

A Qualitative Analysis of the Group Therapy Process  
as Perceived by Adolescent Clients

by

Paul Rezutek

A thesis submitted to the Faculty of Graduate Studies in Partial Fulfillment of the  
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**A QUALITATIVE ANALYSIS OF THE GROUP THERAPY PROCESS  
AS PERCEIVED BY ADOLESCENT CLIENTS**

**BY**

**PAUL REZUTEK**

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University  
of Manitoba in partial fulfillment of the requirements of the degree**

**of**

**Master of Arts**

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Abstract

The present study was the first to qualitatively examine the factors most important to the group therapy process as perceived by adolescent group members. Seven female clients (aged 14 – 17 years) were interviewed using a semi-structured interview. Data were analysed with the qualitative methodology recommended by Miles and Huberman (1994), and Strauss and Corbin (1998). Ten major factors emerged as helpful, with the three most important being: 1) Taking a Vacation From Your Problems, 2) Client Talking, and 3) Imparting of Information. Five major factors emerged as detrimental/disliked, with the three most important being: 1) Lack of Group Cohesion, 2) Negative Group Leader Techniques, and 3) Lack of Structure. Results of the present study suggest potentially significant differences between adults' and adolescents' perceptions of the group therapy experience.

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## A Qualitative Analysis of the Group Therapy Process as Perceived by Adolescent Clients

“Adolescence and the concept of group life are inextricably woven together”

(Aronson & Scheidlinger, 1996, p. 176). Research has repeatedly shown that peer groupings play a significant role in the adolescent's development of self-esteem, interpersonal learning, the formation of a moral code, and the physical and psychological departure from the family (Aronson & Scheidlinger, 1996). Given the importance of peer groupings to adolescents, and given that adolescents are struggling with the development of more mature relationships with peers (e.g., increased closeness and trust), many therapists have favoured group treatment when working with adolescent clients. Furthermore, studies have demonstrated support for the use of group treatment with adolescents. Findings suggest that group therapy is effective in the treatment of various issues, such as relationships with parents (Dinkmeyer, Dinkmeyer, & Sperry, 1987), major life changes (Deck & Saddler, 1983), school drop out (Blum & Jones, 1993), and self-esteem issues (Omizo & Omizo, 1988). While there is considerable research suggesting the effectiveness of group therapy with adolescents, research focusing on the elements responsible for its effectiveness (frequently called *therapeutic factors*) has been sparse.

Several researchers have explored clients' perceptions of the therapeutic factors (e.g., Berzon, Pious, & Farson, 1963; Bloch, Reibstein, Crouch, Holroyd, & Themen, 1979). However, it is the work of Yalom (1995) that has most intensively examined the group therapy process as perceived by the client (focusing on adult groups). Through a combination of his research and clinical work, Yalom developed the therapeutic factor *Q-sort* in an attempt to measure group members' perceptions of the group therapy process.

The Q-sort is comprised of 60 items representing twelve factors. More recently, however, Yalom has reduced his list of therapeutic factors to eleven, and they include the following: 1) instillation of hope, 2) universality, 3) imparting of information, 4) altruism, 5) the corrective recapitulation of the primary family group, 6) development of socialising techniques, 7) imitative behavior, 8) interpersonal learning, 9) group cohesiveness, 10) catharsis, and 11) existential factors (Yalom, 1995).

For the most part, these factors have been examined primarily with adult clients (e.g., Berzon et al., 1963; Bloch & Reibstein, 1980; Kellermann, 1985, 1987; Marcovitz & Smith, 1983; Maxmen, 1973). Unfortunately, research examining the perception of the therapeutic factors in adolescent groups has been limited and has produced mixed results (see Chase & Kelly, 1993; Corder, Whiteside, & Haizlip, 1981; Ozbay & Goka, 1993; Shechtman & Bar-El, 1997). Moreover, three of the four existing adolescent studies have used structured surveys (requiring forced choice rankings by participants), with all four studies strictly adhering to Yalom's (1995) *adult* derived therapeutic factors as the basis for their data interpretation. Thus, all previous research examining adolescents' perceptions of therapeutic factors in group therapy have assumed that Yalom's therapeutic factors describing the group therapy process with adults are applicable to adolescent groups as well.

In an effort to evaluate this assumption, the present study was the first to qualitatively examine the therapeutic process as perceived by the adolescent client. Adolescents responded freely to open-ended questions, allowing participants to describe, in their own words, what factors were helpful and detrimental/disliked during their group therapy experience. Thus, therapeutic factors were not strictly limited to any particular

existing schemata. Therefore, the main purpose of the present study was to examine the group therapy process as perceived by adolescent clients. That is, from the adolescent client's perspective, what factors are helpful and what factors are detrimental or disliked during group therapy?

However, in order to provide a clear context for the present study, a discussion about adolescent group therapy, a brief review of the development of the therapeutic factors, and a review of the adolescent group therapy literature are first warranted.

### *What is Adolescent Group Therapy?*

In general, adolescence refers to the transitional period of development between childhood and early adulthood (Santrock, 2001). Adolescence is typically a difficult period of adjustment for most young people. It is during this period that many adolescents struggle to cope with the vast pressures, both internal and environmental, placed on them (Gladding, 1999). Some of these forces may include intense peer pressures, identity formation, physical changes, imminent career choices, battles for independence and autonomy, self doubt, loneliness, opposite sex peer relations, and an extraordinary need for peer approval (Berg, Landreth, & Fall, 1998; Corey & Corey, 1997; Gladding, 1999). While it has been suggested that these demands affect both genders, it appears girls are especially susceptible, particularly girls older than 14 (Gladding, 1999).

Research has demonstrated that group therapy can be quite useful to assist young people through the turbulence of adolescence. It has been argued that group therapy serves as the perfect place to deal with the many developmental tasks of adolescence. For example, as adolescents attempt to separate from their parents, peer relationships fill

the void. Identity formation is facilitated as adolescents interact with others, fostering their own new ideas and interests; and intimate relationships outside the family are developed and explored (Aronson & Scheidlinger, 1996). Furthermore, groups encourage new learning, offer support, help alleviate personal and environmental tensions, give hope, and model alternatives for group members (Gladding, 1999). This is typically accomplished through the encouragement of open questioning of values and the practice of communication skills with adults and peers. Thus, within the group, adolescents "... can safely experiment with reality, test their limits, express themselves, and be heard" (Gladding, 1999, p. 266).

Given adolescents' strong need for peer acceptance and affiliation, group therapy is especially suitable for them. Group therapy offers a supportive environment to share developmental fears and anxieties, giving adolescents a place where they belong, yet still allowing room for their growing autonomy (Berg et al., 1998; Martin, 2003). Put simply, "A group can provide the opportunity to share common problems and to find ways of making responsible choices" (Corey and Corey, 1997, p. 326). Moreover, groups provide a familiar and comforting environment in which to learn, given that adolescents spend a great deal of their everyday lives in groups (Gladding, 1999). These everyday groups often include a social group at school, the family group, a work group, and perhaps extracurricular groups (e.g., sports teams). Thus, "... the propensity of adolescents to form group relationships can be channelled successfully in a practical intervention measure to promote change and growth – group therapy" (Aronson & Scheidlinger, 1996, p. 176).

### *Types of Group Therapy with Adolescents*

Group therapy with adolescents can include numerous approaches, each varying in its goals, role of the group leader, level of structure, and methods employed (Smith, 1995). As a result, adolescent groups may include "... whole day outings, trips to the gym, and shared projects in addition to what we might think of as more traditional group therapy" (Martin, 2003, p. 86). Despite this tremendous variability, a typical adolescent group usually involves one therapist meeting with six to ten clients, once a week, for an hour and a half session (Martin, 2003). The following sections will discuss the most common group formats used with adolescent clients.

#### *Psychoeducational Groups*

Psychoeducational groups usually focus on imparting information, through the use of films, written material, and lectures. This dissemination of information is then typically followed by a group discussion of the ideas presented and their pertinence to the clients' individual situations (Martin, 2003; Smith, 1995). Psychoeducational groups tend to be structured sessions that revolve around a particular topic such as assertiveness training, anger management, or stress management (Martin, 2003; Smith, 1995). In most instances, the topic covered by the group is of shared concern to group members, and an invaluable outcome of the psychoeducational group is the help and support that group members provide one another (Martin, 2003).

#### *Theme-Oriented Therapy Groups*

Theme oriented groups, like psychoeducational groups, focus on resolving a shared common pathology, personal difficulty, or life crisis among group members (Martin, 2003; Smith, 1995). However, these groups are not as structured and possess

less of a didactic component than psychoeducational groups. Instead, these groups typically involve "... personal ventilation and support around shared experiences, comparing and contrasting one member's situation with another" (Smith, 1995, p. 332). It is through this process that group members work through their issues of concern. Some examples of theme-oriented groups include groups for survivors of suicide, victims of abuse, and clients with eating disorders (Smith, 1995).

### *Interactive Group Psychotherapy*

Interactive group psychotherapy (sometimes referred to as personal exploration group therapy) typically involves a long-term, open-ended format in which adolescents discuss and explore a variety of different issues (Martin, 2003; Smith, 1995). According to Martin (2003):

One of the most interesting and powerful aspects of personal exploration groups is that the process of mutual exploration, honest feedback from peers, and the formation of relationships within the group often become more important and more healing than dealing with any specific issue (p. 100).

### *Expressive/Creative Groups*

Expressive/creative groups make use of such media forms as film, poetry writing, drama, and art. It is through these metaphorical and symbolic methods that adolescents find a voice to express themselves (Martin, 2003; Smith, 1995). Expressive/creative groups are especially useful with adolescents who are unable to reason abstractly, or those who find it difficult to express their feelings and emotions verbally. Adolescents often find it easier to express their feelings in more indirect ways, such as acting out a brief story in which they "pretend" to be a particular character (Smith, 1995). An

important feature of the expressive/creative group is that forms of expression are created in a non-judgemental environment. Group members are simply encouraged to present their message with their art, regardless of their skill or talent (Martin, 2003).

#### *Task/Activity Groups*

Task groups are created and organized around a certain task or activity. Some examples include fitness groups, cooking groups, or environmental groups (Martin, 2003). On the surface, these groups often do not appear to be therapy, as most of the group's activity involves arranging and completing its task (Smith, 1995). However, the group provides other important functions, such as the "... opportunity to form a relationship with the clinician, mutual listening, social development, problem solving, and relating to other adolescents" (Martin, 2003, p. 99).

#### *Efficacy of Adolescent Group Therapy*

Historically, the study of adolescent group therapy has not received the same attention as adult group therapy (Azima, 1996). While the reasons for this inequality remain uncertain, it is well documented that research with adolescents is often inherently difficult. For example, adolescent researchers frequently must deal with issues of participant motivation, compliance, ethics, family interference, increased confidentiality concerns, and developmental factors (Azima, 1996). Notwithstanding this relative paucity of research, existing studies have found group therapy to be an effective tool in dealing with various adolescent issues. As a result, adolescent groups have been highly recommended in the research literature. For example, groups have been found useful in promoting child-parent relationships (Dinkmeyer et al., 1987), easing racial tension between adolescents (Dragoon & Klein, 1979), helping adolescents with major life



changes, such as changing schools (Deck & Saddler, 1983), treating eating disorders (Azima, 1996), helping adolescents with career decisions (Barkhaus, Adair, Hoover, & Bolyard, 1985), keeping adolescents in school (Blum & Jones, 1993), dealing with substance abuse and criminal behaviour (Dryfoos, 1990, 1993), developing self-control and self-esteem (Omizo & Omizo, 1988), and assisting adolescents through parental divorce (Coffman & Roark, 1988; see review by Gladding, 1999).

#### *Advantages of Group Therapy With Adolescents*

There are numerous advantages to using group therapy with adolescent clients (see review by Gladding, 1999). First, given that adolescents spend a large portion of their everyday lives in groups, group therapy often feels familiar and comfortable. Thus, for the adolescent, groups may serve as a rather natural environment for growth and learning to take place. Second, group therapy allows for life skills to be taught through the use of role-playing, modelling, group discussions, and the imparting of information. Third, groups can create a sense of belonging that is often absent in the adolescent's life, something the therapeutic relationship with an individual therapist cannot achieve. Fourth, unlike individual therapy, groups offer feedback from multiple sources. Within the group format, adolescents have the advantage of receiving feedback from other group members as well as the group leader (see Shechtman & Bar-El, 1997). As Gladding puts it, "Many times, the power of the peer group can be used constructively to promote needed change" (p. 283). Finally, groups provide an opportunity for adolescents to help and support their fellow group members. This process often provides a powerful sense of self-esteem and confidence within the adolescent client.

*Disadvantages of Group Therapy With Adolescents*

While there are advantages to using group therapy with adolescents, there are also some key disadvantages (see review by Gladding, 1999). First, it appears that "... some therapeutic processes are more likely to occur in individual therapy" (Martin, 2003, p. 88). Although acceptance from a group of people can be very therapeutic, this is less likely within a group setting than during individual therapy. Furthermore, it is often difficult to establish trust within a group. Consequently, group members often resist sharing information that they would otherwise have revealed during individual sessions (Martin, 2003). Second, due to the remarkably powerful effect of peer pressure, there is always the danger that an adolescent group member may conform to new behaviours that they do not usually endorse, simply to fit in with the group. Third, within the group format, individual group members may not be given adequate individual attention. Some adolescents (e.g., those that are suicidal) need a great deal of individual attention, something a group setting may not be able to provide. Finally, poor group communication may develop when groups are not carefully screened. For example, it is not uncommon for adolescents to scapegoat or blame others for their problems. Moreover, adolescents may "... disrupt, criticize, and/or ignore others because they are so engrossed in themselves" (Gladding, 1999, p. 283). Obviously, this type of negative therapy environment makes the occurrence of behavioural or emotional change unlikely (or at best, difficult).

*What Are Therapeutic Factors?*

"Therapeutic change is an enormously complex process that occurs through an intricate interplay of human experiences" (Yalom, 1995, p. 1). In an effort to explain this

inherently complex experience, researchers have attempted to break down the group therapeutic process into its basic elements termed the therapeutic factors. Over the years, the therapeutic factors (sometimes called the “curative factors”) have been defined in various ways by numerous researchers. However, essentially all definitions agree that they are “agents of change,” “curative elements,” or mechanisms within group therapy that promote growth and contribute to the improvement of the group therapy member (Kellermann, 1987).

Most researchers also agree that dividing the therapy experience into distinct therapeutic factors is, to an extent, an arbitrary process (Bloch & Aveline, 1996; Yalom, 1995). As Yalom (1995) puts it, “The distinctions among [the therapeutic] factors are arbitrary ... they are interdependent and neither occur nor function separately. Moreover, these factors may represent different parts of the change process” (p. 2). Some therapeutic factors refer to something the client learns (e.g., universality); some refer to changes in behaviour (e.g., development of socializing techniques); and others may actually represent preconditions for change (e.g., group cohesiveness; see Yalom, 1995).

### *The Development of the Therapeutic Factors*

#### *Corsini and Rosenberg's Taxonomy*

While the therapeutic factors in group therapy, are most often identified with Yalom (1995), they were actually first systematically conceptualised by Corsini and Rosenberg (1955) almost fifty years ago. Prior to 1955, the group therapy literature discussing therapeutic mechanisms was comprised of reports mainly from psychoanalytic clinicians focusing on their experiences with their own groups (e.g., Borrow, 1927; Wender, 1936; see review by Crouch et al., 1994). However, in seeking an answer to

their own question – “What within the group therapeutic situation is of the essence?” – Corsini and Rosenberg were the first to generate an integrative classification of the therapeutic mechanisms inherent to the group therapy process (Bloch & Crouch, 1985).

To generate this classification system, Corsini and Rosenberg (1955) carried out a form of “factor analysis” that was comprised of four steps. First, they searched the research literature for references to therapeutic elements (67 articles were found). Second, statements referring to therapeutic elements within these articles were taken (220 statements were isolated). Third, any identical statements were combined (reducing the number of statements to 166). Finally, the 166 statements were categorised, resulting in nine factors (plus a miscellaneous category; see Bloch & Crouch, 1985, p. 10). The nine factors identified by Corsini and Rosenberg were the following: 1) acceptance (a feeling of comfort and belongingness within the group), 2) altruism (clients’ increased self worth through their desire to help others), 3) universalization (the realisation that one is not unique in his or her problems), 4) intellectualization (the process of learning, or acquiring wisdom in the group), 5) reality testing (the clients’ evaluation of personal issues through group interactions), 6) transference (the development of strong emotional attachments to the therapist, individual group members, or to the group itself), 7) interaction (beneficial results through communication within the group), 8) spectator therapy (the clients’ benefit from listening to and observing themselves and other group members), and 9) ventilation (the sharing of feelings and ideas usually repressed in other non-therapeutic situations). Finally, a miscellaneous category was developed, consisting of items such as sublimation, rivalry, spontaneity, and sharing difficulties.

Corsini and Rosenberg’s (1955) ten factors reflect a strong psychoanalytic

approach. This is partly a result of the psychoanalytic school's dominance in the group therapy literature at the time, as well as Corsini and Rosenberg's own theoretical values. In fact, Corsini and Rosenberg were keenly aware of this bias stating that, "Whether others operating on other premises or even using the same procedures would have come to the same conclusions is open to question and to further research" (p. 409). Despite this, Corsini and Rosenberg are acknowledged as pioneers in the field, with their work "...marking a critical step as the first attempt in almost half a century of group therapy to produce a unifying classification of the therapeutic elements at the core of the group process" (Bloch & Crouch, 1985, p. 10).

*Berzon, Pious, and Farson's Therapeutic Factors*

Berzon et al. (1963) continued to work on the classification of the therapeutic factors, with a slight modification to Corsini and Rosenberg's (1955) procedures. Instead of asking therapists, Berzon and colleagues asked group members to select the event they regarded as the most helpful to them during group therapy. As with Corsini and Rosenberg, Berzon and colleagues' classification was primarily psychoanalytic in nature. Group members' responses led to the identification of three general classes of responses: cognitive, affective, and behavioural. Within these overall classes, nine categories emerged: four cognitive, three affective, and two behavioural.

The four cognitive categories included the following: 1) recognising similarity to others (a sense of not being alone – similar to Corsini and Rosenberg's; universalization), 2) increased awareness of own emotional dynamics (the acquisition of knowledge about oneself, such as strengths, weaknesses, and patterns of interaction with others – similar to Corsini and Rosenberg's intellectualization), 3) witnessing honesty, courage, openness,

or expression of emotionality in others (observing another group member experiencing something meaningful – similar to Corsini and Rosenberg’s spectator therapy); and 4) seeing the self as seen by others (occurs primarily through group feedback – similar to Corsini and Rosenberg’s interaction; Berzon et al., 1963).

The three affective categories included the following: 1) feeling responded to by others (feeling accepted, understood, and cared for by the group – similar to Corsini and Rosenberg’s; acceptance), 2) feeling positive regard, acceptance, or sympathy for others (similar to Corsini and Rosenberg’s altruism), and 3) feeling warmth and closeness generally in the group (sense of belongingness in the group – similar to Corsini and Rosenberg’s acceptance).

Finally, the two behavioural categories included: 1) ventilating emotions (a sense of catharsis as a result of expressing one’s feelings – similar to Corsini and Rosenberg’s ventilation), and 2) expressing the self congruently, articulately, or assertively in the group (“speaking up” within the group – similar to Corsini and Rosenberg’s interaction; Berzon et al., 1963).

#### *Yalom’s Therapeutic Factors*

Previous attempts at the classification of the therapeutic factors in group therapy eventually led to the publication of Yalom’s (1970) ground breaking text *The Theory and Practice of Group Psychotherapy*. This handbook was the first to dedicate any significant coverage to the concept of the therapeutic factors in group therapy. Making use of theoretical conceptions, clinical observations, and empirical research, Yalom attempted to extend the work of Corsini and Rosenberg (1955; see Bloch & Crouch, 1985).

Yalom's (1970) initial effort at classification gave rise to ten therapeutic factors (at the time referred to as "curative factors"). These factors greatly reflected Yalom's neo-Freudian theoretical approach, which was particularly evident in the importance he placed on interpersonal relations. Influenced by the work of Harry Stack Sullivan and his contention that "... the personality is to a considerable extent the product of a person's relationships with significant other people" (Bloch & Crouch, 1985, p. 14), Yalom incorporated several factors reflecting this theory. These factors are: 1) instillation of hope, 2) universality, 3) imparting of information, 4) altruism, 5) the corrective recapitulation of the primary family group, 6) development of socializing techniques, 7) imitative behavior, 8) interpersonal learning, 9) group cohesiveness, and 10) catharsis.

In 1975, Yalom published *The Theory and Practice of Group Psychotherapy* (2<sup>nd</sup> ed.). In this new text, an eleventh factor (existential factors) was added to the original ten factors as "...almost an afterthought" (Yalom, 1975, p. 84). The following paragraphs will define and briefly discuss Yalom's revised therapeutic factors – which have remained unchanged since 1975.

*Instillation of Hope.* According to Yalom (1995), research has shown that the instillation of hope is of importance to the effectiveness of any psychotherapy form, for two main reasons. First, hope must be present if the client is to stay in therapy and allow the other therapeutic factors to bring about change. Second, belief in the effectiveness of a treatment can itself be therapeutic (Yalom, 1995). In the case of group therapy, it is often the group leader who first conveys faith in the efficacy and value of the group experience. This is eventually modelled by group members, aiding them in overcoming their anxieties and fears of the group therapy process (Smith, 1995).

*Universality.* Universality refers to the discovery by clients that they are not alone in their experiencing. A “we’re all in the same boat” experience is frequently of great relief and comfort to clients who have previously felt unique in their suffering (Smith, 1995).

*Imparting of Information.* Imparting of information refers to the use of didactic instruction by the group leader (about such issues as the nature of psychological disorders, coping techniques, and the dynamics of emotional adjustment) and the imparting of direct advice from either the group leader or fellow group members (Martin, 2003, Yalom, 1995). While the imparting of information occurs to some extent in all forms of group therapy, this factor is of particular importance in psychoeducational groups (Smith, 1995). Many self help groups make use of didactic instruction. Some of these groups include: Adult Survivors of Incest, Parents Anonymous, and Parents Without Partners (Smith, 1995). These groups encourage the sharing of information between group members and embrace the opportunity to learn from invited experts who often present to the group (Yalom, 1995).

*Altruism.* Clients often feel that they have nothing to offer when they first begin therapy. However, as they progress through the group therapy experience, they recognise that other group members value their thoughts, support, and concern. This realisation is often very therapeutic for the client (Smith, 1995).

*The Corrective Recapitulation of the Primary Family Group.* According to Yalom (1995), the therapy group parallels a family in many ways. It contains parental/authority figures, peer siblings, emotions, intimacy, hostility, and competition. Given this marked resemblance to the family group, a “second chance” for a positive



family experience may be found through the group therapy process (Smith, 1995). Group members often begin to interact with fellow members and leaders in ways reflective of how they once related with their own family of origin. Therefore, group therapy allows early family conflicts to be relived and subsequently corrected. Through this process, clients may learn to deal effectively with issues such as jealousy, rivalry, and intimacy (Smith, 1995).

*Development of Socializing Techniques.* While this factor operates in every therapy group, the explicitness of the process can vary greatly between group types. Most adolescent groups, for example, place explicit emphasis on social learning, using role-playing as a therapeutic tool. However, social learning may occur more implicitly in other group modes, as the group provides the client the option to meet and talk with various people. It is for this reason that clients are frequently encouraged to take part in group therapy if their presenting problems involve a lack of social skills (Martin, 2003).

*Imitative Behavior.* By the time therapy is complete, clients will often model many behaviours they have seen displayed by the group leader. For example, it has been shown that group leaders frequently model various communication techniques such as support, self-disclosure, and empathy to their clients (Martin, 2003; Yalom, 1995). However, within the group therapy process, clients' imitative behaviour is not limited to that of the group leader's behaviour but includes the behaviour of the other group members as well (Yalom, 1995).

*Interpersonal Learning.* Interpersonal learning refers to the client learning how their behaviours affect those around them and discovering regular patterns and themes within their own relationships (Smith, 1995). According to Yalom (1995), it is through

the group's evolution into a social microcosm (a miniaturized version of each client's social existence outside therapy) that group therapy assists clients' development of distortion-free relationships with others. Group feedback and self-observation help clients become cognisant of their interpersonal behaviour. Group members come to realise their strengths, their weaknesses, and often their own problem behaviours that lead to unwanted reactions from others (Yalom, 1995).

*Group Cohesiveness.* Group cohesiveness refers to "... a sense of belonging, togetherness, warmth, and mutual acceptance" (Smith, 1995, p. 329). The members of a cohesive group are supportive, empathic and typically develop meaningful relationships amongst themselves. Understanding and acceptance from fellow group members often encourages clients to reveal and explore themselves within the group therapy process. In fact, simply being accepted as part of a group is often therapeutic, particularly in the case of adolescent clients (Martin, 2003). Furthermore, a cohesive group may greatly increase the self-esteem of its group members and ultimately increase the stability of the group. Cohesive groups tend to show less turnover and better attendance. According to Yalom (1995), "... cohesiveness favors self-disclosure, risk taking, and the constructive expression of conflict in the group – phenomena that facilitate successful therapy" (p. 68).

*Catharsis.* Catharsis refers to the client's sense of release after strong emotional feelings are shared and experienced (Smith, 1995). These feelings may include sorrow, affection, anger, or grief that have been painful or even impossible to talk about in the past (Bloch & Crouch, 1985).

*Existential Factors.* Existential factors refer to group members' acceptance that

life is sometimes unjust, that it is impossible to avoid all pain in life, and that one's death is inevitable (Smith, 1995). In addition, group members recognise that, in spite of how much support they receive from other people, in the end they must face life alone and take final responsibility for their lives and decisions (Yalom, 1995).

*Bloch, Reibstein, Crouch, Holroyd, and Themen's Therapeutic Factors*

While the work of Yalom (1975) unquestionably advanced the systematic categorisation of the therapeutic factors in group therapy, there were still those who felt further improvements could be made (see Bloch et al., 1979). The most important difference between Bloch and colleagues' classification and previous categorizations, was the purposely atheoretical approach taken. Potential factors were only considered if they were "... not bound up exclusively with a particular theory" (Bloch & Crouch, 1985, p. 15).

As Berzon et al. (1963) had done years earlier, Bloch et al. (1979) asked group members to select the event they felt had contributed the most to them personally during group therapy. From this research, as well as an examination of the available literature (e.g., Berzon et al., 1963; Corsini & Rosenberg, 1955; Yalom, 1975), Bloch and colleagues developed their own ten therapeutic factors. These factors include the following: 1) universality (same as Yalom's), 2) acceptance (similar to Yalom's group cohesiveness), 3) altruism (same as Yalom's), 4) guidance (similar to Yalom's imparting of information), 5) vicarious learning (similar to Corsini and Rosenberg's, spectator therapy and Yalom's imitative behaviour), 6) instillation of hope (same as Yalom's), 7) catharsis (same as Yalom's), 8) self-understanding (similar to Yalom's interpersonal learning), 9) self-disclosure (the clients' movement toward being more open

and honest), and 10) learning from interpersonal actions (relating adaptively within the group).

The work of Bloch and colleagues (1979) provided another important perspective and the first attempt at a strictly atheoretical approach to the categorisation of the therapeutic factors. However, Yalom's (1995) factors have remained dominant in the field of group therapy research.

#### *Methods of Studying the Therapeutic Factors in Group Therapy*

In general, there have been two principal ways of studying group therapy clients' perception of therapeutic factors thus far, the direct approach and the indirect approach (see Crouch et al., 1994).

##### *The Direct Approach*

When the direct approach is used, clients are asked to rank order the helpfulness of various statements. The measure most often used in this process is called the therapeutic factor Q-sort developed by Yalom in 1970. This measure was not originally intended to be used as a standardized research tool, rather it "... was meant to be an exploratory instrument constructed a priori on the basis of clinical intuition" (Yalom, 1995, p. 72). However, since its development, the original Q-sort and its subsequent questionnaire versions, have been used considerably in group therapy research.

Yalom's (1970) Q-sort is comprised of 60 items, five items describing each of 12 therapeutic factors. When developing the Q-sort, Yalom altered his original ten therapeutic factors slightly, maintaining, "... it was convenient methodologically to have the same number of items representing each category" (p. 66). As part of construction, several versions of the 60 items were distributed to various respected group therapists for

their ideas, critiques, and suggestions (see Yalom, 1995).

Yalom's (1970) Q-sort is comprised of the following categories (see Appendix A): 1) altruism, 2) group cohesiveness, 3) universality, 4) interpersonal learning - input, 5) interpersonal learning - output, 6) guidance, 7) catharsis, 8) identification, 9) family re-enactment, 10) insight, 11) instillation of hope, and 12) existential factors. Each of the 60 items is printed on a 3" x 5" card. The resulting 60 cards are given randomly to the participant who is then instructed to read the statements and place a certain number of cards into seven piles categorised as follows: 1) most helpful to me in the group (2 cards), 2) extremely helpful (6 cards), 3) very helpful (12 cards), 4) helpful (20 cards), 5) barely helpful (12 cards), 6) less helpful (6 cards), 7) least helpful to me in the group (2 cards). "The resultant Q-sort, which resembles a normal distribution curve, allows for the analysis of the respondent's rank-ordering" (Bloch & Crouch, 1985, p. 222).

Many researchers in subsequent years have used abbreviated questionnaire versions of Yalom's (1970) Q-sort, mainly to reduce the lengthy administration and scoring time associated with the original 60 item procedure (e.g., Chase & Kelly, 1993; Corder et al., 1981; Kellermann, 1985; Marcovitz & Smith, 1983; Maxmen, 1973; Ozbay & Goka, 1993). Typically, rather than having the participant rank all 60 items, the questionnaire versions ask the participant to rank only the 12 therapeutic factors from most to least helpful (see Yalom, 1995).

### *The Indirect Approach*

In contrast to the direct approach, the indirect approach consists of the participant responding to an open-ended question, rather than being given statements covering the pre-existing therapeutic factors (see Bloch et al., 1979). The measure most commonly

used in this procedure is termed the *most important event* questionnaire.

The most important event questionnaire was originally developed by Berzon et al. (1963) and was later modified by Bloch et al. (1979). The original version of the questionnaire asked clients, "Of the events which occurred in this meeting, which one do you feel contributed most to you personally? Please describe the incident in detail – the group members involved, the specific behaviors displayed, the words spoken (if any), your reaction, etc." (Berzon et al., 1963, p. 205). In an attempt to reduce bias, Bloch and colleagues revised the questionnaire to read: "Of the events which occurred in the last three meetings, which one do you feel was the most important for you personally? Describe the event: what actually took place, the group members involved and your own reaction. Why was it so important to you?" (p. 258). After the participant has completed his or her response, "most important events" are then assigned to the therapeutic factors, using a systematic manual of therapeutic factors developed by Bloch and colleagues. This approach "... has the advantage of being more indirect in that the group member is not provided with statements reflecting therapeutic factors but responds to an open-ended question" (Bloch & Crouch, 1985, p. 222). Provided categorisation is made reliably, this approach is often considered less biased overall than the direct approach (Couch et al., 1994).

#### *Previous Research*

Only four studies have examined the adolescent clients' perceptions of the therapeutic factors. The first study was conducted by Corder et al. (1981), which looked at 16 adolescents aged 13 through 17 (comprised of both out-patients and in-patients), participating in four therapy groups. Groups met weekly for 9 to 12 months, with

participants completing Yalom's (1970) therapeutic factor Q-sort after a minimum of 6 months group participation. In addition to their completion of the Q-sort, participants were interviewed (for a length of 15 to 20 minutes) concerning the reasons for their choices. Unfortunately, this study provides only rankings of Yalom's 60 individual items, rather than the 12 therapeutic factors. Consequently, comparability with other studies is difficult. Of the 60 individual items, those ranked as most important came from catharsis ("Being able to say what was bothering me instead of holding it in" and "Learning how to express my feelings"), existential factors ("Learning that I must take ultimate responsibility for the way I live my life, no matter how much guidance and support I get from others"), and interpersonal learning – input ("Other members honestly telling me what they think of me").

Chase and Kelly (1993) investigated the perceptions of therapeutic factors in adolescent psychiatric in-patients. Adolescent participants consisted of 33 clients (19 males, 14 females) receiving short-term group psychotherapy. Adolescent participants were a mean age of 14 years, with half the participants diagnosed with dysthymic disorder. Participants completed a questionnaire version of Yalom's (1970) 60-item Q-sort. Results found universality, group cohesiveness, and catharsis to be ranked as most helpful, while guidance, family re-enactment, and identification were ranked as least helpful.

A study by Ozbay and Goka (1993) examined the perceptions of therapeutic factors of 10 adolescents (6 females, 4 males) in an outpatient psychodrama group. Participants ranged in age from 15 to 20 years and had engaged in a minimum of 20 group therapy sessions. Participants were given Yalom's (1970) Q-sort questionnaire

(translated into Turkish) to complete at the end of both their 10<sup>th</sup> and 20<sup>th</sup> sessions.

Results indicated that at the end of both sessions, self-understanding, family re-enactment, and existential factors were ranked most important by participants.

Finally, a more recent study by Shechtman and Bar-El (1997) examined adolescents' perceptions of the therapeutic factors in both counselling and psychoeducational groups. Participants consisted of 148 junior high school students in Israel (109 students in the psychoeducational groups, 39 students in the counselling groups). Interventions were two short-term groups, consisting of 15 45-minute weekly sessions led by one counsellor. Psychoeducational groups were held in a classroom averaging 35 students to a class, while counselling groups were conducted in small groups with an average of 13 voluntary participants per group. Participants completed a modified version of the most important event questionnaire (Berzon et al., 1963) the authors termed the *critical incident procedure*. The critical incident procedure is made up of three items in which participants provide information on: 1) their feelings following the session, 2) things they have learned, and 3) the most important thing that happened in the session. Yalom's (1985) 11 therapeutic factors were used as a basis for data interpretation. For example, a response such as, "It felt good that I could express my feelings" was classified as catharsis (Shechtman & Bar-El, 1997, p. 205). Participants were given the measures following the first, third, sixth, ninth, and fifteenth session. Results showed that for both groups, interpersonal learning was ranked as most important, followed by catharsis and socializing techniques.

#### *Characteristics of Qualitative Research*

The present study was the first to qualitatively examine the group therapeutic



process as perceived by the adolescent client. The qualitative approach typically contains six main characteristics (see Maykut & Morehouse, 1994): 1) an exploratory and descriptive focus, 2) a purposive sample, 3) data collection in the natural setting, 4) qualitative methods of data collection, 5) early and ongoing inductive data analysis, and 6) a rich, holistic approach to reporting results. Each of these components is briefly described below.

#### *An Exploratory and Descriptive Focus*

Qualitative research is interested in obtaining a deep understanding of the experience and phenomena being studied from the participants' perspective. A qualitative study is interested in going beyond simply studying the behaviours and events taking place, to understanding the ways participants' perspectives influence their behaviours (Maykut & Morehouse, 1994; Rubin & Rubin, 1995). Thus, qualitative research is "... well suited for locating the meanings people place on events, processes, and structures of their lives: their perceptions, assumptions, prejudgements, presuppositions and for connecting these meanings to the social world around them" (Miles & Huberman, 1994, p. 10).

#### *A Purposive Sample*

Unlike quantitative research, which uses random sampling and large sample size to increase generalizability, qualitative research makes use of purposive sampling. Purposive sampling is a process in which participants are "... carefully selected for inclusion, based on the possibility that each participant will expand the variability of the sample" (Maykut & Morehouse, 1994, p. 45). Thus, the natural variability of the phenomena being studied is more likely to be represented in the data.

### *Data Collection in the Natural Setting*

Context is important in a qualitative study. Qualitative researchers are interested in the context in which a phenomenon of interest occurs and what sort of effect this context has on the participants and their behaviours. For this reason, qualitative research is typically conducted with a relatively small number of participants in the natural setting where the phenomenon of interest exists (Maxwell, 1996; Maykut & Morehouse, 1994).

### *Qualitative Methods of Data Collection*

Qualitative data is usually in the form of words, based on participant observation, interviews, and relevant documents. Interview and observation data is typically gathered through the creation of field notes and audio-taped interviews (Maykut & Morehouse, 1994; Miles & Huberman, 1994).

### *Early and Ongoing Inductive Data Analysis*

An important characteristic of a qualitative study is that the research design can evolve over the course of the research. Often, relevant new questions and directions for study emerge as data is analysed in the early stages. The qualitative approach encourages the pursuit of these new directions in an attempt to further explore the phenomenon of study (Maykut & Morehouse, 1994). Maykut and Morehouse sum up the most important feature of the qualitative approach: “What is important is *not* [italics added] predetermined by the researcher” (p. 46). For this reason, qualitative research has been considered by many researchers as the strategy of choice for exploring new areas and is particularly effective in the development and testing of hypotheses (Miles & Huberman, 1994).

*A Rich, Holistic Approach to Reporting Results*

Typically, the results of a qualitative study provide a rich and vivid description of the phenomenon of study. Results often include selections from the actual data "... that let the participants speak for themselves – in word or action – thereby giving the reader sufficient information for understanding the research outcomes" (Maykut & Morehouse, 1994, p. 47).

*The Present Study*

The present study was the first to qualitatively examine the group therapy process as perceived by the adolescent client. A qualitative approach was deemed appropriate and important because it allows for the exploration of adolescent clients' perceptions without predetermining their responses. This approach stands in sharp contrast to previous studies which have either required adolescents to make forced rankings of Yalom's (1995) factors (where perhaps none of the factors were actually important to them; see Chase & Kelly, 1993; Corder, et al., 1981; Ozbay & Goka, 1993), or have forced adolescent responses into Yalom's factor categories as part of the data analysis (see Shechtman & Bar-El, 1997). Strict adherence to Yalom's therapeutic factors in the examination of the adolescent's group therapy experience appears inappropriate for two reasons. First, critics of Yalom's Q-sort assert that his 60 items (and 12 factors) may not adequately cover all significant events and may overemphasize some events that may be of little importance (see Kellermann, 1987). Thus, it is possible that "... results reported in earlier studies may be the product of a biased measurement instrument rather than an indication of actual perceptions" (Kellermann, 1987, p. 408). Second, this approach presupposes that Yalom's therapeutic factors, developed to describe the group therapy

process with adults, are also capable of describing the group therapy process with adolescents. This is an assumption that does not appear warranted. Given adolescents' unique developmental, social, and psychological experiences (e.g., powerful peer pressures, identity formation, physical changes, looming career choices, battles for independence and autonomy, self doubt, loneliness, and increased need for peer approval), it does not seem justified to *assume* that the adolescent and adult client perceive the group therapy experience the same way.

In an effort to evaluate this assumption, a qualitative approach was used. Participants responded freely to open-ended questions, allowing them to describe, in their own words, what factors were helpful and also what factors were detrimental or disliked during their group therapy experience. Thus, a major strength of the qualitative interview is that it gives the participant the opportunity to provide much more detailed information than simply a choice among categories (Weiss, 1994). Moreover, while previous research (e.g., Yalom, 1995) helped guide the data interpretation in the present study, the results were not strictly limited to any particular existing categories. Rather, "... the process was inductive, with theory being built from observations of the data rather than a structure being imposed on the data ahead of time" (Knox et al., 1997, p. 276).

It should be noted that the present study is not a study of outcome; rather, its focus is on the clients' *perceptions* of the group therapy experience. While the present data certainly provides rich and important information, we know from the adult literature that clients' perceptions of the therapeutic factors may be limited. Thus, focusing only on perceptions may increase the risk of identifying more superficial elements, while perhaps ignoring more important factors beyond the clients' understanding and awareness.

Factors such as client functioning, length in treatment, type of group, and diagnosis of the client can influence the client's evaluation of the therapeutic factors. Furthermore, different clients may experience the same therapeutic events differently – that is, an event perceived as helpful by one client may be seen as insignificant or even detrimental by another (see Yalom, 1995).

However, despite the inherent limitations of client perceptions, they are a valuable source of information, because after all “... it is *their* experience, theirs alone, and the farther we move from the [client's] experience, the more inferential are our conclusions” (Yalom, 1995, p. 3). Furthermore, clients' perceptions have been found to be important in numerous studies. For example, current research suggests the best predictor of therapeutic outcome is the client's perception of the therapy relationship (Martin, 2000). Thus, a better understanding of adolescents' perceptions of their therapy experience may help to isolate variables associated with group members' improvement, as well as identify variables associated with persistence with therapy and/or dropout. Klein and Carroll (1986), looking at the dropout rate from group therapy, found that of the 700 out-patient referrals who eventually participated in group, over 50% quit before their 12<sup>th</sup> session. The issue of dropout is of particular concern with adolescent clients who often have difficulty dealing with authority figures and frequently lack motivation for treatment (Gladding, 1999).

Therefore, while there are certainly aspects of the therapeutic process that may occur outside the client's awareness, “... it does not follow that we should disregard what [they] *do* say” (Yalom, 1995, p. 3). Thus, the main research question examined in the present study was the following: From the adolescent client's perspective, what factors

are helpful and what factors are detrimental/disliked during group therapy?

## Method

### *Participants*

Participants consisted of seven female adolescent outpatient clients who were currently in a minimum of nine different treatment groups, during the fall/winter of 2001/2002 at Manitoba Adolescent Treatment Centre (MATC). It was decided that female participants should be recruited, since it was believed that females would be better able to articulate their thoughts and feelings than males, thus providing richer and more complete data. Participants ranged in age from 14 – 17 years ( $M = 15.29$ ,  $SD = .91$ ), and had been in group therapy at MATC from 5 to 30 months ( $M = 14.14$ ,  $SD = 9.55$ ). Groups attended by participants included (as described in MATC brochures): 1) Family Group (a semi-structured psychoeducational group with the purpose of "... utilizing activities that relate to family issues and can facilitate discussion"); 2) Rock Talk (a structured expressive group with the purpose of providing "... a medium which allows clients to express their own interpretations of peer selected songs"); 3) Women's Group (a semi-structured psychoeducational group with the purpose of providing "... an opportunity for female clients to increase their knowledge of gender issues"); 4) Survivor Group (an activity group with the purpose being "... to develop positive and cooperative skills needed to function in a group setting"); 5) Store Group (an activity group with the goal to "... enhance ability to work cooperatively with peers, improve self-esteem, to learn the basics of running a store, and to learn appropriate behaviour in a service role"); 6) Rec Group (an activity group with the purpose of providing "... structured physical activity for clients who would benefit from an increase in their level of physical

activity”); 7) Self-Discovery Group (an activity group designed to “... use an alternative modality to address issues of self-awareness and healthy coping strategies”); 8) Rest & Relaxation Group (a psychoeducational group which “... provides a calm, soothing atmosphere where clients can experience and learn healthy techniques they can use to decrease their anxiety and manage the stress in their lives”); 9) Outdoor Rec Group (an activity group designed to “... provide a structural physical activity for clients who have difficulty with the more traditional group room treatment”); 10) Life Skills Group (a psychoeducational group with the purpose of “... learning to be independent, learning about different professions in the community, learning how to access services in the community, enhancing work and job skills, learning to ‘give back’ to the community, and increasing self-esteem”); 11) Large Group (an activity group “... for all staff and clients to come together to begin the week together”); 12) Family Folk Art Group (a creative group designed “... to provide an opportunity for families using a learnable art form as a therapeutic tool to enhance family relationships”); 13) Community Accessing Group (a psychoeducational group designed “... to teach adolescents in community/recreational outings and activities”); 14) Communication Group (a psychoeducational group designed “... to improve communication skills”); 15) Cognitive Behaviour Therapy (CBT) Group (an interactive psychotherapy group designed “... to provide a forum where adolescents can address issues related to interpersonal relationships, school and mental health from a cognitive behavioural perspective”); and 16) Anxiety Group (a psychoeducational group with the goal to “... discuss definition and description of anxiety in general and specific disorders with contributing factors, assess the level of anxiety each client experiences, and to assist clients in developing an understanding of how treatment of anxiety may

work and the role the clients may play in their own treatment”).

To be included in the present study, participants were required to not be diagnosed with a personality or psychotic disorder. This exclusionary criterion was set by the investigators, in an attempt to facilitate compliance and reduce resistance during the interview. Participants’ presenting problems included (not mutually exclusive) the following: depression ( $n = 5$ ), anxiety ( $n = 2$ ), low self-esteem ( $n = 2$ ), bipolar disorder ( $n = 2$ ), oppositional defiant disorder ( $n = 2$ ), poor social skills ( $n = 1$ ), Asperger’s disorder ( $n = 1$ ), substance abuse ( $n = 1$ ), and borderline mental retardation ( $n = 1$ ).

The participant recruitment procedure included several steps. First, an MATC clinician involved in the group program introduced the principal investigator to a group of potential participants who met the exclusionary criteria. This meeting was designed to provide a smooth transition, where the principal investigator could become familiar to the group in the presence of an adult with whom the adolescents had a good relationship. Second, the principal investigator described the study to the group, answered questions and provided consent forms. Third, group members were instructed to inform a specified MATC staff member of their willingness to participate in the study. Finally, participants for the study were recruited from this group by the principal investigator.

### *Materials*

A *semi-structured interview* was used to obtain information from participants (see Appendix B). This interview was a maximum of one hour in length and was conducted by the principal investigator. The interview consisted of three main sections. The first section contained the main body of the interview, in which open-ended questions allowed the participant to explore the main research questions (i.e., “What is helpful and what is



detrimental/disliked in group therapy?"). The second section consisted of specific questions designed to help further explore the main research questions (e.g., what things would they change about group therapy, what advice would they give to group therapists, and what was the most important thing they needed from their therapist?). Finally, the third section included the question: "Is there anything else you would like to add about your experience in group therapy?" This question was posed when it appeared that the participant had nothing further to report, and the interview was concluded following a negative response to this question.

### *Procedure*

*Data Collection.* One-hour semi-structured interviews were conducted individually with participants by the principal investigator. All seven interviews took place in a medium-sized, centrally located conference room on-site at MATC. For privacy, all doors were shut during the interviews; however, all curtains were left open, allowing passers-by to see through the windows into the room. This was done in an attempt to reduce the participants' anxiety, as well as for the protection of the principal investigator. Interviews were audiotaped and subsequently transcribed verbatim by a professional transcriber.

*Informed Consent.* A consent package (see Appendix C) was given to each participant before commencing participation in the study. This package included the following: 1) a written description of all tasks required of the participant (including the purpose and methodology of the study), 2) a statement of confidentiality and its limits, 3) a consent form to be completed by a parent or legal guardian, and 4) a consent form to be completed by the participant herself.

*Confidentiality.* In the interest of maintaining confidentiality, each participant was assigned a code number and code name, and every effort was made to remove identifying information from the typed manuscripts. Likewise, therapist-identifying information was also removed from the typed manuscripts. This included names, as well as any information that could potentially result in the identification of a client or therapist. To further ensure confidentiality, all electronic versions of the data were password protected and all hardcopy manuscripts were stored in a locked room accessed only by the principal investigator and research supervisor.

*Participant Feedback.* Upon completion of each interview, the participant was thanked by the principal investigator for their participation. Participants were also encouraged to ask any questions or voice any concerns about the study at this time. Finally, participants were told they would be informed of the results of the study upon its completion.

*Participant Motivation.* Participant motivation for this study was enhanced in several ways. First, participants received a ten-dollar McDonald's gift certificate for their participation in the study. While the gift certificate was contingent on the participant's presence at the interview, the participant could choose to discontinue the interview at any time and still receive the gift certificate (no participants chose to discontinue). Second, as described above, the principal investigator met the potential participants prior to data collection. By doing this, it was hoped that a level of trust and rapport might be developed between the principal investigator and the adolescents. Third, potential participants were informed that their participation in the study would hopefully contribute to the improvement of group therapy at MATC. Finally, the semi-structured interviews

were conducted in a manner that was designed to build good rapport and make the interviewee feel understood and accepted. This involved the interviewer occasionally paraphrasing comments in a way that “makes sure I understand,” without leading the interviewee in any particular direction.

### Data Analysis

The interviews from the present study were analysed using the qualitative methodology recommended by Miles and Huberman (1994), and Strauss and Corbin (1998). This approach to qualitative data, often called *grounded theory*, is essentially an inductive process, whereby “... data collection, analysis, and eventual theory stand in close relationship to one another” (Strauss & Corbin, 1998, p. 12). In general, this type of data analysis involves the researcher initially staying very close to the original wording of the data and letting the themes or patterns emerge from it.

### *Coding Process*

Coding is the primary data analysis tool used by qualitative researchers. Codes may be defined as “... tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study” (Miles & Huberman, 1994, p. 56). Thus, codes are often used to summarise information contained in the data of a qualitative study and may be thought of as representations of phenomena (important analytic ideas that appear from the data; see Strauss & Corbin, 1998, p.114). Codes may be attached to words, phrases, sentences, or entire paragraphs.

Coding of the data in the present study involved several steps. First, transcripts were read thoroughly by the principal investigator in an attempt to get an overall sense of the interviews. Second, transcripts were searched for sections of data relevant to the

research questions – that is, factors discussed by participants as either helpful or detrimental/disliked during their group therapy experience. Third, these sections of relevant data were divided into *thought units* using blocks of colour to depict the beginning and ending of a unit (grey was used for helpful data, blue was used for detrimental/disliked data). Thought units were defined as a change in topic by the participant or a break in the narrative and typically consisted of several sentences related to the same general topic. Fourth, each thought unit was *microanalysed* – that is, analysed line-by-line, resulting in initial or *first level codes*. The codes were named using the participants' own words as much as possible. During this process, thought units were eligible for more than one code if the participant discussed more than one factor within a thought unit. Care was taken to minimise interview bias by focusing on the participants' words rather than the interviewer's interpretations during the interview. In instances where the interviewer initiated the use of certain words, this data was excluded. Fifth, the first level codes were reviewed and closely examined for similarities and differences. First level codes "... found to be conceptually similar in nature or related in meaning were grouped under more abstract concepts" (Strauss & Corbin, 1998, p. 102) and termed *second level codes*. During this process, codes were revised several times as the analysis progressed. Some codes that developed early in the analysis were discarded, while other, new codes developed in light of new requirements of the data. This process involved collaboration between the principal investigator, a research assistant, and the research supervisor, where the data were discussed in an attempt to come to a consensus about the meaning and categorisation of the data. Consensus was achieved through discussions of individuals' own interpretations of the data, and this eventually led to a final

interpretation upon everyone could agree. This process was used to further increase the validity of the codes assigned to the data. Finally, second level codes were examined for similarities and differences and similar second level codes were clustered together under a broader, more abstract *master code*. During the coding process, the principal investigator maintained a research journal, in order to keep track of meetings with the research advisor, coding rules, questions and concerns, and issues to be resolved.

### *Coding Reliability*

Codes were checked for reliability by having a second research assistant code a portion of the transcripts. This reliability rater had no previous knowledge of the transcripts and had not been involved during the coding process. A random sample of thought units relevant to the research questions were presented, and the reliability rater was asked to code these sections using a list of second level codes that were already developed. Before coding, the reliability rater was given the meanings of the codes and a short training session with the primary investigator. During this session, the reliability rater practised coding and asked questions as needed. After the training session, the reliability rater then coded approximately 30% of the relevant thought units using second level codes. Intercoder reliability was calculated using the formula of agreements divided by agreements plus disagreements multiplied by 100. Agreement was defined as coding a thought unit with the same second level codes. Intercoder reliability was found to be 88%.

### *Checklist Matrix Displays*

Two checklist matrix displays were developed to display the initial results for the main research questions (see Tables 1 and 2). A checklist matrix lists the participants

(using interview number) on the horizontal axis and lists the helpful and detrimental/disliked *major factors* (master codes) and *sub-factors* (second level codes) mentioned by the participants on the vertical axis. Each cell contains the number of times a sub-factor was mentioned throughout the interview. If the discussion went back and forth on a particular sub-factor for several minutes within a thought unit, this was counted as one *mention* for that given sub-factor. However, if the participant returned to discussing the sub-factor after an intervening discussion on a different topic (new thought unit), the return was counted as an additional mention of that sub-factor. Note that within a given thought unit, several sub-factors may be identified; however, the same sub-factor was never counted twice within the same thought unit. In addition to displaying information about sub-factors on the horizontal axis, the checklist matrix display also provides information about major factors (master codes); such as the total number of times a major factor was mentioned in the data and the number of interviews in which a major factor was mentioned.

### *Network Displays*

Two network displays were created to present the factors perceived by participants as helpful and detrimental/disliked during group therapy (see Figures 1 and 2).

## Results

### *Helpful Factors*

From the present study, ten major factors (master codes) emerged as helpful during the adolescent group therapy process (see Figure 1). The major factors ranked 1 – 5 are coloured light orange, while those ranked 6 – 10 are coloured dark blue (major

factors are represented with ovals). These factors are (in rank order): 1) Taking a Vacation From Your Problems, 2) Client Talking, 3) Imparting of Information, 4) Importance of Structure, 5) Group Cohesion, 6) Benefiting From Other Group Members' Experiences, 7) Positive Group Leader Relationship, 8) Development of Social Skills, 9) Interpersonal Learning, and 10) Group Leader Credibility.

The two criteria that were used in the ranking of the participants' perceptions of the major factors were: 1) the number of participants who mentioned the major factor, and 2) the total number of times the major factor was mentioned in the data. During the ranking process, the first criterion was deemed most important and was given more weight. That is, factors were first ranked (highest to lowest) by the number of participants who mentioned the factor. Once this ranking was completed, factors mentioned an equal number of times (e.g., client talking and imparting of information were both mentioned by 6 participants) were then ranked according to the number of times they were mentioned in the data.

Each major factor is comprised of several, sub-factors (second level codes; see Figure 1). These sub-factors (represented with rectangles) are coloured dark blue and were ranked using the same method as the major factors (see above). The top 15 sub-factors are light yellow, indicating their particular importance to participants. See Table 1 for a detailed breakdown of the number of times factors were mentioned in the data and the number of times factors were mentioned per interview.



Figure 1. Network display of the 10 major factors and related sub-factors perceived as helpful by participants.

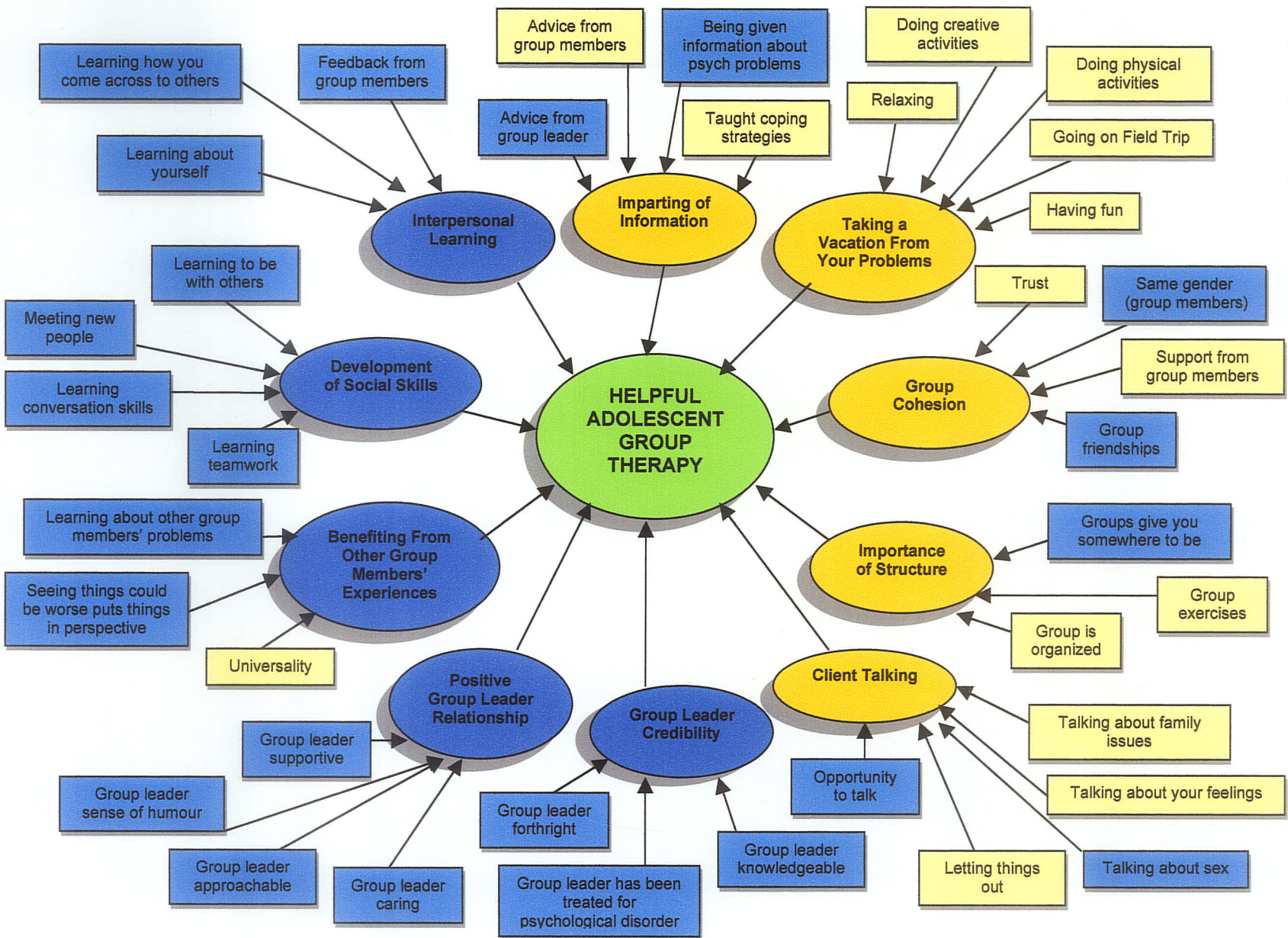




Table 1

*Checklist Matrix Display – Helpful Factors*

Major Factors and Related Sub-Factors	# of times mentioned per interview							# of times mentioned in data	Mentioned in # of interviews
	<u>Interviews</u>								
	1	2	3	4	5	6	7		
Taking a Vacation From Your Problems								38	7
Having fun	1	2	3	1		1	3	11	6
Doing physical activities	1	1		2		1	4	9	5
Relaxing	2		2	1	1			6	4
Going on field trip	1	1				1	1	4	4
Doing creative activities	2		4				2	8	3
Client Talking								33	6
Talking about your feelings	2	2	2	2				8	4
Letting things out	3	1	2			1		7	4
Talking about family Issues	1	3	1					5	3
Talking about sex	1				1	2		4	3
Opportunity to talk	3					6		9	2
Imparting of Information								22	6
Taught coping strategies		3	1	1	2			7	4
Advice from group members			2	2		3		7	3

Table 1 (continued)

*Checklist Matrix Display – Helpful Factors*

Major Factors and Related Sub-Factors	# of times mentioned per interview							# of times mentioned in data	Mentioned in # of interviews
	1	2	3	4	5	6	7		
Advice from group leader			1	2			1	4	3
Being given info about psychological problems				1	3			4	2
Importance of Structure								11	6
Group Exercises	2	1	1	1				5	4
Group is organized			1	1	3			5	3
Groups give you somewhere to be							1	1	1
Group Cohesion								24	5
Support from group members	2	5	2					9	3
Trust	1		3			2		6	3
Same gender group members	3				2			5	2
Group friendships	3	1						4	2
Benefiting From Other Group Members' Experiences								10	5
Universality		1		1	3			5	3
Seeing things could be worse puts things in perspective		1				2		3	2

Table 1 (continued)

*Checklist Matrix Display – Helpful Factors*

Major Factors and Related Sub-Factors	# of times mentioned per interview							# of times mentioned in data	Mentioned in # of interviews
	<u>Interviews</u>								
	1	2	3	4	5	6	7		
Learning about other group members' problems	2							2	1
Positive Group Leader Relationship								10	5
Group leader is supportive		1	1		1			3	3
Group leader has a sense of humour	2				1			3	2
Group leader is approachable			1				1	2	2
Group leader is caring			2					2	1
Development of Social Skills								12	4
Learning teamwork	1			1				2	2
Learning conversation skills							4	4	1
Learning to be with others		3						3	1
Meeting new people							3	3	1
Interpersonal Learning								7	4
Feedback from Group members	1		1	1				3	3

Table 1 (continued)

*Checklist Matrix Display – Helpful Factors*

Major Factors and Related Sub-Factors	# of times mentioned per interview							# of times mentioned in data	Mentioned in # of interviews
	1	2	3	<u>Interviews</u>		6	7		
Learning about yourself	1				1			2	2
Learning how you come across to others	2							2	1
Group Leader Credibility								6	2
Group leader forthright			1		2			3	2
Group leader has been treated for a psychological disorder					2			2	1
Group leader is knowledgeable					1			1	1

*Taking a Vacation From Your Problems.* Taking a vacation from your problems emerged as the major factor most talked about by participants, with all seven participants mentioning it at least once (total of 38 mentions in the data). This major factor may be conceptualised as the adolescent clients “getting away from their problems,” if only for a short period of time (that is, taking their minds off things and/or enjoying themselves). Several sub-factors referring to this theme were mentioned. All but one participant mentioned *having fun* in therapy as a helpful sub-factor, with three participants mentioning it two or more times. For example, when one participant was asked what she found helpful about groups, she mentioned having fun going downhill tobogganing, saying, “... that’s fun ... it makes me happy ... like laughing and all.” *Doing physical activities* such as exercising and swimming was another related sub-factor (mentioned by 5 participants). *Relaxing* was also a helpful sub-factor commonly mentioned by participants. This typically involved the client engaging in relaxing activities during a session (mentioned by 4 participants). For example, one participant noted: “The staff give us massages and we play like relaxing music like waterfalls and stuff, and have hot chocolate, and sometimes we, like, if we’re not getting massages, we can just sleep and just relax.” Other commonly mentioned sub-factors relating to this theme included *going on field trips*, such as shopping, going to the movies, and bowling (mentioned by 4 participants), and *doing creative activities* such as painting and colouring (mentioned by 3 participants).

*Client Talking.* Client talking was another important major factor that emerged from the data, mentioned by six of the seven participants (for a total of 33 mentions in the

data). As the name suggests, this major factor involves the participant talking (in various forms) during the group therapy process. During the course of the interviews, participants mentioned several sub-factors referring to this theme. One such sub-factor was *talking about your feelings*, which was mentioned by four participants. For example, one participant summed up the benefit of this sub-factor by saying: "Some days you feel really shitty and it feels good to be able to tell other people how you feel." Another related sub-factor mentioned by four participants was the process of *letting things out*. This process described by participants in the present study appears to be very similar to the factor Yalom (1995) termed catharsis. This factor generally involves the clients "letting things out" that are bothering them (rather than keeping feelings pent-up inside), which subsequently results in feelings of relief for the client. One participant described it this way:

I mean, that's really nice after you say it because you don't, you hold it in so long and then it just builds up. I mean you just, it's nicer when you can get everything out because then like I get sick if I keep things in and I get headaches and I won't be able to come in because of that.

Other sub-factors related to this theme mentioned by participants included *talking about family issues*, which typically involved the discussion of parents and siblings (mentioned by 3 participants), *talking about sex* (mentioned by 3 participants), and having the *opportunity to talk* (mentioned by 2 participants), which was described by participants as simply having a chance to talk to someone. One participant said it was helpful just to be "... able to talk to people ... even if [she chose] not to."

*Imparting of Information.* Imparting of information refers to the use of didactic

instruction, as well as the giving/receiving of advice from group leaders and fellow group members. This major factor was mentioned by six of the seven participants (mentioned a total of 22 times in the data). Several sub-factors referring to this theme were mentioned. The sub-factor mentioned most often by participants was being *taught coping strategies* (mentioned by 4 participants). This sub-factor refers to the client being instructed by the group leader about different techniques and strategies to deal with problems they encounter. For example, one participant said it was helpful when she was taught "... how to deal with stress." Other related sub-factors were *advice from group members* (mentioned by 3 participants), *advice from group leaders* (mentioned by 3 participants), and *being given information about psychological problems* (mentioned by 2 participants). When talking about advice from group members, one participant said, "... it's helpful for me, to just like get their advice on what they would do, you know, if someone was talking about them behind their back or something."

*Importance of Structure.* Structure within the group therapy experience emerged as an important major factor mentioned by six participants in the present study (mentioned a total of 11 times in the data). One sub-factor related to this theme was the use of *group exercises* during group therapy (mentioned by 4 participants). This typically involved group leader-directed group exercises that focused on a particular topic and usually provided group members with specific instructions to follow as part of participation. For example, one participant said she found it helpful when the group was talking about name-calling "... and everybody wrote down three names, name-calling things people could say to you. And [they] went around and everyone picked one out of the bucket and read it." Another helpful sub-factor was the fact that the *group is*

*organized* (mentioned by 3 participants). For example, when asked why she found a particular group helpful, a participant simply said, "I like the organization of it." Finally, another related sub-factor mentioned by one participant was that *groups give you somewhere to be*. That is, groups help give a sense of structure to one's daily life activities. This participant said, "... you have to get up to do stuff, and actually get out there, [it's] better than staying at home."

*Group Cohesion*. Group cohesion emerged as a helpful feature of group therapy for these adolescent clients, with five of the seven discussing it in some form during the interviews (mentioned a total of 24 times in the data). This major factor is very similar to Yalom's (1995) group cohesiveness, described earlier as "a sense of belonging, togetherness, warmth, and mutual acceptance" (Smith, 1995, p. 329). Three participants described *support from group members* as a helpful sub-factor, while three described *trust* as an important sub-factor within group therapy. One participant highlighted the importance of trust during her group therapy experience: "I trust all the people in there, so I don't need to worry about like whether other people are gonna find out or anything. It helps if there's trust." This participant went on to say that trust is important because she is more likely to open up to the group if feelings of trust are present. Other sub-factors included having *same gender group members* (mentioned by 2 participants), and *group friendships* – that is, the development of friendships with fellow group members (mentioned by 2 participants).

*Benefiting From Other Group Members' Experiences*. Benefiting from other group members' experiences was another major factor that emerged from the data, mentioned by five of the seven participants (mentioned a total of 10 times in the data).



The sub-factor related to this theme that was mentioned most often by participants was *universality*, with three of the participants discussing it. Universality, may be conceptualised as the discovery by clients that they are not alone in their suffering and that their experiences are not entirely unique to them (Yalom, 1995). For example, one participant said:

Before I came here, I never like met anyone else who had bipolar and now that I'm here, all my friends have bipolar, which is the weirdest thing in the world ... all my friends have it too. It makes you feel good ... that you're not the only one suffering.

A different participant indicated that seeing others with similar problems was helpful because it "... makes me feel like I'm not alone." Another sub-factor mentioned by two participants was that *seeing things could be worse puts things in perspective*. While describing groups, one participant noted:

Groups put things in perspective for me and I think that it does help me a lot. It does help me because, you know, I think my life's so horrible, I think everything's so shitty, and then when I actually hear about other people, it puts things in perspective ... it really does help.

Another participant said, "I think it helps to see other problems to know that you're not as bad, hard off." Yet another sub-factor that was mentioned in relation to this theme was *learning about other group members' problems* (mentioned by 1 participant). Although similar to universality, this refers to learning about other group members' problems and seeing they have problems too (although they may not necessarily be the same problems as your own).

*Positive Group Leader Relationship.* Having a positive group leader relationship emerged as a helpful major factor, mentioned by five participants in this study (mentioned a total of 10 times in the data). One sub-factor related to this theme was the group leader being supportive, termed *group leader is supportive* (mentioned by 3 participants). For example, while talking about her favourite group leader, one participant said she found it helpful that "... they're always like willing to make you feel better about yourself." Other sub-factors mentioned as helpful included the group leader being easy to talk to, termed *group leader is approachable* (mentioned by 2 participants), *group leader has a sense of humour* (mentioned by 2 participants), and the client feeling cared for by the group leader, termed *group leader is caring* (mentioned by 1 participant). While talking about the importance of a group leader's sense of humour, one participant said, "I like group leaders that have a good sense of humour. You know? I have to make humour of being sick ... just not take things too seriously."

*Development of Social Skills.* The development of social skills emerged as a helpful major factor mentioned by four participants in this study (mentioned a total of 12 times in the data). This major factor is essentially the same as the factor Yalom (1995) termed the development of socializing techniques. One sub-factor related to this theme was *learning teamwork* (mentioned by 2 participants). While describing the group's sessions in the gym, one participant said, "... it's really nice because we can play as teams and it's team-man-ship we learn." Other sub-factors mentioned by participants included *learning conversations skills* (mentioned by 1 participant), *learning to be with others* (mentioned by 1 participant), and *meeting new people* (mentioned by 1 participant).

*Interpersonal Learning.* This major factor is equivalent to Yalom's (1995) factor of the same name. In general, interpersonal learning refers to group members learning how their behaviours affect those around them and discovering regular patterns and themes within their own relationships (Smith, 1995). Interpersonal learning emerged as a helpful major factor in the present study and was mentioned by four participants (mentioned a total of 7 times in the data). One sub-factor related to this theme was receiving *feedback from group members* regarding their behaviour (mentioned by 3 participants). One participant noted:

I'm not that aware of myself, like, when I'm different or anything ... so it's hard, but it's easier if people in group, like we talk about stuff like that and they tell me about it and then I can look for symptoms and say, "Well maybe I am acting weird," you know?

Another sub-factor mentioned as helpful was *learning about yourself* – that is, clients learning about their fears, as well as discovering why they behave the way they do (mentioned by 2 participants). One participant said that a helpful thing about group therapy was "... finding out how I do things. Like understanding like, uh, when I do things, why I do them." A final sub-factor mentioned by one participant was *learning how you come across to others*. For example, one participant said:

They'll tape us, our group ... to see how we react in it because we don't see it, but when we watch sometimes, our groups, we say "Oh my God," like if I interrupt too many times, or what we say or everything. 'Cause you see what you're doing wrong and then you make, you see yourself, and you're like "Oh my gosh, I look so stupid" so then you're more likely to change your attitude.

*Group Leader Credibility.* As the name suggests, this major factor refers to the credibility of the group leader in the eyes of the client. This major factor was mentioned by two participants (mentioned a total of 6 times in the data). One sub-factor related to this theme was that the *group leader is forthright* (mentioned by 2 participants). While attempting to explain why she found her favourite group leader so helpful, one participant said, “[He/she] gives it straight up, [he/she] doesn’t like hide anything and [he/she] just tells you [his/her] opinion, what [he/she] thinks, even if you don’t like to hear it.” While describing the same group leader, another participant said they were so good because, “[He/she] tells it like it is, [he/she] doesn’t keep anything from you ... so [he/she] just shows you like, like it is, you know.” Another helpful sub-factor mentioned by one participant was if the *group leader has been treated for a psychological disorder*. This participant said:

There’s a lot of times where, you know, I kind of second guess [group leaders] ... so I’ll kind of like, ask them, you know, like, “Have you ever been treated for a psychological illness?” If they say “No,” then I won’t like not take anything they have to say too seriously, I’ll say like “Oh, okay, so you *don’t* know how I’m feeling? You’re just *saying* you know and well, the book reads.” If, ah, if the person says first hand “Yes,” I’ll be more likely to believe them, because I’ll say okay, well you know, they’ve experienced it.

Finally, one participant said it was helpful if *group leaders are knowledgeable* about what they are talking about.

#### *Detrimental/Disliked Factors*

In addition to helpful factors, participants were also asked about detrimental or

disliked factors they have experienced during group therapy in their interview. These were features of group therapy that participants felt had either impeded their progress, or made their group therapy experience more difficult. Five major factors emerged as detrimental/disliked during the adolescent group therapy process (see Figure 2). The major factor ranked first is coloured light orange, while those ranked 2 – 5 are coloured dark blue (major factors are represented with ovals). These factors are (in rank order): 1) Lack of Group Cohesion, 2) Negative Group Leader Techniques, 3) Lack of Structure, 4) Negative Relationship with Group Leader, and 5) Group Boring.

As with the helpful factors, two criteria were used for ranking the participants' perceptions of the major factors: 1) the number of participants who mentioned the major factor, and 2) the total number of times the major factor was mentioned in the data (see earlier section for review of ranking process). Each major factor is comprised of several sub-factors (see Figure 2). These sub-factors (represented with rectangles) are coloured dark blue and were ranked in the same manner as the major factors. The top 5 sub-factors are coloured light yellow, indicating they were of particular importance to participants. See Table 2 for a detailed breakdown of the number of times factors were mentioned in the data and the number of times factors were mentioned per interview.

Figure 2. Network display of the 5 major factors and related sub-factors perceived as detrimental/disliked by participants.

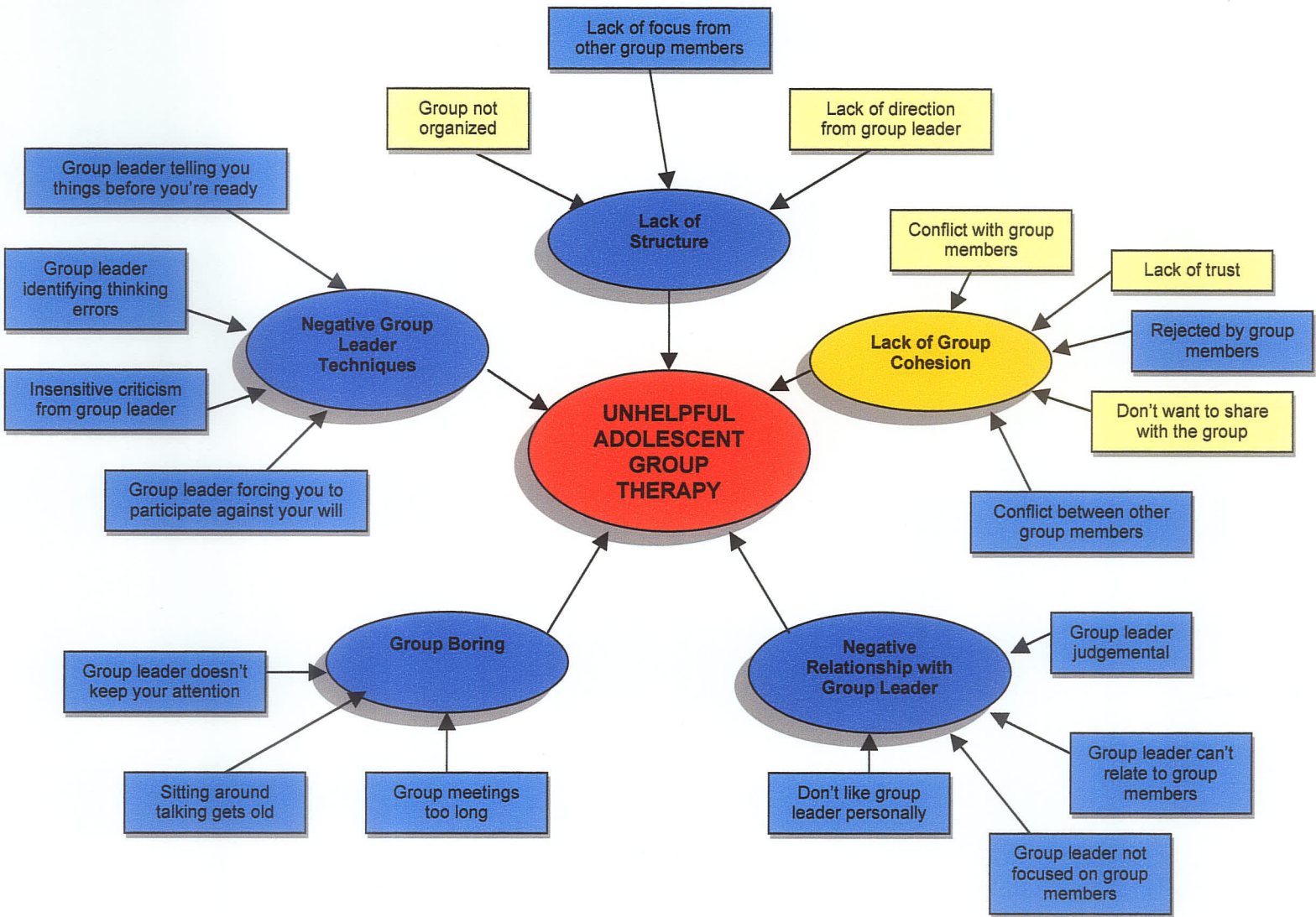


Table 2

*Checklist Matrix Display – Detrimental/Disliked Factors*

Major Factors and Related Sub-Factors	# of times mentioned per interview							# of times mentioned in data	Mentioned in # of interviews
	<u>Interviews</u>								
	1	2	3	4	5	6	7		
Lack of Group Cohesion								23	5
Lack of trust	5		3					8	2
Don't want to share with the group				2		4		6	2
Conflict with group members			3	1				4	2
Conflict between other group members			1		1			2	2
Rejected by group members			3					3	1
Negative Group Leader Techniques								7	4
Insensitive criticism from group leader		2		1				3	2
Group leader identifying thinking errors			1	1				2	2
Group leader forcing you to participate against your will				1				1	1
Group leader telling you things before you're ready	1							1	1
Lack of Structure								11	3
Group not organized				1	3			4	2

Table 2 (continued)

*Checklist Matrix Display – Detrimental/Disliked Factors*

Major Factors and Related Sub-Factors	# of times mentioned per interview							# of times mentioned in data	Mentioned in # of interviews
	1	2	3	4	5	6	7		
Lack of direction from group leader					3	1		4	2
Lack of focus from other group members					3			3	1
Negative Relationship with Group Leader								4	3
Group leader can't relate to group members							1	1	1
Don't like group leader personally							1	1	1
Group leader not focused on group members			1					1	1
Group leader judgemental					1			1	1
Group Boring								9	2
Sitting around talking gets old				5				5	1
Group sessions too long							3	3	1
Group leader doesn't keep your attention							1	1	1



*Lack of Group Cohesion.* Lack of group cohesion emerged as the major detrimental/disliked factor most talked about by participants, with five participants mentioning it throughout the interviews (mentioned a total of 23 times in the data). This major factor may be conceptualised as the opposite of the group cohesion factor mentioned earlier – that is, a lack of togetherness and mutual acceptance within the group. Many sub-factors related to this theme were mentioned. The sub-factor mentioned most often by participants was a *lack of trust* within the group (mentioned by 2 participants). For example, one participant said: “I hate talking about myself in groups because I don’t trust people, but, like if I’m alone with someone and I trust them, I’ll say anything.” Another participant repeated this sentiment while talking about her fellow group members, saying, “... it’s hard in group, ’cause I feel like I can’t talk about anything, ’cause I can’t trust them.” Another negative sub-factor mentioned by participants was feeling pressure when they *don’t want to share with the group* (mentioned by 2 participants). While discussing what she hated about group therapy, one participant said, “... being in a large group with a bunch of people that you know, you know them, I guess you trust them and everything, but you don’t really want to talk about certain things with those people.” Another sub-factor mentioned by participants was *conflict with group members* (mentioned by 2 participants). One group member said, “I got smoke blown into my face intentionally by someone who knows that it pisses me off. Just to piss me off, and it did.” She said this incident contributed to her desire to withdraw from the group. Another participant said conflicts with other group members are particularly difficult because “... it’s hard to talk about [conflicts] in groups, ’cause then the other people get all offended and they know I’m talking about them so they’ll

start, after group, probably talking about me or being rude with me and everything.” She went on to say that, as a result, opening up to group members could be difficult.

*Conflicts between other group members* was also mentioned as a detrimental sub-factor (mentioned by 2 participants). These conflicts did not involve the participant herself, but rather involved conflicts between other group members. For example, one participant said:

There’s been lots of confrontation in group, like the battle of the cats. The last was before Christmas ... they were just calling each other the worst names ... people just ripping at each other ... so that made things pretty tense.

Another sub-factor was being *rejected by group members* (mentioned by 1 participant). This participant said, “I always was the type of person where I wanted everyone to like me. I had to have everyone like me.” When asked what it felt like when fellow group members expressed dislike for her, she said, “... then it’s like, it’s hard.”

*Negative Group Leader Techniques.* Negative group leader techniques emerged as a detrimental/disliked major factor, with four participants mentioning it throughout the interviews (mentioned a total of 7 times in the data). This factor refers to particular techniques or procedures used by the group leader, procedures that participants found to be either detrimental to their progress or that made their group therapy experience more difficult. Participants mentioned four sub-factors referring to this theme. The sub-factor mentioned most often was receiving *insensitive criticism from the group leader* (mentioned by 2 participants). For example, one participant said, “... having one of the group leaders practically tear at you for all your faults. That’s not good.” Another negative sub-factor mentioned by participants was the *group leader identifying thinking*

*errors* (mentioned by 2 participants). Participants who mentioned this sub-factor not only felt that this technique was non-therapeutic, but they also perceived it as aggravating. For example, one participant said:

I just don't, I don't like it, 'cause every time [the group leader] talks, they're always pointing out thinking errors and it gets annoying after awhile and like sometimes I get so frustrated I want to just say "To heck with the thinking errors, just forget about them."

Other negative sub-factors included the *group leader forcing you to participate against your will* (mentioned by 1 participant), and the *group leader telling you things before you're ready* (mentioned by 1 participant).

*Lack of Structure.* Lack of structure within the group process emerged as a detrimental/disliked major factor mentioned by three participants throughout the interviews (mentioned a total of 11 times in the data). Participants mentioned three sub-factors referring to this theme. The sub-factor mentioned most often was that the *group was not organized* (mentioned by 2 participants). For example, one participant said that one thing she hated about groups was that "... lots of the groups aren't really organized. There's a lot of brouhaha, just kind of like, I don't know, people, just unorganized talk. I'm like, 'I'm here for groups you know'... I think it's really ridiculous." She said that this type of unorganized group often made her feel like giving up, saying, "... like, most of the time I'm like 'should we just leave?'" Another negative sub-factor mentioned by participants was a *lack of direction from the group leader* (mentioned by 2 participants). For example, while talking about a particular group leader, one participant said "...[his/her] basis is 'This is your group, so do what you want with it' but, we're like,

well, we don't know what [a particular therapy approach] is, we can't teach it to ourselves, so, [he/she] just sits there, and basically we just end up talking." Finally, one participant mentioned *lack of focus from other group members* as a negative sub-factor. This participant said that it could be difficult to make progress in group when fellow group members do not take it seriously and disrupt the group. For example she said, "... there's like four of them that just don't give a shit ... they're just having a hell of a time just talking about whatever, so ... it's pretty frustrating."

*Negative Relationship with Group Leader.* Another negative major factor to emerge from the data involves the clients' perception of their relationship with the group leader. Three participants mentioned this factor throughout the interviews (mentioned a total of 4 times in the data), and four sub-factors referring to this theme emerged. Responses relating to this theme were quite varied, with each sub-factor being mentioned by only one participant. One negative sub-factor mentioned was a feeling that the *group leader can't relate to group members*. For example, while talking about her group leaders, this participant said:

They're all like old ... so they don't know what they're talking about. They can't really honestly remember how it really felt for them when they were 14, and it was a different world back then too ... so it's not as easy as they think.

Another negative sub-factor mentioned was having a personality clash with the group leader, termed *don't like group leader personally*. One participant called one of her group leaders "a bastard," and said that was all she was willing to say. Other negative sub-factors mentioned were the *group leader not being focused on group members* (mentioned by 1 participant), and the *group leader being judgemental* (mentioned by 1

participant).

*Group Boring.* Boredom during group therapy emerged as the final detrimental/disliked major factor talked about by participants, with two participants mentioning it throughout the interviews (mentioned a total of 9 times in the data). Three sub-factors referring to this theme were mentioned. Responses relating to this theme were also quite varied, with each sub-factor mentioned by only one participant. One sub-factor mentioned was the idea that *sitting around talking gets old*. The participant explained it this way: "... sitting around and doing nothing all the time is very boring... sitting around and doing nothing, and talking about your moods and how stressed you are." When asked what advice she would give her group leaders, she said: "Stop making us sit around and do nothing all the time." Another sub-factor mentioned was that *group meetings are too long* and, subsequently, do not keep your attention. This participant said, "... being there long ... sitting in a seat listening," was what she disliked most about group. This participant also mentioned another sub-factor, that the *group leader doesn't keep your attention* throughout the group session. She said that during group "... I usually, I just sit around and [the other group members] listen, but it's like boring, you know."

### Discussion

The primary purpose of the present study was to examine the therapeutic process as perceived by the adolescent group therapy client. Given that this was the first qualitative analysis conducted with adolescent clients, it can only provide preliminary conclusions.

The results of the present study reveal potentially significant differences between

adults' and adolescents' perceptions of the group therapy experience. These findings are key, since all previous research focusing on adolescent groups in this area have used Yalom's (1995) adult derived therapeutic factors as part of their data analysis. These studies have either required adolescents to make forced choice rankings using Yalom's adult derived 60 item Q-sort (see Chase & Kelly, 1993; Corder et al., 1981; Ozbay & Goka, 1993) or have forced adolescent responses into Yalom's 11 factor categories as part of data analysis (see Shechtman & Bar-El, 1997).

### *Helpful Factors*

The results of the present study found 10 major factors identified by participants as helpful during group therapy. These include (in rank order) the following: 1) taking a vacation from your problems, 2) client talking, 3) imparting of information, 4) importance of structure, 5) group cohesion, 6) benefiting from other group members' experiences, 7) positive group leader relationship, 8) development of social skills, 9) interpersonal learning, and 10) group leader credibility. While several of the major factors that emerged from the present study are consistent with Yalom's (1995) factors (e.g., group cohesion, imparting of information, development of social skills, interpersonal learning), several unique factors emerged as well. This divergence from Yalom's factors is most striking when examining the top two ranked major factors in the present study (i.e., taking a vacation from your problems, and client talking). With the exception of the direct parallel between the sub-factor letting things out and Yalom's (1995) catharsis, both major factors are unique to the present study.

Taking a vacation from your problems emerged as the single most talked about major factor, with all seven participants mentioning it at least once. This factor (which

refers to clients getting away from/taking a break from their problems and pathology) is not referred to in Yalom's (1995) therapeutic factors and consequently, is not reflected in previous adolescent research. Thus, results from the present study suggest the existence of an unrecognised and potentially significant therapeutic factor involved during adolescent group therapy. Although this was a study of group members' perceptions of the group therapy experience (and not a study of actual outcome), these results are still important and worth considering.

Client talking, ranked number two in the present study, suggests further differences between the adult and adolescent group therapy experience. This major factor revolves around the participant talking (in various forms) during the group therapy process. While Yalom's (1995) factors may implicitly recognise client talking as an important component of the group process, none of his factors (with the possible exception of catharsis) acknowledge client talking in itself as therapeutic. In the present study however, talking *in itself* was acknowledged repeatedly by participants as therapeutic. In fact, two participants said simply having the opportunity to talk, even if they chose not to, was perceived as helpful.

Similarly, the importance of structure, ranked number four in this study, is also not considered an important therapeutic factor in the adult group therapy literature. In the present study, the importance of structure was mentioned by all but one participant and primarily referred to the idea that the group was organized and provided group members with specific group activities. Results suggest that participants found it helpful when they were given a structured group therapy environment where ambiguity and uncertainty are kept to a minimum. While structure is not identified as a relevant therapeutic factor

by Yalom (1995; or subsequent adolescent research), these findings are consistent with the existing individual and group therapy adolescent literature (see Martin, 2003). For example, Martin suggests a more structured approach when working with adolescents in groups. This is because, "... an unfocused, ambiguous starting of a group process is especially anxiety arousing for young people who do not know what they are supposed to do but also cannot predict what other group members of the group are going to do" (Martin, 2003, p. 90). Strome and Loutsch (1996) also advocate a more structured process when working with adolescents, making use of various group exercises, such as role modelling, direct education, and giving the group member the task of bringing to each session a topic of discussion (see Martin, 2003).

Other unique factors to appear from the present study are a perceived positive group leader relationship, and perceived group leader credibility. Perceptions of the group leader relationship were mentioned by five of the seven participants in this study. However, this theme is not referred to among Yalom's (1995) factors. Based on the present results, it seems that the relationship between the group leader and client may have a more profound effect on the adolescent client than previously recognised. While the present study is not a study of outcome, these results are consistent with the general adolescent therapy literature, which suggests that the best predictor of successful therapy with adolescents is the therapeutic relationship (Martin, 2003).

In addition to the relationship with the group leader, participants in the present study also mentioned the group leader's credibility as a helpful factor during group therapy. While this factor may not be sufficient to create change on its own, two participants felt that perceiving the group leader as credible was nonetheless a helpful



component of their group therapy. These participants suggested that when they felt confident in the direction and leadership they were given by the group leader, they were consequently more confident in the therapy they were receiving and could more readily accept advice and information given to them during treatment.

Several of Yalom's (1995) therapeutic factors were not mentioned by participants in the present study. These results provide additional evidence of the possible differences between the adult and adolescent group therapy experience. Therapeutic factors not mentioned by participants in this study included: altruism, imitative behaviour/identification, the corrective recapitulation of the primary family group/family re-enactment, instillation of hope, and existential factors.

In addition to the unique results of the present study, several familiar therapeutic factors (i.e., Yalom, 1995) emerged as important to these adolescent participants. For example, group cohesion was a major factor mentioned by five of the seven participants. This therapeutic factor is very similar to Yalom's group cohesiveness, where group members benefit by being accepted and embraced by the group. However, despite this similarity, results of the present study suggest that, *trust* within the group may be an additional key component of group cohesion for the adolescent client (trust is not mentioned in Yalom's conceptualization of group cohesiveness). These general findings are consistent with those of a recent task force on empirically supported relationship factors, which concluded that group cohesion was one of the four relationship factors clearly supported by research (Norcross, 2002).

Another familiar factor to emerge from the present study was the imparting of information. This major factor is similar to Yalom's (1995) therapeutic factors imparting

of information and guidance (from the Q-sort), which primarily refer to the use of didactic instruction and advice giving by fellow group members and/or the group leader. Benefiting from other group members' experiences was yet another major factor identified by participants in the present study. This factor also contains much overlap with Yalom's factors. This is especially true of the sub-factor in the present study called universality, which is identical to Yalom's factor of the same name. Still another familiar factor that emerged from the present study was the development of social skills, mentioned by four participants. This factor parallels Yalom's factor development of socializing techniques, and is also covered in part by his Q-sort category entitled interpersonal learning – output. Finally, interpersonal learning was mentioned as a helpful factor in the present study. This major factor is made up of feedback from group members, learning how you come across to others, and learning about yourself. These themes are described in both Yalom's factor of the same name and his Q-sort therapeutic factor called self-understanding.

#### *Detrimental/Disliked Factors*

In addition to examining the helpful (therapeutic) factors during group therapy, the present study also asked participants about detrimental or disliked factors. These negative factors are features of group therapy that participants felt had either impeded their progress or made their group therapy experience more difficult. The current study was the first to examine such factors during the adolescent group therapy experience.

Five major factors perceived as detrimental/disliked during the adolescent group therapy process emerged from the present study. These factors included (in rank order) the following: 1) Lack of Group Cohesion, 2) Negative Group Leader Techniques, 3)

Lack of Structure, 4) Negative Relationship with Group Leader, and 5) Group Boring. Results of the present study indicate that, while the presence of group cohesion may be perceived as somewhat helpful (as indicated by its fifth ranking), the absence of cohesion within the group is perceived as especially negative. Perhaps the adolescent's perception of a cohesive group is perceived as being less associated with therapeutic improvement and more associated with dropout (or participation). In other words, from the client's perspective, group cohesion may be necessary, but not sufficient for adolescents' improvement in groups. Thus, groups that are perceived as cohesive (i.e., provide the adolescent with a supportive, accepting environment) may be particularly important in keeping the client in therapy and reducing the rate of dropout. This idea is consistent with adult research done by Yalom (1995), which suggests that cohesive groups tend to show less turnover and better overall attendance.

Results of the present study also suggest that, while a positive relationship with the group leader may be perceived as somewhat helpful by adolescent clients (as indicated by its seventh ranking), the absence of a positive relationship with the group leader, in combination with negative techniques by the group leader, is perceived as very negative. This suggests that perhaps the group leader, him or herself, may be perceived as less associated with improvement and more associated with dropout (or participation). Thus, group leaders that are perceived as positive and cultivate a positive relationship with clients may be influential in keeping the client in therapy and reducing the rate of dropout.

Finally, results of the present study suggest that a lack of structure and a boring group experience are also perceived as negative factors (mentioned by 3 and 2

participants, respectively). It appears that the presence of structure may be perceived by adolescents as important to their progress (as indicated by its fourth ranking), while a lack of structure may be seen as quite negative, leading to frustration and uncertainty (and possible dropout). Boredom during group may also be a relevant factor leading to discontent and eventual dropout by adolescent clients.

#### *Limitations of the Present Study*

As with most qualitative studies, the use of a small sample size potentially limits the representativeness of the results in several ways. First, all participants included in the present study were female. While the decision to include only females provided distinct advantages during the course of the study (see participants section), the decision to use only females clearly limits the representativeness of the sample used. However, while this is a legitimate drawback of the present study, it should be noted that previous research examining perceptions of the therapeutic factors with both adults and adolescents have not reported significant gender differences (Ozbay & Goka, 1993; Shechtman & Bar-El, 1997; see Yalom, 1995). Therefore, tentative inferences regarding male adolescent perceptions may be possible from the results of the present study. However, future research with male clients is clearly needed. Second, all participants were Caucasian and from the same geographic region, and therefore may not be representative of the experiences of all female adolescent clients. Third, all participants were seen through MATC and therefore may represent only adolescents with exceptionally serious problems.

Another limitation inherent to all qualitative research is the potential for bias. However, in the present study, several procedures were implemented to minimise this

limitation. First, every effort was made by the principal investigator to minimise bias during the interview process itself. This involved conducting individual semi-structured interviews where all participants were free to engage in discussion without specific direction from the interviewer. The interviewer tried to explore with the participant, making her feel understood during the process, but purposely tried not to lead her in any particular direction. Second, during data analysis, a concerted effort was made to stay very close to the data. Special care was taken to use participants' own words when developing codes and subsequent factors. In instances where the interviewer initiated the use of certain words or terms during interviews, that data was examined carefully and then excluded. Third, the data analysis process involved the collaboration between the principal investigator, a research assistant, and the research supervisor. The data was discussed throughout this process in an attempt to come to the most accurate and valid conceptualisations of the clients' meaning. Finally, codes were checked for reliability by having a research assistant code approximately 30% of the relevant sections of the transcripts. This reliability rater had no previous knowledge of the transcripts and had not been involved during the coding process. Inter-coder reliability was found to be 88%.

Yet another limitation of the present study is that participants who agreed to participate were essentially self-selected and may therefore be fundamentally different from those who chose not to participate. Furthermore, all participants were still in group therapy at the time they were interviewed, and therefore the present study lacks the perspective of the terminated client. Clients terminate for various reasons, such as a lack of important therapeutic factors available to them, or an abundance of detrimental or disliked factors present during treatment. Additionally, participants initially selected by

the MATC clinician and introduced to the principal investigator during the recruiting process may have been particularly successful or amenable clients and therefore may not be truly representative of the typical female adolescent group therapy client. Given these limitations, caution is advised when trying to generalize from the results of this study, and future research in this area is clearly warranted.

#### *Clinical Implications of the Present Study*

The results of the present study provide several provisional implications for outpatient adolescent group therapy. First, the results suggest that adolescent clients may benefit substantially from “blowing off steam” and getting away from their problems. Therefore, groups working with adolescents should try to provide group members with activities that promote fun, exercise, and relaxation whenever possible. This component might be important in keeping adolescent clients engaged in the process, and may have direct therapeutic effects. Second, every effort should be made by the group leader to provide adolescent clients with a group atmosphere that encourages support, acceptance, trust, and friendship between group members. This may be done through modelling by the group leader, presenting clear rules regarding group member behaviour and interactions, and the careful selection of group members that are likely to work well together (Smith, 1995). Third, group leaders should provide adolescents with an organized and structured environment, in which ambiguity is kept to a minimum and expectations are clear and understandable. This may be done through the use of group leader-directed group exercises, and specifically defined tasks for group members to complete (see Martin, 2003). Fourth, adolescent groups should provide group members with practical information that they can use in the future. It appears that adolescent group

members value practical advice from both fellow group members and, to a lesser extent, group leaders. Adolescent group members also appear to value being taught practical coping strategies that they can take with them and use as needed (e.g., progressive muscle relaxation, diaphragmatic breathing). Finally, group leaders should work toward creating a positive therapeutic relationship with each group member. While the therapeutic relationship is important in all types of therapy, it seems that a positive therapeutic alliance is particularly important when working with adolescent clients.

#### *Future Directions*

The present study offers preliminary evidence that Yalom's (1995) therapeutic factors may not be appropriate to measure the adolescent group therapy process. Thus, the exclusive use of Yalom's factors in future adolescent studies should be reconsidered. Results from the present study highlight the need for a more accurate measurement tool that is specific to the adolescent group therapy client's experience. This may be achieved through two main steps. First, further qualitative research with various populations (e.g., males, in-patients, various diagnoses), group types (e.g., psychodrama), and in different geographic regions is warranted to broaden our understanding of therapeutic factors and detrimental/disliked factors operating during adolescent group therapy. Second, results from these studies should be compared and possibly combined with relevant adult research (e.g., Bloch et al., 1979; Yalom, 1995) to develop an assessment tool specific to the experiences of the adolescent client. Such a measure could then be used to conduct future research in this area.

## References

- Aronson, S., & Scheidlinger, S. (1996). Group therapy for adolescents. In Flach, C. (Ed.), *The Hatherleigh Guide to Child and Adolescent Therapy* (pp. 175-189). New York: Hatherleigh Press.
- Azima, F. J. C. (1996). Status of adolescent research. In Kymissis, P., & Halperin, D. (Eds.), *Group Therapy with Children and Adolescents* (pp. 369-386). Washington, DC: American Psychiatric Press, Inc..
- Barkhaus, R. S., Adair, M. K., Hoover, A. B., & Bolyard, C. W. (1985). *Threads* (3<sup>rd</sup> ed.). Dubuque, IA: Kendall/Hunt.
- Berg, R., Landreth, G. L., & Fall, K. A. (1998). *Group Counselling: Concepts and Procedures* (3<sup>rd</sup> ed.). Philadelphia: George H. Buchanan Co..
- Berzon, B., Pious, C., & Farson, R. E. (1963). The therapeutic event in group psychotherapy: A study of subjective reports by group members. *Journal of Individual Psychology, 19*, 204-212.
- Bloch, S., & Aveline, M. (1996). Group psychotherapy. In Bloch, S. (Ed.), *An Introduction to the Psychotherapies* (3<sup>rd</sup> ed.). (pp. 84-115). Oxford: Oxford University Press.
- Bloch, S., & Crouch, E. (1985). *Therapeutic Factors in Group Psychotherapy*. Oxford: Oxford University Press.
- Bloch, S., & Reibstein, J. (1980). Perceptions by patients and therapists of therapeutic factors in group psychotherapy. *British Journal of Psychiatry, 137*, 274-278.
- Bloch, S., Reibstein, J., Crouch, E., Holroyd, P., & Themen, J. (1979). A method for the study of therapeutic factors in group psychotherapy. *British Journal of Psychiatry,*



134, 257-263.

- Blum, D. J., & Jones, L. A. (1993). Academic growth group and mentoring program for potential dropouts. *The School Counsellor*, 40, 207-217.
- Burrow, T. (1927). The method of analysis. *Psychoanalytic Review*, 14, 268-280.
- Chase, J. L., & Kelly, M. M. (1993). Adolescents' perceptions of the efficacy of short-term, inpatient group therapy. *Journal of Child and Adolescent Group Therapy*, 3, 155-161.
- Coffman, S. G., & Roark, A. E. (1988). Likely candidates for group counseling: Adolescents with divorced parents. *The School Counselor*, 35, 246-252.
- Corder, B., Whiteside, L., & Haizlip, T. (1981). A study of curative factors in group psychotherapy with adolescents. *International Journal of Group Psychotherapy*, 31, 345-354.
- Corey, M. S., & Corey, G. (1997). *Groups: Process and Practice* (5<sup>th</sup> ed.). Pacific Grove: Brooks/Cole Publishing.
- Corsini, R. & Rosenberg, B. (1955). Mechanisms of group psychotherapy: Processes and dynamics. *Journal of Abnormal and Social Psychology*, 51, 406-411.
- Crouch, E., Bloch, C., & Wanlass, J. (1994). Therapeutic factors: Interpersonal and intrapersonal mechanisms. In Fuhriman, A, & Burlingame, G. M. (Eds.), *Handbook of Group Psychotherapy: An Empirical and Clinical Synthesis* (pp. 269-315). New York: John Wiley & Sons, Inc..
- Dinkmeyer, D. C., Dinkmeyer, D. C., Jr., & Sperry, L. (1987). *Alderman Counseling and Psychotherapy* (2<sup>nd</sup> ed.). Columbus: Merrill.
- Deck, M. D., & Saddler, D. L., (1983). Freshman awareness groups: A viable option for

- high school counselors. *The School Counselor*, 30, 392-397.
- Dragoon, M., & Klein, R. (1979). Preventative intervention to reduce conflicts among students. *The School Counselor*, 27, 98-100.
- Dryfoos, J. G. (1990). *Adolescents at Risk: Prevalence and Prevention*. New York: Oxford University Press.
- Dryfoos, J. G. (1993). Schools as places for health, mental health, and special services. In Takanshi, R. (Ed.), *Adolescence in the 1990s*. New York: Teachers College Press.
- Gladding, S. T. (1999). *Group Work: A Counseling Specialty* (3<sup>rd</sup> ed.). Upper Saddle River: Prentice-Hall, Inc..
- Kellermann, P. F. (1985). Participants' perception of therapeutic factors in psychodrama. *Journal of Group Psychotherapy, Psychodrama and Sociometry*, 38, 123-132.
- Kellermann, P. F. (1987). Psychodrama participants' perception of therapeutic factors. *Small Group Behaviour*, 18, 408-419.
- Klein, R., & Carroll, R. (1986). Patient characteristics and attendance patterns in outpatient group psychotherapy. *International Journal of Group Psychotherapy*, 36, 115-120.
- Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology*, 44, 274-283.
- Marcovitz, R. J., & Smith, J. E. (1983). Patients' perceptions of curative factors in short-term group psychotherapy. *International Journal of Group Psychotherapy*, 33, 21-39.
- Martin, D. G. (2000). *Counseling and Therapy Skills* (2<sup>nd</sup> ed.). Prospect Heights:

Waveland Press, Inc..

Martin, D. G. (2003). *Clinical Practice with Adolescents*. Pacific Grove, CA: Brooks/Cole.

Maxmen, J. (1973). Group therapy as viewed by hospitalized patients. *Archives of General Psychiatry*, 28, 404-408.

Maxwell, J. A. (1996). *Qualitative Research Design: An Interactive Approach*. Thousand Oaks: Sage Publications, Inc..

Maykut, P., & Morehouse, R. (1994). *Beginning Qualitative Research: A Philosophic and Practical Guide*. London: The Falmer Press.

Miles, M., & Huberman, A. M. (1994). *Qualitative Data Analysis* (2<sup>nd</sup> ed.). Thousand Oaks: Sage Publications Ltd..

Norcross, J. C. (Ed.). (2002). *Psychotherapy Relationships That Work*. Oxford: Oxford University Press.

Omizo, M. M., & Omizo, S. A. (1988). The effects of participation in group counselling sessions on self-esteem and locus of control among adolescents from divorced families. *The School Counselor*, 36, 54-60.

Ozbay, H., & Goka, E. (1993). Therapeutic factors in an adolescent psychodrama group. *Journal of Group Psychotherapy, Psychodrama, & Sociometry*, 46, 3-13.

Rubin, H. J., & Rubin, I. S. (1995). *Qualitative Interviewing: The Art of Hearing Data*. Thousand Oaks: Sage Publications, Inc..

Santrock, J. W. (2001). *Adolescence* (8<sup>th</sup> ed.). New York: McGraw-Hill.

Shechtman, Z., & Bar-El, O. (1997). Therapeutic factors and psychoeducational groups for adolescents: A comparison. *Journal for Specialists in Group Work*, 22, 203-

214.

- Smith, J. D. (1995). Group therapy. In Martin, D. G., & Moore, A. D. (Eds.), *Basics of Clinical Practice: A Guidebook for Trainees in the Helping Professions* (pp. 327-346). Prospect Heights: Waveland Press, Inc..
- Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd ed.). Thousand Oaks: Sage Publications Ltd..
- Strome, S. S., & Loutsch, E. M. (1996). A structured, educative form of adolescent psychotherapy. In Kymissis, P. & Halperin, D. A. (Eds.), *Group Therapy with Children and Adolescents* (pp. 175-187). Washington DC: American Psychiatric Press.
- Weiss, R. S. (1994). *Learning From Strangers: The Art and Method of Qualitative Interview Studies*. New York: The Free Press.
- Wender, L. (1936). Dynamics of group psychotherapy and its application. *Journal of Nervous and Mental Disease*, 84, 54-60.
- Yalom, I. (1970). *Theory and Practice of Group Psychotherapy*. New York: Basic Books.
- Yalom, I. (1975). *Theory and Practice of Group Psychotherapy* (2<sup>nd</sup> ed.). New York: Basic Books.
- Yalom, I. (1985). *Theory and Practice of Group Psychotherapy* (3<sup>rd</sup> ed.). New York: Basic Books.
- Yalom, I. (1995). *Theory and Practice of Group Psychotherapy* (4<sup>th</sup> ed.). New York: Basic Books.

Appendix A

Yalom's (1970) Therapeutic Factor Q-Sort – Twelve Categories and Sixty Individual  
Items

1. Altruism

1. Helping others has given me more self-respect.
2. Putting others' needs ahead of mine.
3. Forgetting myself and thinking of helping others.
4. Giving part of myself to others.
5. Helping others and being important in their lives.

2. Group Cohesiveness

6. Belonging to and being accepted by a group.
7. Continued close contact with other people
8. Revealing embarrassing things about myself and still being accepted  
by the group.
9. Feeling alone no longer.
10. Belonging to a group of people who understood and accepted me.

3. Universality

11. Learning I'm not the only one with my type of problem; "We're all in  
the same boat."
12. Seeing that I was just as well off as others.
13. Learning that others have some of the same "bad" thoughts and  
feelings I do.

14. Learning that others had parents and backgrounds as unhappy or mixed up as mine.

15. Learning that I'm not very different from other people gave me a "welcome to the human race" feeling.

4. Interpersonal Learning – Input

16. The group's teaching me about the type of impression I make on others.

17. Learning how I come across to others.

18. Other members honestly telling me what they think of me.

19. Group members pointing out some of my habits or mannerisms that annoy other people.

20. Learning that I sometimes confuse people by not saying what I really think.

5. Interpersonal Learning – Output

21. Improving my skills in getting along with people.

22. Feeling more trustful of groups and of other people.

23. Learning about the way I related to the other group members.

24. The group's giving me an opportunity to learn to approach others.

25. Working out my difficulties with one particular member in the group.

6. Guidance

26. The doctor's suggesting or advising something for me to do.

27. Group members suggesting or advising something for me to do.

28. Group members telling me what to do.

29. Someone in the group giving definite suggestions about a life problem.
30. Group members advising me to behave differently with an important person in my life.

7. Catharsis

31. Getting things off my chest.
32. Expressing negative and/or positive feelings toward another member.
33. Expressing negative and/or positive feelings toward the group leader.
34. Learning how to express my feelings.
35. Being able to say what was bothering me instead of holding it in.

8. Identification

36. Trying to be like someone in the group who was better adjusted than I.
37. Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.
38. Adopting mannerisms or the style of another group member.
39. Admiring and behaving like my therapist.
40. Finding someone in the group I could pattern myself after.

9. Family Re-enactment

41. Being in the group was, in a sense, like reliving and understanding my life in the family in which I grew up.
42. Being in the group somehow helped me to understand old hangups that I had in the past with my parents, brothers, sisters, or other important people.

43. Being in the group was, in a sense, like being in a family, only this time a more accepting and understanding family.
44. Being in the group somehow helped me to understand how I grew up in my family.
45. The group was something like my family – some members or the therapists being like my parents and others being like my relatives. Through the group experience I understand my past relationships with my parents and relatives (brothers, sisters, etc.).

#### 10. Self-Understanding

46. Learning that I have likes or dislikes for a person for reasons which may have little to do with the person and more to do with my hangups or experiences with other people in my past.
47. Learning why I think and feel the way I do (that is, learning some of the causes and sources of my problems).
48. Discovering and accepting previously unknown or unacceptable parts of myself.
49. Learning that I react to some people or situations unrealistically (with feelings that somehow belong to earlier periods in my life).
50. Learning that how I feel and behave today is related to my childhood and development (there are reasons in my early life why I am as I am).

#### 11. Instillation of Hope

51. Seeing others getting better was inspiring to me.
52. Knowing others had solved problems similar to mine.



- 53. Seeing that others had solved problems similar to mine.
- 54. Seeing that other group members improved encouraged me.
- 55. Knowing that the group had helped others with problems like mine encouraged me.

12. Existential Factors

- 56. Recognizing that life is at times unfair and unjust.
- 57. Recognizing that ultimately there is no escape from some of life's pain and from death.
- 58. Recognizing that no matter how close I get to other people, I must still face life alone.
- 59. Facing the basic issues of my life and death, and thus living my life more honestly and being less caught up in trivialities.
- 60. Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others.

Appendix B

One-Hour Semi-Structured Interview.

A. Main body of interview

1. What groups are you currently in?
2. Based on your experience in group therapy, what part of group therapy has been the most helpful? That is – what thing has really made a difference or helped you during the group therapy experience?
3. What part of group therapy has been the least helpful? Was there anything that the group leader or other group members did that made your progress in therapy more difficult?

B. Specific questions to be asked toward the end of the interview after the participant has exhausted recollections and thoughts on more general themes.

4. What specifically would you have changed about group therapy?
5. If you could give group therapists some advice, what would it be?
6. Think back to your first group therapy session. What was the most important thing you needed from your therapist? What was the most important thing you needed from your fellow group members?
7. Is what you need in therapy now different? How?
8. Was there a specific group therapy session that was of particular significance in your progress? What was it that made it the best?
9. Think of your “best” and “worst” therapist. What made the best one best and the worst one worst? How were they different?

C. Conclusion of interview

10. When it appears the participant has nothing further to report, ask, "Is there anything else you would like to add about your experience in group therapy?" End the interview following a negative response to this question.

## Appendix C

### Participant Consent Form

Research Project Title: The Perception of Therapeutic Factors in Adolescent Group Therapy

Investigator: Paul Rezutek

Sponsor: Dr. David Martin

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

This study is about the perceptions adolescent clients have about group therapy. The main purpose of the study is to find out from clients themselves what was helpful during group therapy and what wasn't. This study is being conducted by Mr. Paul Rezutek and his advisor Dr. David G. Martin as partial fulfilment of Mr. Rezutek's Master's degree in Clinical Psychology at the University of Manitoba.

As a participant in this study, each adolescent client will be interviewed by Paul at Manitoba Adolescent Treatment Centre (MATC) for a maximum duration of one hour. As compensation for your time, all participants will receive a ten-dollar McDonald's coupon for their participation in this study. During this interview, the participant will be asked several questions, all with the goal of exploring the main research question: "From

the adolescent client's perspective, what factors are most helpful, and what factors are most detrimental in group therapy?"

The nature of this study requires the interviews to be audiotaped and subsequently transcribed verbatim to typed manuscripts. In the interest of maintaining strict confidentiality, each participant will be assigned a code number, with all identifying information removed from the typed manuscripts. Likewise, all therapist identifying information will also be removed from the typed manuscripts. To further provide confidentiality, all manuscripts will be stored in a locked room to be accessed only by the investigators (Paul Rezutek and David Martin). However, while information given during the course of the interview will remain confidential, there are special circumstances that may limit confidentiality. One such circumstance involves current laws that requires abuse against children to be reported to MATC staff, if those offences have not already been reported.

All reports of findings will contain only group data, and no individual participant will be identifiable. Results of this study will be provided to participants and MATC staff upon its completion. These results will be presented only as group data.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities.

**You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. In**

**no way will your declining to participate affect the services you are currently receiving or will receive in the future.**

Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project you may contact me

, Dr. Martin

or the Human Ethics Secretariat

A copy of this consent form has been given

to you to keep for your records and reference.

Sincerely,

Paul Rezutek

---

Participant's Signature

Date

---

Investigator and/or Delegate's Signature

Date

Parental/Guardian Consent Form

Research Project Title: The Perception of Therapeutic Factors in Adolescent Group Therapy

Investigator: Paul Rezutek

Sponsor: Dr. David Martin

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

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The nature of this study requires the interviews to be audiotaped and subsequently transcribed verbatim to typed manuscripts. In the interest of maintaining strict confidentiality, each participant will be assigned a code number, with all identifying information removed from the typed manuscripts. Likewise, all therapist identifying information will also be removed from the typed manuscripts. To further provide confidentiality, all manuscripts will be stored in a locked room to be accessed only by the investigators (Paul Rezutek and David G. Martin). However, while information given during the course of the interview will remain confidential, there are special circumstances that may limit confidentiality. One such circumstance involves current laws that requires abuse against children to be reported to MATC staff, if those offences have not already been reported.

All reports of findings will contain only group data, and no individual participant will be identifiable. Results of this study will be provided to participants and MATC staff upon its completion. These results will be presented only as group data.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to allow this legal minor to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities.

**The participant is free to withdraw from the study at any time, and /or refrain from answering any questions they prefer to omit, without prejudice or**



**consequence. In no way will their declining to participate affect the services they are currently receiving or will receive in the future.**

Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project you may contact me

Dr. Martin

or the Human Ethics Secretariat . A copy of this consent form has been given to you to keep for your records and reference.

Sincerely,

Paul Rezutek

\_\_\_\_\_  
Name of Participant (Adolescent Client)

\_\_\_\_\_  
Relationship to Participant (e.g., Mother, Father, Guardian, etc)

\_\_\_\_\_  
Signature of Guardian

\_\_\_\_\_  
Date