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## **Revisiting AGPA's CORE Battery: Another Approach for Group Therapists to Use in Adapting to the Pressure for Evidence-based Group Practice**

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*Research Editor's Note: This is the first in a series of articles introducing members to the newly revised AGPA CORE battery. This feature provides an overview of the work of the Task Force and the development of the Battery. Clinicians may find these tools quite helpful in assessing group dynamics and outcomes, and in selecting members for participation.*

In the early 1980s, AGPA sponsored the development and dissemination of a CORE battery. Roy MacKenzie, MD, FRCP, CGP, DFAGPA, and Robert Dies, PhD co- led a distinguished task force in developing a 50-page manual that was disseminated to AGPA members in 1982. One goal of the CORE was to assist members in evaluating the effectiveness of group-based therapeutic interventions. The original Task Force indicated that:

*"It would appear that most of us are convinced that we are effective in what we do. Unfortunately, it has been difficult to document the faith we have in our techniques...we are faced with the challenge of establishing the nature of therapeutic change and the particular group processes."*

The original Task Force developed the manual as a self-evaluation kit that would press clinicians beyond clinical, global and somewhat imprecise impressions regarding the effectiveness of group treatment to an objective, scientifically grounded basis in evaluating their group and its members. The vision was to use the manual to *augment*

clinical perception and *not replace* it, thereby increasing the options for organizing the complexity of events taking place in psychotherapy groups.

The initial CORE Battery focused primarily upon clinical outcomes, recommending a small set of instruments that could be used to track member change resulting from group psychotherapeutic interventions. It was issued as a pilot with the intent of periodically reviewing the outcome instruments initially recommended and adding process instruments at a later time. The vision also included the development of a data repository that would ultimately benchmark the effectiveness of different group interventions.

Its success was mixed. While the recommended instruments appeared in a host of published studies, the CORE was never fully embraced by clinical members of AGPA. This could be explained by a number of reasons. Many of the recommended instruments were available only through test publishers, and the cost of obtaining and using these instruments may have created a barrier. Some users expressed concerns regarding the complexity of scoring required to implement the full CORE battery. For instance, technology solutions (computers and software) were not readily available in clinicians' offices at the time that the original CORE was introduced. In addition, it was never adapted to be easily administered and scored using a computer, scanner or other technology such as a PDA. Still others opined that the timing of the CORE may have been premature, suggesting that clinicians were not ready to objectively and systematically track member outcomes. Finally, the CORE was never revised to include process instruments to assist clinicians in tracking important aspects of their groups (e.g., climate, therapeutic factors) and the data repository was never realized.

## **Development of the Revised CORE Battery**

A revised CORE Task Force emerged in 2003 due, in part, to three forces. The Co-Chairs of the task force (Gary Burlingame, PhD, GP, and Bernard Strauss, PhD) were working together, under the sponsorship of an international Transcoop grant from the Humboldt Foundation, to produce instrument recommendations for group treatment that incorporated the best of the North American and European literature. The second influence came through Harold Bernard, PhD, ABPP, CGP, FAGPA, then-President of AGPA, and Marsha Block, CAE, CFRE, Chief Executive Officer, who had the vision of revitalizing the CORE as one of AGPA's initiatives to support the evidence-based viability of group treatment. Finally, several members of the AGPA Research SIG had been active for decades developing, refining and testing instruments to support the evidentiary base of group treatment. The Open Research Session at the AGPA Annual Meeting had served as a forum to report, explore and debate the viability of outcome and process instruments for decades. Thus, it seemed natural to include members involved in this process on the reconstituted Task Force which included: Anthony Joyce, PhD; Rebecca MacNair-Semands, PhD, CGP; John Ogrodniczuk, PhD; Shawn Taylor, PhD; K. Roy MacKenzie; and Angela Stephens, AGPA Professional Development Director.

The revised CORE Task Force—CORE-R—was charged with reviewing the original recommendations and advances in the literature in the subsequent two decades so that the CORE-R would be suitable for both clinical practice, as well as research endeavors. A draft was presented for discussion and feedback at the February 2004 Annual Meeting, both at the AGPA Board Meeting and the Open Research Session of the research SIG.

## **Components of the Revised CORE Battery**

The CORE-R is divided into three sections related to materials and measures that can assist a clinician in: (a) starting a group; (b) assessing member outcomes; and (c) tracking group-level processes. Each section begins with a short introduction to the topic followed by a description of the subsequent material. As with the original CORE, our intent is to provide (self-)evaluation guidelines, informing the reader of our recommendations and referring them to original sources to obtain more information about tools they may be interested in implementing. This approach minimizes narrative, getting to the “bottom line” quickly. In addition, whenever possible, the CORE-R will include the measures being discussed so the clinician does not need to hunt them down.

The first section is primarily focused on the beginning group leader who may be less familiar with how to set up a group and select members. This section identifies empirically and clinically grounded principles for selecting group members and preparing them for treatment in a group format. The literature addressing these topics is sufficiently complex that the CORE-R Task Force elected to provide the information on selection and pre-group preparation in outline rather than narrative form. For instance, we identify the primary objectives of pre-group preparation that have been tested and shown to be effective in the literature, as well as the varied methods of implementing these objectives. Readers interested in a more in depth treatment of these topics are referred to original source material (Piper, 1994; Kaul & Bednar, 1994; Yalom, 1995; Burlingame, Fuhriman, & Johnson, 2002). This section also includes four patient handouts that have been used by members of the Task Force in their own clinical practices. These handouts may prove useful in setting up a single group, or a group

program where one triages a large number of potential group members. Finally, the CORE-R recommends two instruments that have shown modest promise in identifying individuals who may have difficulty in fully using the group format.

The bulk of the information in the outcome and process sections is organized using a common format. This format captures fundamental information on basic dimensions of both outcome and process instruments. After identifying the instrument, we begin with author and original source information as well as language translations. Next, logistical considerations such as the amount of time it takes to complete the measure are provided along with a brief description of the instrument, its subscales and method of scoring. Information about the scientific foundation of the test (i.e., psychometric properties) follows along with its interpretative utility with different patient populations (norms). Finally, select references and Internet addresses are identified.

Both outcome and process sections describe a battery of instruments. For instance, the outcome chapter introduces six instruments that tap different dimensions of patient functioning. However, the CORE-R Task Force recognized that it might be impractical in some clinical settings to use more than a single measure. Indeed, the systematic implementation of any instrument in clinical practice may seem alien to some clinicians. Thus, we provide a consensus rating on the best single outcome and process instrument to implement in clinical practice. The complete battery of instruments in the outcome and process chapters may be of greater utility for the group psychotherapy researcher who is interested in a list of available measures that have a track record in the group psychotherapy literature.

## **Benefits and Dangers of Group Assessment**

Today's clinical world is very different than the environment that the original CORE Task Force faced when this group made its initial recommendations. Today's mental health climate has been called the age of accountability (Lambert & Ogles, 2003). Most clinicians are faced with the expectation that the effectiveness of the mental health treatment they provide will be documented by objective measures of outcome. In short, reliable measures of patient change are often implemented to demonstrate that treatments are working. This expectation is driven by several forces including regulatory bodies (such as JCAHO), public and private funding sources, federal and state legislative bodies, third party payers, and professional associations.

In some instances, outcome management initiatives reflect a collaborative enterprise between administrative and clinical forces with effectiveness information being used to improve patient care (Burlingame et al., 1995; Brown, Burlingame, Lambert, et al., 2001). For example, positive and negative patient change profiles (i.e., improvement and deterioration of targeted symptoms/problems) can and are used to assist in treatment planning, discharge, or treatment termination decisions with little attention focused upon aggregate clinician performance across patients.

Other outcome management initiatives have taken on a more nefarious reputation. The concern of some is that administrators may take patient outcomes and aggregate them by individual clinician. These aggregate patient outcomes could then be used to compare individual clinician performance resulting in unfair comparisons and adverse administrative decisions. In the worst case, administrators would use the

aggregate patient outcomes of providers to weed out those practitioners who appear to under-perform on objective measures of patient outcomes.

The CORE-R Task Force was well aware of the benefits and dangers inherent in systematic measurement of patient outcomes and group processes. At the same time, we believe that the zeitgeist of evidence-based mental health treatment is here to stay, at least for the near term. Our goal is to provide group clinicians with our best recommendations regarding psychometrically sound and empirically tested outcome and process instruments that have shown to be of value in the group literature. In the realm of outcome assessment, we envision an evidence-based group clinician as one who periodically uses at least one outcome measure to assess individual member change. The CORE-R Task Force understands the challenge of monitoring individual patient change when one is leading a group composed of six, eight, ten or more members. We also know from the empirical and clinical literature that members often drop out of group treatment when they are dissatisfied with their personal progress. The periodic assessment of individual patient outcomes in a group provides the opportunity for a group leader to have another source of information regarding patients who may evidence no change or deterioration. Such insight may enable a leader to act *before* the member drops out of treatment.

The CORE-R also recommends the assessment of group-level processes that have been shown to be predictive of successful group and individual outcomes. The Task Force believes and embraces the notion that successful group treatment requires attention to, and facilitation of, group-level processes. These include constructs such as the climate of the group and the ubiquitous therapeutic factor of cohesion. We envision the

evidence-based group leader periodically taking the pulse of the group, being curious about group processes and being open to the possibility that measures of such may reveal surprises about differences in individual member experiences of the group-as-a-whole. Most of the Task Force members have “practiced what we’re preaching.” We’ve used outcome and/or process measures in our own groups and learned that clinical practice can be calibrated by information our members provide us on simple, short process measures. Finally, the CORE-R is offered as a dynamic undertaking and we invite AGPA member feedback so that it becomes a living entity with periodic revisions that are driven by feedback from those who have used it.

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