DRUG & ALCOHOL FINDINGS *Review*

analysis

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This entry is our analysis of a review or synthesis of research findings added to the Effectiveness Bank. The original review was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the review. Below is a commentary from Drug and Alcohol Findings.

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▶ Evidence-based psychotherapy relationships: Cohesion in group therapy.

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Burlingame G.M., McClendon D.T., Alonso J.

Psychotherapy: 2011, 48(1), p. 34–42.

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This meta-analytic review commissioned by the American Psychological Association suggests that fostering cohesion between leaders and groups, and within groups, is often an important way to improve group therapy outcomes. Practice recommendations will help group leaders make the most of this common substance use treatment format.

SUMMARY Updated in 2018. See Effectiveness Bank analysis.

[Though not specific to patients with drug and alcohol problems, studies in the analyses described below may have included such patients, and the principles are likely to be applicable to these disorders among others, not least because substance use problems generally form part of a complex of broader psychosocial problems.]

This review is one of several in a special issue of the journal *Psychotherapy* devoted to evidence-based, effective therapist-client relationships. It reports on a research synthesis of the links between outcomes of group therapy and the alliance or sense of cohesion between the members of the group and between the group and the group leader(s).

The concept of alliance was originally developed in individual psychotherapy, where it has been variously defined as a bond between the therapist and client which holds the client in therapy, or as a collaborative working relationship, and is sometimes seen as mainly working at the unconscious level, sometimes at the conscious. In group therapy, multiple relationships develop simultaneously. From the perspective of a group member, these are member-member, member-group, and member-leader. These are duplicated from the perspective of the therapist who is also involved in leader-group and, if there is a co-therapist, leader-leader relationships. Running through the many ways of conceptualising and measuring these concepts can be discerned two fundamental dimensions: relationship *structure*, and relationship *quality*. Studies of how groups perceived relationships in both clinical and non-clinical groups have shown that the quality dimensions concern positive emotional bonds, positive working together on therapeutic tasks and goals, and negative relationships when there is a failure to empathise or conflict in the group. At a structural level, these quality dimensions are found in member-leader, member-member, and (in some studies but not all) member-group relationships.

The review incorporated meta-analyses synthesising results from relevant studies to provide estimates of the overall strength of the link between outcomes and cohesion, and to be able to probe for influences on the strength of that link. Strength was expressed as a correlation using the 'r' metric, which can be squared to calculate how much of the difference in outcomes is associated with differences in the therapy dimension being investigated. The assumption was made that there is no single, true strength of the link between outcomes and cohesion which appears to vary only because of methodological differences, but that instead strength really might vary across the studies included in the analysis.

Studies were included in the analysis if they involved a group of at least three meeting for counselling, psychotherapy or personal growth, cohesion and outcome were measured, and their relationship was assessed in a way in which the results could be combined with those of other studies. A search found 40 relevant English-language studies, 8 in 10 of group therapy.

Main findings

Across all these studies the strength of the link between cohesion and subsequent therapeutic progress equated to a correlation of 0.25, a statistically significant link representing a medium-strength relationship which accounts for about 6% of the variance in outcomes. In other words, the more solid the working relationship or bond between and within therapist and group, the better the outcomes tended to be.

However, the findings were not consistent. The strength of the link varied more than would be expected by chance. Though significant across all studies, most individual studies did not find a statistically significant relation between cohesion and outcomes, though in nearly all the direction of the relationship was as expected. Five features of the studies and their subjects had a statistically significant influence on the strength of the cohesion-outcomes link. First, it was stronger in studies of groups with relatively *young* members. Second was the *theoretical orientation* of the leader. The link was strongest when they adopted an interpersonal orientation (correlation of 0.58) and lowest but still statistically significant when they practiced cognitive-behavioural therapy (correlation of 0.18). Studies of humanistic, behavioural, and eclectic approaches each failed to record a statistically significant link. Third, *mid-size* groups of 5–9 members in each session resulted in the strongest cohesion-outcome relationship (correlation of 0.35); in smaller or larger groups it was much weaker. Fourth, programmes lasting *at least 12 sessions* had stronger cohesion-outcome relationships than shorter programmes. Lastly, there were indications that the cohesion-outcome relationship was strongest when *ways to enhance cohesion* were either explicitly included in the programme, or were likely to form a major part of the group process. The latter was the implication of the finding that the link was weaker in problem-specific groups which focused on a problem shared by each member, and stronger (correlation of 0.38) in more varied groups whose ways of working were more interactive less structured.

Practice considerations

Cohesion is reliably associated with group therapy outcome, typically defined as reduction in symptom distress or improvement in interpersonal functioning. Cohesion is integrally related to the success of group therapy.

Cohesion is most strongly involved with patient improvement in groups with an interpersonal, psychodynamic, or cognitive-behavioural orientation.

Irrespective of their theoretical orientations, group leaders who emphasise member interaction run groups in which cohesion has a stronger link to outcomes than in groups less focused on how they work, rather than what they are working on. Thus, it is important to encourage member interaction.

Cohesion is associated with outcome regardless of the length or size of the group, but is strongest when a group lasts more than 12 sessions and is comprised of five to nine members. Cohesion requires sufficient member interaction and time to build.

More so than older participants, cohesion has the strongest influence on the degree of improvement of younger group members, so fostering cohesion will be particularly important for those working in college counselling centres and with adolescent clients.

Cohesion is associated with outcomes across different settings (inpatient and outpatient) and diagnostic classifications, so all group leaders should try to cultivate and maintain cohesion. Leaders who do so have a stronger cohesion-outcome relationship in their groups. The article provides a list of therapist behaviours which can enhance group cohesion, supported by studies showing that member-reported cohesion is stronger when leaders take specific actions to affect emotional climate, manage verbal interaction, and maintain group structure, and that these actions also associated with less interpersonal distrust and conflict.

COMMENTARY This article was in a special issue of the journal

Psychotherapy devoted to effective therapist-client relationships. For other Findings entries from this issue see:

- Evidence-based psychotherapy relationships: Psychotherapy relationships that work II
- Evidence-based psychotherapy relationships: Alliance in individual psychotherapy
- Evidence-based psychotherapy relationships: The alliance in child and adolescent psychotherapy
- Evidence-based psychotherapy relationships: Alliance in couple and family therapy
- Evidence-based psychotherapy relationships: Empathy
- Evidence-based psychotherapy relationships: Goal consensus and collaboration
- Evidence-based psychotherapy relationships: Positive regard
- Evidence-based psychotherapy relationships: Congruence/genuineness
- Evidence-based psychotherapy relationships: Collecting client feedback
- Evidence-based psychotherapy relationships: Repairing alliance ruptures
- Evidence-based psychotherapy relationships: Managing countertransference
- Evidence-based psychotherapy relationships: Research conclusions and clinical practices

The special issue which contained the article featured above was the second from the task force. The first was a special issue of the *Journal of Clinical Psychology*. While the second aimed to identify elements of effective therapist-client relationships ('What works in general'), the first aimed to identify effective ways of adapting or tailoring psychotherapy to the individual patient ('What works in particular'). For Findings entries from this first special issue see this bulletin. Both bodies of work have also been summarised in this freely available document from the US government's registry of evidence-based mental health and substance abuse interventions.

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