Considerations in Designing a Research Informed, Retreat-Style Group Psychotherapy Experience by Integrating Adlerian and Here-and-Now Approaches

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Abstract

The group psychotherapy literature was reviewed for factors to be considered in designing a research informed, intensive, time-limited, retreat-style group psychotherapy experience by integrating Adlerian and here-and-now theory. The history of group therapy, the birth and death of marathon encounter-style therapy, and retreat-style group therapy practices were investigated. Most evidence on retreat-style therapy was anecdotal. Group goals, measuring group factors and outcomes, group composition, group preparation, group development, group process, group format, termination and re-entry, and ethical considerations were examined. A gap was found between group therapy research and the practice of retreat-style group psychotherapy. Thus, general group therapy practices were extrapolated to inform the design of a retreat-style group therapy model. In conclusion, group therapy practitioners were invited to utilize and contribute to the research body on retreat-style group therapy to provide empirically sound and ethical treatment.

*Keywords:* Adlerian, here-and-now, group counseling, group psychotherapy, marathon therapy, retreat, time-limited therapy
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Considerations in Designing a Research Informed, Retreat-Style Group Psychotherapy Experience by Integrating Adlerian and Here-and-Now Approaches

There are many considerations that must be addressed in designing an intensive, retreat-style group psychotherapy experience. Too often practitioners design psychotherapy group experiences that are not informed by research. Often it is by trial and error or by modifying individual approaches and techniques to accommodate a group setting. This is a dangerous arena considering how different and complex the dynamics are in a group setting compared to individual therapy. Even though the literature supports that designing group psychotherapy based upon research offers stronger outcomes, practitioners often do not invest the time and energy to thoroughly formulate the group experience. One of the struggles when using literature to inform practice is the lack of investigation into certain aspects of the group psychotherapy experience. There is a need for practitioners to collect and publish data to ensure ethical practice, to serve the needs of clients, and create efficacy in the field of retreat-style group psychotherapy.

Increasingly, managed care companies, agencies, and consumers demand evidence-based practices. One could argue that not using research to inform a group experience is unethical and that those practitioners are acting without beneficence. There are many evidence-based group therapy psychoeducational experiences that are based upon curriculums that group facilitators could use. Curriculum-style groups often teach skills, offer support services, and are evidence-based, but do not allow for here-and-now interactions, modifications to tailor the curriculum to the specific group participants and their needs, nor an intensive, brief schedule.

In the group psychotherapy field, groups are generally either process-style here-and-now groups or structured curriculum-based groups targeting specific populations such as individuals with post-traumatic stress disorder or substance abuse problems. The here-and-now approach
deems that regardless of symptoms, the roots of all problems exist in social relationships. The here-and-now approach aims to create awareness and change in the interpersonal realm, by focusing right now, right here in relationships (Yalom & Leszcz, 2005).

Participating in a here-and-now style group offers greater awareness and change in interpersonal relationships for individuals with or without mental health diagnoses. Clients with varying goals and complaints are brought together to learn from one another about how they function in relationships. What better way to create awareness and change in interpersonal relationships than by engaging in diverse interpersonal relationships along with trained therapists?

The addition of an Adlerian perspective to a here-and-now approach may encourage more self-understanding and self-awareness, leading to quicker change in interpersonal relationships. Adler believed people are only as healthy as their capacity for social interest. Many biopsychosocial factors influence our way of being in the world, or in Adlerian terms, our *lifestyles*. In other theories personality is the Adlerian lifestyle equivalent. Adler believed that an individual’s way of being in the world is formed by the time he or she is five or six years old. This way of being in the world impacts how individuals will strive to obtain goals throughout life (Ansbacher & Ansbacher, 1956). By incorporating Adlerian theory and a here-and-now approach into an intensive, brief group psychotherapy experience, participants gain insight into their lifestyle, or personality, leading to change in interpersonal relationships.

Here-and-now style groups are often long-term enduring commitments for participants lasting over a year, but can also be practiced as open groups, in acute inpatient settings, lasting for a brief time, maybe only a day. Adlerian therapy is known to be a brief therapy often with individual meetings lasting less than 20 sessions. The Adlerian group therapy curriculums in the
literature met for 10 sessions (Brough, 1994; Tam, 1995). In the group therapy literature, 17-57% of clients drop out before the termination of therapy, which is a major concern because it adversely impacts the remaining clients (Yalom & Leszcz, 2005). High attrition rates are attributed to several factors with external factors being the major factor in dropout rates (Yalom & Leszcz, 2005). Participation in a one-time, intensive group therapy experience could increase planned and managed termination.

The marathon encounter group therapy movement offers the closest examples in the literature similar to retreat therapy experiences. But the idea of marathon therapy was discredited due to ethical concerns in the 1970s and the investigation into this style of therapy was halted (Stanger & Harris, 2005). Retreat-style therapy is a potential benefit to clients and should be revived and researched as a viable treatment approach.

Kilmann and Sotile (1976) published a review of marathon encounter group therapy. Many of the study designs, methods, and data were questionable given the lack of standardization. There appeared to be a lack of inferable information from the review other than one study indicating that there was a significant difference that suggested participants in marathon-style therapy perceived themselves as being more involved with people three months later. It is indicated that participation in intensive, time-limited group therapy may have lasting positive effects on interpersonal functioning and warrants further investigation.

The purpose of this research paper is to review the literature that is appropriate when considering the use of intensive, time-limited, retreat-style group psychotherapy. It is the writer’s dream to own a farmette and host retreat-style psychotherapy groups. This inquiry will examine if retreat-style group therapy is a beneficial and ethical treatment modality. The research conducted to write this paper has been gathered and presented to inform the future model design
of an intensive retreat-style psychotherapy group experience. The research question is what factors must be considered in designing an intensive, retreat-style process group psychotherapy experience by integrating Adlerian and here-and-now approaches? This paper will inform other practitioners wishing to design and conduct retreat-style therapy urging them to use evidence-based practices and contribute to the group psychotherapy literature.

The history of group therapy is examined paying special attention to the research that supports group therapy being as efficacious as individual therapy. Different designs of group therapy are reviewed with an interest in the birth and death of marathon encounter-style therapy and applications of retreat-style therapy. The integration of here-and-now and Adlerian theory are examined for relevance in informing the design of psychotherapy groups. The different factors of group psychotherapy including group goals, measuring outcomes, group composition, group preparation, group development, group process stressing cohesion, group format, termination, and ethical considerations specific to group psychotherapy are explored. This literature review concludes by tying together the introduction of the problem and purpose to future research and practice implications. The use of time-limited, retreat-style therapy as the modern descendant of marathon encounter group therapy is here.

**History of Group Therapy**

The idea of gathering as a group and addressing issues or problems has its roots in ancient times. It is tied into the survival of the human race. According to Sonstegard (1998a) children are born into a group, often a family. It is through this family unit that children are influenced and impact others in the group. This group experience offers protection, survival, belonging, and informs the psychological development of children. This first group encounter teaches children about the meaning of group affiliation. Children will then move on to interact
with many different groups over their lifetimes, each experience impacting the children and all others involved with the group. It is within groups that people learn to be human; it is within groups that people can learn to heal. Sonstegard (1998a) acknowledged that Alfred Adler was the first to suggest the survival of humans had a psychological dynamic and that Adler was the first psychiatrist to treat patients in a group setting in the 1920s.

Group therapy did not attract a great amount of attention until the arrival of the Human Potential Movement, a cultural revolution of the 1960s based on the idea of freedom of expression (Weigel, 2002). The Human Potential Movement embraced T-groups, encounter groups, growth groups, and birthed marathon therapy. In 1963 Fred Stoller created the process of marathon therapy and reported great results with participants. Stoller’s friend, George Bach was intrigued and became involved coining the term marathon therapy (Weigel, 2002).

Bach and Stoller began applying marathon therapy in a variety of settings, populations, and created an institute to train other professionals in marathon therapy (Weigel, 2002). The media was intrigued and marathon therapy became a household term, yet lacked a presence in the professional literature. It was a craze and many Americans reported participating in marathon therapy groups. The participants raved and shared profound experiences. Then reports of scams and sexual exploitation allegations surfaced concerning a small number of facilitators. The interest and practice of marathon therapy exceeded the amount of scholarly research and the movement died in the 1970s. A shift ensued, participants wanted firm psychoeducational information via group psychotherapy participation (Weigel, 2002).

In the 1980s, the American Group Psychotherapy Association (AGPA) sponsored the development of the Clinical Outcome Results Standardized Measures battery (CORE), which was received by practitioners with mixed reviews (Strauss, Burlingame, & Bormann, 2008). The
intentions of the AGPA were to push clinicians to evaluate the effectiveness of their interventions and encourage them to base their practices on a research informed foundation, hoping to legitimize and standardize the practice of group psychotherapy after the debacle of marathon encounter group therapy.

In 1989, the Agency for Health Care Policy and Research was created to determine the best approach to treat different psychological illnesses (Burlingame & Beecher, 2008). According to Burlingame and Beecher (2008) what succeeded was an interest in evidence-based practice including empirically supported treatments, practice guidelines, and practice-based evidence. The American Psychological Association (APA) released practice guidelines shortly after for individual therapy (Burlingame & Beecher, 2008).

Dies (1992) examined the current state of group therapy and called attention to a lack of group therapists contributing to the theoretical, empirical, or applied literature. The expanding application of short-term and self-help approaches in group therapy often targeted homogeneous and symptom-orientated groups guided by treatment manuals (Burlingame, Fuhriman, & Mosier, 2003; Dies, 1992). Group treatment was common in many settings such as hospitals, private practice, correctional institutions, and counseling centers. At that time, an increase of group therapy use was expected because of its efficiency, cost-effectiveness, and the growing efficacy of group treatment for a wide array of symptoms (Dies, 1992). Dies’ review of the group therapy literature indicated that being in the presence of, and engaging with, others created dynamics not possible in individual therapy; the power of here-and-now interpersonal interaction was highlighted. Dies reported an amplified interest in integrated treatment modalities providing superior outcomes and speculated an increase in integrated group treatment modalities and greater investment in outcome studies lay ahead.
In 2004, the AGPA formed a Science to Service Task Force to support purveyors of evidence-based group psychotherapy (Leszcz & Kobos, 2008). In 2007, the AGPA released the *Clinical Practice Guidelines for Group Psychotherapy* offering practitioners a guide to evidence-based group psychotherapy practice as a result of the Science to Service Task Force’s findings and recommendations. This guide was created from a comprehensive literature review and expert opinion. The AGPA Task Force identified ten domain areas to be considered when designing or practicing group psychotherapy. According to Leszcz and Kobos (2008), the task force hoped that it would offer practitioners a flexible and practical guide to using group psychotherapy to encourage change in participants through offering planning, development, implementation, and evaluation methods.

The recent group psychotherapy literature is interested in specific process concerns such as cohesion, interventions, and the design of assessment and outcome measures (Burlingame, McClendon, & Alonso, 2011; Kivlighan, 2014; Tasca, Francis, & Balfour, 2014). Even though for over 50 years the group psychotherapy field called for practitioners to contribute to the empirical research base, there is still a lack of research on the practice and outcomes of group psychotherapy. There are certain areas, which attracted a large amount of interest and research, but other areas of group therapy remain unexamined. Another concern is the amount of literature that is counter-indicative not offering group practitioners clear understanding for practice. The strongest area of group psychotherapy research focuses on its efficacy compared to individual therapy.

**Individual versus Group Therapy**

It is the general consensus in the field of psychology that group therapy is efficacious (Burlingame et al., 2003). McRoberts, Burlingame, and Hoag (1998) conducted a meta-analysis
of the efficacy of individual and group psychotherapy. It was supported that group therapy produced beneficial results while treating a variety of symptoms, and that the treatment outcomes reliably exceed those of wait-list groups. The current inquiry asks under what circumstances might individual or group therapy be more appropriate?

It is suggested that different processes and therapeutic factors happen in group and individual therapy. McRoberts et al. (1998) included 28 variables for analysis in comparing group and individual therapy. The analysis resulted in one important finding that favored individual therapy over group therapy: that when treating depression, individual cognitive-behavioral therapy had better outcomes than group cognitive-behavioral therapy. In contrast, a few results indicated the superiority of group treatment over individual treatment. For instance, the treatment of chemical dependency and vocational problems were better treated in a group setting. Also, stress syndromes and V-code diagnoses were better treated in a group setting. If a researcher had a clear allegiance to group therapy, group therapy was the preferred treatment modality. The final finding was that group therapy was more effective when 10 or fewer sessions were attended. McRoberts et al. found there are situations and clients that indicate group over individual therapy and vice versa. Additional research is needed to better delineate the differences.

Burlingame and Beecher (2008) concluded that there is no difference between group and individual therapy formats. Group treatment appeared just as effective as a sole or primary modality when combined with other treatment modalities. Burlingame and Beecher (2008) designed a model addressing five sources of influence in group psychotherapy that contributed to positive outcomes that must be addressed to facilitate an evidence-based group including patient characteristics, structural factors, leader characteristics, formal change theory, and small group
If group therapy is superior for those who are not significantly mentally ill and for people attending 10 or fewer sessions, a retreat-style group therapy experience may be indicated for this population. Dies (1992) predicted continuing pressure to offer group interventions because they are as beneficial as individual interventions plus more cost-effective. There is need for future inquiry, to better delineate in what circumstances individual versus group therapy could be more beneficial. If group therapy is indicated for a specific client, there remains the question concerning which type of group therapy would be most effective? Could it be a psychoeducational group, a weekend retreat, ongoing long-term here-and-now therapy, or another group formulation?

**Intensive, Time-Limited, Retreat-Style Group Therapy**

Given the focus of this paper on intensive, time-limited, retreat-style therapy informed by here-and-now and Adlerian perspectives, the following section offers a review of the literature on retreat-style therapy. When doing an EBSCO search with the terms “retreat” and “group psychotherapy” only 30 results were found from 2009-2014. Widening the EBSCO search to all dates offered 91 results. Various other search terms including “group counseling, group psychotherapy, weekend, intensive, marathon, workshop, experiential” and many variations were used in an effort to locate as many pertinent articles as possible. After reviewing the applicable articles most appeared to be anecdotal sharing of specific group experiences designed for participants with homogenous interests such as bulimia nervosa symptoms, couples counseling, or substance abuse. There is definitely a deficit between the empirical research and the practice of intensive, time-limited, retreat-style group psychotherapy. Interestingly, a quick Google search provided multiple retreat-style group therapy experiences indicating there is a market for
this style of therapy. The group psychotherapy field has augmented the group research over the past 90 years, but after the fall of the marathon encounter group therapy movement, the interest in researching intensive, time-limited, retreat-style group therapy faded.

In the past three decades, little research has been published on marathon-style therapy (Stanger & Harris, 2005). There was definitely an appeal to participants in the 1960s and 1970s for marathon encounter type experiences. It is unfortunate that a movement with so much momentum and enthusiasm, in the end was abandoned due to a few unethical practitioners and a weak research foundation. As with any symptomology, it is difficult to be sure of causation and how best to treat different symptoms. It is possible that intensive, time-limited, retreat-style therapy is effective for treating some symptoms or clients. Or it could be indicated for individuals seeking a greater sense of community and connection in the technology era. Unfortunately, there is not a strong body of controlled research to support the efficacy of retreat-style therapy. It seems to be an area of limited research that is worthy of future research endeavors.

Intensive, time-limited, retreat-style therapy has an interesting history and mixed current use. Yalom and Leszcz (2005) stated that there have been recent reports of efficacious retreat weekends for the treatment of eating disorders and substance abuse. These therapeutic encounters involve psychoeducational, group therapy, and theory. Other current retreat-style groups augment ongoing therapy by focusing on meditation, skill building, or reflection (Yalom & Leszcz, 2005).

One of the unique features of retreat-style therapy is that it removes clients from their regular routine and home setting. Scheinfeld, Rochlen, and Buser (2011) conducted a study on men’s adventure therapy. Being physically separated from the home helped the participants gain
clarity and focus on personal issues. When surveyed 73% of the participants said home separation was helpful to the therapeutic experience and 91% claimed that being in the wilderness and engaging in adventure activities helped them gain perspective.

Intensive, time-limited, retreat-style therapy connects individuals to therapy services who may not otherwise participate in ongoing therapy. According to Kilmann and Sotile (1976) during the marathon encounter group therapy fad those who would not have normally sought out therapy or made the commitment to ongoing psychotherapy expected positive outcomes from their participation.

Adequate time is needed to experience being intimate, authentic, and practice these skills in a group setting. Bach (1966) reported that the unique experience of group pressure contributed to intimate, authentic human interaction. He believed that marathon encounter groups allowed participants to remove the masks they wear on a daily basis, become transparent, and discover psychological intimacy.

Bach (1966) conducted marathon group therapy retreats in a secluded private setting that lasted two to four days with 10-14 participants. The slogan “as you are in the group, so you are in the world” was used (Bach, 1966, p. 1001). The marathon group therapy he practiced was concurrent with participation in ongoing individual and group therapy on a weekly basis. Bach believed marathon therapy to be the best way to treat individuals interested in movement towards self-actualization and change in interpersonal relationships.

Bach was a devoted promoter of marathon encounter therapy. Guinan and Foulds (1970) criticized Bach’s statement that “the Marathon Group encounter has been found-- after the first three years of practice and research-- to be the most direct, the most efficient, and the most economical antidote to alienation, meaninglessness, and fragmentation, and other hazards of
mental health in our time” (Bach, 1967, p. 995). Committed to empirical proof, Guinan and Foulds (1970) designed a study to see if well-functioning adults could gain greater positive health and personal growth through a marathon therapy experience. The participants engaged in a 30-hour group weekend experience. A significant increase in positive mental health and self-actualization were reported post-test as compared to pre-test results. Guinan and Foulds suggested that these findings could be attributed to many factors, but called for further research in the efficacy of marathon therapy.

Other researchers have attempted to quantify the marathon encounter group experience. Marks and Vestre (1974) designed a study comparing group therapy twice weekly for two hours for four weeks, a marathon group that met for 16 hours uninterrupted, and a control group with no treatment, to evaluate the effects on interpersonal behavior and self-perception. The results indicated both treatment groups experienced significant changes in interpersonal behavior and self-perception post-treatment. At an eight-week follow up no significant changes remained between the treatment groups and the control group. Could it be that the changes experienced in group therapy must be maintained post-group to have lasting effect? This may suggest that a retreat experience is effective at developing cohesion and change, but must continue with ongoing weekly group therapy for lasting change. This points to an area of intensive, time-limited group therapy requiring further research attention.

For five years, Biggs, Felton, and Hirsch (1976) conducted retreat weekends for their individual therapy, group therapy, and other interested clients. A group structure was used that involved one large group including all participants and then broke out into small groups, contract groups, and transitions groups. Each participant designed goals prior to the retreat experience and created a contract at the beginning of the retreat describing how they would retain and
transfer new learning into their lives. From follow up feedback from the participants and through observation in ongoing therapy, the retention of new insights and behaviors continued once participants returned home (Biggs et al., 1976).

Intensive, time-limited, retreat-style group therapy is indicated to increase self-esteem. Interested in treating the interpersonal isolation and shame associated with bulimia, Gendron, Lemberg, Allender, and Bohanske (1992) designed an intensive group process-retreat model for the treatment of bulimia. The results evidenced significant improvements in self-esteem and severity of binging, along with reduced frequency of binge-purging episodes and dysfunctional eating attitudes.

Encounter, marathon, or intensive brief therapy all fall under the umbrella of experiential therapy. Klontz, Wolf, and Bivens (2000) stated that if psychotherapists want experiential psychotherapy to survive managed care practitioners must contribute to the lack of data and evidence for its effectiveness through empirical, not descriptive data. In an effort to contribute to the empirical research on experiential therapy, Klontz et al. (2000) designed an 8-day, residential group-experiential therapy treatment program that involved 30 hours of psychodrama, six hours of adventure activities, and 15 hours of psychoeducational seminars. The empirical data from this multimodal, brief group approach was effective in enhancing psychological well-being and reducing negative psychological symptoms.

There is published support for different variations of intensive, retreat-style group therapy. Unfortunately, most of the support is anecdotal in nature. Skerrett (2005) shared her design of a personal development group that taught participants to create meaning and purpose in their lives. Group members met every other month for two full days for a year. The program began with exploration into personal values and beliefs, and then moved into creating growth,
change, and outlining future directions. There was no outcome data collected or offered as part of this descriptive study.

Another kind of brief, intensive group discussed in the literature is aimed at couples. Kaiser, Hahlweg, Fehm-Wolfsdorf, and Groth (1998) designed an intervention program administered over a weekend meeting from Friday evening until Sunday afternoon. The group size was three-four couples per group. At pre-treatment assessment, 70% of the couples scored in the marital distress range. There was a four-month and one-year follow up. The couples reported fewer problems post-intervention and displayed greater skill with verbal and nonverbal communication. The results of this study offered significant effects for post-intervention couples compared to the control group.

Stanger and Harris (2005) conducted a marathon therapy group at a university counseling center. They believed that this experience allowed for enhanced therapeutic factors leading to quicker movement in therapy. When evaluating their outcome data in seven domains, the marathon group participants ranked higher than weekly group therapy or individual therapy clients on the relationship with the therapist, recommending the experience to a friend, the therapist being helpful and challenging, the client feeling better about him or herself, the client understanding him or herself better, and the client achieving his or her goals.

A few Adlerian practitioners have published on psychotherapy group designs. Tam (1985) designed a lifestyle analysis group. The purpose of the group was for the participants to explore and understand themselves as whole people. Tam (1985) stated that Adler considered the best way to access lifestyle was through early recollections, dreams, family constellation, and parental relationships. Tam (1985) designed a group limited to eight members, with the shared goals of exploring their personality structure and to understand and accept others. The group met
weekly for eight weeks, two and a half hours each time. At the completion of the trial groups all members rated the group experience as fair to very effective in heightening self-understanding.

Brough (1994) evaluated an Adlerian-based group therapy program on the alleviation of loneliness. Brough cited loneliness as one of the most common psychological symptoms pointing out that it is often part of depression, anxiety, and self-esteem problems. The aim of the 10-week therapy program was to increase social interest, decrease loneliness, examine lifestyle, decrease inferiority and superiority feelings, and encourage the participants to contribute to the life tasks, and risk to be imperfect. One of the instruments used in this study indicated a decrease in the participants’ reports of loneliness after participating in the 10-week therapy sessions.

The idea of common factors in therapy states that regardless of theoretical orientation, techniques, or approach, there is something about therapy that creates a positive outcome for clients. Regarding individual therapy it is often maintained that the main common factor is the client-therapist relationship marked by empathy, kindness, and unconditional positive regard (Swan & Heesacker, 2013). In group psychotherapy, the main common factor is believed to be that of being a member of the group. McCardel and Murray (1974) designed a study with two different encounter curriculums, one control group on-site, and one control group that stayed at home. It was found that participants in all of the groups, with the exception of the stay-at-home control group, showed substantially positive changes on personality tests. Considering these results the researchers suggested that non-specific common factors such as expectancy of change, group enthusiasm, and being away from home in a retreat setting lead to positive changes on personality tests.

Could there be other benefits to intensive, time-limited, retreat-style therapy? Could a therapist’s intention, focus, and emotional commitment be greater in a retreat-style setting?
Clinicians are often juggling 40 clients on a weekly basis, even keeping names straight, much less specific details, is difficult. Could attrition rates be lower in retreat-style therapy experiences?

**Change Theory**

Just as individual therapy sessions should be guided by the therapist’s theoretical orientation, group therapy should be guided by change theory. Change theory refers to the therapeutic orientation that directs the therapeutic activity within the group (Burlingame & Beecher, 2008). Abramowitz and Jackson (1974) compared here-and-now versus there-and-then therapist orientations and found that a hybrid of here-and-now along with there-and-then interpretations in the group demonstrated more positive outcomes than in groups just using one approach or the other. It appears that being able to link current feelings, behaviors, or attitudes with past influences or origins fosters insight and therapeutic gain. In an effort to inform a hybrid model of intensive, time-limited group psychotherapy, an Adlerian then-and-there orientation with a here-and-now orientation could be incorporated.

**Adlerian Theory**

Alfred Adler's Individual Psychology is a humanistic, holistic, growth-model. It is a goal-oriented brief therapy. It addresses the biopsychosocial needs of each individual and has application in the current world of managed care (Corey, 2013). Adler (1954) believed that humans are first and foremost social beings for whom every communication, behavior, and feeling is devised with the purpose of goal attainment. Adler (1954) discussed the idea of being connected to all of humanity, the past, present, and future: He labeled this social interest. Social interest is a combination of feelings of belonging, contribution, and investing in the welfare of humanity (Oberst & Stewart, 2003).
Social interest is one of the main tenets of Adlerian theory. Adler (1954) believed that the capacity for social interest was innate and could be developed leading to a sense of belonging and community feeling. Adler believed that an individual’s level of social interest was indicative of his or her mental health. Socially interested individuals focus outside of themselves and understand that they are an integral part of a community (Adler, 1954).

Adlerians use the term *lifestyle* to describe personality. Lifestyle includes an individual’s unique self-concept, self-ideal, and worldview. Adler believed lifestyle develops at an early age and remains unchanged throughout life. Adler stated that individuals have life goals and use their creative powers to direct movement towards these goals. Adler believed that what is significant is not what happens to us, but what we make of what happens (Ansbacher & Ansbacher, 1956; Oberst & Stewart, 2003).

Adler proposed the idea of social interest or community feeling. Adler believed that individuals strive to belong in social settings (Corey, 1999). The phases of Adlerian counseling and psychotherapy include establishing the therapeutic relationship, assessing and understanding the lifestyle, offering insight on a cognitive and emotional level, and reorientation towards a healthier style of living in all of the tasks of life (Oberst & Stewart, 2003). Corey (1999) stated that the key goals of group psychotherapy are to increase self-esteem and to develop social interest. In groups, inferiority feelings and mistaken beliefs can be challenged, and values at the root of social and emotional problems can be brought into awareness and changed (Corey, 1999). The heart of group therapy is the experience of belonging to a group and being part of a community.

Sonstegard (1998b) proposed the theory and practice of Adlerian group counseling and psychotherapy. He stated that Adlerian groups attempt to reorient faulty living patterns into
socially useful interactions. The group experience is a learning experience and learning follows from action. The group offers the opportunity for participation and learning. The focus of the group process is to develop the democratic skills necessary for cooperative living. Sonstegard continued to state that Adlerian group counselors pursue establishing and maintaining a group relationship, examine patterns and purposes of behavior, disclose the private logic that fuels those patterns and purposes, and reorients individuals to increased social interest.

**Adlerian group techniques.** Adlerians are known to draw from varying theories in their use of techniques. The Individual Psychology of Adler teaches several common techniques such as a lifestyle assessment, analyzing early recollections and dreams, spitting in the soup, and paradoxical suggestion (Oberst & Stewart, 2003). None of Adler’s techniques were specific to group settings even though he was known to practice in group settings. Tam (1985) designed a lifestyle analysis group in which the participants learn about and examine their family constellation, family atmosphere, early recollections, and dreams. Sonstegard (1998a) suggested having group members analyze early recollections for each participant and attempt to uncover the private logic and mistaken goals of each member. Brough (1994) devised a psychoeducational format that taught about social interest, early recollections, striving, inferiority feelings, and encouragement.

**Here-and-Now**

Here-and-now interactions happen on the interpersonal level and include experiencing emotions and affects, and then reflecting and integrating the meaning of the experience that just happened (Yalom & Leszcz, 2005). Here-and-now interactions allow for powerful social learning opportunities, spotting adverse interpersonal interactions, and practicing new forms of social engagement. The goal is to improve interpersonal relationships by practicing new
behaviors in the group and then generalizing them to life outside the group (Yalom & Leszcz, 2005).

**Here-and-now questioning.** A here-and-now approach does not incorporate techniques. Here-and-now questions happen organically in the moment. The focus is always to bring the participants into the present moment even if sharing a fear about the future or experience from the past. The following are several examples of here-and-now questions that can be used in a group setting.

- Which member’s approval are you most interested in gaining in this group?
- It feels like we are all sizing one another up, is this true?
- Who is paying most attention to you right now in this group?
- Who do you think does the best job in this group at getting their needs meet?
- Who in this group do you have most in common with?
- What did it feel like to share your story with the group?
- Do you perceive anyone in this group to already embody what they feel they lack?
- What made you decide to share that at this moment?

**Group Goals**

The general goals of long-term, outpatient group psychotherapy are to create awareness of personal interaction and create behavior change in interpersonal relationships (Yalom & Leszcz, 2005). In contrast, Yalom and Leszcz (2005) state that the goals of acute inpatient group psychotherapy are to engage the client in the therapeutic process, demonstrate the value of catharsis, spot problems in interpersonal functioning, decrease isolation, be helpful to others, and alleviate institutional anxiety. An intensive, retreat-style therapy experience is different from long-term outpatient group psychotherapy and brief, acute inpatient group psychotherapy, but
from these two types of therapy, goals for most any group can be borrowed. The group goals for intensive, brief retreat-style psychotherapy groups could include

- engage the clients in the therapeutic process;
- decrease isolation and feelings of loneliness;
- increase sense of belonging, significance, and security;
- spot problems and gain awareness of functioning in relationships;
- explore lifestyle, personality; and
- create and practice behavior change in interpersonal relationships.

The goals of the therapy group, client, and facilitators should be in alignment to ensure the best results. Kleingeld, van Mierlo, and Arends (2011) found that to increase group performance the individual goals of each participant must target interaction in the group, and the goals should be specific and difficult to obtain. Individual goals can be used to increase group performance. In a retreat-style, intensive therapy experience it would be best to advertise the group experience with the specific goals above and select participants that are interested in similar individual goals to participate in the group.

According to Strauss et al. (2008) treatment outcomes reflect how the patient responds to the treatment. If the goals of a group are to create awareness of lifestyle, behavior change in interpersonal relationships, and a sense of belonging and connection, the treatment must be designed to ensure the best outcome possible. It is important to monitor the outcomes in meeting the treatment goals to add to the empirical research on retreat-style group psychotherapy.

**Measuring Group Factors and Outcomes**

There is a continued push in the group psychotherapy field to increase the body of empirical research supporting group therapy. In an effort to increase the outcome measures the
AGPA released the *Clinical Outcome Results Standardized Measures Battery Revised* (CORE-R) to provide group therapists with a tool kit of instruments to monitor selection, process, and outcome in group therapy (Strauss et al., 2008). It was believed that too many outcome measures with too much variance were being used in the field, offering little consistent value for practitioners of group therapy (Kilmann & Sotile, 1976; Strauss et al., 2008). The specific measures included in the CORE-R are supported to be sensitive to change, provide information, which informs the therapist on the particular patient, allows feedback on the patient’s status, and can be repeatedly administered (Strauss et al., 2008). When considering the design of a group psychotherapy experience practitioners should research and utilize the appropriate measures in an effort to monitor the effectiveness of the treatment and contribute to the pool of research with empirical data.

**Group selection and preparation.** The CORE-R includes handouts for group members and leaders along with two standardized methods for group selection, the *Group Therapy Questionnaire* (GTQ) and the *Group Selection Questionnaire* (GSQ). The GTQ is a complex instrument taking 45 minutes to administer and score. It assesses pre-existing client variables such as previous therapy experiences, expectations, fears, and self-harming behaviors (Jensen et al., 2012; Strauss et al., 2008). The GSQ takes eight minutes to administer and score. It attempts to predict whether participants will benefit from, and contribute to, the group therapy experience (Straus et al., 2008). In 2011, the GSQ was developed as an evidence-based tool for the composition of process-oriented groups (Burlingame, Cox, Davies, Layne, & Gleave, 2011). The GSQ’s name was changed to the *Group Readiness Questionnaire* (GRQ) to better reflect what it is intended to measure (Jensen et al., 2012). The GRQ predicts a client’s process, outcome, and retention based on their interpersonal skills and expectations, but additional support is needed to
show strong validity (Baker, Burlingame, Cox, Beecher, & Gleave, 2013).

**Group process.** According to Strauss et al. (2008) the process of group therapy refers to what happens during the sessions aside of the content. Group process is believed to be the richness of the group experience yet it is difficult to identify. Some agree on several aspects of group process, which include alliance, group climate, group atmosphere, and cohesion (Jensen et al., 2012). The CORE-R Task Force wanted to include measures of a positive relational bond, positive working alliance, and negative therapeutic factors between a member and the group, and a member and the therapist (Straus et al., 2008). The main tool offered is the *Working Alliance Inventory*, its use is recommended when no other process measures will be used. The CORE-R Task Force included five other assessment process tools that are all well-established, psychometrically sound, and short and economical to use (a) the *Empathy Scale*, (b) the *Group Climate Questionnaire*, (c) *Therapeutic Factors Inventory* cohesiveness subscale, (d) *Cohesion to Therapist Scale*, and (e) *Critical Incidents Questionnaire*. The use of all of these tools offers a comprehensive ability to monitor the process in the group to ensure the best outcomes for the clients and should be considered when designing a group.

**Outcome measures.** According to Strauss et al. (2008) practitioners must evaluate the outcome of treatment. Jensen et al. (2012) stated that practitioners could benefit from a structured way of monitoring how the group members are viewing the helpfulness of the group because it is well documented that practitioners are not good judges of therapeutic efficacy. The *Outcome Questionnaire 45* was the primary chosen measure to assist practitioners in evaluating the effectiveness of therapy for participants. It assesses subjective discomfort, interpersonal relationships, and social role performance. There is also a version appropriate for use with youth. If possible, the CORE-R Task Force recommended the use of four additional outcome measures
(a) the *Inventory of Interpersonal Problems*, (b) the *Rosenberg Self-Esteem Scale*, (c) the *Group Evaluation Scale*, and (d) the *Target Complaints* measure. Strauss et al. reported that practitioners must integrate outcome evaluation into their regular practice to increase accountability and to contribute to evidence-based practice.

**Group Composition**

Group composition is important to consider when designing a psychotherapy group because it influences all aspects of the group experience. Group composition includes the participants, facilitators, and structural factors. There is research in each of these areas. According to Yalom and Leszcz (2005) it is nearly impossible to label a good group member: Yalom has facilitated over 250 therapy groups and stated to some degree there is an “unclear blending of the members” that accounts for the success and life of a group (p. 270). Different theories suggest different approaches to group therapy composition. The briefer and more structured a group is the less important are believed to be the compositional factors (Yalom & Leszcz, 2005). No research was found offering advice for the composition of intensive, retreat-style psychotherapy experiences. Thus, information must be drawn from the group therapy research and descriptive accounts of retreat groups.

**Selection of Participants**

Participants are the core component of a group. Without them there would be no group. There is varying and contradictory information on the composition of group participants. There is clearer information concerning what does not constitute a good group member rather than on what does.

Sonstegard (1998a) believed that a group functions better if no one is obligated to participate and if no one is turned away. Sonstegard stated that heterogenous groups provide the
diversity that is reflective of the real world, making the experience more viable. For long-term therapy groups, Yalom and Leszcz (2005) recommended heterogeneity for gender, thinking and feeling, level of activity, interpersonal difficulties, and homogeneity in regard to intelligence, anxiety tolerance, and engaging in the therapeutic process.

According to Sonstegard (1998a) the Adlerian approach to group composition is a democratic approach in allowing all willing clients access to group psychotherapy. He encouraged a balanced mix of ages, ethnicities, genders, and other diversity factors to offer each participant support in the group.

In a meta-analysis of 51 group psychotherapy studies, it was found that homogeneous groups reported more improvement in members than heterogeneous groups (Burlingame et al., 2003). In the same meta-analysis, members of mixed-gender groups obtained higher gains than the same gender groups. Kipper and Ritchie (2003) when doing a meta-analysis of the effectiveness of psychodramatic techniques found that mixed gender groups had greater effect sizes.

Bos, Merea, van den Brink, Sanderman, and Bartels-Velthuis (2014) conducted a study on mindfulness training in a group setting for individuals with varying diagnoses. Their results supported that participants from all diagnostic categories showed improvement. Suggesting that participants with mixed-symptoms in one group setting may not hinder therapy, but may benefit it.

When considering the participants to compose an intensive, time-limited psychotherapy group, the hope would be to obtain a heterogenous group of male and female participants from diverse cultural, socioeconomic, and educational backgrounds along with a variety of personality traits and conflict styles because practitioners appeared to favor a heterogeneous
mode of composition for varying reasons. It is important to eliminate group members that may jeopardize the group therapy experience for the other participants or if participation could cause them harm.

**Exclusion criteria.** There are varying ideas concerning the exclusion of participants in the group psychotherapy literature. Yalom and Leszcz (2005) stated that most practitioners do not select participants that would be good for group therapy, but instead rule-out those who would not seem well suited to the group experience. They suggested ruling out participants in the following instances, if the participant is (a) actively psychotic, (b) paranoid, or (c) believed to be unable to participate in the tasks of the group due to limited logistical, intellectual, psychological, or interpersonal reasons.

The exclusion guidelines offered by Strauss et al. (2008) were more exhaustive, stating that clients may not be appropriate if they display any of the following (a) reports many interpersonal conflicts marked by aggressiveness or hostility, (b) intensely shy or avoidant, (c) reports frequently engaging in self-harming behaviors, (d) somatic symptoms with no psychological insight, (e) presents in a “vague manner” (f) strongly questions if group will be helpful and is sure they will be uncomfortable in group, (g) suffers from paranoia, (h) prone to deviate from tasks of the group, (i) severe incompatibility with one of the other participants, or if the client (j) may jeopardize the group’s safety (p. 1230).

**Facilitators**

When designing intensive, time-limited, retreat-style psychotherapy groups the facilitators must be carefully selected because the therapists facilitating the group have an impact on all dynamics of the group. Sonstegard (1998b) stated that one cannot separate the person and practice of therapy; group therapists must constantly be growing as people and facilitators. The
personal characteristics of the therapists and their theoretical orientations impact the therapeutic outcome in group therapy. A therapist must practice within his or her area of competency, draw from a counseling style based on theory, and be self-aware (Corey, Corey, & Callahan, 2011). Therapists who encourage member-member interactions, implement structure, and expound a warm and empathetic style lead more therapeutic groups (Chapman, Baker, Porter, Thayer, & Burlingame, 2010).

Kivlighan, London, and Miles (2012) found that co-facilitated groups have several advantages over individually led groups. Co-led group therapy has higher rates of session attendance, is preferred by group facilitators, and group members reported greater benefits from therapy than individually led groups. Kivlighan et al. reported that two therapists allow for increased observational range, making the participants feel more attended to. Yalom and Leszcz (2005) suggest that co-led groups decrease facilitator anxiety, model healthy interpersonal interaction, increase objectivity, and allow for greater observational range. Sonstegard (1998b) and Yalom and Leszcz (2005) asserted that groups containing one male and one female facilitator that respect and show admiration for one another offer the best therapeutic team. Two facilitators offer the opportunity to model healthy communication for the participants.

The facilitator’s main objective is to create a safe environment for therapy to happen (Tasca et al., 2014). Aside from maintaining a safe environment, promoting cohesion is the most important task of the facilitator because it is known to have the greatest impact on the reported outcome of group therapy. Sonstegard (1998b) stated therapists must be present, assertive, confident, courageous, take risks, be accepting, model and collaborate, be adaptable, have a sense of humor, and tend to the group process in an effort to create cohesion and a sense of belonging for each individual group member. Group leaders with an interpersonal,
psychodynamic, or cognitive-behavioral orientation were found to have the highest rate of cohesion reported in their respective therapy groups (Burlingame, McClendon, et al., 2011).

**Structural Factors**

The structural factors that must be addressed when designing an intensive, time-limited psychotherapy group include the group setting, size, length, duration, and frequency. There is some consensus in the literature on best practices when devising group structure.

**Group setting.** Scheinfeld et al. (2011) stressed the helpfulness of offering flexibility and space in the environment allowing for self-disclosure and emotional processing. Sonstegard (1998a) noted that the atmosphere can hinder and foster the group therapy experience. He stated outside noise should be limited, the temperature and lighting should be comfortable, and space must allow for the participants to sit in a circle. A group should be conducted in a private area to protect confidentiality and ease anxiety.

**Group size.** Sonstegard (1998b) and Yalom and Leszcz (2005) agreed that process groups containing a maximum of 10 group members are ideal. Sonstegard (1998b) cited the preferred number of eight participants with 12 being the maximum unless the groups are psychoeducational and highly structured. Yalom and Leszcz (2005) warn against facilitating a group with less than five members because the diversity and interactional experiences are limited and it may transform into individual therapy. The larger the group size the less participant engagement noted and levels of conflict increased (Kivlighan et al., 2012). Burlingame, McClendon, et al.’s (2011) research supported groups with five to nine participants that last more than 12 sessions have the highest reported cohesion outcome. Stanger and Harris (2005) found 9-12 participants to be ideal for their 23-hour marathon therapy groups.

**Group length, duration, and frequency.** One of the distinguishing features of intensive,
time-limited, retreat-style group psychotherapy is the single frequency meeting with an extended duration. A review of literature on length, duration, and frequency of groups could be used to inform the design of time-limited, retreat-style group psychotherapy.

Sonstegard (1998b) and Yalom and Leszcz (2005) asserted that meeting for 90 minutes once weekly is often the most effective approach when doing on-going group therapy. Sonstegard (1998a) stated that at more than two hours fatigue sets in for the facilitators and participants, and in an hour or less there is not adequate time to get beyond a check-in and move into the heart of the group therapy experience.

It was the belief of the marathon therapy founders that the intensive, full-on encounter with other individuals was what offered the magic of awareness in interpersonal interaction (Bach, 1966). Kilman and Sotile (1976) reviewed the marathon encounter group therapy literature stating there did not appear to be a significant difference in time-extended, intensive versus traditional weekly group experiences, but pointed out the limitation in this meta-analysis due to multiple confounding variables and design defects. Stanger and Harris (2005) conducted 23-hour weekend marathon therapy groups in a university counseling center with reported success.

The ideas presented in the literature on group length, duration, and frequency vary. There is no conclusive research. This is another area of group therapy research that needs additional information. Could it be that when facilitating a retreat-style therapy experience breaks should be considered?

**Group Preparation**

When contemplating the design of a retreat-style group psychotherapy experience group preparation should be considered. Group preparation offers information, covers informed
consent, and offers an initial meeting for screening, and questions. Group preparation takes place in a pre-group meeting. Strauss et al. (2008) wrote the purpose of preparation is to share the group goals, dynamics of group functioning, organizational aspects, warn of potential problems, and correct myths and misconceptions.

Preparation and screening of group members expedites the course of group therapy, allows a potential member to make an informed decision about joining the group, and creates faith in group psychotherapy (Yalom & Leszcz, 2005). Bednar and Kaul (1994) and Burlingame, Fuhriman, and Mosier (2003) have documented that pre-group preparation reduced the risk of dropouts and raised the effectiveness of group treatment. Also, pre-group preparation fosters cohesion, decreases anxiety, clarifies group roles and behaviors, and increases faith in the group as a whole (Strauss et al., 2008).

There is no research indicating that the use of a pre-group meeting is harmful. In general, if group preparation is helpful in group therapy, it most likely will serve the same purposes in intensive, time-limited therapy. Stanger and Harris (2005) prior to allowing participation in their 23-hour marathon therapy experience met with each university student member for a one-hour screening to discuss the group goals, principles, and secure informed consent. As suggested by Yalom and Leszcz (2005) during this individual preparation session the facilitator should

- clarify common misconceptions of group psychotherapy (e.g., being forced into self-disclosure, group therapy being inferior to individual treatment, there is an adverse impact to one’s mental health by being around mentally ill individuals);
- address common problems (e.g., perceived goal incompatibility, less individual attention from the therapist, extragroup socializing, inability to guarantee confidentiality);
- describe the basis of group psychotherapy, interpersonal theory, the shared goals of the
group, and impart faith in the group;

- explain how to participate by self-disclosing, offering and accepting honest feedback;
- contract for confidentiality, attendance, and participation; and
- provide, review, and sign the informed consent document.

Conducting a pre-group meeting would appear to be the best practice in retreat-style group psychotherapy. The preparation of group members prepares them for the tasks of the group as the group moves through developmental phases.

**Group Development**

Throughout the life of a group, predictable developmental stages are achieved. Lesczc and Kobos (2008) asserted that it is important for effective leadership, to recognize the four phases of group development. In a time-limited, intensive group experience, it is expected that the group will still progress through the four developmental stages, but there is no research to support this hypothesis.

The initial stage according to Yalom and Leszcz (2005) is the “Orientation, Hesitant Participation, Search for Meaning, Dependency” during which the group members are trying to decide if they are “in or out” of the group (p. 311). When using a retreat-style group it is predicted that the group members will quickly pass through this first phase because they probably will have a higher level of commitment due to paying and traveling to participate. If individuals clear their schedules, pack their bags, and drive to a retreat location, their investment is greater. The loss would be greater to dropout than compared to if participating in an ongoing weekly therapy group where one could decide to just not come the following week.

During Yalom and Leszcz’s (2005) second phase “Conflict, Dominance, Rebellion” the members are struggling to decide if they are on “top or bottom” in the group hierarchy (p. 314).
It should be expected that after an initial phase of goodwill that conflicts would rise within the group (Leszcz & Kobos, 2008). The group leader must be prepared to manage the conflicts and use them to build cohesion and honest interaction.

According to Leszcz and Kobos (2008) the “norming stage” is the third phase of development in group therapy (p. 1248). Yalom and Leszcz (2005) referred to this same stage as the “Development of Cohesiveness” phase in which the members are figuring out how “near or far” they want to remain with the other group members (p. 319). It is in this phase that most of the work of group psychotherapy takes place. It is here that trust is developed and authentic interactions transpire (Leszcz & Kobos, 2008; Yalom & Leszcz, 2005).

The final stage of a group is the termination phase (Leszcz & Kobos, 2008; Yalom & Leszcz, 2005). During this phase group members may contribute more than normal, begin to pull away from the group, or express feelings of sadness as the group comes to an end. It is important for the facilitators to allow time to process the termination of the group and to begin preparing the members for termination beginning with the preparation meeting. The termination of a retreat-style group possibly has different dynamics than termination of an ongoing group. This would be an interesting area of analysis for future research.

**Group Process**

Group process is the part of the group that does not include the content. A process-style group is a treatment context in which participants interact with one another under the facilitation of a therapist in an effort to grow personally, alleviate symptoms, and correct behaviors, thoughts, or feelings (Tasca et al., 2014). Group process includes factors such as group climate, cohesion, and alliance. Johnson, Burlingame, Olsen, Davies, and Gleave (2005) suggested that group climate, cohesion, alliance, and empathy may serve the same functions in a group, or be
closely related. Suggesting there could be an underlying common factor across groups that accounts for the positive therapeutic outcomes.

Group facilitators must attend to the process of the group during session. Kivlighan (2011) found that 95% of group variance was at the session level. Group members’ perceptions of therapeutic factors mattered most between sessions. Prediction of therapeutic factors impacted the perceived smoothness of the sessions. Group depth was related to reported levels of group self-disclosure, group learning, and group altruism. Group leaders should primarily focus on the group culture not on individual members changing.

**Group Cohesion**

Group psychotherapy is a powerful modality of therapeutic intervention for clients. At the core of the group psychotherapy experience is the idea of being accepted and belonging to a group (Lorentzen et al., 2012). This connection and commitment to a group is referred to as cohesion. Cohesion is one of the unique components of group psychotherapy experienced by its members. Furthermore, cohesion is one of the most researched areas of group psychotherapy and influences the therapeutic outcome of group psychotherapy by contributing to increased social functioning and reported symptom reduction of participants (Burlingame, McClendon, et al., 2011; Lerner, McLeod, & Mikami, 2013). Group cohesion is important because it supports stability in groups, better attendance by members, and combats early termination. Members of a cohesive group are supportive, accepting, and inclined to form meaningful relationships (Yalom & Leszcz, 2005).

Group cohesion creates the environment for therapeutic change by encouraging self-disclosure, risk-taking, and appropriate conflict, leading to self-awareness and behavior change in group participants. Cohesion is a necessary component of group psychotherapy and must be
established before other therapeutic factors can happen. Cohesion is influenced by the composition of a group and is fostered by the group facilitator in creating a safe, authentic space for open communication. The level and quality of group cohesion is indicative of the health and efficacy of a therapy group (Yalom & Leszcz, 2005).

The facilitator’s role is to foster the level of cohesion or as Sonstegard (1998b) stated “establish and maintain a group relationship” (p. 221). To nurture cohesion the leaders must set treatment expectations, establish group procedures, discuss roles, model self-disclosure and feedback, use non-judging language, create an atmosphere of support and challenge, and involve members in conflict resolution (Burlingame, McClendon, et al., 2011).

The assortment of relationships experienced in a psychotherapy group offers the fundamental mechanisms for interpersonal learning and behavior change. Group therapy dynamics are complex due to the experience of the client-client, therapist-client, therapist-therapist, client-group, and therapist-group relationships all in one therapy group (Burlingame, McClendon, et al., 2011). Retreat-style group psychotherapy offers similar relationship dynamics to traditional group therapy, and may better foster cohesion.

Dies and Hess (1971) compared cohesiveness in conventional group therapy and marathon group therapy. The study participants were found to discuss more personal topics and displayed greater interpersonal sharing in the marathon group. Time-limited psychotherapy might produce greater cohesiveness than ongoing, weekly group psychotherapy.

Norms

Yalom and Leszcz (2005) remarked that each group would develop its unique normative behavior. The norms may develop via the interactions of the members or the group leaders, and may be spoken rules or inferred expectations. Sonstegard (1998b) discouraging the use of group
rules because the term is autocratic in nature and Adlerians wish to encourage democratic practices. He suggested that group leaders facilitate a conversation addressing group norms and allow the participants to come to any agreements. The agreements most often ensure the safety of the individual members and ensure a smooth process. If agreements are created, it is recommended they are clear and concise. Popular agreements are the right to speak and be heard and honoring group confidentiality (Sonstegard, 1998b).

**Group Format**

Utilizing research based on Adlerian and here-and-now change theory, group psychotherapy history, retreat-style group therapy, group goals, measurement instruments, group composition, group preparation, group development, group process, and group termination the format of the group maybe designed. The retreat-style group should follow a sequenced format so that participants and facilitators have an idea of what to expect and to guide the group toward goal attainment.

It is recommended that the group begin with a welcome and brief introduction covering the schedule and logistics of the group setting. All group members and facilitators should have the opportunity to introduce themselves. The informed consent document should be reviewed along with the purpose and goals of the group. Any questions should be answered.

A brief grounding, relaxation, or meditation exercise would be used to bring the group into the here-and-now and to teach techniques that can help manage symptoms and develop resilience and relaxation. It would be appropriate to integrate this practice at the beginning of each day of the retreat and after longer session breaks such as lunch.

Modified Adlerian techniques for group therapy would engage the clients in the therapeutic process, build cohesion, alleviate symptoms, and offer a sense of belonging. The goal
is to empower clients and offer insight about their lifestyle and way of being in interpersonal relationships. Here-and-now interaction would be facilitated by prompted questions concerning what is happening right now, right here in the group. The aim of the here-and-now discussion is to spot problems in relational functioning, hopefully leading to behavior change in the group that can be applied to life outside the group.

The sequence of the retreat modules would be designed to help meet the group’s psychotherapy goals. Breaks would be built into the schedule to allow for the participants and facilitators to have time to process, reflect, and refresh. The group members would be prepared for the termination of the group and re-entry into the community and their homes.

**Termination and Re-Entry**

Due to the number of participants in group psychotherapy, the termination phase is distinctive and complicated (Leszcz & Kobos, 2008). Stanger and Harris (2005) devoted the last hour of their 23-hour marathon group to termination. They framed the weekend experience as the beginning of change, which the clients must carry into their future lives. Marmarosh and Tasca (2013) suggested that during the final sessions of a group, the therapist focus on the feelings of loss, abandonment, and grief the group members are experiencing. Group members may try to avoid feelings of loss by suggesting future meetings or social activities outside of the group and facilitators must be prepared to acknowledge the purpose of these suggestions. Leszcz and Kobos (2008) advised that a termination ritual could be used to manage anxiety and facilitate continued processing of emotions. Participating in a retreat-style group therapy experience could offer a uniquely high level of participation in the ending phase because only 40% of therapy endings are planned (Connell, Grant, & Mullen, 2006). Retreat-style group therapy offers an opportunity for structured learning and interpersonal awareness during the termination phase that must be
planned for accordingly.

**Other Considerations Beyond the Scope of this Study**

There are many other considerations in informing a model for intensive, brief group psychotherapy by integrating Adlerian and here-and-now approaches beyond the scope of this study. The group facilitators should question whether to use evaluation and feedback tools to assist in altering future retreat events. The amount and style of training required for the facilitators should be considered along with any continuing education requirements. Using a retreat-style psychotherapy experience could be concurrent to ongoing individual or group psychotherapy. Or the experience could be used as a precursor to joining an ongoing group or individual therapy. The use of process and progress notes must be examined paying special attention to protecting client confidentiality. Enlisting the expertise of consultants, attorneys, and insurance agents to guide the best business practices for a retreat-style experience. The logistics of where to host the retreat, accommodations, meals, and costs must be decided. Resources must be available throughout the retreat and as part of the termination and re-entry plan. A protocol must be in place in case one of the participants has a crisis during the retreat.

**Ethical Considerations**

The ethical considerations of group psychotherapy are more complex than the ethical considerations in individual counseling. It is unrepresented in the literature if the dynamics of retreat-style versus ongoing group therapy, involve different ethical considerations. It is assumed that the literature on group psychotherapy ethics can be applied in a retreat-style modality. Klontz (2004) stated that the ethical dilemmas and concerns that arise in individual therapy are present in group therapy sessions, but group therapy has additional unique dilemmas. One distinctive difference is that during group sessions the therapist must quickly weigh the cost and
benefit of group interest versus individual interest in the moment (Klontz, 2004).

The marathon-style group is the most similar in the literature to retreat-style therapy. It was discussed earlier how the marathon encounter group therapy practiced by certain practitioners of the 1960s and 1970s was ethically unsound and the marathon encounter group movement suffered. Stanger and Harris (2005) believed that marathon-style therapy could be practiced in an ethical manner similar to weekly group therapy. Just because marathon therapy was discredited due to ethical concerns in the past does not mean that it cannot be practiced ethically now.

The first steps in designing an ethical retreat-style group therapy model are to review the literature and support the model design with a theoretical foundation. To practice ethically therapists must work based on a theoretical framework, be able to conceptualize what they are doing, and for what purpose in counseling sessions (Corey et al., 2011). Group therapists must be competent in group therapy, meaning they must have training and supervision in facilitating groups. The AGPA (2002) offers a list of guidelines of group psychotherapy practice for ethical behavior that can be retrieved online (http://www.agpa.org/home/practice-resources/ethics-in-group-therapy). The therapists must protect confidentiality, exercise nonmaleficence, avoid dual relationships, and utilize an informed consent document.

Confidentiality

The therapeutic alliance is based on confidentiality. Protecting the privacy of clients is the responsibility of therapists in a group setting just as in any individual setting. Protecting confidentiality is more difficult in a group setting due to additional dynamics and limitations. It is virtually impossible to enforce confidentiality in a group setting. Self-disclosure is an important aspect of the therapeutic nature of a group, but participants should be warned to only
disclose what they feel comfortable doing given the exact group dynamics and setting. Group members should be encouraged to keep confidential that which is discussed in the group, but must be informed that there is no way to guarantee privacy between group members outside of the group.

With the exception of privileged communication the same legal and ethical exceptions to confidentiality apply in a group setting whether it is an ongoing or retreat-style experience. It is the responsibility of therapists to inform clients of the limits of confidentiality. Some of the exceptions to confidentiality include when disclosure is ordered by the court, when clients sign a release, any indications of abuse, if clients pose a danger to self or others, and when managed care is paying (Corey et al., 2011). An important consideration is that client-therapist privilege in a group therapy setting is not protected under statute in many states (Klontz, 2004). Group facilitators should contact their appropriate state licensing board for verification and clarification and relay the correct information in their informed consent document.

Nonmaleficence

While facilitating retreat-style group therapy, the therapists must practice nonmaleficence as with any modality of psychotherapy. Regardless of intent, it is the therapist’s responsibility to avoid action or inaction that may cause harm to clients (Herlihy & Corey, 2006; Stanger & Harris, 2005). This concept is more difficult in a group setting where it is the responsibility of the therapist to ensure the safety of each member. According to Corey et al. (2011) developing professional competence is an effective way to avoid nonmaleficence. Additionally, during a pre-group interview therapists should assess candidates for clinical appropriateness and make referrals when necessary. It is important for therapists to participate in consultation groups and supervision specific to facilitating group therapy to be nonmaleficent.
Multiple Relationships

In this literature review it was found that intensive, time-limited therapy is often practiced as an adjunct to ongoing individual or group therapy. Whether offering individual or group therapy, the therapists must be mindful and self-aware when making decisions about whether to serve clients in multiple roles. Therapists must consider the benefits to self and potential threat of harm to the clients by serving the clients in multiple roles. It is not uncommon for therapists to serve the same clients in individual and group therapy. Group therapists must only engage with clients in another capacity if it is in the best interest of the client.

Informed Consent

Utilizing an informed consent document specific to intensive, time-limited group therapy offers transparency and protection to clients and mitigates legal implications for the therapists. Explaining the nature of group therapy dynamics, boundaries, payment expectations, confidentiality, and termination of the therapeutic relationship is best practice, along with offering a list of crisis resources and signing a statement denying any thoughts of harm to self or others (Corey et al., 2011). A signed informed consent document must be obtained before beginning group psychotherapy during the screening appointment. At the beginning of the group experience the informed consent document would be verbally reviewed and time should be allowed for any questions or concerns in the group setting. This should be documented in the progress notes.

Using an informed consent document empowers clients to decide if they wish to participate in therapy after being presented with information on the group therapy retreat (Corey et al., 2011). A necessary aspect of creating a retreat-style therapy model will be designing a solid informed consent document. Licensing boards, the AGPA, and seasoned professionals can
be contacted to obtain examples of informed consent documents. Best practice is to have a draft approved by legal counsel and plan to periodically review the form and make appropriate changes.

**Conclusion**

There are many factors that must be researched when attempting to design a retreat-style psychotherapy group integrating Adlerian and here-and-now theory. The challenge is that there is a gap between group therapy research and group therapy practice that must be bridged (Burlingame & Beecher, 2008; Coché & Dies, 1981). The gap is even greater between practice and research supporting intensive, time-limited, retreat-style group psychotherapy. Historically, several variations of retreat-style therapy have been practiced with reported success, most notably marathon and encounter group therapy. Currently, a quick Internet search confirms the practice of retreat-style therapy offerings around the world. Unfortunately, a review of the current literature on intensive, time-limited group psychotherapy is scarce. Yet, there is a solid research base regarding specific areas of group psychotherapy such as cohesion, outcome and therapeutic factors measurement, and in the treatment of bulimia nervosa and chemical dependence.

The purpose of this study has been to survey the applicable literature when considering the design of an intensive, time-limited, retreat-style group psychotherapy model. Utilizing group psychotherapy research in informing a model design employs evidence-based practice. The research gathered and presented can guide decisions in creating this future model and ensuring it is as ethical as possible.

Practicing ethically involves drawing from a theoretical framework in therapy sessions. Adlerian theory and here-and-now approaches have been integrated to offer the foundation for a
retreat-style therapy experience. The Adlerian principle of belonging to, and contributing, in a social capacity is relevant in a group setting given the goals of group psychotherapy are to create self-awareness and produce behavior change in the interpersonal realm. A here-and-now approach is an excellent compliment to Adlerian theory because it is based on interpersonal theory stating that all symptomology has a social aspect such as in autism spectrum disorders, psychotic symptoms, and the isolation seen in depression and anxiety. Often the level of interpersonal functioning and social interest represented in participants struggling with mental health problems is lower than that of the general public. What better way to treat individuals suffering from interpersonal symptoms than encouraging them into a meaningful group experience?

The history of group therapy was examined highlighting its efficacy in comparison to individual therapy. The rise and fall of the marathon encounter group therapy movement in the 1960s and 1970s was examined because it was an intensive, time-limited modality of group psychotherapy. It was discovered that these models underwent a potentially unwarranted demise due to the unethical practice of a few practitioners and a lack of evidence published by the firm, ethical leaders of this promising therapy. Several studies were reviewed offering insight into the design, use, outcome, and general impressions of intensive, time-limited group therapy. Unfortunately, most of these studies were anecdotal in nature and lacked empirical evidence for the practice and design of retreat-style group therapy. The general reported consensus was that retreat-style group psychotherapy was beneficial to the participants and was viewed as useful by the facilitators.

The different factors of group psychotherapy were explored including group goals, measuring group factors and outcomes, group composition, group preparation, group
development, group process, group format, termination and re-entry, other considerations beyond the scope of this model, and ethical considerations important to group psychotherapy. The literature cited was from the general practice of group psychotherapy and its usefulness was extrapolated when applying it into an intensive, time-limited group psychotherapy experience. In rare cases, research was available specific to retreat-style therapy.

This study indicated several areas of consideration for certain useful methods and a few methods to avoid when designing an intensive, time-limited, retreat-style psychotherapy group. For instance, the AGPA’s Clinical Practice Guidelines for Group Psychotherapy is a practical guide that should be used in the planning, development, implementation, and evaluation of group therapy (Leszcz & Kobos, 2008).

Group treatment is as efficacious as individual therapy and more indicated for clients without severe mental diagnoses (Burlingame & Beecher, 2008; Burlingame et al., 2003; McRoberts et al., 1998). There has been little research on marathon-style therapy over the past three decades, but retreat-style therapy is reported to be successful in treating eating disorders and substance abuse (Stanger & Harris, 2005; Yalom & Leszcz, 2005). Descriptive literature promoted the use of intensive, time-limited therapy that removed clients from their home for an intimate experience (Bach, 1966; Kilmann & Sotile, 1976; Scheinfeld et al., 2011). Retreat-style group therapy experiences were indicated to increase self-esteem, a sense of belonging, and create personality change (Gendron et al., 1992; McCandel & Murray, 1974; Skerrett, 2005; Stanger & Harris, 2005). Ethical clinical practice must be guided by a theoretical framework and an integration of there-and-then Adlerian theory and a here-and-now focus may create positive outcomes for group participants (Abramowitz & Jackson, 1974; Burlingame & Beecher, 2008). There should be goals that are specific, difficult to obtain, and concern the individuals in a group
setting (Kleingeld et al., 2011). The CORE-R outcome measures are effective tools to be used to
monitor group factors and outcomes, and their use adds to the research base of group
psychotherapy (Strauss et al., 2008). Drawing from the group psychotherapy research a group
consisting of five-nine heterogeneous members lead by two facilitators is ideal (Burlingame,
McClendon, et al., 2011; Kivlighan et al., 2012; Sonstegard, 1998a; Sonstegard, 1998b; Yalom & Leszcz, 2005). All willing participants should be included unless they are actively psychotic,
paranoid, unable to participate in the group tasks, or would jeopardize the group’s safety (Strauss
et al., 2008; Yalom & Leszcz, 2005). The group setting should be comfortable and private
(Scheinfeld et al., 2011; Sonstegard, 1998a). There was no clear indication of the duration or
length of intensive, time-limited group psychotherapy. The literature supported the preparation
and screening of participants (Bednar & Kaul, 1994; Burlingame et al., 2002; Strauss et al.,
2008; Yalom & Leszcz, 2005). Group cohesion should be fostered and is unique and necessary
to group psychotherapy, and it may be greater in time-limited psychotherapy (Burlingame,
McClendon, et al., 2011; Dies & Hess, 1971; Lerner et al., 2013). The ethical considerations in
group psychotherapy are more complex than individual therapy and require careful attention. An
ethical practitioner must protect confidentiality, use an informed consent document, practice
nonmaleficence, and avoid multiple relationships. There are many areas in the group
psychotherapy field that are lacking empirical support.

This research has practical and future applications for the writer and practitioners of
group psychotherapy. Especially those interested in designing intensive, time-limited counseling
experiences and those who draw from Adlerian and here-and-now frameworks in their practice.
The research draws attention to areas of group psychotherapy practice that are in need of
additional inquiry and support in the literature. Today, group therapy is strongly supported as
being as efficacious as individual psychotherapy for most disorders. Specifically, studies comparing intensive, time-limited, retreat-style therapy need to be compared to the efficacy of ongoing group psychotherapy treatment. Models that combine individual, ongoing group, and intensive, brief group experiences in different ways need to be explored.

This paper is offered as an invitation to group therapy practitioners to utilize and contribute to the literature on retreat-style group therapy. By doing so practitioners not only avoid ethical risks, they can ensure that they are providing sound and effective treatment for their clients based on reliable empirical evidence.
References


Bos, E. H., Merea, R., van den Brink, E., Sanderman, R., & Bartels-Velthuis, A. A. (2014). Mindfulness training in a heterogeneous psychiatric sample: Outcome evaluation and
comparison of different diagnostic groups. *Journal of Clinical Psychology, 70*(1), 60-71. doi:10.1002/jclp.22008


American Counseling Association.


relationship between number of group leaders and group members, and group climate and group member benefit from therapy. *Group Dynamics: Theory, Research, and Practice, 16*(1), 1-13. doi:10.1037/a0026242


