

CURRENT STATUS OF OUTCOME IN GROUP PSYCHOTHERAPY*

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Adequately designed studies of group psychotherapy have been sparse. Research has been perplexingly difficult, and methodologically it has generally fallen short of effectively evaluating group therapy. In many instances, researchers have neglected to define their parameters adequately, making studies difficult, if not impossible to replicate. More importantly therapeutic variables that influence outcome are still poorly understood and when they are examined, relating them to therapeutic effectiveness is often neglected. The purpose of this paper is to evaluate the problems of studying outcome in group therapy research in the last decade. Although not an exhaustive review of the literature, selected reviews, research articles, and case studies have been examined.

FACTORS AFFECTING GROUP OUTCOME

More often than not, investigators of group therapy have failed to specify the description of the patient and his life circumstances, and the therapeutic techniques employed; both important variables that have been recognized for some time in the study of individual therapy. As Pattison (1965) states, "There seems to be no good reason to repeat in group research the same errors which were discovered in individual therapy research" (p. 390).

DESCRIPTION OF THE PATIENT

The description of the patient is still a difficult problem with researchers in disagreement about what characteristics are important to include. Harris and Christensen (1946) report the patient's character structure, symptoms, habitual modes of adaptation, age, sex, marital status, and intelligence. Bergin (1966) also includes intelligence as a characteristic requiring consideration, but further specifies anxiety, education, verbal skills, insightfulness, impulsiveness, concrete or action orientation, degree of disturbance, and attitude toward therapy as important factors. Based on these two reports, an adequate description of a group member should include physical, educational, and

*This study focuses on "therapy" groups and does not survey literature in which the population is considered "normal," e.g., encounter groups and T-groups.

personality characteristics of the subject. In many cases, however, investigators have not only failed to report these variables, but have completely neglected descriptions of their patients (Bednar, 1965; Catron, 1966; Lomont, Gilner, Spector, and Skinner, 1969; Robinson and Jacobs, 1970; and Truax, 1966). In other cases researchers have reported only vague, general diagnostic statements, for example, "chronic rehabilitated psychiatric psychotic" patients (Cretikos, Halperin, and Fidler, 1966), and those predominantly suffering from either a "depressive illness" or a "personality disorder" (Gunn, 1968). Therapeutic outcome will remain difficult to assess, and replication of studies will be virtually impossible until investigators begin to report patient characteristics in more detail.

REPORTING OF THERAPEUTIC FACTORS

Investigators do not agree completely on which therapeutic variables should be reported. Harris and Christensen (1946) point out that an individual therapy session (and perhaps a group therapy session as well) is affected by a number of variables, the most important being the skill of the therapist, the frequency and duration of treatment, and the type of therapy. In contrast, Bednar (1970) believes that group therapy should be defined in terms of treatment techniques, theoretical models, group goals, and therapeutic orientations. Ramsey (1967) states that group therapy is affected by the structure, size, composition of the groups, selection criteria for membership, and the type of leaders employed. Tuckman (1965) reports that successful outcome is contingent upon the phase at which assessment is attempted and is related to the evaluator's perception and ability to recognize these stages of development.

While the foregoing discussion indicates a number of therapeutic variables that should be evaluated, of the studies reviewed here, the most frequently reported are: 1) group size, 2) leadership, and 3) duration of therapy.

Group Size: The average group size for the studies reviewed was 9.73 patients with Lomont, et al. (1969) reporting the smallest (five to seven subjects). The largest group, fourteen patients, was studied by Mone (1970). Even though there is discrepancy among investigators concerning the optimal size of a therapy group (Lazarus, 1971, for example considers an optimal group to be between fifteen and twenty members), some researchers have even neglected to report the exact number in their groups (e.g., Bailey, 1970; Klett, 1966; and Truax, 1968).

Leadership: Lomont, et al. (1969); Mordock, Ellis, and Greenstone (1969); Truax (1966); Truax (1968); and Truax, Wargo, Carkhuff, Kodman, and Moles (1966) described the group leader by mentioning his orientation, highest educational degree, and/or years of experience. Other investigators have failed to report any description of the therapist (Boe, Gocka, and Kogan, 1966; Cretikos, et al., 1966; Miles, 1969; and O'Connell and Hanson, 1970).

Duration of Therapy: Investigators have chosen various schedules for group therapy. For example, Klett (1966) met with patients continuously for one twenty-six-hour session; and Robinson and Jacobs (1970) treated clients in one-hour sessions six times in two weeks. Two studies utilizing longer periods of time in therapy, six weeks and one year, were Lomont, et al. (1969) and Yalom, Houts, Zimerberg, and Rand (1967). Most investigators have reported the "time" element, but some have not specifically defined it (Finney and Van Dalsen, 1969; Miles, 1969; Schwartz, 1964; and Wolfgang, Banta, and Pishkin, 1964).

In sum, it appears that most studies fail to describe the patient and his life circumstances adequately or to report therapeutic variables clearly. The studies surveyed indicate that: 1) patient variables have been slighted due to the use of broad diagnostic categories, as well as the frequent omission of a description involving physical, educational, and personality characteristics of the patient; and 2) many therapeutic variables which may be important have been neglected; even when variables like group size, leadership, and duration of therapy have been reported they were all too often vague and therefore resistant to evaluation.

EVALUATION OF MEASURES OF THERAPEUTIC CHANGE

Equally as important as a description of the patient and therapeutic variables is the selection of an instrument to denote change. Many investigators have seemed unaware of the strengths and weaknesses of particular assessment measures.

CLINICAL IMPRESSIONS

It appears that prior to 1964 the most frequently employed measure of therapeutic success was the therapist's clinical impressions (Becker, Gusrae, and MacNicol, 1963; Belinkoff, Bross, and Stein, 1964; Burdon and Neely, 1966; Cretkos, et al., 1966; and Teittlebaum and Suinn, 1964). Powdermaker and Frank (1953) find no fault with such subjective observations because they believe that research designs in the beginning must remain close to clinical reports. However, Pattison (1965) states that "the difficulty with clinical evaluative criteria is not their *validity* but their *reliability*" (p. 384). Therefore, it appears that clinical reports are primarily useful as descriptive or hypothesis-formulating tools rather than as means to validate hypotheses. They have, however, also been employed as supportive assessment measures along with other more reliable techniques (Finney and Van Dalsen, 1969; and Lieberman, Yalom, and Miles, 1973).

RATING SCALES

Investigators have employed ratings to assess various aspects of group functioning, for example, patients' and group members' progress, group

dynamics and change, and therapist and treatment effectiveness (Lieberman, et al., 1973; Yalom, et al., 1967). Various persons have been employed as raters; the patient, his associates (ward attendants, teachers, peers, family), the therapist, and others (Gelder, Marks, and Wolff, 1967; Schwartz, 1964; Weeks, 1965; and Whitaker and Lieberman, 1964). Currently, tape recordings and videotapes have helped to make ratings more reliable (Bailey, 1970; Klett, 1966; Robinson and Jacobs, 1970; and Whitaker and Lieberman, 1964). In addition, Bednar (1970) notes that, "The development of the Q-sort methodologies and the Semantic Differential provide good examples of recent developments that help to investigate client perceptions systematically" (p. 150). Also, the Group Therapy Questionnaire (Wile, Bron, and Pollack, 1970) and the Crowne-Marlow Social Desirability Scale (Wolfgang, et al., 1964) have been employed. Nevertheless, even when recent advancements are considered it seems advisable to use ratings in conjunction with other outcome measures to support the creditability of an investigator's findings.

SOCIOMETRIC ASSESSMENT

A few investigators have used sociometric measures to determine how group therapy affects interpersonal relationships (Lieberman, et al., 1973; Miles, 1969; Mordock, et al., 1969; and Yalom, et al., 1967). Pattison (1965) claims that "sociometric evaluations . . . are limited by the fact a person's role in the therapeutic group is an artifact of that group. . . . One's group behavior may only reflect social adaptation rather than therapeutic improvement" (p. 385). Thus, when these measures are utilized, they should probably be employed in conjunction with other methods of assessment.

PSYCHOMETRIC TESTS

In 1965 Tuckman proposed the use of objective techniques that employ pre-existing standards. Subsequently, large batteries of standardized psychometric instruments have been used (Bednar, 1965; Truax and Wargo, 1969; and Truax, Wargo, and Volksdorf, 1970) and investigators have searched for specific instruments that appear to evaluate outcome most adequately. The most fruitful instruments appear to be the MMPI and various measures of intellectual functioning (Bednar, 1970). Examples of studies using these measures are Catron (1966); Klett (1966); Lewinsohn, Weinstein, and Alper (1970); Lomont, et al. (1969); Mone (1970); and Moulin (1969). While some psychometric instruments seem to be sensitive measures of change, it appears desirable to employ them in conjunction with other measures until their reliability is substantiated further.

OBSERVABLE BEHAVIOR CHANGE

Since 1963 there has been an emphasis on measuring therapeutic progress through directly observable behavior rather than covert dimensions of psycho-

logical functioning, such as attitudes and feelings (Bednar, 1970). Many studies have recently employed directly observable criteria (Finney and Van Dalsen, 1969; Lipton, Fields, and Scott, 1968; Paul and Shannon, 1966; and Vernallis, Straight, Cook, and Stimpert, 1965). While it can be claimed that behavioral changes do not measure therapeutic progress, or that the behaviors measured are unrelated to the goals of group therapy, observable behavior change is less subject to perceptual error, and therefore more reliable, than many other measures of assessment, e.g., inferred behavioral change (Bednar, 1970).

To summarize the research on outcome measures, it appears that: 1) Clinical impressions are most useful for formulating but not confirming hypotheses. 2) Rating scales are becoming more systematic and gaining sophistication due to modern technology. 3) Sociometric measures are not often employed for the assessment of personality change. 4) Presently, the most adequate psychometric measures for assessing therapeutic progress in groups appear to be the MMPI and I.Q. tests. 5) Observable behavior change seems to be both an effective and objective means of determining group outcome. 6) An adequate evaluation should include several methods of assessment because each has some limitations of administration and interpretation.

DESIGN PROBLEMS OF GROUP STUDIES

In addition to the problems discussed previously, in many cases conclusions have been formulated by researchers without the benefit of control methods and long-term follow-up. Because of these neglected areas, the superiority of one technique over another, or the effectiveness of group therapy in general, remains questionable.

Many researchers have been content to design experiments without the benefit of a "no-treatment control" group or employing the "own-control" technique. Bednar (1970) reports that since 1946 only forty-five group outcome studies have adopted the no-treatment control design, i.e., at least one experimental group and a control group. In the "own control" design, each patient is evaluated upon application for therapy, again at its commencement, and finally at termination (Cross, 1964). Typical examples of those who have neglected either or both control methods are Lewinsohn, et al. (1970); Lomont, et al. (1969); Mone (1970); Mordock, et al. (1969); Truax (1968); Truax and Wargo (1969); and Truax, et al. (1970); to mention only a few. By neglecting control techniques, most investigators seriously affect the certainty of their conclusions and avoid answering whether any real benefit is derived from group therapy.

LONG-TERM FOLLOW-UP

Except for Gelder, et al. (1967), and Lieberman, et al. (1973), few of the articles surveyed made any attempt to explore permanence of change.

Levenstein, Klein, and Pollack (1966); and Ramsey (1967) make a plea for investigators to be aware of the need for long-term follow-up studies to determine the lasting effect of therapy. Problems related to the length of follow-up are presented by May, Tuma, and Kraude (1965); and Zubin (1953), both advocating a period of follow-up somewhere between two and five years. Paul (1967) summarizes the difficulties encountered in obtaining follow-up data as: 1) Assessment methods at follow-up often differ from those at pre- and posttreatment; and many times those employed at follow-up are of questionable reliability and validity. 2) Frequently, cause-effect relationships are invalidated by subjects receiving additional treatment of an unknown nature between posttreatment and follow-up. 3) Often, an overall difficulty in obtaining consistent follow-up data is the problem of sample maintenance and attrition.

Despite the aforementioned difficulties and the controversy regarding when follow-up should occur, investigators should become aware of the need to include and report such findings.

CONCLUSIONS AND SUMMARY

To answer the question of whether group therapy is an effective method of treatment seems premature at its current stage of development. Before any conclusions can be reached, investigators must first become concerned with tasks they may ordinarily consider to be mundane, clerical, time consuming, and non-productive. Until researchers begin to report important variables related to group therapy (patient and therapeutic variables), and attend to matters of assessment and design, the question of effectiveness may never be resolved. Reporting the essentials in order that replication is possible becomes paramount, not only to verify previous findings, but to evaluate what factors affect outcome.

Three considerations should be reviewed. First, investigators need to describe accurately those factors affecting therapeutic change by defining and reporting the physical, educational, and personality components of the population under study. Also, while numerous therapeutic factors will eventually deserve to be considered, researchers should currently report group size, leadership, and duration of therapy.

Second, due to the fact that there is still contradictory evidence concerning the relevance of various outcome measures, it seems that researchers might follow the examples of Gelder, et al. (1967), and Lieberman, et al. (1973), and employ a multiplicity of instruments to assess therapeutic effectiveness. This method appears to be the most thorough and complete in evaluating group therapy outcome, presently.

Third, it is essential that investigators include control techniques and long-term follow-up plans in their designs. Even though many of the problems of follow-up may appear to be uncontrollable and controversial, researchers

should utilize the same assessment measures for follow-up as were employed during treatment, report the frequency of informal and formal treatment experiences of their patients, and note the number of subjects lost and the reasons for their attrition.

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