attitude change was specified as the goal by 56%, behavioral change was specified by 24.5% and a combination of attitude and behavioral change was specified by 19.5%. The question of specifying goals has become more important with the development of new and specific techniques for different group problems. If a therapist knows what he wants to achieve, then he can emphasize techniques shown to be differentially effective by outcome studies.

4) Size and open/closed issues:

The results of questions 2 and 6 are discussed.

The optimal number of group members the Toronto group leaders include ranged from 3 to 13 with a mean of approximately 8. A recent consensus of the literature (Hansen, et al., 1976) suggests that the optimal size is 7 or 8 members. The general feeling is that when the group is much smaller the members find themselves in individual counselling in a group setting and the opportunities for using group dynamics are reduced. If the group is much larger less time is available for individual attention and disruptive competition for attention can result. Castore (1962) found a marked reduction in dyadic interactions when the group reached nine members. Group size alone as an outcome variable generates rather limited information and is usually viewed and studied as one of many interacting variables. The reader is referred to Shaw (1976) for a recent discussion of group size. Extensive discussions are also provided by Gazda (1973) and Hansen et al. (1976).

When the Toronto group leaders were asked whether their groups were open or closed, 26% said they were open, 52% said they were closed and 22% had both open and closed groups. Presumably, many of the leaders reporting open groups work at hospitals and institutions where group membership depends on the number of admissions and discharges. In a closed group no new members are admitted and usually the duration and frequency of sessions is decided in advance by the group. In an open group, members are replaced as members leave or drop out. The advantages of open groups are that members constantly receive new members to provide feedback and interaction and that the presence of experienced members facilitates the accommodation of new members. The advantages of a closed group are greater group cohesiveness, time limits which facilitate goal directedness and a more permanent sense of belonging.

SUMMARY AND CONCLUSION

What can be concluded from this survey of research and group practices? The group leaders in the Metropolitan Toronto area seem to be generally aware of and concerned with some critical issues of current concern. All of the group leaders were able to describe goals of change. There was general agreement that the goal of group counselling is to assist in modifying attitudes and/or behavior of individuals by improving communication skills and by increasing self-awareness through feedback from the group. However, it will be necessary for group leaders to specify goals in more measurable terms before objective methods of outcome evaluation can become meaningful.

These issues of specification of measurable goals and outcome evaluation procedures would seem to be even more critical in light of recently published reports indicating that group practices actually harm some individuals. Although all of the group leaders reported specific methods of evaluating outcome, it is somewhat disconcerting to note the preponderance of subjective procedures. A wide array of objective tests and scales are available which could provide more precise and relevant feedback of change.

An area of some concern has to do with the orientation and role of the group leaders. The Toronto group leaders often reported confusion with the questions on the role and theoretical orientation of the leader. Many spoke of the large number of competing theories and their inability to develop a theory or describe a role of their own.

The area of most concern has to do with the relevance of research to the group leaders. Over 75% of the Toronto leaders stated that research was of minimal relevance or no relevance. The feelings of Gazda (1971) that practice has out-run research would seem to be confirmed by the response to this question. Some of the reasons for this lack of research relevance have already been discussed. However, it seems particularly unfortunate at a time when a great deal of significant research is appearing in the literature. Even a cursory glance at the recent empirical studies in this area indicates that a great deal has been learned about group processes. It is now possible to obtain a reliable index of the extent of behavioral change resulting from group therapy by using a wide variety of objective instruments. That this is a significant advance becomes obvious when we consider the multifarious related questions which can be investigated. For instance, which method or technique, used by what kind of group leader, in what kind of setting, with what kinds of clients will result in the highest rate of success and the lowest rate of failure?

Perhaps the practice of group counselling has out-run research only because the research findings are either not read by or not thought to be relevant to practitioners. It is obvious that group counselling has been of value to many people who would not have had access to individual therapy. What group leaders need now is a basic familiarity with current research and theory as well as training standards which will establish a minimal level of competence.

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