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COMMENTARY

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Beyond treatment modalities: Clinical decisions and relational dynamics that facilitate change in group treatments

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Abstract

This commentary on six articles comprising this Journal of Clinical Psychology: In Session issue on the therapeutic process in group psychotherapy brings together relevant clinical challenges and opportunities concerning the unique processes of change in group treatments. As illustrated by these six inspiring group therapy cases, therapy groups may vary widely in content and context. To balance the rich clinical illustrations of successful group treatments and the different theoretical formulations offered in these case studies, we highlight the processes that these treatments appear to have in common. Specifically, we describe the clinical considerations about the group format and the group members. We also reflect on the relational dynamics as they play out within the complex interplay between group leaders and group members; the facilitation of the corrective emotional experience as a change mechanism in group therapy, as well as the relational challenges and opportunities inherent in group treatments more generally. It is hoped that in this issue, clinicians will not only be inspired by the clinical description of successful change processes in group treatments but will also be reminded of the therapeutic nuances and opportunities of this multilayered treatment format.

KEYWORDS
common factors, group psychotherapy, therapy process

1 | INTRODUCTION

Group psychotherapy can be an effective mode of treatment that provides a unique environment for therapeutic change. The current literature on group psychotherapy is robust in support of its effectiveness; however, the process by which clinicians effect change requires further elucidation. Given the increasing reliance on group therapy to provide psychological services (Koffel et al., 2015), there is a pressing need to better understand the processes occurring within the group context to facilitate patient treatment outcomes (Paquin et al., 2011). This issue, and its focus on the structured group psychotherapy process is thus timely (Kealy & Kongerslev, 2022). The clinical reports on six group case descriptions, in this issue report on a variety of structured group psychotherapy treatments for different presenting problems. These six cases not only highlight the diversity in therapeutic approaches and theoretical understandings of mechanisms of change in group therapy but also provide corresponding clinical vignettes to illustrate how group psychotherapy can affect change. We will start with a brief summary of each of these proposed mechanisms of change and their clinical case illustration.

1.1 | Group Schema Therapy (GST): The case of Amy

Straarup et al. (2022) examined the process of GST for individuals with anxiety disorders who had not adequately responded to a prior course of cognitive-behavioral treatment. The authors hypothesized that attending more directly to core beliefs and schemas might provide additional benefit above and beyond targeting current symptoms. Patients were treated with 18 group sessions, which were supplemented with two to four individual sessions to develop an individual case formulation and supplement group work as needed. The authors conceived of group work in this setting as modeling a functional family: two therapists play the role of the "good parents," and group members function as siblings to one another. The authors explained that, through the dynamic interactions amongst the participants, core developmental schemas emerged, allowing for reshaping to occur through corrective experiences. In GST, a central component of the treatment involves the use of chair work. Visual effigies were placed on empty chairs to represent core schemas, and individual members were encouraged to embody their vulnerable child states, inner critics, and defenses. The authors reported that, in response, group members help each other generate healthy, more adaptive responses to these inner states. This process is thus expected to foster an environment in which mutual trust and support are encouraged and unmet needs become nurtured.

To illustrate the group process, the authors discuss the case of Amy, a 36-year-old female presenting with anxiety. The authors formulated that her anxiety stemmed from her unmet needs for compassion and unconditional acceptance and her related emotional deprivation and failure schemas. From the case description, it appears that the use of chair work allowed Amy to understand the tension between her punitive mode and her avoidant protector mode. The other group members responded to each of these modes with compassion, generating healthy, adaptive, adult responses to Amy's inner, hurting child. Through the lens of GST, we can see that throughout the group process, Amy experienced what it is like when the vulnerable parts of her are cared for and learned that others can accept her whole self unconditionally.

1.2 | Focused Group Analytic Psychotherapy (FGAP): The case of Emily

Lorentzen (2022) reported on the process of FGAP for individuals with heterogeneous symptom presentations and a moderate to high level of personality organization. The FGAP treatment consists of 20 group sessions in a closed group of up to eight patients with one group leader. Each group member is evaluated before the start of the group to identify central symptoms and/or dysfunctional interpersonal patterns and develop a psychodynamic case formulation. This psychodynamic case formulation is then used to identify how an individual's internal representations of others developed over time in response to relationships with significant others. By examining conflictual interactions between group members in the here-and-now, the therapist then helps each group member understand how their object representations tend to guide their interpersonal responses. This interpretative process is thought to foster increased insight, while the resolution of dysfunctional interactions itself provides an opportunity for corrective emotional experiences.

The authors demonstrate the group process in FGAP using the case of Emily. Emily is a 28-year-old female with panic disorder, mild agoraphobia and paranoid, dependent, and obsessional traits. Emily has developed maladaptive defense patterns in childhood in response to her father's need for control and her mother's invalidation of the shame and fear she experienced in response to his unpredictable temper. The authors illustrate how the group process allowed Emily to explore conflicting self-representations of being both a victim and an abuser. They report that Emily was able to gain insight into the way she projected a sense of weakness onto others to ward off feelings of vulnerability within herself. This insight allowed Emily to be more compassionate in her responses to others in the group and share her desire for others to reciprocate the support as well.

1.3 | Mentalization-based therapy (MBT-G): The case of Sandra

Juul et al. (2022) reported on a short-term group MBT-G model for individuals with a borderline personality disorder. The MBT-G program consists of 20 weekly sessions interspersed with individual sessions every other week and an additional two psychoeducational sessions with the patient's relatives. The therapy group tends to be composed of around eight patients and two therapists. The MBT approach is predicated on the theory that psychopathology can arise from difficulties in an individual's ability to mentalize, defined as the ability to understand and reason about our thoughts and feelings as well as the thoughts and feelings of others. According to MBT, increasing an individual's ability to reflect on the intentions, emotions, and cognitions underlying behavior allows them to improve their understanding of the world and respond in ways that are more adaptive and effective. In other words, engaging in MBT in a group setting is thought to help the patient to understand how their thoughts, feelings, and behaviors impact others in the here-and-now.

The authors demonstrate the process of MBT for borderline personality disorder using the case of Sandra, a 28-year-old Danish female. Sandra presented with emotional regulation difficulties stemming back to her childhood, during which her parents were unable to meet her emotional needs or understand her internal mental states. Sandra also reported struggling to understand the mental states of others and distinguish them from her own; she worried how this might impact her ability to form positive, trusting relationships with the other group members. Though Sandra was reluctant to interact with the other group members at the outset of treatment, she began to open up as she witnessed others having and sharing experiences similar to her own. Once Sandra felt more comfortable sharing difficult situations with the group, the therapist directed her to reflect more on her mental states, recognize her emotional reactions, and consider the perspectives of others. As described by the authors, Sandra was thus able to use the group treatment to adopt a more “curious attitude” toward herself and others.

1.4 | Metacognitive Interpersonal Group Therapy: The case of Sofia

Inchausti et al. (2022) described the Metacognitive Interpersonal Group Therapy adaptation for adolescents (MIT-GA) and examined its effectiveness for teens with an avoidant personality disorder. MIT-GA begins with at least one individual session to build rapport with the group leaders and develop an individualized case formulation. The group component of MIT-GA involves two psychoeducational sessions, 16 weekly group sessions, and five concurrent group sessions for the adolescents' parents or caregivers. Two additional individual sessions occur at the mid-and endpoints of the group component. MIT-GA combines traditional cognitive-behavioral models, which help patients identify the relationships between their thoughts, feelings, and behaviors, with developmental problems specific to the adolescent phase of development, including crises of identity-related to the self and others. The authors present the case of Sofia, a 13-year-old female presenting with social avoidance, depression, paranoid ideation, and self-harm. Sofia initially received 10 individual therapy sessions to develop a case formulation, build rapport, and help Sofia become more engaged in treatment. During the course of the group treatment, Sofia was asked to recall specific autobiographical memories that related to problems associated with development. The authors highlight the group's compassionate responses to several difficult memories, emphasizing how these reactions fostered corrective emotional experiences for Sofia.

1.5 | Compassion Focused Therapy (CFT): The case of Mariana

Griner et al. (2022) examined the effectiveness of CFT in a transdiagnostic sample. Group participants attended a weekly manualized CFT group for 16 weeks at a university counseling center. CFT emphasizes the adaptive nature of emotions and emphasizes the relationships among three core motivational systems: the threat system, drive system, and soothing system. CFT theory posits that problems arise when an individual constantly perceives they are in danger and/or does not have the resources they need to regulate their emotions and enter into a calmer state. Thus, CFT focuses on strengthening self-compassion and fostering an inner sense of safety.

The authors illustrate the CFT process through a vignette highlighting an interaction between Mariana, a 24-year-old Latin(x) female presenting with anxiety, and Brian, a 19-year-old White male presenting with depression and social communication difficulties. In the interaction, Brian uses self-deprecating humor to defend against a vulnerable emotional experience. Mariana provides support to Brian in response, and in doing so, realizes that being compassionate with others while staying critical of herself is her way of defending against her own vulnerable emotional state. The group leader helps each of the group members understand their responses in light of their individual threat systems, bringing them toward a state in which they are more able to self-soothe.

1.6 | Integrating MIT and CFT: The case of Emily

Cheli et al. (2022) utilized an intervention that combined individual MIT (Dimaggio et al., 2020) with a group intervention based on CFT for individuals with perfectionism. The individual presented in the case study received 4 months of MIT individual therapy followed by group therapy for 2 months. The group, Mindful Compassion for Perfectionism (MCP), was composed of eight weekly 2-h sessions and one 4-h intensive session. The core goals of MCP are to increase individuals' awareness of the intrapersonal components of perfectionism, promote acceptance of their need for perfection, and develop greater compassion for themselves, such that they might be able to reduce their tendency toward a perfectionistic self-presentation.

The authors illustrate the process of their group treatment through the case of Emily, a 26-year-old British female presenting with clinical levels of perfectionism. When Emily presented for treatment, she struggled with core beliefs of inadequacy and unworthiness, despite her fastidious attempts to achieve the highest standard

possible in all of her endeavors. This made her particularly wary of revealing flaws to others in a group setting. As others in the group opened up about their struggles with perfectionism and engaging in the treatment itself, Emily began to feel more comfortable expressing her own similar experiences. Emily also provided active support in validating her peers' feelings and expressed compassion toward them. As the treatment progressed, the therapist encouraged Emily to direct the same level of compassion to herself as she had done toward others. This process helped foster a sense of self-acceptance within Emily, who noted that although she might continue to have a perfectionistic approach to life, she could do so without the self-judgment and reproach that had previously accompanied it.

2 | BEYOND THE THEORETICAL PERSPECTIVE: CLINICIAN DECISIONS IN GROUP THERAPY

All six cases presented in this issue demonstrate how the group process can facilitate positive change. Amy, Emily, Sandra, Sofia, Mariana, and Emily were able to make therapeutic use of the group treatments and we can learn a lot from the theorized post hoc understanding of the expert authors on why it was such an effective approach. However, we know from experience that providing effective group treatments is not that easy. To complement these inspiring case descriptions, it is important to also reflect on the complications, challenges, and relational nuances of the therapeutic process in group treatments.

Some of the clinical challenges of providing group treatment already start before the group has even started, when clinical decisions need to be made about who to invite, how to structure the group sessions within the treatment as a whole, and who will facilitate the group. Specifically, the use of individual sessions in the group treatment, the homogeneity or heterogeneity among the patients in the group, and the use of one or two group facilitators warrants reflection.

First, it is widely known that many patients are reluctant to join groups, and maybe as a result therapists are also reluctant to refer patients to group therapy (Shay, 2021). Although it is true that group therapy, like other forms of therapy, can have adverse outcomes (Roback, 2000), patients will most likely not experience an adverse result. Though group and individual treatments appear to be equally effective for the average patient, there may be particular patient characteristics that moderate or mediate the relationship between treatment modality (i.e., group vs. individual) and therapy outcomes. Currently, it is still unknown whether therapies work through common or specific factors, or both (Cuijpers et al., 2019). Future individual participant data meta analyses may help us to examine these more nuanced relationships. This would, for example, help us to better match patients to the treatment likely to be most effective for them (e.g., Storebø et al., 2021).

Despite the established advantages, the reluctance to enroll in group therapy endures (Shay, 2021). When given the option, patients are significantly more likely to choose individual treatment (Shechtman & Kiezel, 2016). This hesitation might reflect a view of groups being "second-best," or might relate to patients' social anxiety, fear of anger/trauma from other group members, dread of experiencing shame or humiliation, and desire for individual attention. These obstacles to participation are also often driven by powerful components of transference and countertransference (Shay, 2021). More specifically, many people might prefer individual attention from a therapist. For some, this type of "sharing of a therapist" feels too depriving and painful. Also, to be heard in a group, patients often must directly ask for attention, and this might be particularly challenging for patients who have internalized beliefs about not being worthwhile. Others worry about being harmed, evaluated, or judged by relative strangers. For people with past childhood trauma experiences, and resulting insecure, anxious, or avoidant attachment styles, this danger of a reenactment in the group of feeling harmed, rejected, or invalidated might feel even more immediate. These fears are not unique to patients. Therapists may also prefer individual therapy over group therapy. In groups, therapists themselves may also experience social anxiety, fears of judgment or rejection, or shame, in response to group interactions or when observed by a colleague (Shay, 2021). Given this common

reluctance to engage in group treatment, it might be important to consider patient preferences before assigning patients to treatment (McLeod, 2012; Swift et al., 2018). Accommodating patient preferences, such as the treatment format, is associated with fewer treatment dropouts and more positive treatment outcomes (Swift et al., 2018). In the included case studies, participants agreed to participate in a group therapeutic setting, though it is unclear whether other treatment options were available to them or how they would have responded given the option to titrate the frequency of group and individual sessions.

Second, once a group treatment is identified, there remains the question of how and if complementary individual sessions are helpful/needed. Patients in four of the six described group treatments in this issue also participated in individual therapy sessions in addition to their group sessions (Cheli et al., 2022; Inchausti et al., 2022; Juul et al., 2022; Straarup et al., 2022). The individual sessions were typically conducted at the beginning of treatment to develop a case formulation, with a couple of additional sessions to supplement the group or help with termination (Inchausti et al., 2022; Straarup et al., 2022). In one case, several months of individual sessions were conducted before the start of the group (Cheli et al., 2022) or individual sessions were interspersed with group sessions every other week (Juul et al., 2022). Notably, one treatment that did not incorporate individual sessions actively discouraged seeking individual treatment immediately following the course of group therapy, as they argued that therapy gains may continue after the treatment ends (Lorentzen, 2022). The question of whether individual sessions in addition to the group sessions significantly add to the therapeutic gains made in the group is an empirical one that should be tested in future research. Is it helpful to prepare patients for the group or do individual sessions help therapists better manage the group? If individual sessions do provide added benefit, it would also be important to know whether the timing of these sessions matters. That is, should individual sessions be conducted before, alongside, or after the group treatment has been completed?

Another clinical decision that was touched on in the six described group treatments is whether to strive for a group with patients with homogeneous or heterogeneous presenting problems. In the case examples presented, three of the studies reported on recruitment for therapy groups based on specific symptom presentations: borderline personality disorder, avoidant personality disorder, and clinical levels of perfectionism (Cheli et al., 2022; Inchausti et al., 2022; Juul et al., 2022). One group, GST, was designed for individuals with anxiety disorders who may share common traits but do not necessarily have the same disorder (Straarup et al., 2022). Two other groups, CPF and FGAP, included individuals with varying presenting problems (Griner et al., 2022; Lorentzen, 2022). Arguably, there are relative merits of each type of group formation. Groups designed for patients with a particular kind of disorder may target strategies or schemas specific to that disorder, whereas groups designed for a cluster of disorders (e.g., anxiety disorders) or a wide range of interpersonal problems may provide individuals with greater understanding and generalization of their learning. Finally, including group members across the diagnostic spectrum may be beneficial when the strengths of some individuals counterbalance the weaknesses of others, in that some group members might become role models for others. Nonetheless, Lorentzen, (2022) note that incorporating individuals with high levels of personality pathology may be challenging in some group settings, which might suggest the need for specific group treatments for individuals with personality disorders. Group diversity can also take form in the demographic makeup of the groups. Including participants of varying ages, races, religions, gender identities, and sexual orientations can also strengthen and broaden the extent to which interpersonal learning takes place within the group (Chen et al., 2003).

Notably, the selection of group members is not necessarily easy. It may be difficult to align the start dates of all patients accordingly, to fill a group, or to truly understand the established relationships in a group. If a patient ends up being placed in a group that does not fit them, this can be a painful experience for all (Rutan, 2021).

Moreover, another important clinical decision that is made before the start of treatment regards the number of group leaders who facilitate the group process. Some, but not all, of the six case studies in this issue mention if the group was facilitated by one or multiple facilitators, and if the latter, what the nature of their collaboration was like. If, for example, there is a sense of competition between the two co-leaders this may complicate the supervision of the group process, and may assume the chief focus of the group interaction at times. Despite the potential

challenges, the benefits of multileaderships of groups have been long been highlighted (Block, 1961). Specifically, the multileadership approach has demonstrated its value as a therapeutic and teaching tool in several ways: (1) Running a group together decreases anxiety in trainee therapists which has a direct bearing on their therapeutic efficiency; (2) The presence of more than one trained observer and participant enhances the perception of events in the group; (3) The two-leader approach more closely approximates the family model for therapeutic working-through; (4) Co-leaders or co-therapists are able to provide a corrective emotional experience for patients in terms of respected figures acting and resolving differences in a constructive rather than destructive fashion. In line with these stated benefits, recent studies suggest that a group treatment with two group leaders may be viewed as more beneficial by patients than groups with only one group leader (e.g., Kivlighan et al., 2012).

Lastly, there is one more clinical decision that was not discussed in any of the case studies in this issue: The choice between in-person groups and teletherapy groups. Within the context of the global pandemic these past few years, it seems important to consider how these different group treatments would have differed if they would not have been in-person but instead took place via videoconferencing. If the described treatments in the six case studies were indeed provided in-person (which we assume), what might the process of the treatment have looked like in a hybrid model or a fully remote group treatment? Video teleconferencing group psychotherapy has been shown to be feasible and has produced similar outcomes to in-person treatments while maintaining high levels of patients' satisfaction both prepandemic (Gentry et al., 2019) and in the most recent years (Puspitasari et al., 2021). Videoconferencing groups may be applied in different therapeutic approaches, including CBT (Kneeland et al., 2021), ACT, and mindfulness (Moulton-Perkins et al., 2020). They have also been shown to replicate therapeutic processes such as a sense of cohesion (Banbury et al., 2018). How would these hypothesized mechanisms of change in groups translate to a remote format? The proliferation of group teletherapy thus likely impacts the aforementioned change processes, including the corrective emotional experience, and the dynamic processes between group members and group leaders, pushing us toward a needed contemporary understanding of the group process in light of the upcoming era of teletherapy and hybrid treatments.

3 | BEYOND THE THEORETICAL PERSPECTIVE: RELATIONAL DYNAMICS IN GROUP THERAPY

In addition to the theorized change processes in the six case illustrations, and the clinical decisions that are made before the start of the treatment, several common-factor group processes are important to highlight. Group therapy settings involve a number of unique process factors that are hypothesized to make this treatment format particularly effective (G. Burlingame & Jensen, 2017; Fuhriman & Burlingame, 1990; Kealy & Kongerslev, 2022): (1) The patient might learn vicariously from observing others in the group; (2) The patient might be able be better able to accept help and feedback from others and try out new relational behaviors, when they can also provide support to others within the group; (3) When the patient acknowledges that other group members have similar difficulties to their own, the group may help to reduce isolation, alienation, and shame by sharing experiences with caring others; (4) The patient may offer support and encouragement to other participants; (5) The patient may re-enact the dynamics of their family of origin within the group, which thus allows the patient to work through parental and peer transference interactions that occur in real time; (6) The patient may engage in relationships in the here and now and learn from interactions within the group.

All these aspects of the therapeutic process in group treatments underline the centrality of the "relationship-climate" (and "other-vs.-self focus") in group therapy processes (Holmes & Kivlighan, 2000). Indeed, group members (and the relationships formed with one another) are argued to be a primary mechanism of change in group therapy (I. D. Yalom, 1995). In the following sections, we will examine how different types of relational experiences in group treatment may impact the therapy process.

3.1 | Corrective emotional experiences (CEE)

In all of the cases presented, the authors note the importance of group members in effecting change in the therapy process. One way in which this may occur is through a CEE, in which an individual receives an unexpected yet healing emotional response, typically one which they have not received in similar situations earlier in life. The CEE is not a new concept in group psychotherapy (Frank & Ascher, 1951), but it is noteworthy that several of the case studies reported the importance of CEE as a mechanism of change in their treatment. The process of a CEE is still defined today as Alexander and French (1946): as encompassing the reenactment of a painful past experience in a therapy session and receiving a different response than what was previously received and possibly wounding. The different response is hypothesized to be healing because of the encouragement, empathy, and compassion provided by the group leader or therapist at this time. When experienced in group therapy, the different response is given by the group leader and/or group members. As becomes clear from these different case examples in this issue, the CEE is seen as a therapeutic factor in group therapy (I. Yalom & Leszcz, 2005), across modalities and approaches. CEE is thought to be valuable for the group member (e.g., promote feelings of acceptance, appreciation, and self-esteem, and "being not alone") and for the group as a whole (e.g., consolidate a positive group climate, and instill hope) (Brown, 2016). However, the case examples were less clear on how exactly the group leader(s) identified the opportunity for CEE and facilitated this process of a CEE within the group session. Did they mean they facilitated a Rogerian default attitude of "unconditional positive regard" or did the group leaders work through misattunement by empathic mirroring to be able to develop a cohesive sense of self (Kohut, 2009). Did they use a particular purposeful corrective intervention in session, or did they facilitate a repeated process of attunement and responsiveness (Silberschatz, 2021). It has been suggested that therapists may be "flying blind" (Renik, 2006), and only recognize later that clinical events were a CEE. These details are especially important for clinicians because we know that affecting a CEE in a group can present a challenge to the group leader, who has to provide for the safety and needs of the group member and, at the same time, attend to the impact and effect on other group members (Brown, 2016). Moreover, in the six case examples in this issue, the authors describe certain moments in treatment as CEE. However, it remains unclear if this was merely an observation of the intention of the group leader(s) or if this was also experienced by the patients themselves, or measured in some shape or form (Friedlander et al., 2018). Straarup et al. (2022) highlight that the group setting is a unique therapeutic context that can mimic the structure of a family; group leaders become "parents" and members become "siblings." Thus, it is possible that a CEE may be intentionally facilitated by the group leaders acting as nurturing parents to the group members, and CEEs facilitated by other group members may arise more organically.

3.2 | Therapeutic alliance, group cohesion, and group culture

Compared to individual therapy, group therapy hosts many more relationships: the relationship between patient and therapist (working alliance, as observed in individual therapy); the patient-to-patient relationship; the patient's perception of unity within the group (group cohesion); and the relationship between other group members and the therapist, perceived by any one individual (Ardito & Rabellino, 2011). Although the quality of the relationship between the group leader and group member is related to the quality of the relationship among the group members and the group cohesion are all interrelated (Johnson et al., 2005), group cohesion and the working alliance are thought to be distinct group processes (G. M. Burlingame et al., 2002).

The therapeutic alliance is a complex concept in dyadic interactions, let alone group format (Rutan, 2021). This is a hard-won sense that "we are on the same side; we share a common goal." We are "allied." The word alliance comes from the Latin, alligare, which translates as "to bind." As Bordin (1979) noted long ago, the alliance includes a relational bond, an agreement on goals, and an agreement on tasks. This alliance is not primarily a conscious relationship but rather a highly subjective, right brain function (Schore, 2020). In a healthy therapeutic alliance, the

patient feels safe enough to share personal, perhaps embarrassing information, to accept new information, and even to disagree with and confront the group therapist. In a cohesive group, the members do not feel alone. The alliance is a two-way relationship in which members and group therapists influence and alter one another (Lo Coco et al., 2019).

While in individual therapy the alliance is between patient and therapist, in group therapy that alliance must also include members of the group, a phenomenon I. Yalom and Leszcz (2005) refer to as "group cohesiveness." I. D. Yalom (1995) described group cohesion as the "we-ness" felt between the group members; the complex interplay of multiple relationships between group members and therapists. The level of cohesion a patient is able to experience in a group is likely determined by the patient, more than by the hard work of the therapist (Tucker et al., 2020). Overall, individual differences accounted for 80%–97% of the total variance in cohesion and are harder to achieve when patients' have an anxious or avoidant attachment style (Tucker et al., 2020). Research suggests that the effect of group cohesion is stronger when there is a high therapeutic alliance between patient and therapist (Vicente et al., 2021). In other words, the level of cohesion is moderated by the therapeutic alliance. Member–leader alliance and group cohesion are both predictive of session attendance (Clough et al., 2022) and predictors of outcome in short–term group psychotherapy (Joyce et al., 2007). Notably, the therapist's and the other group members' perspective on the patient's fit in the group also account for variance in treatment outcome (Joyce et al., 2007).

Cohesion to the other patients in the group might be directly associated with more meaningful self–disclosures, which in turn facilitate more frequent and intense feedback from fellow patients (Tschuschke & Dies, 1994). This means that, arguably, developing a sense of cohesion in the group is of particular significance in the short-term therapy groups described in this issue, as there is limited time for the creation of a safe working environment (Joyce et al., 2007). An early development of cohesion may also lead to a greater ability to tolerate negative emotions and stress that are part and parcel of the therapeutic process (MacKenzie, 1994). Cohesion thus reflects a network of affective bonds that serves as a base for therapeutic "work" in the group process.

Another related and partly overlapping common factor in group psychotherapy that has shown to be related to treatment outcome is the "group climate," defined as an attribute of the group environment that facilitates or impedes the efforts of an individual to reach a particular goal (MacKenzie, 1983). The group climate can be seen as an indicator of the group atmosphere (Kivlighan & Lilly, 1997) that fluctuates throughout treatment (e.g., Tasca et al., 2006) and includes patients' perceptions of other patients' engagement in the group (i.e., similar to cohesion), avoidance of difficult topics (i.e., patients' reluctance to take individual responsibility for a change), and interpersonal conflict among group members. A conflict in the group, for example, heightens patients' concerns about trust and may lead to withdrawal or outbursts of anger, both of which can impede therapeutic work within the group (Ogrodniczuk & Piper, 2003). An engaged group climate reflects patients' efforts to understand their behavior, to self-disclose personal information or feelings, and to challenge and confront each other to sort out difficult issues. All of these behaviors represent different aspects of work in a psychotherapy group.

Although we know that these relationships are not always easy to develop and maintain in treatment, there is a paucity of literature about ruptures in the therapeutic process in group therapy. Black (2019), writing about insecure attachment in group therapy, is one recent exception to that paucity. In group therapy, the alliance between the therapist and an individual member can be breached, or the alliance between the therapist and several members or even the group-as-a-whole can be ruptured. To make matters worse, the alliance between members can also be ruptured (Rutan, 2021). The interactive nature of the therapeutic relationship makes it vulnerable to injuries and ruptures. It is not unusual for the alliance to be tested, doubted, broken, and rewoven. Similarly, the amount and valence of the feedback provided by the group members might have an important impact on the sense of safety in the group (Kivlighan et al., 2012). Group leaders should attend to the amount and proportion of positive and negative members–member feedback in therapy groups to enhance the clinical benefit of these services.

Another aspect of the group process which might lead to ruptures is the challenge of boundary maintenance in therapy groups. Confidentiality is much harder to contain in groups than in individual therapy (Rutan, 2021). Members will chat in waiting rooms, at bus stops, at random encounters during the week. Sometimes members will

develop out-of-group relationships. Amid this, the group therapist must maintain boundaries around the leader's role. Sometimes group leaders find the fellowship and intimacy of the group so compelling that at an emotional level they become members more than group therapists.

Understanding that a rupture has occurred requires noticing certain telltale signs. Has your group or an individual within the group suddenly fallen atypically silent or atypically angry? Do you feel disconnected from the process? Does the overt content of the group discussion refer to hurtful exchanges with important people? Does the process in the group seem more superficial than usual? In a mature, cohesive group, someone will usually bring up the topic of feeling injured or noticing that another group member was hurt by some exchange with the group therapist. In newer, less cohesive groups the therapist may have to be the one to ask if an injury has occurred. The role of the group therapist is a powerful one. Often a comment with even the most benign intent can be experienced as a microaggression. Members of therapy groups may have long histories of feeling (or being) disenfranchised or discriminated against, which makes them uniquely vulnerable to narcissistic injury, which in turn damages the therapeutic alliance.

4 | CONCLUSIONS

Group psychotherapy is a dynamic, unpredictable, and exciting process. It requires flexibility on the part of both the leaders and group members to generate cohesive, effective communication between individuals and foster increased interpersonal effectiveness in the process. Groups can be run from many different theoretical orientations, with individuals presenting with different problems, however, some of the clinical considerations and group dynamics are relevant to consider regardless of treatment approach or patient population.

It is important to carefully think through the size, format, structure, and members of the treatment group. Would the group process benefit from a second facilitator or would patients be more motivated and supported if they receive additional individual therapy sessions? Might there be an additional risk of ruptures in the therapeutic relationships when certain members are added or when the treatment would be conducted via videoconferencing? Including a patient-rated measure of a therapeutic alliance, cohesion (commitment and compatibility, and immersion into the group process over the course of group therapy; Joyce et al., 2007) may provide a comprehensive view of the different types of predictive relationships in group treatments. Arguably it is also important to assess congruences and discrepancies in individual perceptions of alliance between a group member, the therapist, and the group as a whole (Lo Coco et al., 2019).

Based on the clinical cases presented in this issue, coupled with the broader group psychotherapy literature, we have identified several common factors that warrant clinical consideration. The therapeutic alliance, group cohesion, patient engagement, and corrective emotional experiences are all elements of strong group treatments that can be engendered through the skillful, intentional work of the group leader. However, this is not as easy as it sounds. Given these multilayered relational dimensions of the therapeutic process and characteristics of a group treatment, it is crucial to not only read about the successes but also the clinical challenges in group treatments. By reflecting on the dynamic subtleties and nuances it is hoped that we will sketch a balanced picture of its therapeutic potential, as well as the likely challenges such a treatment format might entail. We would very much welcome a future issue that focuses on examples of detailed case studies in which the group process did not go smoothly, to allow for even more clinical learning and reflection to take place (e.g., Kealy et al., 2021; Snyder & Aafjes-van Doorn, 2016).

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