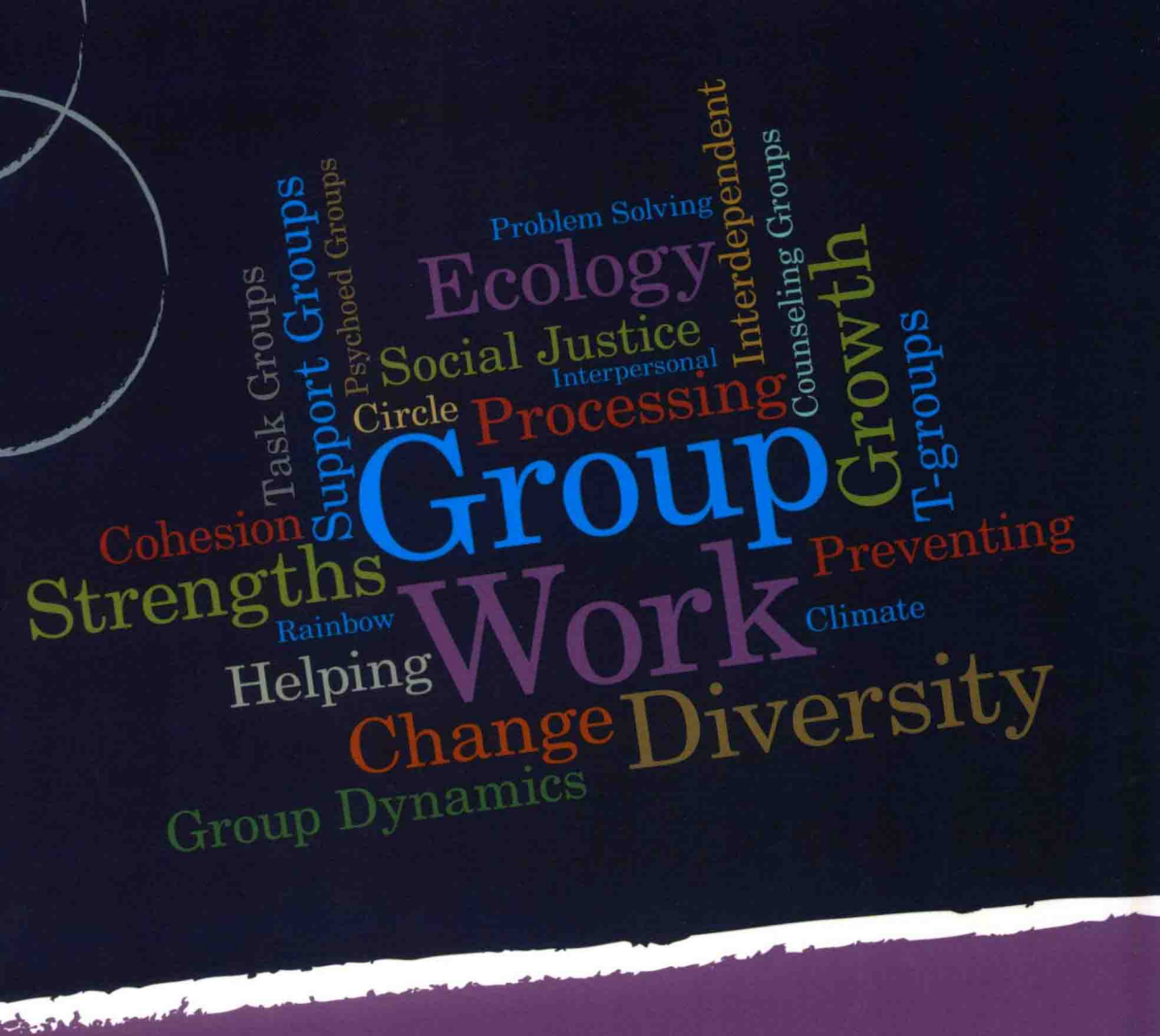

HOW LEADERS CAN ASSESS GROUP COUNSELING

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Endorsed by the Association for Specialists in Group Work

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To my students, who continue to keep me excited about teaching and learning about groups

—Maria T. Riva

To Kelley, who knew I could do this and reminded me when I needed it, and to my babies, who are already teaching me about work–life balance

—Robin E. Lange

Preface

In *Principles and Applications of Assessment in Counseling*, Whiston (2008) outlined several reasons for conducting assessments with counseling clients. One reason certainly is to evaluate the services provided to clients. It is not enough for therapists to believe that their clients have improved, or even for clients themselves to describe treatment as successful or to report that they are satisfied (even very satisfied) with the treatment. With the increasing demand for accountability of services, along with the ethical considerations of providing services that do no harm at a minimum and do good ideally, it is really no longer a question of *whether* we assess but *how* we assess therapeutic treatment. In fact, it seems relatively safe to say that counselors already do assess their counseling sessions, mostly by intuition and other informal methods. These methods are important, but often they may include counselor bias if used as the exclusive method. Since assessment methods are often used to make critical decisions, conducting unbiased, reliable, and valid methods of appraising effectiveness is the fundamental goal.

Decisions concerning treatment effectiveness may have *budgetary* (e.g., an agency decides to spend a large amount of money to train all counselors to provide a certain type of treatment because it is thought to be the best option) and *ethical* implications (e.g., assuming that a specific treatment works best with 20 sessions when actually 10 sessions provide the same benefit). There is a need, then, for careful and multidimensional assessment data that accurately capture questions such as "Is it working?" "How well does it work?" "With whom does it work?" "What specific components are working (not working)?" "What counselor behaviors are essential for it to work?" Given the complexities of human behavior, along with those of any method of therapeutic treatment, assessment should not be unidimensional; rather, multiple measures should be used to determine treatment success. Most of the information on assessment in counseling relates to the appraisal of individual therapy. Much less of an emphasis has centered on the assessment of group counseling, a more intricate therapy modality.

This book is multipurpose. Given the lack of attention to formal and intentional assessment in group work, the goal of this book is to address the need for group practitioners to assess their groups. Our attention is also to

balance the need for group counseling assessment with the reality that group leaders are often not primarily researchers, do not want the assessment methods to interfere with the group counseling process, and, depending on the site where group work is being conducted, are often managing a large case load with limited time to use complicated and time-intensive procedures. This book intends to describe how group leaders can incorporate different methods of assessment into their practice without making the process burdensome. In fact, one of our goals is to outline ways that appraisal can increase effectiveness and be used to make important decisions.

According to Whiston (2008), *assessment* is "defined as procedures for gathering client information that is then used to facilitate clinical decisions and provide information to clients" (p. 5). In many ways, the definition from individual counseling applies to group counseling as well, although group counseling is understandably much more complex to assess. With the multilayered aspects of group counseling, it is understandable why group leaders may have difficulty knowing which of the many potential components to observe and assess in more depth. Yet group counseling is being conducted in numerous mental health, hospital, and other treatment agencies, and the number of groups conducted is thought to be growing rapidly. Without information about how these groups are benefiting the clients, the stakes are very high. Many clients come to therapy—and probably even more so to group therapy—not knowing exactly what to expect. They may have some reluctance to participate, which can interfere with their progress. Conducting assessment measures prior to treatment that look at such variables as motivation levels or leader confidence may help identify potential challenges that can then be addressed. Other assessment measures can target how the group is functioning and can therefore be used as a conversation with the group or for the leader to make necessary changes in how the group is conducted. Other assessment measures are used to determine whether the group is effective and whether the group members are increasing in their stated goals or decreasing in unwanted or problematic behaviors.

The following chapters discuss the assessment of group work at several stages throughout the life of the group and how group leaders can use both information and formal assessment tools to give them vital information about their groups, the members, and their leadership functioning. We have included many examples throughout this book in an effort to clarify our message that assessment is really an essential component in the treatment. We hope that this book encourages group leaders to become evidence-based practitioners.

To provide some clarity, we use some terms interchangeably throughout the book. For example, we use the following terms to imply the same meaning: *counseling*, *therapy*, and *psychotherapy*. We also interchange *group counseling*, *group therapy*, *group psychotherapy*, *group work*, and *therapeutic groups*. We do not make a distinction between assessment and appraisal and will use them to describe the same process. Throughout the book, we do talk about formal and informal assessment. We distinguish between them

but find them both vitally important. Formal assessments are those that have been used in research and have been shown to have reliability and validity. Informal assessments use group leader intuition, observations, and clinical judgments, along with group leader–developed measures or questionnaires created to look at a certain aspect of a group. Informal measures have not been studied for reliability and validity.

We have some viewpoints that are important to state given that they frame the material found in this book. We certainly understand that not everyone will agree with these views. First, we believe that group psychotherapy is more than individual therapy in a group setting. Connected to this statement is a belief that group process variables are invaluable aspects of a therapeutic group and when they are ignored, the group is diminished in its ability to be effective. Research has shown that group therapy is effective for many types of people, for different ages, and for many different problem areas; therefore, we believe that group therapy should be selected as a treatment format *first* because it is *effective* and not just because it is efficient, although we know from experience that efficiency often drives the selection of group as a treatment format. We strongly support a need for increased practitioner and researcher collaboration. This can be accomplished in many ways, but both points of view and expertise are essential. We strongly agree that group leader intuition, astute observations, and clinical hunches *alongside* research findings build the data necessary for our better understanding of group work.

Learning Activities: Checking in With Yourself

Activity 1

Respond to the following questions about your experiences with assessment.

1. What experiences have you had with assessment in the groups you have led, co-led, or participated in in the past? Were these experiences positive? Negative?
2. What assessment methods are you currently using in your group to select members (intuition, interview, paper and pencil, etc.)?
3. What barriers would make it difficult for you to use assessment instruments with your groups?

Activity 2

Respond to the following:

From your experience, how effective is group therapy? What components make it effective?

Brief Contents

Detailed Contents

1 On Becoming an Evidence-Based Group Practitioner

The Why *of Assessment*

The efficacy of group psychotherapy has been supported by meta-analytic findings from control and comparison group studies suggesting that a majority of group participants are better off than those who did not engage in treatment (Barlow, 2011; Burlingame, Fuhriman, & Mosier, 2003). While the advent of empirically supported treatment (EST, Chambless & Hollon, 1998) has attempted to translate such important research findings into practice, barriers remain for those seeking to implement "evidence-based practices," or EBPs (American Psychological Association [APA] Presidential Task Force, 2006, p. 273) in their area of interest. In the practice of group therapy, some of these barriers are more pronounced than in other mental health specialties, due to both the complexities of group research (Burlingame, 2010) and difficulties adapting the research that is available to practice. The complications of implementing EBP have been documented across multiple disciplines, including nursing (Thorsteinsson, 2012), substance-abuse counseling (Hunter et al., 2012), psychology (Jensen et al., 2012), and social work (Macgowin, 2012). The challenges inherent in the assessment of group therapy in particular have been documented since long before the advent of EST (Whitaker & Lieberman, 1964).

Anecdotally, group practitioners have often expressed concern that research fails to identify the common factors (Wampold, 1997) that play such a significant role in therapy, in favor of a focus on easily measured intervention strategies; thus, research studies are perceived as irrelevant (Kennard, 2012). Common factors theory maintains that different theoretical approaches to counseling and therapy have similar elements that operate across all of them, and that these common factors, such as the therapeutic alliance, account for a large part of the positive outcomes—rather than the reverse view that specific theories, techniques, or approaches account for most of this change (Imel & Wampold, 2008).

Alternately, researchers have expressed exasperation with practitioners who may be seen as unwilling to consider the data researchers provide. In the age of EBPs and managed care, it is clear that choosing to rely solely on research findings when implementing and evaluating a group is as precarious as relying solely on clinical intuition. In fact, when the actual language of the APA's recommendations for EBP is considered, it is clear that both research and practitioners' own lived experiences are both valued as potential sources of evidence or data by which to evaluate treatment progress.

Many group practitioners have been influenced by the attempt to synthesize research and clinical practices with the development of ESTs. These treatments are frequently manualized and tend to focus more on the content than the process of treatment and, as such, have been embraced by some as important tools for clinical change and rejected by others for perceived failure to address the relational components of group treatment. While the EST movement is well-known, the lesser-known EBP (APA Presidential Task Force, 2006, p. 273) may be seen as a way to bridge the gap between content and process focus. As valuable as the movement to incorporate ESTs into practice has been, using an EST alone is not sufficient for those of us seeking to become Evidence Based Practitioners. Becoming an evidence-based *group* practitioner also requires inclusion of formal (paper-and-pencil measures, etc.) and informal (clinical intuition, etc.) methods of assessment.

Using assessment measures to generate practice-based evidence has been described as "taking the 'vital signs' of group members" (Jensen et al., 2012, p. 388). For group leaders, collecting data from their groups are integral to determining what types of treatment work best for what types of patients (Strauss, Burlingame, & Bormann, 2008). Obtaining these data and considering them along with recent research findings constitute the "best available evidence" (APA . . . , 2006, p. 278) that should be used by group leaders when making treatment decisions.

For group therapy providers, a range of factors likely influences the decision not to engage in assessment. These factors may vary from lack of agency support to the belief that assessment is best left up to researchers to being unsure of the best methods of assessment to use. Other therapeutic considerations that may deter group leaders are concerns that formal assessment measures may be intrusive and interfere with the treatment process, that there is not enough time to administer them without shortening the group sessions, or that group leaders do not have the time to analyze the results and consider the implications of those results between sessions if the group membership is large.

With these potential barriers in mind, this book seeks to provide practitioners with a framework to incorporate various forms of assessment into practice. A brief overview of the state of EBP in group therapy is provided as a context for the important questions at hand for group leaders. The following chapters address these critical questions:

- *Why* do I need to assess my groups?
- *What* specifically should I assess?

- *When* do I assess these variables?
- *Which* measures do I select?
- *How* do I go about assessing my groups?

These chapters cover the various benefits of assessment (Chapter 1: why assess), an overview of possible areas of assessment in group therapy (Chapter 2: what to assess), factors particular to the timing of assessment (Chapter 3: when to assess), a selection of recommended measures to get you started (Chapter 4: which to select), and information on how to go about conducting your assessment (Chapter 5: how to assess). Also included in this chapter is a description of research designs. While this book is by no means all-inclusive, the intention is to provide you with the inspiration and basic tools to begin to incorporate assessment into your practice of group therapy.

Evidence-Based Practice in Group Therapy

EBP has been defined by the APA Presidential Task Force on Evidence-Based Practice (2006) as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). While most psychologists and other practitioners subscribe to this philosophy in theory, when it comes to finding time to consume the required research and check for adherence in our own clinical work, the follow-through in practice is more difficult. In a recent survey of members of the Society of Clinical Psychology, about 75% of respondents in clinical practice settings and about 65% in private practice reported using EBP (Berke, Rozell, Hogan, Norcross, & Karpiak, 2011). While the majority of those surveyed reported using EBP, far fewer had the requisite knowledge of research methodology and available online research databases that would be required to access and appraise the most recent research (Berke et al., 2011). Unfortunately, Berke et al. (2011) did not inquire about the self-monitoring practices of psychologists in terms of evaluating the efficacy of their own treatments or whether they checked their own adherence to EBP—components required to consider oneself an evidence based practitioner.

The shift toward more efficient and cost-effective treatment over the past 20 years has been well documented (Burlingame, 2010; Wise, 1998). "As the mental health care environment has become more industrialized and managed to improved efficiency of service and economies of scale, practice patterns are necessarily changing" (Wise, 1998, p. 56). To provide structure and scientific guidance to buttress this shift, treatments that were supported by research became increasingly necessary. According to Burlingame (2010), "The empirically supported treatment (EST) movement appears to have affected the group therapy literature less directly than individual treatment" (p. 1).

ESTs are frequently focused more on the content of the treatment and less so on the process of implementation. ESTs are typically manualized

approaches initially developed for use in research settings. The researchers who design these treatments are well versed in the application of treatment in a controlled setting such as a university clinic or lab, with patient populations meeting stringent inclusion or exclusion criteria (no Axis II disorders, only one Axis I diagnosis, no comorbid substance abuse, etc.). Manuals designed for these highly controlled settings are then implemented in the highly uncontrolled and complex settings of outpatient mental health clinics. Consequently, the differentiation between the treatment setting in which empirical support has been found and the treatment setting where actual treatment is conducted often means the treatment is found lacking (Kennard, 2012).

Fortunately, group practitioners have sought to support the provision of treatment in a group setting, and based in part on the large body of literature comparing group and individual treatment, empirical support for group treatment does exist—in spite of the statistical and methodological difficulties inherent in conducting group research (Burlingame, 2010; Burlingame, MacKenzie, & Strauss, 2004). A full review of these limitations is beyond the scope of this chapter. Please refer to Baldwin, Stice, and Rhode (2008) for an excellent overview and recommendations related to statistical analysis in group therapy research, and see Miles and Paquin (2014) for a discussion of best practices in group psychotherapy research. Regardless of the complexities of group research, high-quality group studies are being and have been conducted, though the body of research is considerably smaller than that addressing individual therapies. Given the statistical and design difficulties inherent in research on group psychotherapy, what additional evidence can group leaders access to continue to consider the "best available research" (APA . . . , p. 278) to adhere to an EBP model? Collecting practice-based evidence by routinely implementing a variety of relevant assessment measures throughout the course of group treatments is an excellent way to adhere to the spirit of EBP when empirically supported group treatments fall short (Jensen et al., 2012).

Why Assess?

For the typical clinician practicing in the community, the process of recruiting, screening, implementing, and documenting what occurred in group sessions can require a tremendous amount of time and energy. Even for psychoeducational groups that are run repeatedly and have considerable structure, a new mix of members and changing coleaders provide infinite permutations within the context of the same material. This complex organic variability is what draws many of us to lead groups and sustains us after a particularly difficult session. In other words, the same factors that make group so challenging to research and assess are the factors that make group leadership such a valuable and unique privilege for leaders. The challenge, then, is to find research and assessment methods that account for these complexities, rather than homogenizing the group experience to fit a manual.

From our personal experience, after accomplishing the herculean feat of getting a group up and running, the idea of incorporating the additional task of selecting, administering, and scoring assessment measures can be overwhelming. Strauss et al. (2008) identified group clinician barriers to engaging in assessment, including costs of obtaining the suggested assessment measures, complex and time-consuming scoring procedures, and lack of adequate measures of group process. For some of us, the idea that group leadership is more of an art than a science is pronounced and may result in resistance to assigning numerical values to the group process. For those of us who have conducted research on group psychotherapy in the past, assessment of the various interactions (member–member, member–leader, group as a whole, leader–coleader) produces an unwieldy data set that is difficult to analyze and interpret. When even seasoned researchers and experts on group psychotherapy struggle with these issues and concerns, it is no wonder that leaders conducting groups in the community may be disinclined to consider the idea of assessment.

While assessment resources are available, even interested group treatment providers have had limited success in fully implementing them (Burlingame, 2010). However, given the dedication and determination of the typical group leader, the possibility of improving outcomes for participants is likely worth the effort involved in the undertaking. Member benefit is one of the primary reasons to assess, but other potential benefits also make the initial effort involved in incorporating assessment worthwhile, including enhanced practitioner self-efficacy (Page, Pietrzak, & Lewis, 2001), increased opportunities for funding, cost-effectiveness (Tucker & Oei, 2007), and the ability to serve as a much-needed advocate for the field of group therapy (Conyne, 2011).

In many ways, group therapy has unique features that go beyond the expertise needed for individual therapy. Barlow's (2012) recent article on group-specialty practice delineates competencies of group leaders that are specific to group practitioners. The competency movement in professional psychology practice (APA Presidential Task Force, 2006) included a *Report of the APA Task Force on the Assessment of Competence in Professional Psychology* (APA, 2006) that outlined areas for competency for entry-level psychologists. Many graduate training programs have already begun to employ this competency-based model. Barlow articulated how the competencies that generally respond to individual therapy need to be extended to groups. Her article is timely given that the amount of graduate training in group work has decreased over the years and many group leaders receive little or no training for this more complex form of therapy.

One of the foundational competencies in the competency model is *assessment.* Barlow (2012) outlines additional competencies in this area that are important for group leaders. They include such entry-level applied skills as the ability to "select individual assessments that will assist in the referral to group types," "utilize group assessments that assist the group therapist to compose groups with appropriate members who will readily receive and give help to one another," "demonstrate an understanding of the impact of

assessment strategies on individuals," and "integrate individual- and group-assessment research literature that suggests when individual are not appropriate for treatment in a group setting" (p. 445). Barlow clearly and accurately underscores the need for specialized training for group leaders and the importance of seeing group therapy as a specialty practice.

For Group Members

Incorporating assessment into the practice of group therapy benefits group members in a multitude of ways, including aiding in selection of appropriate group members (MacNair-Semands & Lese, 2000), identifying gaps in members' understanding of material covered in psychoeducational groups, determining when an intervention falls flat and affects the relationship (Norcross & Wampold, 2011), preventing premature termination (MacNair-Semands, 2002), sorting out complex interactions (Jensen et al., 2012), and providing feedback that may motivate members to keep working in treatment (Potson & Hanson, 2010). Vigilance in the interpersonal elements of psychotherapy has been recommended by the Interdivisional Task Force on Evidence-Based Therapy Relationships (Norcross & Wampold, 2011). Conclusions of the task force encourage group leaders to "routinely monitor patients' responses to the therapy relationship and ongoing treatment" and point to benefits of assessment for group member cohesion, including improving the relationship, increasing collaboration, and avoiding premature termination (p. 99).

Outside of the group therapy literature, assessment has been reconceptualized as a vehicle for improving the therapy relationship. Finn (2007) has coined the term *therapeutic assessment* to describe the process of an assessment being used with a client as a therapeutic intervention in and of itself, rather than simply as a precursor to traditional therapy interventions (Potson & Hanson, 2010). In their meta-analysis of the effects of psychological assessment as a therapeutic intervention, Potson and Hanson (2010) found that personalized and collaborative assessment and feedback have positive effects on treatment and recommended that "clinicians should familiarize themselves with therapeutic models of assessment" (p. 205). In my (RL) own clinical practice, I have had clients tell me that they framed the rough graph of their decreasing symptom severity over the course of treatment, or posted it on the refrigerator to keep family members abreast of their progress.

For You and Your Trainees

While few recent studies of the factors that lead to group leader burnout and compassion fatigue have been conducted, the limited literature in this area suggests that feelings of personal accomplishment are inversely related