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Change in Group Therapy: A Grounded Theory Inquiry into Group and Interpersonal Patterns in a Community Sample

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ABSTRACT

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This qualitative study investigated the group process and impact of pre-group feedback information on individuals in an eight-week therapy group. The feedback information was based on group members' results on the Structural Analysis of Social Behavior (SASB) Intrex questionnaire given before the group began. The Intrex is based on Interpersonal Reconstructive Therapy (IRT) theory, which is a combination of interpersonal psychoanalysis, attachment theory, operant conditioning, and studies of imitative learning, and has been utilized primarily in an individual treatment format. Because only a limited number of treatment strategies have utilized IRT theory in the group treatment setting, and because group treatment results often rival those of individual therapy, the researcher chose to introduce IRT information into group therapy in a grounded-theory study. IRT information was given to the group leader and members mainly to inform them of patterns. They were the primary source of IRT feedback in the group sessions.

The purpose of this study was to gain an in-depth understanding of the process experience of this group and the potential impact of IRT theory-based feedback-receiving on this group's therapy. Participants completed the Inventory of Interpersonal Problems (IIP) and the Outcome Questionnaire-45 (OQ-45) at specified points to provide quantitative support for qualitative analyses of group member outcomes. Therapy tapes were transcribed verbatim, watched, and analyzed by two clinical psychology students for important process themes using grounded theory methods. Two main themes were revealed during the qualitative search: 1) Group members tended to express information gained during their interview in covert ways and were highly resistant to overt discussions of early patterns; and 2) For this particular group, religious beliefs played a large role in how information was processed and the degree to which positive change occurred distilled through their struggle internalizing norms and standards.

Keywords: group psychotherapy, grounded theory, Interpersonal Reconstructive Therapy, interpersonal

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Chapter 1: Introduction

Treatment-as-usual (TAU) for patients today draws from a wide variety of interventions designed to address individual clients' specific combinations of symptoms. These interventions include medication, client-centered therapy, cognitive-behavior therapy (CBT), psychodynamic therapy, therapy focusing on attachment, existential-humanistic therapy, and other systems of change. Psychological theories are an attempt to explain a patient's complete presenting problem, but despite this effort to explain, patients tend to be treated as a list of troubles and crises; the goal of therapy appears to have become reducing symptoms of disorders listed in the DSM-IV (Benjamin, 2003).

As a result of this goal and the participation of managed care agencies, increasing efficacy and effectiveness of therapy has become the priority. Benjamin (2003) stated efficacy and effectiveness should be enhanced by basing therapy on the foundation of a valid theory of psychopathology. Such a theory would be able to provide mechanisms of change and hypotheses about etiology of disorder and would account for all psychological symptoms in a given individual at a given time. This theory would include explanations for healthy normality in addition to pathology and would provide suggestions to guide the prevention and treatment of DSM-IV disorders. Currently, no such comprehensive theory exists for testing the effectiveness of different approaches that may or may not be based on tested theory. Instead, the norm is simply to compare treatment A with treatment B without testing whether mechanisms of change were actually operative during the study and could account for the results. Contemporary lack of interest in theory and sharp focus on empiricism is directly reflected in the rule that psychotherapies must be empirically supported (ESTs) by conformity to a specific form of research design (Chambless & Ollendick, 2001). Although these methods show that a modest

percentage of a given sample is likely to respond well to drugs or psychotherapy, especially CBT and dialectical behavior therapy (DBT), improvements are needed. For example, it is increasingly recognized that there is a relatively large "treatment resistant" or "nonresponder" population that continues to present for inpatient and outpatient treatment and is very costly in terms of suffering, health care expenses and lost productivity.

Irvin D. Yalom stated, "if psychiatry is to retain its position of leadership in the mental health field, it cannot neglect a mode of therapy that is demonstrably effective and reaches massive numbers of patients" (Yalom, 1986). He continues to assert the need for group treatments, as well as the need for expert training in this intervention (Barlow, 2008; Barlow, 2003; Burlingame & Barlow, 1996). A study of the effectiveness of group psychotherapy concluded that this form of therapy has been pushed by the rise of health management organizations (HMOs), which cover approximately 70 million lives, and their emphasis on cost effective methods of treatment; in addition, the present growth of research demonstrating particular models to be effective for specific disorders increases the relative importance of group therapy as a treatment (Burlingame, Fuhriman, & Mosier, 2003).

Previous research has demonstrated that group psychotherapy is as efficacious in the treatment of many disorders as individual psychotherapy in addition to being more time and cost-efficient (Burlingame, MacKenzie, & Strauss, 2004). Although, there has been strong resistance on the part of some clinicians to incorporating group training and programs into individual practice and a general public belief of group therapy as perhaps a lesser treatment, researchers have found the effectiveness of the two to be nearly identical. A meta-analysis of 23 articles comparing group and individual therapy found no significant differences between the two.

Those who participated in group therapy were likely to improve on average more than 82% over their wait-list controls (McRoberts, Burlingame, & Hoag, 1998).

HMOs now offer direct mental health care and have forced providers to become responsible for demonstrating the necessity and the effectiveness of their preferred interventions. Managed care agencies will not reimburse for treatments determined to be unnecessary or ineffective; therefore, the goal has become to find a balance between the expense of treatment and quality of care. Group therapy is cost-effective because the provider's fee is divided between the members of the therapy group, usually about six to ten clients (Taylor, Burlingame, Fuhriman, Kristensen, Johansen, & Dahl, 2001). This provides great motivation to discover specific characteristics of group therapy models, such as the effect of IRT on group processes, as the research studies that might explain differences in client improvement in group at a theoretical model level are currently lacking (Bednar & Kaul, 1994). By looking at the group process using both qualitative and quantitative methods, information about what specifically occurs for members may fill some of the theoretical void.

Benjamin (2000) proposes a unique combination of the SASB and group therapy entitled SASB-based reconstructive interpersonal group therapy (SASB-RIGT), which draws heavily from Mackenzie's (1990) group therapy model. By utilizing SASB Intrex questionnaires to assess member relationships with important current and past individuals and widening the interview by culling key figures from the members' individual histories, group members are able to begin group with awareness of their interpersonal patterns and connections to early Important Persons and their Internalized Representations (IPIRs), a more elaborate version of Bowlby's 'internal working models.' Including the SASB in a pre-group individual feedback format facilitated the group therapy process (MacKenzie, 1992).

SASB-RIGT allows for a constant focus on information gathered from the SASB about connections between current patterns of interaction and links to earlier social learning. This type of therapy, like other psychosocial treatments, involves creating learning opportunities for group members about their own patterns, the source of these patterns, and the reason for these patterns. This therapy helps the patient in making a decision to give up the desires and fears that support the continuation of the patterns and in finding more adaptive patterns to replace them. The case formulation for each client again becomes important as it gives the group member a way to recognize these patterns, making clear the connections of personal wishes in relation to early relationships and creating interventions that will allow the client to give up his or her fantasies about fixing those failed attachments and work on new ways of being in the world (Benjamin, 2000).

Supportive group climates might facilitate acknowledgment of problem interpersonal patterns that IRT-primed members are already aware might be an issue. Groups may also have the benefit of inspiring new attachments as members share and learn to trust other participants, enabling the will to change and even allowing the group to serve as a new, healthier IPIR. The models of group therapy, especially those with an interpersonal process focus, can incorporate the five therapy tasks described by the IRT core algorithm with significant impact if correctly implemented. Benjamin (2000) provides the following examples of interweaving group therapy and the five therapy steps: 1) Groups can help members become aware of problem patterns, encourage work, and collaborate against the problem; 2) Experiencing the problem patterns in the here-and-now can contribute to learning, although therapists must beware of groups that may enable these behaviors (e.g., eating disorder groups that inadvertently encourage increased eating problems; 3) Specific topic groups such as those addressing drug use or drinking can help block

maladaptive patterns; 4) Groups can help enable the will to change by creating new adaptive attachments within the group and encouraging such behavior outside the group; and 5) Group therapy is based on offering opportunities for members to practice and learn new patterns. In an optimal application of IRT theory to group therapy, each group member would have a pregroup interpersonal assessment by the SASB Intrex and by IRT diagnostic interviewing to learn his or her own case formulation. Then, with guidance from group leaders, members can experience all elements of the core algorithm in the group setting.

Being privileged enough to attend a school with group psychotherapy experts, the researcher was drawn to this project as a way to study the things that happen within a group and to the group members that allow them to change. The researcher has seen groups make huge changes in small amounts of time whereby group members take interpersonal risks both in and outside of the group setting that they never dreamed would happen in their initial distrust of the group format.

Chapter 2: Review Of Literature

Interpersonal Reconstructive Therapy (IRT)

This section will give a brief overview of IRT theory and go into further depth about specific elements of the theory namely, copy processes, the use and creation of case formulations, and use of the structural analysis of social behavior (SASB) to enhance the therapist or researcher's understanding of the client's relational patterns.

IRT has been under formal development as an Institutional Review Board (IRB) supervised research protocol at the University of Utah Neuropsychiatric Institute (UNI) for the past six years. Constant referrals of chronically suicidal and personality disordered clients prompted the creation of this complex research protocol. These clients at UNI are referred to as CORDS, meaning highly comorbid, often rehospitalized, dysfunctional, and suicidal. Based on subjects' referred to the IRT clinic until June of 2008, the sample treated there can be characterized (pre-IRT) as follows: patients have an average of 2.2 lifetime suicide attempts with an average number of four hospitalizations. Ninety percent are hospitalized for severe suicidal ideation or actual attempt. In the medical record, an average of 2.2 Axis I diagnoses per patient are listed (excluding past diagnoses) with major depression being most prevalent. Other prevalent diagnoses include generalized anxiety disorder and PTSD. About 35% of patients also have a history of comorbid substance abuse or dependence. According to Benjamin's (2003) necessary and exclusionary criteria of diagnosing personality disorders, about 70% of the population is characterized as obsessive-compulsive (OCD PD) or passive-aggressive personality disordered (PAG PD; Benjamin, 2008).

In IRT, it may be useful to think of the patient as being a divided self: two individuals, one being aligned with the Growth Collaborator (Green) and the other with the Regressive

Loyalist (Red). The Green individual is the birthright self; the normative potential self is the one who comes consistently to therapy and hopes to function and feel better. The Red aspect of self wishes to remain loyal to old rules and values associated with maladaptive ways of being, which evolved in relation to loved ones. This constant conflict between the two aspects of "selves" is defined explicitly enough through the case formulation interview that individuals can recognize and talk about if the therapist consistently helps him or her recognize the cognitive, behavioral, and affective patterns classified as Red (i.e., linked to presenting problems) or Green (normative).[1] The patients can see, for example, that they do want to change (e.g., give up an addiction or give up a problem habit such as being hypercritical) but at the same time, do not, and even find comfort in keeping things as they are. At the beginning of therapy, the Red overshadows the Green, but by termination, Green choices will have prevailed if the treatment is effective (Benjamin, 2003).

Interventions from almost any school of therapy may be used in conjunction with the IRT model as long as they follow the core algorithm, which provides the basis of choice for an intervention. This core algorithm consists of six guidelines: a) Accurate empathy must be apparent at all times; b) Interventions should attempt to support the Growth Collaborator (Green) more than the Regressive Loyalist (Red); c) Every intervention should relate back to the case formulation; d) Therapy narratives should focus on episodes that seem to relate to patterns of the

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[1] Since parents are Red/Green too, both Red/Green patterns are learned from parents. Loved ones are not evil or good, they just model patterns.

presenting problems, and each discussion of the episode should have concrete interpersonal detail about input, response and impact on self; e) Each episode should be discussed in terms of its associated ABCs (affect, behavior, and cognition); and f) Each intervention should follow one or more of the five therapy steps. The five therapy steps composing IRT are as follows: a) collaboration; b) learning where problem patterns come from and what they are for; c) blocking maladaptive patterns; d) enabling the will to change; and e) learning new patterns.

Within the context of the therapy steps, interventions are classified into two subgroups, self-discovery and self-management. Techniques from client-centered and psychodynamic therapies tend to facilitate self-discovery through experiencing current and not-so-conscious feelings and thoughts while techniques from behavioral and cognitive therapies tend to fall into self-management through learning and practicing of skills. Both types of therapeutic interventions are needed activities in IRT. Self-discovery targets motivational features while self-management targets functionality.

Interpersonal Copy Processes

The developmental loving and learning (DLL) theory directs IRT case formulation, which seeks to organize presenting symptoms. These case formulations can incorporate the influence of heredity, which sets an envelope of potential, as well as traits, states, situation, and free will. Details of the personality are shaped by interpersonal learning with loved ones (attachment figures). The wish to follow these rules and values learned from IPIRs comprises the Gift of Love (GOL). The wish to be affirmed by others is called psychic proximity. The idea of IPIRs, based in Bowlby's (1988) attachment theory, assumes that important early relationships provide "internal working models" for developing children. The relevant early relationships for individuals in therapy are identified by deduction. If patterns exhibited in

relation to an IPIR are directly related through copy processes to a presenting symptom, then the person is a key figure in the case formulation that accounts for the presenting symptoms. The correspondence between problem patterns and GOL is implemented through three copy processes.

The copy processes are enactments in adult life of relationships with early attachment figures. They are as follows: a) Identification, in which the interpersonal behavior copies an IPIR—"Be like him or her;" b) Recapitulation, in which current behavior is like past interpersonal behavior with an IPIR—"Act as if he or she is still there and in control"; and c) Introjection, which refers to relating to oneself as one has been treated by an IPIR—"Treat yourself as he or she treated you" (Benjamin, 2003). Copy processes are operative in healthy and pathological individuals, the only difference being in whether the processes copied are adaptive or maladaptive (as determined by SASB theory and tested empirically in many different populations). For example, if a client is anxious in situations he or she cannot control, and if the client had a controlling parent, the client is identifying with that parent and presumably seeking to do things the way the parent did them. "See: I am just like you; see how much I agree with your rules and values. Would you love me now?" This is the Gift of Love (GOL).

According to theory, the patient assumes the key to proximity and affirmation from the IPIR is to follow strictly the perceived rules and values of IPIR. The patient supposes that he or she can find a way to be "heard" and loved/valued by the IPIRs if he or she persists in whatever ways of being have been prescribed by the IPIR. Early in therapy, it is important to recognize and if desired, block, problem copy processes as it is attachment gone awry that contributes to problem patterns and the need to block these. Ultimately, the treatment goals become to recognize the impossible desires that support the need for the psychic proximity (e.g., mother's

need to control resulted from her own early injuries, and her demand for perfection in the client

really is not so much about the client as it is about the mother's own inheritance of toxic rules

and values), grieve them (what never was, never will be and the sadness associated with that

loss), and give them up by creating self-activated rules and values (client will need to formulate

own rules and be present for the current generation: spouse, children, and friends).

There have been multiple studies in the literature for support of a connection between

perceived early experiences and adult functioning. Abuse and neglect from childhood recalled as

an adult are associated with adult depression and personality disorders (Battle et al., 2004; Wark,

Kruczek, & Boley, 2003). Clearly, study after study supports the reality and proportion of

adverse childhood events (see Adverse childhood experiences (ACE) study; CDC, 2010).

Inconsistent parenting is correlated with adolescent depression and conduct problems (Ge, Best,

Conger, & Simons, 1996); parenting styles are transmitted from parent to child (van Ijzendoorn,

1992) as are tendencies toward violent behavior (Carr & Van Deusen, 2002) and the repeat of

experiences of victimization by important others (Gladstone et al., 2004).

Rutter and Maughn (1997) conclude there are clear links between childhood experiences

and maladaptive adult problems and have encouraged research into the specific mechanisms and

mediating variables between the two. Currently a wide variety of categories are used in research,

including "abuse," "divorce," "maltreatment," and "violence," and these may obscure the

specific experiences of the child. In varied settings, the child is likely to learn different things

about the self and others. Interpersonal copy process theory is a way to operationalize clinical

concepts in the literature by proposing specific links between past and present and can be

identified for both normal and clinical populations. As stated previously, the copy processes

expand Bowlby's (1973) "internal working models" to include the three ways of linking

perceived relationships with early attachment figures (Critchfield & Benjamin, 2008).

Evidence of the existence of the three copy processes is found in a general way in the

literature on self-reported childhood experiences and adult violence. For example, research

showing links between the experience of childhood abuse and abusing children and romantic

partners as adults is consistent with Identification (being like the early figure) (Heyman & Slep,

2002). Identification with violent figures differs between the genders; men show stronger effects

for direct experience while effects on women seem to be mediated by quality of adult

relationships (Herrenkohl et al., 2004). Connections between exposure to family-of-origin

violence and later victimization by romantic partner are suggestive of Recapitulation (acting as if

the figure were still there and in charge) and also of sexual victimization in adulthood by people

with childhood sexual abuse (Arata, 2002; Heyman & Slep, 2002). The last copy process,

Introjection (treating oneself as one was treated), is supported by findings that showed early

psychological maltreatment is correlated with adult self-depreciation and self-blame (Brewin,

Andrews, & Gotlib, 1993). This also holds true with reported childhood sexual abuse and later

self-harm behaviors (Gladstone et al., 2004)

Although general support has been found, a study by Critchfield and Benjamin (2008)

investigated the question of whether self-ratings of IPIRs for adults' behavior connect through

ways predicted by copy process theory. Two sets of participants, 133 college students and 162

inpatient participants, rated themselves using the SASB-based Intrex questionnaire. Using

RANDCOMP analyses, the researchers found that the female nonclinical sample showed

significant support for all three copy processes, specifically in copying from their relationship

with their parents to the relationship with their significant other. This was also generally true for

the inpatient female sample, except that these participants tended to not identify with their mothers. Males also showed evidence for the copy processes but exhibited less uniformity than females.

Critchfield and Benjamin's (2008) research provides empirical support for the theory that normal attachment processes, which may be mediated by gender as well as other variables, internalize social relationships. The predictions in this study involved all 8 points on the 2 surfaces of the SASB model and provided empirical support that positive (friendly) as well as negative (hostile) behaviors are copied. These copy processes in individual patients are central to case formulation and treatment planning in IRT.

Case Formulation in Detail

The case formulation theory described here can be found in greater detail in Benjamin (2003, chapter 2) and the accompanying figure has been taken from that book. The author presents IRT's case formulation model as needing to relate each of the presenting problems to perceived rules and values expressed by key attachment figures (or IPIRs). The resulting formulation should be in such concrete terms that it is testable, data based, coherent, and refutable, and it should reasonably capture the total presentation.

The following tasks exist for therapists gathering information to create a DLL case formulation: a) Assess presenting symptoms, complaints, and patterns; b) Assess current stressors, social situations, and the response to them; c) Assess self-concept (i.e. listen for words applied to and attitude toward self); d) Make the transition to underlying issues (e.g., Have you ever felt this way before?); and e) Identify key figures whose rules and values link to the presenting interpersonal problems and their associated affects and cognitions and input response and impact on self (i.e. assess attachment, power, differentiation).

After gathering the necessary background information, the therapist then collaborates with the client to find ways to test hypotheses linking presenting patterns to earlier social learning. For each symptom, the copy processes are identified and linked to IPIRs. This assures that key figures are identified with copy processes that relate to the current problems. The therapist then checks these relationships and the "GOL" concept with the patient, and the patient and the therapist begin to formulate a treatment plan that targets the problem patterns and the wishes of affirmation that maintain them. Once the DLL case formulation has been created, problem patterns can be addressed using the core algorithm.

Two teams of clinical raters prepared case formulations from videotaped clinical interviews conducted by Dr. Benjamin. Each member of the group from the University of Utah prepared case formulations, which were compared to allow assessment of within-group reliability. The group from the University of Wisconsin, Madison prepared IRT consensus formulations that were compared against Utah. Kappa and percentage of agreement were computed, and mean scores within group (Utah) and between-group (Utah/Madison) are presented below:

Table 1

Copy Processes

	Key Figures		Copy Processes*		Link to Symptom*		3-Way**	
	Kappa	Percent	Kappa	Percent	Kappa	Percent	Kappa	Percent
Within Group (Utah), *n = 8*	.86	95%	.66	86%	.92	97%	.80	91%
Between Group (Utah / Madison), *n = 6*	.84	94%	.75	88%	.42	71%	.86	93%

Prepared by Natasha Hawley and Ken Critchfield. Poster presented at SITAR, 2006.

*Copy process links to symptoms computed for key figures with agreement.

**3-way comparison measures all categories linked simultaneously.

A regression analysis by Critchfield (2008) on 19 IRT cases found that after controlling for session number (accounting for 50% of variance), therapist empathy significantly predicted an additional 15% of variance; however, after controlling both for dose and empathy, use of the case formulation significantly predicts another 17% of variance; it even had twice the beta weight of either other variable. As further support, when case formulation adherence is included in the regression equation, empathy takes on negative beta weight. If interventions are not consistent with case formulations, empathy can have a negative effect.

Pre-Post Studies

In Benjamin (2003), chapter 10 discusses IRT in research contexts. During prior years, practicum students at the IRT clinic provided brief inpatient therapy for the CORDS population after Benjamin developed the previously supported case formulation for the client. At the time of publication, 50 brief treatments had been conducted with the discharge report, including a summary of the treatment and a consultative report. In addition, five terminated inpatient cases were transferred to the outpatient IRT clinic for follow-up by practicum students for anywhere from 4 months to 2 ½ years. None of the patients had committed suicide by the time of publication, and only one had attempted suicide; none had been rehospitalized despite previous records of many commitments and multiple suicide attempts. Three patients filled out symptom measures before and after treatment. They had all returned to functioning levels that were better or the same as before their first hospitalization. None had felt the need for medication at the end of treatment.

A small sample study consisting of the three outpatient clients and five other clients from Benjamin's own clinical practice who filled out measures before and after treatment showed significant improvement ($p < .01$) on the Symptom Checklist - 90 Revised scales: the General

Symptom index, the Positive Distress level, and scales for somatization, interpersonal sensitivity, anxiety and phobic anxiety. There were also significant changes found on the Wisconsin Personality Inventory scales for narcissism, borderline, avoidant, and dependent personality disorders.

Even those never hospitalized have shown some benefit from participation in IRT treatment. Twenty outpatient "ordinary" cases from UNI's clinic waiting list received counseling from practicum students and showed clear progress during semester-long treatment; none had made a suicide attempt or been hospitalized. The exportation of IRT away from the UNI clinic has also experienced success with six supervisions of IRT students at another university. Their clients were severely disordered (suicidal and homicidal) and had received treatment from multiple therapists previously. These clients made no suicide attempts (one was hospitalized) and most made constructive improvement.

More formal data has been collected recently with 44 inpatient clients at the IRT clinic whose characteristics matched to those described as CORDS previously. Before treatment, 68% of the patients had made at least one suicide attempt with an average of 2.3 attempts and 3.93 hospitalizations per person. Of the 44 clients, currently 88% were currently hospitalized for suicidal action or ideation. Of these clients, 77% were diagnosed with depression and 23% with generalized anxiety disorder; 36% had a history of substance abuse and 11% were currently diagnosed with an eating disorder. In this particular sample, 72% were diagnosed with OCD PD and PAG PD. Pre-post treatment data was collected on number of inpatient days, hospitalizations, and suicide attempts with the following preliminary results (all results are by year): inpatient days pre-IRT decreased from 21.57 to 3.71 post-IRT; hospitalizations dropped from 2.05 to .43, and suicide attempts decreased from 1.24 to .29 (Critchfield, 2008).

As previously stated, any TAU techniques were selected to be consistent with the case formulation and the treatment model.   For example, the case formulation allows one to distinguish between empathy that might enhance presenting problems and empathy that is more likely to support change. Anger at a parent for not having been different is common. In IRT, the empathy would be for the helplessness, confusion, etc. rather than for the "bad parent." This sets up the conversation to move in the direction of learning new patterns (assertiveness) rather than an old direction (blaming, externalizing).

Group therapy is well suited to identifying problem patterns of interpersonal interaction, the core concept of IRT, and practicing new and more adaptive ones. The group is also a powerful "entity" and the possibility of internalizing group rules and values—of having the group become a new IPIR—promises to be perhaps even more effective than work with an individual therapist. Several researchers have demonstrated the importance of the group as a collective identity (Marmarosh & Van Horn, 2010; Marmarosh & Corazzini, 1997). If the group process focuses sharply on problem patterns associated with symptoms and relevant IPIRs and the process of grieving and developing new internal working models, it may be more effective than group TAU.

Structural Analysis of Social Behavior (SASB)

The SASB is an assessment tool that objectively measures perceived interpersonal and intrapsychic behavior on three dimensions: a) attentional focus, b) love versus hate, and c) enmeshment (dominance-submission) versus differentiation (emancipation-separation). Data gathered by the SASB model were central in the development of DLL theory. The measurement methods associated with SASB provide reliable ways of checking the predictions of the model

with data and also of assessing changes in interpersonal and intrapsychic perception throughout treatment.

Through its predictive principles, the SASB permits the clinician to draw connections between current problem behaviors and early social learning in addition to measuring the patterns and links as they change within clients in therapy. Interactions from a broad array of contexts can be brought into focus in a variety of settings including individual, family, couples, and group therapy (Benjamin, 2000; Benjamin, Rothweiler, & Critchfield, 2006).

The following figure shows the division of interpersonal space into three domains, each on orthogonal axes that range from hate to love on the horizontal and from enmeshment to differentiation on the vertical dimension. The three domains are as follows: a) focus on another person (parent-like behaviors), b) focus on self (childlike), and c) focus turned in toward the self (introjection). The three foci are shown by different typefaces—bold (others), underline (self), and italics (introject). This is the simplest version of the SASB, called the simplified cluster model (an octant). There are several methods of generating IPIR assessments for research confirmation. All versions of the SASB model are depicted as a diamond shape rather than a circle as the poles of the axes are thought to be theoretically basic, not arbitrary or relative. The "basics" are murder, sexuality, power, and territory. All other points are conceived in terms of these "biological" basics; the diamond shape allows them to be distinctly represented (Benjamin, 1974). Three versions of SASB Intrex questionnaire assess individuals in terms of either the octant or the full model: the short and medium form measure octants (2-word cluster or 4 parts per focus) and the long form measures the full model (136 points per surface).

One of the strengths of the SASB model is to define normal behavior as qualitatively different from pathological behavior. Normal adult respondents tend be described in terms of the

so-called AG (attachment group) SASB clusters of self/other cognitions and behaviors that

depict friendliness (**ACTIVE LOVE**/<u>REACTIVE LOVE</u>), moderate enmeshment

(**PROTECT**/<u>TRUST</u>), and moderate differentiation (**AFFIRM**/<u>DISCLOSE</u>).
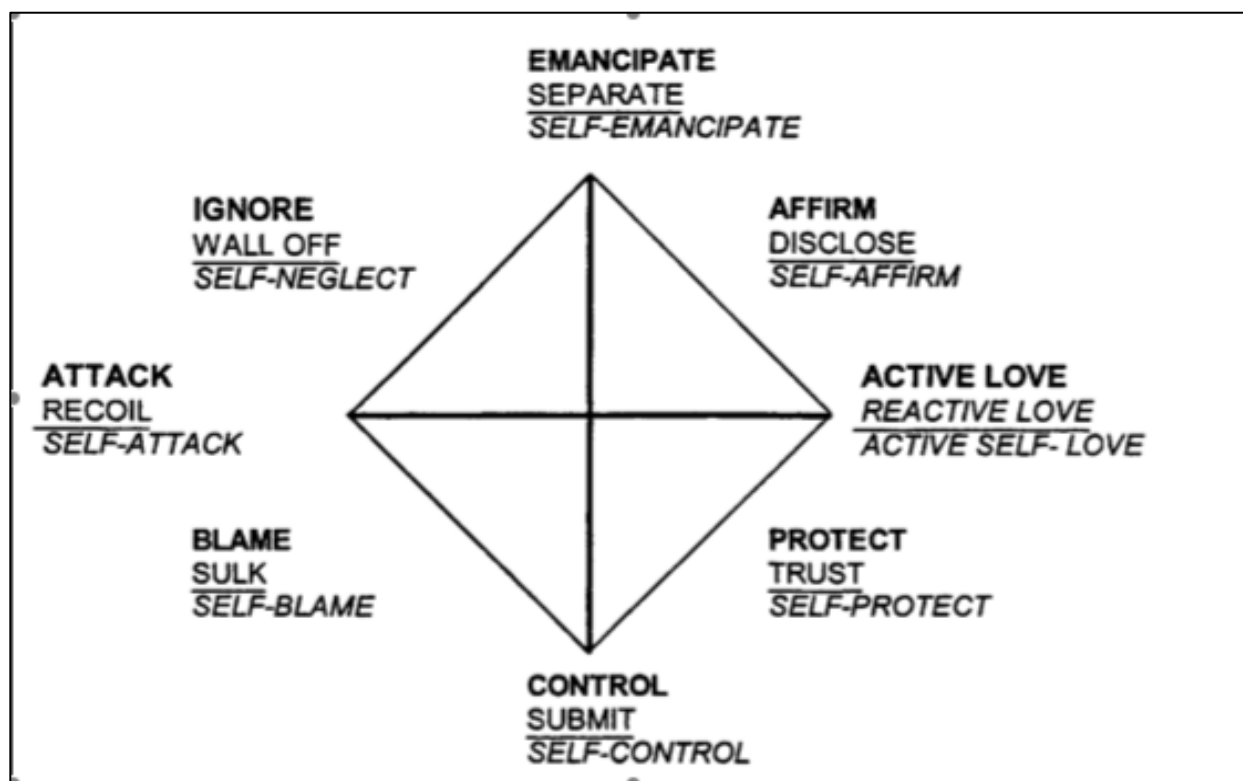
Figure 1. The Structural Analysis of Social Behaviors (SASB), Cluster version. Taken from Benjamin,
    1996, p. 55. Copyright 1996 by Guilford Press. Used with permission.

In adult relationships, focus tends to be distributed approximately equally between self

and other, while imbalance of focus can mark pathology (Benjamin, 1974, 1979, 1996). This

domain of normal points, the Attachment Group (AG), depicts ideal baseline position in relation

to others. Individuals in normal samples rate themselves higher on the AG, whereas patient

samples are more likely to describe themselves in more hostile terms (Benjamin, 1996);

therefore, there is a clear ability to classify individuals as improving or deteriorating using this

standard: increases in hostility, extremes of enmeshment, or differentiation all represent increased psychopathology. Correlations between measures of pathology and hostility were found to be high in a wide variety of databases (Benjamin et al., 2006). The relation between psychopathology and extreme enmeshment or differentiation is less clear empirically.

The profiles produced by the Intrex questionnaires can systematically survey and quantify clients' perceived interpersonal patterns and relationships to IPIRs (Benjamin, 2003) and changes during psychotherapy. The copy process paper cited above is an example (Critchfield & Benjamin, 2008). The ability of the SASB to allow social perceptions to be assessed objectively has been supported by research in many areas with many populations and contexts (Benjamin, Rothweiler, & Critchfield, 2006); it is expected that further research documentation will show that IRT can be helpful for therapists treating a wide range of clients who seek treatment at community outpatient clinics as they also need an empirically supported theory by which to practice.

Utilizing IRT in a group therapy format is a logical step given the cost-effectiveness of group therapy, equally positive outcomes compared to individual therapy (Shapiro, Sank, Shaffer, & Donovan, 1982) and the potential of group to support specific IRT goals. MacKenzie (1990) found using the SASB and gaining information about IPIRs before beginning group therapy helped the process. Benjamin (2000) suggests that groups might have the benefit of inspiring new attachments, enabling the will to change and even allowing the group to be a new communal IPIR.

Change Processes in Group Therapy

The current organization of outcomes in group psychotherapy research proposed by Burlingame, MacKenzie, and Strauss (2004) shows five interrelated factors: patient

characteristics, structural factors, leader characteristics, formal change theory, and small-group

processes.
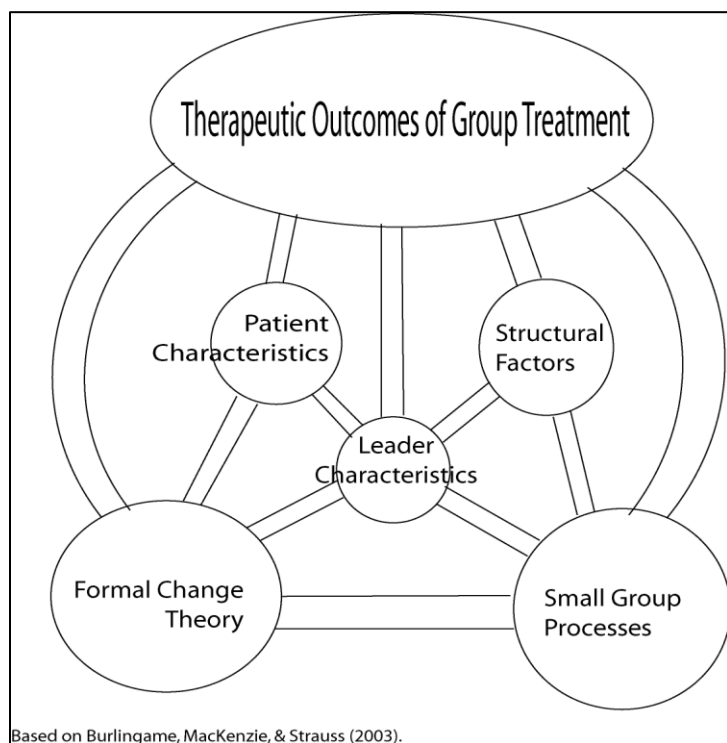
Figure 2. Therapeutic Outcomes of Group Treatment

Initial level of disturbance, personality, and interpersonal style are examples of patient

characteristics established as important predictors of group process (Kivlighan & Angelone,

1992) and outcome (Burlingame, MacKenzie, & Strauss, 2004). Structural factors are

considered the establishment and maintenance of group norms, including frequency of session,

size of group and group setting. Leaders become an important consideration as they impact the

performance of the group through their empathy, openness, and warmth, which have all been

associated with process and outcome (McBride, 1995). Formal change theories refer to the

various therapeutic schools as they impact group therapy processes. These theories usually act as

a framework for directing therapeutic activity within a group. Considerable controversy exists,

however, regarding what these particular frameworks are and how, when, where, and especially

why they operate. More precise group therapy change mechanisms have yet to be delineated (Barlow, Fuhriman, & Burlingame, 2000), such as proposing mid-range theories that account for multiple participants as well as uncovering covert intrapersonal processes such as group member feelings/thoughts about the self (labeled "Introject" on the SASB). Extant group research has focused primarily on behaviorally observable interpersonal behaviors between group members and simple self-report measures. While Burlingame et al., (2004) do not offer a change theory per se, they do suggest, given their review of thousands of articles, that whatever emerges must take into account all five factors listed above.

Areas of the group relationships with known links to therapeutic outcome are encapsulated within Small Group Processes (Burlingame, Fuhriman, & Johnson, 2002; Yalom, 2005). This review of the literature focuses specifically on those areas empirically validated to affect group outcome: cohesion, working alliance, group climate and empathy (Burlingame, Fuhriman, & Johnson, 2002; Johnson et al., 2005;). Cohesion can be defined as the level of togetherness or "we-ness" experienced by group members comparable to therapeutic alliance in individual therapy (Barlow & Burlingame, 2006). Burlingame, Fuhriman, and Johnson (2002) currently describe it as the therapeutic relationship in group; this relationship exists on multiple levels: member to group, member to member, member to leader, leader to group, and leader to leader. It is the feeling of collaborative bonding and alliance on interpersonal as well as intrapersonal levels. High levels of group cohesion have been linked strongly in the literature with therapeutic outcome, declaring a linear and positive relationship between cohesion and outcome (Tschuschke & Dies, 1994). In addition, Marmarosh, Holtz, and Schottenbauer (2005) confirmed Yalom's (1995) notion that cohesion is a critical precursor to group-derived collective self-esteem, hope for self, and psychological well-being— a possible mid-range theory for

multiple participants. Another important factor, working alliance, is considered the shared responsibility of group members and group leader in focusing on and working toward treatment goals (Johnson et al., 2005). When working alliance is described as group member alliance with the therapist working toward treatment goals, it becomes a significant predictor of positive outcome (Brown & O'Leary, 2001).

Group climate refers to a therapeutic climate that encourages emotional expression and self-disclosure of group members, responsiveness of the group to the disclosures, and the meaning derived from these in-group experiences (Burlingame, Fuhriman, & Johnson, 2002). An atmosphere of warmth needs to be provided to allow group members to explore the meanings of their behavior and emotional experiences in group sessions in a cathartic way (Hurley & Rosenberg, 1990; McBride, 1995). The Group Climate Questionnaire (GCQ; MacKenzie, 1983) has helped cement a firm definition of group climate in the literature as it has been used in a variety of studies. The Engagement subscale of the GCQ is positively predictive of outcome while conflict and avoidance subscales are negatively predictive (Johnson, 2004). Equally as important is the client's sense of being understood by other group members, which has gained great respect by many psychotherapeutic orientations. Empathy has been correlated with positive outcomes in a variety of studies; a review by Orlinsky, Grawe, and Parks (1994) found that in 72% of 115 examined studies client reports of empathy were related to positive outcome. Empathetic group leader qualities have also been correlated with positive outcomes for group therapy clients (Hurley & Rosenberg, 1990).

Although strong links have been found for the previously discussed group processes and outcome, there has been little work done determining the relationship between the variables in multiple ways. Johnson et al. (2005) proposed a new model of higher-order constructs of the

group relationship using multiple measures to operationalize constructs and employing exploratory factor analysis to create the following model. Her results consist of three components of therapeutic group relationships, including the other components of group process. The first component, *positive relational bonds*, represents individual group members' emotional attachment and affiliation with other members, leader, and group as a whole. The second component, *positive working relationships*, encompasses individual members' engagement in working toward treatment goals, and the third component, *negative relationship factors*, represents aspects of the process that may negatively affect member bonds or hinder therapeutic work (Burlingame, Strauss, & Hwang, 2006).

This model of group relationships brings greater definition and clarity to the group process research. As greater consensus is reached regarding definitions of therapeutic factors and the relations between them and outcomes, research can help clinicians gain greater understanding of how to promote successful outcomes for group members. This continues to be important as clinicians are being asked with more frequency to measure the progress of their clients and demonstrate the effectiveness of their work (Burlingame, Strauss, & Hwang, 2006).

Chapter 3: Method

Method

Clinicians are consistently looking for more specific methods to predict and manage outcomes in psychotherapy, thus the purpose of the group process model introduced in Chapter 2 as well as Dr. Benjamin's IRT theory. The purpose of this study was to gain an in-depth understanding of the process experience of this group and the potential impact of IRT theory-based feedback-receiving on this group's therapy—an understanding that can add to the current theories on small group processes. More specifically, this study attempted to explain the specific processes occurring in this group in which group members received feedback about their relational patterns. The study also suggests practical implications about utilizing various factors that may mediate how/if/why group members change. The study was primarily qualitative in nature with the change assumptions supported by outcome tracking measures.

Qualitative Research

This section is designed to help the reader better understand the inquiry method of qualitative research. It is multi-method in focus and allows a naturalistic and interpretive approach to the subject matter. This method is mostly used by those interested in studying the topic in question in a natural setting, intending to interpret phenomena by the meanings people bring to them (Denzin & Lincoln, 1994). One formal definition is as follows:

The word qualitative implies an emphasis on processes and meanings that are not rigorously examined or measured… in terms of quantity, amount, intensity, or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry.

Such researchers emphasize the value-lade nature of inquiry. They seek answers to questions that stress how social experience is created and given meaning. (Denzin & Lincoln, 1994, p. 4)

While qualitative researchers express dissatisfaction with the objective, quantitative and value-free methods of traditional science, these researchers also seek to represent a "science," but qualitative research is an alternative approach that rejects supposed freedom from experimenter prejudice and ideas of objectivity. All research is considered to be interpretive. According to Denzin and Lincoln (1994), "…there is no clear window into the inner life of the individual. Any gaze is always filtered through lenses of language, gender, social class, race, and ethnicity. There are no objective observations, only observations socially situated in the worlds of the observer and the observed" (p. 12).

Historically, true knowledge has been placed in the philosophical epistemologies of empiricism and rationalism, in which knowledge is considered to come from factual data or formal structures that orchestrate changing appearances of the world (Packer, 1989). Given an emphasis on meaning and interpretation, qualitative research makes its primary goal understanding (Schwandt, 1994). It allows the researcher to take a central position in the construction of knowledge or research findings (Banister et al., 1994); the researcher, therefore, reports his or her own thoughts, insights, and experiences as part of the data (Patton, 1990). Data collection occurs in the spirit of greater sensitivity to and exploration of human meaning, often achieved through a variety of methods including the following: case study, introspection, life story, interview, field study, and visual texts.

There are many quantitative studies and theories derived from those studies about what happens in therapy, and what factors influence change; however, these types of studies can only reveal a portion of what happens in the room. Information also can be derived from an inquiry

into the experience and meanings assigned to those experiences by therapy members and leader. Polkinghorne noted (1988, p.1), "Experience is meaningful and human behavior is generated and informed by this meaningfulness. Thus, the study of human behavior needs to include an exploration of the meaning systems that form human experience." Narrative is the primary means by which human experience makes meaning (Polkinghorne, 1988). Using qualitative methods to understand change in therapy may be a more analogous perspective to how the narrative of therapy is really processed by the participants. Quantitative data is more often part of the picture, through outcome and personality questionnaires, but therapists must engage in qualitative inquiry by sifting through the emotions, words, and physical movements of the therapy interaction, using themselves as a lens in order to identify relevant themes and plan for future treatment. This particular study will take one step further back and include the therapist as a person of interest, which will allow a similar level of analysis of the group therapy interaction without the need to respond in the moment.

The grounded theory method is designed to create theory that is based wholly on the data uncovered rather than externally imposed ideas (Glaser & Strauss, 1967). The data utilized in this case were the videotaped therapy sessions and transcriptions as well as notes from the therapist and brief reflection from group members. Researchers watched the feedback sessions to understand the information given to clients, but the primary data source was eight weeks of therapy.

Participants

    Leader. Dr. Sally Barlow is a full-time faculty member of Department of Psychology in the clinical psychology program at BYU. Dr. Barlow has extensively studied and practiced IRT in multiple forms of therapy, including advanced training with Drs. Lorna Benjamin and Ken

Critchfield. Dr. Barlow has received ABPP certification in both clinical and group

psychotherapy, akin to being Board Certified in medicine, and has been practicing group therapy

for over 30 years in addition to significantly contributing to the group research literature.

Group Members. Community members who requested services from the BYU

Comprehensive Clinic (BYUCC) were recruited during the regular intake process for a research

study on group therapy. These participants were screened per normal BYUCC criteria during

intake interviews at the discretion of the intake workers. The exclusion criteria include active

intense suicidal ideation, current substance abuse, and severe mental health diagnoses, such as

schizophrenia. The obtained sample was more like the standard outpatient sample than the

CORDS inpatient and outpatient samples as the BYUCC's exclusionary criteria routinely

eliminate at-risk clients. Six clients were selected for the study during BYU's fall semester of

2009. All participants were described as Caucasian, similar to the community population, with

four males and two females within the group. More details about participants is provided in the

findings section. Some participants were enrolled in co-current individual treatment.

All participants signed an IRB-approved consent form prior to the interview (see

Appendix E). The consent form gave permission to the primary investigator to conduct a study

on the effects of the feedback information and group method via questionnaires and videotapes.

Descriptions of and quotes from all interviews to be included in this study are under

pseudonyms. Any potentially identifying information was either altered or excluded from the

study.

Measures

Measures of perceived relationships with self and others that are directly relevant to IRT**.**

SASB Intrex Questionnaires—Medium Form (Appendix A). The SASB Intrex (Benjamin, 1974, 1996) classifies interpersonal and intrapsychic interactions on three dimensions. The system permits assessment of interpersonal patterns and tracks connections between perceived early relationships and current views of self and relationships with others. Formal data are usually generated by two methods: self-ratings by questionnaire and objective observer ratings based on a manual coding system. Both methods of assessment are processed by software that creates a number of parameters that are useful in research and in clinical practice. The Intrex Medium Form gives two points of data for each of the 8 clusters located between and on the axes (dimensions). The Medium Form as assessed by split half reliability, reports average correlations of approximately .82 within clusters. The test-retest reliability between clusters has yielded correlations of .841. The SASB Intrex questionnaires are pivotal to the priming intervention. They also may be used to quantify each subject's changes through therapy and pre post contrasts.

Inventory of Interpersonal Problems (IIP; Appendix B). The IIP (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988) is a self-report measure that looks at subjective distress arising from interpersonal sources. This measure also places individuals on a single circumplex model, which differs from SASB in a number of ways. The circumplex model opposes dominance and submission rather than construing them as "complements" as does SASB. It does not include focus and it does not measure "differentiation." The single circumplex is confined to the enmeshment portion of interpersonal space described by SASB (figure 1). Test-retest reliability is an alpha of .98. There are six subscales (Assertive, Sociable, Intimate, [H] Submissive, Responsible, and Controlling [T]) with anywhere from 10-21 items in each subscale, which divide into two groupings (H - "hard to" and T – "too much") with alphas

ranging from .82 - .94. It provides a simpler, widely published alternative measure of interpersonal patterns before and after group therapy. The measures of the IIP may be used to assess baseline, changes through therapy, and pre-post contrasts.

Outcome measure of symptoms. The following measure was used to track the outcome of members of the group as they participated in therapy. This measure was used primarily because it is part of standard operating procedures at the BYUCC, but it also has good validity as a measure of client symptom change over time.

Outcome Questionnaire— 45 (OQ-45; Appendix C). The OQ-45 (Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse et al., 1996) is a self-report instrument designed for repeated measurement of client changes occurring throughout the course of mental health treatments. The OQ instructions direct respondents to answer the items on the basis of how they have felt over the past week. The instrument consists of 45 items all of which are based on a 5-point Likert scale, including values of 0 (*never*), 1 (*rarely*), 2 (*sometimes*), 3 (*frequently*), and 4 (*almost always*). The 3-week test–retest reliability of the OQ is .84 and the test also has excellent internal consistency reliability coefficients (.93). There are three subscales comprising the following: symptom distress, interpersonal function, and social role (Lambert et al., 1996).

Group process (during treatment) measures. The following measures were used to explore quantitatively and qualitatively the existence of a link between outcome and process in group therapy, which has not yet been shown in the research literature.

Group Climate Questionnaire - Short Form (GCQ-S; Appendix D). The GCQ-S (MacKenzie, 1983) is the most commonly used group process instrument in the literature. The GCQ is a self-report measure that assesses individual group members' perceptions of the group's

therapeutic environment. It contains 12 items rated on a 7-point Likert scale indicating extent of agreement ranging from "not at all" (0) to "extremely" (6). The GCQ-S consists of 3 subscales. The Engagement scale describes constructive therapeutic work, including a positive working atmosphere (item 1), cognitive understanding (item 2), group cohesion (item 4), confrontation (item 8), and self-disclosure (item 11). The Conflict scale measures interpersonal anger (item 6), distancing (item 7), distrust (item 10), and tension (item 12). The Avoidance scale assesses members' avoidance of constructive involvement, such as avoiding issues between members (item 3), depending on the group leader (item 5), and engaging in high social monitoring (item 9).

Sample

There are significant differences between quantitative and qualitative sampling (Miles & Huberman, 1994; Strauss & Corbin, 1990). In qualitative research, the number of participants is often small. This is often in direct opposition to the goals of quantitative sampling, which seeks after large numbers of clients for statistical significance (Miles & Huberman, 1994). The concern of import in quantitative studies is to achieve generalizability with a representative sample of the larger comparison population, but qualitative sampling is concerned with representing concepts. In data collection, evidence of the object of interest is searched for, and questions about the phenomena are asked (Strauss & Corbin, 1990). Understanding the specific conditions of the part (research sample) is considered necessary to understanding the whole (and essential for achieving generalizability).

The study was conducted at the BYUCC where new contacts were screened for the research project during the clinic's intake procedure. Motivation for participation was high quality standard of care through group therapy with an expert, the satisfaction of contributing to

better clinical services for future clients, and a waiver for the $15 cost of group treatment at the BYUCC.

The group ran for 8 weeks from November 2009 to January 2010 with group members agreeing to attend all 8 sessions, although there was variation in attendance. All clients filled out the OQ-45 at each session, the IIP at sessions 1 and 8, and the GCQ at sessions 3 and 8. Each session was videotaped and transcribed by an accredited transcription service to allow for post dissertation coding describing the group process. There were some issues with videotaping as a result of clinic issues - one day the clinic taping was down and another session was not taped because the researcher was not in the room, despite the group and leader being present. Dr. Sally Barlow wrote group notes for qualitative analysis of leader experience.

Table 2

Quantitative Measures Given by Session Number

Pre-Group	1	2	3	4	5	6	7	8
IRT IIP	OQ-45	OQ-45	OQ-45 GCQ	OQ-45	OQ-45	OQ-45	OQ-45	OQ-45 IIP GCQ

Three types of coding used in grounded theory studies (open, axial and selective) were used to analyze each therapy videotape/transcript. The coding was managed and organized using notes or "memos" from the two coders during viewings of videotaped sessions, which included conceptual labels, paradigm features and indications of process (Strauss & Corbin, 1990). Data analysis ended when the two coders reached saturation, which occurs when no additional data are found that the researcher can use to make new themes or concepts (Glaser & Strauss, 1967). The resulting theories were validated against existing data to support the reaching of the saturation point.

Researcher

In the interest of disclosure, the researcher would like to paint a picture of her group

experience so the lens through which she interacted with the data is clear. When the study

occurred the researcher was a 5th year graduate student in clinical psychology with 1000+

clinical hours. The investigator focused her clinical training on group therapy and began running

groups during the 2nd year in the program. The researcher has conducted at least one group a

semester, using various models (psychoeducational, process, and interpersonal) and a variety of

theories, including dialectical behavior therapy (DBT) and acceptance and commitment therapy

(ACT). The researcher has also worked with a range of populations and severity. For a student

of her standing, the investigator is well trained in group methods and theories.

The researcher's background is such that she shares the common religious belief of the

Utah County area—the LDS religion, which helped build understanding of some of the

shorthand and norms of the group and may have influenced some of my interpretations. The

investigator also had a weak connection with two group members outside of the research setting

as common friends referred them to the group. The investigator did not interact with these group

members outside of the study during the duration of the study, but did possess some external

information about the individuals that may have influenced her interpretations.

Tapes were watched after the 8-week treatment concluded, so when giving forms and

surveys, the researcher was unbiased outside of the initial screening. The researcher was

primarily responsible for recruiting and screening members through my position as an intake

officer for the BYUCC. The research team consisted of the primary investigator and another

clinical psychology graduate student, who also shared the local LDS belief system but was

unfamiliar with group therapy and had acquired few clinical hours by the taping of the sessions.

Each tape was watched separately with time in between viewings to let ideas and themes germinate between viewings. For the first few tapes, the research team did not discuss impressions during the viewing but waited until afterward to compare notes. As the researchers became familiar with the data and group members, the team was more likely to stop the tape and discuss during viewings. Quantitative data analysis did not occur until after qualitative analysis ended. There are multiple ways to consider this ordering choice. The quantitative data could have biased the qualitative analysis process, and instead acted as a validation check for the analysis results.

Group Members

This section goes into detail about the individuals who attended the group in order to give some background to both the interpretations and context of quoted sections of dialogue. It is important to have some knowledge of our small group, as in therapy, meaning builds upon itself over the sessions. Clients change from one-dimensional problem statements to multi-dimensional individuals defined both within and outside of the group setting. This provides a high level of data, but most of it is convergent when clients make progress in treatment. The individuals are identified here by letters, but were not assigned to specific sections of text in this study unless it is deemed relevant by the researcher for understanding the quotation or analysis. The focus of this study is on the meaning created by the group through the text, rather than on understanding the individual; however, for general meaning purposes the group identity is formed from the information provided. Information specifically concerning participants' religious identification and attitude is included, because of its importance to the group discussions.

DL – She was a 23-year old college student, whose parents divorced when she was 10 years old. Her stated reason for attending group was learning to deal better with social anxiety and some depression, which was recurring since middle school. She was the oldest child in her family and had taken care of her younger siblings while growing up. She reported having perfectionistic tendencies and being highly submissive in relationships. DL had recently been in a long-distance relationship and was not sure where she wanted that relationship to go and did not feel confident in her ability to commit long-term. Her goals for group were to learn how to be an adult while still being kind to herself and having fun, which she did not feel able to do. She had generally positive views of the LDS church and recognized that the varied cultural behaviors of LDS members could have negative or positive impacts.

MI – He was a 26-year old undergrad who came to group because of social anxiety issues. He wanted practice getting along with people, building relationships, etc. He lived with his older brother who also was not very social; he had very few interactions with people outside of family but was not particularly close to his family. His father had cut off the Internet earlier in his life in order to end an online relationship, which is one explanation for the online relationship he developed with an unhappily married female. It was unclear how romantic the relationship truly was, although it was a source of comfort and learning for him during the group. He had been homeschooled since sixth grade and had trouble in social situations because he did not know what to expect from others.

ML – He was a 30-year old single male who came to group to better understand himself. His parents divorced when he was quite young, which left him in charge often of his mentally handicapped younger brother. He was very close to his family, but his strongest family relationship had been with his recently deceased grandfather, a man who was his example and

friend. ML reported he had been diagnosed with ADHD and bipolar disorder as an 8-year old and had been in and out of counseling as well as taking medication for these issues. Recently, he learned that those disorders were misdiagnosed. He felt during his adolescence that he did not belong in a treatment center, so as an adult, he was interested in "rewiring" his conception of himself to learn new ways to interact and understand himself. He described his experience with the LDS church as somewhat negative, especially during his childhood, although he still attended regularly currently.

DP – She was a 24-year old single female college student, who had just returned from an LDS mission about six months previously. She wanted to improve her relationship with her parents and viewed group as a type of experiment as she was interested in becoming a marital therapist. She wanted to learn how to become happy during difficult situations and have more consistent positive self-esteem across situations.

WA – He was a 34-year old male who had been divorced this past year. He was still in love with his wife and wanted the relationship back but did not view it as a possibility. He also came to group because of issues stemming from a previous divorce (children from both marriages) and family of origin problems. His mother had been married multiple times and was reported to have been fairly abusive to WA and his half-brothers growing up. He was in between careers but was primarily in construction management and had considered becoming an EMT. He came to group to deal with his lack of faith in humanity. WA described himself as previously very social and outgoing but described himself now as a withdrawn person who did not enjoying meeting people. He had been very active in the LDS church during his recent marriage, but when things went bad in the marriage, the LDS members formed negative impressions of him, and it changed his activity level and view of the LDS church in his life.

DU – He was a 57-year old divorced male who was attending group because of poor relations with his adult sons. He had cheated in his marriage, which had resulted in divorce and was also dealing with the loss of his job and religious membership. He reported being angry, depressed, and self-blaming about his situation and feeling like there was no way for him to move forward. He was also still in love with his wife but also angry with her for their poor marital relationship. DU's LDS beliefs were very intertwined with his teaching and personal ideology. His goals for group were to get socially "out there" again, deal with depression issues, and find a way to deal with his behavior and the resulting religious and family fallout.

Data Analysis

The data in this study were analyzed using the grounded theory method developed by Glaser and Strauss (1967). As opposed to quantitative research, which seeks statistical significance in numbers, grounded theory seeks for patterns of meaning from a text or other medium. The qualitative data in this study were video recordings of group therapy sessions as well as transcribed texts of those sessions. Grounded theory analysis utilizes three types of thematic coding: open, axial, and selective (Strauss & Corbin, 1990). The analysis and coding began by labeling concepts in the data, moving into higher order categories, and then synthesizing categories into a few salient constructs. Although each type of coding is a distinct analytic process, the researcher does not proceed step-wise through each process; instead, during analysis, the researcher simultaneously applies the different types of coding.

During coding, it is important to remember that each proposed concept or category, regardless of its level of abstraction, does not directly correspond to the data. The researcher does not read a piece of text and arrive at a conceptual topic that directly references the section of text. Rather, the label encapsulates both a particular segment of text and the implicit context

of the therapy text in that session and over the entire eight weeks. The quoted text is always

related to the larger interview and must be understood in context of the larger discussion taking

place.

Qualitative research assumes that the qualities or properties of an object can not be

broken down and objectively observed in isolation. Instead, understanding the context in which

the segment of text resides is equally as important as the literal words spoken. In actuality, the

"properties" or "qualities" of the object are defined in part by the object's context. The context

and the object of inquiry occur in symbiotic relation to one another as the components cannot be

understood in a vacuum; therefore, any suggested concept or category is a concurrent

consideration of a smaller section of dialogue as well as the larger whole. The foundation of the

creation and properties of the category is the context of the larger therapy interaction. The

researcher must consider the arc of the entire therapy's narrative in the development of concepts

and categories. The three types of coding—open, axial, and selective—in the grounded theory

process are presented and discussed in the context of data from this study.

Open coding is the initial stage of developing concepts and categories. Concepts are

"conceptual labels placed on discrete happenings, events, and other instances of phenomena"

(Strauss & Corbin, 1990, p. 61). Categories are basically a classification of concepts. During

the process of ordering, concepts align into more abstract concepts called categories. In open

coding, data are filed down into discrete parts, and the phenomena under investigation begin to

be grasped. Strauss and Corbin (1990) stated, "By breaking down and conceptualizing, we mean

taking apart an observation, a sentence, a paragraph, and giving each discrete incident, idea, or

event, a name, something that stands for or represents the phenomenon" (p. 63). In grounded

theory analysis, the researcher can code using line-by-line, sentence, paragraph, or entire document analysis.

Open coding is the initial attempt to analyze and break apart the data in order to identify concepts and categories, but the function of axial coding is to take the broken down data and reassemble them into text. Strauss and Corbin (1990) define axial coding as a coding paradigm that involves an explanation of the "phenomenon, conditions, context, action/interactional strategies and consequences" (p. 96). Axial coding makes connections among the categories previously identified during the open coding process by applying the axial paradigm.

The purpose of selective coding is to combine all of the major categories created during open and axial coding into a theory grounded in the session data. As Strauss and Corbin (1990) note, integration in the selective coding stage is similar to axial coding; however, it occurs at a more abstract level of analysis. The first step in selective coding is to articulate a narrative about the data. The objective is to write a "general descriptive overview" of the story that has emerged through the process of analyzing the therapy sessions (Glaser & Strauss, 1965). The research begins to ask detailed queries about what is truly happening in the data in the context of a specific phenomenon of inquiry. In grounded theory analysis, it is important to tell the story both analytically and descriptively. The phenomenon of most importance needs to be named— what grounded theorists describe as the "core category." The core category is abstract enough to encompass all that has been described by the story; it is related to less-central categories through the use of the conditions, context, strategies, and consequences of the interaction in the data. Integration occurs naturally during axial coding, but selective coding explicitly identifies the emergent patterns that materialized at lower levels of analysis. Strauss and Corbin (1990) explain,

A web or network of conceptual relationships is already there, though somewhat loose and tangled, that the analyst will have to sort out and refine later during his or her selective coding. It is very important to identify these patterns and to group data accordingly, because this is what gives the theory specificity. One is then able to say: Under these conditions (listing them) this happens, whereas under these conditions, this is what occurs. (p. 131)

Chapter 4: Findings

In order to understand this analysis, it is imperative to understand what is being studied. As previously stated, the purpose of this study is to *explain the specific processes occurring in this group in which group members received feedback about their relational patterns*. Initially, the researcher approached the data with the question of how IRT feedback impacted the group. That question eventually did not fit as the real phenomenon of inquiry, instead the investigation evolved toward processes that contributed to or hindered the progress of group members towards positive end goals. IRT feedback and behaviors were considered to fit into that broader questioning, and did not play a role in the main effect discovered during this study. The role of IRT in this group and its potential for group therapy will thus be considered further in the discussion section.

The investigator also used standard group development theories such as Tuckman's (1965) model of forming, norming, storming and performing, and group-process tracking models like the Hill Interaction Matrix (1971), a behavioral rating system that measures the therapeutic nature of a group member's communications. The many quotations embedded in this section have been included in order to provide a feel for the therapy sessions and for the experience of listening/watching the group unfold from week to week. This is intended to help the reader hear the speech, camaraderie and struggle of the group, as well as to ground the interpretation and analysis. Any words that were unintelligible or inaudible during transcription are indicated by a blank or underscore. The investigator used coding processes to identify themes that might help explain change and barriers to change.

Open Coding

Before beginning the in-depth analysis of open coding, the investigator studied the therapy tapes, including pre-group interviews, looking for themes and patterns of behavior and meaning. Although the investigator did not conduct the actual sessions, the researcher's personal reactions to the group interaction were noted and used to help identify emerging themes. During training as a therapist, the researcher was often told to "follow the emotion" in sessions in order to understand the core issues behind the client's presentation. Recording the investigator's reactions to the group gave information about what group members might have been experiencing emotionally, as well as providing possible hypotheses for the rationale behind leader interventions. This was a way to conceptualize the group process in "real-time."

Next, a brief interaction between group participants (including the leader), or a significant monologue from the session would be debated, inspected, and assigned a name. In traditional interview-based qualitative research, typically one speaker's statements are analyzed. The primary unit of analysis in this study was usually a conversation, because of the nature of group therapy, where "monologuing" is not encouraged. The question under investigation, the factors influencing change, was assumed to primarily appear in interchanges when the individual was "challenged" by other group members' questions and conceptions. In addition, the researcher chose to use representative segments of text to identify categories that permeated the transcripts, as many concepts were repeated over the eight weeks of therapy. This was the process of open coding used in this study.

As stated earlier, the concept name assigned during the open-coding process reflects both one transcribed segment and the larger context of the group treatment as a whole. In some sense, emerging concepts and categories are artificial when considered in isolation from the multi-

layered nuances of therapy. They become meaningful only in relation to the treatment as a whole. Consider the following short example of open coding:

Client: So she has a group that's this fun [Laughs].

Leader: It's been a good group. Good people in it.

Client: Yeah.

Leader: Eat some M&Ms before I eat them all.

Client 3: Yeah, yeah. Seriously. Stop her from eating them all [Laughs].

Open coding for this particular dialogue segment resulted in the following categories and concepts: bonding (category); friendly; enjoyment; concern; giving; caring (concepts).

This segment came from the last session on the eighth week. It encapsulates the climate in the group at the end of therapy, a climate which was built up over the entire study. In order to understand the segment, it is important to understand the background and context. Before the group started the final session, one male member brought candy to share. As people arrived, they made friendly comments and then immediately asked for candy or were offered some. There was no hesitancy in accepting the offer, and no reactions other than encouragement to requests. When the leader arrived, she was treated as an equal by the other group members. She was offered and took some M&Ms, engaging in a similar level of friendly banter as the rest of the group. The male client was teasing the leader about eating all of the candy because she had grabbed the bag of candy from him before this segment.

Traditional boundaries and norms exist at different levels of relationship. Strangers are more polite and less assuming, with each subsequent increase in closeness equaling an increase in the permissibility of various behaviors. The interaction between these individuals shows a high level of permissiveness, indicating a high degree of closeness. Thus this casual, pre-therapy

conversation was used to characterize the relationship between the speakers as "friendly, enjoyable and giving."

The fact that cohesion emerged in the sessions was important to note and categorize, especially as it later contributed to higher-level analyses. The investigator considered the possible meanings of the laughter and banter during the segment, including such ideas as "fun", "teasing", and even the negative idea of "insolence." This particular group's goal and interactions generally seemed to be positive, so negative characterizations were thrown out. At the end of therapy, choosing words that highlighted a deeper level of connection and feeling between the group members seemed more accurate. "Bonding" was then considered as a possible concept label. These kinds of interactions are considered relevant in the literature about positive change in group therapy. This is one reason for including the GCQ in the analysis.

According to Strauss and Corbin (1990), a group of concepts that are inherently related forms a category, although it is the researcher's responsibility to name that category. In the above example, the researcher chose "Bonding" as the title of the category, which included the concepts friendly; enjoyment; concern; giving; and caring. The category name was broad and abstract enough to encompass the concepts it represented, and "bonding" best fit all of the emerging concepts.

Here is an example of a second category that emerged. This category tended to appear exclusively with two group members, DU and ML, but it shaped how they interacted with others in the group, as well as the amount of progress they made. The following is an example of the dialogue in this category:

ML: But, you know, you are – 'cause I'm, you know, you got stuck in a situation that you weren't adequately prepared to deal with and boom – you're right at the break point. And you're crying out, okay, what the crap's going on here?

ML: And now you have a group that's been prepared for you to tell and talk about things. You know, you have all the things to succeed. You just need to start concentrating more on the success patterns and what – taking advantage of the tools to succeed, because they're all there for you. And this may be the point in time in which God said, okay, look. Either this is the circumstance that I'm preparing you to marry this guy or this is horribly going to blow up in your face. But at least you'll walk away with the understanding so that when the next person comes along or, you know, it may be the next ten people, you know, but when the right person comes along –

Female Client: I'll be ready.

ML: - it will – you will be ready and he will have prepared the way years before you were ever even ready to even know that you were gonna struggle with that. That's, that's where the faith in God does come in.

Open coding for this particular dialogue segment resulted in the following category and concept formation: Counseling (category); advice-giving; helpful; arrogant; distancing; and safe (concepts).

In this segment, ML is attempting to respond and relate to another client's previously shared experiences. ML is not talking about himself or his own experiences with a similar event or feeling as the client. Instead, he is sharing prepackaged advice and information about how to handle the situation. The intent of the speech is clearly to be helpful: "You know, you have all the things to succeed. You just need to start concentrating more on the success patterns and what

– taking advantage of the tools to succeed, because they're all there for you." He is trying to encourage her, but by telling her what to do he changes the tone of the group in this session. The previous client was emoting and vulnerable when sharing her story, but ML's response is distancing and safe because he does not relate to her in a vulnerable manner. Instead he is arrogant. He assumes he knows what she should do because of his own experiences, instead of responding to her emotionally using those same experiences.

This researcher's training in group therapy encouraged teaching clients to relate rather than to lecture. Almost all groups go through a stage of advice giving, but it is more meaningful and beneficial to use personal experience to connect with other members. Group members who found it easier to do this changed more than clients who tried to act as a second "therapist" and doled out recommendations. The category title "counseling" seemed to describe the ideas brought up by this and similar passages, as well as fit with the researcher's previous experience of "second helpers" in groups needing to abdicate that role in order to make progress.

Axial Coding

Categories become more developed through the use of the axial coding paradigm. Questioning the concepts in the text helps the researcher develop categories. Strauss and Corbin (1990) state:

There are certain general questions that can be raised quite automatically about the data. Each question is likely to stimulate a series of more specific and related questions, which in turn lead to the development of categories, properties, and their dimensions. The basic questions are Who? When? Where? What? How? How much? And Why? (p. 77).

The "central idea, event, happening, incident" is the phenomenon "about which a set of actions or interactions are directed at managing, handling, or to which the set of actions is

related" (Strauss & Corbin, 1990, p. 96). The "causal conditions" are the "events, incidents, happenings that lead to the occurrence or development of a phenomenon" (Strauss & Corbin, 1990, p. 96). "Context" is the "specific set of properties that pertain to... the locations of events or incidents pertaining to a phenomenon along a dimensional range" (Strauss & Corbin, 1990, p. 96). In order to move to the next step in investigating the specific phenomenon, 'action/interaction strategies' are used with the purpose of managing, handling, or responding to the phenomenon in a specific context. The strategies lead to detailed outcomes, which are part of the axial paradigm model (Strauss & Corbin, 1990).

The current research project resulted in the following segment of axial coding: Phenomenon: managing/encouraging positive change. Context: Leader references IRT theory-based interventions. Consequence: Clients resist, subvert, distract. Two examples follow:

Leader: "You know – you went – you were willing to take that long instrument [Intrex]. And, um, would you be willing to talk a little bit about the – sort of where you came from and what you – what was – what were the strengths of your family? Because that's usually where we learn our patterns. And then what maybe you'd like to work on interpersonally. We know one thing about eye contact. And you're – you're deciding.

Client: "Hm. Well, do you have specific questions, or –I mean, because I could go on for hours about things, so – So, I mean, my inclination is to just do more of a – go around the circle, do more brief introductions and then – and then maybe we can get into the deeper stuff…That's what I was thinking because I – I kinda feel self-conscious about – you know, here I am talking" (Dec. 8).

Leader: "One of the things this group is about is sort of looking at where we got our pattern,

and where did those patterns come from? And the, um, theory behind inter-personal

relationship therapy, IRT, which is a part of the ___ theory that the ___ comes from

just that instrument you took. The theory behind it is that we, we develop certain

patterns."

Client: "And so as you were talking, it brought up some things that have been bothering me

over the past week. Like I realized – I couldn't sleep one night, which isn't very

common for me."

This section of axial coding describes a specific experience (i.e. managing/encouraging

positive change), and a specific context (i.e., IRT theory interventions from leader). Deeper

investigation of this experience and context required observing the videotapes, reading and re-

reading the group therapy texts, questioning transcripts, and comparing the segments and ideas.

Asking such questions opens up the data to potential categories and associated concepts.

Grounded theory analysis is a non-linear method, as the discovery process does not lead easily

from phenomenon to context to strategy to consequence.

The first example above was one of the few direct challenges to the leader's role. The

challenge occurred much earlier in this group's process than in many other groups the researcher

has participated in. This event happened during the introductions portion of the group therapy,

when members are usually looking for lots of guidance from the leader, and have little resistance

to following her lead, despite the new experience of sharing private information with strangers.

Possibly, the 90-minute pre-group interviews made clients more comfortable with the therapist

and more forthcoming about preferences earlier on. Pre-group interviews are usually short (30

minutes or less) and more general and informative in nature than the intensive IRT feedback

session these group members experienced. While that may have given members the ability to resist the leader, it does not explain why they would have resisted these kinds of leader statements, especially given the group's discussion of IRT theory-based conceptions of self, which the clients appeared to find helpful and insightful.

One hypothesis is that group members resisted talking about themselves in a revealing way at the beginning of the study. The level of vulnerability required for the Intrex conversation was off-putting at the time. This theory is supported by the client's statement: "my inclination is to just do more of a – go around the circle, do more brief introductions and then – and then maybe we can get into the deeper stuff…That's what I was thinking because I – I kinda feel self-conscious." This may explain the first example, but the second segment requires a different explanation.

In the second example, the client ignored a direct prompt to discuss information gained during the pre-group sessions, choosing instead to talk about her current problems. Initially, it seemed as if she might address the issue, "and so as you were talking, it brought up some things that have been bothering me over the past week"; but the prompt sent her in a different direction than the leader intended. The leader anticipated a more direct discussion of the information gained during the pre-group feedback, which did not really occur at any time during the study. The explanation used for the first segment – feeling self-conscious – is less relevant in this instance as the client *is* sharing private information in the group, just not the requested material. Why? Perhaps the example is best explained by the times when the data does not follow the divert/distract strategy pattern following directive leader statements.

Axial coding's most important function is to compare statements about hypothesized relationships to evidence in the data, and if necessary to find examples of data that do not match

the hypotheses, and ensure their inclusion in the process (Glaser & Strauss, 1967). As Strauss

and Corbin (1990) explain, "It [axial coding] is a complex process of inductive and deductive

thinking involving several steps. These are accomplished, as with open coding, by making

comparisons and asking questions" (p. 114). In the current study, the researcher moved from one

therapy text to another, as well to different parts of the same session, in order to find similarities

and differences in the categories that emerged from each group meeting. This comparative

process helped create categories as well as statements of relationship between groups of data

(Glaser and Strauss, 1967). Consider the following exchange:

> Leader: Yeah. We're sorta at the place in – where groups, ah, ah, if they stay being polite and
> civilized that the things don't hec-, don't get done. So we could get [rolling] here.
>
> Client 1: We have to be not polite and not civilized?
>
> Client 2: Well, well, see what she's talking about –
>
> Leader: Well, actually, it's a good point. It's not what are you gonna mean.
>
> Client 2: - it's just that, just that there, you know, like – see this, this thought came to me
> when I was filling out those, ah, those, the really big form that we were just given,
> ah, where it's like we don't really talk about how we actually feel about each other
> in the group or, you know, for good or bad, really; because we're blank. But, you
> know, we definitely avoid talking about each other in [bad]. It's like I don't, I don't
> like it when you do this – that kind of thing. And so that's more what she's talking
> about is talking more openly about our feelings when, normally, we don't hold back
> even though it's gonna hurt –

In the first two examples, clients resisted the leader's IRT theory statements, but in this

exchange the group did value the intervention. A reference to Tuckman's (1965) stage of

storming (where clients begin to confront group norms and each other in order to grow) causes a group member to follow the direction and act to move the group toward a more open conversation. In week three, when this interchange occurred, groups are often ready to approach these kinds of risks, at least at the subconscious level. By capitalizing on where the group was in terms of development, the leader's interventions resonated with the group and did not result in distraction or diversion. This provides a possible rationale for the second example used above.

Because clients resisted talking about problems in theoretical terms, as time went on the leader stopped pushing those types of statements. Instead, she joined the group more often where they were on other topics, i.e. religion. This may be one reason why positive change was mediated through those topics.

Categories

By focusing on similarities and differences in the text, the researcher's biases are continually questioned. The researcher looks at the data not only for confirmation of her hypotheses, but for falsifying examples that resist the developing theory. This strengthens the grounded theory, as the researcher re-evaluates assumptions and biases. After analyzing the therapy sessions using open and axial coding, other higher-order categories emerge. In this case these included the categories of connection; openness; avoidance; and religious justification. Leader coherence will be discussed in more depth, as it emerged as important to both the selective coding section and the main finding of this study.

Leader coherence. The Leader Coherence category is represented by this segment:

Leader: I did ask [do you have sex online], and I mean that, that, psychologists are curious about behavior that we generally don't talk about.

Client: Mm-hm.

Leader: But I've, I was realizing I might have offended you, and I'm truly sorry.

Client: It, it was a very personal question, and I'm not sure I would answer it honestly. But I did at the time. You know, it's not something we've done. Part of it, of course, is because um, I have certain standards and values, and I try to live up to them, and she knows that. And that's part of why she likes me so much. You know, it's part of why she loves me. Um, and another thing is that the only time I was able to get online last semester was on campus or at the public library, and so I didn't feel comfortable enough to even –

Leader: Flirt.

Client: – yeah, to even go to a certain point. So –

Leader: So I hope you forgive me.

Client: Yeah, I do. It's okay.

In a previous session, the leader violated an unstated norm about a group member's comfort, and he had answered honestly, but it threw off the group dynamic. The leader recognized the boundary issue and came back into coherence with the group by discussing the violation openly. As a result, members continued to make gains and consider her input. Being in coherence, or in lay terms on the same emotional level as the group, was especially important during religious conversations, which occurred often. Consider the following:

WA: "That's – the church played a really big role in my attitude this last year because I – I was devoted to church. And I gave a lot of time and effort and [pause] I listened to what, you know, everybody would talk about, and then it would – nobody really lived – like, in the last two wards I was in, nobody really actually lived those principles. And I – I just got more and more bitter."

Leader: But I wanna back up just a minute. Is – is WA not gonna have room in here to be

   disappointed and mad – mad at hypocrisy?

Client 2: I have no idea what you just said.

Leader: Okay. WA was saying that he was really disappointed [laughs] in… Is it okay to be

   burned out on the church?

Client 3: Yeah.

Client 4: I'd say so.

WA: Because, I mean, I – I – I understand that. Um, it's taken a lot,

actually, for me to –

Leader: Is that better?

WA: Yeah.

The purpose of the leader's intervention was to make sure that all group members'

associations with religious identity were allowed and engaged. This was important to ensure

coherence with multiple group members and encourage multiple conceptions of religion. The

leader often defended the expression of negative views about the LDS religion, which was

sometimes buried by the voices of those who taught religious beliefs outside the group. This

allowed the therapist to be in coherence with what was significant to the group, while still acting

for the group's long-term good. Theory statements by the leader resulted in a loss of power, but

including "good practice" – a different theoretical intervention – in a group-coherent way

restored that power.

   Connection. One of the theories posited by IRT is that the group can become a new

attachment figure for the individuals who compose it. The SASB model, instead of more

traditional definitions by developmental theory, defines attachment here. As a result of this new

attachment, the members may let go of emotions that held previous patterns in place, and use the group as a new norm. Having the group as a new authority figure accelerates positive change, as the group creates new norms that will allow for the creation of healthy behaviors and guard against the maintenance or creation of unhealthy behaviors. The category of connection, which came out of the "bonding" open-coding category, reflects these ideas. The following conversation is early evidence of interest in a group member's well-being:

> Client: "People could hurt me. You know, just any number of ways. I – If I trust people, they
> have an opportunity to hurt me.
>
> Client 2: "Define 'hurt you'."
>
> Client: "Well, if I make myself – well, there are lots of things. There's –
>
> Client 3: "Physical or emotional?"

This particular dialogue is interesting for the underlying meanings that can be derived from it. If taken out of context, the questioning can be construed in many ways. However, as there is conversation before and afterward, as well as audio/video recordings, important information is added to the interchange. Client 1 makes a comment about being hurt, and Client 2 interrupts Client 1 twice in order to clarify the specific type of hurt Client 2 experienced. The tone used by Client 2 in the audio is direct, abrupt and somewhat harsh, which is understood here as not being directed toward Client 1, but rather toward those who may have injured Client 1. A high degree of protectiveness and concern is demonstrated toward Client 1.

This attachment appeared to strengthen throughout the study. WA missed many group sessions without informing the group. Group members focused conversation on his absence during groups when he was not in attendance, mentioned his absence during their post-group evaluations of the worst part of that day's session, and rewarded the missing member with

immediate time when he did show up. The following is the indicative of the type of dialogue that occurred when his absence was noted:

Client: Did you ever get a hold of WA to see why he's not coming anymore?

Leader: No, I've called three times, and I know Rebecca has, and –

Client: He hasn't _____ get a hold of you? He hasn't said anything to anyone?

Leader: No.

Client: That's weird.

Leader: You know what? I was actually tempted to like drive to his work. But I was afraid
      he'd feel sort of stalked.

Client: Ah [laughs].

Leader: But he's such a good guy, you know? And I really think he could have gotten some
      things out of this group, and I don't know.

Client: I was learning from him, you know because he, you know, had a –

Leader: He's a cool guy.

Client: It really is too bad. I mean I really would have like to have at least have heard his
      reason for not coming.

Leader: Me too. Me too.

A client initially broached the subject of the absences and asked the leader if she was following up on WA. Parts of various sessions were also spent hypothesizing why he left a session before it started and why he did not show up at all at other times. Group members wondered if they had done something to offend him, or occasionally externalized responsibility by suggesting that data collection was off-putting. WA did show up unexpectedly at a later

session and provided some closure to the group by explaining his absences. Some members rated this as the best event of that group.

Although WA is the strongest example of connection, clients were constantly checking in with each other about how much group members shared or making sure to follow up on events from week to week. It was very important to them that their fellow attendees benefitted from the group experience by participating. The primary motivator seemed to be a true sense of connection and caring. This category's emergence is essential to supporting the use of IRT in group therapy, as well as being the foundation of strategies to manage positive change.

Openness. Essential to successful group change is the ability to adjust previously held norms and beliefs by challenging others and accepting feedback from group members. Typically this happens after the group has had some time to normalize, to get to know each other and had enough experience with the therapy medium so that the potential risk of sharing intimate details appears to have potential payoffs. This group took the plunge on December 8, three weeks after group started. Two clients, including one who had not shared many of his concerns in the group until this session, took the lead:

DU: But, but maybe this is a good place, too, as she offered. One of the reasons I haven't been wanting to dump, you know, you – I enjoy you guys and your strug- – and I know that there are some serious concerns in everybody's families and lives. But – and I probably wouldn't trade my – what's on my plate for what's on yours. None of us would. But mine is a, maybe a little hippier, if you look at the whole – you've got a little bit ___ made it to this side, but I've also been excommunicated. I've lost my job, and I've lost my family, and my families not talking to me. I had a hard time getting employed since. I had a couple of bad issues. I figure if I'm not emotionally ready and want to, want to rebuild life, wanna get on, wanna know what I can and

should. [Deep breath] I don't have a lot of energy, and you can sense a little resistance to any sol- – anyone that's got a nice easy solution. Ah, I liken it a little bit to post-traumatic stress, and it just feels like that. It just feels like I've just been through a wringer.

DU's dialogue is directed partly toward his trust level and relationship with others in the group, but the segment primarily concerns his willingness to take a risk in the group setting. In general group members tend to feel the need to protect others from their problems, and only want to provide help to others. DU encountered these problems – his position in the group (as oldest member) and previous experience teaching college students predisposed him to a particular role. Many of his comments tended to fall into the counseling category, or into the avoidance category. He made open comments very rarely, but when he did this tended to connect him to the group more. If a client does not feel a sense of connection to other members, they take fewer risks, and in this study vulnerability was found to be related to willingness to engage in the core conflict in this group, religious struggle, which is explained in more detail in the selective coding section.

The openness category also includes how difficult it is to talk about private things, which is a fundamental step towards openness. For example:

Client 1: It's just easier for – and especially for him because well, I'm just a really big mouth. [Laughs]. But he's more sensitive and caring, so it's probably easier for him just to not to show up and try to have to have to explain, "Well, no offense".

Client 2: Yeah, but the thing about group is that it's okay to talk about things like that.

Client 1: Well, but here's the thing though. Is you've been in group situations before –

Client 2: – and so have I. But [WA] never has. This is the first time _____.

Leader: This is really new for him.

Client 1: And point blank and period when your issue is that you are burned out on trusting

people

Client 2: They come in and trust people is a fundamental part of group. It's a big thing to

overcome.

Leader: It's a Catch 22. You're here to open up, but you're afraid of talking to people.

This segment was about one member's explanation of why WA was not attending group, but it was really a discussion of the experience of the group setting. It is partly a socialization attempt by those who had been in group before to encourage openness among those who had not been in group before, i.e. "Yeah, but the thing about group is that it's okay to talk about things like that." This segment also functions as an acknowledgement of the struggle those adjusting to the format were experiencing: "It's a Catch 22. You're here to open up, but you're afraid of talking to people." Addressing vulnerability indirectly serves to encourage openness through lower-risk conversation about group experience, facilitating future higher-risk conversations.

The openness category can be best understood as reflecting the therapeutic quadrant on the Hill Interaction Matrix (HIM; Hill, 1971). The HIM Scoring Manual defines Quadrant 4, the therapeutic quadrant, as communication focused on personal exploration, member reactions to others, and challenging inconsistencies in group member's presentation of relevant issues both in and out of group. The openness category is both a coping strategy as clients work towards positive change, and a mechanism through which change happens.

Avoidance. The avoidance category is the opposite of the openness category. It belongs to the conventional and assertive work-style categories on the HIM.

Client 1: Well, at a certain point, it probably becomes an irrational fear. But the thing is If I,

if I open up in here, if I make myself vulnerable by expressing emotions, by sharing

things that happened to me, then, you know, there's the possibility that someone here will say something insensitive or specifically to make fun of me or hurt me.

Leader: Another cool thing about this kind of a group is that we're not based on social polite norms, you know. And so if we get our feelings hurt – right? It would be really important if we can say, "You know, you may not have intended it, but, man, that hurt. Can we process that?" Can we deconstruct that interaction because I'm feeling really shitty, and I know that's not what you – maybe you didn't intend it. If you did intent it, please own it more directly, and tell me what you mean.

Client 2: Like the four times she said, "Shut up," to me.

Client 3: Oh, yeah.

Client 2: Oh, no.

Client 2: She hit me.

Client 4: I like that girl.

Client 3: She hit him.

Client 4: I think she only hit your shoe, actually, ____.

Client 3: I'm really happy to ___ .

Client 4: I don't, I don't mean to minimize it.

Leader: But see, the cool thing about that is that we can say, "Whoa. Did you really mean that?" And if you – that happened in a social group, they'd go, "Oh, what planet are you from?" Or, "Who are you? A psych major?" [Group laughter] You know, that's our purpose here. So I'm, I'm just – good experiences with positive chances and then also being able to revisit it.

Some clients found it inherently difficult to share their experiences. This resulted in attempts to distract, often through laughter, especially at the leader's expense. Although this segment may seem similar to the interchange noted above with regard to bonding, the context is everything. In this instance, the leader is setting up expectations for how the group can potentially interact with each other in order to make progress, and encouraging the efforts of Client 1 to express fears about surviving group interactions. However, Client 2 distracts from the tone of the group by moving from the therapeutic quadrant to the assertive work-style on the HIM. In order to get the group back to work, the leader has to persevere through the change in attitude.

In the bonding segment, the interaction occurred before the group started, which is an appropriate time for a lighter conversational tone and teasing. Bonding can also occur between intensive work periods in the therapeutic quadrant. If, however, the interjection occurs during a work period, then it is considered an aggressive action against self-exposure. The action becomes counter-productive. Acknowledging the barriers to change is as important as describing the categories that contribute to positive outcomes. Confronting those whose comments often fall into this category can encourage them to switch to a less defensive style and yield better outcomes for all group members.

Religious justification/explanation. Clients often used religious information in order to explain their behavior, which was a strategic response in the context of the communication of complex personal ideas. The following section is a small snippet from a larger statement about Client 1's current situation:

Client 1: The problem is the thing like – as I've talked to my mom – my mother about it, and she told me. She's like, you know, it could be that there are things in our marriage

that would really scare you. Or there are things that you're afraid of will happen in your own marriage. And so I put on my Facebook [status] – I was like, I was so angry, you know. I was thinking about it like Biblical stories of, like, marriages that I don't think are ideal. Probably like the Leah and Rachel's situation where Leah – her husband favored Rachel, worked 14 years for her. And Leah bore him, like, ten children. She only bore him two. But he still favored those two kids and, like, completely ignored ___. I mean this, you know, I was angry – just negative thoughts and so I put on my Facebook [status], like, please tell me something good about marriage, 'cause I couldn't think of anything like. I know it's a good thing. I know it's the right thing, and I want to like and ___, but I think I can use assistance.

Client 2: I'm gonna talk about President [Kimball], he said, "Any two people willing to keep the commandments, can make it happen."

Client 1 was using a variety of metaphors to explain her problems in school and in her current relationships, but like many conversations in the group religion eventually played a role in her explanation and in the solution offered to the problem. Religion acted as a common language for group members when trying to convey highly personal and intricate thoughts. Misunderstanding was less likely when religious stories were used, as members grasped their emotional content more easily. Religion was an easy fallback as the dominant mode of speech for the group, probably because some members communicated primarily in religious rhetoric. This was very true for DU, whose career was spent teaching in religious institutions designed to combine secular knowledge with religious explanations. The following is typical of DU's narrative swings between vulnerability and explanation:

DU: I was digging for something else, too, that I might answer to. But I think our only wholeness is in the Savior. If we can be secure there, then we can deal with all the other stuff. We have to find some place... And sometimes it's our family. I was just thinking if you have scars from your family part is that different than your, ah, in your other life – in your romantic part? Does that mean that this is me. I'm damaged. You know, I had problems with the family, and so I'm going to carry that into here. You know, like… you know, a good question to have. Our, our psychologies tell us we are… We don't need [to say] that we're victims and products of – we're a lot more than that, you know, whenever we become… clouds of glory, we're – and that's what we can know. We can know who we really are, with all this other garbage piled on it.

Client 2: Yeah.

Client 3: You know, but we can.

DU: I think, I think – well, again, I'm glad you said that, too. Like, I, we weren't gonna be ___ today. When they were talking, she was waiting, talking about, like, _____ and everything like that. But I've been trying to, over the past couple of days, past this really, like, and past week just praying and rehearse… And being more active in my heart other than being [passive]. And I think you're right, like, I felt a lot of feeling. And I felt like more of a whole person... I guess that's what the atonement's for… I'm glad you said that.

In order to make progress in therapy, DU defined "wholeness" or health in religious terms. He cast psychology as an inferior explanation, "our psychologies tell us we are… we don't need [to say] that we're victims and products", and then explained the potential for good

outcomes in religious terms: "We're a lot more than that [we're] clouds of glory…we can know who we really are." There is a clear imposition of a religious world view in his statements. He is trying to show vulnerability, but he can only express himself in group by using religious terminology:

But I've been trying to, over the past couple of days, past this really, like, and past week just praying and rehearse… And being more active in my heart other than being [passive]. And I think you're right, like, I felt a lot of feeling. And I felt like more of a whole person.

These types of interactions start to build toward the core category in the selective coding process. Each of these major categories was related to subcategories, which were defined during the axial and open coding analysis. The purpose of selective coding is to discover the patterns of relationship among the major categories and their over-arching relationship to the core category. Each major category should relate to the core category through a larger web of relations including paradigm-defined conditions, context, strategies, and consequences.

Selective Coding

After the eight weeks of data collection and the initial analyses, the researcher studied the categories, which resulted from careful analysis of the interview texts, and their relationships. The function of selective coding is to find the implicit relationships existing among the major categories and subcategories of analysis. After many months of analysis, the researcher had a general understanding of how the categories interrelated with each other. In this stage of the project, the investigator had to explicitly articulate the patterns of relationship among the higher-order categories. The researcher thus developed a narrative around those higher-order categories. The major question driving this project was how to better assist in the creation of positive change in group therapy attendees, considering both theory-specific interventions and

the literature on factors contributing to group therapy change. To respond to this issue, the researcher asked questions of the data such as: What were the salient factors in the therapy sessions? What were the major connections between the factors and phenomenon of interest that emerged during analysis of the data? Thinking through these kinds of questions resulted in the following "story" about the current research project. This process attempts to integrate the relationships among the existing categories to reveal the "story" in the data. The following interchange is a chapter of that story:

> Client: Yeah. I mean, I've been in a group before, just a couple years ago, and I was the only LDS member there, and it was back in Illinois. And, um [pause] it was completely different talking about my church experience there versus what it's probably gonna be like here. So –

> Leader: So what was the difference?

> Client: Um [pause] well –

> Leader: Because it's important, and I – I – I was being sort of a smart aleck

> [laughs].

> Client: Yeah, but –

> Leader: The point I was trying to make, I think it has to do with what you're about to say.

> Client: Yeah. Part of it is just that I have to explain a lot of things, and they're a lot of things I'm uncomfortable about, see, because they don't under – they don't really have a firm understanding of what I'm talking about. Um, you know, the – the – the organization of the church, the – you know, how – how – how we pick our leaders, and how we, you know, pick callings and so forth. And, um [pause] you know, just all sorts of things, really. I mean, it's actually amazing how many things come up

when you're in a situation. So I tried to keep it as simple as possible so we could, you know, spend our group time focused on what we needed to talk about.

Leader: Okay.

Client 2: The thing that our religion, like, is so important to us to be able to have a group that has, like, similar understandings, like we were talking about because I think that, like, it affects the way we, like, are psychologically, and the way we are emotionally and mentally, and how we see the – see the world, and, like, how we see ourselves. And I don't know about your guys, but, like, a lot of ways the stuff I'm dealing with actually, like, involves, you know, the stuff I've learned ___ and ___ perspective also, so –

Leader: It's – it's a huge, huge way of seeing the world, of being in the world.

Client 2: I think it also is due to the fact that you know – like, you list – you go to church, and you hear how it's supposed to be, and the – one of the reasons why it's so hard is because it's not that way for you, which is – unfortunately, like, my sister, her husband passed away a few – like a year ago, so now she has to deal with the – the ones who don't understand the gospel, giving her junk about the fact that she's been sealed before what's gonna happen, all those type of things, where in reality it's because of a lack of understanding. They don't – it's actually more they just live the culture versus understanding the gospel that causes the problem. And I've noticed just, like, being here in Utah, it's like there's a very large culture aspect that causes, I think, some of the problems –

Leader: Me, too.

Client 2: And not the gospel. It's the culture.

Leader: Huge.

The story in the data is centered around how religious beliefs, norms, rules and discourse shape the context in which this group's members experience positive change. Because of the predominance of the LDS religion in the community surrounding our clinic and in which our clients operate religion is often a topic of discussion, as many issues are measured against religious standards. In this group, some members' professions involved teaching religious principles to others, which seemed to encourage group members to relate to each other through their own experiences with their religious culture and leaders. These included both negative and positive events, based on which the group members expressed and interpreted their current behavior and situations.

The choice for group members seemed to be either finding ways to internalize their religious beliefs within their personal struggles and feeling better over time, or continuing to apply externally-imposed definitions of doctrine to their problems and remaining stuck in their current situation. Some clients used the safety and acceptance present in the therapy group to take risks, to violate certain religious norms or previously-held conceptions, and change their situations in ways that positively addressed their referral problems. One example was MI, who was "dating" a married woman online, which caused him to take risks in his real-world relationships.

Other clients continued to maintain the religious overlay on their behavior and situation, and did not eliminate the negative effects externalized standards had on their ability to change their current condition. This was reflected in the case of DU, who lost everything important to him because of an extramarital affair. He made himself into a villain and deified the LDS church

and the actions of LDS members. He made very little progress in group, because there was no space to negotiate his conceptions of himself within this dichotomy.

By writing the storyline of the therapy sessions, the researcher can better identify the core category – the central phenomenon around which all other categories can be organized. In this group, conversation continually centered on trying to integrate religious ideals with the members' conceptions of self and relationships. The category "Religious Struggle" was therefore chosen as the main story title. Once the storyline and the core category were delineated, the researcher systematically and analytically related the core category to the major categories that resulted from the analysis. The relationships between the core category and the major categories should fit the narrative storyline. As Strauss and Corbin (1990) explain:

Using such a story as a guideline, the analyst can begin to arrange and rearrange the categories in terms of the paradigm until they seem to fit the story, and to provide an analytic version of the story. Otherwise the categories remain just a list of items. (p. 127).

Outliers

Exceptions to the developing hypotheses inevitably arose, challenging the researcher's initial conceptions of the relationships among the major categories. In qualitative research, it is important to remain open to the existence of disconfirming data, because of their potential to radically alter or enrich the developing theory. Strauss and Corbin (1990) note that the appearance of data that contradict the hypothesis does not necessarily negate the developing grounded theory, instead "the analyst must now trace back and try to determine what conditions are causing this particular variation. Once identified, these can be built into the theory" (p. 140). Several instances of disconfirmation appeared during this study, as one member in particular did not seem to benefit much from religious conversation.

ML's stated purposed in attending therapy was to learn more about himself. However, his dialogue rarely allowed for anyone to provide a new conception of the information he had already learned and processed:

ML: I don't deal well with people hurting my family. It's something I don't go back to, you know. My grandpa always said if a snake bites you once, it's, it's the snake's fault. If it bites you twice, it's your fault. You know? But I was just like, I said to the Bishop, I was like, "Bishop, I don't think I can in good conscience get ready to go to the Temple knowing that I harbor such hatred for somebody in my heart." I said, "I don't know what to do to get over that. I don't know how to push past that. I don't know how to move past it because I don't know." You know, I said, "Part of me just wants to take them out to dinner and just yell every dirty little thing I could think of and make them feel absolutely terrible about themselves. And just like explain, 'Look. This is your bullshit right here. I don't want to deal with this anymore. It belongs to you and I'm tired of burying it. My only way that I know how to get past this is to tell you how horrible I think you are and how much I hate you, and I want nothing more to do with you, and I'm going to let you know so that you can deal with that. And as I get up, I'm going to walk out and I'm going to forget all about it. So that you can deal with that and I don't have to anymore,'" and I couldn't –

Client: Can I add something to that?

ML: Sure.

Client: Have you been to the Temple?

ML: No, I never, I never _____ this is my – that's the other thing, is like I, I was a member of the church – since I was a kid. I mean my grandparents belonged to the church and

_____ the church _____ a lot of deep spiritual roots in our family. But I was born

into the church, you know, went to primary or preschool or primary, and my mom

was a Sunday school teacher. She was the chorister and I'm just like – I was born

into all that, and I, you know, I went and got baptized at 8. I got the priesthood when

I was 13. And I did the sacrament and I, you know, I held my arm behind my back

and I don't know why I did that. It always impressed people. Oh, it's so wonderful

how you hold your hand behind your back _____. I did everything that I was

supposed to 'til I got to be about 14 or 15. And I was like, "I don't get any of this

and I don't want anything to do with it."

ML does engage in the primary theme of the group – religion – but he does not truly

engage the subject. He refers to his past rather than processing the experience, and jumps from

fact to fact without clearly communicating the connections. He did this with most of his

commentary: long speeches that stopped the flow of the group until the leader redirected him or

he eventually circled back to the issue that started his train of thought. Compared to other group

members, he was extremely talkative about his life and the events that led him to seek insight

through the study. However, he was the least able to benefit from the study, because he was not

open to exposing his previous beliefs to the process of therapy. ML's experience exposes the

weakness of a leader focusing solely attention on the top layer of conversation, without paying

attention to how the conversation occurs. ML is an outlier in that he did contribute to religious

struggle as the main theme for this group, but did not experience much positive change.

Nevertheless, following the same set of rules as the other members would have helped him:

challenging static norms; engaging in questioning of those norms; and creating new rules based

on new experiences.

Quantitative Analysis

The quantitative analysis in this study was primarily designed to add to the structure of the developed grounded theory. The data was used to both confirm and if necessary contradict themes found in the qualitative analysis. The GCQ related to the openness category as well as to connection. The OQ was used to investigate the emergent theory that group members were more likely to experience positive change if they participated in the Religious Struggle narrative. The IIP was used in a similar way. Because of this study's small N, the data is discussed instead of using a particular quantitative test used to look for significant differences. This is in keeping with the spirit of the qualitative process – there is more information to be gained by theorizing why clients reported outcomes as they did than by assigning numerical significance.

GCQ. The GCQ was given at weeks 3 and 8, in order to give the group time to gel and then to see how they rated themselves at the end of the group. The GCQ does not have norms to compare data. Mackenzie (1983) suggests assessing the group over multiple time periods, as scores are likely to change. Each of the three scales was averaged over the five participant data points: WA was excluded, as he did not fill out the questionnaire at either time period. The results are given in table 3.

Table 3

GCQ Data

Client	Week 3			Week 8		
	Engaged	Conflict	Avoiding	Engaged	Conflict	Avoiding
DP	22	1	1	23	3	3
ML	24	0	11	28	0	12
MI	23	1	7	21	5	9
DL	16	2	8	24	3	7
DU	17	6	9	16	6	11
Means	20.4	2	7.2	22.4	3.4	8.4

In Table 3, there are no large differences among the members in how they rated the groups' climate at time 1 and 2. At both times engagement was high and conflict very low. This effectively describes the group. The group had high levels of friendliness and support for each other. Lower levels of avoidance would have increased the progress members made in therapy. The scores reported are associated with questions like: the group members depended on the leader for direction and group members appeared to do things the way they thought would be acceptable to the group. If group members had been more confident in challenging each other and directing their own group experience they would have made more positive change. This is especially true for the two group members who qualitative analysis predicted would make the least positive change, DU and ML. They had the highest avoidance scores, which increased over the course of group.

OQ-45. The OQ-45 was given to clients each time they met in order to track symptom levels throughout the study. Half of clients started in the white alert, which indicates below clinical levels of distress. The other half started at moderately high to moderate levels of distress and stayed in the green alert status, which means group was not hurting the client and most clients experienced some symptom reduction during the group. Only one group member reached a secondary status of blue, an alert suggesting recovery and to consider termination for the client. The qualitative analysis predicted two clients would get the least benefit from group therapy, DU & ML. DU's scores ended at the highest score compared to other group members and in the clinical range. ML's score was never in the clinical range.

IIP. The IIP was given at week one and eight in order to see how clients' self-reports of their interpersonal problems changed during the course of the group. Only a few clients reported scores on any scale in the clinical range, with only MI and DU reaching a clinical total score by

week eight. The scale that was at least above average for every group member but ML was Cold/Distant. This included such items as: show affection to people; make a long-term commitment to another person; feel close to other people; and I keep other people at a distance too much. All clients, excluding WA who did not have a week eight score, went up on almost every scale and their total score from week one to week eight. ML's total score stayed the same, but his scale scores increased while staying in the average range. Usually therapy results in a short-term worsening of symptoms, as client are more open and realize the depth of problems, followed by more long-term symptom reduction.   This may be an indication the group needed to run for a longer period of time in order to get full benefits for group members.

     Intrex. The Intrex was primarily used in this study for pre-group interviews. Although clients were given the measure at week 3 and 8, confusion over how to rate other group members as well as misunderstanding of the instructions seemed to negate the value of the Intrex after pre-group interviews for this particular study.   Clients complained about knowing how to rate individuals as some questions did not seem to apply to the group for a few minutes at the session following the first administration; also an initial mix-up with printing made questionnaires and answer sheets not match up correctly. Pronoun usage on the forms also confused members as they may have been ranking opposite sex individuals. The data is available to those interested in further investigation.

Chapter 5: Discussion

The purpose of this study was to gain an in-depth understanding of the process experience of this group and the potential impact of IRT theory-based feedback-receiving on this group's therapy. Sessions were videotaped, transcribed and sorted into categories deemed relevant to the therapy experience. The categories that emerged indicated that for this group, as for many others, client openness, the absence of avoidant behaviors, and well-timed leader interventions were related to positive gains. The importance of religion for meaning creation was specific to this group, to the extent that managing the religious narrative was the main finding of this study. IRT feedback appeared to have the most impact during the feedback session itself, but had little relevance in group.

This study began as an inquiry into the effects of IRT priming on a community interpersonal process group, but the data from this particular group does not address specifically that issue. Instead, this chapter discusses hypotheses for the role IRT-based information may have played, as well as suggestions for strengthening its impact during group therapy. The main finding of this study are related to global ideas for creating positive change in group therapy, and to possible connections to previously proposed group process theories. Therefore, though most papers would conclude by tying the findings back to the introduction, the researcher instead considers how to best use this data, which is relevant to the group therapy experience and literature, to inform future studies in this area.

An assumption of this study was that a deeper understanding of IRT by group members would inform the current group process in addition to subsequent therapy groups. This portion of the study discusses theories of overt resistance to discussing early relational patterns by group members, as well as implications for future research. It is assumed that the ultimate success of

IRT in group therapy relies on group members' willingness to discuss it. Group leaders also bear responsibility for dealing with resistance and using the information in session.

IRT Theory Behaviors

In feedback sessions, group members showed great interest in their results and reported that they found them insightful with regard to their current issues. They were also aware that this information was to be used as a guide for change during their group sessions, and seemed excited about the tool. However, during the group therapy itself group members seemed very resistant and hesitant to engage in this type of conversation. This resistance was discussed in detail during the leader coherence category. This section will examine the potential relationship between overt discussion and covert behaviors.

Group members may have been resistant to talking about their early relational patterns, but that data was still present in the group. The unwillingness to be open about it meant that the information was expressed covertly. It does not appear in the transcripts of a particular segment, but rather is an understanding of the person developed throughout the course of the group. The kinds of comments made, reactions to others, and interpretations of the world illustrated members' early patterns at a very deep level. For example, one client was consistently self-blaming throughout the group, but it was his actions, rather than any spoken words, which revealed those beliefs and patterns. The method used in this study, primarily based on using transcripts informed by videotape, meant a reliance on the spoken word.

Previous research suggested that the act of filling out the SASB Intrex survey activated family internalizations. This may explain the resistance to discussing IRT theory in this study. Attempts to maintain *psychic proximity* to family members and keep old patterns alive are an identified issue within the IRT literature. The therapist's job is to mitigate those desires by

encouraging the Green collaborator to grow. However, in this group the leader made a "telling" error (Benjamin, 2003), wherein a group or individual psychotherapy therapist tells people about patterns rather than the patterns emerging as part of a natural unfolding process during therapy (c.f. Mackenzie, 1990, where he found natural unfolding of process helped members change versus the "telling" error).

The behavior revealed through the pre-group interviews allowed the researcher and leader to know what to look for. However, therapy is most effective when the covert becomes accessible to discussion and therefore to potential change. Some members of this group were able to engage in the five therapy steps, while others with entrenched problems had more difficulty doing so. This group had difficulty with direct conversations about IRT related concepts, but by making information about early patterns known, intervention becomes possible. The next step is to find ways for the group to overcome their natural hesitation in order to make larger gains.

Religious Struggle

For the clients, LDS culture and norms seemed to both create and alleviate the problems they were experiencing. Although the researcher has run many groups with LDS members, including groups that existed primarily because of the culture (e.g. those around pornography), the researcher had not previously encountered a group that discussed religion as overtly as this group. This may have been because of these specific group members – two members were or had been previously employed teaching LDS doctrine on a daily basis.

This is relevant to the process group literature as a connection between variables influencing change. The research team measured the cohesiveness or climate of the group, but perhaps there is something about the group culture that needs to be measured in order to provide

information about how this *particular* group will or will not change. Religious rationalization was the cultural overlay for this group, and depending on the level of personalization ("I" statements), it determined what risks the individuals in the group were willing to take. Although religion is a particularly powerful force, the determining factor could be whatever a particular group identifies around.

For example, the investigator has participated as a leader in groups where stagnation was the rule of relationships. This was strong around relationships that contained power differentials, focusing on opposite-sex rules, probably because many of the group members were divorced. One female member could be classified in layman's terms as a "people-pleaser," and worried about others' perceptions of her, particularly about dating. However, as the group continued to talk about their behavior around the other sex, she was able to challenge the supposed norms and ask males within the group about their opinions of her level of attractiveness and sexual preferences.

The topic around which group identity coalesces sets the type of internalization struggle that will take place. Externalized and imposed rules of religion or social norms need to give way to a negotiated internalized standard, which the individual develops during the group. The ability of each member to do this determines the quality of the positive change the member and eventually the group can achieve. As more members challenge their norms from previous attachment figure, other members are reinforced in their efforts, and so on.

This may also suggest a direction for the implementation of IRT theory in the group space. While the group may become an attachment figure, the leader role is severely diminished, so that change cannot come directly from her as in the individual model. The leader can influence the new attachment figure, but what is the best way to do that? This group rejected

direct statements from the leader about theory. However, when she joined the group dialogue around religion she was both "sucked in" and able to impact the type of conversation and push people toward internalization. The organizing theory proposed by Burlingame et al. (2004) could be organized using the SASB-defined meaning of group attachment to create better outcomes for participants.

Strengths of the Study

A strength of this study is that it takes information that otherwise is withheld or only shared in private contexts and puts it in a public venue. This study takes what a group leader thinks through internally, in order to guide and direct a therapy group toward progress, and comes up with qualitative data-driven support for those interventions. This study's findings are congruent with group therapists', including this researcher's, self-reports of their activities during sessions. Group leaders often do a post-mortem immediately after each session, writing down impressions and themes of the group for the day. They try to pick out where group members made progress and areas where pressure should be placed on members needing more support in the next session. This study identified some of the major factors that were salient to group members' positive growth, including general factors therapists can look for and monitor to improve the outcomes of their clients.

Unlike interview-based qualitative research, this study closely approximates the true experience of a group in therapy. Group therapy, while not new, is still not as well studied as individual therapy. This study can supply suggestions for how to fill in some of the theoretical gaps, as the qualitative method provides a large amount of data that is not available in quantitative studies. The assumption here is that more information about what people are actually thinking and feeling and doing increases applicability. In contrast to data gathered via survey or

outcome measures alone, this format gives participants more voice by allowing them to use their own language. Taped sessions highlight meanings not easily captured in a survey, and incorporate the depth of insight that can come from contextual exploration.

Limitations of the Study

While qualitative research does not presume high generalizability, this researcher took steps to ensure that data was gathered and interpreted in a fair, responsible, and reliable manner. Nevertheless, this investigation was reliant on the subjectivity of one primary investigator and secondary rater, which has inherent limitations. These limitations include the recruiting process as directed by the investigator; the relationship between investigator and participants; and the way the content of the interviews was interpreted. Using the same approach, a different researcher would recruit differently and create different relationships with the group members. Even if the transcript material were similar, other researchers would analyze and interpret data differently and probably identify different or additional meanings. This group experience is also specific to the six people who participated in the study. In this group religious dialogue was so powerful that it became the main narrative. While a main narrative may be likely in other groups, this group may be an outlier because of its specific makeup.

There are perhaps two easily identifiable major flaws in this study. One was that clients were not able to give feedback about the emergent categories and main story; two – that the group only ran for 8 weeks. Clients did not have an opportunity to respond to the researcher's interpretations. Providing a clear way for participants to be involved in research results could be mutually beneficial by funneling participants' creativity to the researchers, and helping participants feel part of the process. Those who were initially reluctant to struggle with issues may have if given a chance to do so over a longer period of time. If the group continued for a

longer period of time, members should also be encouraged to talk more directly about their IRT feedback. This would likely increase the relevance of the feedback information to findings and outcomes. Those interested in developing mid-level group therapy theory might be able to include participants in the process by following up with clients, or by extending the length of a similar study with more emphasis on clients engaging IRT pre-group data.

One last concern is that the phenomenon under investigation may be too broad and the data pool of hours of tape and conversation too large for the expansive question of inquiry. Subsequent research may provide more specific or detailed findings by narrowing their scope, and by attempting to flesh out topics of particular interest with the same or similar data.

Conclusion

Group therapy is a powerful medium for change, but the mechanisms for that change are more complicated than in individual treatment. Referring back to the model built by Burlingame, MacKenzie, & Strauss (2004), areas listed in the model are relevant in individual treatment too, but having multiple players leads to each factor having multiple interpretations that impact the ability to achieve and the manifestation of positive change. This group was just one example of the ways those factors can combine to produce the environment in which change must occur. While there were multiple categories that emerged at the open coding level, the story of the selective coding level emerged as an important one for the therapist to engage. For a group leader this requires simultaneously letting go of control of the narrative and at the same time tightly following and shaping its path, in order to ensure successful outcomes for the group members. Group is not just individual therapy with more than one person. As shown in this study, it is truly a different thing.

Although this group did not engage with IRT theory very well, they did provide support for the creation of the group as an alternative attachment figure. The most important activity a group therapist can do – after building a high level of cohesion or bonding between individual members and the leader – is to identify the storyline that will mediate change in that particular group. In the group previously discussed in this section, sexual and social relationships between the sexes was the primary focus, and change occurred when clients directly took risks (in or out of group) associated with that theme. In other groups, trust may have been the primary issue. Fortunately, these themes seem to be important for humans in general, so they are not difficult for a therapist to find in the group.

Once the story is identified, then theory can give clients a format for reshaping the story. Theory can guide the therapist in how best to approach treatment using the narrative. By knowing the patients' characteristics, the leader can anticipate how one might create meaning in the world of the major theme. If DU had challenged the story in his group more often, he might have scored lower on the OQ by the end of group, as well as had higher cohesiveness ratings and a generally more positive outcome. Pulling major plots from a group discussion is something the researcher has done as a therapist, but so much of the work of pinpointing this major theme occurs after the session, or after the entire group treatment has ended. If this process was accomplished early enough in the group setting, a therapist could better predict who would need extra help to reach positive outcomes, anticipate resistance, and push clients to the behaviors that would most help them change.

Clearly more research needs to be done to see how the "story" may connect to higher-level theories on group change, but emphasizing the "plot" is one way to empower the group therapy format and even increase its effectiveness over individual therapy alone.

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Appendix A

SASB Intrex – Medium Form

INTREX Medium Form A /Introject. Copyright 1995, University of Utah
----
Please use an answer sheet marked "introject" and indicate how well each question describes
YOURSELF.

Rate yourself twice: at your best, and at your worst. First, try to remember a specific time a few
days/weeks/months ago when you were at your best, and while thinking of that time, rate the best
version. Then think of a specific time a few days/weeks/months ago when you were at your worst, and
rate the worst version. Please do not go back in time further than one year.

YOURSELF AT YOUR BEST

   Use the scale that appears at the top of the answer sheet.
----
1.   Without concern or thought, I let myself do and be whatever I feel like.
2.   Without considering what might happen, I hatefully reject and destroy myself.
3.   I tenderly, lovingly cherish myself.
4.   I put energy into providing for, looking after, developing myself.
----
5.   I punish myself by blaming myself and putting myself down.
6.   Aware of my personal shortcomings as well as my good points, I comfortably let myself be "as is".
7.   I am recklessly neglectful of myself, sometimes completely "spacing out".
8.   To make sure I do things right, I tightly control and watch over myself.
----
9.   I let myself do whatever I feel like and don't worry about tomorrow.
10. Without thought about what might happen, I recklessly attack and angrily reject myself.
11. I very tenderly and lovingly appreciate and value myself.
12. I take good care of myself and work hard on making the most of myself.
----
13. I accuse and blame myself for being wrong or inferior.
14. With awareness of weaknesses as well as strengths, I like and accept myself "as is."
15. I carelessly let go of myself, and often get lost in an unrealistic dream world.
16. To become perfect, I force myself to do things correctly.

[Items are presented a second time to rate introject at WORST]

Intrex Medium Form B: He/Present.   Copyright 1995, University of Utah.

Please use an answer sheet marked "interpersonal" and indicate how well each question describes:
YOUR SIGNIFICANT OTHER PERSON AT HIS BEST
Use the scale that appears at the top of the answer sheet.
----
1. He lets me speak freely, and warmly tries to understand me even if we disagree.
 2. He walls himself off from me and doesn't react much.
 3. He puts me down, blames me, punishes me.
 4. Without giving it a second thought, he uncaringly ignores, neglects, abandons me.
----
 5. He learns from me, relies upon me, accepts what I offer.
 6. He happily, gently, very lovingly approaches me, and warmly invites me to be as close as I would like.
 7. With much sulking and fuming, he scurries to do what I want.
 8. He clearly and comfortably expresses his own thoughts and feelings to me.
----
 9. To keep things in good order, he takes charge of everything and makes me follow his rules.
10. He thinks, does, becomes whatever I want.
11. He knows his own mind and "does his own thing" separately from me.
12. Without worrying about the effect on me, he wildly, hatefully, destructively attacks me.
----
13. With much kindness, he teaches, protects, and takes care of me.
14. Without much worry, he leaves me free to do and be whatever I want.
15. He relaxes, freely plays, and enjoys being with me as often as possible.
16. With much fear and hate, he tries to hide from or get away from me.
----
17. He likes me and tries to see my point of view even if we disagree.
18. He closes off from me and mostly stays alone in his own world.
19. He tells me my ways are wrong and I deserve to be punished.
20. Without giving it a thought, he carelessly forgets me, leaves me out of important things.
----
21. He trustingly depends on me, willingly takes in what I offer.
22. With much love and caring, he tenderly approaches if I seem to want it.
23. He bitterly, resentfully gives in, and hurries to do what I want.
24. He peacefully and plainly states his own thoughts and feelings to me.
----
25. To make sure things turn out right, he tells me exactly what to do and how to do it.
26. He defers to me and conforms to my wishes.
27. He has a clear sense of what he thinks, and chooses his own ways separately from me.
28. Without caring what happens to me, he murderously attacks in the worst way possible.
----
29. In a very loving way, he helps, guides, shows me how to do things.
30. Without much concern, he gives me the freedom to do things on my own.
31. He is joyful and comfortable, altogether delighted to be with me.
32. Filled with disgust and fear, he tried to disappear, to break loose from me.

For questions #33 through 64, change from rating him to rating

YOURSELF IN THIS RELATIONSHIP.

----

33. I let him speak freely, and warmly try to understand him even if we disagree.
34. I wall myself off from him and don't react much.
35. I put him down, blame him, punish him.
36. Without giving it a second thought, I uncaringly ignore, neglect, abandon him.

----

37. I learn from him, rely upon him, accept what he offers.
38. I happily, gently, very lovingly approach him, and warmly invite him to be as close as he would like.
39. With much sulking and fuming, I scurry to do what he wants.
40. I clearly and comfortably express my own thoughts and feelings to him.

----

41. To keep things in good order, I take charge of everything and make him follow my rules.
42. I think, do, become whatever he wants.
43. I know my own mind and "do my own thing" separately from him.
44. Without worrying about the effect on him, I wildly, hatefully, destructively attack him.

----

45. With much kindness, I teach, protect, and take care of him.
46. Without much worry, I leave him free to do and be whatever he wants.
47. I relax, freely play, and enjoy being with him as often as possible.
48. With much fear and hate, I try to hide from or get away from him.

----

49. I like him and try to see his point of view even if we disagree.
50. I close off from him and mostly stay alone in my own world.
51. I tell him his ways are wrong and he deserves to be punished.
52. Without giving it a thought, I carelessly forget him, leave him out of important things.

----

53. I trustingly depend on him, willingly take in what he offers.
54. With much love and caring, I tenderly approach if he seems to want it.
55. I bitterly, resentfully give in, and hurry to do what he wants.
56. I peacefully and plainly state my own thoughts and feelings to him.

----

57. To make sure things turn out right, I tell him exactly what to do and how to do it.
58. I defer to him and conform to his wishes.
59. I have a clear sense of what I think, and choose my own separate ways.
60. Without caring what happens to him, I murderously attack him in the worst way possible.

----

61. In a very loving way, I help, guide, show him how to do things.
62. Without much concern, I give him the freedom to do things on his own.
63. I am joyful and comfortable, altogether delighted to be with him.
64. Filled with disgust and fear, I try to disappear, to break loose from him.

Note: Copying of the **Intrex, Medium form** *without written permission from University of Utah is a violation of copyright law.*

Appendix B

Inventory of Interpersonal Problems

IIP-64 Question Sheet

Name: _____

Date: _____ / _____ / _____
　　　　Month　　Day　　Year

Sex: Male ☐　Female ☐

People have reported having the following problems in relating to other people. Please read the list below, and for each item, consider whether it has been a problem for you with respect to **any** significant person in your life. Then fill in the numbered circle that describes how distressing that problem has been.

The following are things you find hard to do with other people.

It is hard for me to:

	Not at all	A little bit	Moderately	Quite a bit	Extremely	
1. Trust other people	⓪	①	②	③	④	1.
2. Say "no" to other people	⓪	①	②	③	④	2.
3. Join in on groups	⓪	①	②	③	④	3.
4. Keep things private from other people	⓪	①	②	③	④	4.
5. Let other people know what I want	⓪	①	②	③	④	5.
6. Tell a person to stop bothering me	⓪	①	②	③	④	6.
7. Introduce myself to new people	⓪	①	②	③	④	7.
8. Confront people with problems that come up	⓪	①	②	③	④	8.
9. Be assertive with another person	⓪	①	②	③	④	9.
10. Let other people know when I am angry	⓪	①	②	③	④	10.
11. Make a long-term commitment to another person	⓪	①	②	③	④	11.
12. Be another person's boss	⓪	①	②	③	④	12.
13. Be aggressive toward other people when the situation calls for it	⓪	①	②	③	④	13.
14. Socialize with other people	⓪	①	②	③	④	14.
15. Show affection to people	⓪	①	②	③	④	15.
16. Get along with people	⓪	①	②	③	④	16.
17. Understand another person's point of view	⓪	①	②	③	④	17.
18. Express my feelings to other people directly	⓪	①	②	③	④	18.
19. Be firm when I need to be	⓪	①	②	③	④	19.
20. Experience a feeling of love for another person	⓪	①	②	③	④	20.
21. Set limits on other people	⓪	①	②	③	④	21.
22. Be supportive of another person's goals in life	⓪	①	②	③	④	22.
23. Feel close to other people	⓪	①	②	③	④	23.
24. Really care about other people's problems	⓪	①	②	③	④	24.
25. Argue with another person	⓪	①	②	③	④	25.
26. Spend time alone	⓪	①	②	③	④	26.
27. Give a gift to another person	⓪	①	②	③	④	27.
28. Let myself feel angry at somebody I like	⓪	①	②	③	④	28.
29. Put somebody else's needs before my own	⓪	①	②	③	④	29.
30. Stay out of other people's business	⓪	①	②	③	④	30.
31. Take instructions from people who have authority over me	⓪	①	②	③	④	31.
32. Feel good about another person's happiness	⓪	①	②	③	④	32.
33. Ask other people to get together socially with me	⓪	①	②	③	④	33.

→

It is hard for me to:	Not at all	A little bit	Moderately	Quite a bit	Extremely	
34. Feel angry at other people	⓪	①	②	③	④	34.
35. Open up and tell my feelings to another person	⓪	①	②	③	④	35.
36. Forgive another person after I've been angry	⓪	①	②	③	④	36.
37. Attend to my own welfare when somebody else is needy	⓪	①	②	③	④	37.
38. Be assertive without worrying about hurting the other person's feelings	⓪	①	②	③	④	38.
39. Be self-confident when I am with other people	⓪	①	②	③	④	39.

The following are things that you do too much.

	Not at all	A little bit	Moderately	Quite a bit	Extremely	
40. I fight with other people too much.	⓪	①	②	③	④	40.
41. I feel too responsible for solving other people's problems.	⓪	①	②	③	④	41.
42. I am too easily persuaded by other people.	⓪	①	②	③	④	42.
43. I open up to people too much.	⓪	①	②	③	④	43.
44. I am too independent.	⓪	①	②	③	④	44.
45. I am too aggressive toward other people.	⓪	①	②	③	④	45.
46. I try to please other people too much.	⓪	①	②	③	④	46.
47. I clown around too much.	⓪	①	②	③	④	47.
48. I want to be noticed too much.	⓪	①	②	③	④	48.
49. I trust other people too much.	⓪	①	②	③	④	49.
50. I try to control other people too much.	⓪	①	②	③	④	50.
51. I put other people's needs before my own too much.	⓪	①	②	③	④	51.
52. I try to change other people too much.	⓪	①	②	③	④	52.
53. I am too gullible.	⓪	①	②	③	④	53.
54. I am overly generous to other people.	⓪	①	②	③	④	54.
55. I am too afraid of other people.	⓪	①	②	③	④	55.
56. I am too suspicious of other people.	⓪	①	②	③	④	56.
57. I manipulate other people too much to get what I want.	⓪	①	②	③	④	57.
58. I tell personal things to other people too much.	⓪	①	②	③	④	58.
59. I argue with other people too much.	⓪	①	②	③	④	59.
60. I keep other people at a distance too much.	⓪	①	②	③	④	60.
61. I let other people take advantage of me too much.	⓪	①	②	③	④	61.
62. I feel embarrassed in front of other people too much.	⓪	①	②	③	④	62.
63. I am affected by another person's misery too much.	⓪	①	②	③	④	63.
64. I want to get revenge against people too much.	⓪	①	②	③	④	64.

→

Appendix C

Outcome Questionnaire (OQ™-45.2)

Instructions: Looking back over the last week, including today,help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Never Rarely Sometimes Frequently Always

1. I get along well with others.
2. I tire quickly.
3. I feel no interest in things.
4. I feel stressed at work/school.
5. I blame myself for things.
6. I feel irritated.
7. I feel unhappy in my marriage/significant relationship.
8. I have thoughts of ending my life.
9. I feel weak.
10. I feel fearful.
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")
12. I find my work/school satisfying.
13. I am a happy person.
14. I work/study too much.
15. I feel worthless.
16. I am concerned about family troubles.
17. I have an unfulfilling sex life.
18. I feel lonely.
19. I have frequent arguments.
20. I feel loved and wanted.
21. I enjoy my spare time.
22. I have difficulty concentrating.
23. I feel hopeless about the future.
24. I like myself.
25. Disturbing thoughts come into my mind that I cannot get rid of.
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")
27. I have an upset stomach.
28. I am not working/studying as well as I used to.
29. My heart pounds too much.

30. I have trouble getting along with friends and close acquaintances.
31. I am satisfied with my life.
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")
33. I feel that something bad is going to happen.
34. I have sore muscles.
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.
36. I feel nervous.
37. I feel my love relationships are full and complete.
38. I feel that I am not doing well at work/school.
39. I have too many disagreements at work/school.
40. I feel something is wrong with my mind.
41. I have trouble falling asleep or staying asleep.
42. I feel blue.
43. I am satisfied with my relationships with others.
44. I feel angry enough at work/school to do something I might regret.
45. I have headaches.

Appendix D

GCQ

Name: Date:

Group:

Read each statement carefully and try to think of the whole group. Using the Rating Scale as a guide, circle the number that best describes the group during today's meeting. Please mark only ONE answer for each statement.

Rating Scale: 0 (not at all) - 6 (extremely)

1.	The members liked and cared about each other.	0 1 2 3 4 5 6
2.	The members tried to understand why they do the things they do, tried to reason it out.	0 1 2 3 4 5 6
3.	The members avoided looking at important issues going on between themselves.	0 1 2 3 4 5 6
4.	The members felt what was happening was important and there was a sense of participation.	0 1 2 3 4 5 6
5.	The members depended on the group leader(s) for direction.	0 1 2 3 4 5 6
6.	There was friction and anger between the members.	0 1 2 3 4 5 6
7.	The members were distant and withdrawn from each other.	0 1 2 3 4 5 6
8.	The members challenged and confronted each other in their efforts to sort things out.	0 1 2 3 4 5 6
9.	The members appeared to do things the way they thought would be acceptable to the group.	0 1 2 3 4 5 6
10.	The members rejected and distrusted each other.	0 1 2 3 4 5 6
11.	The members revealed sensitive personal information or feelings.	0 1 2 3 4 5 6
12.	The members appeared tense and anxious.	0 1 2 3 4 5 6

The GCQ, a 12-item measure (MacKenzie 1981; MacKenzie et al. 1987), contains three subscales:

Engaged: a positive working climate comparable to the working alliance (items 1,2,4,8,11)

Conflict: anger and rejection (items 6,7,10,12)

Avoiding: personal responsibility for group work (items 3,5,9)

Results are best shown as simply the mean item scores for each subscale. It should be noted that these scores will vary over time, so that sequential measures provide the most useful application of this instrument. (Note: Previously published norms are not recommended because they shift considerably depending on the nature of the group population.)

Appendix E

Consent Form

Experience of a Client in Group Therapy

Consent for Participation in Research

Introduction

      This research study is being conducted by Rebecca Canate, and Sally H. Barlow, PhD, at Brigham Young University to better understand a client's experience in group therapy. You were selected to participate because you were interested in attending a group at the BYU Comprehensive Clinic.

Procedures

      You will be asked to participate in a pre-group interview, 8 group therapy sessions, and complete several questionnaires during those 8 sessions at the BYU Comprehensive Clinic. This will consist of a significant time commitment of 24 hours of therapy. There will be a weekly questionnaire that consists of 45 questions, which will take approximately 10 minutes. Questions will ask about how you felt about your life in the previous week. There will also be questionnaires that will ask about your previous relationships, any interpersonal difficulties you may have experienced and how you feel about your therapy group. These will be given on a one or two-time basis, which will take up to an hour of your time before or after group therapy. The therapy group will last for approximately 90 minutes for 8 sessions. It will be tape-recorded and then transcribed.

Risks/Discomforts

      You may feel emotional discomfort when answering questions about personal history and beliefs. When participating in the therapy group, it is possible that you may feel embarrassed when talking in front of others. The leader will be sensitive to those

who may become uncomfortable, but will also focus efforts on positive outcomes for all group participants.

Benefits

You will be receiving quality therapeutic intervention by a professional, expert therapist, Sally H. Barlow, PhD, at no cost. You will potentially experience symptom relief from your presenting concerns as well as potential personal insight that might be beneficial to you in preventing future relapses. However, it is hoped that through your participation researchers will learn more about the process of group therapy and ways to improve the experience, which will have potential benefits for society.

Confidentiality

All information provided will remain confidential and will only be reported as group data with no identifying information. All data, including questionnaires and tapes/transcriptions from the focus group, will be kept in a locked storage cabinet and only those directly involved with the research will have access to them. After the research is completed, the questionnaires and tapes will be destroyed.

Compensation

You will be receiving group therapy at no-cost, as we will waive the BYU Comprehensive Clinic's one-time $15 group fee.

Participation

Participation in this research study is voluntary. You have the right to withdraw at anytime or refuse to participate entirely without jeopardy, and we will provide recommendations for other avenues of treatment.

Questions about the Research

If you have questions regarding this study, you may contact Rebecca Canate, at 422-7759, rcanate@gmail.com, who is a doctoral student in clinical psychology at Brigham Young University or Sally H. Barlow, PhD, at 422-4050, shb@byu.edu.

Questions about your Rights as Research Participants

If you have questions regarding your rights as a research participant, you may contact Institutional Review Board, A-285 ASB, Provo, UT 84602, 801-422-1461, irb@byu.edu.

I have read, understood, and received a copy of the above consent and desire of my own free will to participate in this study.

Signature: Date: