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EXPLORING THE EXPERIENCES

OF ADOLESCENTS PARTICIPATING IN

INTERPERSONAL GROUP PSYCHOTHERAPY

BY

FRANCINE ROSE BIANCA PINGITORE

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

NURSING

UNIVERSITY OF RHODE ISLAND

2015

DOCTOR OF PHILOSOPHY DISSERTATION

OF

FRANCINE ROSE BIANCA PINGITORE

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2015

Abstract

Given the number of adolescents who present with mental health issues, it is important to explore the best treatment options for this population. Group psychotherapy has been described in the literature as the ideal choice for adolescents who engage in mental health treatment. It is considered a "natural" fit, as adolescents are focused on their peer group during this developmental period. There has been an abundance of research examining behavioral oriented group psychotherapy with adolescents suggesting positive clinical benefits and outcomes. However, process oriented group psychotherapy research with adolescents has been lacking. In particular, the "voice" and perspectives of adolescents who attend group psychotherapy is significantly sparse. The aim of this research study was to address this gap in the literature by interviewing adolescents about their experiences of participating in an interpersonal psychotherapy group.

A qualitative descriptive method was the design of choice for this study. Semi-structured, open-ended interviews were conducted with eight adolescents who attended an interpersonal psychotherapy group for a period of three months. The data was analyzed using qualitative inductive manifest content analysis. All eight participants described their experiences and the meaning of their experiences. Surprisingly, all eight participants also described and focused on the group process rather than the content. A number of therapeutic factors including universality, cohesion, interpersonal learning, altruism and instillation of hope emerged from the data which are consistent with Yalom's theoretical framework. The participants described a number of benefits resulting from their participation and made

recommendations for future group therapists related to the physical space, group composition and characteristics and style of the group leader.

Implications for knowledge development, research, education and clinical practice, were discussed. Recommendations included future qualitative studies with a broader representation of adolescents participating in heterogeneous and homogenous psychotherapy groups. Increasing psychiatric nurses' awareness of the benefits of interpersonal psychotherapy groups is warranted along with training opportunities for group leaders in interpersonal psychotherapy.

Acknowledgements

Without the hundreds of adolescents with whom I have had the great privilege to sit among in groups week after week, month after month, year after year, this dissertation would not have happened. The adolescents I have worked with have been and continue to be my greatest inspiration. In particular, it has been an honor to work with the inspiring eight teenagers who agreed to be interviewed for this study. Sharing your experience is a gift to all those who read this work. You have offered the group therapy community wonderful insights and thoughtful suggestions. I am so thankful to each one of you for sharing your group psychotherapy experience.

Just as a "group" is composed of several members who support and offer new possibilities for each of it's members, I have considered my acknowledgements as the "group" of individuals who have supported me, guided me, inspired me and ultimately, positively impacted my life.

My deepest gratitude is to my major professor, Dr. Ginette Ferszt. Your mentorship, guidance and support have made this an amazing and wonderful journey. Thank you for your selfless dedication and for embracing my passion for group work. You inspire me, Ginette. You have had the greatest impact on my journey, alongside me every step of the way. I am blessed to have you as my major professor. More than that, I am blessed to have you in my life.

I am deeply grateful to Dr. Donna Schwartz-Barcott. You encouraged me to reflect as a group psychotherapist in a way I never had previously considered in my career. I am so thankful to have had this opportunity. It has been deeply meaningful,

leaving a lasting impression on me both academically and professionally. Thank you Donna, for your depth and the profound impact you have had on my scholarly journey.

I would also like to acknowledge the additional members of my committee: Dr. Jasmine Mena, Psychology; Dr. Mary Leveillee, Nursing; and Dr. Grant Willis, Psychology. Thank you for all your support, dedication and participation in my work.

I have had the support of so many colleagues at Hasbro Children's Hospital. While there are too many to list, there are three colleagues I would like to name who have been intimately involved in my work. Ana Crook, my research assistant, thank you for your incredible work in interviewing these adolescents. There is no one I trust more clinically, than you. Angela Silveira, my office mate and colleague. For all the encouragement, the conversations, the ideas, the typing, your support in every way, every single day. Lastly, to Myra Edens, the administrative director at Hasbro Children's Hospital. Truly, a role model to our nursing profession. You have been so supportive, providing me the professional opportunity to attend this program over the past several years. Thank you Myra, for the countless scholarly dialogues and your vision. I look forward to our ongoing collaboration and future research endeavors.

Achieving this goal would never have become a reality if I didn't have the incredible support of my immediate and extended family. Truly, it has been a family affair. To my husband, Brad. Thank you for all the processing of my doctoral work and taking care of everything at home for so many years. Your unconditional love and support has meant the world to me. To my son, Brad Jr. We both "went to school together" for a very long time. Thank you for being patient, understanding and supporting Mom. I love you so much. You are my greatest gift from God.

The strength and encouragement of my two brothers, Joe and Dave (along with Lynn), have been a consistent source of support in this journey as well. Finally, to my parents, Lucille and Joe. You have been such an inspiration to me throughout my life. I have had so many opportunities because of you both. You have always enthusiastically encouraged me in all my goals and dreams. Thank you for your loving support as I pursued this goal. I am blessed to have the two best parents in the world.

Dedication

This dissertation is dedicated to my Dad. I have had incredible and countless opportunities throughout my life because of his hard work and sacrifice for his family. He has been the "rock" always, encouraging me and never wavering in his support of all my endeavors. Thanks for always believing in me, Dad.

Years ago, when I decided to move across the country to San Francisco, it was not a very popular decision in my family. Dad drove me to the airport. I remember the day vividly. Filled with emotion, he said to me, "In life, you need to let your children fly. Like birds, they will spread their wings and fly to far away places and have many journeys, but they will return one day, to the place they came from. They will return home." I'm home Dad. I'm here to stay, right along side you always. This accomplishment is dedicated to you. *I love you Papa.*

Preface

My interest in adolescent group psychotherapy began early in my career, more than 27 years ago. During the first year of my clinical practice, as a novice child and adolescent psychiatric nurse, I was offered the opportunity to co-lead a group for adolescents who were admitted to a child and adolescent locked psychiatric unit. At that time, I was quite overwhelmed and thought, "What would I do? What would I say? How would I get the patients to talk to each other?" Those initial anxious thoughts quickly faded as I sat in the room with the adolescents. During the first couple of groups, I was struck by the interactions among the group members. While the patients were diagnostically quite different and struggling with a variety of issues, they had a great deal in common and genuinely seemed to relate to one another. The heartfelt and thoughtful support and suggestions the adolescents offered each other was incredibly intense, and at the same time, so easy and natural. As I witnessed the powerful work that was happening in the context of the group setting, I found myself wanting to lead more groups as often as possible with the goal of providing help and support to patients using the modality of group psychotherapy. That initial impressionable clinical experience almost three decades ago has resulted in a career journey filled with the privilege and honor to have worked with adolescents in groups on inpatient units, partial hospital and day treatment programs, as well as on an outpatient basis.

Though the setting has changed over the years, along with the patients, the intense experience of sitting in a room with a group of adolescents and witnessing the interactions and the relatedness has not changed. As I reflect on the interactions, I am

reminded of the nonjudgmental understanding, support, suggestions, feedback, insights, questions, confrontations, and disclosures that have often surfaced during the groups. While adolescents are often struggling with different diagnosis, family issues, social issues, pressures and problems with school, alcohol and drugs, the commonality of struggling with mental health issues, experiencing emotional pain, of being misunderstood and feeling intensely isolated is what continues to uniquely bond them. Yalom (2005) refers to this phenomenon as universality, when members recognize that other members share similar feelings, thoughts and problems. Years ago, I remember a day after a group when an adolescent asked to talk to me privately about her group experience. She shared, "I just want you to know how much I love this group. I feel like I belong and the other kids get me. I don't feel invisible any more. I'm not alone." With her permission, I wrote down her comments at the time. I am often reminded of these words over and over again.

At this point in my career, I find myself still most excited about leading psychotherapy groups with adolescents. The "best hours" of my week continue to be when I am sitting in a room with adolescents engaged in group psychotherapy. I am passionate about group psychotherapy and its possibilities for adolescents. I have experienced the positive impact a psychotherapy group can have on its members. I have listened to the stories of the adolescents as they share with each other. So many adolescents with thoughts of suicide work through their sadness and hopelessness during the group, finding reasons to live. Some adolescents gain strength from the group with the goal of eating healthy after months of starving themselves. Still others experience interactions with peers for the first time in their young lives without being

bullied. Others share their journey of being transgender. Some adolescents disclose, for the first time, the horrific abuse they have endured receiving nonjudgmental support and validation that is wasn't their fault, and that they will get through it with the group helping and supporting them every step of the way. These are just a couple stories that have unfolded in the context of a safe and trusting group. I believe in the power of group psychotherapy where healing can happen and ultimately, change can take place.

As I entered into the doctoral program, during the very first class, the professor asked the students to "choose to investigate something you are passionate about in this doctoral program." Without hesitation, I immediately responded that I would pursue adolescent group psychotherapy, more specifically interpersonal adolescent group psychotherapy. I assumed I would find an overwhelming amount of research on the topic. This was not my experience. I have spent the last five years reviewing the literature and it turns out there is very little research on the topic on adolescent group psychotherapy. Moreover, I was particularly struck that the perspective and "voice" of adolescents as they experienced group psychotherapy, was just not present in the literature.

As a result of the lack of research on this topic, it was very clear to me what I wanted to pursue and investigate for my dissertation. I wanted to explore the experiences of adolescents attending group psychotherapy, in their own words. I was also interested in developing a better understanding of what was meaningful to them, and what they found helpful and beneficial. Lastly, I was interested in knowing if they

had suggestions for group psychotherapy leaders to help those of us who believe and

engage in this work.

Table of Contents

List of Tables

Chapter I

Introduction

Adolescence has been described as a period of change marked by significant physical, cognitive, emotional, social and moral changes (American Psychological Association, 2002; Blos, 1962; Erikson, 1968; Fisher, 2011; Garrison & Felice, 2009; Malekoff, 2014; Pojman, 2009). The primary developmental tasks of adolescence include separation from family, biological and sexual maturation, development of personal identity including a moral system or values, establishing independence or autonomy in society and preparing for the future (Christie & Viner, 2005; Garrison & Felice, 2009; Malekoff, 2014).

Although adolescence is part of normal development, it may also be a time of turbulence and risk taking behaviors (APA, 2002; Fisher, 2011; Malekoff, 2014; Pojman, 2009). The changes that take place during adolescence and the experience of getting to know oneself as well others, while at the same time developing a sense of personal identity and a place in world, can bring with it anxiety, vulnerability and challenge.

While it is a dynamic developmental time, adolescents are more at risk if they have low self-esteem, difficulty socially, impairment in interpersonal interactions, or are unable to trust others (Patel, Flisher, Hetrick & McGorry, 2007; Remschmidt, Nurcombe, Belfer, Sartorius & Okasha, 2007). Also, Patel et al. (2007) highlight that adolescents are more vulnerable to mental health problems if they have intellectual, learning, sensory or physical disabilities.

Additionally, when adolescents experience external pressures and conflicts with their family, peer groups, school or social organizations, and intimate relationships, they may have difficulty mastering normal healthy development (Fisher, 2011). For example, when adolescents are feeling as though they are "not fitting in," and are isolated from their peer group, or believe that their families "just don't get it," a sense of rejection may develop and significantly impact their mental health.

In general, the pressures and conflicts experienced by adolescents can sometimes be severe enough to result in serious changes or difficulties in their thinking, feelings and behaviors. Consequences may lead to anxiety, depression, anger, aggression, substance abuse and attempts to commit suicide. That being said, approximately 20% of adolescents meet criteria for a diagnosable mental health illness (Kessler, Berglund, Demler, Jin, & Walter, 2005; Merikangas et al., 2010). As a result of the significant adolescent mental health issues that exist, providing intervention is more urgent than ever before (Abbass, Rabung, Leichsenring, Refseth & Midgley, 2013).

Interventions can minimize impairments associated with mental health issues while supporting transition to independence and a healthy adulthood. Interventions may occur on an inpatient psychiatric unit, day hospital or outpatient basis and include individual, family, milieu and group psychotherapy.

While there are several psychotherapy modalities that adolescents may engage in, group psychotherapy is considered the ideal clinical modality (Aronson & Scheidlinger, 2002; Cramer-Azima, 2002; Garrick & Ewashen, 2001; Glodich & Allen, 1998; Kahn & Aronson, 2007; Kaminer, 2005; Leader, 1991; Malekoff, 2014;

Scheidlinger, 1985). This makes good sense as adolescents are taught in groups, live in groups and often play in groups (Bandura, 1989). According to Malekoff (2014), "Group work is an indispensible method for helping children to meet the developmental tasks and navigate the changing currents of adolescence" (p. 6).

Group psychotherapy approaches utilized with the adolescent population have historically been categorized as cognitive behavioral or psychodynamically oriented (Garrick & Ewashen, 2001; Reid & Kolvin, 1993). The cognitive behavioral therapy model assumes that adolescents develop cognitive misconceptions that may evolve into irrational beliefs as to how they perceive themselves, as well as others. Treatment is focused on identifying dysfunctional cognitions and developing a plan to change them. These groups are generally prescriptive, short term and more structured with specific content covered during each session (Brabender, Fallon & Smolar, 2004; Caplan, Usher & Jellinek, 2009; Garrick & Ewashen, 2001).

Process oriented groups such as psychodynamic and interpersonal, on the other hand, are less structured and often open-ended. Psychodynamic groups rely heavily on the principles of psychoanalytic theory and assume that maladaptive behaviors and beliefs are a result of unconscious drives and conflicts (Delgado, 2008; Garrick & Ewashen, 2001; Rutan, Stone & Shay, 2007). Countertransference and transference play an important role in psychodynamic groups as well.

Interpersonal group psychotherapy focuses on interrelationships, that is, the human interactions of group members and connections made in the group. In this type of group, adolescents share their thoughts and feelings as well as receive feedback from other adolescents. This is particularly relevant as adolescents are focused on

3

their peer group and seek to spend most of their time with their peers. The peer group is essential, important and very influential for adolescents. Hence, group psychotherapy is a natural "fit" for treating adolescents (Leader, 1991; Malekoff, 2014; Mishna, 1996; Pojman, 2009; Shechtman, Bar-El & Hadar, 1997; Tuckman, 1995).

Yalom (2005), an internationally known clinician and researcher, has made a major contribution to the therapeutic benefit that comes from the adolescent's participation in interpersonal group psychotherapy. He emphasizes that adolescents have a developmental need to "belong" to a group with their peers and proposes that within group therapy, there is an opportunity to focus on interpersonal interactions, to discover their peers and come to learn from others as well (Garrick, & Ewashen 2001; Kahn & Aronson, 2007; Reid & Kolvin 1993; Yalom, 2005). Yalom (2005) suggests that as connections are made among the members and interpersonal interactions take place in the "here and now" during the group, change can happen.

While research in cognitive behavioral group therapy has been robust, research in the area of process oriented group psychotherapy has been lacking (Pollock & Kymissis, 2001; Shechtman, 2007). More specifically, research with adolescents who engage in interpersonal psychotherapy groups is significantly sparse. Researchers have suggested that interpersonal group psychotherapy has received far less attention than behavioral group therapy due to the difficulty and challenge of measuring interrelatedness and the therapeutic factors (Pollock & Kymissis, 2001; Shechtman, 2007; Sugar 1993).

While it may be more challenging to investigate interpersonal group

psychotherapy, continuing to "avoid" it will only perpetuate the lack of scientific inquiry and studies conducted in this area. Perhaps, as researchers engage in and investigate interpersonal group psychotherapy with adolescents and share their findings, others will also be inspired to consider such endeavors.

Aim/Purpose of This Study

The aim of this research study was to address this gap in the literature by interviewing adolescents about their experiences of participating in an interpersonal psychotherapy group. The perspective of the adolescents was of prime importance for this researcher. Insights gleamed from the adolescents' interviews will be used to inform interpersonal group psychotherapists regarding helpful strategies that can be utilized in future groups with this population. The goal is that the information that has been revealed will have a positive impact on adolescent groups and ultimately contribute to the emotional health of adolescents who participate in group psychotherapy.

The next chapter begins with a discussion of normal adolescent development incorporating the work of key theorists who have made a significant contribution to this field. Given the dynamic changes that occur throughout adolescence and the impact on their mental health, the importance of providing support and intervention is addressed. The latter section of the chapter includes a discussion of research studies of interpersonal group psychotherapy.

Chapter II

Review of Literature

Normal Adolescent Development

Adolescence has been defined as the transitional time between childhood and adulthood (Garrison & Felice, 2009; Levey-Warren, 1996; Malekoff, 2014). It is a period that is heavily influenced by socialization and interpersonal interactions with peers (Erikson, 1969; Garrison & Felice, 2009; Meeks & Bernet, 2001; Sullivan, 1953). In essence, adolescent development occurs in the context of socialization with peers where friendships are extremely important.

Garrison and Felice (2009) lists this time as ranging from 10-20 years of age while the American Academy of Child and Adolescent Psychiatry (2011) identifies the adolescent stage ranging from 13-19 years of age. A number of authors have described three phases of adolescence which all have their own physical, psychological and social characteristics (AACAP, 2011; Blos, 1962; Christie & Viner, 2005; Garrison & Felice, 2009; Malekoff, 2014).

Early adolescents are typically 12 to 14 years old and are 7th and 8th graders in junior high school. This period is marked by strong peer identification; the early adolescent's best friend is usually a child of the same sex. Developmental changes including primary physical changes begin around 13 years of age, though changes can begin as early as the preteen years between 9 and 13 (APA, 2002; Christie & Viner, 2005; Garrison & Felice, 2009; Malekoff, 2014). For girls, this includes the first menarche and the development of breasts. For boys, shoulders broaden and voices deepen. These physical changes continue to develop for several years. During this

early phase, the emotional separation from parents begins (APA, 2002; Christie &

Viner, 2005; Garrison & Felice, 2009; Malekoff, 2014; Meeks & Bernet, 2001).

Psychologically, the young adolescent is a concrete thinker, though begins to think

about moral concepts. Additionally, the young adolescent may have vague or

unrealistic plans for a future career (Christie & Viner, 2005; Garrison & Felice, 2009;

Malekoff, 2014).

Middle adolescence typically begins at age 14 and extends to 16, when

adolescents are in the 9th, 10th and 11th grades (APA, 2002; Garrison & Felice, 2009;

Meeks & Bernet, 2001). During this period, girls are maturing earlier and faster than

boys in sexual development and achieve their adult height. Social relationships

revolve around a specific group of friends and many adolescents begin dating (Christie

& Viner, 2005; Garrison & Felice, 2009). During this time, adolescents become more

abstract thinkers and begin to think about issues related to morality. This is also a

time of increased experimentation and many firsts: first romantic relationship, first

driver's license, first real job, first substance use and sometimes, first serious rebellion

against parents or other authority figures (Christie & Viner, 2005; Malekoff, 2014;

Meeks & Bernet, 2001). Career plans may begin to take some shape, though they are

often not definite and may change frequently.

Later adolescence bridges ages 17 to 20. During this time period, the

adolescent is typically in the last part of high school and extends until a couple years

after graduation. The developmental emphasis during this time is on separation from

parents and development of social autonomy (Christie & Viner, 2005; Erikson, 1969;

Garrison & Felice, 2009; Malekoff, 2014; Meeks & Bernet, 2001). Emotional

investment in a significant intimate relationship with another person often develops during late adolescence. During this later phase, there is further development of personal identity and movement towards a more mature sense of self and purpose (Christie & Viner, 2005; Erikson, 1968; Malekoff, 2014; Meeks & Bernet, 2001). The adolescent, in this late phase, has the ability to think in a complex and abstract way (Christie & Viner, 2005; Garrison & Felice, 2009). Also, during late adolescence, a commitment to a general career interest or area occurs. Adolescents, during this developmental period, socialize with their peers to test out their freedom and explore their ideas (Erikson, 1968; Meeks & Bernet, 2001) as they integrate into the adult world around them. They rely heavily on each other as they begin to experience independence and establish their identity in society (Erikson, 1969; Meeks & Bernet, 2001; Sullivan, 1953).

While the developmental changes of adolescents are complex, most emerge with having achieved the maturational tasks of an increased sense of identity, a set of personal values, an increase in autonomy, an ability to engage in healthy relationships, and the capacity to make a contribution to society (APA, 2002; Erikson, 1969; Fisher, 2011).

Adolescents and Mental Health

Most adolescents are healthy and free of mental health issues (APA, 2002; Fisher, 2011; Merikangas et al., 2010). They are able to engage with their families and friends as well as participate in school and community/social organizations as they continue to grow and develop emotionally, socially and physically (APA 2002; Fisher, 2011).

However, today adolescents are living in an age of particular vulnerability as young people are facing increasing social and educational demands, experiencing the sexual awakening of puberty and experimenting with more freedom, autonomy and choice than in the past (Malekoff, 2014; Schwarz, 2009). This time of increased psychosocial vulnerability can be a time where either self-actualization or psychopathology can occur (Leader, 1991; Malekoff, 2014; Patel et al., 2007). Successful adolescent development can produce positive psychological growth, an increase in ego strength, self-esteem and self-confidence. On the contrary, when there is a failure to establish a sense of identity, confusion of one's sense of self as well as a low self-esteem can result (APA, 2002; Blos, 1962; Erikson, 1968; Malekoff, 2014). Adolescents who remain unsure of their beliefs and desires may often feel insecure with themselves and others which can impact their interpersonal relationships with family and friends, as well as their future.

Adolescence can be a time when mental health illness may surface if developmental needs are unattended to and not met (Erikson, 1968). The emotional, physical and social changes of adolescence may be a highly stressful time (Kirshner, 1994; Pojman, 2009) and can lead to adolescents experiencing problems that can negatively impact psychological functioning in the immediate future. Additionally, longer term difficulties including strained family relationships, problems with peers, poor school performance, involvement with the juvenile system, substance abuse and engaging in risky behavior can develop (Fisher, 2011; Haen & Weil, 2010; Kapphahn, Morreale, Rickert, & Walker, 2006; Malekoff, 2014; Schwarz, 2009).

Adolescent mental health statistics are disturbing. One in every four to five youth in the general population meet criteria for a lifetime mental health disorder that is associated with severe role impairment and/or distress (Merikangas et al., 2010). Infact, the prevalence of severe emotional and behavioral disorders is even higher than the most frequent physical illnesses of adolescence, such as asthma and diabetes (Merikangas et al., 2010).

Merikangas et al. (2010) conducted a national survey of 10,123 adolescents 13 to 18 years of age in the continental United States exploring mental health disorders of adolescents. The results of the survey were significant. Mood disorders affected 14.3% of the total sample and 11.2% were severe cases of mood disorders. Nearly one in three adolescents (31.9%) met criteria for an anxiety disorder with 8.3% meeting criteria for a severe anxiety disorders. The prevalence of attention deficit hyperactive disorder (ADHD) was 8.7% with three times as many males affected as females. Four point two percent of the adolescents met criteria for severe ADHD. Oppositional defiant disorder (ODD) was present in 12.6 % of the adolescents and 6.8% met criteria for a conduct disorder (CD). Substance abuse was present in 11.4 % of the sample that also included drug abuse/dependence and alcohol abuse/dependence. Behavior disorders were present in 9.6% of the sample. Finally, 2.7% of the adolescents surveyed had developed an eating disorder. These disorders were more than twice as prevalent among females as compared to males. These findings provide the first lifetime prevalence data on a broad range of mental disorders in a nationally representative sample of American adolescents (Merikangas et al., 2010).

A national and international literature review conducted by O'Connell, Boat and Warner (2009) found that an average of 17% of young people experience an emotional, mental, or behavioral disorder. The authors found that substance abuse or dependence was the most commonly diagnosed group for young people, followed by anxiety disorders, depressive disorders, and attention deficit hyperactivity disorder. Also, Kessler et al. (2005) found the onset for 50% of adult mental health disorders occurred by age 14, and for 75% of adults by age 24. These statistics highlight the prevalence of mental health issues of adolescents on a national and international level.

Group Psychotherapy as a Treatment Modality for Adolescents

As stated earlier, peer group interaction and belongingness are essential psychosocial needs of adolescents. In fact, most learning takes place as a result of social interactions (Erikson, 1968). Since groups are a natural setting for adolescents, it makes sense that group psychotherapy is an appropriate treatment approach for adolescents with mental health issues (Aronson & Scheidlinger, 2002; Cramer-Azima, 2002; Kapp, 2000; Leader, 1991; Malekoff, 2014; Mishna, 1996; Mishna & Muskat, 2004; Pojman, 2009; Scheidlinger, 1985; Sheppard, 2008).

The use of groups as a therapeutic treatment modality with children and adolescents first became popular during the 1940's. According to Reid and Kolvin (1993), the origins of group psychotherapy began with children and adolescents in the 1940's as activity groups were practiced by Slavson (1943) and Axline (1947) in inpatient settings based on psychodynamic principles. Lomonaco, Scheidlinger and Aronson (2000) also highlight the historical contribution that Redl (1944) made to the early groups that were practiced. The psychodynamic model was widely used by

Axline (1947), as well as others, in the treatment of children and adolescents in groups. Notably, at this time, the influence of Erikson and his theory of development also played a significant role in bringing adolescents together in group therapy (Lomonaco et al., 2000; Pollock & Kymissis, 2001).

Following the end of World War II, the emergence of several theories including operant learning theory (Skinner, 1938), cognitive theory (Beck, 1978) and social learning theory (Bandura, 1989) had a major impact on the next phase of the development of group psychotherapy (Pollock & Kymissis, 2001). By the 1990's, these therapies had taken hold and resulted in cognitive behavioral groups playing as strong a role in psychotherapy as did psychodynamically oriented groups (Reid & Kolvin, 1993; Pollock & Kymissis, 2001).

Today, the two primary types of group psychotherapy that continue to be practiced are classified as cognitive behavioral oriented groups and process oriented groups (Garrick & Ewashen, 2001; Reid & Kolvin, 1993). Behaviorally oriented groups generally include cognitive-behavioral group therapy, dialectical behavioral group therapy and psycho-educational groups. These groups typically have structured interventions and are often centered on a particular behavior, diagnosis or theme (Garrick & Ewashen, 2001; Pojman, 2009). They are often manualized, with certain topics covered during each group session. Generally, they are composed of a homogenous group of patients and are short term. The goal of cognitive behavioral groups is to support the members in changing how they think, feel and act (Garrick & Ewashen, 2001; Pojman, 2009).

Process-oriented groups include psychodynamic and interpersonal models.

The aim of psychodynamic group psychotherapy is to provide an opportunity for

personality change to bring about through nondirective free association during group.

Unconscious dynamics between group members are examined and personality change

can be achieved as the members work through new understandings of their thoughts

and feelings (Montgomery, 2002; Rutan, Stone & Shay, 2007).

Interpersonal group psychotherapy provides an opportunity for members to

explore their interpersonal interactions with other group members (Kline, 2003;

Montgomery, 2002; Pojman, 2009; Yalom, 2005). Through the repeated interactions

within the group, members learn about their interpersonal responses and distortions

that elicit negative responses and feedback from others and how to make

improvements leading to successful interactions (Garrick & Ewashen, 2001; Kirshner,

1994; Kline, 2003; Mishna, 1996; Mishna & Muskat, 2004; Rutan et al., 2007; Yalom,

2005). According to Yalom (2005), a key therapeutic factor, interpersonal learning,

occurs through the interactions that take place among the members during the group,

ultimately leading to change.

The interpersonal psychotherapy group provides an environment that supports

the opportunity for "here and now" interpersonal learning and a corrective emotional

experience (Aronson & Scheidlinger, 2002; Brabender et al., 2004; Kirshner, 1994;

Kline, 2003; Leader, 1991; Mishna, 1996; Montgomery, 2002; Rutan, et al., 2007;

Yalom, 2005). The "here and now" refers to a focus on talking about immediate

interactions and interpersonal patterns happening among the group members "in the

room, at the present moment" (Aronson & Scheidlinger, 2002; Brabender et al., 2004;

Kline, 2003; Leader, 1991; Pojman, 2009; Rutan et al., 2007; Yalom, 2005). The

corrective emotional experience provides an opportunity for peers to interact with other peers and receive feedback in a safe and supportive environment fostering new possibilities for change (Aronson & Scheidlinger, 2002; Leader, 1991; Mishna & Muskat, 2004; Pojman, 2009; Rutan, et al., 2007; Tuckman, 1995; Yalom, 2005)

Additionally, the interpersonal group acts as a social microcosm. That is, a miniature representation of each group member's social universe outside the group (Kline, 2003; Leader, 1991; Ormont, 1992; Rutan et al., 2007; Yalom, 2005). This miniature real life situation that occurs during the group provides an opportunity for group members to learn about and change behaviors (Aronson & Scheidlinger, 2002; Malekoff, 2014; Mishna,1996; Mishna & Muskat, 1998; Yalom, 2005). Ultimately, the newly learned and changed behaviors can be brought into the group members' real world, outside the group (Brabender et al., 2004; Pojman, 2009; Rutan et al., 2007; Yalom, 2005).

In interpersonal group psychotherapy, the therapist promotes interpersonal relationships and interprets interactions (Kirshner, 1994; Mishna & Muskat, 1998; Reid & Kolvin, 1993; Rutan, et al., 2007; Yalom, 2005). The group leader's use of self as a therapeutic tool is central in interpersonal group psychotherapy, and directly impacts the group environment and the work that occurs among the group members (Aronson & Scheidlinger, 2002; Montgomery, 2002; Phipps & Zastowny, 1988; Pojman, 2009; Tellerman, 2001; Yalom, 2005). The leader helps group members identify their needs and encourages group members to support and at times, challenge one another. The group leader's role is to build and maintain a therapeutic group climate (Kivlighan & Tarrant, 200l; Kline, 2003; Yalom, 2005). Ultimately, the

leader's role is to facilitate group cohesion while providing an emotionally contained and safe environment (Garrick & Ewashen, 2001; Kirshner, 1994; Mishna & Muskat, 1998; Rutan et al., 2007; Yalom, 2005).

According to Deering (2014), during group psychotherapy, members are able to give voice to their current experience and find others with whom they can identify. During the group process, adolescents connect with others who are dealing with similar problems. This experience of universality is powerful as adolescents begin to feel less isolated by their own condition and gain a greater sense of normalcy by sharing with one another (Aronson & Scheidlinger, 2002; Mishna, 1996; Pojman, 2009; Yalom, 2005). While thoughts and feelings are expressed and behavior is often learned during group psychotherapy, it is the peer feedback that is fundamental to the process that effects change (Leader, 1991; Mishna, 1996; Rutan et al., 2007; Shechtman, 2007; Yalom, 2005).   This feedback may lead to an improvement in social skills, a decrease in their sense of isolation and build self-esteem through feeling accepted by their peers and helping others (Aronson & Scheidlinger, 2002; Hoag & Burlingame; 1997; Malekoff, 2014; Mishna, 1996; Mishna & Muskat, 1998; Shechtman, 2007; Yalom, 2005).

Through interpersonal group psychotherapy**,** adolescents find a forum of peer support, gaining strength as they share their feelings and experiences with others who are facing similar issues (Aronson & Scheidlinger, 2002; Hoag & Burlingame, 1997; Malekoff, 2014). Some gain strength in seeing others in the same situation and feel less isolated, while others renew their feelings of self-worth by helping others (Mishna & Muskat, 2004; Sugar, 1993). Typically, the honest and raw exchange that is

experienced during group psychotherapy is the catalyst for change that impacts

adolescents and ultimately results in an improvement in their physical and

psychological health (Pojman, 2009; Yalom, 2005).

Adolescent Group Psychotherapy Research

A review of the literature began in September 2010 during this researcher's

doctoral coursework and continued through December 2014.   The data bases that

were searched included PsycArticles, PsycINFO, CINAHL, Web of Science and

Dissertation Abstracts using the key terms "group psychotherapy" "adolescent group

psychotherapy" "psychodynamic group psychotherapy" "interpersonal group

psychotherapy" "process oriented group psychotherapy" "Yalom's therapeutic

factors" "Yalom's theory" "qualitative adolescent group psychotherapy research"

"benefits of group psychotherapy with adolescents" and "history of adolescent group

psychotherapy." Only a limited number of quantitative and qualitative research

studies investigating adolescent group psychotherapy were found.

Most of the research studies to date related to group psychotherapy with

adolescents have been with cognitive behavioral groups and have reported positive

clinical outcomes (Baer & Garland, 2005; Garber et al., 2009; Habigzang et al., 2009;

Hayward et al., 2000; Hudson et al., 2009; Kaminer, Burleson & Burke, 2008;

Kastner, 1998; Ruffolo & Fischer, 2009; Wood, Trainor, Rothwell, Moore &

Harrington, 2001). In contrast to cognitive behavioral group psychotherapy,

interpersonal group psychotherapy is process oriented and often considered more

challenging and difficult to study (Pollock & Kymissis, 2001; Shechtman, 2007;

Sugar, 1993). Although clinical reports of interpersonal-psychodynamic groups have

also consistently described positive clinical outcomes, research examining process oriented group models is negligible and has been very rarely explored and examined.

The very first study using Yalom's theory as a framework in adolescent group psychotherapy was conducted by Corder, Whiteside and Haizlip (1981). This seminal work is the most often cited study in the adolescent group therapy literature. Corder et al. (1981) investigated adolescents' perceptions of Yalom's therapeutic factors. The adolescents in this quantitative study were given cards (Q sort) containing statements describing Yalom's curative factors and were asked to sort them from most to least helpful. The adolescents identified and rank ordered cohesion and universality as most helpful. The authors suggested that these results supported the importance of interrelationships among the group members.

Following the above noted study, a significant gap in the literature exists for the next decade until Chase and Kelly's (1993) study, in which the therapeutic factors that teens valued most during inpatient short term group therapy were examined. The thirty-three teens who participated in this quantitative study were administered a questionnaire based on Yalom's therapeutic factors. The teens most valued universality and cohesion. The least two helpful therapeutic factors were family reenactment and identification. Not surprisingly, this study has similar findings to the study conducted by Corder et al. (1981).

Bernstein (1995) conducted a yearlong case study of psychodynamic group therapy for inner city traumatized boys. The theoretical orientation of this study was a combination of interpersonal and psychodynamic theories. The purpose of the study was to illustrate and examine group processes, as well as explore the co-therapists'

17

(one male and one female) responses and challenges of conducting this type of group psychotherapy with children. This yearlong case study was the first of it's kind with this population and as result, made a significant contribution to the group psychotherapy literature. In the end, Bernstein (1995) reflected on the hands-on learning experience and meeting the needs of the boys who attended the group over the year using a process oriented model. The boys had positive clinical outcomes including a reduction in their aggressive symptoms and an increase in their ability to engage in therapeutic play and express themselves verbally.

In 1995, Abraham, Lepisto and Schultz investigated adolescents' perceptions of process group therapy and time limited group therapy. In this quantitative study, eighty two emotionally disturbed adolescent patients were surveyed living in a residential treatment center. The adolescents rated their perceptions of process and time limited group therapy. Ongoing process groups were rated as more helpful in relating to staff and establishing relationships with peers, while specialty groups were considered more helpful with cognitive, social and interpersonal skill development. Though the findings of both types of groups were identified as helpful in different ways, all participants preferred individual psychotherapy to work through their problems and issues.

Though not specific to adolescents, the work of Kivlighan, Multon and Brossart (1996) has made a significant contribution to the group therapy literature. This group of researchers developed the Group Counseling Helpful Impacts Scale (GCHIS), a tool that has been widely accepted and used to examine the presence of therapeutic factors in group therapy. These authors have conducted numerous

quantitative studies with the adult population using this tool that continued to suggest the helpful factors of group therapy which were categorized into four components: emotional awareness-insight, relationship-climate, others versus self-focus and problem identification. The tool is beginning to surface in quantitative studies with children and adolescents as well (Shechtman & Gluk, 2005).

In 1997, Hoag and Burlingame conducted a meta-analytic review of child and adolescent group treatment. This study reviewed 56 outcome studies between 1974 and 1997 examining the effect of group treatment with children and adolescents. A variety of group treatments were assessed including prevention, psychotherapy, counseling, guidance and training groups. Results demonstrated that the children and adolescents who received group psychotherapy treatment improved significantly more than wait list and placebo control groups. This is the only meta-analysis that has been conducted on child and adolescent group psychotherapy to date.

Over the past several years, Zipora Shechtman, another clinician and researcher, also made a significant contribution to the adolescent group psychotherapy literature using a process framework. She has conducted several quantitative research studies investigating Yalom's therapeutic factors in groups with children and adolescents. In one of Shechtman's studies (2003), she compared the therapeutic factors in individual psychotherapy versus group psychotherapy as well as outcomes regarding the reduction of aggression. The results revealed that the boys who had a history of aggression were more aware of their behaviors as a result of participating in group psychotherapy as opposed to individual psychotherapy. The boys who attended the group psychotherapy had a greater reduction in their aggressive behaviors.

Shechtman, Bar-El and Hadar (1997) conducted a mixed method study investigating the therapeutic factors in groups of adolescents who exhibited social and emotional difficulties. Using Yalom's eleven therapeutic factors, the researchers found that the three most significant factors were cohesion, catharsis and developing socializing techniques.

Eight years later, Shechtman and Gluk (2005) examined the therapeutic factors in children's groups. This study investigated children's perceptions of the critical incidents of the group process. It employed the Group Counseling Helpful Impacts Scale (Kivlighan et al., 1996) as well as recorded interviews. The results suggested that the children perceived the group relationship-climate as most important. The authors defined the group relationship-climate as similar to group cohesion.

Lastly, Mishna (1996) conducted a study with adolescents participating in interpersonal group psychotherapy. This is the only qualitative study found in the literature that specifically explored adolescents' experiences in this type of group psychotherapy. The purpose of the study was to identify and articulate therapeutic elements of the group as perceived by adolescents, all who had been diagnosed with a learning disability and related psychosocial problems. Mishna (1996) conducted one semi-structured interview with seven adolescents lasting approximately one and half hours. Although interview questions were not included in this article, Mishna described the focus of the questions. The participants were asked about the following: their understanding and experience of their disability, the reasons they came to the group; their experience of being in the group; roles of each member in the group; sense of self, trust and relating to others. The results suggested that the adolescents

found the group to be beneficial. The adolescents identified the interpersonal process (talking with each other) as most helpful. In the end, from the adolescent's perspective, the group enhanced their self- esteem, awareness and understanding of self and others, as well as their ability to relate to peers.

As evident from this literature review, Pollock and Kymissis (2001) highlight the need to conduct research in the field of adolescent group psychotherapy that could prove highly effective results in treating adolescents with various kinds of mental health issues and problems. Hoag and Burlingame (1997) report research regarding group treatment with children and adolescents has failed to keep up with the adult literature and investigation needs to continue to address questions and provide answers in this area. In addition, Sugar (1993) emphasizes that there is broad field awaiting research attention for adolescents who engage in group psychotherapy.

Pollock and Kymissis (2001), Hoag and Burlingame (1997) and Sugar (1993) concur with Shechtman (2007) who also strongly encourage researchers to conduct studies exploring groups to contribute to advancing knowledge related to child and adolescent group psychotherapy. More specifically, Shechtman urges researchers to conduct research examining process oriented groups. This researcher responded to the challenge by exploring adolescents' experiences in an interpersonal psychotherapy group. Benefits or outcomes of this group emerged from the data as well as the meaning of the group process for the adolescents. In addition, the adolescents provided insightful recommendations regarding physical space, group composition and group leader characteristics and style.

Chapter III

Theoretical Framework

"I have approached all of my patients with a sense of wonderment at the story that

will unfold."

Irvin Yalom, 1970

Irvin Yalom was born in 1931 to Russian emigrant parents. He grew up in a

very poor inner city neighborhood in Washington, DC.   From a young age, he was

always intrigued by human interactions and individual's telling their stories. He was

an extremely curious child and spent countless hours in the local library. He did well

in school and eventually decided to attend medical school, focusing on psychiatry.

After graduating from Boston University Medical School in 1956, he completed his

residency and fellowship at Johns Hopkins University. In 1962, he joined Stanford

University, where he has remained for his entire career that has included a significant

contribution to the theory and practice of group psychotherapy.

While the focus of Yalom's work has been on adults, his theoretical framework

applies to adolescents as well. Yalom (2005) believes that improving interpersonal

communication is a major focus for adolescents with emotional and behavioral issues.

In groups, adolescents learn to recognize and correct maladaptive interpersonal cycles.

The emphasis on interpersonal interactions is in the "here and now" which is

particularly relevant to adolescents as they can practice, in the moment, what and how

they communicate with others (Sullivan, 1953; Pojman, 2009; Yalom, 2005). The

group acts as a social microcosm for the adolescent's world outside of the group,

providing an opportunity "to practice" healthy interpersonal interactions. Yalom

(2005) also highlights that the group provides an opportunity for the facilitation of close friendships, an essential developmental need during adolescence (Erikson, 1969; Sullivan, 1953).

Yalom trained in the Sullivanian tradition. "Many of his notions are derived from that interpersonal orientation" (Rutan et al., 2007, p. 26). One can easily see Sullivan's influence in Yalom's work, particularly Sullivan's Theory of Interpersonal Relations (1953). Sullivan believed that the personality is almost entirely the product of interactions with other people. His theory emphasized the desire for all human beings to experience interpersonal relationships. Sullivan (1953) believed that disruptions in this experience may significantly impact the individual and lead to psychopathology. Further, he suggested that the need to be closely related to others is as basic as any biological need and equally important for survival.

In his discussion of adolescence, Sullivan (1953) suggested that true friendships are formed beginning around the age of nine or ten and move into adolescence. He referred to these friendships as "chumships" which pave the way for later healthy relationships (Aronson & Scheidlinger, 2002). Sullivan emphasized the importance of friendships and described friendships as offering consensual validation, bolstering feelings of self-worth, providing affection and a context for intimacy, promoting interpersonal sensitivity, and setting a foundation for romantic and parental relationships (Rutan et al., 2007; Yalom, 2005).

In summary, Sullivan contends "people need people." Yalom (2005) embraced this notion as he reflected, "People need people - for initial and continued survival, for socialization, for the pursuit of satisfaction. No one - not the dying, not

the outcast, not the mighty – transcends the need for human contact" (p. 24). This theme weaves itself throughout the fabric of all his work.

A Historical Description of Yalom's Framework

Yalom (1970, 2005) asserts that the major therapeutic change occurs in the context of group interaction among it's members and takes place in the here and now. A key assumption found in his first text and in subsequent revisions is that interpersonal interaction in a group is crucial. In his first text, *The Theory and Practice of Group Psychotherapy,* Yalom clearly states that the purpose of the book was twofold: to provide an approach to group therapy that could be used to train therapists and secondly, to describe the scientific basis of group therapy. He believes that training and research will shape the future of the field. He states that the approach to group therapy he describes is "based upon the best current scientific evidence" (p. 374). Further he states, "as continued investigation leads to new conceptualizations of the therapeutic process, the principles of therapy must be changed accordingly" (p. 374).

Yalom (1970) describes curative factors (Appendix A) as the central organizing guiding principles of his framework and the primary agents of change. These curative factors were derived from observations he had of individuals, their interactions and the group system (Rutan et al., 2007). The ten curative factors identified by Yalom (1970) include: Imparting of Information, Instillation of Hope, Universality, Altruism, The Corrective Recapitulation of the Primary Family Group, Development of Socializing Techniques, Imitative Behavior, Interpersonal Learning, Group Cohesiveness and Catharsis. The curative factors operate differently in a

variety of groups, depending on the goals and composition of the group. Yalom stated "groups with similar goals use similar curative factors" (p. viii), regardless of their form. However, Yalom highlights curative factors that are minor in one group approach may play a major role in another. Additionally, group members may benefit from different curative factors, all in the same group. The curative factors "represent different parts of the change process; some refer to actual mechanisms of change, while others may be more accurately described as conditions of change" (Yalom, 1970, p. 5). Though the goals of groups may vary depending on the leader and the group composition, change relies "heavily on the curative factors" (Yalom, 1970, p. viii).

Regardless of the theoretical orientation of the group therapist, "the actual mechanism of change in the patient in group with these goals is the same" (p. viii). While group leaders have their own specialized training and therapeutic approach, Yalom believes that each group therapist will master a style of facilitating groups that enhances the operation of the curative factors" (p. viii). That being said, Yalom (1970) also highlights the "therapist's sensitivity and his ability to convey empathy and positive regard for the group members are clearly influenced by training" (p. 379) and these qualities have an effect on all levels and types of change that occur in the group.

In his second revision of the text, Yalom (1975) highlights a couple of major additions. Most notably, an additional curative factor called the "existential factor" was identified and described. Essentially, this factor has to do with members accepting responsibility for their life decisions. The contribution of the existential

factor adds to the existing ten curative factors, now totaling eleven. Also, in the second revision, there is a more in-depth discussion of the role of the therapist and how the group therapist creates a therapeutic culture and "shapes an appropriate set of norms, or unwritten rules of behavior" (Yalom, 1975, p. viii). The therapist's task in the "here and now" is also given additional attention and consideration regarding the process and how this process effects change.

In the first and second editions of his text, Yalom referred to the mechanisms of change as the curative factors. However, in the third edition of the text, Yalom (1985) renames the mechanism of change as "therapeutic factors" rather than "curative factors." He acknowledges that psychotherapy's goal is not to cure, but rather to impact change and growth.

In the fourth edition (1995), Yalom made major revisions. He urges "clinicians to remain conversant with the world of research…..as one must know how to evaluate the research of others" (p. xiii). He notes that he has tried to rely on social and psychological research as he has continued to revise his framework, and urges researchers to continue to evaluate therapeutic modalities, identifying areas that have yet to be studied. Yalom goes on to say that "the truly potent therapy group first provides an arena for patients to interact freely with others, then helps them to identify and understand what is going wrong in their interactions, and ultimately enables them to change those maladaptive patterns" (p. xiv). In this revision, Yalom also discusses the concern he has with the advent of managed care and the new diagnostic system which could reward the use of efficient, prescribed and highly structured groups such as the cognitive-behavioral and symptom oriented groups. Again, he emphasizes the

importance of using the therapeutic factors, even in the more structured groups. Yalom does make some changes regarding the role of the therapist, now discussing the importance of addressing transference and transparency. He has addressed patient selection and group composition in light of the DSM IV. For the first time, he introduces the role that group psychotherapy can play on acute inpatient psychiatric units. Finally in this revision, Yalom has included educational requirements and teaching techniques that can be used in student education.

In the latest fifth edition of the text (2005), Yalom again reflects that as he has become more educated and humbled over many years, which led him to renaming of the mechanisms of change. "Hence, yielding to the dictates of reality, I now refer to the mechanisms of change as therapeutic factors rather than curative factors" (Yalom, 2005, p. xiii).

Since the publication of the first text and in all revisions spanning the past 35 years, Yalom highlights one of the most important underlying assumptions of group psychotherapy. He states "interpersonal interaction within the here and now is crucial to effective group therapy" (Yalom, 2005, p. xv). He suggests that the group provides an opportunity where members can interact freely with each other in the here and now. This, in turn, helps the members identify and understand what goes wrong in their interactions and ultimately supports them to change past maladaptive patterns. This allows for a corrective emotional experience supporting personal and interpersonal development. The ultimate goal is to impact positive change.

Further, he suggests that this underlying principle applies to all types of group psychotherapy, not just interpersonal groups. According to Yalom (2005), groups

that rely only on assumptions such as cognitive-behavioral or psychoeducational principles "fail to reap the full therapeutic harvest" (p. xv) and recommends that even such forms of behavioral group therapy can be more effective when incorporating an awareness of the interpersonal process. He proposes that while there are several types of group therapies that are practiced, focusing on interpersonal interactions and therapeutic factors are applicable to any type of group. His goal continues to be to "offer a set of principles that will enable the therapist to modify this fundamental group model to fit any specialized clinical situation" (Yalom, 2005, p. xiii). Yalom acknowledges the significant growth in the field of group psychotherapy that has emerged over the past fifty years as well as the multiplicity of types of groups. Specifically, he identifies clinical approaches that exist today include interpersonal, cognitive-behavioral, psychoeducational, gestalt, supportive-expressive, psychoanalytic, dynamic-interactional and psychodrama. He continues to contend that "the interactional focus is the engine of group psychotherapy" (Yalom, 2005, p. xvi) and that group therapy "ultimately enables them (group members) to change those maladaptive patterns" (Yalom, 2005, p. xv)

An Interview with Yalom

In an interview with Yalom conducted in 2007 by Shaughnessy, Main and Madewell, he reflected on group psychotherapy. He identified a significant change that has occurred in the field of group therapy since the early 1960's when he first began facilitating groups; the greater use of brief group therapy (8-12 weeks), particularly with more homogeneously composed groups. That is, groups of people who are put together because they share a certain type of issue such as an eating

disorder, anxiety disorder, or some other problem. He believes that this has real value, as patients can form an allegiance to the group more quickly if they are with people who have a like set of circumstances. However, he emphasizes that heterogeneity in groups can also lead to productive change.

Lastly, Yalom (2005) acknowledges that group psychotherapy has undergone several changes to meet the changes in clinical practice over the past several decades. As new diagnosis, clinical settings and theoretical approaches emerged, he believes group psychotherapy as a field has responded, and in fact, has responded well (Yalom, 2005).

Chapter IV

Methodology

The focus of this study was to explore adolescents' experiences who participated in an interpersonal psychotherapy group.

The specific research questions were:

- What are the experiences of adolescents participating in interpersonal group psychotherapy?

- To what extent is the group process meaningful to the adolescents?

- What do adolescents describe as the benefits of their participation in this type of group?

- What suggestions do adolescents have for group therapists who facilitate interpersonal groups that could be beneficial for its members?

Research Design

Qualitative descriptive research was the design of choice for this study. Qualitative descriptive research seeks to gain an understanding of the experience of individuals. This type of research is the method of choice when straight description of phenomena is the goal (Sandelowski, 2000). Qualitative description stays closer to the data including the words and events and is less interpretive than other qualitative approaches such as phenomenology or grounded theory (Sandelowski, 2000, 2010). Recounting of personal experiences that are significant to individuals can make a contribution to the building of knowledge and inform recipients of information (Marecek, 2003).

In order to continue to develop the most effective adolescent group psychotherapy approaches, it is important to understand the adolescents' experiences. In this study, the researcher sought to understand the perspective of the adolescents participating in an interpersonal psychotherapy group, how it was constructed and what gave them meaning. A qualitative descriptive study was an ideal method to support this inquiry.

Recruitment

Following approval from the Lifespan Institutional Review Board (Appendix B) and the University of Rhode Island Institutional Review Board (Appendix C), a recruitment flyer (Appendix D) was posted in a central location at an urban children's hospital that briefly described the study and the researcher's contact information. Recruitment flyers were also mailed to eight potential participants who had previously participated in outpatient interpersonal group psychotherapy in this setting in the past year. In addition to the flyers that were posted and mailed, the research assistant joined the last group of the series and explained the study. In this group, four were female and there were no males. Taken into account the flyers that were mailed as well the research assistant attending the last group (four members), the total possible potential sample was twelve adolescents, eleven female and one male.

When an adolescent expressed interest in being enrolled in the study, a meeting was scheduled with the potential participant, his/her parent(s) or legal guardian, the researcher and the research assistant to describe the study in detail and answer any questions prior to obtaining consent and assent. Of note, the participants and parents asked very few questions. The questions asked included: "How long will the

interview take?" and "If I participate in this study, will I be precluded from attending a future series of these groups?" The questions were answered directly. The parents were informed that the interview time would not be longer than one hour and participating in the study would not prevent someone from attending future groups. Once all questions were answered, consent (Appendix E) was obtained from the parent or legal guardian and assent (Appendix F) was obtained from the adolescent. At the time of the meeting, three of the participants were eighteen or older. For these participants, while their parents were also invited to join the meeting, the older adolescents, now young adults, consented (Appendix G) to participate in the study. While attending the meeting, participants also completed a demographics forms (Appendix H). The meetings took place in a private office of an urban children's hospital.

Participants

Since the aim of this study was to explore experiences of adolescents who participated in an interpersonal psychotherapy group, a purposive sample of ten participants were enrolled in this study out of a possible twelve (85%). All participants were adolescents, between the ages of thirteen and eighteen years old with a mean age of 15.75 years, who had participated in a psychotherapy group over a period of three months. Three participants were in early adolescence, four participants were in middle adolescence and three participants were in late adolescence. Of the ten adolescents who were enrolled in the study, four participants attended one 12 week group, four participants attended two different 12 week groups, and two participants attended three different 12 week groups. All the participants were female, nine

Caucasian and one Hispanic. The inclusion criteria of this study were any adolescent

who had participated in an interpersonal psychotherapy group in this setting and was

also actively engaged in individual therapy and ongoing medical treatment. The

participants had a range of diagnosis including: Major Depressive Disorder,

Generalized Anxiety Disorder, Post Traumatic Stress Disorder, Obsessive Compulsive

Disorder, Social Anxiety Disorder, Asperger's Syndrome, Autism Spectrum Disorder,

Seizure Disorder, Anorexia Nervosa, Bulimia Nervosa and Eating Disorder NOS. All

participants had had at least one inpatient hospitalization. All efforts were made to

include a diverse sample. A purposive convenience sample was used. According to

Sandelowski (2000), the goal of purposive sampling is to obtain cases deemed

information rich for the purposes of the study.

While ten participants were initially enrolled in the study, only eight completed

the interviews. One participant decided not to complete the interview when the date

drew near as she expressed concern that the interview may "trigger" what she had

previously worked on during group psychotherapy. She expressed worry that the

interview may negatively impact her since she had attended group when she was

painfully struggling and "not in good place." She acknowledged that although the

group had helped her, she did want to return to the hospital to be interviewed.

Another participant agreed to participate in the study and an interview date was set.

However, when the research assistant called to confirm the time, her phone had been

disconnected. The research assistant attempted to contact the participant a second and

third time, and again was unsuccessful. Also, a mailing was sent to this participant

and it was returned to the hospital stating "wrong address."

Data Collection

  Semi-structured, open-ended interviews were used in this study to collect data. An interview guide (Appendix I) was developed based on a literature review and this researcher's twenty seven years of experience conducting interpersonal psychotherapy groups with adolescents.

  Semi-structured interviews were selected because of their flexibility, fluidity and the opportunity to obtain the information required, yet at the same time, giving the participants the freedom to provide as many answers and explanations as they wished (Bernard & Ryan, 2010). This type of interview had a conversational style allowing the interviewer to use a topic guide and at the same time "encouraged participants to talk freely about all topics on the guide, and to tell stories in their own words" (Polit & Beck, 2012, p. 537). These semi-structured interviews allowed participants the chance to be the experts and to inform the research (Leech, 2002).

  The interviews were conducted at a time mutually agreed upon by the participant, parent or legal guardian, researcher and research assistant. A one time private (1:1) interview was conducted that lasted for a period of forty-five minutes to one hour. The interview was focused on the adolescent's experience of participating in an interpersonal psychotherapy group. The questions touched on different aspects of the group from the adolescent's point of view.

  The interviews took place in a private, large office on the fifth floor of an urban children's hospital. The fifth floor of the hospital included several offices as well as thirty inpatient pediatric general care rooms. The office was conveniently located a short distance from the elevator, before entering the area of the patient

rooms. It had a sitting area with several comfortable oversized chairs that were set in a circle. The office also had several floor to ceiling windows that allowed for an expansive view of the city. The office was decorated in calming colors and decor that lent itself to an inviting and relaxing space.

The adolescents were asked to choose a "pseudonym" for the interview to protect their confidentiality (Table 1). The interview was audiotaped and assigned a code number. The taped interview was professionally transcribed. A $25 gift card was offered as a thank you to each adolescent for taking the time to complete the interview and a free parking coupon was also offered for use in the hospital visitor parking lot.

Training of the interviewer (research assistant) is based on the prior experience and familiarity of the research process (Polit & Beck, 2008). For this study, training took place over a number of weeks. Since this research assistant had fifteen years of experience working with adolescents in diverse psychiatric settings, she was comfortable with this population and with the interviewing process. Initial training of the interviewer was conducted by this researcher and the chairperson of her dissertation committee. The interview questions were reviewed and a mock interview took place. After the first participant was interviewed, the chair of the committee listened to the audiotape and feedback was given to the interviewer.

Data Analysis

The transcripts of the interview data were analyzed using qualitative inductive manifest content analysis. Qualitative content analysis is the analysis of choice in qualitative descriptive studies (Elo & Kyngas, 2007; Hsieh & Shannon, 2005;

Sandelowski, 2000). Since this researcher was especially committed to hearing the voice of the adolescents, manifest content was utilized in order to stay close to the text. Although there are different approaches to content analysis, each author emphasizes a systematic approach (Elo & Kyngas, 2007; Graneheim & Lundman, 2004; Krippendorff, 2013; Schreier, 2012) consisting of the following steps: formulating the research questions, selecting the sample, determining data collection approaches, coder training, coding the data, or in this case coding the texts from the transcribed interviews, implementing the coding process and analyzing the results of the coding process. This circular process occurred a number of times. Even after reviewing the initial findings, this researcher returned to the interview texts and made further changes.

The analytic process began with this researcher listening to the audiotapes while reading the transcript to check for accuracy of the transcription. The researcher and the chair of her committee coded the transcripts separately and then compared their coding. Minor changes were made if differences were found until there was 100% agreement. Codes were then collapsed into overarching categories that reflected the major topics that emerged from the data. The transcripts were repeatedly re-read a number of times as this analytic process continued. Once all of the overarching categories were determined, direct quotations were taken from the transcribed interviews to provide rich descriptions from the adolescents' perspectives and related to each of the research questions.

Ethical Considerations

When interviewing adolescents with active mental health illnesses, several issues that need to be carefully considered including obtaining consent, confidentiality and clinical history/presentation. The essential ethical principle of research with humans is that participants freely volunteer to participate in the research. Potential participants must know enough about the research so that they can make a decision to proceed or not to proceed (Seidman, 2013). Meeting this standard is the underlying logic of informed consent. During the initial invitation to participate in the research being conducted, the interviewer emphasized that the adolescents would not receive any different treatment if they decided not to participate. The adolescents needed to be assured that there was no consequence if they choose not to participate in the research.

Since adolescents are minors, the consent of the parent/legal guardian was needed, along with the assent of the adolescent to participate in the research. The interviewer was prepared to spend as much time as needed with the adolescent and parent/legal guardian so that they had a thorough understanding of the research project and interview process. Many of the adolescents who participated in the interview had complex psychiatric illnesses, therefore the interviewer had been thoughtful about explaining the research project in basic terms that made sense to the adolescent.

In addition to consent and assent, the issue of confidentiality was addressed. The participant always has the right to privacy (Polit & Beck, 2012; Seidman, 2013). The interviewer explained to the participants that they would not be identified by name. Their identity was protected. It was important that the interviewer shared with

the adolescent and their parent/legal guardian the steps that would be taken to protect their identity.

When discussing confidentiality with potential participants, the limits of confidentiality were explained. The interviewer needed to be clear and direct with adolescents about the limits of confidentiality including the possibility of a subpoena as well as mandated reported requirements. Research information is not privileged and is subject to subpoena by the courts. Adolescents were informed of this during the consent process. This may be an issue for some adolescents if they are involved in illegal activities such as using/selling illegal street drugs, stealing, and prostitution, to name a few.

The other limit of confidentiality was related to child abuse or neglect that may be disclosed during the interview. If the adolescent shared any type of abuse, the interviewer was mandated to report it to the appropriate authorities (such as the Department of Children, Youth and Families, and law enforcement officials). Again, this needed to be discussed with the adolescent when the initial explanation of the research project was presented and before informed consent/assent was obtained. There were no discussions or disclosures of child abuse or neglect by any participants.

An additional issue that needed to be considered related to interviewing adolescents with active mental health problems was the interview itself may trigger difficult and sensitive topics for the participant. In this study, adolescents were asked to share their experience of group psychotherapy. The adolescents could discuss sensitive topics in response to the questions. It was possible that this could have led to emotional distress during the interview. Therefore, the interviewer was prepared to

38

provide psychological support if the interview created or raised psychological distress. In addition, all of the participants had to be in individual psychotherapy in order to be eligible to participate in the study. There were no incidents of emotional distress with any participants during this study.

In qualitative studies where difficult and sensitive topics may surface, process consent is a strategy that is used (Polit & Beck, 2012; Speziale, Streubert, & Carpenter, 2011). In process consent, the interviewer engages in an ongoing process of negotiating consent with the participant, allowing the participant to have a collaborative role in the decision making process regarding their continued participation. Process consent occurred throughout the interviews. The participants were also informed if at any time, during the course of the interview, the interview could cease at their request.   These strategies were employed in this study as a way to manage distress that could surface during the course of the interview. None of the participants presented with or reported any distress.

Lastly, a couple of additional considerations in interviewing adolescents included the location and timing of the interview. The interview took place in a comfortable, private and safe environment. The length of the interview did not exceed one hour with breaks built in as needed. As a final step, the interviewer processed the interview at its conclusion with the adolescent to bring closure to the interview experience.

Trustworthiness

Lincoln and Guba (1985) are well known for describing the essence of, what is referred to in qualitative research as, trustworthiness.   In qualitative inquiry, the

researcher bears the responsibility of using a number of strategies that increase the probability that the findings are credible. These authors identified and described in detail the importance of establishing trustworthiness.

Qualitative research is trustworthy when it accurately represents the experience of the study participants. According to Lincoln & Guba (1985), trustworthiness of a research study is important in evaluating its worth and includes establishing credibility, transferability, and confirmability.

Credibility refers to the confidence in the truth and interpretation of the data (Lincoln & Guba, 1985; Polit & Beck, 2012). In other words, there must be confidence in the findings. This can be achieved through activities that increase the probability of true and credible findings (Lincoln & Guba, 1985). Establishing credibility in this study included inviting adolescents to participate in this study who had attended interpersonal psychotherapy groups since the purpose was to explore the experience of teens in this type of group. Selection of the appropriate participants was the one of the first steps in achieving credibility. Selecting semi-structured interviews as a data collection method was the most appropriate method as it provided specific questions, and at the same time, provided an opportunity for the adolescents to describe their experience in their own words. Selecting the most appropriate method was an additional step in establishing credibility.

Prolonged engagement with the data was another way credibility was established (Lincoln & Guba, 1985). This researcher listened to the interviews several times for accuracy, read and reread the transcripts over several months. Additionally, according to Graneheim & Lundman (2004), one way credibility is established is to

"select the most suitable meaning unit." Meaning units include words, sentences and paragraphs of containing aspects related to each other. This was achieved, as numerous direct quotes from the interviews were transcribed verbatim and were included in the findings.

Transferability refers to the probability that the findings of the study have meaning to others in similar situations. In this study, transferability was achieved as very specific descriptions were provided regarding the selection and characteristics of the participants, how the data was collected and how it was analyzed. These details, along with thick descriptions of the text, enhanced transferability. According to Polit & Beck (2012), transferability cannot exist unless researchers provide detailed information. Verbatim quotes from participants contributed to the authenticity and vividness of this qualitative study.

Confirmability refers to the potential for agreement between two or more independent people about the data's accuracy, relevance or meaning (Polit & Beck, 2012). This researcher and major professor read the interviews separately several times to obtain a sense of the whole. In addition, peer debriefing was a strategy employed. Two members of the dissertation committee met and discussed the transcriptions of the adolescents' interviews.

Lastly, an audit trail, which records the activities of the entire research endeavor over time, was followed by another individual (Lincoln & Guba, 1985; Polit & Beck, 2012). From the very beginning of this study, all documentation including the application to the IRB, the approval letter, participant recruitment process, raw data (tapes and interview transcripts), data analysis and findings of the study was

audited. Accurate documentation has been kept throughout all steps of the study and is available for review.

Chapter V

Findings and Discussion

The purpose of this research study was to explore the experiences of adolescents who participated in an interpersonal psychotherapy group. The results of this study are based on semi-structured interviews with eight adolescents who participated in a one hour interpersonal psychotherapy group on a weekly basis for a period of three months. The group was facilitated by an expert clinician with twenty-seven years of experience facilitating groups with this population. The specific research questions were:

- What are the experiences of adolescents participating in interpersonal group psychotherapy?

- To what extent is the group process meaningful to the adolescents?

- What do adolescents describe as the benefits of their participation in this type of group?

- What suggestions do adolescents have for group therapists who facilitate interpersonal groups that could be beneficial for its members?

Discussion of the results is presented in the order of the research questions.

Experiences of Adolescents

The descriptions, meaning and impact of the experiences of the adolescents who attended the interpersonal psychotherapy group were woven throughout the interviews in response to different interview questions. Some of the most striking comments were:

When we were in group, it was fantastic…I got a lot from it… I took

advantage of it and made sure that it got me really strong and on a

really good path. I thought the group was amazing and ever since then

I have had challenges I have had to face (Katherine).

In terms of the actual people that were there, we were all kind of on the

same journey of recovery, whether we wanted to be or not…this is a

safe place where, you know, we are all in the same kind of special

situation (Alex).

The first interview question specifically asked the adolescents to "think about

their participation in the group over the past three months, and describe in as much

detail as possible about being a member of this group." The participants described

their experiences as follows: the group as a gathering of hope; the group as a source

of support; the group as a place where one can talk; the group as a collection of

people; and the group as a place to get help. Alex described her experience as a

gathering.

I could call it like a gathering, it's almost kind of like a gathering of

hope. Because you kind of, you gather together and you all kind of

have the same, you're all kind of on the path to recovery, so you're all

kind of aiming for the same goal and recovery is defined differently

for everyone but you take very similar steps in getting there.

Two group members referred to it as a support. Katherine stated *"I would say*

support group...with the definition of being able to make friends and really get to

know people that understand you and can help you and it's probably one of the best

things you can do." Brianna described the group as:

> A form of support…I feel like being in a group where you talk about
>
> your feelings and not be judged. Just knowing the fact that other
>
> people can relate to you in situations and they can support each other
>
> during difficult times and you know, relate to different struggles that
>
> you've been through…once again feeling support.

Three of the group members described it as "a place." Scarlette stated, *"It's a place where you can talk about how you feel or experiences that you can share to help other people or even a place where you gain knowledge and have it help yourself."* Rose also referred to it as place. *"It's a place where you can talk about pretty much anything you want with people who get what you're going through."* Ivan described it as:

> A place where you go to get help with your problems and it makes
>
> you feel a lot better about things and like you can talk about stuff you
>
> wouldn't normally be able to talk to with your friends or parents or
>
> anyone else.

Marsey reflected that group therapy was *"A collection of people who have experienced things that are similar but not exactly the same, that kind of offer different perspectives on whatever you are facing and help you through whatever you might be going through."* Lastly, Agatha's description was *"you get help with a certain problem, you can talk privately with a group, kids your age, and you get the help that you need."*

These descriptions in the adolescents' own words underscore their experiences. It was not surprising that the adolescents described the group as a place where they can talk, receive support and get help. The adolescents often identified how helpful it was to talk with others about the thoughts and feelings they held inside themselves. Additionally, they described the support and being listened to by their peers as extremely beneficial and helpful. It was not unusual for the adolescents to express feeling truly heard for the first time by others who "totally got it and totally got them."

The Experience of Group Therapy as a Process

When asked to describe more about their specific experiences, the participants did so as though it was a process that evolved over the 12-week sessions. All eight participants focused on what was actually happening during these sessions.

Feeling nervous (beginning phase). In the first one or two group sessions, the participants identified feeling more uneasy. As they became more comfortable, they began to connect with each other leading to meaningful interactions on a variety of topics. One of the topics in the first couple of group sessions that emerged included their experiences of attending school and feeling as though their peers and teachers did not understand their issues. Another popular topic was the conflict the adolescents were experiencing at home with their parents and siblings as a result of their struggles and feeling unsupported.

The initial session was quite anxiety provoking and a sense of "not knowing what to expect" was a shared feeling. Scarlette captured this well when she said, "*I was kind of nervous because I really didn't really know anyone and it was kind of nerve racking because I never really was in groups.*" Katherine felt similarly stating,

"I was pretty nervous, I didn't know like anything about it. I was afraid that it would trigger stuff but I was also hopeful that it would help me a lot because I heard that it would." Rose stated, *"I didn't know what it was gonna be like or what I was gonna get out of it."* Marsey shared similar feelings too. *"I didn't really know what to expect."* Agatha also talked about feeling uneasy at the first group meeting. *"Since I didn't really know many of the people there, it was kind of a little hard to talk and I kind of didn't want to speak much about it until I actually got to know people."* Ivan described feeling nervous too. She stated, *"Kind of scary...made me really nervous...the first day I did talk, but it was just like really awkward...everyone just went through how they ended up in group and like what happened with their...conditions."* In reflecting on the first group, Alex stated, *"It's okay to feel kind of nervous and anxious and scared...my first group intro...getting to know people who are walking the same life that I was and walking the same path."* As evident from the participants, at the time of the initial session, all felt somewhat nervous and uncomfortable.

Settling in and sharing (middle phase). Somewhere between the second and fourth session, all eight participants described beginning to feel more comfortable with the group as they spent time together. Brianna stated:

> By the end of the second group, we were all talking like we've known each other for years, so it's definitely being able to gain their trust and you know, kind of deepen the conversation and share like past experiences. We would say what we were struggling with to each other.

Alex stated, *"After my first group, like we all just showed up in sweats and we'd all just get comfy."* Safety and trust began to develop and with that, the group members began opening up to each other, expressing their thoughts and feelings. Agatha stated:

The first day was a little bit uncomfortable but as it went along into the sessions, it started to be more comfortable because we bonded as a group…It was around the third or fourth session where after I kind of got an idea of everyone else in the room. I kind of felt like I could speak up.

Agatha shared that this was the first time in her life she connected with peers and could freely express herself without feeling bullied by others. *"It's like really open, so you can say whatever you want to say without feeling that people will react badly to you."*

Scarlette commented on becoming comfortable after the first couple of group sessions. *"Maybe like the third time being there…everyone started to get to know each other a little bit better after talking about things."* Marsey shared, *"It didn't really take too long for everybody to kind of get accustomed to each other in a way…There's sort of a level of trust that is established."* Katherine described the safe environment as important in the group process. *"It felt like a safe environment where you could talk and like know you weren't judged, you weren't being watched like you know, so you felt very okay to talk about things."*

Deepening connections and sharing (continuing middle phase). As the group progressed from week to week, the participants talked a great deal about their

48

connections with other group members. They also shared their thoughts and feelings with each other and they became more personal as the weeks went on, exposing vulnerabilities and taking chances sharing with others some of their deepest fears. The connections continued to deepen.

The adolescents began sharing with each other, supporting each other, gaining insight from one another, challenging each other and at times disclosing to one another. Brianna highlighted the importance of relating with peers. She stated:

> It was really important that I had someone to talk to outside of school
> and hear what they had to say and what opinions they had on their
> issues…I was feeling alone so it was really important for me to really
> trust others to understand what I was going through and being able to
> support them as well as being able to support myself.

The connections and relationships the group members formed with each other were intensely moving. Alex spoke about *"sitting with like minded people and having the same goal…but if you sit with like minded people and have an alternative goal, you're just clashing gears."* In reflecting on the connections she made in the group, Alex also stated:

> We understand how much pain you are in. We don't feel it, but we feel
> our own pain and from that we can feel your pain and we can say it's
> okay, like let's talk about it and let's talk about some ways in which we
> can move on.

Rose added*, "I like the connection that you make with other people…we ended up becoming close because of what we shared."* Ivan, who has a history extreme

difficulty in communicating with peers, also talked about the connections she made in the group. *"I felt like other people were also dealing with it and I felt like I wasn't alone and we would usually share what we did that would help overcome our struggles."* Alex reflected on the connection she had formed with the others girls. *"We were all kind of on the same journey of recovery…this is a safe place."* Rose said it simply, *"People feel better…connecting with people."* Lastly, Marsey stated, *"There's sort of a level of trust there that is established…you form this connection with them because you're seeing them give their soul to you."*

Marsey also commented on the closeness of the group members stating, *"You become friends so quickly and get to know each other quickly and you can say anything…you feel comfortable with one another."* Ivan talked about the closeness that developed with the other group members and caring about how they were doing. She stated, *"like to see how they are doing and make sure they were getting better…I know I care about other people a lot and then I don't want to see them do bad or have bad things happen to them."* In fact, Ivan described thinking about the girls and their well being in between sessions as well.

Nearing the end (end phase). At the end of the 12-week group sessions, the participants expressed mixed thoughts and feelings. As the group series neared the end, several members began to process how it felt that it would end soon. Once in a while, one of the group members would spontaneously say something like *"I don't want the group to end. Can we just keep it going forever?"* During the interviews, six participants described this end phase of the group as being filled with mixed emotions.

Rose stated, *"I felt like I was gonna miss talking to people and having like a structured group every week."* Katherine stated:

> I felt it was a bittersweet feeling because I felt that I was ready to move
>
> on…I didn't want to because I would miss all the girls and I would miss
>
> Susan…I would miss it all so much and it was a great routine and I got
>
> to do it after school.

Marsey felt similarly stating, *"I didn't want it to end. I guess because I mean I've gotten use to seeing everyone…all these people every Tuesday…it was sad."* Agatha stated, *"It was kind of a little upsetting because I kind of grown onto the group and growing up, I wasn't a big fan of being in groups because of my autism."*

Benefits of Group Participation

During the interview, the participants were asked "What they had hoped to gain from the group and did that occur?" The participants responded to this question by describing the benefits of participating in the group generally or specifically. For example, Brianna responded, *"Overall the experience was very helpful…an experience where you can gain support and just trust overall."* Alex stated, *"It was beneficial to be with people who wanted to share."* For some group members, they felt less alone and less isolated as a result of their group experience. *"It's like this layer of loneliness disappears because you're now able to communicate."* Katherine stated, *"It was awesome. The first time ever I could talk to someone who had the same mindset as me…group was fantastic."* Agatha also described the overall benefit in attending the groups.

> It helped me get out of my shell a little but more… I mean in my

opinion, if I never went to group therapy I would probably still be

in a tough situation. Like I probably wouldn't be where I am. I

would probably still feel depressed or stressed.

Rose also gave an insightful response:

I understand people better because you don't really know what

everyone's story is and like you can see people and judge them and

then like when you're in group you find like all these things, like

everyone has something they are dealing with and so you're kind of

more careful to think about like judging someone.

Communication and Friendship. Several group members identified specific

benefits, or outcomes, of attending the group, such as an improvement in their ability

to communicate with others and relate to others as a result of attending the group.

When asked what she learned and accomplished in group, Rose stated, *" I think being*

able to relate to people more." This was particularly significant for Rose since it was

extremely difficult for her to be in social situations with other people and make

friends. Marsey, who also struggled with developing friendships, stated, *"I made*

friends because of the group." As did Alex, *"You automatically gain this social*

interaction of people who get it…you develop friends in the group." While some

group members commented on the positive impact of communication with peers and

developing friendships, Alex also identified an improvement in her communication

specifically with her Mom as a benefit of the group. She stated, *"I was then able to go*

home and say things to my Mom, and you know I'd never been able to say that

before." Alex elaborated that she wasn't particularly empathic in the past and now

felt differently. *"I'm able to look at people and have this empathy for them that maybe they're going through something…something similar that contributes to the same self hatred and self loathing that I felt."*

Skill Building. In addition to an improvement in communication and developing friendships as benefits of group psychotherapy, several group members identified specific skills they learned such as journaling. Katherine discussed journaling and stated, *"It was an awesome idea. She gave us each a journal and we wrote whenever we had an issue. We would talk about and would see how we felt …journaling was fantastic."* Ivan identified the support of the group members as extremely beneficial and it became a coping skill. She stated:

> I usually remember some of what the group members said that helped so it's if it's like a bad day…I remember what they say and I'll think of one of those things to get my mind off of it and I don't end up doing anything I'll regret.

Katherine also identified the support of the group as a coping skill she incorporated into helping her in the "outside world" when feeling challenged. She stated, "*Every time I come to one of those challenges, first off, I think what would my friends say from the group and what would Susan say?"* She found this very helpful during the week between groups and at the time of this interview, reflected that she continues to think about what the group would say when she is struggling and having a difficult time. *"Group was amazing and ever since then I have definitely had challenges that I had to face, but with the things that I learned here"* she has found that she continues to stay on track and make healthy choices.

Recommendations for Future Group Leaders

In order to elicit recommendations from the participants the interviewer stated: "Try and imagine yourself talking to a large number of group therapists that want to improve the groups they facilitate for teens. What you have to tell us will help make our group therapy better for teens in the future."

In describing their own experiences, all eight participants talked specifically about the space and some of the details of the room, the composition of the group and characteristics of the group leader.

Physical space. The participants talked about the importance of a comfortable private space, "a place where you can speak your mind." Agatha captured this well:

> You kind of want to make sure that you keep the kids in a comfortable environment. I feel like a place where it's secured and they become comfortable with what they have to say…you can tell them that this is a place where you can speak your mind. You don't have to worry about anyone knowing about this. You don't have to worry anything like spreading out on things like Facebook or Twitter.

Rose stated, "*It was nice cause you could see out the window…and the chairs were comfortable, so it wasn't like being in a hospital setting.*" Katherine felt similarly and stated, "*The seats were really comfortable…the air conditioning was really good because this was summer…I liked the view of Providence.*" Scarlette also commented on the physical space. "*It was set in a circle with arm chairs. Wasn't too tight of a circle, but there was enough space to have your own area.*" Brianna commented on the space too. "*I was always comfortable in it…it was definitely private.*" Marsey

injected humor as she commented on the physical space. *"I think I was expecting…the movie, you see like this giant gym with all these chairs around…but it was just like this little office where all these chairs were around…it didn't feel claustrophobic…it felt comfortable."*

Group composition. The participants also talked about the importance of the size and composition of the group. They identified the optimum number of group members as 4-6. Alex stated, *"You kind of have to watch the sizes of the groups. Because if you have a group that's too big, then you're just kind of lined up with all of this chatter."* Scarlette also mentioned the size as being an important consideration. *"I would say maybe have a limit of how many people can be there….me personally, I don't like a lot of people."* Rose commented on the size of the group too. She had attended three series of groups, the first with ten members, the second with three members and the most recent one with five members and felt it was a more positive experience. *"It was better with 5 people…when there were more people, I felt like a lot of people didn't get to say what they wanted to say."* Marsey also commented that she preferred a smaller group.

> There were a few girls who came to the first session and then never came back so it ended up only being four us the first time…it was nicer too because then you only had this group of people who stuck it out, you know.

Two group members, Rose and Scarlette, commented that the age spread of 13 to 18 years old felt too wide of a range. Interestingly, Rose was the oldest group member. She stated, *"Like I was older and then there were some people who were 13.*

I think it was a big difference…between just a 13 year old is a lot different than like a 17 year old." Scarlette, on the other hand, was the youngest group member of the series she attended. She also identified the age range of the group members as being too big and this impacted her experience. *"At that time, I was younger…they were all older than me and I didn't get a real good connection with any of them."* Notably, while she didn't feel connected to other group members specifically, she still felt positive about the group process overall. *"I felt it was a good experience to go through…it helped me a lot."*

Several group members also highlighted another factor regarding group composition. They expressed that adolescents should only attend the group if they want to be there, as opposed to being forced to participate. Rose stated, *"Like the first group there were a lot of people who didn't want to be there, and when they stopped coming it was more productive…I think it's helpful for people who want to be there."* Ivan also shared this feeling. She stated:

> I could say if you can tell the kid doesn't want to go and the parents push them to go it's not going to work out well because you want to go to group because you want to go yourself and you want to go there to get yourself help…you won't get anything out of it if you don't want to get anything out of it.

During her interview, Scarlette agreed that it was important for adolescents to attend that wanted to be there. She went on to say, *"It's important that the group leader be aware of the reason a group member is not talking during group. It may be that the adolescent really doesn't want to be there,"* she offered. However, it may be

they are just quieter, and do want to be there. She stated, *"Even if a person isn't talking, they should still have an opportunity to be in group, even if they are just listening. It gives them an opportunity to hear other people's experiences."*

Characteristics and style of the group leader.   In order to elicit information about the participants' perceptions of the group leader they were asked: "What can you tell me about the group leader? Was there anything that she said or did in the group that you found helpful? Not helpful? If you could make any suggestions to her right now, what would you say?"

The participants described several characteristics of the group leader such as upbeat, energetic, positive, happy, friendly, honest, sensitive, nonjudgmental, nonconfrontational, empathetic, understanding, being laid back, wanting to help and a willingness to listen as beneficial. Brianna shared several thoughts about the group leader's style.

> She'd kind of find a way to just lay it down and let the group sort of go
> around talking about it and then she related it to other people's
> ideas…She seemed to understand so much of it… really she would just
> help us communicate…She was laid back and that's what made it really
> easy to talk…she was a better listener and that's important to me so I
> was definitely able to trust her…she was sure to ask the right questions
> in the right form so it definitely made me feel like I was talking to
> someone I could trust…Susan definitely fits the definition of someone
> who truly took responsibility and was really wanting to help us.

Alex reflected that the group therapist had an impact on the mood of the group and was also a resource for the group members. She stated:

> Her entire presence set the mood…we were able to see her as like this resource and this person who wants to hear us share and then shed positive light on it…she was actually able to really understand what was happening with us, what was happening internally with us and she was able to put a lot of things into words, which we couldn't find the words for.

Rose identified several characteristics of the group leader that she also found helpful.

> She's very empathetic with people… and can understand what is not helpful for some people…it was helpful that she was like honest...she became a part of the conversation and like it just felt easy to talk to her…she's not judgmental either…she's upbeat and energetic and positive.

Scarlette was also quite detailed in describing the group therapist and the importance of engaging the group members.

> She was a good group leader because she kind of brought us out…she was always happy and she tried to get everyone to participate, so she wasn't just sitting there waiting for someone to talk…she was always smiling so that was a good thing…it made everyone more positive…she wouldn't wait for someone to bring up a topic…she would bring up a subject for us to start on...or she would start one and say how was everyone's week.

Marsey also commented on the importance of the group leader engaging the group members. *"She's a very friendly person…her being friendly was really helpful because it really got people talking…helps a lot to have somebody there that's kind of neutral."* Katherine identified the neutral and nonjudgmental characteristic as important too. She stated *"You don't feel like you're being judged…you feel safe talking…and knowing someone cares about you is probably the most beneficial part."*

Several group members specifically identified redirection as a helpful strategy the group leader used to support helpful interpersonal interactions. When asked about the role of the group leader, Rose shared that at times conversations were not helpful and when that occurred, the group leader *"would try to bring us back to something that was helpful."* Katherine also identified redirection as an important style of the group leader. She stated:

> She kept everyone on topic, but like she would give us space to talk about anything that we needed to talk about you know... She was really good at getting us back to talking or keeping us on track and everything.

Ivan also reflected on the importance of redirection and added that the group therapist was sensitive to group members that may be getting off topic. She stated:

> She made sure the group didn't get too off topic…She directed the conversation…in a way it didn't seem like, no stop you're not good, she would make the conversation flow somewhere else without it seeming like the girl talking about her experience was wrong.

Marsey stated, *"Initially she would be directing the conversation."* However, Marsey elaborated about not having too much structure and stated, *"I don't think there's necessarily a format you can follow when it comes to discussion…like a natural progression of information and discussion."*

Discussion of the Findings

There is very little in the literature related to the investigation of the process from the perspective of the adolescents that unfolds during adolescent group psychotherapy. Surprisingly, all eight participants actually described the group process and the group structure as though it had a beginning, middle and end. This is consistent with Malekoff (2014), who is well known for his group work with adolescents and described these three stages of group development. Integrated in their discussion of these stages, the participants described in detail the unfolding of the group process. The insight the group members had when they described the process was impressive as this researcher assumed that the participants would focus more often on the content, and not the process.

While Yalom's (2005) theoretical framework is more often applied to adult group psychotherapy research, it is evident from this study's findings that Yalom's framework is also relevant for adolescent interpersonal group psychotherapy. A number of studies in the adolescent literature have documented the presence of some of the therapeutic factors (Chase & Kelly, 1993; Corder et al., 1981; Mishna, 1996; Shechtman et al., 1997; Shectman & Gluk, 2005). In this study, the therapeutic factors that emerged were universality, cohesion, interpersonal learning, altruism and instillation of hope.

All participants described the experience of universality, that is, the recognition that other group members experience similar thoughts, feelings and problems (Yalom, 2005). This study corroborates the work of Corder et al. (1981) and Chase and Kelly (1993). This therapeutic factor played a significant role in the interpersonal group. The opportunity to engage with peers who shared similar thoughts, feelings and experiences was powerful. As the group members shared with each other, often a sense of relief filled the room. The adolescents would express great relief and say things such as *"I'm not the only one!"* and *"I feel the exact same way!"* Universality surfaced early on in the group process. Each week, as topics continued to emerge for discussion, group members related to experiencing similar thoughts and feelings with each other. The adolescents' shared experiences that connected them with each other. The more they shared, the more the connections deepened. The adolescents eventually shared their deepest concerns and fears with one another. During one of the sessions, Brianna stated:

> Knowing the fact that other people can relate to you in situations and that can support each other during difficult times and you know, relate to different struggles that you've all been through….they were there and understood what I had been through and you know, once again, I didn't feel so alone.

Another member, Alex, when asked what she found helpful about being in a group with others that had similar issues stated:

> I know if I talk to someone walking a similar path and walking in similar shoes they're going to be like…I just get it…there's no

explanation and you kind of feel like it's almost like you're talking to

experts as well.

She went on to say "*unless you've been through it, or unless you've helped someone*

who's going through it, or unless you've gone through it yourself, you really have no

idea." Rose shared a more general response about being with others that share similar

thoughts, feelings and problems. She stated, "*When you're a teenager…you wanna be*

with people who are like you." Scarlette summed up universality when she stated,

"*This is a place where I can actually talk with people who feel the same as me.*" And

lastly, Marsey reflected on the power of universality. "*You know a lot of the*

experience that other people have, mirror your own, in some way."

Alex also spoke about the experience of universality in the context of the

removal of stigma. She stated:

It was really eye opening to me in a situation where the stigma of

having all of these issues disappeared and it was like we get it, we

understand that you're not seeking attention here, you're seeking relief

from this constant battle you're having inside of yourself every moment

of every day…the stigma was removed and then I was able to leave that

room and be like the stigma doesn't have to be there… there are other

people like me and they are going through the same turmoil. They get

it.

Another therapeutic factor of Yalom's (2005) framework, cohesion, was also

prominent in this study corroborating the work of Corder et al. (1981), Chase and

Kelly (1993) and Shechtman et al. (1997).

According to Yalom (2005), "Members of a cohesive group feel warmth and comfort in the group and a sense of belongingness; they value the group and feel in turn that they are valued, accepted and supported by other members" (p. 55). When groups are cohesive, the participants will be able to be freer in expressing and exploring themselves as well as relate more deeply to other members. The adolescents in this group identified and described the importance of participating in what they perceived to be a cohesive group. This is especially important to adolescents, as they are very focused on acceptance by their peers during this development period. For adolescents, nothing seems of greater importance for their self-esteem and their healthy emotional development than to be included in and accepted by their peers. The experience of the group members accepting each other, supporting each other, valuing each other and understanding each other was intense. Members of cohesive groups more often form meaningful relationships (Yalom, 2005). This is consistent with the experiences of the adolescents in this study. They described the importance of forming relationships with others in a cohesive group.

Several group members commented on the cohesiveness they felt with other group members. The trust and closeness the group members shared were described by several of the girls as having a positive impact on their experience in the group. Brianna stated:

I definitely feel like we grew as individuals and a group and were able

to trust each other and not in just a relatable way based on our habits,

but definitely just getting to know each other and how to face this

63

whole life thing…it was good to know that anything that was bothering

us in general we were able to bring up.

Ivan also described the impact of a trusting group that led to openness. *"We would share what we did that would help overcome our struggles."* Alex reflected on the closeness and togetherness she felt with the other group members, and captured it when she said, *"They're going to just kind ease you along in your journey as you're going to ease them along in their journey."* According to Yalom (2005), the presence of cohesion early in the groups correlates with positive outcomes. Since the adolescents described cohesion as having a major impact on their group experience, it is not surprising that they experienced positive changes. In the end, no participants in this study described negative changes as an outcome.

Three additional therapeutic factors emerged in this study that have only been noted in one prior study conducted by Mishna (1996). These factors include interpersonal learning, altruism and instillation of hope. According to Yalom (1985, 1995, 2005), cohesion and interpersonal learning are the most essential therapeutic factors in group therapy. Interpersonal learning occurs when members gain personal insight through feedback provided from other members in an environment that allows members to interact in a more adaptive manner (Yalom, 2005). Brianna gave an excellent example stating, *"Just listening to one another, and trying to understand if you can relate to them or not. Then just trying to give each other the best feedback possible."* She went on to say:

As the groups went on, I definitely became closer with all of the other

patients and was able to rely on them to give me feedback on anything

that was going on. So it was nice to have, you know, to join that

experience.

 Alex also reflected on interpersonal learning, stating:

I was actually able to sit there and share my experience for the entire

group session and they just listened. It was so eye opening, I never had

people want to listen to what I had to say…I felt that they were helping

me and pushing me forward in this new wonderful glorious direction.

Ultimately, when members shared their perceptions and reactions, others

received information that gave them the opportunity to correct interpersonal

distortions. In addition, group members received feedback regarding their

interpersonal behaviors which can improve their relationships.

It is important to note that the experience of relating to each other was a core

component of the group process. It is clear from all eight interviews that the

interpersonal psychotherapy group was a meaningful experience as it provided an

opportunity for the group members to safely interact and offer feedback to each other.

The adolescents shared with each other, supported each other, gained insight from one

another, challenged each other and at times, disclosed to one another.

Not surprisingly, the older adolescents (15-18 years) engaged in interpersonal

learning more often than the younger group members (13-14 years). The younger

group members appeared less sure of themselves when it came to giving feedback and

suggestions. Perhaps due to the development stage of adolescence and the wide range

of the age of the group members, interpersonal learning was not described by all the

group members as part of the process. While interpersonal learning emerged at times, it was not as significant as the concepts of universality and cohesion.

Three group members also highlighted altruism as becoming a very meaningful part of the interpersonal process. According to Yalom (2005), altruism is described as members gaining a boost to their self-concept by extending help to other group members.   Brianna provided the following example: *"I tried to make it more comfortable for them just by putting myself out there and I mean I hope it helped a little bit."* During the third or fourth session, Agatha stated:

> It made me feel like I could be part of the group and try to help others out and give an idea of what I've been through and hopefully to help others who may be in a situation similar…maybe it will help them to be able to branch off and hopefully make their lives better.

This was particularly striking, as Agatha was usually very quiet and hesitant to engage in discussions and openly discussed her painful, lifelong struggle with connecting and communicating with peers. Ivan also highlighted that it made her feel good to be helping out the other group members and stated "*I like to see how they are doing and make sure they are getting better."*

Instillation of hope was another therapeutic factor that emerged in two of the interviews. Alex stated:

> You can change. It's a hard transition, but we're here to help you get there…you know, we can shed that positive light on your situation, we can move away from this and we can move you in a very gentle way.

Another participant, Agatha, also reflected that she experienced feeling hopeful as a result of participating in the group, *"It brings you hope that you'll experience a better day."* During group, when a member shared something that she found particularly helpful in managing an issue, other members would often comment that it gave them hope moving forward and that their situations could actually improve as well. It was not uncommon for an adolescent to share they felt hopeless before joining the group and as a result of how others handled difficult situations, the honest sharing with others and hearing what others did that worked, they would try out the suggestions. Ultimately, this was perceived as bringing them hope for the future.

In addition to the emergence of therapeutic factors, a significant finding in this study related to skill building was the ability of the members to take what they experienced and learned in the group and apply it in their "outside world." Several members described positive interactions and experiences that occurred in the group and how they incorporated what they learned from each other with family and friends. Members identified the group's influence on their ability to make healthier choices, even in between group sessions. The group truly served as a social microcosm that positively impacted the adolescents' "outside world."

Another interesting finding was how much detail the participants gave about the type of physical space that is used for their groups. The adolescents felt it was a comfortable, pleasant and relaxing space, often commenting that it didn't feel as though they were "at the hospital." Several adolescents highlighted that the space felt safe and private.

Yalom (2005), as well as other authors, have identified the importance of selecting a space that is private, free from distractions, comfortable, where participants can sit in a circle. As highlighted by several of the participants, the space where the interpersonal psychotherapy groups were held positively impacted their overall experience.

Additionally, the participants discussed group composition. The literature is not consistent regarding the optimum group size. Yalom (1995) recommends 7-8 as the optimum size for adults groups, while Brabender et al. (2004) suggests 8-10 members. In the adolescent literature, Malekoff (2014) states "adolescent groups of five to nine members are usually ideal. However, smaller or larger groups can work just as well" (p.79). In this study, the adolescents recommended 4-6 as an ideal size of group. This was a strong recommendation by the adolescents. They preferred a smaller group as they felt it provided more opportunity for all members to talk as much as they needed. Also, the smaller group size felt more intimate and the adolescents were able to connect more quickly with each other since there were less of them.

The participants also emphasized that it is best when participants want to be there rather than when they are forced by a family member or court ordered. In this researcher's experience, adolescents who participate in voluntary groups are often more motivated to work on their issues. When it is the adolescents' decision to participate in group psychotherapy, as opposed to the decision of adults in their life, they more easily engage in the group process and are open to sharing with others. Another important finding regarding engagement was related to one participant's

positive experiences even though she had minimal participation during group. Scarlette described the group as a very supportive experience. This was a striking comment from Scarlette as she was extremely quiet and minimally engaged verbally in the group. She elaborated that *"not all group members are as talkative as others, but it doesn't mean they are not engaged."* Surprisingly, she found it very helpful to hear from the other group members while the group leader often wondered if she was getting anything out of the group. In the end, she found it to be a beneficial experience and her mother also shared that the group was extremely supportive and helped her "turn a corner."

An additional finding related to group composition had to do with the diagnostic profile of patients who attend group psychotherapy. Typically, clinicians assume that adolescents with specific psychiatric disorders who are significantly impaired in their social interactions are not a good fit for groups. This was not the case with Agatha and Ivan, who have a history of extreme difficulty communicating with peers and tolerating social settings. These adolescents thrived, as result of the containing and safe environment, and interacted very well with their peers. Often, adolescents with a diagnosis that involves impaired communication and social interactions are in environments that are not supportive. This finding speaks to the importance of not making assumptions about who should attend a group, based on diagnosis. The therapeutic environment of a psychotherapy group can have a profound positive impact for adolescents with significant communication and social challenges.

Another important finding, which has not been discussed in the adolescent group psychotherapy literature, was the benefit some members described as a result of their participation in more than one 12 week group which has important implications for group therapists. While three participants only attended one series of groups, another three participants attended two series of groups and two participants returned for a third series of groups. The participants who chose to attend more than one 12 week group series arrived at the second group series with a sense of calm and ease. The tentativeness and uncertainty that these group members experienced during the first series of groups no longer existed. Perhaps this was a result of their previous positive experience of connecting with other group members. Several members were familiar and comfortable with each other. The previously established connections directly impacted their experience. While some of the participants participated in one series of groups, such as Katherine who stated, *"one session was really good for me,"* others participated in more than one. Five of the eight group members decided to participate in at least one additional series of sessions as a result of the positive experience of the first series of groups they attended. Those who returned for a second or even third series, appeared to have greater comfort earlier on in the beginning of the group process. When asked specifically about attending more than one series, Brianna stated, "*The second group I chose to participate in myself because the first group had helped so much."* Rose had a similar experience. *" I did the first 8 weeks and I was like okay I went back for the second one and then I guess it was just like I kind of liked being able to talk to people."* Marsey also described the comfort she gained as she began the second series:

The first one was you know, it took a while to get accustomed to

everybody but the second group, there were a lot of the same people

from the group before so it was more friendly...a family atmosphere

because we all knew each other.

As did Agatha when she was specifically asked about choosing to return for the

second series of groups. She stated:

I can kind of like talk to people I'm familiar with easier...I felt like I

was getting into a better situation, but felt like it could be even a little

bit better. So I thought that maybe the better thing to do was come

back.

In addition to the information the adolescents shared about group composition,

they provided numerous details about the characteristics and style of the group leader.

All eight adolescents identified the importance of the group leader actively engaging

them. This finding corroborates the work of Aronson & Scheidlinger (2002) who state

that it is absolutely necessary that the group leader is active and not passive during

groups with adolescents. If a group leader is too passive, the adolescents will find a

way to engage the leader, and often not in productive fashion.

It was not surprising to hear from the adolescents that group leader

characteristics such as being friendly, upbeat, energetic, happy and positive were

helpful. Perhaps this was especially notable to adolescents in this group who were

emotionally struggling and looked to the group leader to maintain a positive stance.

The adolescents also described the importance of the leader as "being real," honest,

sensitive, nonjudgmental, empathetic, and understanding. These findings mirror those

of Aronson & Scheidlinger (2002) and Pojman (2009) who assert that adolescents respond well to leaders who are direct, authentic and genuine in their interactions. Additionally, the adolescents commented that they often felt misunderstood by adults in their lives and it was extremely meaningful to spend time with an adult they felt genuinely understood them and wanted to help them "feel better." They highlighted the importance of the group leader actively listening to them, reflecting back what they said and offering alternative positive ways to think about things and how to deal with difficult situations.

One specific strategy that the participants commented on regarding leader style was redirection. This was a surprising finding in that all eight group members actually identified and described redirection as a very important technique the group leader utilized during the sessions. Redirection kept the group members feeling safe and contained the process. Both Shechtman (2007) and Yalom (2005) discuss the importance of using redirection to help the group stay focused and at the same time, prevent too much disclosure that may result in harm to other group members. Ultimately, it is the responsibility of the group leader to create and maintain a safe environment (Aronson & Scheidlinger, 2002; Brabender et al., 2004; Malekoff, 2014; Pojman, 2009; Shechtman 2007; Yalom, 2005).

Outcomes

Although the adolescent group psychotherapy literature research has been quite limited, a number of positive clinical outcomes have been described. These outcomes include an ability to improve communication and relate to others, establish relationships with peers, decrease isolation, decrease negative symptoms, learn

positive coping skills, enhance self-esteem, and increase awareness of self and others. This study supports these findings and also contributes to the literature.

In conclusion, this study contributed to nursing knowledge in the client domain. The voices of the adolescents provided rich descriptions of their experiences illuminating a number of positive benefits as well as the emergence of Yalom's (2005) therapeutic factors as part of the process. Several thoughtful recommendations were provided that could be considered by group leaders who facilitate groups for adolescents.

Chapter VI

Summary, Conclusions and Implications

This chapter summarizes this research study which focused on the experiences of adolescents who participated in an interpersonal psychotherapy group. The meaning of the group process, the benefits the adolescents described as a result of their participation and recommendations were provided for consideration by group leaders. Limitations and implications for future research, knowledge development, education and clinical practice are also discussed.

Summary

Group psychotherapy has been identified as the optimum treatment approach for adolescents who have psychiatric mental health issues. Two primary approaches have been discussed in the literature; behaviorally oriented and process oriented groups. To date, the empirical literature has focused primarily on quantitative studies with cognitive behavioral interventions with little attention paid to qualitative studies with adolescents who participate in a process oriented group including interpersonal psychotherapy groups. More specifically, the voice of the adolescents has only been represented in the literature in one other study.

To capture the experiences of the adolescent who participated in an interpersonal psychotherapy group, a qualitative descriptive design was selected for this study. Data was collected by using semi-structured interviews with a purposive sample of eight adolescents. The audio-taped interviews were transcribed verbatim. Since the intent of this researcher was to stay as close as possible to the participants'

own words, inductive manifest content analysis was selected to analyze the data. The study spanned a total of ten months.

Conclusions

The findings of this study validated for this researcher the positive impact that an adolescent interpersonal psychotherapy group can have on its members. Capturing the voice of the adolescents was of prime importance for this researcher who concurs with Yalom's (1985) statement that "patient reports are a rich and relatively untapped source of information" (p. 5). The participants provided rich descriptions of their experiences as participants in an interpersonal psychotherapy group.

The participants described the group process, and the meaning that the process had for them. The safe and trusting environment of the group provided a milieu for a number of therapeutic factors to emerge. Although universality and cohesion were the most dominant therapeutic factors, interpersonal learning, altruism and instillation of hope also emerged from the data.

The participants identified a number of benefits or outcomes as a result of their participation including an increased ability to communicate and relate to others, development of friendships, decreased isolation, learning a number of positive coping skills and gaining a greater understanding of themselves and others. Lastly, the adolescents gave recommendations related to the physical environment, group composition, and characteristics of the group leader, which have major implications for education of group therapists and clinical practice.

Limitations

As in any study, there are always limitations. First, the participants were all females and lacked diversity. Seven participants were Caucasian and one identified herself as Hispanic. Secondly, this was a self-selected group. The decision to attend the group as opposed to attending an involuntary group may have influenced the overwhelmingly positive experience. Perhaps if this were an involuntary group, the experiences would be described differently. For example, if this was a court mandated group or inpatient group on a locked adolescent psychiatric unit, group members feeling forced to attend may not describe this as a positive experience.

The wide age range in the age of the participants was another limitation. Adolescents are focused on different developmental tasks in early adolescence as opposed to later adolescence. The younger members were more concerned with social challenges of middle school while the older adolescents were thinking about transitioning from high school to college.

An additional limitation was the variation in attendance in the number of interpersonal psychotherapy groups for some of the members. While some members attended one series of groups, three members attended two series and two members attended three series. In some ways this is a limitation, yet it may also serve as benefit since the group members were consistent in their perceptions, regardless of how many groups they attended.

Implications

Implications for future research and knowledge development. This is the second qualitative research study that has explored the experiences of adolescents who participated in an interpersonal psychotherapy group. More specifically, it is the only

study that has explored the experiences of adolescents with a variety of psychiatric diagnosis participating in an interpersonal psychotherapy group. The adolescents in this study have given one voice and their perspectives. More qualitative research studies with diverse groups of participants including a variety of diagnosis, age, gender, ethnic backgrounds as well as LGBT need to be conducted and will significantly add to the literature. In particular, a future study with all male participants is needed. Also, studies need to be conducted in a variety of settings including inpatient, outpatient, day treatment and schools.

In addition to conducting more qualitative studies interviewing adolescents, interviewing group leaders who conduct interpersonal groups is another area that could be explored. Also, future research might include detailed analysis of videotaped psychotherapy groups, with a focus on the behaviors of group members as well as group leaders. This too could lead to several additional studies.

Future studies could specifically focus on Yalom's (2005) therapeutic factors. Universality, cohesion, interpersonal feedback, altruism and instillation of hope emerged in this study and further investigation of these factors will contribute to the literature. It would also be interesting to look at three additional factors: catharsis, the corrective recapitulation of family and development of socializing techniques. These additional therapeutic factors are particularly relevant to adolescent development.

To date, little research has been conducted using the Group Counseling Helpful Impacts Scale (GCHIS) that was created for adults. It will be important to carefully examine the items on this scale to determine if they are appropriate for

adolescents. Modification of the scale might be indicated, yet may have great utility

for future research.

Implications for education. Results from this study have identified a number

of areas that are related to the facilitation of interpersonal psychotherapy groups and

the need for education of advanced practice nurses as group psychotherapists in this

therapeutic modality. The recommendations the adolescents provided need to be

incorporated into educational offerings of group psychotherapy training. Presently,

excellent group therapy training exists that includes several important aspects

including the history of group therapy, types of groups, selection and preparation of

groups, stages of group, group leadership style, the group process and group

dynamics. However, process oriented groups are not practiced widely enough mainly

because counselors and therapists are not trained to conduct them (Shechtman, 2007).

That being said, the perspective of the adolescents is presently not incorporated

into group therapy training programs. This researcher plans to enhance the group

therapy training program she previously developed at an academic urban children's

hospital by incorporating the data from this study into the curriculum and presenting

the "voice" of the adolescent in the content. Inviting adolescents who previously

attended groups to share their experiences during training sessions, with future group

therapists, may also be incorporated into the training.

Implications for clinical practice. There are a number of implications that

can be considered in clinical practice when conducting groups with adolescents. The

physical space should be comfortable, inviting, private and teenager friendly. Also, it

is important to be mindful of the size of the group. According to the adolescents interviewed in this study, 4-6 is an ideal number for group.

In addition to the physical space and size of the group, another aspect the leader needs to be mindful of is group composition. Ideally, prescreening of group candidates is ideal. This provides the leader an opportunity to assess willingness to participate in the group as well as developmental level and diagnostic profile.

Also, group leaders need to be cognizant of their verbal and nonverbal communication at all times. Group leaders need to be aware of the impact their presence has on the group and the responsibility of creating a safe environment. According to Yalom (2005), it is essential the leader of interpersonal groups create a safe, supportive and therapeutic environment.

Given the health disparities in accessing health care including mental health, conducting groups in a variety of settings is essential. In addition to group being offered in hospitals, day treatment programs and outpatient settings, school based group programs may be one mechanism for addressing this need. The usefulness of school-based groups have been described by Aronson and Scheidlinger (2002) and Malekoff (2014). Examples of groups in schools with a specific focus include anger management groups, groups for loss and grief, groups for traumatic stress disorders, groups for substance abuse and alcohol abuse and groups for mood disorders.

Further exploration in several areas of interpersonal group psychotherapy with adolescents is needed to enhance clinical practice. The "voice" of the adolescents provides researchers and clinicians with great possibilities of areas to be investigated

79

moving forward. Ultimately, future research will contribute to advancing clinical

practice and knowledge development of adolescent group psychotherapy.

Yalom's Therapeutic Factors

Therapeutic Factors	Definition
Universality	Members recognize that other members share similar feelings, thoughts and problems
Altruism	Members gain a boost to self concept through extending help to other group members
Instillation of hope	Member recognizes that other members' success can be helpful and they develop optimism for their own improvement
Imparting information	Education or advice provided by the therapist or group members
Corrective recapitulation of primary family experience	Opportunity to reenact critical family dynamics with group members in a corrective manner
Development of socializing techniques	The group provides members with an environment that fosters adaptive and effective communication
Imitative behavior	Members expand their personal knowledge and skills through the observation of group members' self-exploration, working through and personal development
Cohesiveness	Feelings of trust, belonging and togetherness experienced by the group members
Existential factors	Members accept responsibility for life decisions
Catharsis	Members release of strong feelings about past or present experiences
Interpersonal learning	Members gain personal insight about their interpersonal impact through feedback provided from other members and provide an environment that allows members to interact in a more adaptive manner

Appendix B

Lifespan Institutional Review Board Approval

Research Protection Office
Office of Research Administration
CORO West, Suite 1.300
One Hoppin Street
Providence, RI 02903
Tel 401 444-6246
Fax 401 444-7960

E. P. Bradley Hospital
Rhode Island Hospital
The Miriam Hospital
Newport Hospital
Gateway Healthcare

DATE: June 11, 2014

TO: Francine Pingitore

FROM: Patricia E. Houser, R.N., M.S.J.
                     Director, Research Protection Office

SUBJECT: **HUMAN SUBJECTS PROTECTION of New Project**
                     FWA-00001230, 00003538 IRB Registration #: 0000396, 00004624

CMTT/PROJ: 206614 45CFR 46.110(F)(7)
TITLE: [605766-1 & 605766-2] Exploring the Experiences of Adolescents
                     Participating in a Group Psychotherapy

Your research project was reviewed and approved on June 5, 2014. Requested IRB revisions were received and accepted on June 11, 2014. This research has been approved as meeting the Expedited criteria for the protection of humans per 45 CFR 46.110(F)(7) by the Lifespan - The Miriam Hospital IRB. This institution is in compliance with the ICH GCP as they correspond to the FDA/DHHS regulations. This review and approval are applicable for RIH.

This notification CONSTITUTES AUTHORITY FOR ACTIVATION of this application.

Your protocol involves children and has been classified as Category A according to Federal pediatric assent guidelines. Please follow the instructions indicated for this classification.

It is the responsibility of the principal investigator to ensure that the study is conducted as approved by the IRB. All protocol modifications/changes must be approved by the IRB before any changes are implemented except when necessary to eliminate immediate hazards to subjects.

If written informed consent is required for this study: The newly stamped consents are included with this letter. Please review these informed consents to be sure you have received all the documents necessary to conduct this study. Please be sure all informed consents you submitted for approval, specimen banking forms and ads if applicable, are included and stamped with the approval and expiration dates. These newly stamped informed consents and other documents are to be used immediately for this study and supersede any previously issued documents, if applicable.

You are required by Federal regulations and Hospital policy to immediately report any unanticipated problems, untoward effects or reactions, serious side effects and/or deaths of subjects involved and related to this project to the IRB through the Research Protection Office.

IRB approval for this project expires on June 4, 2015. If you wish to continue your research after this date you are required to submit a continuation report (CR) prior to expiration of approval. A reminder notice will be sent approximately 30 days before the continuation report is due. The CR must be reviewed by the IRB no later than the date of expiration in order for the study to be in compliance with federal regulations. Federal regulations do not allow for ANY grace period for renewal.

Please provide a termination report to the IRB when the research is completed and IRB approval may be terminated.

NO RESEARCH DATA SHOULD EVER BE STORED ON A LAPTOP. This includes data collected for chart reviews, surveys and all other types of research. Obtaining consent and research authorization does not remove the requirements and restrictions of the HIPAA Security Rule.
  If data must be collected using a laptop do not save it to the hard drive. Save it to a Lifespan encrypted password protected thumb drive before leaving the research site. For more information contact Patricia Houser at (401) 444-2099, **phouser@lifespan.org**.

Appendix C

University of Rhode Island Institutional Review Board Approval

FWA:	00003132
IRB:	00000599
DATE:	November 5, 2014
TO:	Ginette Ferszt, Phd, RN
FROM:	University of Rhode Island IRB
STUDY TITLE:	Exploring the Experiences of Adolescents Participating in a Group Psychotherapy
IRB REFERENCE #:	662172-2
LOCAL REFERENCE #:	HU1415-044
SUBMISSION TYPE:	Revision
ACTION:	APPROVED
EFFECTIVE DATE:	November 5, 2014
EXPIRATION DATE:	November 4, 2015
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category # 7

Thank you for your submission of Revision materials for this research study. The University of Rhode Island IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation 45 CFR 46 and 21 CFR 50 & 56.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

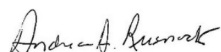All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate **Appendix S - Event Reporting** for this procedure. All FDA and sponsor reporting requirements must be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office. Please note that all research records must be retained for a minimum of five years after the project ends.

Based on the risks, this project requires Continuing Review by this office by November 4, 2015. Please use the **CONTINUING REVIEW FORM** for this procedure.

If you have any general questions, please contact us by email at researchintegrity@ds.uri.edu. For study related questions, please contact us via **project mail through IRBNet**. Please include your study title and reference number in all correspondence with this office.

Please remember that <u>*informed consent*</u> *is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document unless the signature requirement has been waived by the IRB.*

Andrea Rusnock, Ph.D
IRB Chair

Generated on IRBNet

Recruitment Flyer

WE WANT TO HEAR FROM YOU!

Adolescents (13 to 19 years old) who have attended group therapy over three months at Hasbro Children's Hospital are invited to participate in a Lifespan research study and share their opinions and ideas about group therapy. We are interested in learning from you so that we can improve the groups and contribute in a positive way to adolescents.

If you are interested, please contact:

Fran Pingitore, MSN, RN, PCNS-BC at 444-5636

Appendix E

Parent Consent

Parent/Guardian Initials _____

Lifespan Affiliate Site where research will be conducted

x ☐ Rhode Island Hospital   ☐ The Miriam Hospital
☐ Bradley Hospital   ☐ Newport Hospital

Agreement to Participate in a Research Study
And Authorization for Use and Disclosure of Information

_206614_
Committee #   Name of Study volunteer

Exploring the Experiences of Adolescents Participating in a Group Psychotherapy

Your child is being asked to take part in a research study described below. All research studies at
Lifespan hospitals follow the rules of the state of Rhode Island, the United States government and
Lifespan. Before you decide whether to allow your child to be in the study, you and the researcher will
engage i the "informed consent" p ocess. h r   ing tr s poc ss, the researcher will e plain te
purpose of the study, how it will be carried out, and what your child will be expected to do if he or she
decides to participate. The researcher will also explain the possible risks and benefits of being in the
study, and will provide other information. You should feel free to ask any questions you might have.
The purpose of these discussions is for you to decide whether participating in the study is the best
decision for your child.

If you decide to allow your child to be in the study, you will be asked to sign an agreement which
states that the study has been explained, that your questions have been answered, and that you agree to
have your child participate. You will be given a copy of this form to keep.

Federal and Lifespan institution rules require that if your child is 8 years or older, the "assent"
(agreement) of your child must be obtained by the researcher before your child can participate in this
study. Your child must sign the consent form as well. You will be given a copy of the signed consent
form to keep.

1. <u>Nature and Purpose of the Study</u>   Your child is being asked to take part in a research project
    because he/she has participated in group therapy with other adolescents over the past 3 months.

    Group therapy is considered an ideal choice of therapy for adolescents. The purpose of this
    study is to explore the experiences of adolescents who have participated in an interpersonal
    group therapy. This researcher wants to learn about the group therapy experience through the
    view and voice of the adolescents.

    We expect to enroll 10 subjects into this study.

2. <u>Explanation of Procedures</u>
   - Your child will be interviewed one time. The interview will last for a period of 45 minutes to one hour. The interview will focus on your child's experience of participating in the group therapy. The questions will touch on different aspects of the group therapy from your child's point of view.
   - The interview will take place in a private office on the fifth floor of Hasbro Children's Hospital.
   - The interview will be audiotaped. Your child will be asked to use another name while being audiotaped to maintain confidentiality. The tapes will be kept in a locked file cabinet in a locked office. The tapes will be destroyed immediately after being transcribed.
   - A $25 gift card will be offered to your child as a thank you for taking the time to complete the interview.

   <u>Contact Information:</u>
   Fran Pingitore, MSN, RN, PMHCNS-BC, office #401-444-5636, pager #401-350-1958
   Ana Crook, BS, MT, office #401-444-8638

3. <u>Discomforts and Risks</u>
   It is possible, though unlikely, that your child may experience emotional discomfort at some point during the interview in thinking about a question. If this happens, the research assistant will check with your child about how he/she is feeling. Also, the research assistant will ask your child if he/she is comfortable continuing the interview or if he/she would prefer to stop the interview.

4. <u>Benefits</u>
   By participating in this research study and answering questions about the experience in group therapy, your child may gain insight into what he/she has been working on which may be beneficial to his or her treatment. In addition, knowledge gained from this study could be beneficial in improving the mental health of adolescents who participate in group therapy in the future.

5. <u>Alternative Therapies</u>
   There are no alternative therapies involved in this research study.

6. <u>Refusal/Withdrawal</u>
   It is up to you whether you want your child to participate in the study. You are not required to enroll your child to participate. If you decide you want your child to participate, you can always change your mind and remove him or her from the study at any time. If you decide not to have your child be in the study, or if you remove him or her later, your child will still be able to get the health care services they would normally get. If new information becomes available that might change your mind about whether you want your child to stay in the study, the researcher will share this information with you as soon as possible.

7.   Medical Treatment/Payment in Case of Injury
      A research injury is any physical or mental injury or illness caused by being in the study. If
      your child is injured by a medical treatment or procedure they would have received even if they
      were not in the study that is not a research injury. To help avoid research injury and added
      medical expenses, it is very important to follow all study directions carefully. If your child
      does experience a research injury, Lifespan or the study doctor can arrange medical treatment
      for them. Such treatment will be paid for as described below.

      If you have insurance and your child has a research injury that is not covered by the study, it is
      possible that some or all of the cost of treating your child could be billed to your insurer. If
      your health insurance will not cover such costs, it is possible you would have to pay out of
      pocket. In some cases, Lifespan might be able to help you pay if you qualify for free care
      under Lifespan policy. However, Lifespan has no policy to cover payment for such things as
      lost wages, expenses other than medical care, or pain and suffering.

8.   Rights and Complaints
     Signing this form does not take away any of your lawful rights. If you or your child have any
     complaints about your child's participation in this study, or would like more facts about the
     rules for research studies, or the rights of people who take part in those studies, you may
     contact Patricia E. Houser, anonymously if you wish, in the Lifespan Office of Research
     Administration, telephone number (401) 444-6246

9.   Confidentiality and Research Authorization for Use and Disclosure of Your Health Care
     Information.
     Your child's research records will be treated as private health care records and will be protected
     according to Lifespan privacy practices and policies that are based on state and federal law.   In
     particular, federal law requires us to get your permission to use or disclose (release your child's
     information to someone outside of Lifespan) their health information for research purposes. If
     you sign this form you agree to have your child be in this research study and you permit the use
     and disclosure of your child's health information for the purpose of conducting the research,
     providing treatment, collecting payment and running the business of the hospital. This
     permission has no expiration date. You may withdraw from the study at any time. However, if
     you do not want the researchers to use or disclose any further information in this study you
     must cancel permission in writing and may do so at any time. If you cancel your permission,
     you will stop taking part in the study and no new information will be collected about you.
     However, if you cancel your permission, it will not apply to actions already taken or
     information already collected about you by the hospital or the researchers before you canceled
     your permission.

     Generally, the entire research record and any medical records held by the hospital may be used
     and released for research purposes. The following people or businesses/companies/ might use,
     release, or receive such information:

     •   The researcher and their support staff.

RPO Minor IC and Auth – v.8-2013[2]
Parent-Child Consent   Page 3 of 6   *5/21/14*

89

- The United States Food and Drug Administration, the Department of Health and Human Services, the Office of Inspector General, and the Office of Civil Rights; European Medicines Agency
- People who volunteer to be patient advocates or research volunteer protectors.
- Members of the hospital's administrative staff responsible for reviewing, approving and administering clinical trials and other healthcare or research activities.
- Accrediting Organizations

There are times when the law might require or permit Lifespan to release your child's health information without your permission. For example, Rhode Island law requires researchers and health care workers to report abuse or neglect of children to the Department of Children, Youth and Families (DCYF) and to report abuse or neglect of people age 60 and older to the Department of Elderly Affairs.

All researchers and health care providers are required to protect the privacy of your child's health care information. Other people and businesses/organizations that are not health care providers are not required by law to do that so it is possible they might re-release your child's information.

You have the right to refuse to sign this form and not allow your child to participate in the research. Your refusal would have no affect on your child's treatment, charges billed to you, or benefits at any Lifespan health care site. If you do not sign, your child will not be able to enroll in the research study and will not receive treatment as a study participant.

If you decide to have your child quit the study after signing this form (as described in Section 6) no new information will be collected about them unless you gave us permission to do so. However, the hospital or the researchers may continue to use information that was collected before you removed your child from the study to complete analysis and reports of this research.

For more detail about privacy rights see the Lifespan Joint Privacy Notice which has or will be given to you.

SIGNATURE

<u>I HAVE READ THE ABOVE DESCRIPTION OF THIS STUDY.   ALL OF MY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED, AND, AND I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THIS RESEARCH STUDY.</u>

> **This informed consent document expires on 6/4/2015 .**
> **DO NOT sign this document after this expiration date**

_____   _____   _____
Signature of parent/guardian*   Date   and   Time when signed

_____   _____   _____
Signature of parent/guardian*   Date   and   Time when signed

I AGREE TO PARTICIPATE IN THIS STUDY

_____   _____
Signature of study volunteer (child)*   Date

_____
Age of study volunteer (child)

I WAS PRESENT DURING THE CONSENT PROCESS AND SIGNING OF THIS
AGREEMENT ABOVE BY THE PARENT/GUARDIAN OR AUTHORIZED
REPRESENTATIVE

_____   _____
Signature of witness (required if consent   Date
is presented orally or at the request of the IRB)

IF STUDY VOLUNTEER IS UNABLE TO SIGN OR EXCEPTION TO ASSENT IS
SOUGHT, PLEASE EXPLAIN:
_____
_____

I CERTIFY THAT I HAVE EXPLAINED FULLY TO THE ABOVE PARENTS AND
STUDY VOLUNTEER, THE NATURE AND PURPOSE, PROCEDURES AND THE
POSSIBLE RISK AND POTENTIAL BENEFITS OF THIS RESEARCH STUDY.

_____   _____   _____
Signature of researcher or designate   Date   and   Time when signed

* If signed by agent other than parent and study volunteer, please explain below.
_____
_____

Parent/Guardian Initials _____

Documentation that a copy of this Informed Consent was given to the research participant is a Federal requirement. Prior to making a copy of the signed and dated Informed Consent please check appropriate box(es) as applicable to indicate copy provided to:

☐ **Study Volunteer**   ☐ **Medical Record**   ☐ **Researcher**   ☐ **Other (Specify)**

Appendix F

Child Assent

Lifespan Affiliate Site where research will be conducted

X ☐ Rhode Island Hospital   ☐ The Miriam Hospital
☐ Bradley Hospital   ☐ Newport Hospital

Child Assent to Participate in a Research Project

__206614____   _____
Committee #   Name of Study Volunteer

Exploring the Experiences of Adolescents Participating in a Group Psychotherapy

This assent form may contain words that you do not understand. Please ask the study researcher or the study staff to explain any words or information that you do not clearly understand. You may take home a copy of this assent form to think about or discuss with family or friends before making your decision

Reason for Study
We are trying to learn from adolescents about their experiences participating in group therapy, in order to best help other teens in the future. We are interested in learning from you how we might improve the groups in order to best contribute to helping our teens in a positive way.

What kinds of things will you do if you take part in this study?
We will interview you after the last group is over. The interview will happen at the hospital. We will ask you some questions about your experience of participating in group therapy over the past three months. The interview will take about 45 minutes to one hour. We will tape record our talk with you to be sure we have covered all the information correctly.

How long is this study?
The length of the study is a one-time interview that will last about 45 minutes to one hour.

Will you feel uncomfortable during the study?
We do not expect any major risks, although you may sometimes feel uncomfortable answering some of the questions. If you feel uncomfortable, the researcher will talk with you and be sure you feel OK to finish the interview. Also, we may call your therapist as an additional support if needed, but not anyone else unless your parents, your guardian, and you say it's OK.

You will receive a gift certificate for $25 after you finish the interview as a thank you.

Assent Form   Page 1 of 2

Contact Information:
- Fran Pingitore, MSN, RN, PMHCNS-BC, office #401-444-5636, pager #401-350-1958
- Ana Crook, BS, MT, office #401-444-8638

Refusal/Withdrawal
It is up to you whether you want to be in the study. If you decide to be in the study now, you can always change your mind and quit at any time. If you decide not to be in the study, or if you quit later, you will still be able to get treated.

Complaints or Questions about Research
If you have any complaints about this study, or would like know more about you may contact Patricia E. Houser, or Janice Muratori in the Lifespan Office of Research Administration, at (401) 444-6246

Your mom, dad, and/or guardian know about this study, and they think it is OK for you to be in this study. If you want to be in this study, you can tell the interviewer and sign your parents' form. If you do not want to be in the study, it is OK to say no. You can stop being in the study any time you want to, and nobody will be upset with you.

Appendix G

Informed Consent

_____
Study Volunteer Initials

Lifespan Affiliate Site where research will be conducted

X ☐ Rhode Island Hospital   ☐ The Miriam Hospital
☐ Bradley Hospital   ☐ Newport Hospital

Agreement to Participate in a Research Study
And Authorization for Use and Disclosure of Information

__206614__
Committee #

_____
Name of Study Volunteer

Exploring the Experiences of Adolescents Participating in a Group Psychotherapy

You are being asked to take part in a research study. All research studies at Lifespan hospitals follow the rules of the state of Rhode Island, the United States government and Lifespan. Before you decide whether to be in the study, you and the researcher will engage in the "informed consent" process. During this process, the researcher will explain the purpose of the study, how it will be carried out, and what you will be expected to do if you participate. The researcher will also explain the possible risks and benefits of being in the study, and will provide other information. You should feel free to ask any questions you might have. The purpose of these discussions is for you to decide whether participating in the study is the best decision for you.

If you decide to be in the study, you will be asked to sign and date this form in front of the person who explained the study to you. This form summarizes the information you discussed. You will be given a copy of this form to keep.

1. Nature and Purpose of the Study   You are being asked to take part in a research project because you have participated in group therapy with other adolescents over the past 3 months.

Group therapy is considered an ideal choice of therapy for adolescents. The purpose of this study is to explore the experiences of adolescents who have participated in an interpersonal group therapy. This researcher wants to learn about the group therapy experience through the view and voice of the adolescents.

We expect to enroll 10 subjects into this study.

2. Explanation of Procedures: If you take part in this study,
   - You will be interviewed one time. The interview will last for a period of 45 minutes to one hour. The interview will focus on your experience of participating in the group therapy. The questions will touch on different aspects of the group therapy from your point of view.
   - The interview will take place in a private office on the fifth floor of Hasbro Children's Hospital.
   - The interview will be audiotaped. You will be asked to use another name while being audiotaped to maintain confidentiality. The tapes will be kept in a locked file cabinet in a locked office. The tapes will be destroyed immediately after being transcribed.
   - A $25 gift card will be offered as a thank you for taking the time to complete the interview.

- Also, a free parking coupon will also be offered for use in the hospital visitor parking lot.

Contact Information:
Fran Pingitore, MSN, RN, PMHCNS-BC, office #401-444-5636, pager #401-350-1958
Ana Crook, BS, MT, office #401-444-8638

3. Discomforts and Risks
It is possible, though unlikely, that you may experience emotional discomfort at some point during the interview in thinking about a question. If this happens, the research assistant will check with you about how you are feeling. Also, the research assistant will ask if you are comfortable continuing the interview or if you would prefer to stop the interview.

4. Benefits
By participating in this research study and answering questions about your experience in group therapy, you may gain insight about what you have been working on which may be beneficial to your treatment. Knowledge gained from this study could be beneficial in improving the mental health of adolescents who participate in group therapy in the future.

5. Alternative Therapies
There are no alternative therapies involved in this research study.

6. Refusal/Withdrawal
It is up to you whether you want to be in the study. You are not required to enroll or participate. If you decide to participate, you can always change your mind and quit at any time. If you decide not to be in the study, or if you quit later, you will still be able to get the health care services you normally get. If you join, but later on the researcher or your doctor feels being in the study is no longer good for you, they may choose to take you out of the study before it is over. If new information becomes available that might change your mind about whether you want to stay in the study the researcher will share this information with you as soon as possible.

7. Medical Treatment/Payment in Case of Injury
A research injury is any physical or mental injury or illness caused by being in the study. If you are injured by a medical treatment or procedure you would have received even if you were not in the study that is not a research injury. To help avoid research injury and added medical expenses, it is very important to follow all study directions carefully. If you do experience a research injury, Lifespan or the study doctor can arrange medical treatment for you. Such treatment will be paid for as described below.

If you have insurance and have a research injury that is not covered by the study, it is possible that some or all of the cost of treating you could be billed to your insurer. If your health insurance will not cover such costs, it is possible you would have to pay out of pocket. In some cases, Lifespan might be able to help you pay if you qualify for free care under Lifespan policy. However, Lifespan has no policy to cover payment for such things as lost wages, expenses other than medical care, or pain and suffering.

8. Rights and Complaints

Signing this form does not take away any of your lawful rights. If you have any complaints about this study, or would like more facts about the rules for research studies, or the rights of people who take part in research studies you may contact Patricia E. Houser, or Janice Muratori in the Lifespan Office of Research Administration, at (401) 444-6246

9. Confidentiality and Research Authorization for Use and Disclosure of Your Health Care Information.

Your research records will be treated as private health care records and will be protected according to Lifespan privacy practices and policies that are based on state and federal law. In particular, federal law requires us to get your permission to use or disclose (release your information to someone outside of Lifespan) your health information for research purposes. If you sign this form you agree to be in this research study and you permit the use and disclosure of your health information for the purpose of conducting the research, providing treatment, collecting payment and running the business of the hospital. This permission has no expiration date. You may withdraw from the study at any time. However, if you do not want the researchers to use or disclose any further information in this study you must cancel permission in writing and may do so at any time. If you cancel your permission, you will stop taking part in the study and no new information will be collected about you. However, if you cancel your permission, it will not apply to actions already taken or information already collected about you by the hospital or the researchers before you canceled your permission.

Generally, the entire research record and any medical records held by the hospital may be used and released for research purposes. The following people or businesses/companies/ might use, release, or receive such information:

- The researcher and their support staff.
- The United States Food and Drug Administration, the Department of Health and Human Services, the Office of Inspector General, and the Office of Civil Rights; European Medicines Agency
- People who volunteer to be patient advocates or research volunteer protectors;
- Members of the hospital's administrative staff responsible for reviewing, approving and administering clinical trials and other healthcare or research activities.
- Accrediting Organizations

There are times when the law might require or permit Lifespan to release your health information without your permission. For example, Rhode Island law requires researchers and health care workers to report abuse or neglect of children to the Department of Children, Youth and Families (DCYF) and to report abuse or neglect of people age 60 and older to the Department of Elderly Affairs.

All researchers and health care providers are required to protect the privacy of your health care information. Other people and businesses/organizations that are not health care providers are not required by law to do that so it is possible they might re-release your information.

You have the right to refuse to sign this form and not participate in the research. Your refusal would have no affect on your treatment, charges billed to you, or benefits at any Lifespan health

care site. If you do not sign, you will not be able to enroll in the research study and will not receive treatment as a study participant.

If you decide to quit the study after signing this form (as described in Section 6) no new information will be collected about you unless you gave us permission to do so. However, the hospital or the researchers may continue to use information that was collected before you quit the study to complete analysis and reports of this research.

For more detail about your privacy rights see the Lifespan Joint Privacy Notice which has or will be given to you.

SIGNATURE

I have read this informed consent and authorization form. ALL OF MY QUESTIONS HAVE BEEN ANSWERED, AND I WANT TO TAKE PART IN THIS RESEARCH STUDY.

By signing below, I give my permission to participate in this research study and for the described uses and releases of information. *I also confirm that I have been now or previously given a copy of the Lifespan Privacy Notice*

> **This informed consent document expires on __6/4/2015__ .**
> **DO NOT sign this document after this expiration date**

_____   _____   _____
Signature of study volunteer/authorized representative*   Date   and   Time when signed

I WAS PRESENT DURING THE CONSENT PROCESS AND SIGNING OF THIS AGREEMENT BY THE STUDY VOLUNTEER OR AUTHORIZED REPRESENTATIVE

_____   _____
Signature of witness (required if consent   Date
is presented orally or at the request of the IRB)

I HAVE FULLY EXPLAINED TO THE ABOVE STUDY VOLUNTEER/AUTHORIZED REPRESENTATIVE, THE NATURE AND PURPOSE, PROCEDURES, AND THE POSSIBLE RISKS/BENEFITS OF THIS RESEARCH STUDY.

_____   _____   _____
Signature of researcher or designate   Date   and   Time when signed

* If signed by agent other than study volunteer, please explain below.
_____
_____

Documentation that a copy of this Informed Consent was given to the research participant is a Federal requirement. Prior to making a copy of the signed and dated Informed Consent please check appropriate box(es) as applicable to indicate copy provided to:

☐ Study Volunteer   ☐ Medical Record   ☐ Researcher   ☐ Other (Specify)

Appendix H

Demographics Form

CODE NUMBER_____

Title of Study: Exploring the Experiences of Adolescents Participating in Interpersonal Group Psychotherapy

Age_____

Gender_____

Ethnic Background_____

Grade in School_____

Family Composition_____

Current Living
Situation_____

Diagnosis_____

Medications_____

Is this the first series of groups you have attended? Yes_____   No_____

If you answered no, how many have series of groups have you attended in the past?
_____

Appendix I

Interview Guide

Title of the Study:

Exploring the Experiences of Adolescents Participating in Interpersonal Group

Psychotherapy

Purpose of this Study:

The purpose of this study is to explore the experiences of adolescents who have

participated in an interpersonal group therapy. The researcher seeks to understand the

experience through the view and voice of the adolescents. Data collected from

interviews with adolescents will help inform best group practices.

Script:

Try and imagine yourself talking to a large number of group therapists that want to

improve the groups they facilitate for teens.   What you have to tell us will help make

our group therapy better for teens in the future.

Interview Questions:

- As you think about your participation in this group over the past three months,

    can you tell me in as much detail as possible about being a member in this

    group?

- Was there anything you particularly liked? Or disliked?

- What can you tell me about the group leader? Was there anything that she said

    or did in the group that you found helpful? Not helpful? If you could make

    any suggestions to her right now, what would you say?

- What can you tell me about the other members of the group? Was there anything that other members said or did that you found helpful? not helpful? If you could make any suggestions to another member(s) right now, what would you say?

- Were there any specific interactions with the other group members that stand out in your mind? (If yes, then explore…)

- Are there experiences in the group that have benefited you outside of group?

- Did you ever think about the group in between your meetings? (If yes, then pursue)

- What was challenging about the group?

- What did you hope to gain from the group? Do you think that happened? (explore, whether the answer is yes or no)

- If you were going to tell another teen about the group and how it can impact your life, what would you say?

Table 1

Demographics Table

PSEUDONYM	AGE	GENDER	GRADE	# OF GROUP SERIES
"Brianna"	13	female	7	2
"Alex"	17	female	11	3
"Rose"	18	female	12	3
"Katherine"	16	female	11	1
"Marsey"	15	female	10	2
"Agatha"	17	female	11	2
"Ivan"	15	female	9	1
"Scarlette"	14	female	8	1

Bibliography

Abbass, A., Rabung, S., Leichsenring, F., Refseth, J. & Midgley, N. (2013). Psychodynamic psychotherapy for children and adolescents: A meta-analysis of short-term psychodynamic models. *Journal of the American Academy of Child & Adolescent Psychiatry, 52* (8), 863-875.

Abraham, P., Lepisto, B. & Schultz, L. (1995). Adolescents' perceptions of process and speciality group therapy. *Psychotherapy, 32* (1), 70-76.

American Acadamy of Child and Adolescent Psychiatry (2011). Normal adolescent development, Part I. *Facts for Families,* 57. Retrieved November 17, 2014 from www.accap.org.

American Acadamy of Child and Adolescent Psychiatry (2011). Normal adolescent development, Part II. *Facts for Families,* 58. Retrieved November 17, 2014 from www.accap.org.

American Psychological Association (2002). *Developing adolescents: A reference for professionals.* Washington, DC: American Psychological Association.

Aronson, S, & Scheidlinger, S. (2002). *Group treatment of adolescents in context: Outpatient, inpatient and school.* Madison, CT: International Universities Press.

Axline, V.M. (1947). *Play therapy.* Boston: Houghton Mifflin.

Baer, S. & Garland, J. (2005). Pilot study of community-based cognitive behavioral group therapy for adolescents with social phobia. *Journal of the American Academy of Child and Adolescent Psychiatry, 44* (3), 258-264.

Bandura, A. (1989). *Social cognitive theory.* Greenwich, CT: Jai Press.

Beck, A. (1978). *Cognitive therapy and the emotional disorders.* New York:

International Universities Press.

Bernard, H.R. & Ryan, G.W. (2010). Analyzing qualitative data. Systematic

approaches. Los Angeles: Sage Publcations.

Bernstein, J. (1995). "Real Men" don't talk: Attempting psychodynamic group therapy

with inner-city boys. *Journal of Child and Adolescent Group Therapy, 5* (2),

83-106.

Blos, P. (1962). *On adolescence: A psychoanalytic interpretation.* New York: Free

Press of Glencoe.

Brabender, V. Fallon, & Smolar, A. (2004). *Essentials of group therapy.* Hoboken,

NJ: John Wiley & Sons, Inc.

Caplan, J., Usher, C. & Jellinek, M. (2009). Psychotherapy with children and

adolescents. In Cary, Crocker, Coleman, Elias & Feldman (Eds.),

Developmental-Behavioral Pediatrics (4ᵗʰ ed.), (pp. 876-884).

Philadelphia: Saunders Elsevier.

Chase, J. & Kelly, M. (1993). Adolescents' perceptions of the efficacy of short term,

inpatient group therapy. *Journal of Child and Adolescent Group Therapy, 3*

(3), 155-161.

Christie, D. & Viner, R. (2005). Adolescent development. *British Medical Journal,*

330 (7486), 301- 304.

Corder, B., Whiteside, L. & Haizlip, T. (1981). A study of curative factors in group

psychotherapy with adolescents. *International Journal of Group*

Psychotherapy, 31, 345-254.

Cramer-Azima, F. (2002). Group psychotherapy for children and adolescents. In M.

    Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook.* (3rd

    ed.) (pp. 1032-1036). Philadelphia: Lippincott, Williams & Wilkens.

Deering, C. (2014). Process-oriented groups: Alive and well. *International Journal of*

    Group Psychotherapy, 64 (2), 165-179.

Delgado, S. (2008). Psychodynamic psychotherapy for children and adolescents: An

    old friend revisited. *Psychiatry,* May, 67-72.

Elo, S. & Kyngas, H. (2007). The qualitative content analysis process. *Journal of*

    Advanced Nursing, 62 (1), 107-115.

Erikson, E.H. (1968). *Identity: Youth and crisis.* New York: Norton & Company.

Fisher, J. (2011). Adolescence: Developmental stage and mental health morbidity.

    International Journal of Social Psychiatry, 57 (S1), 13-19.

Garber, J., Clarke, G., Weersing, V. Beardslee, W., Brent, D., Gladstone,

    T.,…Iyengar, S. (2009). Prevention of depression in at risk adolescents: A

    randomized controlled trial. *Journal of the American Medical Association, 301*

    (21), 2215-2224.

Garrick, D. & Ewashen, C. (2001). An integrated model for adolescent inpatient group

    therapy. *Journal of Psychiatric and Mental Health Nursing, 8,* 165-171.

Garrison, W. & Felice, M. (2009). Adolescence. In Cary, Crocker, Coleman, Elias &

    Feldman (Eds). *Developmental-Behavior al Pediatrics (4th ed.).* (pp.62-   72).

Philadelphia: Saunders Elsevier.

Glodich, A. & Allen, J. (1998). Adolescents exposed to violence and abuse: A review

    of the group therapy literature with an emphasis on preventing trauma

    reenactment. *Journal of Child and Adolescent Group Therapy, 8* (3), 135-154.

Graneheim, U. & Lundman, B. (2004). Qualitative content analysis in nursing

    research: Concepts, procedures and measures to achieve trustworthiness.

    Nursing Education Today, 24, 105-112.

Habigzang, L., Stroeher, F., Hatzenberger, R., Cunha, R., Ramos, M. & Koller, S.

    (2009). Cognitive behavioral group therapy for sexually abused girls. *Rev

    Saude Publica, 43* (1), 70-78.

Haen, C. & Weil, M. (2010). Group therapy on the edge: Adolescence, creativity and

    group work. *Group, 34* (1), 37-52.

Hayward, C., Varady, S., Albano, A. Thienemann, M., Henderson, L. & Schatzberg,

    A. (2000). Cognitive-behavioral group therapy for social phobia in female

    adolescents: Results of a pilot study. *Journal of the American Academy of

    Child and Adolescent Psychiatry, 39* (6), 721-726.

Hoag, M. & Burlingame, G. (1997). Evaluating the effectiveness of child and

    adolescent group treatment: A meta-analytic review. *Journal of Clinical Child

    Psychology, 26* (3), 234-246.

Hudson, J., Rapee, R., Deveney, C., Schniering, C., Lyneham, H. & Bovopoulos, N.

    (2009). Cognitive behavioral treatment versus active control for children and

    adolescents with anxiety disorders: A randomized trial. *Journal of the

    American Academy of Child and Adolescent Psychiatry, 48* (5), 533-544.

Hsieh, H. & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15* (9), 1277-1288.

Kahn, G. & Aronson, S. (2007). Group treatment of traumatized adolescents: Special considerations. *Group, 31* (4), 281-293.

Kaminer, Y. (2005). Challenges and opportunities of group therapy for adolescent substance abuse: A critical review. *Addictive Behaviors, 30,* 1765-1774.

Kaminer, Y., Burleson, J. & Burke, R. (2008). The efficacy of aftercare for adolescents with alcohol use disorders: A randomized controlled study. *Journal of the American Academy of Child and Adolescent Psychiatry, 47* (12), 1405-1412.

Kapp, S. (2000). Positive peer culture: The viewpoint of former clients. *Journal of Child and Adolescent Group Therapy*, *10* (4), 175-189.

Kapphahn, C., Morreale, M., Rickert, V. & Walker, l. (2006). Financing mental health services for adolescents: A position paper of the society for adolescent medicine. *Journal of Adolescent Health, 39*, 456-458.

Kastner, J. (1998). Clinical change in adolescent aggressive behavior: A group therapy approach. *Journal of Child and Adolescent Group Therapy, 8* (1), 23-33.

Kessler, R., Berglund, P., Demler, O., Jin, R. & Walter, E. (2005). Life-time prevalence and age of onset distribution of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*, 593-602.

Kirshner, K. (1994). Fostering the sense of self: Group psychotherapy for girls in early adolescence. *Journal of Child and Adolescent Group Therapy, 4* (1), 27-45.

Kivlighan, D., Multon, K. & Brossart, D. (1996). Helpful impacts in group

    counseling: Development of a multidimensional rating system. *Journal of*

    Counseling Psychology, 43 (3), 347-355.

Kivlighan, D. & Tarrant, J. (2001). Does group therapy mediate the group climate-

    group member outcome relationship? A test of Yalom's hypothesis of

    leadership priorities. *Group Dynamics: Theory, Research and Practice, 5* (3),

    220-234.

Kline, W. (2003). *Interactive group counseling and therapy.* New Jersey: Merrill

    Prentice Hall.

Krippendorff, K. (2013). *Content analysis: An introduction to it's methodology (3rd*

    edition). Los Angeles: SAGE.

Leader, E. (1991). Why adolescent group therapy? *Journal of Child and Adolescent*

    Group Therapy, 1 (2), 81-93.

Leech, B. (2002). Asking questions: Techniques for semi-structured interviews.

    Political Science and Politics, 4, 665-668.

Levy-Warren, M. (1996). *The adolescent journey.* New York: Rowman & Littlefield

    Publishers.

Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage

    Publications.

Lomonaco, S., Scheidlinger, S. & Aronson, S. (2000). Five decades of children's

    group treatment-An overview. *Journal of Child and Adolescent Group*

    Therapy, 10 (2), 77-96.

Malekoff, A. (2004). *Group work with adolescents.* (2nd ed.). New York: The

    Guilford Press.

Malekoff, A. (2014). *Group work with adolescents.* (3rd ed.). New York: The

    Guilford Press.

Maracek, J. (2003). Dancing through mindfields: Toward of a qualitative stance in

    psychology. *Qualitative Research in Psychology,* Washington, DC: APA, 49.

Meeks, J. & Bernet, W. (2001). *The fragile alliance* (5th ed.). Malabar, Florida:

    Krieger Publishing Company.

Merikangas, K., He, J., Burstein, M., Swanson, S., Avenevoli, S., Cui, L.,…Swendsen,

    J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results

    from the National Comorbidity Study-Adolescent supplement. *Journal of the*

    American Academy of Child and Adolescent Psychiatry, 49 (10), 980-989.

Mishna, F. (1996). Finding their voice: Group therapy for adolescents with learning

    disabilities. *Learning Disabilities Research and Practice, 11,* 249-258.

Mishna, F. & Muskat, B. (1998). Group therapy for boys with features of asperger

    syndrome and concurrent learning disabilities: Finding a peer group. *Journal*

    of Child and Adolescent Group Therapy, 8 (3), 97–114.

Mishna, F. & Muskat, B. (2004). "I'm not the only one!" Group therapy with older

    children and adolescent who have learning disabilities. *International Journal*

    of Group Psychotherapy, 54 (4), 455-476.

Montgomery, C. (2002). Role of dynamic group therapy in psychiatry. *Advances in*

    Psychiatric Treatment, 8, 34-41.

O'Connell, M., Boat, T. & Warner, K. (2009). *Preventing mental, emotional, and*

    behavioral disorders among young people: Progress and possibilities.

    Washington, DC: The National Academies Press.

Ormont, L. (1992). *The group therapy experience: From theory to practice.* New

    York: St. Martin's Press.

Patel, V., Flisher, A., Hetrick, S. & McGorry, P. (2007). Mental health of young

    people: A global public health challenge. *Lancet, 369* (9569), 1302-1313.

Phipps, L. & Zastowny, T. (1988). Leadership behavior, group climate and outcome in

    group psychotherapy: A study of outpatient psychotherapy groups. *Group, 12*

    (3), 157-171.

Pojman, A. (2009). *Adolescent group psychotherapy: Method, madness and the*

    basics. New York: American Group Psychotherapy Association, Inc.

Polit, D. & Beck, C. (2012). *Nursing research: Generating and assessing evidence for*

    nursing practice. Philadelphia: Lippincott, Williams and Wilkins.

Pollock, K. & Kymissis, P. (2001). The future of adolescent group therapy: An

    analysis of historical trends and current momentum. *Journal of Child and*

    Adolescent Group Therapy, 11 (1), 3-11.

Redl, F. (1944). Diagnostic group work. *American Journal of Orthopsychiatry, 14,*

    53-67.

Reid, S. & Kolvin, I. (1993). Group psychotherapy for children and adolescents.

    Archives of Disease in Childhood, 69, 244-250.

Remschmidt, H., Nurcombe, B., Belfer, M., Sartorius, N. & Okasha, A. (2007). *The*

    mental health of children and adolescents. Chichester: Jon Wiley and Sons.

Ruffolo, M. & Fischer, D. (2009). Using an evidence-based CBT group intervention model for adolescents with depressive symptoms: Lessons learned from a school based application. *Child and Family Social Work, 14,* 189-197

Rutan, J., Stone, W. & Shay, J. (2007). *Psychodynamic group psychotherapy* (4th ed.). New York: The Guilford Press.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23,* 334-340.

Sandelowski, M (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health, 33*, 77-84.

Scheidlinger, S. (1985). Group treatment of adolescents: An overview. *American Journal of Orthopsychiatry, 55* (1), 102-111.

Schreier, M. (2012). *Qualitative content analysis in practice.* Los Angeles, CA: Sage.

Schwarz, S, (2009). Adolescent Mental Health in the United States. *National Center for Children in Poverty (www.nccp.org).* Retrieved November 21, 2014.

Seidman, I. (2013). *Interviewing as qualitative research: A guide for researchers in education and social sciences* (4th ed.). New York: Teachers College Press,

Shaughnessy, M., Main, D. & Madewell, J. (2007). An interview with Irvin Yalom. *North American Journal of Psychology, 9* (3), 511-518.

Shechtman, Z. (2003). Therapeutic factors and outcomes in group and individual therapy of aggressive boys. *Group Dynamics: Theory, Research, and Practice, 7* (3), 225-237.

Shechtman, Z. (2007). *Group counseling and psychotherapy with children and adolescents: Theory, research and practice.* New York: Routledge.

Shechtman, Z., Bar-El, O. & Hadar, E. (1997). Therapeutic factors in counseling

　　groups and psycho-educational group for adolescents: A comparison. *The*

　　Journal for Specialists in Group Work, 22, 203-213.

Shechtman, Z. & Gluk, O. (2005). An investigation of therapeutic factors in

　　children's groups. *Group Dynamics: Theory, Research and Practice, 9* (2),

　　127-134.

Sheppard, T. (2008). *Group psychotherapy with children.* New York: American Group

　　Psychotherapy Association, Inc.

Skinner, B.F. (1938). *The behavior of organisms.* New York: Appleton-Century-

　　Crofts, Inc.

Slavson, S.R. (1943). *An introduction to group therapy.* New York: International

　　Universities Press.

Speziale, H., Streubert, H. & Carpenter, D. (2011). *Qualitative research in nursing:*

　　Advancing the humanistic imperative. Philadelphia: Lippincott, Williams &

　　Wilkins.

Sugar, M. (1993). Research in child and adolescent group psychotherapy. *Journal of*

　　Child and Adolescent Group Therapy, 3 (4), 207-226.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: W.W.

　　Norton & Company

Tellerman, J. (2001). The solutions unlimited now program: Psychodynamic/cognitive

　　structured groups for teens, pre-teens and families. *Journal of Child and*

　　Adolescent Group Therapy, 11 (4), 117-134.

Tuckman, J. (1995). Short-term groups with children: The yellow brick road to healthy

    development. *Journal of Child and Adolescent Group Therapy, 5* (1), 3-17.

Wolf, Z. (2007). Ethnography: The method. In Patricia Munhall (Ed.) *Nursing*

    research: A qualitative perspective (pp. 293-330). Boston: Jones and Bartlett

    Publishers.

Wood, A., Trainor, G., Rothwell, J., Moore, A. & Harrington, R. (2001). Randomized

    trial of group therapy for repeated deliberate self harm in adolescents. *Journal*

    of the American Academy of Child and Adolescent Psychiatry, 40 (11), 1246-

    1253.

Yalom, I.D. (1970). *The theory and practice of group psychotherapy.* New York:

    Basic Books.

Yalom, I.D. (1975). *The theory and practice of group psychotherap* (2nd ed.).

    New York: Basic Books.

Yalom, I.D. (1985). *The theory and practice of group psychotherap* (3rd ed.).

    New York: Basic Books.

Yalom, I.D. (1995). *The theory and practice of group psychotherap* (4th ed.).

    New York: Basic Books

Yalom, I.D. (2005). *The theory and practice of group psychotherapy* (5th ed.).

    New York: Basic Books