A helping hand for the daily practice

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R.W. Koks and P. Steures (ed.)

A publication from the Dutch
association for group dynamics
and group psychotherapy (NVGP)

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The following chapters have been translated in English

From the editors:

Dutch Practice Guidelines for Group Treatment: contemporary group therapy in the Netherlands.

March 31, 2021

At the end of 2019 the Practice Guidelines for Group Treatment in (Mental) Health Care were published online on the website of the Dutch Group Therapy Association (NVGP).
The AGPA practice guidelines published in 2007 were a source of inspiration for the NVGP, and the starting point for the development of a Dutch version. Besides a large overlap there are also some important differences on account of the specific development in group treatment in Dutch (mental) health care.
These differences include the theoretical frame of reference used, the group settings addressed and some differences in the content or the covered key domains.
Because of the diversity in terms of methods and professional background of the therapists the NVGP chose for the theory of group dynamics, as a universal and trans-theoretical frame of reference for all kinds of group treatment, whether it concerns group versions of CBT, SFT, MBT, DBT or otherwise. Another difference concerns the therapeutic setting: the AGPA guidelines focus mainly on group psychotherapy in an outpatient setting whereas the Dutch guidelines focus on both outpatient, inpatient and multidisciplinary group treatment.
Furthermore, five new chapters were added, on the following topics: managing adverse effects of group treatment; applying a specific treatment method in a group setting and combining a specific theoretical orientation or treatment method with group dynamic processes; group treatment in a multidisciplinary treatment program in a more or less intensive treatment setting; group treatment and co-leadership; and education and training in group treatment.
As a service from the NVGP and on request of the board of the AGPA we have provided online an English translation of the afore mentioned chapters for the AGPA and its members.
The Dutch Practice Guidelines is a living document, and we intend to update the document according to the latest research on groups and group treatment, and in close cooperation with our American colleagues. We hope that joining forces gives the opportunity to learn from each other and will lead to added value in both American and Dutch practice guidelines.
We welcome questions and comments on: steures@gmail.com

Kind regards and warm greetings from the Netherlands,

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Chapter 1. The Dutch Practice Guidelines: background and starting points

Rob Koks (MSc) and Pepijn Steures (MD).

1. 1 Introduction:

The Dutch Association for Group Dynamics and Group Psychotherapy (NVGP), founded in 1957, is a specialist group psychotherapy association dedicated to all forms of group treatment, ranging from training to group psychotherapy. Members of the NVGP also focus on all kinds of group processes that take place outside the (mental) health care area, such as stalled team processes and conflicts in partnerships. This has led to the NVGP expanding its activities, to include consulting and coaching of teams and organizations. The NVGP aims to promote the study of group dynamic processes and the practice, development and monitoring of the quality of group treatments in the Netherlands (statutes, art.2). In this light, at the end of 2015, the board of the NVGP conceived a plan to formulate practice guidelines for daily practice in the Dutch (mental) health care system. Through these practice guidelines, the NVGP wants to offer group practitioners a resource, to help them shape their group treatments in accordance with knowledge available from empirical science and years of clinical experience. In addition, the NVGP hopes that the further development of the practice guidelines will in the long term contribute to the development and application of *evidence-based* group treatments by providing a bridge between everyday practice and the current state of scientific research on groups, group processes and group treatment. With the Practice Guidelines for Group Treatment, the NVGP aims to guarantee the quality of group treatments in the (mental) health care system in the Netherlands and where possible to improve them.

In this chapter we will discuss the background, the purpose and the target group of the practice guidelines. In addition, we give a brief overview of the main principles, which form the basis of these practice guidelines. We then go on to describe our procedure or working method. The chapter ends with a discussion, a summary and recommended literature, allowing the reader to further orient himself to the themes of this chapter.

1.2. Objective and target group

The Science to Service task force of the American Group Psychotherapy Association (AGPA) published the *Practice Guidelines for Group Psychotherapy* in 2007. The purpose of these guidelines was 'to bridge the gap in the group psychotherapy field between research and clinical practice,…..to integrate science with ongoing clinical practice' (AGPA, p.2). With these guidelines, the AGPA wanted to support practitioners in order to meet the requirements of *evidence based practice* (Leszcz & Kobos, 2008). The importance of the American guidelines for Dutch practice was shortly thereafter endorsed by the NVGP. While

recognizing that the American practice guidelines can also provide guidance on group treatment in the Netherlands, some expert NVGP-group psychotherapists recommended developing guidelines for the practice in the Netherlands (Snijders & Berk, 2008; Snijders, 2009). At the beginning of 2016, the board of the NVGP gave the go-ahead for this endeavour. Because the Dutch practice is in line with that in the United States, the objective of the NVGP-Practice Guidelines in many respects corresponds to that of our AGPA colleagues. The NVGP practice guidelines, however, are aimed at a broader target group. The following will provide a closer look at the purpose and target group of the NVGP Practice Guidelines.

The number of practitioners offering group treatment has increased significantly in the last two decades. In the current practice of Dutch (mental) health care, many psychotherapeutic, psychological and psychiatric treatments are offered in a group setting to a large number of target groups, in all kinds of treatments with different methodical frameworks, and led by professionals from different backgrounds, with different levels of education and training. This diversity is a richness, but can hinder quality if one is not sufficiently aware of the results of empirical research in the field of groups, group processes and group treatment, and of the expertise in this field that has been accumulated over decades. With these practice guidelines, we aim to help this broad group of practitioners to shape their group treatments in a well-considered way. They give group practitioners a common basis and a common language from which their work is done. The practice guidelines formulate the minimum that you as a group practitioner need to know and do to work responsibly with groups, and constitute a first step towards defining evidence-based group treatments.
In recent years, the number of group treatments offered has also increased. The modern group practitioner is often well trained in a specific method, but is hardly trained in recognizing and handling the group dynamic processes that can strengthen or weaken the active ingredients of the method. In view of the diversity of group treatments and group practitioners, the NVGP Practice Guidelines focus on the broad multidisciplinary practice of group treatment and not on specific change theories and methodologies such as cognitive behavioural therapy (CBT), schema-focused therapy (SFT), mentalization based therapy (MBT) or the dynamic-interpersonal model. The Practice Guidelines are transtheoretical and can be applied to any treatment framework that seeks to make use of the group, the group dynamics and the group processes as a means of achieving the individual treatment goals of the group members. The NVGP hopes to appeal to a broad group of practitioners with basic or specialist experience.

1.3. Positioning the Dutch Practice Guidelines

In order to ensure the quality of healthcare treatments, several quality instruments have been developed in the Netherlands in recent decades (AKWA, 2019). Each instrument has its own objective, function and scope. The NVGP Practice Guidelines for Group Treatment in Healthcare are above all a guide to help group practitioners shape their treatment groups

according to the knowledge available from current empirical science and expert consensus. They serve as a tool for group practitioners in the complex daily treatment practice. As a compact guide, they formulate the minimum of factors that the practitioner who works with groups should take into account. Practice guidelines are not a handbook, but a practical and compact document, which takes into account the expertise of practitioners and the preferences of clients (AGPA, 2007).
Other quality tools available to the group practitioner are (multidisciplinary) treatment guidelines for various disorders, standards of care and generic modules. We describe in short how these instruments differ from practice guidelines.
Treatment guidelines or protocols define binding regulations and specific methodologies and interventions for the treatment of a specific disorder (Landelijke Stuurgroep, 2008). They are part of the professional standard, contain normative statements and therefore have a legal connotation (www.nvvp.net). Practice guidelines, on the other hand, describe what is common in the broad multidisciplinary treatment practice, in all forms of treatment, and do not describe factors unique to a specific form of treatment (Colijn, 2009).
Practice guidelines are also not a standard of care or generic module. A standard of care is a general standard for the organization of the entire care continuum around a specific condition, from the perspective of the patient (AKWA, 2019). A standard of care is a general framework for the treatment of people with a particular condition, which defines all the necessary components of multidisciplinary care (www.nvvp.net). A generic module describes elements of care that are relevant to a broad range of mental illnesses (AKWA, 2019). These include topics such as self-management, support for loved ones, day care and work participation (www.ggzstandaarden.nl).

1.4. Basic principles of the Practice Guidelines for Group Treatment

The NVGP Practice Guidelines for Group Treatment in (Mental) Health Care are based on three principles. These principles form the bedrock of the topics that are elaborated on in the various chapters that comprise the guidelines. First, the taskforce assumes that structural characteristics of a treatment group as well as group dynamic processes are the fundament of any group treatment. Secondly, the taskforce sees it as one of the main tasks of the group practitioner to integrate group dynamic processes in an adequate way with a specific treatment framework . Finally, as far as possible and practically feasible, the taskforce bases the various chapters on the current status of scientific research into groups, group processes and group treatment, combined with expert knowledge of leading clinicians where no research is available.
In order to give the reader an idea of how the above principles have steered the creation of this practice guideline, they are explained succinctly.

1.4.1 Group processes and group dynamics

In each group there is dynamism, processes take place that affect the execution of the task, the purpose of the group. The competence of the group practitioner to recognize and

influence the structural and dynamic properties of a group in a way that is conducive to the treatment goals of the group of patients forms the bedrock of any form of group treatment, according to the taskforce. Knowledge in the field of group dynamics is the basis from which a group practitioner operates.

Group dynamic processes take place mainly at a non- or pre-verbal level, in attitude and behaviour, i.e. outside of substantive, verbal and often rational communication. Social behavior in groups develops in predictable forms or structures. These processes arise in all kinds of groups, such as a patient group, a treatment team, a billiards association, a company in the army, a board of directors et cetera.

Socio-psychological research between 1950 and 1970 indicated the existence of five important process structures, which develop in each group (Forsyth, 2017; Remmerswaal, 2001; De Haas, 2008, 2010, 2013; Hoijtink, 2001, 2007). These are: interaction, group development, cohesion, group norms and group roles.
These group processes are not in themselves therapeutic processes. A group also has negative, even destructive tendencies (Nitsun, 1996, 2006). But group processes, if adequately managed, have a great learning potential (Bloch & Crouch, 1985). In addition to interacting with the group practitioner, group members can learn a lot from interacting with each other. They can learn from both positive and negative experiences, especially when the link to the treatment task and personal treatment goals of the group members is clear. It is an art and skill to be able to provide room for, steer and discuss these processes to a certain extent, depending on the purpose of the group.

1.4.2 Group dynamics and a specific treatment framework

In order to achieve therapeutic change, the combination of group processes with a well-defined treatment framework is needed, consisting of a theory of change, a methodology, and sufficient knowledge of the target group. The success of group treatment depends to a large extent on the correct way of combining a strong methodology and a functional use of group processes (De Haas, 2010; Van Reijen & Haans, 2008). It is the task of the group practitioner to 'integrate the components into a coherent, fluid and complementary process' (AGPA, 2007, p. 3; Snijders & Berk, 2008, p. 42). It is only then that the group and the specific methodology will not become a 'lead weight' for each other (De Haan, 2011, p. 20); the group dynamics will not be 'sacrificed' (Snijders, 2009, p. 50), but the methodology and the group processes will 'like a flywheel' strengthen each other's potential positive effects (Koks, 2015, p. 46). The group practitioner acts as the 'manager' of this whole (AGPA, 2007, p. 40).

1.4.3 Scientific research on groups and group treatment

The NVGP Practice Guidelines for Group Treatment in (Mental) Health Care are based on the best available empirical research in the field of groups and group treatment, and the clinical expertise that has been built up over decades. A good overview of the state of scientific

research in the field of groups and group treatment can be found in Burlingame et al. (2004, 2013). The 2013 review involved three hundred and fifty studies that are methodically of good quality. A summary of twenty-five years of scientific research into group processes and group treatment can be found in Burlingame & Jensen (2017). However, given the state of (the)current scientific research, agreement among clinical experts is a necessary complement to the available empirical evidence.

In general, two types of scientific research are distinguished (Burlingame et al., 2004, 2013; Colijn et al., 2003; Snijders, 2011); first, disorder-oriented effect research through *randomized controlled trials.* This form of research leads to a description of treatments that are proven to be effective, also called *empirically supported treatments (EST);* and secondly patient-centered process research. This type of research focuses in particular on the treatment process and common active factors, and leads to a definition of factors that a treatment and a practitioner must meet in order to be effective and efficient, also called *evidence based practice (EBP).*
Since the practice guidelines try to answer the question *of how* practitioners in daily practice can shape their treatments in an adequate and effective way, this latter form of research is best suited to this. Therefore, in these practice guidelines we chose a broader concept of evidence than that pursued by a *randomized controlled trial (RCT)* (AGPA, 2007; Burlingame et al., 2004 and 2013; Snijders & Berk, 2008), whose results are often difficult to generalize to daily practice. This choice makes it possible to take into account qualities and preferences of the client and of the practitioner, as well as research that also comes from other areas, such as in this case from social psychology.

1.5. Creation and methodology

Given the state of current scientific research on group treatment, as in other guidelines, consensus among clinical experts is a necessary complement to the available empirical evidence. The following section describes the way the NVGP has attempted to achieve the best possible integration of these two sources.
For the preparation of the NVGP-Practice Guidelines for Group Treatment in (Mental) Health Care, an editorial committee, an advisory committee and a working group were put together. The editorial committee consists of the authors of the present chapter, Rob Koks and Pepijn Steures. The advisory committee, consisting of Dutch experts in the field of group treatment, group dynamics and group processes, was formed by: Arnout ter Haar, editor-in-chief of *Groups, journal for group dynamics and group psychotherapy;* Willem de Haas, senior lecturer, chairman of the science committee of the NVGP and author of a now widely used standard work on group dynamics and group treatment; and Roelof Wolters, former head trainer of psychotherapy, and former chairman of the NVGP.
In an initial meeting of the advisory committee and the editorial committee a global classification of fifteen chapters was drawn up. The classification of AGPA's practice guidelines was taken as a starting point. Specific topics and chapters, characteristic for Dutch clinical

practice and literature, were added to this. During this meeting a working group of authors was formed, consisting of group practitioners and group workers with broad clinical experience and expertise in the field of group treatment, and with specific experience in science, training, supervision, specific treatment methods or specific target groups.
At the beginning of 2017, the working group, the advisory committee and the editorial staff met for the first time with the aim of reaching a broad agreement, *expert consensus,* on the structure and content of the practice guidelines. For almost every chapter, a pair of authors was commissioned to define the minimum knowledge and competence that a group practitioner must have when shaping a group treatment, based on the current state of scientific research.
The writing and editing of the chapters was done in two intensive rounds, where necessary in consultation with the advisory committee. A second meeting of the working group, the advisory committee and the editorial staff took place at the end of 2018. This meeting gave the working group the opportunity to provide feedback on the draft chapters, dealt with open discussion points and reached consensus on the content of the individual chapters.
The final draft version of the NVGP Practice Guidelines for Group Treatment in (Mental) Health Care was submitted to the board of the NVGP for approval and publication in early 2019.

1.6. Discussion

The NVGP Practice Guidelines for Group Treatment in (Mental) Health Care can be seen as a first step towards the development of evidence-based group treatments in the Netherlands. As mentioned earlier, the practice guidelines are a guide to group practitioners, who want to shape their treatment groups according to the current state of science supplemented with expert consensus. A number of critical comments regarding this extensive project and the final results are, however, appropriate. Addressing these should promote further development and a better underpinning of the guidelines. Some of these comments are briefly elaborated below.

Despite the large amount of research, it is still not quite clear what makes a practitioner an effective group practitioner and a group into a therapeutic group. Effect studies show that it is plausible that group treatment is as effective as individual treatment, especially if the group practitioner uses the interactive qualities of the group. For a number of specific disorders (DSM classifications) this has even been demonstrated (Burlingame et al., 2004, 2013). And while process studies help us better understand how group treatment works, and which elements or general factors play a role in it, this knowledge should (still) be supplemented by the consensus among leading clinicians in the field of group treatment. Further research is necessary for additional substantiation of the various quality instruments available to us.
Moreover, it is not easy to determine which conclusions can be derived from the results of scientific research. Rarely if ever can causal links be made, more often a certain relationship

between effect and variable can be deduced; research differs in methodological quality; repeated studies have more credibility than a single study. Treatment guidelines therefore define the level of evidence in conclusions or recommendations. The table below distinguishes four levels of evidence (MRP, 2008). For each level the required type of research is indicated.

Type of research	Level of evidence	Conditions
Impact study (EST)	1: It has been shown	RCT meta-analyses
	2: It is plausible	RCTs or multiple pre-post studies
Process investigation (EBP)	2: It is plausible	RCTs or multiple pre-post studies
	3: There are clues	Comparative and non-comparative research
Clinical consensus	4. The experts believe that	Consensus among experts

Table 1: Levels of Evidence of Scientific Research (by: MRP, 2008)

In the various chapters of the NVGP-Practice Guidelines for Group Treatment in (Mental) Health Care, we aim to distinguish as far as possible when a statement is based on scientific research or on consensus among the experts. The working group was not asked to provide an exact description of the level of evidence. Our decision was firstly driven by legibility considerations; the practice guidelines are intended above all as a handy guide for group practitioners. Secondly, a detailed description of the levels of evidence at this time in the working group was practically not feasible. In a future revision of the Practice Guidelines the question of whether a definition of the evidential level is of added value should be addressed.

A further comment concerns the quality of the literature review on which the practice guidelines are based. The AGPA task force conducted a thorough research and literature review for the American Practice Guidelines up to 2007. The working group for the NVGP-Practice Guidelines builds on this and has conducted an additional and more global literature search for practical reasons. The relevant literature after 2007 and the Dutch literature from 2000 onwards were consulted. It should be noted that no systematic literature study has been carried out. The NVGP practice guidelines are seen as a 'living' document. The intention is to revise two chapters every two years on the basis of the scientific state of the art on the topic in question. Since such a revision is less extensive, it provides an opportunity for a more systematic substantiation from the literature.
In addition to clinical experts in the relevant field, various other partners, such as family and patient organizations, relevant professional associations and insurers, are involved in the development of treatment guidelines, standards of care and generic modules. The NVGP Practice Guidelines for Group Treatment in (Mental) Health Care were developed by clinical

experts in the field of treatment and research. Experiences from the patient perspective are not yet included. In addition, the selection of clinical experts was mainly drawn from the network of the NVGP. In the future revision of the separate chapters, the editors should consider involving collaborative partners and organizing feedback on the form and content.

The intention is to make the NVGP Practice Guidelines for Group Treatments in (Mental) Health Care available free of charge via the NVGP website to group practitioners, collaborative partners and anyone who is involved in any way with group treatment in the Netherlands. They can communicate their experiences, comments and suggestions for the future to the editors via a message to secretariaat@groepspsychotherapie.nl. This feedback will be taken into account in the further development of the practice guidelines and will help the NVGP to develop a document that can stand the test of time.

1.7. Finally

The chapters form a whole, but are written in such a way that they can be read separately from each other and can serve as a reference book on which the group practitioner can fall back on with regard to specific questions in daily practice.

The Practice Guidelines Group Treatment are divided into four areas of focus:

Part I Preparation of a group treatment.
This includes: the setting up of a group, the selection of clients and composition of the group, the preparation of a group.

Part II Group processes and group dynamics.
This includes: the active factors and mechanisms, the group processes such as cohesion, interactions, roles, norms, the developmental phases and specifically the ending phase.

Part III Methodology of group therapy.
This includes: treatment interventions, reduction of negative effects of groups, combining group dynamic processes and various specific theoretical frameworks, group treatment as part of a multidisciplinary treatment program, co-leadership and co-therapy.

Part IV Other relevant topics.
This includes: ethical issues in group treatment, outcome measurement or monitoring, and education and training.

1.8. Summary

- The Practice Guidelines for Group Treatment in Healthcare are a guide from the NVGP to professionals who want to offer treatment or counseling in a group setting.

- The practice guidelines help group practitioners to shape their treatment groups in accordance with the knowledge available from the current state of science and expert consensus.
- The practical guidelines formulate the minimum that you as a group practitioner need to know and do to work responsibly with groups, and are a first step towards defining evidence-based group treatments.
- The basis for any form of group treatment is the competence of the group practitioner to recognize and influence the structural and dynamic properties of a group in a way that is conducive to the treatment goals of group members. Knowledge in the field of group dynamics is the basis from which a group practitioner operates.
- In order to achieve therapeutic change, it is necessary to combine group processes with a well-defined treatment framework, consisting of a theory of change, a methodology, and sufficient knowledge of the target group. The success of group treatment depends largely on the correct way of combining a strong methodology and a functional use of group processes.
- The practice guidelines try to answer the question *of how* group practitioners can shape their treatments in an adequate and effective way in daily practice. Therefore, in these practice guidelines a broad concept of evidence is chosen in which expert consensus has a place in addition to effect and especially process research.
- The task force intends to revise two chapters of the practice guidelines every two years on the basis of the current state of scientific research on the theme in question.

1.8. Recommended literature

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Chapter 9: Destructive group processes and negative effects of group treatment

Cor de Haan and Silvia Pol

9.1 Introduction

The complexity of working with groups is often seriously underestimated. The strength of the group can be very stimulating, and of great additional value for the development of the group and the individual group members. However, the strength of the group can also have a hindering effect, leading to deterioration or even destruction if certain conditions are not met, or not properly managed (de Haan, 2012; Hoijtink, 2001).

A group not only provides a safe environment, a degree of friction is inevitable because differences between members can easily lead to fears, collision and conflict, both within and between the participants. If conflicts can be resolved properly, cooperation will develop. Members learn new behavior and the group as a whole develops to a higher level of functioning (de Waal, 2017). This is the constructive power of groups that we as group practitioners want to use for treatment purposesHowever, there may also be stagnation in group development when conflicts cannot be resolved properly and tension within the group is unnecessarily high. If this lasts longer, we speak of an *anti-group* (Nitsun, 2002; 2015); a group in which destructive forces come to the fore, members are no longer safe and the group as a whole can fall apart. A recent example cited by the international press is an investigation launched after the suicide of two Amnesty International staff members relatively shortly after each other. It was concluded that there was "a toxic corporate culture" in the headquarters in London. The investigators speak of a culture of secrecy, distrust, discrimination, bullying and abuse of power (NRC-Handelsblad, 2019). This example shows that even in groups where you may expect a degree of empathy for fellow human beings, as well as the awareness of risks associated with unequal power relations, working relationships are not immune from destructive processes.

Processes that are difficult to manage and lead to negative effects can also occur in treatment groups. Working with groups requires knowledge of the powerful potential of groups and skills to guide groups in a responsible way.

This chapter discusses the background of destructive group processes and negative effects of participation in group treatment, how they can occur and be reduced. At the end of the chapter, the summary lists the main tools and points of attention aimed at reducing risks.

9.2 Background

Nitsun (2002) described the group as a complex and often incomplete experience, i.e. an experience the significance of which is not always well understood . A group is formed by a collection of strangers and by definition creates a confrontation between individual differences. Influenced by its members, a group develops with periods of growth and decline. As a result, groups can be unpredictable at times. These factors together bring with

them tension-filled interpersonal situations that offer opportunities for learning, but which can also lead to negative experiences. The risk of this is greatest in unstructured groups without a cleare agenda, in which confusion and fear can arise and members are largely left to fend for themselves.

9.2.1 Negative effects in the group

The aims of group treatment are to give participants more insight into themselves and the problems they struggle with, to make progress in dropping dysfunctional patterns, and to develop better skills and stronger self-esteem. This can lead to better prospects for the future and the opportunity to grow in warm and meaningful relationships (Yalom & Leszcz, 2005). Patterns that group members struggle with have typically arisen and are energized in the dynamics of the social group, such as the family of origin and the broader social environment in which the participants have grown up. For some group members, the group can represent an environment in which recognition of past experiences occurs. It is such a powerful medium that deeper emotions and painful memories, including past traumas, can be touched and come to the surface. In addition, it can be difficult to distinguish between emotions and experiences from the past, and those that belong to the present and the contact with the group in the here-and-now. If this confusion arises and skills fall short, it can be difficult to experience and accept emotions, and participants can end up acting-out their emotions. If this phenomenon is not recognized and limited in a timely manner, it can lead to destructive processes in which negative past experiences are repeated. Acting-out can lead to renewed damage, deterioration and premature termination of treatment (drop-out). Karterud (2015) discusses examples of negative effects in the group:

- acting-out emotions by not talking about emotions, but behaving in anger, infatuation, boredom, etc.;
- subgroup formation by engaging closer with some participants and turning away from other participants;
- acting overtly dependent and avoiding one's own responsibility;
- excess of cohesion and proximity in which conflicts are avoided;
- scapegoating, by excluding or disqualifying a participant;
- fight-flight reactions that leave no room for reflection and awareness;
- rigid interaction patterns and role fixation that do not create room for development towards new behavior.

For a discussion of various forms of early termination or dropout and scientific research on this topic, we refer to Chapter 8.

9.2.2 Negative processes in the group

Bion has described the development of negative processes in groups extensively (Berk, 2005; Roth, 2013). Each group member enters the group with basic emotional questions about goals and needs, about identity and group membership, about power, control and influence, and questions about intimacy. In response to these questions, each group develops a number of basic assumptions. Bion distinguishes three basic assumptions: 1) fight / flight; 2) pairing; and 3) dependence. Fighting / fleeing is about responding to tension with criticism, aggression and rivalry, or by avoiding, intellectualizing and staying away. In pairing, support is sought from each other, sometimes with shielding from the group. In case of dependence, support is sought from the group practitioner with a request for more structure, but rebellion and resistance to authority can also occur. Group members are not

aware of these assumptions, but the associated behaviors can be recognized in the atmosphere and climate in which the group work is carried out. The culture of a group is formed by the task in combination with the basic assumptions that prevail in the group (Remmerswaal, 2013). Bion described how these basic assumptions can lead to intense and primitive emotions in groups. Emotional processes from the early development of group members then become decisive and lead to a mutual entanglement of group members within the group. The atmosphere in the group can be characterized by hatred and hostility, by violation of boundaries, by ignoring current problems, and/or by idealization and subsequent devaluation of the group therapist. These occurrences leave members feeling helpless, worthless and unprotected. In these cases, we speak of a destructive group process.

Today, however, it is recognized that every basic assumption has its value. Research shows that the most productive group contains all the abovementioned emotional tendencies (Remmerswaal, 2013). Fighting brings vitality, commitment and creativity to the group, pairing contributes to the cohesion in the group, and dependency fits when there is insufficient sense of competence in the group and there is a need for support. It can be concluded that emotional behavior of group members can have a constructive or destructive effect on the group process, depending on the circumstances of the group at that time.

Nitsun (2002; 2015) is another important author when it comes to negative processes in groups. He describes a functional or natural anti-group which signals a phase in group development. The anti-group represents the destructive aspect of group. It is variable from group to group but is part of most, if not all, groups. The anti-group threatens the cohesion of the group but working through this phase stimulates the creative power and development of the group. In a functional anti-group, there is expression of emotions, which calls for a discussion and an acceptance of such (sometimes violent) emotions. In this group, the usual intervention strategies are sufficient. However, a dysfunctional or pathological anti-group can also develop as a result of a stagnation in group development. In this group, there is fear and distrust of the group process. The group is experienced as negligent and undermining, with direct and indirect aggression taking place between group members. The members experience negative experiences and the group may even fall apart. It is important for the group therapist to recognize and locate the anti-group (individual, subgroup, group as a whole), to confirm and restore boundaries and to look for the source of stagnation in the group. The group practitioner draws attention to the trauma in group development and helps group members connect their thoughts, emotions, and behavior. Intervening in such a field of tension is very complex, and support must be available for the group practitioner in the form of peer consultation or supervision.

9.2.3 Negative effects and leadership

The group practitioner uses the group as a vehicle for change and pays attention to the dynamics of the individual group members, to the interpersonal dynamics, and to the dynamics throughout the group. Together, these components form a whole and it is the task of the group practitioner to integrate them (Berk, 2011). The aim of the leader is to support the group in its group task and to keep the group together as a group. However, feelings and interpersonal relationships can take on violent forms in the group, with group practitioners facing the challenge of finding a balance between avoidance and confrontation. Group

practitioners sometimes fail to do so. Karterud (2015) lists some examples of negative effects of the leader:

- provide insufficient clarity on the framework within which the group is offered;
- provide insufficient clarity on the group task;
- insufficient monitoring of safe boundaries in interaction between participants;
- insufficient recognition of a negative effect of one's own actions;
- insufficient use of one's own influence to adjust negative effects;
- insufficient coordination in the co-therapy, or co-counseling relationship.

Group practitioners should also be aware of their dominant position as the leader of a group and of the risk of that position in terms of power, influence and status (AGPA, 2007; Leszcz, 2004). Group practitioners can put too much pressure on participants, or fail to provide an intervention when a risky interaction develops between group members. Group practitioners therefore need strategies to help them resist their own negative tendencies, and help participants to profit from the interpersonal exchange taking place in the group (Karterud, 2015).

9.3 Practice

We will now look at some basic conditions that group treatment or a group practitioner must meet in order to avoid destructive group processes and negative effects of the treatment. Next, a number of specific situations or topics are discussed that can negatively affect the group process and which the group practitioner regularly encounters in daily practice.

9.3.1. Basic conditions to avoid negative effects

Not all individuals benefit from a group setting. The risk should be limited to group members getting worse as a result of joining a group because they cannot take the level of stress that arises in the group. This requires proper diagnostic research, if necessary with the use of adequate instruments (AGPA, 2007). Indication for participation in a group therefore begins with clarification of the problem or diagnostics, together with an appropriate rationale for treatment. The consideration about the indication for group treatment should be discussed with the participant. Careful selection of participants, possibly with the support of selection and monitoring tools, and a thorough design of the group, are prerequisites for success and avoid negative effects as much as possible (De Haas, 2008; AGPA, 2007). An explicit task structure prevents it from being unclear to group members; being transparent about what is expected of them reduces feelings of insecurity (Karterud, 2015). Some institutions provide information about group treatment in the form of a leaflet.
In the design of a group, it must also be clear how to deal with time boundaries when the group is incomplete. How many members are needed for the group to continue? Time boundaries that will be applied when the group is not complete must be clearly defined (e.g. with no more than four members an unstructured group should be limited in time to one hour). When too much time is given to a group that is too small, members may be overwhelmed and negative emotions may arise that can dominate the group. We refer to chapter 2 for aspects that need attention when designing a group, and to chapter 3 for subject selection and composition of the group.

Offering group treatment with a specific treatment method has the risk that too much emphasis is placed on the method as such. These groups require a careful balancing between content and process. When too little attention is given to group dynamics, impending destructive processes can be missed, and too much is expected from the specific treatment method (De Haan, 2011). We refer to Chapter 11 for further reading on the combination of group dynamics and specific psychotherapeutic methods.

Group treatment is a special interpersonal situation because participants are expected to share often shameful aspects of themselves in the group. A general condition for the success of a group is therefore that there is confidentiality within the group and that participants commit themselves to this , so that personal information can be shared securely in the group (AGPA, 2007). It should be discussed how participants can share their own experiences in the group with third parties without violating these rules. It should be clear how rules and agreements are handled, contact within and outside the group, social media and any recordings for supervision purposes (AGPA, 2007). Participants agree on participation in the group and are informed that reporting takes place, on the group and on each individual without naming other participants. It is also made clear to participants how touching, offering gifts and openness (disclosure) are handled by the leader (AGPA, 2007).

It is clear that good preparation can prevent many negative effects. But in each group there are dynamics and in each group, if not sufficiently recognized and dealt with in time, this can lead to destructive group processes and negative effects. In the following, we discuss how practical situations that often take place can be dealt with.

9.3.2 The group that stays put

Even with the best preparation, it is possible that a group fails to get off the ground. It is important for a starting group that the group practitioner does not allow silences to arise for too long and that the group is taken by the hand. The group practitioner provides clarity about the task of the group by explaining its the purpose, the working method, rules, and other agreements.
A clear and safe start determines the success of the group. In order to get a starting group going or to have a new group member find his place, the first introduction is essential. By using a fixed ritual or a pre-structured way of making acquaintance, the group practitioner ensures optimal safety and clear boundaries. The introduction should prevent group members from sharing personal or intimate information about themselves without feeling safe or connected to the group and the other group members. Self-disclosure must be consistent with the built up trust in, and relationship with, the group.
If, in the initial phase of a group treatment, there is strong passivity out of fear, then the group practitioner adjusts his activity accordingly. Long silences increase anxiety and are prevented by offering structure. The group practitioner questions all group members and connects the group members by drawing attention to common themes. In addition, he explains common themes and feelings that belong to a starting group, such as the combination of the desire to change, the fear of change, and the doubt about the usefulness of the group.

9.3.3 Dealing with obstructive roles

Group development suffers when fixed patterns arise and a group member becomes trapped in a role. Certain roles of group members may hinder group development and can have a destructive effect on the group process (Janzing & Kerstens, 2012; Yalom & Leszcz,

2005, Rutan,-Stone & Shay, 2014; Berk, 2005; Remmerswaal, 2013). When obstructive roles occur it is important to discuss not only the role of the group member but also the dynamics, i.e. the interaction with the group. Roles can have a function for the group as such (see also Chapter 6). If a role issue cannot be explained in terms of group dynamics, only then should the characteristics of the participant with this role be considered. How does the role fit with the person's history and what significance does the role have at that time?

In the table below, we provide an overview of obstructive roles, the context in which they may arise, the function of the role for the group, and guidelines for dealing with the situation that has arisen.

Role	Function	Context	Risk	Approach
Scapegoat	Channeling tension (fear and aggression)	Anxious and insecure group	Disqualification, rejection, renewed victim	The scapegoat is often anxious to fit in and familiar with the scapegoating role. Discuss function of channeling anger/ discontent of other group members.
Dominating and/or belligerent group member	Shielding own vulnerability	Group is overwhelmed, falls silent	Unsafe atmosphere, group members drop out	Embrace content but limit verbosity, tone, and emotion: your point is clear, you may leave it at that. What you're telling is clear, but just try saying it calmly.
Joker	Provides some levity, a good atmosphere.	Avoiding group	Undermining objectives and serious character of the group	Name both the positive side and the avoiding side, with (appropriate) appreciation.
Helpful group member	Stress reduction	Group in need of care	Impeding independence and autonomy of other group members	Set limits because it makes others unnecessarily dependent. The group member who immediately comes to the rescue with a handkerchief: let that be for a moment, crying (in case of sorrow) is allowed.
Resister	Naming the downside	Group that finds differences difficult	Conflict, struggle	Embrace content, use the quality of resistance.
Lightning conductor	Stress reduction	Anxious and insecure group	Aggression goes to role carrier	Discuss the function of a lightning conductor for the group.
Silent person	Anxious group member	Group can be perceived as threatening	Drop-out	Friendly invite at the end of the group (so that the person stands not central for too long).
Narcissistic group member	Makes group an extension of one's own greatness	Group can be perceived as threatening	Group can be experienced as an aggressor.	Praise and also invite self-reflection. Slight narcissism is tolerable in the group; with severe narcissism individual treatment is often more suitable.
Absent group member	Undermines group stability	The group should be a safe base	Fragmentation, 'dovecote'	Direct discussion, positive standard regulation.
Distrustful group member	Keeps his distance	Group can be perceived as threatening	High tension in group, drop-out	Check group safety, rethink selection/diagnostics, validate experiences in history.

table 1: Overview of obstructive roles, their functions, and how to deal with them

Group leaders can also get stuck in a role. In those situations the group practitioner can benefit from the help of the co-group practitioner in order to distance himself from it. Group

practitioners can offer a good model to group members by easily changing roles, thus showing different sides of themselves and dealing with their role in a relaxed way (Hoijtink, 2001).

9.3.4 Dealing with incidents

Incidents in the group can provoke fear and anger among group members and cause reluctance among group members and group practitioners to act. We shall consider incidents of aggressiveness. After that, we shall name a number of other types of incidents and offer suggestions for appropriate action (see table).

When it comes to aggression, Molnos (1995) talks about a distinction between healing aggression and destructive aggression. Healing aggression means expressing your anger against the right person, about the right subject, at the right time. Destructive aggression is about expressing your anger against the wrong person, about a minor point, at an inappropriate time when it can cause great tension. According to Molnos, the most destructive thing is the anger that is not recognized as such, but is acted out. Within the group, this anger can express itself through violation of group boundaries, through scapegoat phenomena, and attacks on the group leader. The security and stability of the group is then in danger. In order to prevent destructive aggression in the group and to ensure adequate security, it is important to be clear about rules and agreements: anger is allowed provided there is willingness to discuss and investigate, but threatening or physical aggression is not allowed.

Incident	Approach
Threatening aggression or revenge	- immediately stop the interaction - provide boundaries - repeat group rules
Violent emotional outburst	- confirm emotion - invite to put emotions into words - support the individual and group - temporize
Running away from the group	- support by validating feelings and the tendency to leave the group - invite to tell about the reason for the tendency to leave the group - offer structure by temporizing
Being late or not showing up	- invite to investigate the behavior - investigate consistency with interaction with the group - dwell on (good) cooperation - explain the importance of attendance for coherence and continuity - underline group members' responsibility
Suicidal tendency	- normalize, thoughts on suicide are common and human - explain and make agreements on responsibilities of individual group members and the group leader

	- make arrangements regarding safety - consider individual contact
Suicide attempt or suicide	- support by validating different feelings - discuss the significance of the incident for the group members (Kerkhof & van Luyn, 2010; Robbertz, 2011).
Dissociation or conversion	- explain and make agreements on responsibilities of individual group members and the group leader - make friendly but firm suggestion to bring attention back to the group
Disruption in vulnerable group members (confusion, psychosis)	- explain vulnerability and discuss what the group member, but also the group needs - make agreements on responsibilities of the individual group members and group leader
Out of control contacts outside the group (also digital)	- discuss on the one hand the desire for more contact, and on the other hand the importance of group boundaries - reiterate the group rules
Feelings of love and sexual contact between group members	-discuss in the group and investigate the meaning of the feelings and behaviors for the two group members and the group as a whole - reiterate the group rules

Table 2: Overview of common incidents and how to deal with them

9.3.5 Dealing with leadership

In a well-functioning group a participant receives more support and feedback than an individual practitioner can ever provide. This makes group treatment an extremely powerful intervention that we want to offer in a responsible manner. As soon as the group process starts, powerful active factors start to work (Yalom & Leszcz, 2005) that require expertise in leading groups.

The starting point is that the type of leadership should fit the aim of the group. The more training-oriented the group, the more structure the group leader puts in and the less room is left for developing group dynamics (De Haas, 2008). The group leader will tailor his own attitude and interventions to what the group needs. These needs differ for starting and advanced groups, and also depend on the developmental phase (see Chapter 7) of the group. During the development of the group, it is important that the group leader transfers part of the responsibility to the group members, and that the members then support the group's goals more independently. Below are the group developmental phases (Levine, 1982) described with the corresponding pitfalls and tasks for the leader.

Development phase group	**Trap**	**Task for leader**
Parallel phase	Providing too little control and connection, increasing tension too much	Clarify the task and working methods, provide guidance, promote coherence

Authority crisis	Explaining, reassuring or defending instead of receiving anger and fear, aggression can't take a constructive form	Name anger and fear, accept them without defending
Inclusion phase	Too little room for differences, fear of deviating from the group	Recognize that differences may exist
Intimacy crisis	Not giving enough space for deepening contact	Provide support when entering into deeper contact
Reciprocity phase	Providing too much guidance, being too present	Facilitate exchange by group members
Termination phase	Not enough room to discuss letting go of contact	Dwell on meaning of terminating contact

Table 3: Development phases, pitfalsl and how to deal with them

Where there are signs that group dynamics are interfering with the task-oriented functioning of the group, it is important to prevent the emergence of a group dominated by a basic assumption. The group leader does this by (Remmerswaal, 2013):

–opting for a more active attitude, less silences and a less distanced attitude;
- providing more structure and task-oriented functioning;
- showing involvement and empathy and adopting a less authoritarian attitude;
- offering not only group interventions but also support for the individual group member;
- offering selective self-disclosure.

Prevention of a pathological anti-group is achieved by giving room to and working through conflicts, receiving feelings of anger as a leader, and trying to recognize in time when the group is stagnating in its development. Leading a group in which destructive processes play a role is difficult, and support from colleagues is essential. Prevent professional isolation; engaging in consultation represents a high degree of professionalism (AGPA, 2007, p. 49-50). Supervision or peer review (see Chapter 16) is ideal for professional support (Leszcz, 2004).

9.4 Summary

- A group does not necessarily offer a safe environment because ever-present differences between members can lead to fear, collision and conflict both within and between the participants.
- When conflicts can be resolved properly, cooperation develops in the group.
- When conflicts are insufficiently resolved, cooperation can stagnate, causing destructive forces, insecurity and possible disintegration of the group.
- Careful selection of participants and a good design of a group are prerequisites for successful group treatment and for avoiding negative effects as much as possible.
- It is important to be clear about rules and agreements in order to prevent emotions being acted out and to ensure sufficient safety.
- Angry, conflicting or aggressive behavior by group members can have a constructive (functional) and destructive (dysfunctional) effect on the group process.

- Group practitioners recognize negative effects, discuss these effects and limit them where necessary. They can themselves contribute to destructive processes in the group by intervening too much or too little on conflicting behaviors.
- When offering groups with a specific treatment method it is important that, in addition to offering the protocol, there is room to work with the interaction in the group.
- Prevention of a pathological anti-group is achieved by giving room to and working through conflicts, receiving feelings of anger as a leader, and trying to recognize in time when the group is stagnating in its development.
- Supervison or peer review is an important support for the group practitioner when confronted with destructive powers and processes in groups.

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Chapter 10: Combining group dynamics and specific psychotherapeutic treatment methods

Helga Aalders and Ingrid Krijnen

10.1 Introduction

The previous chapters of this guideline apply to group treatments across the entire field of health care. In this chapter we will focus on the integration of group treatment with specific psychotherapeutic frames of reference, and in doing so we will mainly focus on the practice of mental health care.

Characteristic of Dutch mental health care in recent decades is that psychotherapeutic treatment methods are often offered in a group setting. This may involve weekly outpatient treatment, but also a more intensive outpatient-plus, part-time or clinical setting (see also chapter 11). This concerns specific methods that are derived from a cognitive-behavioral, a psychodynamic or an integrative frame of reference. Examples include: Schema-focused therapy (SFT), Mentalization-based therapy (MBT), Dialectical behavioral therapy (DBT), Interpersonal therapy, Acceptance and Commitment Therapy (ACT) and Affect phobia therapy (AFT). In the following we will consider such group treatments, in which the therapist combines one of the treatment methods with a well-considered use of group processes.

An argument often put forward for this combined form is that group treatments are more cost effective than when the method is presented individually (Burlingame et al., 2013). As important, if not more important, is that research and various studies have shown that when a psychotherapeutic method is offered in a group this will enhance the ultimate results of the treatment, provided that the group dynamic processes are managed appropriately (Burlingame, et al., 2004; Farrell et al., 2009; Burlingame et al., 2013; Karterud, 2014; Koks, 2015).

In current Dutch practice however there appears to be a gap: most practitioners who offer group treatment are well trained in the specific method, but are hardly skilled in the therapeutic use of the group they work with. How to lead a group in a responsible manner has already been discussed in detail in the other chapters. The central question for the practitioner will be how to find a good balance between the group dynamic framework and the specific psychotherapeutic method that is used. An important approach is how to let the group processes serve as a catalyst for the method and how to integrate that method in such a way that the outcome produces fruitful group dynamics. Focusing on an appropriate balance between group dynamics and method ensures treatment results that are larger than those of the specific treatment method itself. However, this is not an easy task. The therapists will constantly encounter dilemmas and have to make choices.

In this chapter we will start with a brief overview of the research on combining group dynamics and specific treatment methods. Then we discuss a number of dilemmas that the group practitioner may encounter in practice when combining a specific, individual

framework and a group framework. We will discuss the considerations he can make with regard to these dilemmas. We will end this chapter with a short summary and recommended literature.

10.2 Background

In this section we will discuss what is known about factors that contribute to the effect of individual psychotherapeutic treatment and factors that contribute to the effect of group treatment. Recently developed measuring instruments for group variants of some specific treatment methods are also reviewed.

10.2.1 General

In various studies (Duncan & Miller, 2006; Godley et al., 2004; De Haan, 2011; Bergin & Garfield, 2013) it has been shown that the specific method used in an individual treatment contributes only 8% to 15% of the effect of the treatment and that the quality of the treatment relationship has a significantly larger influence on the final results. Patient compliance and patient participation also explain part of the outcome.
Of course, using a good, effective treatment relationship with a group and its group members requires knowledge and skills differing from individual treatment. The same goes for promoting compliance and participation.
As mentioned in 10.1, research has shown that offering a treatment method in groups can enhance the results of the treatment provided the group dynamics are adequately used. Unfortunately, no study has yet been published which clearly sets out what proper handling of group dynamics entails, nor in which a comparison is made between group treatment given by practitioners with and without specific knowledge of group dynamics. However, there is sufficient evidence from research and practice that specialist knowledge of and experience with group dynamics make an important contribution to better treatment results. We list these indications below.

10.2.2 Research into group factors and specific methods

Various studies and research have shown that treatment groups can have a non-specific, but important treatment effect due to a number of common factors (Bloch & Crouch, 1985; Lieberman, 1983; Kvilighan, 1988; Colijn & Snijders, 1993). This is discussed in detail in Chapter 4. Colijn and Snijders distinguish between factors that work in any form of psychotherapy, factors that work in any form of group therapy and those that work in specific treatment groups or specific target groups. Factors that work specifically with certain types of groups or target groups include self-understanding, reliving the earlier family situation, awareness of existential factors, and learning through modeling or imitation. Depending on the tasks and goals of the treatment group, some active factors will have more and others less influence on the treatment results. In a structured treatment group, for example, 'providing information' is an accessible and easily deployable intervention, while in insight-oriented psychotherapy group 'steering the process towards

corrective experiences' is an important tool of the group therapist (Sanders & Van der Veer, 2018). Burlingame et al. (2004) conclude that it is very plausible that in the case of cognitive-behavioral therapeutic group treatments, cohesion (in the initial phase) and conflicts (in the middle phase) contribute to a positive effect.

It should be noted that strengthening the cohesion or inter-relatedness of the group proves to be the central active factor in group treatment and that this factor promotes the occurrence of other treatment factors. Cohesion is therefore considered to be the group equivalent of the treatment relationship in individual treatment (Burlingame, 2011; Yalom & Leszcz, 2005; Leszcz, 2014). In groups, too, cohesion is at least as important as, if not significantly more important than, the psychotherapeutic method used (AGPA, 2007). Recent research (Bastick et al., 2018) shows that, regardless of the method used, groups with optimal cohesion enhance in patients both the sense of emotional connection and the sense that they are working together on a clearly defined task. In addition, for group members the idea not to be alone with certain problems and for patients of certain focus groups, often for the first time, experiencing to be part of a whole, is essential. Because of this sense of connection and not being alone anymore, the drop-out risk decreases and the tendency to actively participate increases. Various studies have shown how a group therapist can strengthen cohesion: by providing a clear group structure, by promoting frequent verbal interactions between group members and by creating an emotionally safe and therapeutically active climate. Strenghtening cohesion makes an important contribution to increasing treatment outcomes (AGPA, 2007; Burlingame et al., 2011; Burlingame et al., 2013; Leszcz, 2014; Karterud, 2015). For a more detailed description of this, see also chapters 4 and 8 of these Practice Guidelines.

During the past five years, literature from both the SFT (Farrell & Shaw, 2012) and MBT (Karterud, 2015) has been published, focusing on the use of a specific method within a group setting. The Ratingscale for mentalization-based group therapy and the Ratingscale for mentalization-based group therapy quality (Karterud, 2015) and the Group Schema Therapy Rating Scale - Revised (Bastick et al., 2018) are corollaries of this. Both lists are currently being used in research into the hypothesis that being able to properly handle group dynamics in combination with a specific method is essential for the effectiveness of a treatment.

10.3 Practice

For a successful combination of a specific methodology with a well-considered use of group processes, it is above all important that the group therapist is well trained in the treatment method, i.e. has sufficient knowledge of the theoretical background and is able to adequately apply the corresponding therapeutic techniques. Following an official training program including supervision is a basic condition for this. The consistent application of the

method not only provides clarity, guidance and hope to the patients, the group practitioner also needs a view on the pathology and treatment of a specific target group as a guideline in his actions. In addition, to better understand each other in a team of practitioners the method provides a common language.
In addition, for the effective application of a specific method it is important that the group practitioner is well acquainted with how to adequately lead a treatment group. This has been discussed in detail in previous chapters, and group practitioners who want to apply a specific method in the group would do well to deepen their knowledge of the main topics of group treatment such as organizing a group (chapters 2 and 3), what one should know about group processes (chapters 4, 5 and 6), how an effective group therapist should act (chapter 8), and how the group therapist tries to prevent negative group treatment effects (chapter 9).
In summary, in addition to using a specific method, promoting group cohesion will be the central activity . As mentioned earlier, creating a clear group structure, promoting verbal interaction and creating an emotionally safe and effective climate are important elements to consider when leading the group.

So far, no research is available on how to combine group processes and a specific psychotherapeutic method; how to keep the balance between the two frames and determine the correct dosage of both. Specific treatment methods often follow a certain structure both in the design and in a session, are usually individual-oriented and have their own language or jargon. If you want to combine a method with the use of group processes and the promotion of group cohesion, as a group therapist you are always confronted with dilemmas or questions. In the following sections we will discuss some of these dilemmas on the basis of practical examples.

10.3.1 Application of individual treatment methods in a group setting

Most, if not all, specific psychotherapeutic treatment methods were originally developed out of and for an individual treatment setting. Although often a group-oriented approach is also defined over time, whether or not as a treatment protocol, in the specific treatment method often the focus is on the individual. For knowledge about group dynamics and processes and ways to use them for the benefit of the individual and the group, the group therapist will fall back on literature and research from social psychology and group psychotherapy. Regardless of the specific treatment method used, the group practitioner will always balance between focusing on either the individual or the interactions between the group members and the group as a whole. The group practitioner will have to choose in his interventions whether he will be guided by the theoretical background, principles and sometimes even prescriptions from the specific frame of reference or by those from the group dynamics, group processes and group psychotherapy. Adhering to group rules, promoting positive group norms and values, and increasing group cohesion by inviting group members to interact are just a few examples where the group therapist can either focus on the individual or on the group and its group members.

In a group for patients with social anxiety, based on the principles of cognitive behavioral therapy, we always discuss last week's homework. For the third time it appears that two group members did not do their homework. In past sessions this has been addressed several times. The group therapists are faced with the dilemma of either spending yet again time on the therapy-interfering behavior of not doing homework, which would certainly be put on the agenda in individual treatment, or validating the group members who did make their homework. The group therapists could also comment on the somewhat covered irritation of a number of group members who might well be annoyed by the behavior of the group members who did not make their homework. This would provide a useful training situation.

Although many roads lead to Rome, where group norms are undermined it always is important to make the group members aware in a non-disapproving way that their behavior has an impact on the group as a whole. Not addressing the therapy-interfering behavior would undermine important group norms ("we make our homework") and would have a demotivating effect. In order not to waste too much time on the planned program, a second group norm, the group therapist will consider how much time he wants to spend on this. The group therapist takes into account the developmental phase of the group. During the first meetings of a treatment group, it does not seem sensible to investigate the underlying individual motives in the group, but rather to plan separate individual sessions for this. The group can briefly consider the impact of not doing homework at an individual and at group level, emphasizing the importance of doing homework. In a group that is further advanced in the program, the situation in the group could be used as a training situation with regard to dealing with and expressing criticism. The group therapist will especially encourage group members to talk about this with each other.

In an MBT group Monique, with visible tension and in an almost provocative tone , announces that next month she will marry a man who recently kicked a hard drugs habit and whom she met less than six months ago. She wants to talk about how little understanding for her choice she gets from her friends and family. Some group members congratulate her in a rather obligatory way, while others remain remarkably quiet, and Arnie, who is always sitting next to her, even turns away from her. When asked, Arnie indicates that to his discomfort he thinks that he is unable to congratulate Monique, even though he is very fond of her. He thinks this is because he is concerned about her future: "She hardly knows this man yet!" However, for fear of her reaction, he was afraid to tell her this. While Arnie is still speaking, Monique starts shouting that she is going to do what she has planned, after all, she loves that man. It seems as if she barely hears Arnie, let alone grasp his intentions. Upon further investigation of her behavior in the group, she spontaneously starts telling that her father, when as a young girl she indicated what she believed or wanted, often knocked her across the room. Once she left home, she resolved never to let anyone tell her what to do anymore. She mainly appears to experience Arnie's concern as an attack and as a sign of interfering, and feels let down by him. Other group members indicate that they have previously noticed that Monique seems to find it difficult when they think along with her and Monique hardly seems to accept what is being put to her.

A group therapist continuously makes the decision either to encourage the group to further investigate a problem introduced by one of the group members together, or to broaden the attention and to focus on the mutual interaction. It is not uncommon that tension arises between individual interests and the interests of the group members or the group as a whole. In such situations it is important that the group therapist is aware of the verbal and non-verbal responses within the group, as well as the unspoken feelings with which those responses are fraught, in order to decide whether to focus directly on what is going on in the interaction between the group members or not.

10.3.2 Integration of ideas and language from different frames of reference

Each specific treatment method or frame of reference is based on a theoretical background, in which through specific jargon the practitioner tries to give meaning to problems, complaints, symptoms or intrapsychic and interpersonal phenomena. By giving meaning we try to understand and influence the reality. A group therapist, who tries to understand from multiple frames of reference and influence what is going in a treatment group, does so by alternately observing the interaction from one frame of reference, with its own concepts, and then from the other frame of reference. He faces the challenge to repeatedly integrate the ideas and the related language from the different frames of reference, so he can optimally help the group and the group members in achieving their task or goal.

The group therapists of a depression group leave the session rather disillusioned. For several weeks they have been trying to get the group moving and motivate the members to change their behavior. But it seems as if the group is getting more and more passive. During the follow-up discussion, they wonder whether a number of group members should consider changing their medication. They also doubt the content of the program they offer. They decide to present these considerations to their supervisor. At first however the supervisor asks a number of questions about the group cohesion and the course of the sessions over time. Looking back, the group had started off well in the first weeks. Initially the group members were pleasantly surprised by the mutual recognition and they actively participated and encouraged each other. After five weeks, however, a group member had dropped out. This group member turned out to be increasingly manic and had to be admitted. The group members had heard nothing more about him. The supervisor discusses with the group therapists the effect of the departure of a group member on the cohesion in the group and the possible fear of their own disturbance that might have come up. The supervisor hypothesizes that the increase in the depressive symptoms is related to the interaction in the group and that the group processes should then be the starting point for change.

In addition to the explanatory model (for example, the medical model) and the specific frame of reference, a group therapist is aware of the group dynamic processes that affect the group and its members. The group dynamics and processes in terms of cohesion, group norms, roles, group developmental phases on the one hand, and the expression of problems and complaints on the other, intertwine and influence each other.

10.3.3 Method-specific interventions and the group process

Each psychotherapeutic method or frame of reference has its own set of method-specific interventions in addition to its own theoretical background. Often these interventions are originally aimed at the individual and ignore the important task of the group therapist to handle the group dynamics and group processes in such a way that they optimally support the purpose and task of the group. Applying method-specific interventions aimed at one individual, such as sorting out a G-scheme in a CBT group, performing an imagery exercise with rescripting within a SFT group or doing individual psycho-drama in a group, this all requires the group therapist to repeat a clear view of how to involve the other group members. If group members know that they are expected to actively contribute by thinking along, playing a role, or sharing their own experiences in the follow-up discussion, their involvement will be greater than when they are waiting for the group therapists and the protagonist to have “done their thing”.

The group therapists make a schedule during the preliminary discussion of the Schema Focused group therapy. In the previous meeting, group member Marianne had indicated that she wanted to investigate how to deal with her mother, who constantly asks her to perform all kinds of care tasks. She has been promised to work on this in the next session. The group therapists think about a chair technique that could be carried out with Marianne. As soon as they start the group session, Robert appears to be very agitated. He clearly shows that something is bothering him, but does not say anything about it. One of the group therapists mentions what she sees and wants to briefly pay attention to Roberts state without going into further detail, based on the idea that there should be enough time for Marianne. Dominique, another group member, immediately indicates that he is done with Robert's behavior. It bothers her that he is often charged without saying anything, but still gets the attention of the group therapists.
The group therapists are faced with the choice of how to continue the group session. One possibility would be to ask Robert for the next session to make a G-scheme of what is bothering him, to validate Dominique for expressing her feelings, and at the same time explain that they do not want to deviate from the initial plan, namely exploring together how Marianne can deal differently with her demanding mother.

When choosing interventions, the group therapist must consider whether it will be effective and appropriate to jointly investigate the dynamics that currently play a role in the group, or to divert as it were the group process through structuring, method-specific interventions.

10.3.4 Handling tensions and conflicts in the group

In general, the effects of group treatment are significantly better if there is interaction between the group members. Therefore it is important to consider how to deal with mutual tensions and rising emotions in interactions between group members. The various psychotherapeutic approaches use their own methods for this. The way in which tensions and conflicts are handled influences the underlying group dynamics and group processes.
In a DBT group training, it is often chosen to keep the interactions between the group members to a minimum and to have the group treatment run mainly through knowledge transfer by the trainers. The added value of the group and the group process may be less in

this way, but the risk of escalation remains small. Group therapists of an open, insight-oriented group treatment often let tensions rise for some time before focusing joint attention on them. In treatment groups with members with emotion regulation problems, discussing mutual tensions requires a very active attitude from the therapist in order to increase the learning effect and to avoid harmful interaction as much as possible. For example, MBT therapists will immediately stop interactions between group members when emotions run too high, and explain that it is not possible to mentalize properly in such an atmosphere. They may stick up for a vulnerable group member who is subject of the group members' anger. Then, together with the group members, a step-by-step and detailed investigation is conducted into the reason why these emotions ran so high among the different group members. A SFT therapist will use limit setting in such a situation and then investigate with the group members which schemas prior to the conflict were activated in each of them.
When considering whether tensions or conflicts vshould be further explored on the spot by analyzing the feelings and thoughts that arose in the interactions, it is important to also consider the phase in which the group finds itself before deciding what approach to follow. In general, discussing interactions that have led to tension in the group works better and is more effective if the group has been working together for some time and the cohesion has increased.

10.3.5 Dividing tasks and time between the two group therapists

Specific psychotherapeutic methods not only make use of method-specific interventions, they often also use a certain structure in which there can be a thematic division of time and a division of tasks between the group practitioners.

In the psycho-education group for clients with a first psychosis the program is divided into two parts. The first part of the session focuses on giving information about the condition and the various treatment options. The second part focuses on contact with fellow members and the exchange of experiences. By making a distinction in the task of both parts of the session, it is better to give the information in a structured way and then make room for their own experiences and emotions, and for mutual support. Certainly for a target group with a short attention span and a risk of loss of coherence in thinking, such a task orientation and clear structure in the design of the group session can be essential for feelings of safety and the treatment results.

When agreeing on a division of tasks between group practitioners, based on the amount of experience, function or preference, it is important to realize the effect of this on the group dynamics. As long as it is clear why the tasks are distributed in a certain way and how this interferes with the group process and the method a division of tasks is not right or wrong.

Michiel and Anja recently started doing an AFT group together. Michiel is an experienced group therapist and has led this group for a long time, together with another therapist, Irene. Anja is the successor of Irene and has little experience with AFT and with groups. She is enthusiastic and wants nothing more than to master the profession. The group was very attached to Irene and the group

members have a hard time with the arrival of the younger Anja. Michiel lets Anja know that for the time being she has to see which way the wind blows and advises her not to intervene too often in the group. Anja is therefore modest and somewhat reserved. When after a number of sessions she only speaks up now and then, she feels that the group is ignoring her and not taking her seriously. During the follow-up discussion, the group therapists wonder whether they should be patient and whether this is part of the acceptance process or whether there may be another problem. One hypothesis could be that Michiel still has difficulty parting with the previous group therapist and that he therefore keeps Anja on the sidelines unknowingly.

In treatment groups that use method-specific interventions which place group members at the center, such as when working out G-schemes or mentalizing about one group member's problems, it is important that group practitioners carefully consider how to divide the tasks. When both of them pay attention to the protagonist, they take a risk of making the other group members passive spectators and this does not benefit the treatment result. In that case one of the group therapists may mainly focus on actively involving the other group members in thinking about or playing out the problem of the group member who is at the centre of attention. For a further description of the cooperation between two group practitioners, we refer to chapter 12 of the Practice Guidelines.

10.4 Summary

- In the Dutch mental health care system, specific psychotherapeutic treatment methods that are originally aimed at the individual are now often offered in a group setting.
- A good balance between the group dynamic framework and the specific psychotherapeutic method ensures treatment results are better than that of the specific treatment method itself.
- Strengthening the cohesion or interrelatedness of the group is the central active factor in group treatments. This factor promotes the occurrence of other non-specific and method-specific treatment factors.
- The way in which tensions and conflicts are handled from the perspective of specific frames of reference influences the underlying group dynamics and group processes.
- When shaping the group, the group therapist will seek a balance between focusing on the individual and on the interactions between group members and the group as a whole.
- The group therapist is faced with the challenge of integrating the ideas and associated language of the chosen specific frame of reference and those of group dynamics, so that the group can optimally focus on its task.
- When choosing interventions, the group therapist considers whether it is effective and appropriate to jointly investigate the dynamics that currently play a role in the group, or to divert the group process as it were by means of structuring, method-specific interventions.

- When agreeing on a division of tasks between the group therapists or a thematic division of time, it is important to realize the effect of this on the group dynamics. Dividing tasks or time is not right or wrong as long as it is clear why the tasks are divided in a certain way and how this interferes with the group process and the method.

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Chapter 11: Group treatment as part of a multidisciplinary treatment design

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11.1 Introduction

Group treatment can be a stand-alone option, but is often part of a more comprehensive treatment offer. When outpatient-treatment has insufficient effect, the intensity of the treatment can be increased. The program can consist of a combination of group and individual treatment.

In addition to group treatment, treatment modalities from other perspectives can be added, such as medical treatment, art- and psychomotor therapy, family therapy, social work therapy, social counseling or pharmacotherapy. The combination of treatment modalities can be offered over several half-days in an outpatient or parttime setting, or offered in an intensive multi-day or inpatient setting. The treatment is usually carried out by several practitioners from different backgrounds, disciplines or specialties, who form a multidisciplinary treatment team around a client or group of clients.

In a setting of multidisciplinary treatment, in addition to the group dynamics, the dynamics of the organization also influence the treatment process. The degree of coherence in the view on, and in the organization of, the entire treatment program has a major influence on the effect of the treatment as a whole. We know from daily practice that a lack of coherence and vision can lead to a reduction in the therapeutic effect and sometimes even to worsening the clients' psychological symptoms and problems.

In this chapter we describe what is known in science and literature about the relation between the organization and the result or effect of a psychological treatment. Then we describe various ways in which multidisciplinary treatment can be designed in small, well-organized or in more extensive and complex composite treatment teams.

After that we will discuss how to use the organization of a treatment setting in practice. You will find a description of the Model of Coherent Treatment. We elaborate on the task and process side of a treatment team in terms of Imposed and Emergent Structure. And finally, we discuss a phenomenon that can undermine the treatment process, the so called parallel process.

11.2 Background

There is little scientific research into the effect of whether or not there is coherence in the design of the treatment, or into the effect of good cooperation within the treatment. Several

studies are known in which the positive effect of this was determined through participatory observation research in psychiatric clinics (Stanton & Schwarz, 1954; Caudill, 1959). Later, the importance of coherence and good cooperation was emphasized in both psychotherapy and somatic care, but also in the public service and business. The importance of these factors is usually recognized (Janzing & Claassen, 2014).

Why there is so little research has to do with its complexity. Because there are many variables within a multidisciplinary treatment set-up, it is difficult to determine to what extent there is causality between good coherence, cooperation, and the treatment results. Various qualitative studies have shown that coherence in the organization of, and vision on, treatment and cooperation have a major impact on the effect of the treatment. However, it is difficult to determine whether these findings are sufficiently valid. Design-oriented scientific research (Van Aken & Andriessen, 2011) may be useful here. This form of application-oriented fundamental research is used within existing social situations, such as companies and teams, and is therefore a suitable form of research into group and team processes.

In the next paragraph we point out an overview of the studies of forms of multidisciplinary treatment.

11.2.1 Scientific research into forms of multidisciplinary treatment

Much of our knowledge about the effect of multidisciplinary treatment has been gained in qualitative research into day-clinical or inpatient psychotherapy, which is pre-eminently a form of treatment characterized by a high degree of coherence between vision on psychopathology and organization of the treatment.

In the authoritative Handbook of Psychotherapy and Behavior Change, Burlingame et al. (2013) conclude that the evidence for the effectiveness of group inpatient treatment for various disorders is promising.

In the Netherlands, there have been two long-term studies in the past decades into the effect of day-clinical and inpatient psychotherapy. In the STEP project (Timman & Groenink, 2008), the treatment results of fourteen psychotherapeutic institutions in the Netherlands have been collected and processed over twenty-five years. The conclusion was that inpatient psychotherapy has an effect on the reduction of psychological problems and symptoms in clients with personality problems and that this effect persists or even increases for more than a year after discharge.

The SCEPTRE study (Bartak, 2010), a benchmark study including the effect of group therapy, day-clinical treatments and inpatient psychotherapy, showed that group treatment in a day- or inpatient setting is an effective form of psychotherapy for clients who did not recover before in individual therapy.

In the Dutch Multidisciplinary Guideline for Personality Disorders (2008), which is based on the current state of scientific research, the conclusion is that (psychodynamic or MBT-oriented) day-clinical psychotherapy, in combination with subsequent outpatient group therapy, has a 'plausible' to 'demonstrated' effect in terms of symptoms, personality pathology and social functioning. The effect of inpatient psychotherapy with outpatient group therapy as a follow-up treatment is "plausible".

Bateman and Fonagy (2000) stated from a large review of psychotherapeutic treatments for personality disorders that sufficient duration and intensity are important. In addition, the model must be offered in a way that is theoretically consistent and in accordance with the standards of the therapeutic models. This aspect of coherence is also supported by the multidisciplinary guidelines (MDR, 2008).

In recent years, most institutions have chosen to introduce more or less specific therapeutic methods in existing inpatient and day-clinical programs (Bosch et al., 2013; Kooiman et al., 2013; Blom & Colijn, 2012; Hutsebaut, 2011; De Haan, 2011; Muste et al., 2009). This also applies to less intensive but combined treatments in an outpatient and parttime setting (Knapen, 2013; Pol & Hulshof, 2009). These studies show, among other things, that a clear vision on the organization of the setting and on collaboration in a multidisciplinary team are of great importance for the successful introduction of a specific method in a multidisciplinary setting. A cautious conclusion is therefore that it is plausible that coherence and cooperation have an effect on the treatment results.

11.2.2 Forms of cooperation in a multidisciplinary treatment design

In a healthcare setting treatment of clients, individually or in groups, is often performed by collaborating practitioners from different professional backgrounds. It is known that integration of multiple forms of treatment can increase the number of clients that can be treated in groups (Feldman & Feldman, 2005).

In daily practice, the importance of a vision on coherence between the various components and disciplines and on good cooperation between the different practitioners who carry out the treatment appears to be important for relatively clear, small teams as well as for larger teams. First, we discuss the most common combinations of disciplines in the outpatient setting. This is followed by an overview of the main qualities of a more intensive day-clinical or inpatient treatment setting. And finally, we briefly discuss the development of large healthcare organizations that offer a range of treatments spread across multiple locations.

11.2.2.1 The outpatient treatment setting

In the outpatient treatment setting, group treatment can be combined with various other modalities of treatment. A brief overview is given below to give an impression of the possibilities.

The combination of group and individual treatment (concurrent treatment) usually takes place with clients with a complex need for help, for example serious personality, trauma or addiction problems (Yalom, 2005; Berk, 2005; Karterud, 2015).

There is a large amount of literature on the benefits of concurrent treatment (Karterud, 2015), including for clients with borderline problems who have difficulty to benefit from group treatment (Hummelen et al., 2007). However, little research has been conducted into the difference in effect between stand alone group treatment and the combination of group treatment with individual treatment.

The combination of group and individual treatment has specific indications and technical requirements (Karterud, 2007). The first consideration is whether the two forms are complementary or facilitative, i.e., enable each other's effectiveness (Yalom, 2005). For example, they complement each other when, in addition to an intrapsychic, an interpersonal treatment focus is offered, and a participant can experiment with new behavior in the safe environment of the group. The two forms of treatment can make it possible to make strong emotions in the group bearable or, for example, to prevent dropout from the group treatment (Berk, 2005; AGPA, 2007).

The next consideration is whether the individual treatment should be offered temporarily or permanently parallel to the group treatment. In particular, short treatments that focus on specific problems (for example a depressive episode, phobic anxiety, partner relationship problems, or acute trauma problems) can be combined well with longer-term group treatment (Berk, 2005).

Two variants can be distinguished in the implementation of concurrent treatment. In one variant, the same practitioner gives both treatments (combined), in the other model, the two treatments are performed by different practitioners (conjoint). No research has been conducted into the difference in effect between the two variants (Karterud, 2015).

The combination of group treatment and psycho-pharmacotherapy frequently occurs in practice. In this combination, it is desirable that group therapy and pharmacotherapy be given separately because of the possibility to monitor the medication. The emotional significance of receiving medication, its impact on self-esteem, the significance of a therapist's extra emotional availability, all of this may be the topic of research and discussed in group treatment (AGPA, 2007).

In the combination of group treatment and art- and psychomotor therapy, clients in the art- and psychomotor therapy come into contact with non-verbal ways of communicating, playful elements, or with aspects of themselves that are not yet conscious. In the group treatment, the emotional significance of these experiences can be considered.

The combination of psychological group treatment with medical or paramedical treatments, such as in a hospital or rehabilitation clinic, aims to promote adaptation to the physical disability or illness.

In recent years, psychological and group treatments have increasingly been combined with e-health modules (blended treatment). Online group treatments, group chats or a group app are also part of a treatment setting that must be discussed in terms of overall coherence. The group dynamic processes will work mostly as previously described (see chapter 5).

The various outpatient combinations are shown in the diagram below.

Outpatient multidisciplinary combinations	**Explanation**
Individual and group treatment	Conjoint: by different practitioners Combined: by the same practitioner
Group treatment and psycho-pharmacological treatment	Emotional significance of the use of medication can be elaborated in the group treatment
Group treatment and subject therapy	In subject therapy: experimenting with and experiencing nonverbal and playful skills; the emotional significance of this is the subject of both subject therapy and group treatment
Group treatment and (para) medical treatments	Emotional significance of physical limitations and self-image can be elaborated in the group treatment
Group treatment and e-health	Blended treatment Use of technical options such as group chats and apps.

Table 1: Common outpatient multidisciplinary combination treatments

In the literature on the various outpatient combination treatments, there is agreement about a number of advantages and disadvantages, and about the requirements for cooperation. Mutual clarity about the goals of the various components increases the chance of treatment success (AGPA, 2007).

When both treatments are given by the same practitioner or practitioners, there is less risk of contradiction or resistance and feelings of confusion. The disadvantage may be that the group practitioner loses his open-mindedness in group treatment (Yalom, 2005). In practice, it is more common for two treatments to be offered by different practitioners. This has the advantage that the severity of a treatment is shared. However, this variant places high demands on the quality of the collaboration (AGPA, 2007). Both practitioners must communicate openly with each other, have respect for - and knowledge of - each other's working methods, and investigate the interfaces between the two forms of treatment. Lack of communication between practitioners can undermine both forms of treatment. In

addition, it is important that the client gives permission to the practitioners to exchange information and accepts that transfer of information takes place between the different practitioners (AGPA, 2007). If the individual treatment supports the group treatment, it should mainly focus on the current problems that arise for the client within the context of the group treatment (Yalom, 2005; AGPA, 2007; Karterud, 2015).

When combining a group and individual treatment, it is preferable not to start these at the same time, in order to avoid it becoming confusing or too much for the client. Given lack of experience, it may be difficult for the younger practitioner to combine both roles (Yalom, 2005).

11.2.2.2 Intensifying the treatment setting

Outpatient treatment can be intensified if it produces insufficient results, or if the complexity of the problem requires it (stepped care). The treatment is not only multidisciplinary, but also takes place over several days. In the most intensive form, the setting in which treatment takes place is temporarily used as a substitute social environment for the purpose of treatment.

The treatment team in such an intensive setting includes substantially more members. This places high demands on the cohesion of the organization and on the quality of the cooperation of the members of the treatment team. Knowledge of organizational processes is therefore essential for the manager.

Extensive, mainly psychodynamic and developmental psychological studies (Berkouwer, 2004; Van den Berg, 2011) show a number of characteristic qualities or common factors of a treatment team or treatment organization, which are described in the diagram below. These factors have a major influence on the development and treatment result of the target group. If these factors are sufficiently present, the treatment setting promotes treatment; if these factors are insufficiently present, the organization will hinder treatment.

Characteristics /qualities	**The treatment organization**
Holding	is aimed at promoting development, focused on interaction and connection, and offers structure and boundaries (the 'carrying function')
Containment	has the ability to mirror and process strong affects, focused on understanding and giving meaning (the "tolerance function")
Consistency	strives for coordination between the program components, and unity in the joint methodology and vision on problems (compare with adherence)
Constancy and clarity	is predictable in terms of schedule, time, place, and person; there is clarity about the course of events and

	about absolute and variable limits; this applies to both clients and practitioners
Reliability and availability	applies the rules in a respectful and consistent manner; there are no personal interests; staff members are available and provide protection in an emergency
Variance	is flexible and meets the needs, possibilities and transcultural differences in the target group
Commitment and transparency	Staff members have an interested and validating attitude, there is openness, one is focused on togetherness, and shows exemplary behavior
Legitimacy	is well known to social, political and supervisory authorities

Table 2: enhancing characteristics /qualities of the treatment organization (according to Berkouwer, 2004; Van den Berg, 2011)

Concerning the organization of treatments, so-called *care paths* and *care units* are increasingly being developed. These are healthcare organizations that transmurally run through different (locations of) institutions. This places high demands on the quality of cohesion and organization. Recent responses to this can be found, for example, in the Guideline Informed Treatment for Personality Disorders (2015), which has many similarities with the Structured Clinical Management of Bateman and Krawitz (2013), and in the Good Psychiatric Management of Gunderson (2014). Quality standards in mental health care are also current attempts to guarantee the quality of the treatment organization; this includes Care Standards (written from the client's route), and the Generic Modules (agreements in the organization of care for multiple illnesses, for example Psychotherapeutic Treatment).

11.3 The Practice

The importance of a view on coherence between the different parts and disciplines and organizing the cooperation of the different practitioners who carry out the treatment was described above. As mentioned, clarity about the goals of the different components is of great importance for the success of the treatment (AGPA, 2007). Organizational science provides descriptions of organizational processes using various models. It is beyond the scope of this chapter to provide a comprehensive summary of the literature published in this area. We have chosen to describe the model of Coherent Treatment, which is based on psychoanalytic, system theoretical, social and organizational psychological insights. We then discuss the concepts of Imposed and Emergent structure and the phenomenon of parallel processes in more detail. These concepts can serve as a steppingstone for the group practitioner. They help the group practitioner to understand the place of the group and the

group treatment within the organization and how it relates to the treatment team and the institution as a whole. The description below of the Model of Coherent Treatment and the description of the concepts of Imposed and Emergent structure is based on the work of Janzing and its elaboration together with others (Janzing, 2009, Janzing & Kerstens, 2012; Claassen & Janzing, 2014).

11.3.1 Model of Coherent Treatment

The larger the treatment organization, the more tension can arise between the requirements from the content and from the operational management. Janzing developed the Model of Coherent Treatment, with the aim of promoting coherence between content and organization. In this model, organizational, group dynamic, and client factors are integrated.

Coherent treatment concerns the design of a stable, coherent social or treatment organization, in which the treatment model, attitudes, treatment methods, treatment forms, human resources, spatial resources, and organizational structure are aligned with and related to the treatment goal and the target group to be treated (VKP, 2006). The conditions in which the treatment is applied form a more or less controlled whole, whether it is an outpatient, day-clinical or inpatient treatment setting, or a treatment offer that is carried out in phases at different locations by different treatment teams.

The treatment conditions (context or setting) are adapted to what the clients need. The starting point is a coherent view on the problems and the capacity of the target group. This results in a choice for a treatment method and the degree of structure and support that is required to perform this treatment adequately.

On the basis of this, a choice is made for suitable staffing and associated resources, such as finance, space and communication channels. Management, treatment and support staff must have the required competences (including communication skills). This includes an appropriate budget and adequate workspaces with sufficient administrative facilities.

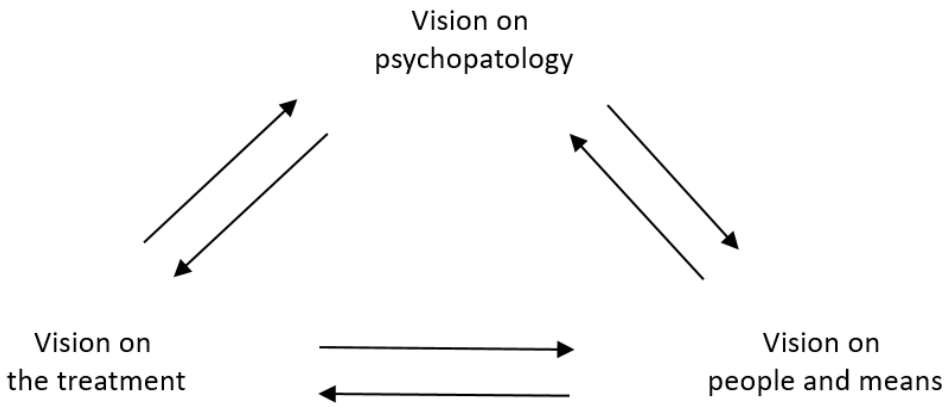

Figure 1: The basics of the Model of Coherent Treatment (Janzing & Kerstens, 2012).

There is thus a connection between management and treatment. This makes a coherent treatment organization an intrinsic part of the treatment, an important 'supporting framework', which can increase the effect of the treatment.

Lack of coherence can initiate negative processes, reduce the effect of the treatment, or even cause psychological damage to the group members. For a description of this, see chapter 9. It is therefore important that the organization and the treatment team ensure a coherent and consistently applied framework (Hutsebaut et al., 2011). This concerns the way in which the total treatment offer is set up and organized up to and including the quality of the cooperation.

11.3.2 The Imposed and Emergent structure of treatment teams

A treatment team can be understood as a task group which is faced with certain tasks. To gain more insight into the functioning of a treatment team it can be described in terms of the Imposed and Emergent structure (Burlingame, Strauss and Joyce,2013). The meaning and importance of these terms is briefly explained below. A more detailed description of the organizational science of treatment teams can be found in the recommended literature.

11.3.2.1 The Imposed structure of a treatment team

Each organization or treatment team has its own task or imposed structure.
The imposed structure of an organization is formed by the way in which the organization is structurally and functionally ordered. On the one hand, it must be clear to the team members what their task is and how to perform it, on the other hand they must have the means to perform this task adequately.
The structural organization consists of specific elements of the treatment team or organization. This includes the various team members, the work and treatment rooms, the budget, the work and treatment schedules, and the absence arrangements.
The functional setup of the organization includes the regulated, agreed cooperation and communication between people in the organization, such as the distribution of tasks and responsibilities, working methods and working arrangements within the treatment team and the communication structure.
In order for a treatment team to function properly, it is important that the structural and functional organization are directly derived from the vision on the treatment, are supported by the open consent of the employees, and are well coordinated.
Steering the Imposed structure is called Imposed management. Usually, a team leader is charged with this task. The team leader follows, guides and corrects the work. That is, he monitors the tasks of the team and helps the team to reflect on its functioning.
Problems can arise within a treatment team if there are defects in the imposed structure. A weak imposed structure can have various causes. Common causes are described in the table below.

Causes of weak Imposed structure	**Consequences**
No or unclear basic philosophy (vision)	- Team members act on their own - Inconsistent approach to clients or group members - Management cannot chart a clear course
No clear division of tasks	- No boundaries of the disciplines

	- Tasks are performed by unauthorized persons
Unclear agreements about communication moments	- Not all disciplines involved in certain consultations - Not passing essential information
Absence of leadership	- Bogged down in discussions about procedures - Team members will act on their own

Table 3: Causes of a weak Imposed structure

11.3.2.2 The Emergent structure of a treatment team

The functioning of a treatment team or an organization also depends on deeper, personal factors. These are, for example, the personal preferences, mutual relationships, or the problems of a team member. The context that this creates is called the Emergent structure. A good team organization is characterized by a clear Imposed structure and by alignment between the imposed and the emergent structure. However, the personal factors may hinder alignment within a treatment team and the effectiveness of the treatment task. One speaks then of a contrast, mismatch or incongruence of the imposed and emergent structure. Below is a list of common causes of this incongruence

Cause of incongruence Imposed and Emergent structure	**Consequences**
Unconscious problems of Staff members'	- He/she cannot deal appropriately with group members - He/she distorts the agreements made within the team - Border violations
Dysfunctional treatment team as a group	- A dysfunctional team culture is created: the disunited team, the dependent team, the closed team - The team relies on fixed, rigid interaction patterns
Dysfunctional leadership	- Team members are given limited space for individuality or creativity - Team members become indifferent or don't feel involved - The creation of mutual distrust, the creation of a gossip circuit - Emergence of covered or uncovered

	admiration and / or disapproval of the team leader
Disturbed relationship with the organization of which the treatment team is part	- unequal distribution of resources - rivalry between teams - disturbed transfer of information - the emergence of a dysfunctional team culture
Problems of the clients or group members	- disagreement within the team about approach or treatment of the clients - insufficient distance to group members

Table 4: Causes of the incongruence between Imposed and Emergent structure

To ensure that the imposed and emergent structure are congruent, the team leader and the treatment team take care for a good working atmosphere, good working relationships and open communication channels in combination with good and appropriate working arrangements. This requires systematic reflection on the cooperation, for example by periodically organizing a policy meeting, cooperation discussions, peer review, supervision or external consultation.

With the specific knowledge that a group practitioner has of group processes and group dynamics and his training to notice, observe and investigate these processes, the group practitioner can be a valuable team member when it comes to identifying and highlighting what is going on in the imposed and emergent structure. The extent to which the group practitioner is assigned the task to take care of the imposed and emergent structure management depends on the choice made by the organization or the team leader. This choice ideally fits in or is coherent with the treatment model used by the department.

11.3.3 Parallel processes

A phenomenon that occurs frequently in a multidisciplinary treatment program is that the same interaction patterns appear in both the treatment team and the treatment group within the same time frame. This phenomenon, that was discovered through observation, is called a parallel process. On the one hand, unresolved conflicts in a treatment team can lead to an increase in problem behavior or dysfunctional interaction patterns in the treatment group (Stanton & Schwarz, 1954). On the other hand, the problems of a treatment group can lead to dysfunctional behavior in a treatment team (Main, 1957).

A parallel process can have both positive and negative effects. An example of a positive parallel process is the active promotion of openness. When team members are sincere and honest with each other, this can lead to more openness and honesty of the group members in the treatment. If the treatment team consistently arrives on time for meetings and in general, the client group will also adopt this standard. Janzing (2009) describes that negative

parallel processes can also arise if the Imposed and Emergent structure are not aligned. The previous section has already listed possible causes of such an incongruence.

Signs of a negative parallel process are, for example: emergence of conflicts or blurring of existing work agreements and working relationships, reduction of the reflective capacity of the treatment team, blurring or reversal of authority relationships between the treatment group, the treatment team and / or the management team (Haans, 2006).

When there is a negative parallel process, this can reduce the effect of the treatment. For example, when annoyances cannot be pronounced in a treatment team, this can lead in parallel to avoiding pronouncing mutual irritations and anger in the treatment groups. Haans (2006) sees it as the task of the team leader to identify and influence positive and negative parallel processes. He emphasizes the importance for the team leader (of a multidisciplinary treatment setting) to have knowledge of organizational science and group dynamics.

11.4 Summary

- Group treatment is often part of a more comprehensive treatment offer. The offer can be more or less complex and vary from the combination of two different treatments in an outpatient setting to intensive inpatient psychotherapy or transmural care units.
- In a multidisciplinary treatment offer, coherence is a necessary condition for a good treatment result.
- Coherence in a multidisciplinary treatment is determined by: 1) a coherent view on the problem, with a consistently applied methodology; 2) good quality of cooperation in the treatment team; 3) a consistent, constant and more or less controlled setting; 4) the circumstances in which the treatment is applied (organization of people and resources).
- The complexity of providing a coherent treatment design is caused by factors in both the Imposed structure and the Emergent structure of the treatment setting and so-called parallel processes.
- In addition to knowledge of group processes, knowledge of organizational processes is essential for the manager of a treatment team and the group practitioner to ensure coherence in the treatment offer and good cooperation.

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Chapter 12: Co-counseling and co-therapy

Charles Huffstadt and Mila Remijsen

12.1 Introduction

The present chapter discusses the cooperation relationship between two practitioners who lead a group within the mental health care. In psychotherapy groups this approach is known as co-therapy, in a broader sense we speak of co-counseling.
Goossens (2003) defines co-counseling as a form of functional collaboration between two group leaders whose aim is to achieve the intended group goals, to create the appropriate group climate and to support the group process.
Not much has been published on this subject in the Dutch language region in the last fifteen years (Goossens, 2003) and what was written about it before is based mainly on clinical expertise and not on empirical research. The only relevant empirical research that underlines the benefits of co-therapy is the study of Kivlighan, London and Miles (2012). That little empirical research has taken place on co-counseling is related to the fact that researching this is a methodologically complex phenomenon.
In this chapter we draw on an anthology of publications from the past 60 years on this subject within the English language literature, and of the past 25 years from the Netherlands. Most of the publications concern the sub-area co-therapy in psychotherapy groups.
This chapter will address knowledge on co-counseling, advantages and disadvantages of co-counseling, phases in the cooperation relationship, inflexible role patterns, a translation of theory into practice. Finally, the summary lists the main tools and points of attention for those who intend to lead a group together.

12.2 Theoretical background

Berk (2005) discusses how group therapists in the United States sometimes do and sometimes do not work with a co-therapist, how group therapists in Great Britain usually lead groups alone and how it is common practice in the Netherlands to work with two practitioners. Although he is a supporter of co-counseling, he indicates that most of the benefits of co-therapy can also be considered disadvantages (Berk, 1986).

12.2.1. Benefits of co-counseling

First, co-counseling is a *complementary* approach (Hubert**,** 1993; Goossens, 2003; Bernard, 1995; Mol & Peeters, 1992). The therapists complement each other (e.g. in terms of professional background, style, interventions, skills), the weaknesses of one are complemented by the strengths of the other. In short, two may offer more than one.
The *continuity* of the group is enhanced by co-guidance as the group can continue when one therapist is ill or on holiday (Berk, 1986; Bernard, 1995).
Negative or rigid interaction patterns that arise from the life history of the group members, for example in the form of transference, can be better handled by two practitioners. Due to the co-counseling situation, these interaction patterns and the reactions of the supervisors can be considered together in the debriefing, for example in the form of counter-transference (Hubert, 1993; Demarest & Teicher, 1954). This allows these interactions to be better digested *(containment),* understood and used. Mintz (1963) mentions how the

presence of two practitioners makes the transference easier. Clients can more easily express their anger when they know that there is another practitioner who offers safety (Krijnen, 2004).
Within the Dutch situation, it is customary to lead a group, in particular a psychotherapy group, with a *mixed therapist couple* (i.e. male-female) if possible. The advantage of this is that this increases the possibility of resemblance with the family situation, which allows problems that have their roots in family interaction to be more easily addressed (Bernard, 1995).
Co-therapy can *support personal and professional development* (Hubert, 1993; Bernard, 1995; Remmerswaal, 2015, Yalom & Leszcz, 2005), for example, when creating a learning environment for a relatively inexperienced therapist or when one of the therapists wants to gain more experience with certain interventions. A therapist may take more risk when deploying an intervention because of the safety that results from the presence of the other co-therapist.

12.2.2. Disadvantages of co-counseling
In economic terms, the fact that either of the two practitioners could lead a group alone makes co-counselling *more expensive and/or time-consuming*.
Depending on the type of group it takes a while before two practitioners are well matched (see 12.2.3). This is especially true for the longer-term psychotherapy groups.
Apart from time, co-counseling also costs *energy* (Goossens 2003, Hubert 1993). Investment is needed in building an emotional bond (Krijnen, 2004) and time and motivation is also needed to discuss each group session.
Co-counseling can include several rigid role patterns, which may be a reason to start supervision (Remmerswaal, 2015).
Jongerius (1993) indicates that it is an almost impossible task to achieve a balanced, mature cooperation relationship and that a group therefore does not benefit from doubling the number of interactions by adding a second group leader.

12.2.3. Development of the cooperation relationship
Just as can be seen in the group, a bond develops between the co-therapists in which phases and crises can be distinguished before it reaches a mature stage (Hubert, 1994). Levine (1982) has developed a phase model parallel to his group phase model.

1. Parallel phase: 'it's nice to work with you'
In the early days of the cooperation relationship, certain stereotypical role patterns (e.g. expert versus newcomer) often arise. As long as there is room for change within these patterns, this need not be a problem. If this is not the case, 'it's nice to work with you' can become a façade.

2. Authority crisis and inclusion phase: 'one of us is no good'
This phase is successfully completed when the stereotypical role patterns of the first phase within the cooperation relationship are examined and recognized. If this does not happen, problems within cooperation (e.g. rivalry) are more likely to arise.

3. Intimacy crisis: 'we might make it'
An early sense of ‘we’ arises when an intimacy crisis, which can be accompanied by rejection, competition and/or frustration, is completed.

4. Reciprocity phase: 'we are a good team'
Cooperation is free and productive; status and power are not an issue.

5. Termination phase: 'too bad we have to give this up'
The end of the cooperation relationship, as with any separation, evokes all kinds of (negative) feelings that can be shared.

12.3 Practice

12.3.1. Preparation for co-counseling
The conditions for successful cooperation partly corresponds with those for a successful marriage (Wiley, 2015). Thorough preparation increases the chances of a sustainable cooperation. It is advisable that the potential group practitioners have one or more conversations *before starting a group treatment together* (Goossens, 2003).
These discussions should address various themes, such as the group task, the target group, the working method and the framework. But also their view on groups, the training and theoretical preference of the group leaders, as well as the personal motivations, needs, allergies of both practitioners, can be discussed. A sufficient ‘goodwill factor’ (i.e. granting the other moments of success during a group session) is also a relevant topic to discuss. Practical circumstances (e.g. agenda planning) should not be the main reason for starting a group, but agreement (including possible differences) on these topics. Thorough preparation increases the likelyhood of sustainable cooperation.
Department management can promote the establishment of a successful cooperation relationship by giving space to the preparatory introductory phase, providing sufficient time for administration, and facilitating the debriefing and start-up of supervision when obstacles are met.

12.3.2 Discussion of the group meetings
During the debriefing of each session, it should be explicitly discussed what both therapists have experienced regarding the group members but also regarding each other (Yalom & Leszcz, 2005; Berk, 2005). This debriefing preferably takes place immediately after the session when the reactions are still fresh, and lasts about 15 minutes. The establishment of a positive emotional relationship between the two therapists takes precedence over talking about substantive matters (Heilfron, 1969) since a conversation about the content only makes sense when there is good contact between the two.
The literature mentions how negative or rigid interaction patterns, e.g. in the form of transference and counter transference, can be processed in a co-guidance situation (Mol & Peeters, 1992). The therapist who is less involved in the negative transference situation can help to unravel what is going on (Bernard, 1995). This creates space for both the patient and the practitioner to reflect (Krijnen, 2004). Especially in a group with severe disorders, the presence of two practitioners can help to avoid the tendency to split (Mintz, 1965; Berk, 1986). If one practitioner is experienced as a negative and the other as positive, this is a primitive defense which is unwittingly used by the patient to protect one of the two practitioners (Krijnen, 2004). In groups with participants with complex problems, such as a

traumatization background, it is necessary to work with two practitioners, whereas participants with more simple problems could be dealt with by a single practitioner (Berk, 2005).

12.3.3 Stagnation of co-counseling

Between two therapists the cooperation can fail due to a difference in personal and professional orientation, although the latter can also be an enrichment. There may also be rivalries, e.g. seeking popularity, or the quality and/or quantity of the interventions, which the group soon notices and negatively affects the quality of the treatment group. Practitioners who have a strong dominant interaction style and/or a strong need for affirmation or admiration are more easily caught up in a dynamic of rivalry (De Haas, 2008). Berk (2005) points out how 'tandeming' (i.e. when one therapist intervenes, the other therapist also reacts shortly after) is an indication that there is rivalry within the cooperation relationship.
Supervision, for both co-practitioners makes sense in order to promote good cooperation and also when both become entangled in an a role fixation for example: The Expert and the Novice, The Teacher and the Student, The Good guy and the Bad guy, (Goossens, 2003). Hubert (1993) mentions the important function that supervision can have for a co-counseling "couple" to overcome the disadvantages and pitfalls of co-counseling. The supervisor acts as a container for the therapist couple, as do the therapists for the group members (Hendriksen, 2004).
Some practical rules are suggested to promote the cooperation relationship (De Haas, 2008;): sit opposite each other and make regular eye contact, do not intervene too quickly after each other, avoid focusing on the same group member all the time (when one zooms in, the other zooms out, the 'tennis double' principle), have the other let his say when he explains something to a group member/group.

12.3.4 Co-counseling in training situations

In terms of professional development, a well-known situation within practice is the training situation in which one therapist is in a senior position and the other supervisor is in a junior position. In this way the trainee can take a look in the kitchen of an experienced colleague. A precondition for this is that the group is aware of the training situation (Hendriksen, 2004). This form of collaboration is common in the Dutch mental health care and poses specific problems because of the inequality between the two practitioners. Berk's recommendation (2005) is that this construction should not exist for more than two years in order to avoid the risk of the trainee getting stuck in his role.

12.4. Summary

- The quality of the cooperation relationship between two group practitioners affects the quality of the interactions between the group members. The relationship can therefore affect the group process in both a negative and a positive way.
- A majority of authors who have written on the theme of co-counseling, believe that the benefits outweigh the disadvantages
- Problems in cooperation between co-practitioners can be avoided by proper preparation. Topics to be discussed during the preparation include the group task,

view on groups, allergies, needs, and points of agreement and difference between the two practitioners.

- Once a group has started, it remains important to pay attention to the quality of the cooperation relationship between the co-practitioners.
- At the debriefing, talking about cooperation and the process takes precedence over talking about the group members. During the debriefing attention should be paid to pitfalls such as role fixation and rivalry.
- Supervision can be called in if there is a stumbling block in cooperation, but can also be used preventively.
- The management team can promote the creation of a successful cooperation relationship.

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