# 3

# The History of Group Practice

## *A Century of Knowledge*

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The history of group practice follows the history of humans. Human primates, nonhuman primates, and many other species congregate for the purpose of survival based on sociality. But what makes an aggregate of humans participating in group psychotherapy or a group of undergraduates participating in a group social psychology experiment different from a woop of gorillas; or for that matter, a gaggle of geese, an exaltation of larks, and a pride of lions? Of course, the answer is obvious, but at a far more subtle level, we must examine the uniquely human quality of written history based on words; how humans communicate with each other, both in the written and spoken forms. This linear view of history has its advantages and its disadvantages. On the one hand, we are able to line up chronological events in order and examine them (e.g., with literature searches of empirical studies over a century); on the other hand, the deconstructionists remind us that this can be a fairly compressed and sometimes inaccurate view of true historicity. Scholars remind us that there are alternate views of reality (Abbott, 1884/1984). In addition, these forays into history are clearly bounded by the Western World. No doubt, we could learn much from other traditions, cultures, and countries (often aggregated under the appellation, Eastern World). With these limitations in mind, we will proceed with an accounting of the facts culled from articles and the empirical literature over the last century and into the present regarding the many types of group practice. Sources included but were not limited to Medline, PsycLit, ERIC, and Social Science Index, from

the beginning of the 20th century to the beginning of the 21st century. Although not exhaustive, these reviews are representative.

## History's View

When the physician Dr. John Pratt treated his tuberculin patients in a group class in 1905 and subsequently published the findings about his "Thought Control Classes," the written history of group practice most likely got its start. Certainly, philosophers, scientists, and literary authors had written about the power of human groups through the ages (i.e., Plato's societal groups, Le Bon's dangerous "crowd"; Ibsen's contrast of external and internal groups in "Ghosts;" even Abbott's clever mathematical tale of two-dimensional groups). What distinguishes Dr. Pratt's writing is that it represents an early attempt to explain how the unique properties of the group, not simply the traditional medical treatment of doctor and individual patient, could actually have healing properties. The interdependence of these patients contributed to the quality of their care and recovery from tuberculosis. Forsyth (1999, p. 6) reminds us that although interdependence is the key, other words also help to describe groups: communication, influence, interaction, interrelations, psychological significance, shared identity, and structure.

A number of other contributing authors to this text may cite different beginnings, reflecting the great variety of an emerging discipline. Perhaps by the *fin de siècle* of the 1800s, the combination of the refinement of science and society's growing self-reflection allowed curiosity about the nature of individual humans operating in social groups. For whatever reason, the study of groups appears to have popped up in several places and disciplines at the same time (Ruitenbeek, 1969). Since these early beginnings in medicine, sociology, politics, theater, and psychology, the study of group dynamics has spread to business, criminal justice, anthropology, sports, and many other systems (Anthony, 1968; Forsyth, 1999, p. 19; Fuhriman & Burlingame, 1994, p. 3). The application of groups to a variety of human issues continues to grow. No longer viewed as simply a "second best" way to educate, treat, or consult with people, group practice is seen as a potent change agent in global politics, ethnic strife, religious differences, and almost all majority/minority group struggles. The amazing scope of group treatments has been amplified by our entrance into the Internet age. Although they are controversial, virtual groups on the Internet may in fact possess many of the qualifying attributes of real groups (although the face-to-face interaction is clearly missing). Only time will tell.

Generally, group practice is used to address issues in psychotherapy such as group treatments for depression, eating disorders, and so on where the purpose is to reduce troubling symptomatology. Group practice also deals with group dynamics (group interventions in such areas as business, education, and politics, where the purpose is to raise awareness or improve group functioning). These groups range in duration from brief to long term and occur in a variety of settings from hospitals to corporate boardrooms. In this chapter, we will review the individuals who were early group vanguards. The "conglomerate, complex, confabulatory, and conflictual" theoretical and empirical developments (Anthony, 1971, p. 4) will be discussed as well. Finally, the efficacy of group practice as a change agent is explored. After all, what's all the enthusiasm about if groups don't really work?

## Early Group Pioneers

Just who garners the title "father or mother" of group practice remains debatable. It would be easy to assign it to Sigmund Freud and his Wednesday night meetings in Vienna, or perhaps to Alfred Adler (although he would strongly object, as he did not see himself primarily as a group therapist), or Jacob Moreno, whose entire body of work

promoted interpersonal dynamics, or perhaps Samuel Slavson, considered by many to be the father of modern group psychotherapy. Each in turn made substantial contributions, both to the literature and to application, regarding the underlying properties of group dynamics: Freud's beliefs about the role of the conscious and unconscious in compromise formations and his training in medicine; Adler's unshakable belief that humans seek to belong to mediate inferiority and his background in psychiatry; Moreno's active psychodrama techniques and his training in theater; Slavson's belief in activity group therapy for children.

Gazda (1968, p. 7) reminds us that many definitions of group psychotherapy existed in the early years, and that may be one of the reasons we cannot quite settle on one father. Even so, this multifaceted view created a rich background from which group dynamics emerged as a discipline. Thus, psychoanalytic tenets, interpersonally goal-directed belonging, role-playing theatric interventions, and individual and group processes with children, to name just a few, all became part of group dynamic's patchwork theoretical background.

Group practice forged ahead with the continuing work of Dreikurs (1932, 1956), Marsh (1931), and Lazell (1921). Syz (1928) broadened the growing field to include the power of member influence, the psychoeducation approach, the milieu treatment, and a here and now focus. Moreno and Whitin eventually applied the term *group therapy* to these endeavors in their 1932 publication, *Application of the Group Method to Classification.*

Kurt Lewin's (1936) field theory made group dynamics (a term he coined) available to many segments of the population, not just to mental health professionals. Wender (1936), Schilder (1937), Slavson (1940), and Wolf (1949) added re-creation of the primary group, group treatment of children, and credentialing. As noted by Fuhriman and Burlingame (1994) in their seminal textbook, *Handbook of Group Psychotherapy: An Empirical and Clinical Synthesis,*

> Contributors themselves came from diverse origins. Traces of theory emanate from such diverse areas as personality theory, field theory, and systems theory, thus influencing our intra-, inter-, and contextual focus. Theoretical orientations also left their mark at various times and to differing degrees, but with lingering influence. Traces of psychoanalytic, group dynamics, existential-experiential, and behavioral theories can be found today in the way group therapy is defined, conceptualized, implemented, and evaluated. Current theory and practice contain threads from multiple disciplines, including psychiatry, psychology, education, social work, and organizational behavior. (p. 6)

This sheer array of diverse origins reflects the complexity of the group phenomenon we are addressing. No wonder many early observers asked: Is this a singular (client or group member), dyadic (subgroup), cumulative (passage of time), or collective (the group-as-a-whole) phenomenon? Well, it is all of them. That is exactly why group researchers can sometimes quake in their boots—dealing with error terms alone causes understandable fear! Still, over the last century, the examination of group processes has continued to improve. Current research has reached a level of sophistication the early researchers would envy (thanks to innovative statistical analyses and advanced methodologies). And what does 100 years of empirical research tell us? Groups work.

## Efficacy

The science historian Thomas Kuhn (1977) reminds us that when we look back on earlier forms of thinking, we must be careful not to gaze on them with chronologically biased eyes. That is, we must not assume that ideas of the past constitute quaint notions in view of what we know now. In fact, many theories and applications of theories were contextually quite sound, given the context at the time. This also is true of group

research. It would be easy to dismiss the early forays into examining the efficacy of group practice, given the level of sophistication we have reached at the beginning of the 21st century. But a careful reading of those early studies gives us the rich background of curiosity about humans working together. These findings give us a rare glimpse into the early researcher's questions about the group phenomenon, their take on what variables were worthy of study, and their fledgling attempts to explain multilevel phenomena. They were curious about the same basic questions in the 1900s that we are in the 2000s: Do groups work? and if so, How?

Do the same basic group principles that manifest positive outcomes exist consistently across all the diverse applications of group practice? Currently, there are a number of competing theories about how and why groups work, but we may be on the brink of a unified theory. Burlingame, MacKenzie, and Strauss (2004) suggest underlying unifying variables that may be much like the work of Nobel prize- winning physicist Edward Witten. It seems science has been grappling with the problem of unifying the four known forces in physics. String theory (or M theory as it is now dubbed) may be the unifying theory. But there was a problem: Five string theories existed! In 1995, at the international meeting of string theorists, Whitten provided the mathematical evidence that there really was just one theory. The five previous theories were but different reflections in a mirror of one underlying phenomenon. What underlies the immense power of group phenomena likely has profoundly simple roots as well. Burlingame and his colleagues (2004) invite us to consider this with regard to group practice.

What allowed Burlingame and others like him to build such a theory were the scores of studies that have been conducted since the beginning of the 20th century. Table 3.1 presents those studies in the second half of the century that helped us know what kinds of interventions at the level of different models (e.g., cognitive behavioral, psychodynamic) worked for what kinds of group members; whereas, the first half of the century involved studies that mainly catalogued group studies (Burchard, Michaels, & Kotkov, 1948; Thomas, 1943).

For instance, in Burchard et al. (1948), the researchers essentially catalogued 15 scientifically oriented studies and developed a seven-factor descriptive framework to handle the wide variety of orientations, methods, interventions, and goals that were apparent across the disparate studies. The factor they labeled evaluation, which examined success of treatment, had the least amount of information of all the other factors. It is no wonder it was difficult to do anything but catalogue the 15 group treatments. However, from the 1960s on, reviews of group practice efficacy were much more likely to include equal amounts of information in several important areas: treatment orientation, number of studies, characteristics of the group members involved, overall conclusions, and the research methods employed to examine all of this (WLC—wait list control or comparable control group; OT—other group treatment comparison including pharmacotherapy; I—individual therapy comparison groups; COM—combined treatment group). Instead of basic descriptions and cataloging, calculating was occurring, a kind of statistical calculation that allowed for all sorts of important comparisons. Table 3.1 includes 31 reviews of overall efficacy, 22 from the original Fuhriman and Burlingame (1994) text; the remaining reviews cover those articles published from 1993–2003.

## Group Therapy Outcomes

### In the 1960s

Several important characteristics dominate the data included in the reviews of group research from the 1960s. First, a great deal of diversity existed in the various treatment models. Remember that in the first half of the century, researchers' studies mainly focused on anecdotal reports and case or group studies. By the 1960s, empirical investigations were under way, including

**Table 3.1** Group Psychotherapy Review Articles

| *Author* | *Treatment Orientation* | *Number of Studies* | *Comparison* *WLC* *OT* *I* *COM* | *Sample* | *Conclusions* |
|---|---|---|---|---|---|
| Rickard (1962) | Nondirective, psychoanalytic, psychodrama | 22 | X X X X | Mixed inpatient and outpatient | Too much variability among patients, therapists, and measures for comparison to be more than tentative. Efficacy of group remains to be empirically validated. |
| Pattison (1965) | Psychodrama, milieu, analytic | U | | Inpatient, prison, addict, delinquent | Group activity is therapeutic using behavioral criteria, disappointing with psychometric criteria, and promising with construct criteria. Notes that the research on individual psychotherapy and small group research has yet to be effectively incorporated into group psychotherapy research. |
| Stotsky & Zolick (1965) | Psychodrama, round table, and heterogeneous group | U | X X X X | Psychotics | The results of controlled experimental studies do not offer clear support for using group therapy as an independent modality, but they do support group as an adjunctive or helpful intervention when combined with other treatments (drugs, individual, etc.). |
| Mann (1966) | Psychodrama, nondirective | 41 | X X X | Mixed diagnosis, adult and children, most institutionalized | Group therapy produces change in behavior, attitude, and personality regardless of orientation, method of comparison, or instruments. |
| Anderson (1968) | Counseling groups | 6 | X X X | Elementary students | Group counseling associated with higher grade point average and personality change when compared to control. No difference when compared to other treatment combined. |

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**Table 3.1** (Continued)

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| Meltzoff & Kornreich (1970) | Heterogeneous, expressive, nondirective, systematic desensitization, behavior, Analytic | 6 | X X X | Hospitalized adults, adult outpatients, children | 80% of adequately controlled studies reviewed showed primarily positive results with both individual and group therapy. Six studies that made direct comparisons between group and individual therapy found equivalent outcomes, with a slight tendency for individual to be more effective. |
| Bednar & Lawlis (1971) | Heterogeneous, group psychotherapy, self-help, activity, milieu, work, insight | 38 | X X X X | Mixed inpatient, seven outpatient, delinquents, alcoholics, sex offenders, students | Group therapy is valuable in treating neurotics, psychotics, and character disorders. It is a two-edged sword that can facilitate client deterioration. |
| Luborsky, Singer, & Luborsky (1975) | Heterogeneous | 12 | X X X | Unspecific | Majority of comparisons showed no significant differences between group and individual treatment. There was a tie in nine comparisons, group was better in two comparisons, and individual was better in two comparisons. |
| Grunebaum (1975) | Unspecified | U | X | Heterogeneous | Only meager data exist comparing group and individual therapy, and the evidence suggests that they are equally effective in most instances. Some findings suggest that benefits may be disorder specific: for example, individual therapy better for phobias, and group more effective for schizophrenic outpatients. |
| Emrick (1975) | Heterogeneous | 384 | X X X | Alcoholics | Found a general trend for both individual and group to be effective in treating alcoholism. |

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| Lieberman (1976) | Heterogeneous, psychotherapy, and personal growth groups | 47 | X X | College students, adults | Group consistently produced favorable outcome over controls. Rported no outcome differences in studies that compared group with individual format. Noted that the indices used to measure outcome are relatively insensitive to the potentialities of different treatment contexts such as group and individual psychotherapy. |
| Parloff & Dies (1977) | Heterogeneous, psychotherapy groups | 39 | X X X X | Psychoneurotic, schizophrenic, addiction, legal offenders | Group has no unique advantage over other treatments with schizophrenic patients, no firm conclusions can be drawn with psychoneurosis, and limited support for effectiveness with addicts. |
| Bednar & Kaul (1978) | Heterogeneous, behavioral, transactional analysis, unspecific group therapy, and encounter groups | 21 | X X X | College students, delinquents, prisoners, psychiatric patients | Group treatments have been more effective than no treatment, placebo, and other recognized psychological treatments. |
| Solomon (1983) | Psychodynamic, aversion | 2 | X X X | Alcoholics | Combined individual and group therapy are related to poorest outcome while individual and group as independent treatment showed equivalent outcomes. |
| Kanas (1986) | Heterogeneous | 32 | X X | Outpatient and inpatient schizophrenic | Group therapy proved to be superior to controls in 67% of inpatient and 80% of outpatients studied, with long-term therapy being the best. |
| Kaul & Bednar (1986) | Experimental psychotherapy groups | 17 | X X | Primarily adult mixed diagnosis | Mixed but favorable outcomes for the efficacy of group psychotherapy. |

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**Table 3.1** (Continued)

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| Toseland & Siporin (1986) | Heterogeneous | 32 | X X | Heterogeneous | Results of this review indicated that group treatment was as effective as individual treatment in 75% of the studies included and was more effective in 25%. In the 32 studies reviewed, there was no case in which individual treatment was found to be more effective than group treatment. |
| Bostwick (1987) | Unspecified | 13 | X X | Unspecified | Individual treatment had less premature termination than group while combined individual and group treatment proved superior in reducing dropouts over either modality. |
| Oesterheld, McKenna, & Gould (1987) | Heterogeneous (e.g., behavioral, insight, cognitive behavioral, dynamic) | 18 | X X X | Bulimia | Group seems to be helpful but methodological limitations preclude robust conclusions. |
| Zimpfer (1987) | Heterogeneous (e.g., group counseling, multimodal, growth, insight) | 19 | X X | Elderly | Group seems to be helpful but methodological limitations preclude robust conclusions. |
| Freeman & Munroe (1988) | Cognitive behavioral, eclectic, supportive, didactic | 13 | X X X X | Bulimia | Neither drug nor group therapy are as effective as individual, but all are more effective than placebo. Group is most cost-effective and combined group and individual are most effective of all treatment. |

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| Cox & Merkel (1989) | Heterogeneous | 32 | X X X | Bulimia | In a review of 15 groups and 17 individual studies (only one study provided a comparison between the two modalities, the rest were inferential), it was concluded that there was no support for the two treatments having any differential effectiveness. |
| Zimpfer (1990) | Cognitive behavioral, psychoeducational behavior | 31 | X X | Bulimia | Regardless of treatment type and outcome criteria, group was shown to be an effective treatment. |
| Piper & McCallum (1991) | Self-help, consciousness, cognitive restructuring, behavioral skills, dynamic | 5 | X X X X | Grief | Group treatment has not been adequately tested to determine its efficacy. |
| Vandorvoort & Fuhriman (1991) | Cognitive behavioral, psychodynamic, cognitive | 12 | X X | Outpatient, depression | Group is efficacious in treating depression with little evidence for differences between individual and group. |
| Piper & Joyce (1996) | Behavior 30%, cognitive behavior 26%, interpersonal/ psychodynamic 14%, didactic 1% | 86 | X X X X | Lifestyle problems, medical conditions, mixed psychiatric disorders, mostly adults | Preview of a variety of patient problems treated in interactive therapy groups for 6 months or less were examined for evidence of efficacy, applicability, and efficiency of time-limited, short\-term group therapy (TSGT). Strong evidence for all three factors was found. Of 50 studies that had TSGT versus control comparison, 48 provided evidence of benefit of group treatment. A difference in benefit was found for the 6 studies that used TSGT versus individual. |

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**Table 3.1** (Continued)

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| Hoag & Burlingame (1997a) | 60% behavioral or cognitive behavioral | 56 | X X X X | Male and female children and adolescents (4–18), primarily problems of disruptive behavior, self-esteem | Review of studies from 1974–1997 of group interventions for children and adolescents (including preventative, psychotherapy, guidance) revealed that treatments occurred mostly in school setting and groups were beneficial. |
| Marotta & Asner (1999) | Psychoanalytic, cognitive behavioral, self-help, psychoeducational | 21 | X X X X | Adult females | Review of studies from 1978–1995 of group interventions for women with incest histories (using a wide array of treatment models)—categorized by six criteria: design, sample, inclusion criteria, replicability, analysis, and outcome. Fourteen were descriptive or case studies. Some support for group treatment was provided. Minimal adequacy of research designs was noted. |
| Harney & Harvey (1999) | Cognitive behavioral, interpersonal transaction (Yalom), information processing, psychodynamic | 5 | X X X | Male and female adults | Review of studies of trauma survivors assessed important variables along eight domains: authority over memory, integration of memory with affect, affect tolerance, symptom mastery, self-esteem/self-care, self-cohesion, safe attachment, meaning-making. Multidimensional, stage-oriented approaches worked best. |
| Shechtman (2002) | Educational, counseling, psychotherapy (multitheoretical and cognitive behavioral) | U | X X X X | Male and female children and adolescents | Review of studies of group interventions for children found that all three types of groups were effective as long as suitable goals were set. Findings regarding process in children's groups showed that very little research exists. |

NOTE: WLC = wait list control or comparable control group, OT = other group treatment comparison including pharmacotherapy, I = individual therapy comparison groups, COM = combined treatment group, e.g., group plus individual or group plus inpatient ward treatment.

SOURCE: Fuhriman & Burlingame, 1994. Adapted with permission.

permutations of the combinations allowed, with many kinds of comparison groups. Researchers used control groups (no-treatment condition), alternative treatments (rival group treatments), individual therapy, and combined treatment conditions (e.g., conjoint individual and group therapy). The only problem was the population under study was captive (institutionalized participants). In addition, comparisons were often made simply for convenience—for instance, two wards in the same hospital, which Cook and Campbell (1979) remind us constitute nonequivalent comparison groups.

Methodological problems aside, the studies provided tentative support for the efficacy of group treatment. Rickard (1962) essentially repeated the claims of Burchard and his colleagues from 1948 that enormous variability of patients, therapists, and treatment models leads to questionable findings. Pattison's (1965) work reported modest behavioral support for success with institutionalized patients. However, he was one of the first researchers to point out the problem with selecting dependent measures that did not match the hypotheses. The work of Stotsky and Zolik (1965) suggested that group therapy was an adequate adjunct to individual and/or psychopharmacological therapy, although their findings were far from enthusiastic. Mann (1966) and Anderson (1968) independently concluded in their reviews that groups do work; but each of these authors emphasized the nature of the reviews. Mann had used 11 of the studies reviewed by Rickard in 1962, when he examined a total of 40 "diversely conceived and executed studies" (Fuhriman & Burlingame, 1994). Mann's findings suggested that improvement was uniform across these diverse studies but that it was still not clear if one particular group treatment was superior to another.

## In the 1970s

More rigorous research methods were employed in the major group reviews of the 1970s. These seven reviews offered a most optimistic picture. In this decade, some of the giants of group research got under way in what became a lifelong love for studying psychotherapy phenomenon. Bednar and Kaul (1978), Lieberman (1976), Yalom (1975/1985), and others added not only to the more rigorous research methodology but also to the growing maturity of the underlying theoretical components. More representative populations also were being studied (e.g., inpatient and outpatient). These researchers were joined by Emrick (1975) and Meltzoff and Kornreich (1970) in their general conclusion that group psychotherapy was effective, and actually superior, to alternate treatments in many cases.

Another result of the reviews from the 1970s was the growing awareness of the importance of matching. Matching refers to the fact that certain disorders warranted certain kinds of treatment (Bednar & Lawlis, 1971; Grunebaum, 1975; Parloff & Dies, 1977). Still, researchers were unclear about the underlying curative factors operating in groups that might explain positive outcomes. However, this curiosity only was possible because certain other variables had been better controlled.

## In the 1980s

One of the by-products of the initial matching studies of the 1980s was the specificity that researchers invoked. They carefully examined specific kinds of patient diagnosis such as depression, eating disorders, bereavement, old age, schizophrenia, and so on. In this decade, carefully controlled comparison groups were de rigueur for researchers. This included multiple comparison groups of both inert and active treatment conditions. Such rigor allowed the researchers to make more definitive statements about general and differential efficacy (Cox & Merkel, 1989; Freeman & Munro, 1988; Kanas, 1986; Kaul & Bednar, 1986; Oesterheld, McKenna, & Gould, 1987; Solomon, 1983; Toseland & Siporin, 1986; Zimpfer, 1987), although Bostwick (1987) drew

our attention to the problem of premature termination or dropouts, which continues to wreak havoc with group findings.

### In the 1990s and Beyond

Piper and McCallum (1991) began a fruitful examination into complicated bereavement and the differences in supportive versus psychodynamic group therapy, although their initial findings suggested that effectiveness could not be determined, given the flawed methodology. The reviews of Vandervoort and Fuhriman (1991) and Zimpfer (1990) strengthened the growing empirical claim that groups work. Hoag and Burlingame (1997a, 1997b) and Shectman (2002) branched into groups with children, whereas others (Harney & Harvey, 1999; Marotta & Asner, 1999) reviewed particular problem areas such as trauma and incest.

### Into the Twenty-First Century

Forsyth (2000) devoted an entire journal to the advances in group research methodology, detailing the impact of carefully controlled group studies that yielded reliable findings. This advancement alone will encourage many more complex research designs as group psychotherapy is studied into the 21st century. By examining the 750 or so studies over the past 100 years, we are able to state that the group format produces positive effects with a number of disorders using a variety of treatment models. Future studies will likely refine these empirical claims.

## Special Concerns: Comparing Individual and Group; Combining Individual and Group

This vast literature provides us with a reputable foundation on which to base our confidence that groups really do work. Nevertheless, several concerns have cropped up. First, recent meta-analyses have shown group to be inferior to other active treatments and comparable to inactive treatments. The second concern surrounds the practice of combining group therapy with other treatments. Understandably, this makes it more difficult to determine which effects can be attributed to group and which to the other treatments.

### Meta-analysis

As this large data set of group effectiveness accumulated, Smith and Glass (1977) introduced a new statistical method (meta-analysis) into research designs as a way to estimate the average amount of change one could expect in a given treatment. The resulting effect size (ES), or single index, contrasts with the box score method that had dominated research methodology to that point. This latter method sorted studies according to positive or negative findings. Many researchers and clinicians believe that meta-analysis, in contrast to the box score method, is a much more reliable method. Still, others (Mullen, Driskell, & Salas, 1998) raise concern that our heavy reliance on such a statistical method may be premature. For example, Barlow, Fuhriman, and Burlingame (2004), wrote:

> With the 1977 Smith and Glass publication, the statistical method of meta-analysis burst onto the empirical scene and offered researchers a way to essentially compare oranges and apples. As long as studies included means and standard deviations, comparisons could be made that yielded an effect size. This rendered previously disparate pieces of information comprehensible at an overall level. Still, having an estimate of the average amount of change one could expect from a given treatment has both negative and positive consequences.

> On the one hand, it allows researchers and consumers to directly compare certain kinds of treatments. On the other hand, a number of excellent qualitative studies and/or N-of-1 studies are generally left out of the database. In addition, as scientific journals generally only publish statistically significant results, even studies that included traditional methods of statistical analysis but confirmed the null hypothesis are generally excluded from research journals. Thus it has been argued by some that meta-analyses represent only a certain type of investigation. A harsh evaluation of meta-analysis as "junk science" has been leveled at researchers by some authors. (p. 10)

Only time will tell. At present, meta-analysis is the only way researchers have of examining what essentially amounts to comparing apples to oranges.

Nine meta-analyses in Table 3.2 compare the relative effectiveness of group with individual format or compare group format with inert or inactive treatments. Although the resulting effect sizes reflect a convenient, often powerful bottom line, such single indexes may eclipse the rich data available (Dush, Hirt, & Schroeder, 1983; Miller & Berman, 1983; Nietzel, Russel, Hemmings, & Gretter, 1987; Robinson, Berman, & Neimeyer, 1990; Shapiro & Shapiro, 1982; Smith, Glass, & Miller, 1980; Tillitski, 1990). In addition, the various studies may contradict each other.

Horne and Rosenthal (1997) have attempted to understand this state of affairs. They conclude that although individual treatment has been shown to be superior to group, this was true *only* in studies where group formats were used as a convenient and economic way to offer psychotherapy. None of the curative factors unique to group process had apparently been highlighted by the leaders or singled out for examination. Those meta-analyses conducted on studies that directly measure therapeutic factors in groups, as separate from individual factors, yield larger and, hence, significant effect sizes (Hoag & Burlingame, 1997a; McRoberts, Burlingame, & Hoag, 1998).

The meta-analyses conducted by de Jong and Gorey (1996) and Reeker, Ensing, and Elliott (1997) did not include a direct comparison between group and individual formats. Rather, they were comparing long-term versus short-term group formats and different kinds of specific formats. What they found was that groups were effective regardless of length and regardless of specific format. In research parlance, these studies that compare one treatment modality with another modality have been dubbed, "horse races." The horse races in group psychotherapy research appear to yield about the same findings as the horse races in individual psychotherapy research. Years ago, when researchers first noticed this, Luborsky and his colleagues dubbed this the "Dodo" phenomenon (Luborsky, Singer, & Luborsky, 1975)—that although most treatments were effective, no one treatment was superior to another—recalling the *Alice in Wonderland* race. Much has been made of these issues, especially as consumers demand the best treatment, and insurance companies more selectively reimburse only empirically supported treatments (ESTs.) Both individual and group psychotherapy researchers are hoping to find answers to the question: What is it precisely that accounts for the variance?

Beutler (personal communication, November 15, 2003) suggests that as researchers, we must avoid the tendency to pit one treatment against another in a "dogma-eat-dogma" competition and that we must look for the principles (not the treatment packages and manuals) that address *all* the aspects that help people change. This is because even if we could accurately determine what portions of the therapeutic pie were enhanced by treatment method, therapist interventions and so on, we still would face the sobering issues that a great deal of the variance is still unaccounted for and that some variables may be inevitably uncontrollable. The patients go home to families, jobs, and other environments, which

**Table 3.2** Group Versus Individual Meta-Analyses

| *Author* | *Treatment Orientation* | *Group Characteristics* | *Sample* | *Conclusions* |
|---|---|---|---|---|
| Smith, Glass, & Miller (1980) | Heterogeneous | Variable | Heterogeneous | The mode in which therapy was delivered made no difference in its effectiveness. Indeed, the average effects for group and individual therapy are remarkably similar. The average effect size was 0.87 for individual therapy and 0.83 for group therapy. Of the studies reviewed, 43% were individual, and 49% were group. |
| Shapiro & Shapiro (1982) | Heterogeneous | Average time spent in therapy was 7 hours. | Heterogeneous | This refined meta-analysis of the one conducted by Smith and Glass (1977) reported that although individual therapy appeared the most effective mode (M = 1.12), it was closely followed by the predominant group mode (M = 0.89), and the only striking treatment mode finding was for couple/family therapy (M = 0.21). |
| Miller & Berman (1983) | Cognitive behavioral | Duration of treatment relatively short. | Adolescents and adults, student/ community volunteers and outpatients, anxious and/or depressed | This meta-analysis of 48 studies reported that cognitive behavioral treatment was equally effective in group and individual formats when compared to a nontreatment group (individual 0.93, group = 0.79) and when compared with other treatment controls (individual = 0.31, group = 0.18); it should be noted that none of the studies in the review directly compared individual with group treatment within a single study. |

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| Dush, Hirt, & Schroeder (1983) | Cognitive behavioral self-statement modification | Mean weeks of treatment were 5.9 with a range of 1 to 26. | About one fourth of studies used outpatients, one fourth used community volunteers, and half used undergraduate depressed and anxious volunteers. | Treatment modality was highly influential, with the mean effect for individual therapy nearly double that of group therapy across all comparisons. When compared to no-treatment controls, the effect size was 0.93 for individual and 0.58 for group; when compared to placebo controls, it was 0.71 for individual and 0.36 for group. |
| Nietzel, Russel, Hemmings, & Gretter (1987) | Cognitive, behavioral, and other | Mean number of hours in treatment was 16.3, with a range of 3 to 69 (distribution between group and individual hours not made). | Individuals with unipolar depression, adults | Reports a reliable difference between individual and group treatment, with group treatment being less effective. Clients treated with group (M = 12.47) reported more depressive symptoms than clients receiving individual treatment (M = 0.06). |
| Robinson, Berman, & Neimeyer (1990) | Included treatments with a prominent verbal component (i.e., cognitive, cognitive behavioral, behavioral, and general verbal therapy) | Number of clients per group ranged from 3 to 12 (M = 7). | Depressed individuals | Analysis indicated that both group and individual therapy produced more improvement than no treatment and that the effects of the two approaches were comparable. The 16 studies that compared individual and group therapy with a wait-list control, and the 15 studies that compared group with a wait-list control produced nearly equal effect sizes (0.83 and 0.84 respectively). |

*(Continued)*

**Table 3.2** (Continued)

| | | | | |
|---|---|---|---|---|
| Tillitski (1990) | Therapy, counseling, psychoeducational | Heterogeneous | Adults, adolescents, children diagnostically heterogeneous | In this reexamination of a subset of the studies looked at by Toseland and Siporin (1986), Tillitski reports finding the same average effect size for both group and individual treatment (1.35) and states that this effect was consistently greater than that of controls (0.18). Also, group counseling was found to be almost twice as effective as either therapy or psychoeducation. Recent studies produced larger effect sizes, and group tended to be better for adolescent, whereas individual tended to be better for children. |
| Hoag & Burlingame (1997) | 60% behavioral or cognitive/behavioral | 79% took place in school groups (focused primarily on disruptive behavior, social skills, self-esteem. Average group size was 5 to 9. Average treatment length: 14 sessions. | Male and female children and adolescents (4 to 18) | 56 outcome studies from 1974 to 1997 of group interventions (including preventative, psychotherapy, guidance) revealed effect size of .61 for group treatment over wait list and placebo controls. |
| McRoberts, Burlingame & Hoag (1998) | Cognitive, behavioral, dynamic, supportive, eclectic | Average groups of 16 sessions, lasting 90 minutes each, 44% had cotherapists. | Adult outpatients with heterogeneous diagnoses | In this meta-analysis of group versus individual therapy, the general finding was overall equivalence (0.01), although under certain circumstances, individual therapy fared better (depression, cognitive behavioral approach, .16); in other circumstances, group fared better (with circumscribed problems, researcher's allegiance to format, attendance of member). |

| | | | | |
|---|---|---|---|---|
| McDermut, Miller, & Brown (2001) | 95% behavioral or cognitive behavioral; 5% interpersonal, psychodynamic, or nondirective | Highly diverse clinical settings, typical group lasted 12 sessions, once a week, variety of therapists. | Male (30%) and female (70%) outpatient adults with diagnosis of depression (mean age 44) | 48 studies from 1970 to 1998 examined group therapy for depression. Patients showed clinically meaningful improvement compared to untreated controls, although their scores on Beck's Depression Inventory were still higher than normals. Of studies that compared group with individual therapy, slightly more reported individual to be superior. |
| Burlingame, Fuhriman, & Mosier (2003) | Cognitive, behavioral, dynamic, supportive, eclectic | University, correctional, and outpatient mental health settings | Adult outpatients with heterogeneous diagnoses | Examining 20 years of studies, the report found that patient diagnosis resulted in differential effects, homogeneous groups outperformed those in groups with mixed symptoms, and behavioral fared better than eclectic orientation. |

SOURCE: Fuhriman & Burlingame, 1994. Adapted with permission.

influence their overall ability to get better or not. Here is where group therapy just might be ahead of individual psychotherapy research. The social environment is being replicated in the very treatment strategy. In some ways, generalization is more likely to take place because the patient has already practiced in other social settings. Only time will tell how these particular issues in group psychotherapy will be resolved.

Researchers also compare group treatments with other kinds of treatments such as milieu therapy (inpatient treatment that includes an array of interventions), psychopharmocotherapy (some form of psychotropic medication), and so on. Obviously, differential effectiveness would be difficult to determine. Did a patient become healthier because of the milieu therapy, the group therapy, the individual therapy, or the medication? This represents a real conundrum.

One of the most robust findings of these studies found ways to tease apart effects from several lugubrious sources, with the conclusion that combined group and individual therapy resulted in superior outcomes when compared with the independent outcomes of either treatment alone (Amaranto & Bender, 1990; Bostwick, 1987; Freeman & Munro, 1988; Pattison, Brissenden, & Wohl, 1967), although there were dissenting opinions (cf. Anderson, 1968; Stotsky & Zolik, 1965).

Such different combinations of treatments, matched by research methodologies that allow researchers to isolate one effect from another, have led to expanding conceptual models of efficacy. Potential patients benefit from this because clinicians are armed with good data that allow them to tailor a treatment protocol. For instance, in some cases, it is clear that group treatment is the main treatment—the format of choice (Burlingame et al., 2002; Piper, Rosie, Joyce, & Azim, 1996; Taylor et al., 2001). In other cases, however, the combination of one format with another is more helpful to the patient. In 1978, when Ormont and Strean suggested this innovative idea, little did they know it would lead to an explosion of alternatives and further delineate combined from conjoint therapy. In summary, as more data are analyzed, we will know more clearly both the impact of complicated statistical analyses and permutations of treatment combinations.

## The Evolution of Group Psychotherapy and Group Psychology Research: Content Complexity and Sophisticated Methodology

Recall that the origins of research on the small group phenomenon come from diverse fields. In particular, two somewhat independent although interacting domains—group psychology and group psychotherapy—constitute the two main contributors to the research (Back, 1979; Fuhriman & Burlingame, 1994). Group psychology research is subsumed within general social psychological research. Probably, an in-depth examination of the 100 years of research would be less helpful than an overview of themes or topics of research (See Tables 3.3 and 3.4).

In group psychology, the topics have focused on group characteristics and dynamics and how these influence the completion of the particular group tasks at hand. Data are typically collected based on analogue groups. Other issues of structure and communication were addressed in the 1940s (Zander, 1979a, 1979b). Researchers expanded to include such topics or themes as the development and maintenance of norms, the effect of member composition, the operation of member roles, the growing awareness of different developmental stages in groups, and finally, the impact of leaders.

In contrast, group psychotherapy researchers initially borrowed from the individual research literature. Understandably, data were derived from actual therapy groups. Although some topics overlap with group psychology (e.g., structure, format), in the main, group psychotherapy researchers were interested in different areas of

**Table 3.3** Small Group Psychology: Thematic Evolution

| | *1900–1910* | *1911–1920* | *1921–1930* | *1931–1940* | *1941–1950* | *1951–1960* | *1961–1970* | *1971–1980* | *1981–1990* | *1991–2003* |
|---|---|---|---|---|---|---|---|---|---|---|
| Models/approaches | | | | | | X | X | X | | X |
| Interpersonal influence | X | | | | X | X | X | X | X | X |
| Problem-solving/ Decision-making | X | | X | X | X | | | X | X | X |
| Group structure | | | | X | X | | X | X | X | X |
| Group climate | | | | X | X | X | X | X | X | X |
| Leadership | | | | | | X | X | X | X | X |

SOURCE: Fuhriman & Burlingame, 1994. Adapted with permission.

**Table 3.4** Group Psychotherapy: Thematic Evolution

| | *1900–1910* | *1911–1920* | *1921–1930* | *1931–1940* | *1941–1950* | *1951–1960* | *1961–1970* | *1971–1980* | *1981–1990* | *1991–2003* |
|---|---|---|---|---|---|---|---|---|---|---|
| Formats/theories/ models | X | X | X | X | X | X | X | X | X | X |
| Patient/client populations | X | X | X | X | X | X | X | X | X | X |
| Therapeutic relationship | | | X | X | X | X | X | X | X | X |
| Therapist variables | | | | | | | X | X | X | X |
| Therapeutic factors | X | X | X | X | X | X | X | X | X | X |
| Structure | | | | | | | X | X | X | X |
| Interaction analysis | | | | | | | X | X | X | X |
| Client outcomes | | | | | | X | X | X | X | X |
| Ecosystem | X | X | X | | X | | X | X | X | X |

SOURCE: Fuhriman & Burlingame, 1994. Adapted with permission.

examination such as models, therapeutic relationship, ecosystem, therapeutic factors, and the mentally ill, across the entire lifespan (child, adolescent, adult, elderly). In the early years, the study of psychodynamic and psychodrama models dominated the research. Interest broadened to include more models, different populations, and an array of settings. This research

shaped conceptual explanations of group therapy as investigators examined three main foci: interpersonal, intrapersonal, and integral; that is, between members, within members (their intrapsychic dynamics), and group as a whole. By the 1980s, researchers were convinced that all three areas were critical to examine.

Eventually, researchers from the two camps began to take note of each other's research. For instance, by the 1970s, both camps were examining leadership. Table 3.4 highlights the diversity of interests that continued to grow over the decades, until by the end of the century, virtually every relevant topic was under scrutiny. Certain topics gained ascendancy and then faded (leadership), whereas others remained steady (therapeutic factors) throughout the decades as researchers' questions were answered and curiosity drove them toward other topics. Although each camp followed divergent interests, it is impossible to think of group psychology and group psychotherapy researchers as not having influenced each other (Tables 3.3 and 3.4). The sheer number of group articles in the latter half of the 20th century as compared with the first half is an impressive manifestation of burgeoning interest in diagnosis, treatments, members, leaders, therapeutic factors, structure, process, and outcome.

Researchers were aided in their search for relevant variables by changes in research methodology as well. What were once simple tallies turned eventually into advanced statistical methodology and carefully controlled experimental designs. In fact, so many advances have been made that an entire issue of the group journal published by Division 49 (Group Psychology and Group Psychotherapy, American Psychological Association) was dedicated to these advances (Forsyth, 1998). But just how did we arrive at this sophistication? Ideally, we hope to find rich idiographic data (e.g., $N = 1$ case studies) as well as the nomothetic data of carefully controlled empirical studies. Early-century investigations were often based on single-group studies using mostly descriptions. As research methodology matured, preexperimental or pseudoexperimental studies were added to the earlier studies. By the late 1970s, thanks to a wide acceptance of Cook and Campbell (1979), most studies used one of five accepted empirical designs: experimental, quasi-experimental, correlational, survey, and descriptive. In this way, decreasing levels of rigor could be employed depending on such things as: (a) feasibility of random assignment into at least two treatment groups with a control; (b) manipulation of an independent variable without random assignment; (c) relationship between certain variables; (d) use of survey methods; and finally, (e) use of case studies, one-group pretest/posttest designs, and nonequivalent comparisons. Thus, rich, in-depth single-case studies complemented carefully controlled empirical studies, balancing the necessary demands of relevance and rigor.

Often, the limits of certain populations, settings, and models determined the number of studies in any given decade that used one type of design over another. Studies that were focused on efficacy (e.g., examining various models with particular patients, such as those with eating disorders) often employed quasi-experimental and experimental designs, whereas those focused on process variables (e.g., comparing therapeutic factors with patient diagnosis) relied heavily on correlational designs. Finally, unusual or emergent models (e.g., alternative treatments such as drama or dance therapy) were likely to be studied with single-case methods.

## The Future of Group Research

It makes intuitive sense that the last 100 years of research include methods and models that have become increasingly broad (examining an array of populations, settings, etc.) and deep (using complex methods of inquiry). Does the past predict the future? After reviewing about 500 studies from the last two decades—and

if these studies are typical—then we can expect more studies dominated by treatment of depression, children and adolescents, criminal offenders, physical and mental illnesses, eating disorders, and inpatient populations (Fuhriman & Burlingame, 1994). If the future of research is more than the "same old thing," we might also expect examinations of Internet groups, even though certain characteristics fail to meet traditional standards (e.g., face-to-face interaction). Other areas of inquiry, equally as intriguing, also may emerge.

In Table 3.5, we have added one more view of the many research studies reviewed thus far. Substantive themes were crossed by the principal characteristic of members for each study. This highlights once again major themes and client populations, although studies that concentrated on as-yet-understudied populations (e.g., stutterers, pathological gamblers) were eliminated for the sake of brevity, as were studies on certain topics for the same reason. If we take a closer look at these mainstream models and group members, we may notice several interesting trends.

Cognitive-behavioral models dominate, as do short-term treatment strategies (these two often go together). The more traditional process groups à la Yalom (1975/1985) are much less prevalent, as are those that are longer term. Are these longer-term, open-ended process groups a thing of the past, even though there is substantial data to support their efficacy? Do the ascent of cognitive behavioral models and the descent of long-term process models reflect growing budget concerns, HMO pressures for shortened treatment strategies, or the dwindling expert group professionals who are less and less likely to take group courses as part of their curriculum?

Therapists, as a unit of observation, also may be dwindling. Of these 500 or so studies from the last few decades, only those that specifically manipulated or measured a therapists variable were included in Table 3.5. Of these, most of them measured the therapist effect post hoc. However, therapeutic factors still are widely examined. A large number of studies work across patient population categories. Still, therapeutic factors (i.e., curative factors) are generally measured using client self-report. Lambert and Hill (1994) remind us that relying on only one source is clearly problematic. We must, instead, use a multisource strategy that includes expert raters and therapist input, along with client input.

What catches our attention next as we examine Table 3.5 might be the number of studies interested in structure or lack of structure. Far fewer studies looked at such things as pregroup training (clearly related to positive outcome) and development. Finally, it is obvious that measuring verbal and nonverbal interaction—those process analysis systems that allow a researcher to carefully track interactions between member and member or leaders and members—are on the rise. This is a good thing. Perhaps the increased awareness of, and training for, analyzing process is helping (Beck & Lewis, 2000; Benjamin, 1993). Finally, the "not specified" column has far too many Xs. In other words, we still need researchers to detail all the important aspects of their group studies.

## Conclusion

Humans gather. They have been doing so since the dawn of time. A very specific group gathering in the 19th and 20th centuries is group psychotherapy, which has a set of recognizable factors: appropriately referred group members, skilled leaders, and defined goals. Group psychology and group psychotherapy research help us understand *how, why*, and *when* this intervention form works, and it generally finds that groups work for a variety of patients, in a variety of settings, encompassing a variety of problems. Studies spanning 100 years inform us about the powerful process of group. Still, our optimism must be tempered. Burlingame et al. (2004) remind us that we have yet to identify some

**Table 3.5** Substantive Themes by Clinical Populations

| | *Child/ Adolescent* | *Medical* | *Depressed* | *Eating Disorder* | *Substance Abuse* | *Criminal* | *Inpatient* | *Family/ Marital* | *Elderly* | *Outpatient* | *Schizophrenic* | *Sexual Abuse* | *Personality Disorder* | *Not Specified* | *Other*[a] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Models/ Approaches* | | | | | | | | | | | | | | | |
| Cognitive behavioral | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Short-term | X | X | X | | X | | X | X | X | X | X | X | X | X | |
| Rogerian | | | | | | | | | | X | | | | | X |
| Gestalt | | | | | | | | | | | X | | | X | |
| Personal growth | | | | | | X | | | | | | | | X | |
| Psychodrama | X | | | | | X | X | | | | | | | | |
| *Therapist variables* | X | X | X | X | X | X | X | X | X | X | X | | X | X | X |
| Directiveness | | | X | | | | | | | | | X | | X | |
| Interpretation | | | | | | | | | | | | X | | X | |
| *Therapeutic factors* | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| *Structure* | X | X | X | X | X | X | X | | X | X | | X | | X | |
| Development | | | | | | X | | | | X | | | | X | |
| Pregroup training | | | | | | | | X | | X | | | | X | |
| *Interaction* | | | X | | X | X | X | X | X | X | X | X | | X | X |

NOTE: The topical and methodological themes of the 1980s and 1990s were derived from roughly 500 articles about group psychotherapy. A bibliographic listing of the selected literature may be obtained from the authors.

a. Various nontherapeutic designations.

SOURCE: Fuhriman & Burlingame, 1994. Adapted with permission.

underlying processes in groups *and* connect these processes to certain outcomes.

Initial studies examined a variety of group variables in a fairly nonsystematic way. By mid-century, statistical and methodological sophistication allowed us to know more about group processes and outcomes in a much more systematic way, yielding rewarding and sometimes perplexing findings. What will the next century bring? Perhaps the combination of adequate methodologies and statistics—coupled with the continued curiosity of group researchers, who are attempting to understand all the variables involved in outcome and process research, how they relate to each other, and how they inform an overall theory—might bring us ever closer to understanding this powerful process.

## References


Abbott, E. (1984). *Flatland: A romance of many dimensions.* New York: Penguin. (Original work published 1884)

Amaranto, E., & Bender, S. (1990). Individual psychotherapy as an adjunct to group psychotherapy. *International Journal of Group Psychotherapy, 40*(1), 91–101.

Anderson, A. (1968). Group counseling. *Review of Educational Research, 33,* 209–226.

Anthony, E. J. (1968). Reflections on twenty-five years of group psychotherapy. *International Journal of Group Psychotherapy, 18,* 277–301.

Anthony, E. J. (1971). The history of group psychotherapy. In H. Kaplan & B. Sadock (Eds.), *Comprehensive group psychotherapy* (1st ed.). Baltimore, MD: William & Wilkins.

Back, K. W. (1979). The small group: Tightrope between sociology and personality. *The Journal of Applied Behavioral Science, 15*(3), 283–294.

Barlow, S., Fuhriman, A., & Burlingame, G. (2004). The history of group counseling and psychotherapy. In J. DeLucia-Waack, D. Gerrity, C. Kalodner, & M. Riva (Eds.), *Handbook of group counseling and psychotherapy* (pp. 3–22). Thousand Oaks, CA: Sage.

Beck, A., & Lewis, C. (2000). *The process of group psychotherapy: Systems for analyzing change.* Washington, DC: APA Press.

Bednar, R., & Kaul, T. (1978). Experiential group research: Current perspectives. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed., pp. 769–815). New York: John Wiley.

Bednar, R., & Lawlis, G. (1971). Empirical research in group psychotherapy. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 812–839). New York: John Wiley.

Benjamin, L. (1993*). Interpersonal diagnosis and treatment of personality disorder.* New York: Guilford.

Bostwick, G. (1987). Where's Mary? A review of the group treatment dropout literature. *Social Work with Groups, 10*(3), 117–132.

Burchard, E., Michaels, J., & Kotkov, B. (1948). Criteria for the evaluation of group therapy. *Psychosomatic Medicine, 10*(3), 257–274.

Burlingame, G. M., Earnshaw, D., Hoag, M., Barlow, S. H., Richardson, E. J., Donnell, A. J., & Villani, J. (2002). A systematic program to enhance clinician group skills in an inpatient psychiatric hospital. *International Journal of Group Psychotherapy, 52*(4), 555–587.

Burlingame, G., Fuhriman, A., & Mosier, J. (2003). The differential effectiveness of group psychotherapy: a meta-analytic perspective, *Group Dynamics: Theory, Research, and Practice, 7*(1), 3–11.

Burlingame, G., MacKenzie, K. R., & Strauss, B. (2004). Small group treatment: Evidence for effectiveness and mechanisms of change. In M. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (pp. 213–249). New York: John Wiley.

Cook, T., & Campbell, D. (1979). *Quasi-experimentation: Design and analysis issues for field settings.* Boston: Houghton Mifflin.

Cox, G., & Merkel, W. (1989). A qualitative review of psychosocial treatments for bulimia. The *Journal of Nervous and Mental Disease, 177*(2), 77–84.

de Jong, T. L., & Gorey, K. (1996). Short-term versus long-term group work with female survivors of childhood sexual abuse: A brief meta-analytic review. *Social Work with Groups, 19*(1), 19–27.

Dreikurs, R. (1932). Early experiments with group psychotherapy. *American Journal of Psychotherapy, 13,* 882–891.

Dreikurs, R. (1956). The contribution of group psychotherapy to psychiatry. *Group Psychotherapy, 9*(2), 115–125.

Dush, D., Hirt, M., & Schroeder, H. (1983). Self-statement modification with adults: A meta-analysis. *Journal of Consulting and Clinical Psychology, 94,* 408–422.

Emrick, C. (1975). A review of psychologically oriented treatment of alcoholism. *Journal for the Study of Alcoholism, 36*(1), 88–108.

Forsyth, D. (Ed.). (1998). Special issue: Research methods. *Group Dynamics: Theory, Research, and Practice, 4*(2).

Forsyth, D. (1999). *Group dynamics* (3rd ed.). New York: Brooks-Cole.

Forsyth, D. (Ed.). (2000). Special issue: 100 years of research. *Group Dynamics: Theory, Research, and Practice, 4*(1).

Freeman, C., & Munro, J. (1988). Drug and group treatments for bulimia/bulimia nervosa. *Journal of Psychosomatic Research, 32*(6), 647–660.

Fuhriman, A., & Burlingame, G. (1994). Group psychotherapy: Research and practice. In A. Fuhriman & G. M. Burlingame (Eds.), *Handbook of group psychotherapy: An empirical and clinical synthesis* (pp. 3–40). New York: John Wiley.

Grunebaum, H. (1975). A soft-hearted review of hard-nosed research on groups. *International Journal of Group Psychotherapy, 25*(2), 185–197.

Harney, P., & Harvey, M. (1999). Group psychotherapy: An overview. In B. Young & D. Blake (Eds.), *Group treatment for post traumatic stress disorder* (pp. 1–15). Philadelphia: Bruner-Mazel.

Hoag, M., & Burlingame, G. M. (1997a). Child and adolescent group psychotherapy: A narrative review of effectiveness, a case for meta-analysis. *Journal of Clinical Child Psychology, 7 (2*), 51–68.

Hoag, M., & Burlingame G. M. (1997b). Evaluating the effectiveness of child and adolescent group treatment: A meta-analytic review. *Journal of Clinical Child Psychology, 26,* 234–246.

Horne, A. M., & Rosenthal, R. (1997). Research in group work: How did we get where we are? *The Journal for Specialists in Group Work, 22,* 228–240.

Kanas, N. (1986). Group psychotherapy with schizophrenics: A review of controlled studies. *International Journal of Group Psychotherapy, 36,* 339–351.

Kaul, T., & Bednar, R. (1986). Experimental group research: Results, questions, & suggestions. In S. Garfield & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 671–714). New York: John Wiley.

Kuhn, T. (1977). *The essential tension: Selected studies in scientific tradition and change.* Chicago: University of Chicago.

Lambert, M., & Hill, C. (1994). Assessing psychotherapy outcomes and processes. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 72–113). New York: John Wiley.

Lazell, E. W. (1921). The group treatment of dementia praecox. *Psychoanalytical Review, 8,* 168–179.

Lewin, K. (1936). *Principles of topological psychology.* New York: McGraw-Hill.

Lieberman, M. (1976). Change induction in small groups. *Annual Review of Psychology, 27,* 217–250.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapy: Is it true that "everyone has won and all must have prizes? *Archives of General Psychiatry, 32,* 995–1008.

Mann, J. (1966). Evaluation of group psychotherapy. In J. Moreno (Ed.), *The international handbook of group psychotherapy* (pp. 129–148). New York: Philosophical Library.

Marotta, S., & Asner, K. (1999). Group psychotherapy for women with a history of incest: The research base. *Journal of Counseling and Development, 77*(3), 315–323.

Marsh, L. C. (1931). Group treatment for the psychoses by the psychological equivalent of the revival. *Mental Hygiene, 15,* 328–349.

McDermut, W., Miller, I. W., & Brown, R. A. (2001). The efficacy of group psychotherapy for depression: A meta-analysis and review of the empirical research. *Evidence-Based Mental Health, 4*(3), 82–101.

McRoberts, C., Burlingame, G., & Hoag, M. (1998). Comparative efficacy of individual and group psychotherapy: A meta-analytic perspective. *Group Dynamics: Theory, Research, and Practice, 2,* 101–117.

Meltzoff, J., & Kornreich, M. (1970). *Research in psychotherapy.* New York: Atherton.

Miller, R., & Berman, J. (1983). The efficacy of cognitive behavior therapies: A quantitative review of research evidence. *Psychological Bulletin, 94,* 39–53.

Moreno, J., & Whitin, E. (1932*). Application of the group method to classification.* New York: National Commission on Prison and Prison Labor.

Mullen, B., & Driskell, J., & Salas, E. (1998). Meta-analysis and the study of group dynamics. *Group Dynamics: Theory, Research, and Practice, 2,* 213–229.

Nietzel, M., Russel, R., Hemmings, K., & Gretter, M. (1987). Clinical significance of psychotherapy for

unipolar depression: A meta-analytic approach to social comparison. *Journal of Consulting and Clinical Psychology, 55*(2), 156–161.

Oesterheld, A., McKenna M., & Gould, N. (1987). Group psychotherapy of bulimia: A critical review. *International Journal of Group Psychotherapy, 37*(2), 163–187.

Ormont, L., & Strean, H. (1978). *The practice of conjoint therapy: Combining individual and group treatment.* New York: Human Science Press.

Parloff, M., & Dies R. (1977). Group psychotherapy outcome research. *International Journal of Group Psychotherapy, 27,* 281–319.

Pattison, E. (1965). Evaluation studies of group psychotherapy. *International Journal of Group Psychotherapy, 15*(3), 382–397.

Pattison, E., Brissenden, A., & Wohl, T. (1967). Assessing specific effects of inpatient group psychotherapy. *International Journal of Group Psychotherapy, 17,* 283–297.

Piper, W., & Joyce, A. (1996). A consideration of factors influencing the utilization of time-limited, short-term group therapy. *International Journal of Group Psychotherapy, 46*(3), 311–328.

Piper, W., & McCallum, M. (1991). Group interventions for persons who have experienced loss: Description and evaluative research. *Group Analysis, 24,* 363–373.

Piper, W., Rosie, J., Joyce, A., & Azim, H. (1996). *Time-limited day treatment for personality disorders: Integration of research and practice in a group program.* Washington, DC: American Psychological Association.

Reeker, J., Ensing, D., & Elliott, R. (1997). A meta-analytic investigation of group treatment outcomes for sexually abused children. *Child Abuse and Neglect, 21,* 669–680.

Rickard, H. (1962). Selected group psychotherapy evaluation studies. *Journal of General Psychology, 67,* 35–50.

Robinson, L., Berman, J., & Neimeyer, R. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. *Psychological Bulletin, 108*(1), 30–49.

Ruitenbeek, H. (1969). *Group therapy today.* New York: Atherton Press.

Schilder, P. (1937). Analysis of ideologies as a psychotherapeutic method especially in group treatment. *American Journal of Psychiatry, 93,* 601–615.

Shapiro, D., & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin, 92,* 581–604.

Shechtman, Z. (2002). Child group psychotherapy in the school at the threshold of a new millennium. *Journal of Counseling and Development, 80*(3), 293–299.

Slavson, S. (1940). Group psychotherapy. *Mental Hygiene, 24,* 36–49.

Smith, M., & Glass, G. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32,* 752–760.

Smith, M., Glass, G., & Miller, T. (1980). *The benefits of psychotherapy.* Baltimore, MD: Johns Hopkins University Press.

Solomon, S. (1983). Individual versus group therapy: Current status in the treatment of alcoholism. *Advances in Alcohol and Substance Abuse, 2*(1), 69–86.

Stotsky, B., & Zolik, E. (1965). Group psychotherapy with psychotics. *International Journal of Group Psychotherapy, 15*(3), 321–344.

Syz, H. C. (1928). Remarks on group analysis. *American Journal of Psychiatry, 85,* 141–148.

Taylor, N. T., Burlingame, G. M., Fuhriman, A., Kristensen, K. B., Johansen, J., & Dahl, D. (2001.) A survey of mental health care provider and managed care organization attitudes toward, familiarity with, and use of group interventions. *International Journal of Group Psychotherapy, 51*(2), 243–263.

Thomas, G. (1943). Group psychotherapy: A review of recent literature. *Psychosomatic Medicine, 5,* 166–180.

Tillitski, L. (1990). A meta-analysis of estimated effect sizes for group versus individual versus control treatments. *International Journal of Group Psychotherapy, 40*(2), 215–224.

Toseland, R., & Siporin, M. (1986). When to recommend group treatment. *International Journal of Group Psychotherapy, 36,* 172–201.

Vandervoort, D., & Furhiman A. (1991). The efficacy of group therapy for depression. *Small Group Research, 22*(3), 320–338.

Wender, L. (1936). Dynamics of group psychotherapy and its application. *Journal of Nervous and Mental Diseases, 84,* 54–60.

Wolf, A. (1949). The psychoanalysis of groups. *American Journal of Psychotherapy, 3,* 525–558.

Yalom, I. D. (1975/1985). *The theory and practice of group psychotherapy* (2nd/3rd ed.). New York: Basic Books.

Zander, A. (1979a). The psychology of group processes. *Annual Review of Psychology, 30,* 417–451.

Zander, A. (1979b). The study of group behavior during four decades. *Journal of Applied Behavioral Science, 15*(3), 272–282.

Zimpfer, D. (1987). Groups for the aging: Do they work? *Journal for Specialists in Group Work, 12,* 85–92.

Zimpfer, D. (1990). Group work for bulimia: A review of outcomes. *Journal for Specialists in Group Work, 15,* 239–251.