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The Revised CORE Battery: Assessment of Group Therapy Process

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Research Editor's Note: This is the third in our series of columns introducing members to the newly revised AGPA CORE Battery. This column focuses on measures of group process.

The CORE Battery working group, led by Gary Burlingame, PhD, CGP, and Bernhard Strauss, PhD, and supported by a grant from the Humboldt Foundation, aims to develop a user-friendly measurement toolbox for informing clinical group therapy practice. The Battery consists of four sections: (1) an introduction to the use of measurement tools in clinical practice; (2) materials for use in patient selection and preparation for group; (3) assessment of group therapy outcome; and (4) assessment of group therapy process.

Assessing Group Therapy Process

Generally speaking, *process* is whatever occurs during a group therapy session independent of the content of what is discussed by the participants. The therapy process thus includes dimensions that are directly observable (e.g., the quality of inter-member interactions), and those dimensions that must be inferred (e.g., the members' experience of the therapist's empathy or group cohesion). The CORE Battery Task Force believes that the assessment of process variables can provide the clinician with indications of the quality of the therapeutic environment in his or her group. The therapeutic environment, in turn, is a function of the individual member's relationship both to the therapist and to the other members. The Task Force also believes that the assessment of process variables can provide information on the action of critical change mechanisms that are held to operate in group therapy. In this sense, evaluation of

the process of the group can inform the clinician about whether the group is working therapeutically (i.e., if the treatment is being effectively delivered in real time), while assessment of outcome indicates whether the group treatment worked (i.e., whether the members derived benefit from their group therapy experience).

A number of criteria for selection of process measures were established in the CORE working group's early discussions in 2003. The original CORE Battery, developed by K. Roy MacKenzie, MD, FRCP, CGP, DFAGPA, and Robert Dies, PhD, was formulated to "establish the nature of particular group processes." The objective of incorporating measures of group therapy process into the original Battery was never realized but was regarded as an integral part of our plans for the revised Battery. The Task Force's perspective on the concept of particular group processes was to select instruments that addressed process variables regarded as essential to the change process in therapy groups, in line with the research literature since the early 1980s. We agreed that selected measures had to be well-established and psychometrically sound or had to show particular promise at an advanced stage of development. The measures also had to represent process variables that had been demonstrated to be linked to successful whole group and individual member outcomes. The measures would encompass both individual-level process variables (e.g., therapeutic alliance) and member perceptions of group-level or group-as-a-whole processes (e.g., group cohesion). Finally, selection of measures was restricted to patient self-report, both for convenience and because the patient's experience provides the critical perspective on group process. It should be noted that each measure can be manually scored quite quickly, without the need for computer software or complex scoring algorithms.

A Conceptual Model of Group Process

The Task Force still needed to be sure we chose measures of process variables that the literature suggested were essential for understanding therapy phenomena in the group setting. We relied on a simple but elegant model for a selection framework. The model is based on recent and state-of-art research by Jennifer Johnson, conducted for her dissertation under the supervision of Gary Burlingame (Johnson, 2003, 2004). The model asserts that there are three main components of the therapy process, each encompassing a number of constituent variables. The first component represents the *positive relational bonds* in the group, that is, the individual member's emotional connection or attachment to the other members of the group, including the therapist, and the group-as-a-whole. The second component represents the *positive working relationships* in the group, that is, the individual member's collaborative engagement in therapeutic work with the other members, the therapist, and the group-as-a-whole for the purpose of progressing towards treatment goals. Finally, the third component represents the *negative relationship factors* that may be operating in the group, that is, those aspects of the group process that may adversely affect member attachments or impede the therapeutic work. A given group member can provide information on these three components of process from two perspectives: first, in terms of his or her relationship with the therapist, and, second, in terms of his or her relationship with the other members and/or the group-as-a-whole. Crossing the three process components with these two perspectives results a matrix of six cells (see Table 1). Our task was to select measures that would provide for an evaluation of each of these six component-perspective combinations.

Table 1: Group Process Measures and Process Component-Perspective Combinations

Measure	Bond Relationship		Working Relationship		Negative Factors	
	Therapist	Group	Therapist	Group	Therapist	Group
<u>Working Alliance Inventory</u>						
Bond	X					
Tasks			X			
Goals			X			
<u>Empathy Scale</u>						
Positive	X					
Negative					X	
<u>Group Climate Questionnaire</u>						
Engagement		X				
Conflict				X		
Avoidance						X
<u>Therapeutic Factors Inventory</u>						
Cohesion		X				
<u>Cohesion to the Therapist Scale</u>						
Positive Qualities	X					
Personal Compatibility			X			
Dissatisfaction					X	

Process Measures

At the time of this writing, the working group has agreed to incorporate five measures into the process section of the CORE Battery. The measures provide for good coverage of the component-perspective combinations described above.

1. *Working Alliance Inventory* (WAI, Horvath & Greenberg, 1989). This instrument will be recommended as a primary measure should the clinician desire only the most basic assessment of the therapy process. A strong working alliance is regarded as a foundation for the effective implementation of specific therapeutic techniques--the alliance enables and facilitates the impact of specific interventions. Patient reports of a strong alliance, particularly early in the course of therapy, augur well for positive therapy process and outcome. The 36-item WAI can be completed within 10 minutes and provides an assessment of the quality of the therapeutic collaboration between the individual member and the group leader. In addition to a global score reflecting the overall quality of the patient-therapist alliance, three subscale scores can be calculated: (1) the *Bond* subscale considers the personal attachment (trust, acceptance) of patient and therapist; (2) the *Tasks* subscale addresses the level of patient-therapist agreement on in-session behaviors and activities; and (3) the *Goals* subscale evaluates the level of patient-therapist agreement on the target objectives of the treatment. Importantly, measures of the alliance early in the course of treatment, or averaged over the whole of therapy, have shown moderate but consistent relationships with outcome (Martin, Garske, & Davis, 2000). In terms of our component-perspective matrix, the WAI reflects the member's experience of his or her Bond Relationship (Bond subscale) and Working Relationship (Tasks, Goals subscales) with the therapist (see Table 1).

2. *Empathy Scale* (ES, Persons & Burns, 1985). The 10-item ES assesses the patient's perception of the therapist's warmth, empathy, and caring. Five of the 10 items are worded positively (reflecting a good therapeutic relationship) and five are worded negatively (reflecting a poor therapeutic relationship). Scores on the ES have been found to predict remaining versus dropping out of therapy, and also to be associated with therapeutic change on measures of depression (Persons & Burns, 1985). In terms of the matrix (Table 1), the ES addresses the Bond Relationship with the therapist (Positive Empathy subscale) and Negative Relationship Factors in the patient-therapist dyad (Negative Empathy subscale).
3. *Group Climate Questionnaire-Short Form* (GCQ-S, MacKenzie, 1983). The short-form of the popular GCQ evaluates members' perceptions of the emotional tone of the group interaction, specifically in terms of closeness, conflict, and withdrawal. Three dimensions of group climate can be evaluated using the 12-item GCQ-S. (1) The *Engaged* subscale (five items) reflects the degree of self-disclosure, feedback and understanding, and confrontation present in the group interaction. (2) The *Conflict* subscale (three items) reflects the degree of interpersonal strain and mistrust between the members. (3) The *Avoiding* subscale (four items) reflects the degree to which the members avoid taking responsibility for the work of therapy. The research literature is mixed on the clinical utility of the Avoiding subscale, but there is good evidence that the Engaged and Conflict subscales are useful for tracking group development and as predictors of group therapy outcome. An important finding is that the early emergence and resolution of conflict in a group is directly related to a positive working process and benefit (Kivlighan & Lilly, 1997; MacKenzie, 1994). With regard to the matrix in Table 1, then, the Engaged subscale provides an assessment of the member's Bond Relationship with the group, and the Conflict subscale provides an assessment of the

member's Working Relationship with the group. The Avoiding subscale can be seen to reflect the member's perception of negative factors in his or her relationship with the group; however, the CORE working group felt further empirical study of this subscale was warranted and it will not be recommended for clinical use.

4. *Cohesion Subscale of Therapeutic Factors Inventory* (TFI, Lese & MacNair-Semands, 2000).

The TFI was designed to assess the range of therapeutic factors originally formulated by Yalom (1995). The nine items of the TFI-Cohesion subscale reflect the member's sense of belonging and experiences of acceptance, trust, and cooperation in the group. Cohesion represents a consensus investment in and commitment to the group by the members, a step that is required before engagement in the work of therapy can proceed. In turn, the group members' experience of significant therapeutic work during sessions further increases the level of group cohesion. By way of contrast, problems with subgrouping or member acting-out can have deleterious effects on group cohesion and, in turn, the productivity of sessions. Research has shown that the TFI-Cohesion scale is correlated with a number of the other factors assessed by the parent instrument (e.g., Existential Factors, Instillation of Hope, Universality, Interpersonal Learning), indicating that cohesion is important to the operation of these other elements of the group experience (Lese & MacNair-Semands, 2000). Research has also demonstrated that the TFI-Cohesion subscale can be a reliable marker of changes in group development, as well as differentiating the experiences of members with contrasting interpersonal "styles" (MacNair-Semands & Lese, 2000). In terms of our component-perspective matrix, the TFI-Cohesion subscale represents the member's perception of his or her Bond Relationship with the group-as-a-whole.

5. *Cohesion to the Therapist Scale* (CTS, Piper, Marrache, Lacroix, et al., 1983). The final measure selected for the process section was originally designed to evaluate the “basic bond” between patient and therapist, as one element of group cohesiveness. More recent empirical study has suggested that the CTS may be more appropriately regarded as an indicator of the therapist’s perceived qualities as a group leader. The nine-item CTS provides scores on three subscales. The *Positive Qualities* subscale reflects the member’s perceptions of the therapist’s trustworthiness and likeability. The *Personal Compatibility* subscale reflects the member’s perceptions of the therapist’s similarity, familiarity, and friendship potential. The *Dissatisfaction with the Therapist’s Role* subscale reflects the member’s perception of problems with the therapist’s activity, attentiveness, or expressiveness. Recent unpublished analyses of data from a comparative trial of two forms of short-term group therapy for complicated grief (Piper, McCallum, Joyce, et al., 2001) indicated that the CTS was able to discriminate the two forms of treatment, showed relationships in the expected directions with the GCQ-S and measures of the therapeutic alliance, and was predictive of patient attendance and therapy outcome. The Positive Qualities subscale appears to have the most utility of the three CTS indices. In terms of the matrix in Table 1, the CTS reflects the member’s perception of the Bond Relationship with the therapist (Positive Qualities subscale), the Working Relationship with the therapist (Personal Compatibility subscale), and negative factors in the patient-therapist relationship (Dissatisfaction subscale).

The process section of the CORE Battery will provide detailed information on each measure, including how to obtain the instrument and score and interpret the group members’ ratings. In addition, hypothetical case examples will be provided to demonstrate how process evaluation can be used to inform and facilitate the clinical practice of group therapy. As

examples of these uses, consider the following. Gauging the quality of the group therapeutic environment early in the life of a new group can indicate whether the group is on track and likely to be beneficial, or whether problems with member engagement need to be addressed. Similarly, frequent process assessments may help clarify the nature of the group's development over time, or help identify dimensions of process that are absent or having a negative impact, either for individual members or for the group as a whole. The identification of problems in the group process can help suggest strategies for intervening with individual members or the group. Direct feedback of process assessment findings to group members can increase their awareness of group dynamics and optimal group work, and help clarify issues the group may need to address to clear impediments to an effective process.

My involvement with the CORE Battery working group has been very enjoyable, and all members are excited about the potential of the Battery to inform group practitioners and, ultimately, the field of group psychotherapy. We look very much forward to presenting the complete Battery to the AGPA membership and initiating a dynamic process of feedback and revision.

Anthony Joyce, PhD, is a member of the AGPA CORE Battery Task Force. Other members include: Gary Burlingame, PhD, CGP; Rebecca MacNair-Semands, PhD, CGP; John Ogrodniczuk, PhD, Shawn Taylor, PhD; K. Roy MacKenzie, MD, FRCP, CGP, DFAGPA; and Angela Stephens, CAE, AGPA Professional Development Director.

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