Measuring Leadership Competence in Group Therapy: Development of an Adapted Version of the Group Leadership Questionnaire

by

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Abstract

To contribute to the active efforts of increasing consistency and availability of group psychotherapy training, the present study sought to adapt a measure of group leadership styles into a brief, written measure of knowledge and skills related to the provision of process-oriented group therapy. The Group Leadership Competency Questionnaire (GLCQ) consists of 10 scenarios that could occur in a process-oriented therapy group, with five response options per scenario. It was created by synthesizing the categorization of response options as excellent, moderate, or poor choices by 10 expert group therapists. Each GLCQ scenario was accompanied by two excellent response options, one moderate option, and two poor options, as determined by the aforementioned expert sample ($N = 10$). The GLCQ was given to group therapy experts ($n = 60$), trainees ($n = 67$), and novices ($n = 80$). Respondents were asked to choose the two best responses on each scenario, and each scenario yielded a total score of 0-4 (2 points for each excellent response, 1 point for a moderate response, and 0 points for each poor response). The mean total GLCQ score, calculated as the sum of all scenario scores, was significantly different across groups, Welch's $F(2, 134.624) = 315.285$, $p < .001$. The mean score of experts ($M = 37.4$, $SD = 1.9$) was higher than that of trainees ($M = 35.8$, $SD = 2.3$, $p < .001$). Likewise, the mean for experts was higher than that of novices ($M = 24.3$, $SD = 4.1$, $p < .001$) and the trainee mean was higher than the novice mean ($p < .001$). The internal consistency of the GLCQ across the combined sample was high ($\alpha = .88$), although it was low for experts ($\alpha = .44$), trainees ($\alpha = .52$), and novices ($\alpha = .48$) when sample scores were analyzed separately. Data on response speed,

completion rates, and completion time are also reported. Analysis of the completion time data suggested that the GLCQ can be completed in approximately 10 minutes. These data provide promising indicators for the utility of the GLCQ in research and training.

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List of Abbreviations

ABPP American Board of Professional Psychology

AGPA American Group Psychotherapy Association

APA American Psychological Association

APPIC Association of Psychology Postdoctoral and Internship Centers

CBT Cognitive Behavioral Therapy

CCCI-R Cross-Cultural Counseling Inventory-Revised

CGP Certified Group Psychotherapist

CRSPPP Commission for the Recognition of Specialties and Proficiencies in Professional Psychology

CTAS Cognitive Therapy Awareness Scale

CTS Cognitive Therapy Scale

GIQ Group Incidents Questionnaire

GLCQ Group Leadership Competency Questionnaire

GPIRS Group Psychotherapy Intervention Rating Scale

GTQ Group Therapy Questionnaire

GTQ-C Group Leadership Questionnaire

IBCGP International Board for Certification of Group Psychotherapists

MAKSS Multicultural Awareness, Knowledge, and Skills Survey

MCAS Multicultural Counseling Awareness Scale

MCI	Multicultural Counseling Inventory
PPCT	Columbia Psychodynamic Psychotherapy Competency Test
PSR	Perceiving, Selecting, Risking Model
SoA	Standards of Accreditation

Chapter I. Introduction

Context of the Problem

Effectiveness of group therapy. Whether its beginnings are attributed to Sigmund Freud, John Hersey Pratt, Alfred Adler, Jacob Moreno, or any combination of these and many other contributors, it is clear that over the past century group therapy has evolved into a broadly-practiced, generally well-accepted, and valuable mode of psychological treatment (Barlow, Burlingame, & Fuhriman, 2000; Strauss, Spangenberg, Brähler, & Bormann, 2015). Over the last several decades, researchers have amassed compelling data documenting its efficacy and effectiveness (Barlow, 2013; Barlow et al., 2000; Burlingame et al., 2016; Burlingame, Fuhriman, & Mosier, 2003; Burlingame, Strauss, & Joyce, 2013; Fuhriman & Burlingame, 1994; Kivlighan, Coleman, & Anderson, 2000; McRoberts, Burlingame, & Hoag, 1998). Findings of a large meta-analysis revealed no difference in overall effect size between group and individual therapy when these two modes of therapy were compared within the same study (McRoberts et al., 1998). In another meta-analysis of 111 experimental and quasi-experimental studies, Burlingame et al. (2003) found an active versus waitlist control effect size of .58, concluding that among the studies they analyzed, recipients of group therapy fared an average of 72% better than those without treatment. Most recently, findings from a large archival analysis of Outcome Questionnaire (Lambert et al., 1996) data from clients in individual, group, or conjoint individual and group treatment in a naturalistic setting provided further support for this equivalency, as they found individual and group outcomes to be equal (Burlingame et al., 2016).

In addition to support for the effectiveness of group therapy, the influence of managed care is likely to have an effect on the prevalence of group treatments within the mental health profession (Taylor et al., 2001; The Group Specialty Council, 2014). Because fees can be spread

out among group participants, group is therefore less expensive for each individual and has become an attractive option for many managed care organizations.

Group therapy as a specialty. The current zeitgeist appears to be one in which group treatments are gaining acceptance in the field and no longer seen by most as a substandard or back up option to individual treatments, yet group therapy has not yet received full recognition as a specialty requiring specific training (Barlow, 2008). Group psychology is currently recognized as a specialty by the American Board of Professional Psychology (ABPP), but is not recognized as such by the American Psychological Association (APA) and the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). A petition to the latter for the official APA/CRSPPP recognition of Group Psychology and Group Psychotherapy as a specialty (The Group Specialty Council, 2014) was recently reviewed and CRSPPP made a request for a revised petition to be submitted by January 1, 2018 (D. Rosenthal, personal communication, April 3, 2017). Recognition was sought unsuccessfully in 2009 and 2012.

The CRSPPP petition states that group is traditionally assumed to be contained within the generalist competencies of professional psychology, but that competent group leadership, in fact, requires a specialized set of skills that are not automatically included in the training of all professional psychologists (The Group Specialty Council, 2014). Although there is of course some crossover with general psychological practice, the petition lists many distinctive skills required of group psychologists, including in areas of assessment (e.g., determining appropriateness for group), intervention (e.g., group-level interventions and process comments), consultation (e.g., group-specific ethical issues, such as boundaries), supervision (e.g., integrating group development and process into supervision), research and inquiry (e.g., specific

complexities in group research design), and public interest (e.g., teaching socializing techniques). Dies (1994a) also emphasized the uniqueness of the skills required to successfully lead a therapy group and stated that individual therapy skills are not sufficient and are sometimes even detrimental in providing quality group therapy.

Training availability and deficits. Despite these indications that group therapy is an established and enduring specialty field of psychology and counseling, many authors have argued that specific training in group psychology and group therapy during professional training is insufficient for those who will be leading groups in their professions (Barlow, 2008; Conyne & Bemak, 2004; Crozier & Collier, 2015; Fuhriman & Burlingame, 2001; Goodman, Knight, & Khudododov, 2014; Markus & King, 2003). In a recent nationwide survey of graduate psychology programs, Crozier and Collier (2015) found that while a group class was offered by about two thirds of respondents and opportunities for group practice and research experience was available in many programs, the training opportunities were inconsistent and did not reliably prepare all students for competent group practice. Likewise, they found that a group class was more commonly offered in counseling psychology programs than in clinical psychology programs, so this problem may be even more pronounced in clinical psychology students.

The desire for more training in group therapy during graduate programs led a group of students, professors, administrators, and local practitioners at Rutgers University to create a dedicated group therapy training clinic and affiliated, comprehensive training program (Mueller, 2010). The clinic appears to still be thriving today; however, the aforementioned recent survey of clinical and counseling psychology programs nationwide revealed no such group-specific practicum opportunities at the programs of any of the respondents in the sample, which

presumably did not include Rutgers (Crozier & Collier, 2015). Thus, it appears that opportunities for such comprehensive training in group therapy are rare.

To investigate the validity of an assumption that group training during the predoctoral internship will make up for any training that is not achieved in coursework and practicum experiences, Markus and King (2003) surveyed 177 Association of Psychology Postdoctoral and Internship Centers (APPIC) training directors and found inadequate training availability overall in the four areas of didactic instruction, group leadership experience, supervision, and experiential group opportunities. In regards to group leadership, they found opportunities for experience with groups of different lengths, structures, and theoretical orientations to be especially lacking. Although there were certainly exceptions to this inadequacy of training in some APPIC training centers, Markus and King expressed great concern about the competence of many new psychologists to lead groups as they enter the workforce. It is unclear whether this situation within internship sites has changed substantially in the years since this 2003 study.

Following the completion of doctoral training, specialist credentialing in group therapy is available through multiple avenues. These include board certification in group psychology through the ABPP, the certified group psychotherapist (CGP) credential through the multidisciplinary American Group Psychotherapy Association (AGPA), and recognition as a fellow of Division 49 of APA, also named the Society of Group Psychology and Group Psychotherapy (Barlow, 2008). Since none of these credentials are required to provide group therapy, however, they only provide additional training for those who seek them out.

This insufficiency of group training also extends to other mental health fields outside of professional psychology, including psychiatry (Kovach, Dubin, & Combs, 2015), social work (Goodman et al., 2014), and counseling (Ohrt, Ener, Porter, & Young, 2014). Fuhriman and

Burlingame (2001) documented inconsistencies in training across clinical, counseling, and school psychology, psychiatry, and social work programs. They found large differences in number of required group courses, with psychiatry programs having the most required courses. In the same study, directors of psychiatry, counseling psychology, and social work programs reported valuing group therapy more than did directors of clinical and school psychology programs. Existing programs have also experienced substantial challenges including budget cuts, lack of administrative support, and competing demands for trainees that have resulted in gradual reductions in the comprehensiveness of training available (Stone, 2010). Regarding the training of masters-level counselors, Ohrt et al. (2014) reported that when reflecting on their training, many practicing group counselors noted a desire for more group classes, inconsistent and sometimes inadequate supervision of their early group work, and a belief that group counseling requires its own unique skillset and should be given more attention in training than it is. Concerns about the lack of group training across disciplines are important to this work because practitioners in all of these fields provide group therapy services, and it is therefore vital to the public that those providing services are competent in group therapy and not merely doing individual therapy in a group setting.

This widespread concern about the inconsistencies and inadequacies of training in group psychology and group psychotherapy makes research in the areas of group training, leadership, and competency very important to the delivery of quality group services. Several have called directly for further research into group leadership behaviors (Kivlighan, 2008; Ward, 2005) and, specifically, group leadership competence (Brown, 2011; Stockton & Morran, 2011). This study was an attempt to heed this call. Specifically, the aims of the present study were to take the first important steps towards a reliable and valid written measure that can assess competence to

provide interpersonal process group therapy that can be used in further research in the areas of group therapy training and competence.

Overview of Existing Measures

The Group Leadership Questionnaire (GTQ-C; Wile, 1972a) was created by Daniel Wile in the 1960s to measure leadership behaviors and tendencies in group therapy. It appears to have sat unused from the late 1970s until early this century, when it was used in a series of studies (e.g., Kivlighan & Kivlighan, 2009) to examine cognitive processes of group leaders. The GTQ-C is a scenario-based measure that contains vignettes describing situations that could occur in a therapy group and a lengthy list of potential responses for each scenario. There is no right or wrong response on the GTQ-C. Rather, it was originally created to measure leader tendencies toward different types of interventions.

The Group Incidents Questionnaire (GIQ; Stokes & Tait, 1979) was created around the same time as the GTQ-C as a written measure of skills and competence in group therapy. It consists of scenarios that could occur in a process group and three possible responses of varying quality. On each scenario, there is a designated best answer, an acceptable answer, and an unacceptable answer (i.e., a poor response). Although psychometrics for the GIQ were favorable, the distinction between the quality of responses are so obvious that the measure only results in variability for those who know nothing about group therapy. Thus, it has no utility for measuring skills or competence in experienced clinicians or group therapy trainees.

Wile and colleagues (1970b) reported that they initially created the GTQ-C and its previous two versions as an attempt to bridge clinical meaningfulness and scientific measurability in regards to group leadership behaviors. The current study was a further attempt to do just that in regards to group leadership competence, and more specifically, to attempt to

provide a mechanism for measuring competence in a written measure that is much less time- and labor-intensive than are existing measures (reviewed in Chapter II) requiring direct observation of behavior.

In the present study, I sought to adapt the GTQ-C to create a measure that uses an approach similar to that of the GIQ, but that fully integrates the complexity and nuances involved in the many clinical decisions made while leading a process group.

This new measure could open the door to many research applications. For example, it could allow for examination of the effects of group leader competence on member outcomes. It may also subsequently be used in numerous contributions to the discussion of group therapy training, such as an examination of the relationship between competence and self-rated perceived competence. The measure could possibly even be used for gatekeeping purposes as one component of a global assessment, as with the Columbia Psychodynamic Psychotherapy Competency Test (PPCT; Mullen, Rieder, Glick, Luber, & Rosen, 2004). The PPCT, discussed in more detail below, is a scenario-based measure designed to assess competency to provide psychodynamic therapy. It is used as one component of gate-keeping for psychiatric residents in some programs (Mullen, 2015).

Hypotheses

The purpose of this exploratory study was to develop an adaptation of the GTQ-C as a written measure of competence to lead a process-oriented therapy group. As such, most aspects of the study did not lend themselves to traditional scientific hypotheses; however, the primary goals and aspects of the study are listed below. Hypotheses are listed where appropriate, however numbering is continuous between goals and hypotheses for readability and consistency.

Phase 1: The responses of subject matter experts to the full GTQ-C, with minor revisions made for the this study, will be used to reduce the number of vignettes and response options and to create the scoring system for the resulting measure, to be deemed the Group Leadership Competency Questionnaire (GLCQ).[1]

Goal 1a: The ratings of 10 experts classifying each response option as excellent, moderate, or poor will yield satisfactory agreement, such that the options can be reduced to two options in each category per vignette.

Goal 1b: Intracorrelation coefficients (ICCs) for expert ratings on each vignette will be used as a measure of interrater reliability to reduce the GTQ-C to the 10 vignettes with the highest reliability to make up the GLCQ.

Goal 1c: Expert ratings will be used to create the scoring criteria for the GLCQ.

Phase 2: Three samples (experts, trainees, and novices) will be used to provide pilot validity data for the revised measure resulting from Phase 1.

Hypothesis 2a: GLCQ scores of experts will be significantly higher than those of trainees.

Hypothesis 2b: GLCQ scores of experts will be significantly higher than those of novices.

Hypothesis 2c: GLCQ scores of trainees will be significantly higher than those of novices.

Goal 2d: Internal consistency will be measured via Cronbach's alpha.

Goal 2e: Data on response rate, completion time, and incomplete responses will be reported to provide insight regarding the utility of the measure.

1. Note that the GLCQ title of the adaptation developed in the present study is being used only to distinguish this adaptation of the GTQ-C from the original. See Appendix E for email exchange with Wile regarding conditions for use of the instrument created in the present study.

Chapter II. Literature Review

Competence

Merriam-Webster defines competence as, "the ability to do something well; the quality or state of being competent" ("Competence," n.d.). More specifically, Sharpless and Barber (2009) define intervention competence for psychologists as a complex, nuanced construct that is developmental in nature and should ultimately focus more on clinical judgement about when and why to take any specific action rather than specific rules and techniques of delivering an intervention. Competence is often conceptualized as a list of individual competencies (Bienenfeld, Klykylo, & Knapp, 2014) or broken into domains of knowledge, attitudes, and skills (as made popular by Sue et al., 1982). Others, however, have argued that actual professional competence is greater than the sum of its parts, or more holistic than just demonstrating individual competencies (Ridley, Mollen, & Kelly, 2011; Rodolfa et al., 2005; Yager, Mellman, Rubin, & Tasman, 2005).

The cube model of competence. Over the last 15 years, a great deal of energy has been put into the task of defining and carefully delineating competence in professional psychology (e.g., Kaslow et al., 2006). A key component of this effort was the Competencies Conference, held in 2002 by APPIC, APA, and approximately 30 other co-sponsors (Kaslow et al., 2004). Based largely on work from that conference, the most widely-accepted framework for defining competence is the cube model (Rodolfa et al., 2005). This model outlines foundational competencies, functional competencies, and broad stages of professional development. Within Rodolfa's cube model, the six domains of foundational competency, which are the basic building blocks of the professional identity of psychologists, include reflective practice/self-assessment, scientific knowledge/methods, relationships, ethical/legal standards/policy, individual/cultural

diversity, and interdisciplinary systems. The six domains of functional competency, which are the primary areas of work responsibilities and tasks of psychologists, are assessment/diagnosis/case conceptualization, intervention, consultation, research/evaluation, supervision/teaching, and management/administration. Finally, the five stages of professional development in which the development of competence occurs are doctoral education, internship, postdoctoral supervision, residency/fellowship (where applicable), and continuing competency. Within this framework, all domains purportedly stay the same for all psychology specialties, but the relative importance of each domain shifts based on the characteristics of the specialty, including factors such as population, setting, or work tasks (Rodolfa et al., 2005). This model has been become the basis over the last decade for further work in developing competencies in professional psychology, and these are discussed in more detail below (APA Council of Representatives, 2015; Fouad et al., 2009).

Group competencies. In her volume in a series on Specialty Competencies in Professional Psychology, Barlow (2013) adapted the cube model to delineate competencies in group psychology. Following the format of Fouad et al. (2009), but adapting it to apply more directly to this area of specialty, Barlow listed an essential component and one to four behavioral anchors for each component of each competency at varying stages of professional development. Closely mirroring the overall competency benchmarks for the profession (Fouad et al., 2009), the seven foundational competencies include group professionalism, reflective practice/self-assessment/self-care, scientific knowledge and methods of group research, group relationships, group issues of diversity, ethical/legal standards and policies of groups, and interdisciplinary systems involved in groups. Similarly, the six functional competencies include group assessment, group interventions, group research and evaluation, supervision and training,

teaching, and management/administration. Note that the cube model competencies of consultation and advocacy were left out of the group competencies. This adaptation of the competency benchmarks of the profession as a whole is in line with Rodolfa et al.'s (2005) assertion that the competencies apply to specialties in psychology but at differing configurations of importance.

Other explications of competencies, best practices, or guidelines in group psychology and group therapy are primarily from professional organizations. AGPA, a multidisciplinary group organization independent of any larger professional organizations, has a list of Clinical Practice Guidelines intended to augment clinical judgment rather than serve as compulsory standards of behavior (American Group Psychotherapy Association [AGPA], 2007; Bernard et al., 2008; Leszcz & Kobos, 2008). These guidelines, which were recommended to be revised by 2015 (AGPA, 2007) but have not been yet, include sections on creating successful therapy groups, therapeutic factors and therapeutic mechanisms, selection of clients, preparation and pre-group training, group development and stages, group process, therapist interventions, reducing adverse outcomes and ethics, concurrent therapies, and termination of group therapy (AGPA, 2007; Bernard et al., 2008). Meanwhile, the Association for Specialists in Group Work, a subsidiary of the American Counseling Association, has a set of Best Practice Guidelines (Thomas & Pender, 2008), as well as specific principles for multicultural and social justice competence in group work (Singh, Merchant, Skudrzyk, & Ingene, 2012).

Assessing competence. Following the development of the cube model (Rodolfa et al., 2005), the obvious next question was how competence should be assessed. An APA task force that was convened following the Competencies Conference produced several articles and a final report outlining principles, challenges, and recommendations of assessing competence in

professional psychology for gate-keeping and other practice-related purposes (Kaslow et al., 2006, 2007; Leigh et al., 2007; Lichtenberg et al., 2007). This body of work defining competence culminated in a comprehensive document of competency benchmarks (Fouad et al., 2009). Fouad et al. modified the cube model by adding one foundational competency (professionalism) and two functional competencies (teaching and advocacy) and delineating three specific training levels (readiness for practicum, readiness for internship, and readiness for entrance to practice). They further defined and listed the essential components and behavioral anchors for each of the 15 competency domains at each of the three developmental levels. The revised benchmarks document, though lengthy, was for a time the most-accepted list of standards for general competency in psychology (American Psychological Association, n.d., 2011).

More recently, the new Standards of Accreditation (SoA), which went into effect in January 2017, have collapsed the foundational and functional competencies down into the following nine domains for the doctoral and internship levels: research; ethical and legal standards; individual and cultural diversity; professional values, attitudes, and behaviors; communication and interpersonal skills; assessment; intervention; supervision; and consultation and interprofessional/interdisciplinary skills (APA Council of Representatives, 2015). At the post-doctoral residency level, the SoA also require competencies in integration of science and practice, individual and cultural diversity, and ethical and legal domains, as well as program-specific, area-of-focus, or specialty competencies. Specific requirements for the demonstration of each competency at each level of training are outlined in the Implementing Regulations (Commission on Accreditation, 2015).

Although the benchmarks and SoA have great utility in assuring quality training, assessment of these competencies requires extensive supervision and observation and therefore have limited research applications. Whether global or specific, measurement of competence is notoriously challenging (Brown, 2011; Sharpless & Barber, 2009).

One key principle that is emphasized in general methods of assessing competence is that of fidelity to practice (Kaslow et al., 2006, 2007). That is, to accurately assess competence, assessment methods should mimic actual practice as closely as possible. For example, computerized simulations or role plays with simulated patients are preferable to multiple choice examinations or other simple measures of knowledge. Of course, assessment methods of higher fidelity to practice bring with them substantial practical challenges, as they are time-consuming, expensive, and require substantial training to obtain reliable ratings or interpretations of results (Kaslow et al., 2006; Lichtenberg et al., 2007). These practical considerations become even more salient when attempting to assess competence for the purposes of research rather than practice. For example, supervisors often conduct global assessments of competence after supervising someone for several months or more, but this is often not feasible within the confines of a research study. Sharpless and Barber (2009), however, argued that psychologists have both ethical and professional obligations to determine ways of measuring competence, despite the challenging and murky nature of this task.

As a counterpoint to the call for measures that have high fidelity to practice, measures that involve actual therapy clients can introduce additional uncontrolled variables, especially when the purpose of the assessment is research. In a meta-analysis of therapy outcomes as a function of training and experience, Stein and Lambert (1995) noted that even after many stringent eliminations of inadequate studies, the ones that remained were fraught with myriad

design issues inherent to this type of research. These issues included unequal caseloads, failure to assign cases randomly, unequal access to supervision or consultation by study therapists, and no standardized length of therapy. Although this meta-analysis focused on a slightly different domain (i.e., therapy outcomes rather than direct measures of competence), the analysis provides further support for the necessity of using measures of competence not involving actual therapy clients, so that more variables can be controlled, at least in the case where competence is being measured for research purposes rather than for certification or gate-keeping.

Measurement of Competence

The following is a review of ways in which others have measured competence, both for research and practice purposes. Although the present study was primarily aimed at measuring competence for research, there is considerable overlap between these two domains, so it is important to review both.

Global competency assessment. In terms of evaluating trainee competence for educational and gate-keeping purposes, Kaslow et al. (2006) and Leigh et al. (2007) broke methods of assessment into four categories. The first category is measures of knowledge, which often involve multiple choice exams. The second, measures of professional decision-making, refers primarily to a case-based oral exam, which is used in several fields. The third, measures of performance and professional attributes, consists of global rating scales, portfolios, direct observation, and 360-degree evaluations that look at all aspects of the trainee's performance. The fourth category is integrated assessments of practice-based skills and tasks, which includes clinical case situations, role play, and other simulations that intend to mimic real life practice and have high fidelity to practice. Both case-based oral exams and simulations have been piloted in psychology licensure, but neither successfully (Leigh et al., 2007; Smith, 1983). The

comprehensive Competency Assessment Toolkit further details these assessment methods (Kaslow et al., 2009).

Some authors have advocated for a multi-method approach (Sharpless & Barber, 2009; Yager et al., 2005). Others have presented numerous potentially helpful modes of assessment, including simulations and models, among others (Manring, Beitman, & Dewan, 2003). Manring et al. (2003) specified that in general, written examinations are not helpful for competency assessment in trainees, however they noted intriguing promise in a more complex multiple choice exam that integrates written scenarios and requires trainees to recognize and choose the best response to various psychological phenomena in vignettes. The latter commentary was in reference to the PPCT, which is further discussed below (Mullen et al., 2004).

General individual therapy effectiveness and competence. Of course, many researchers have sought to measure effectiveness and competence specifically in the provision of individual therapy (e.g., Budge et al., 2013). Early attempts to do so used clients' ratings of their therapists or therapy sessions, collected via several different surveys completed immediately following a session (Ponterotto & Furlong, 1985). More recently, researchers have measured competence through self-reported perceived competence, either generally (Calabrese et al., 2010) or regarding a particular presenting problem such as problem gambling (Drebing et al., 2001). This approach is obviously very limited, as it only measures an individual's perception of his or her competence rather than providing any objective measurement. Client outcomes are also often used to approximate competence in individual therapy (Budge et al., 2013; Stein & Lambert, 1995). In a very different approach, Fernández-Liria et al. (2010) used a scenario-based assessment tool similar to the PPCT (Mullen et al., 2004), with the addition of an open response component, to test general psychotherapeutic microskills, but their measure appears to

be less-widely used and not thoroughly validated. Global psychology competency assessment such as 360-degree evaluations, particularly when used for professional progression and gate-keeping purposes, typically include extensive evaluation of individual therapy competence (Kaslow et al., 2006, 2009; Leigh et al., 2007).

Multicultural counseling competence. Measures of multicultural competence are quite commonly used in research (e.g., Dillon et al., 2016; Johnson & Jackson Williams, 2015). In the early-1990s as the construct of multicultural counseling competence gained momentum, several measures of multicultural competence were developed concurrently, including the Cross-Cultural Counseling Inventory-Revised (CCCI-R), the Multicultural Counseling Awareness Scale (MCAS), the Multicultural Counseling Inventory (MCI), and the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS; Ponterotto, Rieger, Barrett, & Sparks, 1994; Sodowsky, Taffe, Gutkin, & Wise, 1994). Three of these, the CCCI-R, MCI, and MAKSS, are all brief self-report measures, while the MCAS is a brief rating by a supervisor based on observation of individual therapy or a response to a role-played vignette (Cartwright, Daniels, & Zhang, 2008; D'Andrea, Daniels, & Heck, 1991; Kim, Cartwright, Asay, & D'Andrea, 2003; Ponterotto et al., 1994; Sodowsky et al., 1994). Some of these, in particular the MCI and MAKSS, are still commonly used in counseling research today (e.g., Hill, Vereen, McNeal, & Stotesbury, 2013; Johnson & Jackson Williams, 2015). The original article detailing the MCI's development (Sodowsky et al., 1994) was listed in Google Scholar as having been cited 666 times as of May 13, 2017.

There is substantial reason, however, to question the validity of self-report multicultural competence measures. In the limitations section of the aforementioned article on the MCI, Sodowsky et al. (1994) discussed concerns related to face validity and social desirability, but

they made no mention of fidelity to practice, which is low in this instrument. They stated that social desirability appears not to affect ratings, but discussed the possibility of including a validity scale in the future to ensure that social desirability was not in play. Kim et al. revised the MAKSS-Counselor Edition in 2003, although this most recent version of the scale is still based entirely on self-evaluation and has high face-validity. The small exception here is the awareness subscale, which assesses belief rather than strict self-evaluation. Not surprisingly, counseling students' scores on the MAKSS-Counselor Edition-Revised were significantly higher than their observer-rated competence, measured by MCAS scores based on observation of a counseling role-play scenario (Cartwright et al., 2008). Thus, when presented with a face-valid self-report measure, students demonstrated an inflated view of their own multicultural counseling competence. Constantine and Ladany (2000) compared scores on four major measures of this type with a measure of social desirability and multicultural case conceptualization ability, as rated by an objective coding system. The scales investigated included the CCCI-R, MAKSS, MCI, and the Multicultural Counseling Knowledge and Awareness Scale, which is a revised version of the MCAS. Three of the four scales were positively related to social desirability. After statistically controlling for social desirability, none of the multicultural competence scales had any significant correlation with multicultural case conceptualization ability. Despite this rather condemning evidence that this type of scale most likely measures confidence or *desired* multicultural competence, instead of providing any evidence of actual competence, these scales are still very widely used in research.

Similarly, another study around the same time found that self-rated multicultural competence was positively related to social desirability and had very little relationship with multicultural competence as rated by observers based on a case conceptualization of an ethnic

and gender minority client (Worthington, Mobley, Franks, & Tan, 2000). The knowledge subscale, however, of the self-rated multicultural competence scale used in this study was positively related to observer-rated competence. In other words, participants' self-rating of their multicultural competence appeared to be unrelated to actual skill in this area, but questions directly testing their multicultural knowledge did correspond to their skills. This study simultaneously adds to the argument against the general utility of self-rated multicultural competence scales and lends support to the virtues of measures of knowledge in assessing competence.

Supervision competence. The area of clinical supervision is often discussed in a manner similar to group therapy, in that despite the widespread practice of supervision by professional psychologists and the special skills and training required to do it well, training and regulation in supervision are quite insufficient and often inconsistent (Falender et al., 2004; Scott, Ingram, Vitanza, & Smith, 2000). Following a three-day work group at the 2002 Competencies Conference, Falender et al. (2004) made a preliminary attempt to define supervision competencies and called for the development of evidence-based mechanisms to assess supervision competence. They noted that supervision competence is far more complex and multifaceted than the unitary construct it is often assumed to be. At that time, methods of assessing supervision competence included the documentation of training and experience, supervisor evaluations, and supervisee feedback. Recent efforts include self-assessment instruments (Falender, Shafranske, & Ofek, 2014) and the use of portfolios to assess clinical supervision competence (Bagnall & Sloan, 2014). This area is clearly still forming and evolving (Genuchi, Rings, Germek, & Cornish, 2015).

Psychotherapy competence in psychiatric residents. Training sites for psychiatric residencies are mandated to demonstrate residents' competence in delivering cognitive behavioral (CBT), psychodynamic, and supportive psychotherapy (Manring et al., 2003; Sudak & Goldberg, 2012; Truong, Wu, Diez-Barroso, & Coverdale, 2015; Weerasekera et al., 2003; Yager et al., 2005). These efforts to produce psychiatrists who are skilled in psychotherapy have led to fierce debate (Yager et al., 2005) and numerous attempts to reliably assess competence in these domains (e.g., Mullen et al., 2004; Sudak, Beck, & Wright, 2003). Despite the existing mandate, Truong et al. (2015) reviewed studies of the efficacy of psychotherapy training in residency programs and found very few studies using validated measures of competence. This specific area of psychotherapy competence in psychiatric residents still warrants some focused attention in this review of literature, particularly in regards to CBT and psychodynamic psychotherapy, because of the widespread efforts put into measuring competence as a result of the aforementioned mandate.

CBT. In the case of CBT competence, assessment methods largely consist of scales that provide a structured method of gathering observer ratings of trainees' performance, using supervisor or other trained experts to complete the scales (Barber, Liese, & Abrams, 2003; Sudak et al., 2003). This type of competence assessment is typically used in measuring overall psychotherapy competence in trainees, as well (Fernández-Liria et al., 2010; McGowen, Miller, Floyd, Miller, & Coyle, 2009; Weerasekera et al., 2003). The most commonly used scales include the Cognitive Therapy Scale (CTS; Sudak et al., 2003) and the Cognitive Therapy Adherence and Competence Scale, a broadening and deepening of the CTS (Barber et al., 2003). Weerasekera et al. (2003) reported regular use of the CTS in their competency-based psychotherapy training program. Additionally, the Cognitive Formulation Rating Scale assesses

trainees' ability to conceptualize cases using a CBT framework and the Cognitive Behavior Therapy Supervision Checklist is used to track the accomplishment of specific competencies (Sudak et al., 2003).

The notable exception to scales using ratings of actual performance is the Cognitive Therapy Awareness Scale (CTAS), which uses true-false questions to directly test CBT knowledge and has been validated in both English and Japanese (Fujisawa et al., 2011; Sudak et al., 2003). The CTAS was originally developed to assess basic knowledge of patients being treated with CBT, but has been used as a pre- and post- measure in CBT training courses. In their validation of the CTAS-J, the Japanese version, Fujisawa et al. (2011) suggested the measure as an initial gatekeeper, requiring that trainees get at least 32 of the 40 questions correct before they begin to see patients. They also found that although the scale only measures knowledge, it correlated with trainees' training and practice experience.

Psychodynamic. Regarding psychodynamic psychotherapy competence, some have argued that truly demonstrating such competence is not possible and therefore should not be required for psychiatric residents (Yager et al., 2005). For example, Weerasekera et al. (2003) noted their difficulty in finding an objective measure of psychodynamic therapy competence despite their training program's regular use of standardized rating scales to measure competence in other types of psychotherapy. Others, however, argue that a multi-method approach can adequately demonstrate competence (Yager et al., 2005).

One promising attempt to measure psychodynamic competence, and perhaps the most notable exception to the general disdain for multiple choice exams or questionnaires in the assessment of competence, is the aforementioned PPCT (Mullen et al., 2004). Mullen et al. used eight detailed vignettes to create a multiple-choice measure that maintains a relatively high

fidelity to practice. The format of this 57-question measure includes an overview of a case, followed by vignettes from numbered sessions. Each vignette is followed by one or more questions that requires test takers to recognize and respond appropriately to various situations, all from a psychodynamic perspective. Mullen et al. (2004) used experts both to write questions and determine the most correct answer, crafting questions in a way that assesses nuanced aspects of professional decision-making rather than solely the cut and dry situations that are often assessed in standard measures of knowledge. The test was then validated with both psychoanalytic experts and second, third, and fourth-year psychiatric residents. They found both training and experience effects, as well as a correlation with supervisor ratings in advanced residents. Some authors have asserted, albeit in commentary unsupported by data, that the PPCT has little to no translation to what people would do with real clients (Yager et al., 2005). However, there are data supporting its validity, reliability, and practical utility as a method of measuring competence in psychodynamic psychotherapy (Mullen et al., 2004), and others have made particular note of its practical benefits, particularly for research purposes (Zoppe, Schoueri, Castro, & Neto, 2009). The authors crafted the measure to assess psychiatric residents' competence and it continues to be given to residents in many psychiatry programs each year (Mullen, 2015).

Group therapy. The following is a review of several measures related to competence in group therapy.

Observer rating scales. One category of these measures is structured rating scales used to quantify direct observation of group leadership, whether of real or practice clients. In their study of the efficacy of a skill-based training for group counseling interventions, Toth and Stockton (1996) measured the frequency of here-and-now interventions in five minutes of

videotaped group leadership. As discussed by the authors, a notable limitation to this study was the use of a simple skill count as the dependent variable measure, because this only measures quantity and ignores quality and depth of the skill.

Another observer-based measure of group leadership competence is the Group Psychotherapy Intervention Rating Scale (GPIRS; Chapman, Baker, Porter, Thayer, & Burlingame, 2010). The GPIRS is a validated, 48-item scale used by trained observers to rate the quality of interventions in three dimensions: group structuring, verbal interactions, and creating and maintaining a therapeutic emotional climate. Ratings are provided based on the observation of one full group therapy session. The items and domains on the GPIRS were all chosen based on specific interventions that have evidence linking them to the enhancement of group therapeutic factors. Although several other measures exist for directly rating group leader behaviors within a therapy session, most of other measures of this type were created for a single study and lack empirical validation (Chapman et al., 2010; e.g. Toseland, Rossiter, Peak, & Hill, 1990).

Cognitive processes of group therapists. Another line of research related to competence and experience in group leadership has examined cognitive processes of group therapists and how those processes differ between clinicians of differing experience levels. Hines, Stockton, and Morran (1995) used a thought-listing instrument to collect and categorize self-talk of group therapists as they watched a 20-minute video of a group session. The authors found that two categories of thoughts accounted for 56% of the variance in amount of group leadership experience. These categories were "interpretations of group process," in which the subject posited an explanation or analysis of an interpersonal event between two or more group members, and "internal question regarding member," which reflects a desire or need to gather

additional information to help reach another interpretation or conclusion about that specific group member. Thoughts in both categories occurred more frequently in more experienced group leaders and distinguished participants of different experience levels.

A series of five studies by Dennis Kivlighan and colleagues took several different approaches to examine this same vein of inquiry. In the first of these, participants watched a videotaped group counseling session and then rated the perceived similarity of each pair of group members (Kivlighan & Quigley, 1991). Experienced therapists were found to use more dimensions to conceptualize group members than did novice therapists, and the experienced therapists made greater cognitive distinctions between group members. In short, it appears that experienced therapists' conceptualizations were more complex than those of novice clinicians. In a much later follow-up to Kivlighan and Quigley (1991), Kivlighan, Markin, Stahl, and Salahuddin (2007) found that the conceptualizations of novice therapists, as determined by similarity judgments, became more complex with a semester of group training and became more similar to the conceptualizations of the experienced group therapist who was training them.

The next three studies in this program of research examined the cognitive structure of different types of group interventions in novice and experienced clinicians (Kivlighan & Kivlighan, 2009, 2010; Kivlighan & Tibbits, 2012). All three studies used the GTQ-C (Wile, 1972a) to measure the co-occurrence of each pair of interventions, that is, how frequently they were provided as potential responses for the same scenario. They then used the co-occurrences to create a cognitive network map of how these interventions are seen by participants as conceptually related. In the first study, Kivlighan and Kivlighan (2009) found that trainees' maps became more complex and hierarchical after a semester of group practicum class. In the second, Kivlighan and Kivlighan (2010) found that group members tended to be more satisfied

with their group leader's behaviors when the leader's knowledge structure was more closely aligned with the aggregate knowledge structure of five experts in group therapy. In the most recent study in this series, Kivlighan and Tibbits (2012) looked more closely at the specific differences between the knowledge structures of novices and those of experts. That is, they examined specifically which links, each representing co-occurrences of interventions, were present (i.e., errors of commission) or absent (i.e., errors of omission) in trainees' network maps as compared to the aggregate expert referent map. Additionally, the authors used cluster analysis to identify four subsets of trainees that had similar errors of omission and commission.

Measures of knowledge. As mentioned in the introduction, there has been one previous attempt, the GIQ (Stokes & Tait, 1979), to design a measure of knowledge to assess competence in providing group therapy, as the present study attempted to do with its adaptation of the GTQ-C (Wile, 1972a). It should be noted that the GIQ was designed to assess skills in leading process groups, but authors discussed its value as a measure of competence. The GIQ consists of 15 items, each of which presents a vignette of an incident that might occur in a process group, along with three possible interventions of varying quality. For each vignette, there is a preferred response; an intermediate response which is seen as acceptable, but less preferable; and a poor response. Respondents rank the choices in order of what they view as most to least appropriate and receive one of four possible scores for their rank-order choices. Although the researchers obtained some desirable reliability and validity data, Stokes and Tait noted in their discussion that these data only support the use of the GIQ with an inexperienced population. Based upon the following sample item, it appears that the vignette and its response options may have been written in such a way that the correct order of choices would be obvious to most individuals with some group psychotherapy training.

Alice has been talking about problems she has been having with her husband She has told the group of the fights that they have, how they cannot talk with each other without arguing, and how she has begun to look outside the marriage for gratification. As she talks, her voice starts to tremble and her eyes fill with tears. When Paul remarks on how miserable Alice seems, Alice breaks into tears and says, "I *am* miserable and there's nothing the group can do about it. Just leave me alone for a few minutes." As she continues crying, John says, "I'd like to talk about some problems I'm having with my boss."

Interventions

1. "You're still having troubles with your boss, John? Could you tell us what kinds of things have happened? I thought that you and she had worked things out."
2. "Alice, I understand that it's a difficult situation that you're in, but trying to ignore it won't help. Tell us more about your problems with your husband."
3. "John, I sense that you're responding to Alice's request. Alice is feeling bad enough to cry. How do people in the group feel about that?"

[*Key and Explanation*]

The preferred response is 3, a group-focused intervention that rates high on immediacy and responsibility. Response 2 is less immediate and probably will elicit there-and-then information. Response 1 is the poorest because it actively diverts the group from immediate, process-related material. Notice that in responses 1 and 2 the leader directs the course of the conversation and may promote a lot of leader-to-member interaction. (Stokes & Tait, 1979, p. 251)

This aspect of the instrument limits its utility. Stokes and Tait (1979) listed several potential uses for the GIQ, including as an instructional tool for students, to guide clients' expectations for group process at the beginning of a new group, or for the selection of paraprofessionals. On the other hand, it may have little utility with more advanced trainees or experienced group clinicians.

Leadership styles and the GTQ-C. The final area of competence-related measures in group therapy is that of leadership styles or tendencies. DeLucia-Waack (1997) reviewed four measures of this type, including the Leadership Characteristics Inventory, the Group Counselor Behavior Rating Form, the Effective Group Leadership scale, and the Trainer Behavior Scale. The former two scales are entirely self-report, and the latter two were intended to be completed by self-report, group members, co-leaders, or other parties who have knowledge of the group leadership skills of the individual being rated. An older instrument of this same type, the Group Leader Behavior Instrument (DePalma, Gardner, & Zastowny, 1984), can be completed by self-report, group members, or other observers. The 19 items in this instrument were derived from the 19 leader behaviors assessed in the GTQ-C (Wile, 1972a), which will be discussed in more detail below.

The central focus of the current study, the GTQ-C (Wile, 1972a), is a 21-item written questionnaire designed to examine the group leadership styles of individuals. The GTQ-C is a revised version of the Group Therapy Questionnaire (GTQ; Wile, 1970; Wile et al., 1970b). Although the name was changed to expand the measure's use from only group therapy to all group leadership, the original letters, GTQ, were retained for the sake of continuity (Wile, 1972b). Several sources related to the GTQ-C (Wile, 1970, 1971, 1977) are unpublished manuscripts provided by Wile (contact: dan@danwile.com).

The GTQ-C consists of descriptions of 21 realistic situations that could occur in a group, and each scenario is accompanied by 19 possible interventions that a leader could use in response to the situation. The 21 scenarios are written in a manner to depict 21 different situations encountered throughout the course of 10 meetings of the same group. Thus, they begin with the start of the first session, and the final scenario takes place in the 10th session. Respondents to the GTQ-C are asked to imagine that they are leading the group in question in each scenario and indicate all of the responses they would consider using if that situation occurred. Although the interventions are not labeled in any way, each of the 19 interventions on each scenario belongs to one of 19 specific types of intervention but is adapted to fit each specific scenario. The measure was initially designed to measure group leaders' tendency to use each of these 19 types of intervention, deemed Group Leadership Scales (see Appendix A for scale names and definitions; Wile, 1973).

Based on descriptions in several published and unpublished works (Wile, 1970, 1971; Wile, Bron, & Pollack, 1970a; Wile et al., 1970b), it appears that the leadership scales in three iterations of the GTQ were created based on the authors' knowledge and expertise, rather than through an empirical process. The response options on each scenario were written organically based on the situation in the scenario and were then categorized into leadership scales for scoring purposes, and this original measure went through two major revisions to the current format of the GTQ-C.

Wile (1970) noted that in revising the GTQ-B into the GTQ-C, he included response alternatives that incorporated leadership techniques that had been developed or become more popular between 1963, when the original GTQ was created, and 1970, when form C was created. It stands to reason that much may have changed in group leadership between 1970 and the

present. However, the GTQ-C has been used in its original 1972 format (Wile, 1972a) without any updates to the included interventions in several recent studies by Dennis Kivlighan, Jr., one of the most prominent existing group therapy researchers (Kivlighan & Kivlighan, 2009, 2010; Kivlighan & Tibbits, 2012).

Although the GTQ-C was not pursued extensively by its original author, some psychometric data are available. Test-retest reliability coefficients obtained from a sample of 55 subjects over periods ranging from 2 to 29 days were moderate and somewhat varied (Wile, 1977). Of the 19 leadership scales (see Appendix A), 15 reached a reliability coefficient of at least .60, 8 scales reached at least .70, and 3 scales reached .80 or better. One scale (Past and Parents) had a coefficient below .50, but this scale was noted to be a response used very infrequently by participants.

Initial validity evidence was established when the original GTQ, which included 20 scenarios and nine possible interventions on each, discriminated between more and less experienced group therapists and between an experimental group that attended a three-day training seminar and a control group (Wile et al., 1970a). In the former study, the experienced group was comprised of individuals with at least 15 years of group experience and the novice group contained individuals with less than one year of group experience. In the latter study, the primary differences seen were increases in non-directive interventions in the experimental group that were not present in the control group.

A similar study found changes reflected in the GTQ-C following a five-day group therapy workshop that corresponded to the type of training provided and the types of interventions taught in the workshop (Wile, 1973). Stone and Green (1978) found that the GTQ-C responses of group members became more similar to those of leaders throughout the course of

a 20-week group training seminar that consisted of an 8-week didactic portion and a 12-week experiential training group. Additionally, the GTQ-C was successfully used as such to demonstrate changes in the frequency of specific types of leadership behaviors following a 4-month group leadership training program for nurses (DePalma, 1979). In other words, the GTQ-C has been shown to be sensitive to both short-term and long-term training.

As discussed above, one prominent concern about written measures is that of the balance between expediency and fidelity to practice. When detailing the creation of an earlier version of the GTQ-C, the authors stated that their goal in writing the scenarios was "to provide sufficient detail to set a scene which is clear and concrete, but not so much that the description is cumbersome and distracting in its complexity and length" (Wile et al., 1970b, p.266). Additionally, the aforementioned format such that the scenarios progress from the first to the tenth meeting of an imaginary group provides an additional degree of realism and context.

Vignettes in competency measurement. In addition to the vignette-based measures in the previous sections, several other instruments have used a similar approach, especially in recent years (e.g., Carpenter et al., 2016; Hudelson, Perron, & Perneger, 2011; Humbert, Besinger, & Miech, 2011). Perhaps in response to the increase in vignette studies, Evans et al. (2015) recently provided an overview of methodological considerations in this type of design. In doing so, they presented vignettes as a hybrid design that can benefit from both the higher internal validity of experimental designs and the higher external validity of survey research. They presented ample evidence that well-crafted vignettes are often strong predictors of real-world decision-making and behaviors. Their specific methodological considerations will be further explicated later in this chapter.

Measures using vignettes. The Assessment of Clinical decision-making in Evidence-based treatment for Child Anxiety and Related Disorders (ACE CARD; Carpenter et al., 2016) presents vignettes featuring anxious children and adolescents at varying stages of treatment. Respondents are asked to select from four options the one that is most consistent with a CBT approach. In describing their development of the instrument, Carpenter et al. (2016) cited rationale and motivation similar to those described in the present study, such as to provide a measure that is clinically meaningful, but brief and cost-effective. After creating vignettes and response options from CBT manuals, literature, and clinical expertise, study authors first went through internal revisions and then facilitated review by an expert panel. In creation and revisions of the instrument, they specifically sought to exclude clear CBT terminology in order to measure understanding rather than vocabulary recognition. They also aimed to create items and options that would be challenging for a novice clinician and to include plausible response options that were consistent with other treatment methods aside from CBT. In the ACE CARD, each vignette has a correct answer and three incorrect alternatives. For their final measure, they created two parallel six-question forms that can be used in a pre-test, post-test manner with novel content in each administration. In initial validation, they found significant differences in the scores of novices and experts, with three vignettes accounting for most of the variance. Based on these results, the authors said that they intend to work towards creating more difficult items that will provide greater discrimination between experts and novices.

As with the ACE CARD (Carpenter et al., 2016), other measures of competency, skill, or clinical decision-making utilizing vignettes often are structured and scored such that there is one right answer and multiple distractors. The PPCT (Mullen et al., 2004) provides a correct answer and four distractors on each vignette. In a slightly different approach, the GIQ (Stokes & Tait,

1979) presents three possible interventions of varying quality and asks participants to rank order the choices. The structure proposed in the present study bears similarities to both approaches.

Methodological considerations for vignette studies. As previously mentioned, Evans et al. (2015) outlined numerous considerations for studies utilizing vignettes for clinical decision-making and behavior. In part, they listed 15 recommendations for the content and structure of vignettes, including such areas as derivation from literature and/or clinical experience, clarity, brevity, narrative-style, and consistency. They state that vignettes should be realistic, culturally-neutral, engaging, and thorough. They argued that vignettes should avoid bizarre content, should use present tense for everything except history and background information, and should avoid placing the participant directly in the vignette as a first or third person character. In regards to the last recommendation, it should be noted that the entire GTQ-C was written in such a way that the participant is the leader in the group in question and is directly involved in many scenarios. Although leaving the vignettes this way goes against the recommendations of Evans and colleagues, this aspect will be maintained in the present study because of the pre-existing GTQ-C measure and the lack of rationale or background for this recommendation provided by the aforementioned authors.

In regards to study design, Evans et al. (2015) recommended several steps. They recommended starting with a larger pool of vignettes than necessary for the eventual measure, expert review and revision of the vignettes and choices, and separate pilot testing after finalization. As further described in the Phase 1 method section, the present study followed this general structure with some differences due to utilizing the adaptation of the GTQ-C rather than writing a new measure from scratch. The full pool of 21 GTQ-C items were reduced by approximately half for the resulting measure. Some degree of the expert review of the vignettes

occurred in the development of the GTQ-C. Additionally, instead of basic content review and discussion at the current stage of measure adaptation, the vignettes and responses were selected for the resulting measure based on an empirical process as described below. Pilot testing of the measure occurred in Phase 2 of the present study.

Other Aspects of the Study Design

The following is a brief review of the literature in several other areas that affect the study design. These include the decision to focus on process-oriented groups, a model of group therapy training, the importance of context in intervention selection, and the demonstration of expertise in group therapy.

Types of groups. Brown (2011) delineated the differences between types of groups, including educational, skills training, work teams or task-oriented, psychoeducation, self-help, support, counseling, and psychotherapy groups. Counseling and psychotherapy process-oriented groups have a greater need for trust, risk, and careful evaluation of group dynamics and process and are generally thought to require greater skill of group leaders. For that reason, this study focused specifically on process-oriented therapy groups to most directly assess the complexity of skills required for effective group leadership.

The PSR model. The Perceiving, Selecting, Risking (PSR) model of group therapy training asserts that there are three interrelated dimensions required to make any successful group intervention (Stockton, Morran, & Chang, 2014). This model states that to make an intervention, the group leader must first perceive all aspects of dynamics and process present in the current situation in the group, select from an internal list of possible interventions, and then engage in the risk-taking necessary to deliver the intervention without knowing for certain what the result will be. This adapted administration procedure of the GTQ-C assessed, at least

partially, each aspect of the PSR model. Although the perception and risk-taking required are inherently less dynamic and complex in a written scenario than in a live group, this was a necessary trade-off to gain an analogue assessment of competence in a questionnaire format.

The uniformity myth. The "uniformity myth" assumes that certain behaviors are inherently indicative of therapist competence regardless of the context in which that behavior occurs (Kiesler, 1973). In reality, however, psychotherapy is a complex undertaking requiring a wide breadth of skills and a great deal of clinical judgment (Ridley et al., 2011; Stockton et al., 2014). Because of this complexity, a given behavior may be highly desirable in one context and quite inappropriate in another. Thus, an ideal written measure of group leadership competence should not only count frequency of certain interventions across all situations or scenarios, but should examine which interventions are chosen in which scenarios. In other words, a skilled group therapist uses different interventions at different times and for different purposes. For example, in many cases providing specific direction or structure to group members can get in the way of unfolding group process. In other situations, such an intervention can be quite appropriate, such as early in a group in which many of the members are new to group therapy, or when a member violates an established group boundary. Thus, it is important that a measure of competence is reflective of that context-dependent nature of practice.

Determining expertise. Tracey, Wampold, Lichtenberg, and Goodyear (2014) suggest that competence is the ability to perform a task adequately, whereas expertise is a notation of expert performance that goes beyond competence. Thus, in assessing competence, expertise can be viewed as the aspirational goal beyond what we are trying to measure.

In order to collect expert responses, we must first define expertise. According to Glaser and Chi (1988), there are several pivotal characteristics of experts' performances that seem to

revolve around experts having large amounts of knowledge, high levels of automaticity, and sophisticated, complex knowledge structures within their domains of expertise. They solve problems quickly and with little error, and they conceptualize problems on a deeper level than do novices. Research in the provision of group therapy has lent support to the latter characteristic, finding that experts' knowledge structures of interventions and conceptualization of members were more nuanced and complex than those of novices (Kivlighan & Kivlighan, 2009; Kivlighan & Quigley, 1991). Other group therapy research has found that more experienced group leaders are more successful at fostering openness in group members and tend to focus more on process versus content than do their novice counterparts (Brabender, 2010).

In psychotherapy research, experts are often defined by peer nomination (Bedics, Atkins, Harned, & Linehan, 2015; Rubel & Kline, 2008), personal knowledge of the researchers (Kivlighan & Tibbits, 2012), quantity of experience (Kivlighan & Quigley, 1991), or based on a specific set of criteria (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Hickman, Arnkoff, Glass, & Schottenbauer, 2009). It should be noted that Eells and colleagues (2005) found that in terms of skills in case formulation, experience and expertise were not synonymous. Similarly, Tracey et al. (2014) argued strongly that there is currently no development of greater expertise with increased experience in the profession of providing psychotherapy. Thus, quantity of experience may be too simple to be an accurate representation of expertise.

In an exploratory study of expert group leadership, Rubel and Kline (2008) used peer identification to choose expert group leaders, specifically seeking those who were "identified by their peers as being exceptionally effective, knowledgeable, and skilled in their leadership of groups" (p. 140). Although they did not outline specific credential criteria ahead of time, seven

of their eight experts identified by their peers in the manner described above were CGPs, and most were fellows in AGPA or the Association for Specialists in Group Work.

As mentioned earlier in this chapter, there are two well-respected specialty certifications for group therapists, CGP and board certification through ABPP. Both have detailed requirements such that they thoroughly demonstrate the applicant's knowledge, experience, and skill in group therapy. In both cases, this knowledge, experience, and skill must also be assured by other experienced group therapists. Requirements for each credential are outlined below.

The CGP credential is issued by the International Board for Certification of Group Psychotherapists (IBCGP), which is associated with AGPA. In addition to basic training and licensure in the applicant's field, this credential requires specific didactic instruction, 300 hours of group experience as a leader or co-leader, 75 hours of supervision of group work by supervisors who must themselves be a CGP or equivalent, and at least two reference forms from supervisors or from a supervisor and a colleague (IBCGP, n.d.). It also carries a group-specific continuing education requirement to maintain the certification.

Board certification in group psychology is issued by the American Board of Group Psychology, a representative of ABPP. In addition to education, internship, and licensure requirements, the diploma requires specific didactic training, two endorsements from experienced professionals, and three years of group experience, of which at least two must be supervised and one can be during internship (American Board of Professional Psychology [ABPP], n.d.). A minimum of 150 supervised group contact hours and at least 600 unsupervised group contact hours are required. Finally, the diploma requires the submission of a detailed, video- or audiotaped work sample and an oral examination.

Based on these requirements and the above review of expertise, the CGP and ABPP credentials appear to be appropriate markers of expertise for the present study.

Summary

Group therapy is an effective and growing modality of mental health treatment. Due to the specialized nature of group therapy as a professional competence and many concerns about inconsistent availability and standards of training, research related to group leadership and competence is vital to the provision of quality group therapy.

Great efforts have been put forth in the past 15 years within the field of psychology to define and carefully delineate professional competence. However, measuring competence remains a difficult task. Some of the most successful efforts involve detailed 360-degree evaluations or global competence ratings based on several months or years of direct supervision. Briefer measures of competence that lend themselves well to research purposes, reviewed above, face many difficult design issues. Self-report measures are most commonly used in the area of multicultural competence. Although they are widely used in research, their validity is questionable due to face validity and social desirability concerns. Some evidence suggests that this type of instrument actually measures *desired* multicultural competence or a number of other factors more than it does actual competence, although evidence behind measures of knowledge show some promise in this area. The use of vignettes for competency measurement is increasingly gaining momentum as both a valid and pragmatic approach.

Attempts to measure competence in group therapy consist primarily of observer rating scales and those examining cognitive processes of group leaders. One previous attempt at a written, vignette-based measure, the GIQ, is reliable and valid, but is simplistic and is therefore only useful for those with no knowledge or experience related to group therapy. An overview

and review of the creation of the GTQ-C is also provided above. Finally, the literature review concluded with a brief review of additional aspects that influenced the design of the present study.

Chapter III. Phase 1

Initial Expert Sample for Measure Development

Design Overview

This study was conducted in two phases. First, data were collected via an initial expert sample for the general adaptation of the GTQ-C into a newly-formed version, the GLCQ. This sample was used to reduce the number of scenarios by approximately half, to reduce the response options to five per scenario, and to create the GLCQ scoring system. Second, three samples (expert, trainee, and novice) of participants were administered the GLCQ. These data were used to provide initial reliability and validity evidence for the GLCQ.

Method

Participants. The initial expert sample was composed of practitioners ($N = 10$) with valid CGP certification or board certification in group psychology from ABPP. As outlined above in Chapter II, the CGP credential requires basic training and licensure, specific didactic instruction, 300 hours of group experience as a leader or co-leader, 75 hours of supervision by a CGP or equivalent, and at least two references, as well as group-specific continuing education (IBCGP, n.d.). ABPP in group psychology requires basic training and licensure, specific didactic instruction, endorsements from experienced professionals, three years of group experience (minimum 150 supervised and 600 unsupervised group contact hours), a detailed work sample, and an oral examination (ABPP, n.d.). Both certifications provide direct demonstration of specialty training and supervision in group therapy. Board certification entitles holders to increased pay rates at the Veterans Administration, the Department of Defense, and other organizations, as well as exemption from written psychology examinations for licensure in approximately two-thirds of U.S. states (ABPP, n.d.).

Although all those with ABPP group certification are licensed psychologists, the CGP certification can be attained by group therapists in a variety of clinical mental health disciplines, including psychology, psychiatry, social work, psychiatric nursing, marriage and family therapy, substance abuse counseling, clinical mental health counseling, creative arts therapy, pastoral counseling, occupational therapy, or other international mental health disciplines. To maximize external validity of the resulting measure, active CGPs from any discipline were included.

In accordance with the focus of the study and due to the lack of available literature on theoretical orientation in group work, experts were only included if they do at least some group work from a general interpersonal process approach. Additionally, to ensure clinical relevance, only those who engage in active clinical practice were included, defined as having regularly led or co-led a group within the past year. These qualifications were included in the recruitment email (Appendix B) and were confirmed through the endorsement of statements at the beginning of the survey (Appendix C).

A recruitment email (Appendix B) was sent to the APA Division 49 listserv and was distributed to CGPs with the assistance of the IBCGP (see Appendix D). Specifically, at the direction of the IBCGP, the recruitment email was sent to the AGPA members listserv with approval of the AGPA board. Due to the specialized nature of the population, snowball sampling was also used, in that participants were asked to forward the study to other CGP or ABPP group certified professionals known to them.

Due to the length of the measure, which took approximately 45 minutes to complete, and the professional qualifications of the sample, participants who complete the study were offered $50 each in exchange for their participation. They had the option of being compensated via

PayPal or personal check, or to decline compensation by not providing their information in the separate, linked survey.

Recruitment continued until 10 responses were received. A quota restriction was used within Qualtrics to ensure that no more than 10 complete response sets were received.

Of the full sample, nine participants had the CGP credential and one had both the CGP and ABPP group credentials. There were five men and five women, with all identifying as cisgender. Ages ranged from 32 to 80 (M = 58, SD = 15.6). Eight self-identified as White or Caucasian (non-Hispanic), one as Asian, Pacific Islander, or Asian-American, and one as other identity (Jewish). Regionally, all identified the United States as "home," with four from the South, three from the Northeast, two from the West, and one from the Midwest. Seven participants self-identified as heterosexual, one as gay/lesbian, and one as bisexual, with one declining to answer. Regarding religion, participants self-identified as agnostic (3), Buddhist (2), atheist (1), Christian (1), Jewish (1), and other organized religion (1), with one declining to answer. Years of experience providing group therapy ranged from 8 to 40 (M = 26.5, SD = 11.8). Five participants reported leading or co-leading more than two process-oriented group sessions per week, on average, over the past year, while four reported leading or co-leading one to two sessions per week, and one reported leading or co-leading sessions biweekly or more frequently, but less than one per week. Participants' highest degrees (6 Ph.D., 2 Psy.D., 2 masters or equivalent) were conferred between 1966 and 2011. Participants' CGP certifications were earned between 1981 and 2016. The single participant's ABPP credential was earned in 2014. Mental health disciplines were psychology (7), social work (2), and clinical mental health counseling (1). Current work settings were independent practice (7), community mental health (1), university counseling center (1), and other (1; rehabilitation center). In their overall practice,

not limited to group, participants identified their theoretical orientations as psychodynamic/psychoanalytic (5), interpersonal (2), eclectic and/or integrative (1), humanistic/existential (1), and systems (1). All 10 participants accepted the offered compensation via either PayPal or personal check.

Measures.

GTQ-C, with revisions. The GTQ-C, described in more detail including reliability and validity data in the literature review, was used and adapted in the present study by direct permission of the author, Daniel B. Wile (see Appendix E). In the present study, the GTQ-C was used not for its original purpose of measuring leadership tendencies, but as a stimulus and framework from which to create the GLCQ. Prior to its use, small adaptations were made to the wording of some scenarios, and some additional response options were added. In particular, an option that attends to multicultural and/or feminist aspects of the situation was added to each scenario. These changes were all made with the collaboration and approval of the dissertation committee. The full text of the GTQ-C with revisions is included in Appendix F, with any additions from the original GTQ-C provided in bold and italics and omissions from the original included in strikethrough.

Following these changes and additions, the GTQ-C, with revisions consists of 21 scenarios and 20 to 21 response options on each scenario. Because responses can vary greatly with context, participants in the present study were asked to imagine that they were leading a heterogeneous, process-oriented therapy group when completing the GTQ-C. Participants were asked to rate each response option as “excellent,” “moderate,” or “poor.”

The GTQ-C was written such that the scenarios appear in the order that they occur in the fictional group, starting from the beginning of the first session and progressing to the tenth

meeting. For that reason, the scenarios were left in their original order for all participants. The response options, however, were randomly presented on each scenario to avoid any order effects and to reduce potential inattention to individual responses that may result from fatigue and seeing the same intervention types in the same order throughout the survey. The response options were randomized by the Qualtrics software such that individual participants saw them in different orders.

Demographics questionnaire. Demographics relevant to the study were also collected from each participant in order to thoroughly describe the expert sample. See Appendix G for the full list of items.

Data collection procedure. Participants were recruited from the sources listed above. They were directed to an online survey hosted on the Qualtrics platform, where they saw the informed consent letter (Appendix H) and were asked to click through to verify their consent. They were initially asked two questions to confirm that they qualified for the study (see Appendix C). First, they were asked to endorse a statement that they conduct general interpersonal process groups and have led or co-led at least one such group in the past year. Next, they were asked about their current CGP and/or ABPP group credentials. The two participants who accessed the survey but did not qualify were redirected to the end of the survey. Participants who confirmed their qualification for the expert sample completed the full GTQ-C, with revisions, and demographics questions. There were five individuals who qualified but did not complete the study. In the primary survey, only demographics to describe the sample were collected, with no attached identifying information. A face-valid validation question was included in the demographics questionnaire asking participants, “Did you carefully read and pay

attention to each item while taking this survey?" All Phase 1 participants answered "yes" to this question; however, any other answer would not have affected the provision of compensation.

Participants who provided complete data were redirected to a separate survey in which they input their name and physical or email address to receive compensation. They had the option of receiving a check in the mail by providing a physical address or receiving a payment through PayPal by providing their email address. They were informed that if they chose the latter, they were to provide the email associated with their PayPal account. Those who did not have a PayPal account were able to set up a free account to which the compensation could be transferred. Payment information was kept entirely separate from the survey data and was discarded after the payment was made. The data resulting from Phase 1 were used for the development of the GLCQ as described in the results section below.

Results

> Goal 1a: The ratings of 10 experts classifying each response option as excellent, moderate, or poor will yield satisfactory agreement, such that the options can be reduced to two options in each category per vignette.

Initial scenario reduction. The data were examined and an initial cut was made of scenarios in which there was insufficient expert agreement on the response option ratings. The initial proposed plan was that each scenario would be retained only if there were at least two response options in each category (i.e., excellent, moderate, and poor) on which at least 7 of the 10 experts agreed upon that rating. However, this process yielded only two scenarios, far fewer than the target number of 10. Several alternative solutions were explored, including using different levels of agreement ranging from 50% to 70% (although 50% agreement was never

seriously considered as a viable option), having fewer than 10 scenarios in the GLCQ, and using fewer than two response options in each category. After subsequent consultation with the dissertation committee, we agreed that the best adapted course of action was to reduce the required agreement to 6 of the 10 experts and to change the scoring system slightly (see below) such that scenarios were retained if there were at least two excellent, one moderate, and two poor response options on which at least 60% of the expert sample agreed on the appropriate category. This option allowed for the GLCQ to still contain 10 scenarios.

In accordance with this process, Scenarios 9, 11, 13, 14, 15, 16, and 20 were eliminated, leaving 14 scenarios that met the required criteria (see Appendix F for full numbered scenarios).

Response option reduction. For all 14 scenarios retained after this initial reduction, the response options were reduced as follows. The one or two responses in each category (i.e., excellent, moderate, and poor) with the highest level of agreement from the 10 experts were retained as response options for the GLCQ, yielding five total response options per scenario. For 16 of the 42 total categories, which occurred in 11 of the 14 total scenarios, more than the required number of responses were tied for the highest level of agreement. When this occurred, I consulted with the dissertation committee to select the required number of options using a combination of the following approaches. We attempted to diversify the response types used in each category, as well as selected responses that appeared to be more nuanced and less obvious answers. The latter strategy was intended to increase variability in responses and address the primary problem encountered by Stokes and Tate (1979) in designing the GIQ. In addition, in one scenario we removed a response that all 10 experts agreed was poor in favor of one on which 9 of the 10 experts agreed on the poor rating. This was done because of the harsh wording of this response (“Describe them as a group of whiny complainers,” on Scenario 5), and the

committee agreed that it would be a wasted response that even novice participants were extremely unlikely to choose. As a result of this process, each of the retained scenarios were accompanied by two excellent, one moderate, and two poor responses, as rated by the experts (see Appendices I and J). These two previous sections partially completed Goal 1a. Although the original goal was to reduce the options to two per category per vignette, this was adapted to account for the low level of agreement of what constitutes a moderate response to a scenario.

> Goal 1b: Intracorrelation coefficients (ICCs) for expert ratings on each vignette will be used as a measure of interrater reliability to reduce the GTQ-C to the 10 vignettes with the highest reliability to make up the GLCQ.

Final scenario reduction. In accordance with Landers (2015) and Shrout and Fleiss (1979), intraclass correlation coefficients (ICCs) were computed to measure interrater reliability on each scenario. Data from the 10 subject matter experts were used to calculate two-way random intraclass correlation coefficients [ICC(2)] for the totality of the five retained response options on all 14 retained scenarios. This process yielded one ICC for each scenario, which represents the consistency with which the 10 experts rated the five retained responses on that scenario (see Table 1). The 10 scenarios with the highest reliability (i.e., the highest ICCs) were retained to make up the full set of scenarios in the GLCQ. Thus, Scenarios 1, 2, 4, and 7 were dropped from the resulting measure. This process completed Goal 1b.

Table 1

Intraclass Correlation Coefficients (ICCs) for Retained Scenarios

Scenario Number	Scenario Title	ICC(2,10)
1	Starting the Group	.927
2	Personal Questions	.948
3	**The Chairperson**	**.973**
4	A Filibuster	.941
5	**An Attack Upon the Leader**	**.972**
6	**A Group Silence**	**.974**
7	A Distressed Woman	.958
8	**The Late Arrival**	**.984**
10	**The Quiet Member**	**.970**
12	**Marital Problem**	**.978**
17	**A Group Attack**	**.959**
18	**A Member Comes Drunk**	**.960**
19	**A Side Conversation**	**.972**
21	**The Sexualized Meeting**	**.977**

Note. The 10 scenarios in bold were those retained to make up the GLCQ measure.

Among the resulting set of 10 scenarios, the number of experts agreeing on the rating for each response option are reported below (see Table 2). Additionally, the intervention type [as defined by Wile's (1973) Group Leadership Scales on the GTQ-C; see Appendix A] of each item in the full set of retained responses is reported. The original scenario numbers and response option numbers from the GTQ-C are provided (see Appendix F for full text). Those responses that were written solely for this study are also reported as such. These data are grouped by their expert classifications as excellent, moderate, or poor responses.

Table 2

Response Type and Expert Agreement for Retained Response Options

GTQ-C Scenario Number	Classification	GTQ-C Response Option	Response Type	Expert Agreement
3	Excellent	10	Clarification-Confrontation Question	90%
		11	Group Dynamics Question	90%
	Moderate	12	Group Atmosphere	70%
	Poor	3	Reassurance-Approval	90%
		4	Subtle Guidance	90%
5	Excellent	3	Reassurance-Approval	70%
		13	Group Dynamics Interpretation	80%
	Moderate	16	Past and Parents	70%
	Poor	4	Subtle Guidance	90%
		5	Structure	90%
6	Excellent	7	Member Feelings	70%
		11	Group Dynamics Question	70%
	Moderate	15	Personal Life	70%
	Poor	5	Structure	100%
		6	Attack	100%
8	Excellent	2	Group Directed	70%
		7	Member Feelings	70%
	Moderate	15	Personal Life	90%
	Poor	6	Attack	100%
		9	Leader Experience	100%
10	Excellent	3	Reassurance-Approval	70%
		7	Member Feelings	70%
	Moderate	11	Group Dynamics Question	70%
	Poor	5	Structure	100%
		6	Attack	100%
12	Excellent	10	Clarification-Confrontation Question	80%
		11	Group Dynamics Question	80%
	Moderate	3	Reassurance-Approval	60%
	Poor	4	Subtle Guidance	100%
		6	Attack	100%
17	Excellent	7	Member Feelings	80%
		12	Group Atmosphere	80%
	Moderate	3	Reassurance-Approval	70%
	Poor	5	Structure	100%
		9	Leader Experience	100%

Table 2, Continued

GTQ-C Scenario Number	Classification	GTQ-C Response Option	Response Type	Expert Agreement
18	Excellent	7	Member Feelings	80%
		13	Group Dynamics Interpretation	60%
	Moderate	3	Reassurance-Approval	60%
	Poor	4	Subtle Guidance	100%
		9	Leader Experience	100%
19	Excellent	2	Group Directed	80%
		11	Group Dynamics Question	90%
	Moderate	5	Structure	70%
	Poor	3	Reassurance-Approval	100%
		13	Group Dynamics Interpretation	100%
21	Excellent	11	Group Dynamics Question	90%
		12	Group Atmosphere	80%
	Moderate	15	Personal Life	60%
	Poor	4	Subtle Guidance	100%
		6	Attack	100%

Note. Scenario and response numbers are in accordance with the original GTQ-C. Full text of the GTQ-C is available in Appendix F.
Note. Definitions of the Group Leadership Scales (response type) can be found in Appendix A.

Wording for three scenarios in the GLCQ was changed slightly to make the scenarios logically flow from one to the next even with many of the original GTQ-C scenarios removed. For example, the first scenario in the GLCQ, which was Scenario 3 in the GTQ-C, previously began, "Later in this first session." It was changed to read, "In the first session." The full text of the GLCQ is included in Appendix J. Although the scenarios are numbered as they appear in the GLCQ, their original number within the GTQ-C is included in parentheses. The response options are listed with their original scale number from the GTQ-C. Note that when presented in the GLCQ, the response options were not numbered and were presented in random order via the Qualtrics platform. Any wording changed from the GTQ-C is included in Appendix J, with omissions presented in strikethrough font and additions presented in bold and italicized font.

Goal 1c: Expert ratings will be used to create the scoring criteria for the GLCQ.

GLCQ scoring system. Based upon the classifications by the Phase 1 expert sample, excellent responses were given a score of 2 points, moderate responses were given a score of 1 point, and poor responses were given a score of 0 points. All response options should be presented randomly on each scenario in the GLCQ. Respondents to the GLCQ are asked to select, from the list of five, the two response options that they believe to be the best potential interventions to consider for the situation described in the vignette. They receive the appropriate number of points for each response option they selected, yielding a score between 0 and 4 for each vignette and a total GLCQ score ranging from 0 to 40. Thus, Goal 1c was completed.

Chapter IV. Phase 2

Preliminary Reliability and Validity Evidence

Method

Participants. Two hundred seven participants were recruited across three separate pilot samples of experts ($n = 60$), those with some training and experience in group therapy (i.e., trainees; $n = 67$), and complete novices ($n = 80$). The expert sample was recruited in the same manner and with the same qualifications as the initial expert sample in Phase 1, although the recruitment email (Appendix K) asked participants from Phase 1 not to participate in Phase 2. The trainee sample was obtained by contacting directors of training of doctoral programs in clinical and counseling psychology and asking them to forward a recruitment email (Appendix L) to their students. To qualify for the study, members of the trainee sample had to have taken a graduate-level course in group therapy and had to have led or co-led a process-oriented therapy group. The novice sample was recruited utilizing an undergraduate research pool in the College of Education at a large Southeastern university. Due to the specialized nature of the populations, snowball sampling was used for the expert and trainee samples, in that participants were asked to forward the study to others known to them who may qualify.

Recruitment efforts continued until an appropriate sample size had been obtained. When necessary, additional recruitment emails were sent and the Sona system post was left active until the target sample size was reached. Johanson and Brooks (2010) recommended a minimum sample size of 30 for pilot studies of preliminary survey development, but a power analysis for between-group differences was also taken into account. Based on data using the G*Power software, a sample size of 53 per group yielded a power of .80 for a medium effect size ($f = .25$) at $\alpha = .05$. Thus, this was the minimum size sought for each group in Phase 2. In compensation

for their time and effort, participants in the expert and trainee samples who completed the survey had the option to be entered to win one of four $25 Amazon gift cards. At the end of the survey, they were directed to a separate survey in which they entered an email address to enter the drawing. The drawing was held following the completion of data collection. Two winners were selected from each sample, and gift cards were sent electronically from www.amazon.com to the email listed. Participants in the novice sample who completed the study received class credit through the participant pool for their participation.

Expert sample composition. Most of the expert sample (*n* = 60) had the CGP credential (*n* = 57, 95%) while one (1.7%) had the ABPP credential in group and two (3.3%) had both credentials. There were 35 (58.3%) women and 25 (41.7%) men, with all identifying as cisgender. The average age was 57 (*SD* = 12.6), with the 59 reported ages ranging from 34 to 89. Regarding racial or ethnic group, 50 (83.3%) participants identified as White, five (8.3%) as Asian, Pacific Islander, or Asian American, three (5%) as biracial or multiracial, and one (1.7%) as other identity, Middle Eastern. One participant declined to respond. Most participants were from the United States (Northeast- 29, 48.3%; South- 13, 21.7%; West- 10, 16.7%; Midwest- 4, 6.7%; Pacific- 1, 1.7%), while two (3.3%) were from other nations and one declined to answer. Participants reported their sexual orientation as heterosexual (51, 85%), gay/lesbian (5, 8.3%), bisexual (2, 3.3%), and other identity, pansexual (1, 1.7%), while one declined to answer. Participants reported diverse religious affiliations, including Christian (15, 25%), Jewish (13, 21.7%), Agnostic (11, 18.3%), Buddhist (4, 6.7%), atheist (3, 5%), Muslim (1, 1.7%), other organized religion (5, 8.3%; included Quaker, Mormon, Episcopal/Buddhist, and two Unitarian Universalist), and other identity (5, 8.3%; included kindness, spiritual, Christian Buddhist, pagan, and no "fixed" beliefs). Three declined to respond. Years of experience providing group

therapy ranged from 4 to 50, with an average of 25 years (*SD* = 12.7). Twenty-eight (46.7%) participants reported currently providing more than two process group sessions per week and 26 (43.3%) reported one to two sessions per week, while only six (10%) reported leading less than one session per week. Participants reported their highest degree as Ph.D. (26, 43.3%), Masters or equivalent (22, 36.7%), M.D. (6, 10%), Ed.D. (3, 5%), and Psy.D. (3, 5%). They received said degrees between 1965 and 2013. They received their CGP certification between 1986 and 2017. Four (6.7%) participants reported that they received their CGP in the first year that it began. The few who reported having the ABPP in group attained the credential between 1976 and 2014. Experts were from a variety of disciplines, including psychology (29, 48.3%), social work (12, 20%), clinical mental health counseling (8, 13.3%), psychiatry (6, 10%), occupational therapy (1, 1.7%), and other (4, 6.7%, including psychiatric nursing, marriage and family, creative arts therapy, and psychoanalysis). They also reported numerous work settings, including independent practice (42, 70%), university counseling center (9, 15%), community mental health (3, 5%), hospital (1, 1.7%), prison/jail/forensic (1, 1.7%), university academic department (1, 1.7%), VA (1, 1.7%), and other (2, 3.3%, including training program faculty). Lastly, in their overall clinical practice, they reported primary theoretical orientations of psychodynamic or psychoanalytic (28, 46.7%), interpersonal (16, 26.7%), eclectic/integrative (9, 15%), humanistic/existential (2, 3.3%), systems (2, 3.3%), cognitive behavioral (1, 1.7%), feminist/multicultural (1, 1.7%), and other (1, 1.7%, somatic experiencing).

Trainee sample composition. Of the 67 participants in the trainee sample, there were 51 (76.1%) women, 14 (20.9%) men, one (1.5%) who identified as a nonbinary identity, and one who declined to provide gender. Most (*n* = 66, 98.5%) identified as cisgender, while one (1.5%) chose, “Neither answer applies or I prefer not to answer.” Ages ranged from 24 to 40, with a

mean age of 29 (*SD* = 3.8). In terms of racial or ethnic group, 52 (77.6%) participants identified as White, four (6%) as Black or African American, three (4.5%) as Asian, Pacific Islander, or Asian American, three (4.5%) as Latino/a or Hispanic, three (4.5%) as biracial or multiracial, one (1.5%) as Middle Eastern, and one (1.5%) as "Arab American/White." The latter two were written in from the other identity option. Most participants were from the United States (Midwest- 22, 32.8%; South- 19, 28.4%; Northeast- 11, 16.4%; West- 8, 11.9%; Pacific- 4, 6%), while two (3%) were from other nations and one declined to answer. Most (*n* = 58, 86.6%) participants identified as heterosexual, with the rest identifying as bisexual (5, 7.5%), gay/lesbian (1, 1.5%), other identity- pansexual (1, 1.5%), and other identity- queer (1, 1.5%). One declined to provide sexual orientation. Like the expert sample, religions in the trainee sample were diverse, including agnostic (25, 37.3%), Christian (24, 35.8%), atheist (5, 7.5%), Jewish (4, 6%), Buddhist (3, 4.5%), Muslim (2, 3%), Mormon (1, 1.5%), and Catholic (1, 1.5%). One (1.5%) participant selected other identity and wrote in "spiritual not religious," and one declined to answer. There were 50 (74.6%) Ph.D. students and 17 (25.4%) Psy.D. students. Forty-five (67.2%) were in counseling psychology programs, while 22 (32.8%) were in clinical psychology. Regarding highest earned degree, 56 (83.6%) had a masters degree or equivalent, 10 (14.9%) had a bachelors degree or equivalent, and one (1.5%) had an additional doctorate, presumably in a different field. Of the full trainee sample, four (6%) were in the first year of their program at the time of the study, six (9%) in the second year, 11 (16.4%) in the third, 22 (32.8%) in the fourth, 17 (25.4%) in the fifth, and seven (10.4%) in the sixth year or beyond. Fifty-two (77.6%) had not yet begun their pre-doctoral internship, while 11 (16.4%) were on internship and three (4.5%) had completed all requirements except the dissertation. One participant did not provide their internship status. When asked to estimate their total hours of process-oriented group

therapy provision, seven (10.4%) endorsed 10 or fewer hours, 33 (49.3%) endorsed 11-50 hours, 17 (25.4%) endorsed 51-100 hours, and 10 (14.9%) endorsed more than 100 hours. Fifteen (22.4%) participants stated that they plan to seek specialty certification in group psychotherapy, 20 (29.9%) stated that they do not intend to do so, and 32 (47.8%) stated that they are unsure if they will seek such certification. In their overall clinical practice, the trainee participants reported primary theoretical orientations of interpersonal (17, 25.4%), eclectic and/or integrative (16, 23.9%), cognitive behavioral (12, 17.9%), humanistic/existential (10, 14.9%), psychodynamic/psychoanalytic (5, 7.5%), feminist and/or multicultural (3, 4.5%), behavioral (1, 1.5%), and other (3, 4.5%; relational cultural, gestalt, and emotion-focused therapy).

Novice sample composition. Of the 80 participants in the novice sample, there were 69 (86.3%) women and 11 (13.8%) men. Most (n = 79, 98.8%) identified as cisgender, while one (1.3%) identified as transgender. Their ages ranged from 18 to 44, with an average age of 20 (SD = 3). Only three (3.8%) participants were over the age of 22. In regards to racial or ethnic group, most (n = 69, 86.3%) identified as White, three (3.8%) as Black or African American, three (3.8%) as Latino/a or Hispanic, two (2.5%) as Asian, Pacific Islander, or Asian American, two (2.5%) as biracial or multiracial, and one (1.3%) as Native American. Most participants were from the United States (South- 68, 85%; Midwest- 5, 6.3%; Northeast- 3, 3.8%; West- 2, 2.5%), while one (1.3%) was from outside the United States and one declined to answer. The sample was primarily heterosexual (n = 76, 95%), with others identifying as bisexual (1, 1.3%) or other identity (1, 1.3%), and two declining to answer this question. In regards to religion, participants identified as Christian (65, 81.3%), agnostic (3, 3.8%), Catholic (3, 3.8%), atheist (2, 2.5%), Jewish (1, 1.3%), and other identity (1, 1.3%; "unsure"). Five participants declined to answer. There were 16 (20%) freshmen, 27 (33.8%) sophomores, 22 (27.5%) juniors, 12 (15%)

seniors, and three (3.8%) who were second-year seniors or beyond. In regards to college major, 19 (23.8%) participants were in education majors, 11 (13.8%) in business, four (5%) in psychology, social work, or other mental health fields, 34 (42.5%) in other science or technological fields, six (7.5%) in other liberal arts or humanities fields, and six (7.5%) who stated that their major does not fit any of the listed categories. When asked if they have ever been a counseling or therapy client, 34 (42.5%) stated that they have and 46 (57.5%) that they have not. When asked if they have ever taken a psychology course in which group therapy was covered, 26 (32.5%) responded yes, 47 (58.8%) said no, and seven (8.8%) stated that they do not remember. Only six (7.5%) participants stated that they have been a client in group therapy, while 74 (92.5%) said that they have not.

Measures.

GLCQ. The GLCQ is the adaptation of the GTQ-C created as a result of Phase 1 of this study. The response options and scenarios of the GTQ-C, with revisions, were reduced as described in Chapter III to the resulting GLCQ of 10 scenarios with five response options each. These consist of two excellent responses, one moderate response, and two poor responses, as rated by a minimum of 60% of the initial expert sample.

Responses were presented randomly for each scenario in the GLCQ. Participants were asked to select, from the list of five, the two response options that they believed to be the best potential interventions to consider for the situation described in the vignette. Each response the initial expert sample had judged to be “excellent” was assigned a score of 2 points, responses judged “moderate” in quality were assigned one point, and “poor” responses a score of 0 points. This yielded an item score between 0 and 4 for each vignette and a total GLCQ score ranging from 0 to 40.

Demographics questionnaire. Participants were given a demographics questionnaire similar to that used in Phase 1, with some adjustments made for each individual sample. See Appendices G, M, and N for the full list of questions asked for each sample.

Data collection procedure. Participants were recruited from the source listed above via a recruitment email (Appendices K & L) or Sona system post (Appendix O). They were directed to an online survey hosted on the Qualtrics platform, where they saw the informed consent letter (see Appendices P and Q) and were asked to click through to verify their consent. All samples were initially asked one or more questions to confirm that they qualified for the study (see Appendix R). The experts were asked to confirm that they had CGP or ABPP group certification, that they had led or co-led a process-oriented therapy group in the past year, and that they did not participate in the initial expert sample. The trainees were asked to confirm that they had taken a graduate-level group therapy course and had led or co-led a process-oriented therapy group. The novices, recruited through an undergraduate participant pool, were informed on the study information page in the Sona system that they must be at least 18 years of age to participate. All samples were asked to confirm that they were at least 18 years of age at the time of the study. If they responded to any qualification question in such a way that indicated that they did not qualify for the study, they were redirected to the end of the survey. Participants who confirmed their qualification for study completed the GLCQ and demographics questions. In the primary survey, only demographics for sample description were collected, with no identifying information connected to the data. Upon completion of the study, participants were directed to a separate survey where they had the option to submit an email address for entry into the compensation drawing or for confirmation of their participation for class credit. A face-valid validation question was included in the demographics questionnaire asking participants, "Did

you carefully read and pay attention to each item while taking this survey?" The response sets of two participants (1 novice; 1 trainee) who completed the survey but did not answer "yes" to this question were discarded.

All responses in the three pilot samples were scored in accordance with the scoring system created above in Phase 1.

Analysis. A one-way Welch analysis of variance (ANOVA) was used to test whether the GLCQ scores differ between the three samples and Games-Howell post hoc tests were used to examine differences in mean scores between samples. The more robust Welch ANOVA and Games Howell tests were used to account for heterogenous variances across samples (see below for further discussion of assumption violations).

Within each sample (expert, trainee, and novice) and the aggregate of the three samples, Cronbach's alpha was computed as a measure of reliability. The item score, ranging from 0 to 4, on each of the 10 scenarios was the basis for this measurement, which yielded an alpha value for each sample and an overall alpha for the GLCQ based upon the complete Phase 2 dataset.

Information on response rates was collected, including speed of data collection in each sample, average completion time, and data on incomplete responses received. These data provided valuable information regarding the feasibility and utility of the GLCQ.

On a related note, it is important to note that this phase of the study was only intended to provide initial reliability and validity data on the newly-created GLCQ. As such, any conclusions based on this sample are preliminary and much further study is needed to fully validate the GLCQ for more widespread use.

Results

Hypothesis 2a: GLCQ scores of experts will be significantly higher than those of trainees.

Hypothesis 2b: GLCQ scores of experts will be significantly higher than those of novices.

Hypothesis 2c: GLCQ scores of trainees will be significantly higher than those of novices.

GLCQ scores across groups. A one-way Welch ANOVA was used to determine whether the GLCQ scores were different across the expert (n = 60), trainee (n = 67), and novice (n = 80) samples. Some assumption violations had to be addressed prior to the analysis. There were outliers in each sample, all lower than the remainder of the sample scores. An examination of boxplots revealed one outlier for the experts, one for the trainees, and two outliers of the same score among the novices. These scores were 7, 11, and 10 points below the sample mean, respectively. There is no way to determine if these are due to measurement error, so we must otherwise assume that these variable scores reflect real differences. Significance of the ANOVA did not change with or without the outliers, so they do not appear to have compromised the test results. The data also did not meet the assumption of normality of distributions. According to a Shapiro-Wilk test, the novice distribution was normal (p = .145), but the trainee (p < .001) and expert (p < .001) distributions were not. Looking further, both the trainee and expert sample datasets were negatively skewed and positively kurtosed, with respective skewness values of -1.664 (SE = .293) and -1.308 (SE = .309) and respective kurtosis values of 6.372 (SE = .578) and 3.026 (SE = .608). See Figures 1-4 for GLCQ score distributions in the combined sample and by sample group. Several data transformations were attempted. The data from a reflect and logarithmic (log10) transformation approached closest to normality, as well as removed all outliers, but still did not achieve a normal distribution per Shapiro-Wilk tests for trainee (p = .002) and expert (p = .011) samples. However, Welch ANOVA and post hoc results were

significant at the same levels with both the original and transformed values, so the original values were used. The homogeneity of variances assumption was also violated, according to results from Levene's Test of Homogeneity of Variance ($p < .001$). This was the case for both original and transformed data. To account for heterogenous variances, the Welch ANOVA and Games-Howell post hoc tests were used.

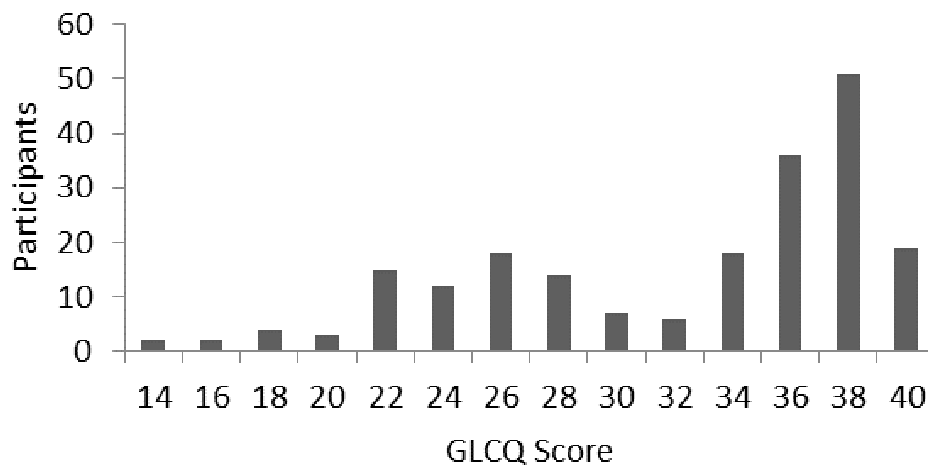

Figure 1. Full sample (N = 207) GLCQ score distribution

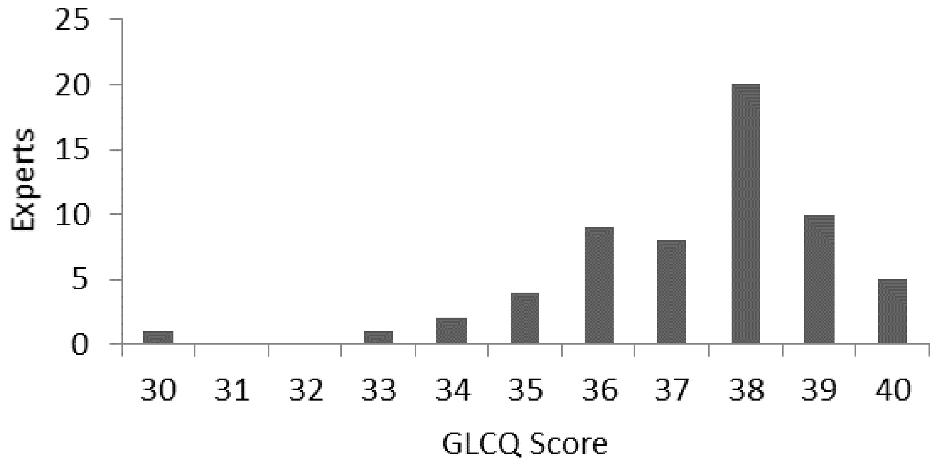

Figure 2. Expert sample (n = 60) GLCQ score distribution

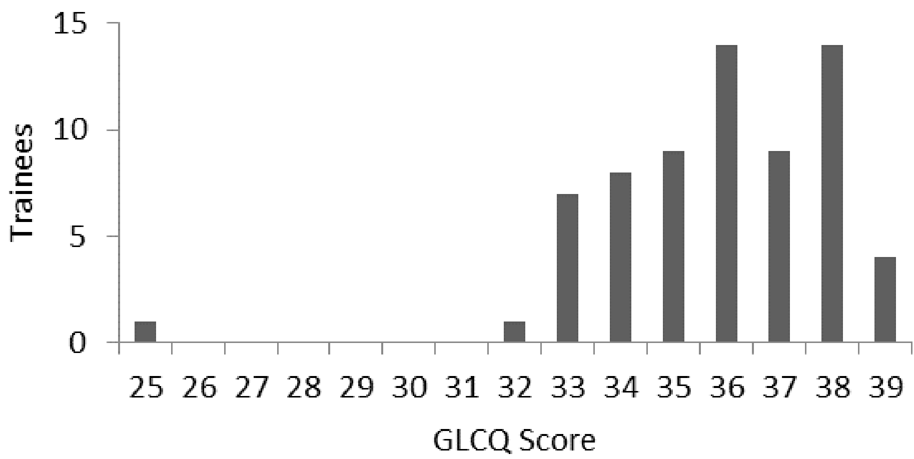

Figure 3. Trainee sample (n = 67) GLCQ score distribution

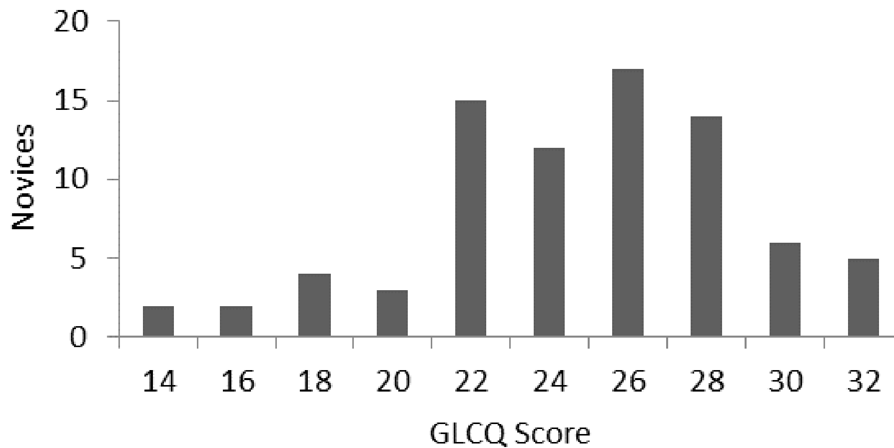

Figure 4. Novice sample (n = 80) GLCQ score distribution

GLCQ scores were statistically significantly different across samples, Welch's $F(2, 134.624) = 315.285$, $p < .001$. GLCQ scores were larger in accordance with higher levels of group therapy expertise, as seen across the novice (M = 24.3, SD = 4.1), trainee (M = 35.8, SD = 2.3), and expert samples (M = 37.4, SD = 1.9; see Figure 5). Games-Howell post hoc analysis revealed that the mean score of experts was significantly higher than that of trainees (M^{DIFF} = 1.5, 95% CI [.7, 2.4], $p < .001$). Likewise, the mean for experts was significantly higher than that of novices (M^{DIFF} = 13.0, 95% CI [11.8, 14.3], $p < .001$) and the mean for trainees was significantly higher than the mean for novices (M^{DIFF} = 11.5, 95% CI [10.2, 12.8], $p < .001$). Thus, Hypotheses 2a, 2b, and 2c were each supported.

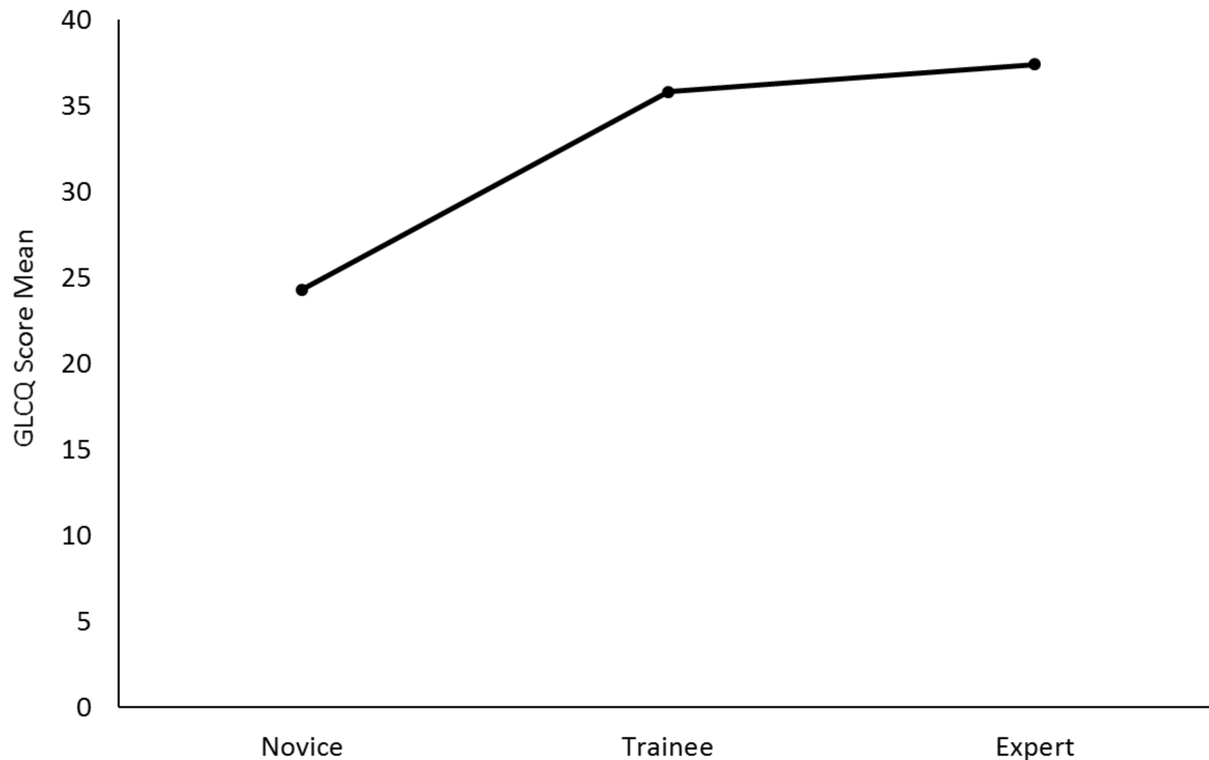

Figure 5. Mean GLCQ scores across groups.

GLCQ scores in relation to participant characteristics. To further describe the data, GLCQ scores within the trainee and novice samples were examined in relation to several participant variables related to training and experience. In the trainee sample, scores did not differ between clinical and counseling psychology students ($M^{DIFF} = .55$, $p = .36$) and there were no differences across varying hours of prior group therapy provision [$F(3,63) = .260$, $p = .85$]. Similarly, there was no correlation between GLCQ scores and year of graduate training ($r = .05$, $p = .71$). In the novice sample, there was no difference between scores of those who had and did not have previous therapy experience, whether general ($M^{DIFF} = -1.20$, $p = .20$) or group therapy ($M^{DIFF} = -4.69$, $p = .10$).

Detailed results by scenario and response option. To further examine the structure of the GLCQ measure, detailed response data by both scenario and individual response options are

presented below. Statistics by scenario are presented in Table 3. All item-total correlations were positive, although they ranged from .21 to .79. All expert and trainee means were higher than the corresponding novice means. However, the trainee mean was higher than the expert mean on Scenarios 6, 10, and 17.

Table 3

Statistics by Scenario

	Scenario Mean Scores					
Scenario Number	Full Sample	Expert	Trainee	Novice	*SD* (Full Sample)	Item-Total Correlation
3	2.80	3.70	3.42	1.60	1.16	.79
5	3.15	3.82	3.61	2.26	1.04	.61
6	3.62	3.98	3.99	3.04	.74	.67
8	3.18	3.78	3.55	2.41	.94	.62
10	3.28	3.38	3.40	3.10	.81	.21
12	3.12	3.57	3.45	2.51	.84	.57
17	3.30	3.75	3.94	2.44	1.08	.62
18	3.45	3.85	3.78	2.89	.76	.65
19	2.87	3.70	3.34	1.86	1.15	.73
21	3.05	3.82	3.34	2.23	.99	.68

Note. Scenario numbers are from original GTQ-C.
Note. Possible scenario scores range from 0 to 4.

Table 4 lists the percentage of each sample group that endorsed each individual response option, and these are broken out by scenario. Since each participant was instructed to choose the best two options on each scenario, the percentages listed add up to 200% for each group, although rounding to the nearest percent created slight deviations. Visual inspection of these data reveals that on several scenarios, trainee responses were quite similar to those of experts.

Table 4

Percent of Sample Groups Endorsing Each Response Option

Scenario Number	Response Number	% of Experts	% of Trainees	% of Novices
3	3	2	3	90
	4	2	0	9
	10	90	72	18
	11	83	73	41
	12	23	52	43
5	3	92	96	80
	4	2	0	15
	5	0	1	61
	13	92	67	23
	16	15	36	21
6	5	0	0	11
	6	0	0	9
	7	98	100	53
	11	100	99	71
	15	2	1	56
8	2	80	55	24
	6	2	0	8
	7	100	100	61
	9	0	0	36
	15	18	45	71
10	3	63	48	81
	5	0	1	30
	6	0	0	8
	7	75	94	66
	11	62	57	15
12	3	43	49	86
	4	0	3	29
	6	0	0	3
	10	72	78	64
	11	85	70	19
17	3	12	0	46
	5	2	1	24
	7	88	99	61
	9	5	1	31

Table 4, Continued

Scenario Number	Response Number	% of Experts	% of Trainees	% of Novices
(17)	12	93	99	38
18	3	15	22	66
	4	0	0	14
	7	87	93	51
	9	0	0	9
	13	98	85	60
19	2	83	60	18
	3	3	12	60
	5	20	42	81
	11	92	87	35
	13	2	0	6
21	4	0	1	48
	6	0	0	11
	11	88	66	51
	12	93	70	30
	15	18	63	60

Note. Scenario and response numbers provided are based on the original GTQ-C numbering.

Goal 2d: Internal consistency will be measured via Cronbach's alpha.

Internal consistency. Cronbach's alpha was calculated for the GLCQ, using the total score for each of the 10 scenarios as individual items. When measured in the full, combined sample ($N = 207$), the GLCQ had high internal consistency, with a Cronbach's alpha of .88. When separated by sample, however, the GLCQ appeared to have a low internal consistency within each sample. This was true for experts ($\alpha = .44$), trainees ($\alpha = .52$), and novices ($\alpha = .48$). As discussed further in Chapter V, there is far less variability in scores within each sample of relatively similar levels of group training and experience.

Because of this interesting pattern of internal consistency figures, and as a result of the scenario and response option details included above, I calculated several other internal consistency statistics. When Scenario 10, which had a low item-total correlation and on which the trainee mean was higher than the expert mean, was removed, the full sample, expert, trainee, and novice Cronbach's alpha statistics changed to .90, .54, .59, and .44, respectively. Thus, the reliability was higher in all cases except for the novice sample. When the expert and trainee samples are combined, the full GLCQ internal consistency is still low ($\alpha = .53$), and it is slightly higher, although still low, when Scenario 10 is omitted ($\alpha = .61$). Similarly, when Scenarios 6, 10, and 17, which all appeared to differentiate poorly between trainees and experts, are omitted from the analysis, the internal consistency remains low ($\alpha = .62$).

Goal 2e: Data on response rate, completion time, and incomplete responses will be reported to provide insight regarding the utility of the measure.

Response data.

Response speed and completion rates. Since recruitment methods utilized emails and recruitment posts distributed widely to listservs, directors of clinical training, and participant pools, rather than invitations to a specific and measurable group of individuals, it is impossible to calculate response rates in the traditional sense. However, speed of data collection and completion rates among those who began the study are reported below.

Expert sample. Data collection of the 60 valid responses spanned 57 days, across which two waves of email requests were sent to listservs. A total of 34 incomplete responses were removed from the full data set of 94 responses. Of these, 19 did not qualify for the study, four

entered no data at all, and 11 dropped out at some point after qualifying for the study. Based on the latter, the completion rate for those who began and qualified for the study was 85%.

Trainee sample. Data collection of the 67 valid responses spanned 73 days. Throughout almost this entire span, individual emails were sent to directors of clinical training of APA accredited clinical and counseling psychology programs. No follow up emails were sent. A total of 35 incomplete or invalid responses were removed from the full data set of 102 responses. Of these, 22 did not qualify for the study, five entered no data at all, seven dropped out at some point after qualifying for the study, and one reported that they did not read and answer carefully when completing the study. Thus, the valid completion rate for those who began and qualified for the study was 89%.

Novice sample. Data collection of the 80 valid responses spanned 56 days. A Sona research request remained open to the full potential undergraduate participant pool in a College of Education at a large, Southeastern university during this time. The research request was removed when 80 valid responses were received. A total of 10 incomplete or invalid responses were removed from the full data set of 90 responses. Of these, three entered no data at all, six dropped out immediately after completing the qualification question, and one reported that they did not read and answer carefully when completing the study. Thus, the valid completion rate for those who began and qualified for the study was 92%. It should be noted that the novice sample was required to participate in research for class credit, so this completion rate may be artificially inflated by the degree of their motivation to complete the study.

Completion times. Among the full sample of 207 valid responses, the average completion time was 14 minutes and 42 seconds (*SD* = 32:50). However, when five extreme outliers that each exceeded one hour were removed, the average completion time was 10 minutes

and 14 seconds (*SD* = 6:01). Presumably completion times over one hour were cases in which a browser window with the survey was left open while other tasks were completed. With all times over one hour removed, the subsample averages were 12 minutes and 45 seconds (*SD* = 7:21) for experts, 10 minutes and 49 seconds (*SD* = 5:54) for trainees, and 7 minutes and 57 seconds (*SD* = 3:53) for novices.

Chapter V. Discussion

This study sought to adapt the GTQ-C from its original purpose of examining types of interventions most frequently chosen by group therapists, into a multiple-choice measure, the GLCQ, that would provide data relevant to the test taker's competence to lead interpersonal process group therapy. A small sample of expert group therapists was used to shorten the measure and create the key and scoring for the GLCQ. The resulting measure successfully discriminated between novices with no group therapy training or experience, psychology trainees with some training and experience in group therapy, and expert group therapists, thus providing concurrent criterion-related validity. All directional hypotheses regarding these mean differences were supported. The GLCQ had good internal consistency when measured among the combined sample of experts, trainees, and novices. Although some refinement of the measure and additional validity and reliability data are recommended before the measure is used in practice, this study provided an important first step in creating a written measure of competence for group therapy leadership.

Phase 1

The initial phase of the study asked a small group of experts in group therapy to read each of the 21 scenarios in the GTQ-C, with revisions, and rate each of the 20 or 21 response options on each scenario as excellent, moderate, or poor. While there were certainly distinct patterns of agreement amongst their responses, there was also significant disagreement across some scenarios and response options. This necessitated an adaptation from the original plan in order to translate their responses into a cohesive 10-question GLCQ. The minimum level of agreement was lowered from 70% to 60%. Even with this change, there was still an inadequate number of moderate responses. In retrospect, it was not surprising that experts were much more

likely to agree on the responses that were excellent or quite poor than they were on the responses of more moderate quality. This yielded a GLCQ with only one response option receiving partial credit (1 point instead of the full 2 points for excellent responses). Despite these adaptations to the analysis plan, the process still resulted in a GLCQ in which each response option was categorized in accordance with the key by a majority of the initial expert sample. Among the 10 GLCQ scenarios, only four of the total 50 response options were agreed upon by 60% rather than 70% or more of the expert sample.

The use of intraclass correlations (ICCs) as a measure of interrater reliability also minimized the effect of the lower level of required agreement by keeping the 10 scenarios with the highest interrater reliability. This resulted in all GLCQ scenarios having an ICC value of .959 or higher. Thus, even for the scenario with the lowest ICC, only about 4% of the variance in the mean ratings is due to rater variability or error. This puts all GLCQ scenarios in the upper end of the excellent range of clinical significance for ICCs (.75-1.00; Cicchetti & Sparrow, 1981).

Two other aspects of this measure adaptation process are particularly notable. First, the experts were particularly quick to agree on the poor interventions. In other words, there was substantial disagreement, especially on some of the discarded scenarios, on what constituted an appropriate or effective intervention, but experts often had very similar ideas of which interventions would be completely ineffective or inappropriate to the situation. This is likely due in part to the construction of the original GTQ-C. Regardless of the situation itself, each scenario was supplied with an intervention for each of the 19 Group Leadership Scales. These were adapted to each scenario at hand, but they remained present regardless of whether they could be considered a realistic intervention. Among the 10 GLCQ scenarios, only four of the

total 20 poor responses had less than 100% agreement, and these were all still at 90%. On the other hand, of the 20 excellent responses in the 10 GLCQ scenarios, the agreement levels ranged from 60%-90%, with none of them reaching complete agreement. This seems to speak to the great variability present in ideas of what constitutes good group therapy (AGPA, 2007), just as there is substantial variability in theoretical orientation and interventions in terms of individual therapy (Heinonen & Orlinsky, 2013). Of course, this presents a core challenge in the aims of this dissertation study.

Second, there were five Group Leadership Scales, or types of responses, that were not included at all in the GLCQ measure, regardless of excellent, moderate, or poor category. This was also the case for the multicultural/feminist responses and the one safety-related response written by the author and committee. The scales not included were Leader Feeling, Psychodynamic Interpretation, Behavioral Change, Nonverbal, and Role Playing (see Appendix A for definitions). This most likely indicates that there was greater disagreement on the suitability of these intervention types among the expert sample, potentially in relation to response types that do or do not map well onto specific theories. This could be an interesting phenomenon to explore further in a future study.

Phase 2

GLCQ scores across groups. Hypotheses 2a, 2b, and 2c were supported, in that the mean GLCQ scores differed across groups in all expected directions. Expert scores were the highest, followed by trainee scores, and then novice scores. All mean differences were significant with *p* values less than .001. As explained in the Phase 2 results section, there were some violations of ANOVA assumptions that had to be addressed. However, the occurrence of these violations made sense within the context of the data. First, given the above discussion

about theoretical differences and variability in leadership approach, outliers were not surprising and may represent actual differences in group leadership knowledge rather than measurement error. Given this possibility and since Welch ANOVA results were the same with and without outliers, they were left in the dataset for analyses. Second, neither the trainee nor expert scores were normally distributed. Both were negatively skewed and positively kurtosed. These distributions make sense, however, considering the composition of the samples and the purpose of the measure. In both samples, participants who have both training and experience in providing interpersonal process-oriented group psychotherapy were being tested on their knowledge and decision-making regarding ideal interventions in a process group. It is expected, then, that scores would cluster near the higher end of the distribution of GLCQ scores. Regardless of this non-normality, significant differences between groups were detected with both original and transformed values, so original values were used. Third, variances were heterogenous across groups. Once again, this assumption violation is not surprising, given the composition of the samples and purpose of the measure. As mentioned above in regards to non-normality of distributions, the scores for the trainee and expert samples were clustered around higher GLCQ scores, most likely due to their training and experience, thus resulting in relatively low variances. In the novice sample, however, these participants had no training or experience in group psychotherapy, so their answers were expected to be primarily guesses after reading the scenario and responses. This resulted in a much wider variance, with a standard deviation more than two times that of the expert sample scores. To account for this heterogeneity of variances, the more robust Welch ANOVA and Games-Howell post hoc tests were used.

GLCQ scores in relation to participant characteristics. No differences were found in GLCQ scores within sample groups on any participant variables related to training or experience,

including type of graduate program (i.e., clinical or counseling psychology), hours of group therapy provision, year of study, or experience as a therapy client. Following refinement of the GLCQ, similar variables may be worth future examination, but no differences were found in the present study.

Detailed results by scenario and response option. Data presented in Tables 3 and 4 break down responses and scores by scenario and by individual response options, respectively. Although no scenario had a negative item-total correlation, this correlation for scenario 10 was rather low, and there were three scenarios (6, 10, and 17) on which the trainee mean was higher than that of experts. Since the difference between the overall GLCQ score means of experts and trainees is already rather small, although significant, examination of these tables suggests that scenarios 6, 10, and 17 may be less effective in distinguishing between the trainee and expert samples. That is, when individuals have some degree of group training, these three scenarios may be minimally effective at distinguishing between those who are more and less experienced.

Future studies, discussed below, should continue to explore these characteristics of the measure. A possible avenue for exploration includes also gathering responses to the four scenarios that yielded sufficient agreement in Phase 1, but were dropped because their ICCs were lower than those of the 10 retained scenarios. Another option would be to consider using fewer than 10 scenarios on the final GLCQ.

Internal consistency. Cronbach's alpha, using the score for each of the 10 scenarios as individual items, was high ($\alpha = .88$) for the full, combined sample, but low when measured within each separate sample, with coefficients ranging from .44 to .52 for experts, trainees, and novices. When potentially problematic scenarios were removed from the analysis, internal consistency improved slightly, but was still low, with coefficients alpha ranging from .44 to .59

in subsamples. In a combined subsample of experts and trainees, internal consistency of the measure was also low, ranging from .53, with all 10 scenarios included, to .62, with three potentially problematic scenarios omitted. Thus, when given to participants with widely varying skills and knowledge in providing group therapy, the scenario scores were highly correlated, but when examined only among a group with similar levels of training and experience, the correlations between scenario scores were smaller. This may argue for greater utility of the GLCQ in groups with heterogenous levels of training or experience.

Response data.

Response speed and completion rates. Among all the response data collected, the most interesting are those describing the completion rates for participants who began and qualified for the study. The rate was 85% among experts, 89% among trainees, and 92% among novices. These rates were relatively high, indicating that 15% or less of the study participants encountered substantial difficulty or boredom during the GLCQ to cause them to not complete the measure. The completion rate was lowest among the expert sample, whether because of competing professional demands, frustration or disagreement with the measure content, boredom, or some other reason. One participant from the expert sample wrote an email explaining his withdrawal from the study after discontinuing his participation. With his permission, his comments are included here. He stated, "As quick as only the second item on the questionnaire, I got stuck. None of the options presented are anything like what I would do." This is certainly one limitation to the GLCQ, as the structure of the measure cannot possibly capture the wide variability in the way group therapists choose to respond to the myriad situations that one encounters in a process group.

Completion times. With all times over one hour removed, the GLCQ and demographic questions took an average of 8-13 minutes to complete, depending on the sample, with more time spent on the study by samples with greater amounts of training and experience. It can be surmised from these data that the GLCQ itself, without accompanying demographics questions, can be completed in about 10 minutes. Thus, it is a relatively short measure and does not take an inordinate amount of time. This completion time argues for its utility in many research or training capacities.

Limitations

There are several limitations important to note. First, in the development of the GLCQ in Phase 1, the original plan for analysis and measure adaptation had to be changed due to lower levels of agreement among the initial expert sample than those for which the committee and I had hoped. Thus, the resulting GLCQ measure only included one moderate response per scenario rather than two and had four responses for which the categorization was agreed upon by 60% of the sample rather than the target 70% or greater. Of these, the change in number of moderate responses seems to be the lesser limitation, because the GLCQ still functions adequately with this change in structure. It does, however, reduce the options available for partial credit on the GLCQ and therefore makes each item more a question of good and bad responses, or right and wrong, reducing the nuance present in the available responses. Of greater concern is the reduction in required expert agreement on response option categorization from 70% to 60%. This has left four responses (1 excellent; 3 moderate) on the resulting measure on which only 6 of 10 expert participants agreed. Thus, the GLCQ attempts to measure competence based on answers that have been deemed right, wrong, and partially correct, but based on lower levels of expert agreement than preferable.

In part, this agreement issue reflects methodological choices, in that the structure and confines of the dissertation study required adjustment to the agreement level, whereas the measure could alternatively be redesigned using a different process. For example, one potential option would be to convene a committee of experts in real time and task them to come to consensus after discussion of each scenario and response choice. It is also possible that there is some characteristic of the very small sample of experts used for Phase 1 that may have led to a misrepresentation of the actual levels of agreement in the full population of experts. This possibility could be explored by attempting to recruit a more representative sample. On the other hand, as briefly mentioned earlier, this problem likely reflects a broader issue within the field of psychotherapy, in that there is enormous variability in how we do our jobs. This problem begs the question: how do we measure competence when even the experts do not agree? Furthermore, is it *possible* to measure competence in such a paradigm?

Our profession has put substantial effort, energy, and resources into measuring competence (Kaslow et al., 2004, 2009; Rodolfa et al., 2005). While these efforts do not appear to be abating anytime soon, we must bear in mind the inherent variability in choices made when providing psychotherapy. Despite the reduction in agreement by experts in the present study, the GLCQ was still able to distinguish between groups. That said, it is crucial that with any present or future use of the GLCQ, users remember that the basis for the correctness of responses and therefore scoring of the GLCQ is not an absolute.

Second, although GLCQ scores of experts were significantly higher than those of trainees, the mean difference was still relatively small, at only 1.5 points on the 40-point scale. This small distinction was also apparent in the internal consistency of the measure in the combined subsample of experts and trainees, which remained low ($\alpha = .61$ to $.62$) even when

removing potentially problematic items. Thus, the initial version of the GLCQ in the present study may have more utility in measuring competence across trained and untrained individuals, rather than clearly distinguishing between trained individuals with varying degrees of experience. Although the data resulting from the present study indicate some promise for this methodological approach, the GLCQ would benefit from refinement before it is finalized and ready for use. Possible next steps in this venture are discussed later in this chapter.

Third, participants self-selected into the study, and this may have introduced bias. This is most notable in the trainee sample, where it is possible that trainees who chose to participate may be particularly interested in group and therefore may differ in some ways from trainees who have the same level of training and experience to qualify for the study, but have lower levels of interest in group therapy. For example, it is possible that trainees who decided to participate in the study may have more group interest, experience, and knowledge than those who did not participate, which therefore may have led to a trainee sample with higher GLCQ scores that that of the population. This selection bias therefore reflects a threat to external validity of the study, as these results may not generalize to the full population.

Fourth, external validity is limited by the demographic composition of the samples. Most notably, all samples were predominately White participants. This was especially apparent in the initial expert sample, in which only one participant identified as a person of color. Across all four subsamples in both phases, participants identifying as White ranged from 78% to 86%. Neither expert sample, from Phases 1 or 2, consisted of a single participant who identified as Black or African American or as Latino/a or Hispanic. Across all samples, only one participant identified as Native American. This represents a threat to external validity in the present study,

as well as a much broader reflection of the lack of diversity in the professions of psychology and mental health practitioners.

Fifth, as previously mentioned, the structure of the GLCQ cannot capture all variability in responses to scenarios. As reflected in the Phase 1 process, there are abundant differences in the choices made by inexperienced and experienced group therapists alike. The GLCQ represents an attempt to find some common ground on what expert therapists agree are excellent or poor responses to certain situations, but this is inherently limiting and does not embody the full range of choices made by individuals in real world situations. This can be frustrating for some who may feel that their approach as a therapist is not represented within the options available. This both reduces the fidelity to practice, or reflection of real-world situations, and may lead test takers to become frustrated with the measure and either stop taking it, as one participant expressed via email, or pay less attention throughout the measure.

Sixth, another limitation to external validity exists in the Phase 2 study design, which limited participant samples to three specific groups. The levels of training and experience in group therapy included in the novice, trainee, and expert samples were intentionally truncated to leave some distance between groups. This was done in hopes that it would increase the likelihood of detecting differences in GLCQ scores in this exploratory study, but this came at the cost of generalizability. The requirements for participation left out large swaths between groups, such as psychology trainees who have some group therapy knowledge, but did not have a group class and/or have not led a process group. Likewise, experienced group therapists who have not obtained their CGP or ABPP credentials were also left out of the sample. For one thing, this limitation to who could participate means that our current data on the GLCQ cannot generalize to individuals who were not in the populations sampled. It also leaves a question as to whether the

GLCQ scores will differ across samples with less distinct differences in levels of group training and experience. This is a big and important question that can be aptly addressed in future research.

Seventh, the study design also provided no ability to manipulate the independent variable of group membership (novice, trainee, or expert). This will be further discussed below in possible future directions for this line of inquiry.

Future Directions

Before any broader use of the GLCQ is pursued, refinement of the measure is recommended and additional reliability and validity data should be obtained on the finalized measure. As discussed above, the version of the GLCQ created in the present study differentiates well across the full sample of experts, trainees, and novices, but the mean difference between expert and trainee scores was small (although significant), the internal consistency within the subsample of experts and trainees remains low, and examination of the statistics by scenario (Table 3) shows that there are three scenarios on which trainee means were higher than the mean scenario scores of experts. These concerns should all be addressed in the next steps of measure development before the GLCQ reaches its finalized and usable state. A possible approach would be to collect more data in a method similar to that of Phase 2 of the present study, using all 14 scenarios that were retained in the first step of Phase 1, prior to the elimination of four scenarios based on ICCs. Among all 14 retained scenarios, the lowest ICC was .927, which is still in the upper end of the excellent range of expert agreement. This approach would allow for a larger pool of possible items that could then be reduced not based on the highest levels of expert agreement, but instead on individual scenario statistics, response patterns, and internal consistency across different versions of the measure.

After the measure is refined, a possible next step would be to build on the initial finding of between group differences by using a regression analysis to examine the effects on the GLCQ of a continuous independent variable, such as years of group experience. If this research were undertaken, the study could sample a broader range of participants, no longer excluding the potential participants mentioned above such as psychology trainees without a group course or process group leadership experience, or experienced group therapists who do not have advanced group credentials. Such a study would examine the viability of the GLCQ using a higher bar that would detect differences with greater nuance than the current study design.

Another possible next step, perhaps after the above study, would be to measure change in GLCQ following a group training or educational course using a pre-test, post-test study design. This would allow for the manipulation of the independent variable with a suitable control group. Another step in the validation of the GLCQ could include comparing GLCQ scores with scores on an existing observation-based measure of competence such at the GPIRS (Chapman et al., 2010).

One additional future direction for this line of research would be to look further into aspects of measure adaptation in Phase 1. As previously mentioned, several types of interventions were dropped entirely from the GTQ-C, with revisions. These included Leader Feeling, Psychodynamic Interpretation, Behavioral Change, Nonverbal, and Role Playing responses (see Appendix A for scale definitions), as well as the multicultural/feminist responses and the single safety-related response written by the author and committee. This may indicate greater disagreement on the appropriateness of this type of response among experienced group therapists, and further inquiry into this dynamic could be illuminating.

Implications for the Field

This study made distinct strides towards developing a written measure of competency, via knowledge and skills, to provide process-oriented group therapy. Utilizing a method similar to that of the PPCT (Mullen et al., 2004), the GLCQ appears to be able to overcome some of the challenges encountered by Stokes and Tate (1979) in their creation of the GIQ. By utilizing this process, I was able to create a measure that contains more nuanced responses than did the GIQ. Future research will reveal whether the GLCQ is still able to distinguish between participants across a continuous variable with a broader sample, rather than between groups whose members were intentionally quite distinct. After further refinement of the measure and additional psychometric data are obtained, the GLCQ may have promising applications in both research and training.

A quick, multiple-choice measure that assesses leadership competence may have broad utility in research on group therapy training and competence, providing researchers with a new way to measure effectiveness of training interventions in increasing therapist competence. The GLCQ may also provide a new tool for the investigation of therapist variables in group research studies. Prior investigations of therapist effects in group psychotherapy research utilized primarily client or observer ratings of the therapist (Dies, 1994b). The GLCQ could be used in conjunction with these other methods to generate more robust data about therapist effects, or it could be used in place of other methods, as a much more cost-effective and efficient means of adding information about therapist effects to a study.

If future pre-test, post-test studies with the GLCQ are successful, this could provide for countless direct applications in group training. It could be used in semester-long group courses, shorter trainings, and clinical practicum or internship training sites to assess trainees' growth in group knowledge and skills. Even if results from pre-test, post-test studies are not favorable, the

GLCQ could still have utility as a training tool to discuss responses to various situations or to assess baseline knowledge. A particularly intriguing use of this measure would be to compare competence, as measured by the GLCQ, to self-reported perceived competence in group psychotherapy. This could provide a valuable contribution to the group training literature in regards to trainees' and new professionals' readiness to provide group psychotherapy.

As previously noted, the preliminary reliability and validity data in the current study are not sufficient to support these uses of the GLCQ just yet, but its successful initial creation paves the way for many promising future applications.

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Appendix A

Definitions of the 19 Group Leadership Scales of the GTQ-C

Reprinted from Wile (1973). Note that singly-gendered pronouns were retained from original printing.

1. Silence (O): the leader does nothing; he remains silent.
2. Group Directed (GD): the leader appeals to the group as the leadership agency. He indicates that the stewardship of the group and the management of problems which arise in the group are the responsibility of the group. GD consists of two types of responses: a relatively unchallenging abdication of leadership and a relatively challenging insistence on the responsibility of the group.
3. Reassurance-Approval (RA): the leader supports, comforts, compliments, or expresses reassurance, approval, respect, agreement, acceptance, liking, concern, sympathy, or empathy.
4. Subtle Guidance (SG): the leader guides the group in a nonconfronting or in-direct manner. When situations, particularly difficult situations, arise in the group, he does not make an issue about them, but ignores them or unobtrusively redirects the attention of the group in a different direction.
5. Structure (S): the leader structures the group meeting. He makes rules, sets limits, or indicates how the group might best proceed.
6. Attack (A): the leader is aggressive and provocative, criticizing the group (or a member) in a more or less derisive manner. He accuses, chides, insults, ridicules, makes fun of, undercuts defenses, or caricatures.
7. Member Feelings (MF): the leader asks members to say how they are feeling or reacting to what is going on.
8. Leader Feelings (LF): the leader expresses his own feelings.
9. Leader Experience (LE): the leader tells the group about experiences he has had which are related to what is going on in the group. The combined LF and LE score can be considered as a measure of *self-disclosure.*
10. Clarification-Confrontation Question (CQ): the leader asks members why they are doing what they are doing. Depending upon the manner and context of this response, the effect could be either an invitation to clarify or a challenge to justify.
11. Group Dynamics Question (GQ): the leader encourages the members to step back from the immediate situation and examine what is happening from a wider perspective, i.e., taking into account underlying dynamics.
12. Group Atmosphere (GA): the leader describes what is going on in the group, but with a minimum of interpretation and inference. He describes the mood in the group as he is sensing it or draws attention to group events which, while not hidden, are being overlooked or disregarded. GA is the first of three categories in which the leader tells the group what he thinks is going on; the remaining two, GI and PI, are more ambitious and more clearly interpretative statements.
13. Group Dynamics Interpretation (GI): the leader interprets the underlying group interaction. His focus in the interpretation is on what is happening in the group as a whole. In situations which involve the activity of only one of the members, the leader

interprets this member's behavior in relation to, as a function of, or in the context of, the rest of the group.

14. Psychodynamic Interpretation (PI): the leader interprets events and behavior in terms of the psychodynamics of the individual members. Their behavior is interpreted as resistance or defense, as a manifestation of anxieties, guilt, or anger, or as a reaction to specified preceding events. Since many psychodynamic interpretations are also group dynamic interpretations and many group dynamic interpretations are also psychodynamic interpretations, GI and PI are not always clearly distinct from each other.
15. Personal Life (PL): the leader encourages members to talk about themselves as individuals separate from the group. If members are talking about themselves or about their lives outside the group, he encourages them to continue; if they are talking about the group or about themselves in the context of the group, he encourages them to talk about themselves as individuals distinct from the group.
16. Past and Parents (PP): the leader encourages members to talk about the significant events in their past lives and about their relationships with their parents and siblings.
17. Behavioral Change (BC): the leader encourages members to consider (discuss and specify) those aspects of their behavior which they may wish to change.
18. Nonverbal (NV): the leader initiates a nonverbal procedure of some kind.
19. Role Playing (RP): the leader initiates a role-playing or psychodrama procedure of some kind.

Appendix B

Recruitment Email- Phase 1

Dear Group Therapist,

My name is Erin Crozier, and I am a doctoral candidate in counseling psychology in the College of Education at Auburn University. I am currently conducting a dissertation study that seeks to adapt a measure to provide insight on competency and skills in providing group therapy. For the first phase of this research, I am seeking a small sample of experienced group therapists who have a specialty certification in group psychology or group therapy to read a series of clinical vignettes and rate potential response options to each situation in the vignettes. The study will be completed online and is estimated to take approximately 45 minutes of your time. **At the end of the study, you will be compensated with $50 as a thank you for your time.**

In order to participate, you must (a) be currently certified as a Certified Group Psychotherapist and/or Diplomate in Group Psychology from the American Board of Professional Psychology AND (b) have conducted at least one therapy group in the past year from a general interpersonal process approach. Please note that those from any mental health discipline who meet these qualifications are welcome to participate.

I know that many of you receiving this email are passionate about group therapy, and it is this same passion that led me to conduct my dissertation in this area. This study has the potential to make a significant contribution to the areas of training and competency in group therapy, and I hope you can find time to help with these efforts. Even if you do not qualify for the study or do not have time to participate, **please forward this email to others who may qualify**.

If you would like to participate in our study, please click on the link below and you will be directed to the online survey, beginning with the informed consent document:
https://auburn.qualtrics.com/jfe/form/SV_0JrYHDUxUhqUAHX

Thank you very much for your time! If you have any question about this study, please feel free to contact me or my dissertation chair using the contact information below. This research study has been approved by the Auburn University Institutional Review Board (IRB# 16-307 EX 1609).

Sincerely,

Erin F. Crozier
Principle Investigator
Doctoral Candidate
Auburn University
elf0003@auburn.edu

Randy Pipes, Ph.D.
Dissertation Chairperson
Professor
Auburn University
pipesrb@auburn.edu

Appendix C

Qualification Questions- Phase 1

Are you at least 18 years of age?

- Yes, I am 18 years of age or older
- *No*
- *I prefer not to answer*

Please respond to the following statement:

I have led or co-led at least one group in the past year utilizing a general interpersonal process approach.

- True, this statement describes me
- *False, this statement does not accurately describe me*
- *I don't know if this describes me, or I prefer not to answer*

Which of the following group credentials do you hold?

- Certified Group Psychotherapist (CGP)
- American Board of Professional Psychology Diploma in Group Psychology (ABPP)
- Both CGP and ABPP in Group Psychology
- *Neither of these*

Responses in italics will be included in regular font in the survey, but any such responses will lead to an alternate end of survey screen informing participants that they do not qualify for the study.

Appendix D

Email from IBCGP Chairman Regarding Recruitment of CGPs

From: Tony Sheppard (email omitted)
5/3/16 at 8:51 am

Erin,

So nice to hear from you. Congratulations on making it to this point in your training. Once you have IRB approval for your study, let me know. I can then take that our Executive Committee so that we can discuss how to grant you access to CGP's. I really appreciate your utilizing the CGP in your research in this way. I look forward to hearing from you once you have approval.

My Best,
Tony

Tony L. Sheppard, Psy.D., CGP, FAGPA
Licensed Psychologist (KY/IN)/Certified Group Psychotherapist
Chair, International Board for Certification of Group Psychotherapists
www.drtlsheppard.com

On Mon, May 2, 2016 at 9:46 AM, Erin Crozier <elf0003@tigermail.auburn.edu> wrote:

Hi Tony,

I'm not sure if you remember me, but we met in an intense psychodrama workshop at last year's AGPA in San Francisco. I am currently in the fifth year of my doctoral program at Auburn University and am nearing my dissertation proposal (thankfully, before I leave for internship this summer!). My dissertation seeks to explore a methodology for measuring leadership competence in group therapy. In pursuit of this goal, my current design (if approved by the committee) will involve two separate samples of subject matter experts, for which I am hoping to use CGPs and those with ABPP in group psychology. In regards to the former, I am writing for your advice and assistance on the best way to contact CGPs. Although this will certainly depend on the decisions of my committee, I am hoping to sample CGPs of all professions and work settings, so I am looking for a way to disseminate the request as broadly as possible. Do you have any suggestions as to the best way to do this?

Thank you in advance for your help!

Erin F Crozier
Doctoral Candidate in Counseling Psychology
Auburn University, Auburn, AL
elf0003@auburn.edu

Appendix E

GTQ-C Author Permission

From: dan@danwile.com
5/31/2016 at 7:27 pm

Erin,

I just read your email and what you propose is perfectly fine with me—in fact, I'm glad you're doing it, since no one else I know is working on the instrument. When it's in easy form to send me, I'd like to see the changes—the gender-neutral language, new scenarios, and new scoring. I'm curious to see the changes in sensibility forty years later.

Dan

From: elf0003@auburn.edu
5/2/2016 at 8:34 am

Dear Dr. Wile,

As you could imagine, much has happened in the progress of my dissertation since we last wrote six months ago. I have my proposal meeting scheduled for this summer, and I would like to confer with you once more before I proceed.

As I prepare for my proposal, my evolved dissertation design will require me to make some alterations to your measure (using gender-neutral language where possible, generating new items on some scenarios, etc.) and to use data from group therapy experts to create a new, shortened version of the instrument with alternate scoring and instructions. I can provide you with more detailed information on these alterations if you would like.

In my proposal draft, I have also included the following items to ensure the protection of your instrument and your work: 1) In an appendix, I have included the full, cited text of the GTQ-C with clear notations of any text that has been added, changed, or removed from the original. 2) I have given the shortened measure a separate name, the Group Leadership Competency Questionnaire, simply to distinguish it from the original, and I have included the following statement: "Note that the GLCQ title of the adaptation developed in the present study is being used only to distinguish this adaptation of the GTQ-C from the original, but Daniel Wile and other authors of the GTQ-C retain all rights to the instrument." Of course, I am happy to change this statement if there is any alternation you prefer.

I am excited about the opportunity to explore this methodology for creating a measure of leadership competency, but I am also aware that it requires some alterations to your work. Please note that the permission I seek is only for the extent of my dissertation. If this methodology is successful and I seek to expand upon this research in any way that continues to

utilize your instrument or the alteration thereof, I will consult with you and seek separate permission at that time.

At your earliest convenience, please let me know if you are supportive of my proceeding as described above.

Thank you,

Erin F Crozier
Doctoral Candidate in Counseling Psychology
Auburn University, Auburn, AL
elf0003@auburn.edu

From: dan@danwile.com
10/27/2015 at 12:19 pm

Hi Erin,

I am happy to hear of you interest in using the GTQ-C. Tell me what materials you have on it and I will send any ones that I have that you don't have. I assume that you're not interested in the early version (GTQ-B), so I won't bother to send those. Also, would you send me the Dennis Kivlighan references or, if you have them, digital copies of the articles. I'm not sure I have them. And yes, you have my full permission to use the measure. Also, I would very much like to see what you come up with.

Dan

From: elf0003@auburn.edu
10/27/2015 at 8:47 am

Good morning, Dr. Wile. I am a fifth-year doctoral candidate in Counseling Psychology at Auburn University. I discovered the GTQ-C through Dennis Kivlighan's work, and I have so enjoyed reading about the instrument. I am passionate about group therapy and would like to use the measure in my dissertation. Specifically, I would like to explore its use with an alternative scoring system that will allow me to directly compare participants' responses to individual scenarios with the responses of experts in group leadership. I am writing to ask your permission to use the measure. Additionally, I believe I have all published works on the GTQ-C, but it appeared in a few articles that you may have additional unpublished works that may be of help in this venture. I would greatly appreciate any materials you might be willing to provide. I will also gladly provide you with a copy of the completed dissertation if you would like upon its completion. Thank you for the work you have done in this area and for your time and assistance.

--
This mail is sent via contact form on COLLABORATIVE COUPLE THERAPY http://www.danwile.com/2012

Appendix F

Group Leadership Questionnaire (GTQ-C), with Revisions

Note: Additions to the original GTQ-C are indicated in bold and italics font. Deletions from the original are indicated by strikethroughs.

Directions

This questionnaire presents 21 situations which sometimes occur in human interaction groups and asks you to indicate how you would respond if you were the leader in the group. ***Please imagine that you are the leader of a heterogenous, interpersonal process therapy group when you respond to the questionnaire.*** A list of ***20 to 21*** alternative responses is provided for each situation.

For each situation, ~~select *all* of the responses among the 19 that you might consider making if you were~~ ***please consider the ideal actions of*** the leader faced with this particular situation ***and rate each response option listed as an excellent response option, a moderate response option (i.e., neither an excellent nor poor choice), or a poor response option***. ***You may place as many or as few response options in each category as you choose.***

Situation 1: Starting the Group

You are the leader in a group which is meeting today for the first time. All eight members, young adults, are present as you enter the room and sit down. You introduce yourself and the members introduce themselves. Then everyone turns and looks at you expectantly. There is silence. What do you do?

1. Do nothing.
2. Say that the group is theirs to make use of as they wish.
3. Reassure them that a certain amount of tension is typical in the beginning of a group.
4. Break the ice with casual conversation.
5. Describe the purposes and procedures of the group.
6. Say that everyone seems so uptight that you wonder if the group is going to get off the ground.
7. Ask how they feel in this first meeting (about being in the group or about each other).
8. Say how you are feeling (example: tense and expectant).
9. Share an experience in your own life.
10. Ask why everyone is silent.
11. Ask what they think might be going on in the group.
12. Describe how they seem to be expecting you to start things.
13. Suggest that they are wanting you to be an inspirational and protective leader.
14. Describe the silence as an expression of their anxieties about the group.
15. Ask ***all members*** ~~everyone~~ to say why ***they*** ~~he~~ came to the group.
16. Lead into a discussion of their family relationships and past experiences.
17. Encourage them to discuss their goals in behavioral terms.
18. Use a nonverbal procedure (examples: milling around; focusing on bodily tensions).

19. Use a role-playing or psychodrama procedure (example: encourage ~~a~~ member***s*** to act out one of ***their*** ~~his~~ problems).
20. Say that you wonder whether cultural expectations of deference to a person in a position of power is keeping them from speaking.

Situation 2: Personal Questions

Near the beginning of the first meeting, the members ask you personal questions about your family and background. What do you do?

1. Do nothing.
2. Invite them to say what they think your answers to these questions might be.
3. Say that you can understand why they might be curious about you.
4. Avoid answering the questions without drawing attention to the fact that you are not answering – bring up another issue.
5. Say that you cannot see how this information would be of any use to the group.
6. Say that it is none of their business.
7. Ask how they feel about you and about the way the group has been set up.
8. Say how you are feeling about their questioning (example: uncomfortable).
9. Answer the questions.
10. Ask why they are asking these questions.
11. Ask what they think might be going on in the group at the moment.
12. Describe how the group's attention has become concentrated upon you.
13. Describe these questions as an expression of their concern about what is going to happen between you and them.
14. Suggest that they may be asking about you to avoid talking about their own thoughts and feelings.
15. Encourage them to talk about themselves.
16. Lead into a discussion of their family relationships and past experiences (example: ask if they would like to answer these same questions about themselves).
17. Encourage them to consider behavior they may wish to change.
18. Ask them to express nonverbally how they feel about you and the group.
19. Ask one of the members to role-play your position in the group.
20. Acknowledge the leader-member power differential and how this may be affected by uneven levels of self-disclosure.

Situation 3: The Chair*person* ~~man~~

Later in this first session, someone suggests that the group appoint a chair***person*** ~~man~~ to conduct the meetings. This idea is received enthusiastically. They explain that this will permit the group to function in a more orderly fashion. Everyone appears to agree with the idea. What do you do?

1. Do nothing.
2. Say that you are willing to go along with whatever the group decides about this.
3. Agree that it is worth a try.
4. Direct attention away from this idea by bringing up another issue.

5. Recommend against the idea.
6. Say, "It's beginning to sound like a PTA meeting in here- I guess no one is really interested in group interaction."
7. Ask how they feel about the way the group has been set up.
8. Say how you are feeling about the discussion.
9. Share a similar experience in your own life.
10. Ask why it is important for the group to function "in an orderly fashion."
11. Say, "What happened that made us decide we need a chair***person*** ~~man~~?"
12. Describe the group's feeling of enthusiasm about the idea.
13. Suggest that their interest in a chair***person*** ~~man~~ may be a way of dealing with the ambiguity of the group situation.
14. Interpret their discussion as resistance to becoming involved in the group.
15. Encourage them to talk about themselves.
16. Lead into a discussion of their family relationships and past experiences.
17. Encourage them to consider behavior they may wish to change.
18. Ask them to express nonverbally how they feel about you and the others.
19. Ask them to role-play how the group would be with a chair***person*** ~~man~~.
20. Ask them to consider what cultural norms may be contributing to their felt need for a chairperson and an orderly group.

Situation 4: A Filibuster

The group spends much of the second session talking about politics. No one appears displeased with the discussion, and it looks like it may continue for the remainder of the meeting. What do you do?

1. Do nothing.
2. Ask if they are satisfied with how the group is going today (say, "Is this really the way you want to use ***your*** ~~the~~ time?").
3. Join in on the discussion.
4. Try to draw them into a more meaningful discussion without criticizing what they were doing.
5. Suggest that they talk about more immediate things.
6. Describe their discussion as cocktail party chatter.
7. Ask how they feel about what has been going on.
8. Say how you are feeling (example: bored).
9. Share an experience in your own life.
10. Ask why they are talking about politics.
11. Ask what they think might be going on in the group today.
12. Describe the group mood of avoidance and withdrawal.
13. Suggest that their interest in politics may have something to do with their concern about the interrelationship – or "politics" – within the group.
14. Suggest that they are discussing politics to avoid talking about more immediate thoughts and feelings.
15. Encourage them to talk about themselves.
16. Lead into a discussion of their family relationships and past experiences.
17. Encourage them to consider behavior they may wish to change.

18. Use a nonverbal procedure to get things going.
19. Use a role-playing or psychodrama procedure.
20. Make a comment about how differences in political opinions are being handled by the group.

Situation 5: An Attack upon the Leader

After spending much of this second meeting talking about dieting and politics, the group suddenly turns on you, accusing you of being uninvolved, distant, and uncaring. What do you do?

l. Do nothing.
2. Say that it is up to them what happens in group, not you.
3. Talk in an approving way about the directness and honesty with which they are able to say how they feel.
4. Direct attention away from their attack by bringing up another issue.
5. Defend yourself – say that you do not see yourself as uninvolved and uncaring.
6. Describe them as a group of whiny complainers.
7. Ask how they feel when they are criticizing you in this way.
8. Say how you are feeling.
9. Share an experience in your own life.
10. Ask why they suddenly became angry at you.
11. Ask what they think might be going on in the group today.
12. Describe the group attitude of dissatisfaction with you.
13. Suggest that they are disappointed that you are not the inspirational and protective leader that they had wanted you to be.
14. Describe how you may be a scapegoat for their dissatisfaction with their own participation in the group.
15. Encourage them to relate this to what is happening in their lives outside the group.
16. Lead into a discussion of their family relationships and past experiences (example: suggest that you may be reminding them of people they have known).
17. Encourage them to use this situation to consider behavior they may wish to change.
18. ***Ask them to express nonverbally (but nonviolently) how they feel towards you.*** ~~Use a nonverbal procedure (example: arm wrestling).~~
19. Suggest that they role-play both how they see you and how they would want you to be.
20. Invite them to explore how culture may be impacting their interpretation of your silence in the session.

Situation 6: A Group Silence

The third meeting begins with a silence. Several minutes pass and still no one says anything. It is beginning to look like the silence might continue for some time. What do you do?

l. Do nothing.
2. Ask if they are satisfied with how the group is going today.
3. Say that silences are often productive.

4. Help the group get started without making a special point about their silence (ask questions or bring up things to talk about).
5. Say that they are wasting time.
6. Remark that they look pretty foolish, sitting around waiting for someone else to say something.
7. Ask how they feel when everyone is silent.
8. Say how you are feeling ***about the silence.*** ~~or, possibly, laugh at the absurdity of the situation.~~
9. Share an experience in your own life.
10. Ask why everyone is silent.
11. Ask what they think might be going on in the group today.
12. Say that it seems that no one wants to talk today.
13. Say that each person appears to have resolved not to be the first to speak.
14. Interpret their silence as an expression of resentment about how the group is going.
15. Encourage them to talk about themselves.
16. Lead into a discussion ~~of~~ ***about how silence is viewed in*** their family relationships and past experiences.
17. Encourage them to consider behavior they may wish to change.
18. Encourage them to express themselves nonverbally.
19. Use a role-playing or psychodrama procedure to get things going.
20. Ask them what cultural messages they have received about silence.

Situation 7: A Distressed Woman

Later in this third meeting, one of the women describes how her ***partner*** ~~boyfriend~~ ***just*** ~~told her that he wants to break off~~ ***ended*** their relationship. She seems quite upset, skipping from one idea to another, and returning repetitively to the same few despairing thoughts. She has been looking directly at you from the beginning of her remarks, ignoring the rest of the group. When she finishes talking, she asks for your comments. What do you do?

l. Do nothing.
2. Redirect her question to the group (ask how the group might be able to help her).
3. Express interest in her and concern about her difficulties.
4. Try to draw the others into the discussion without making a point of the fact that she had left them out.
5. Suggest that she ask the group rather than you.
6. Accuse her of basking in self-pity.
7. Ask the members how they feel about what is going on.
8. Say how you are feeling.
9. Share a similar experience in your own life.
10. Ask why she is asking you.
11. Ask what they think might be going on in the group today.
12. Describe how the group has accepted the role of passive observer.
13. Suggest that her appeal for your undivided attention may be an attempt to regain the feeling of being valued – special – which she lost when her ***partner*** ~~boyfriend~~ rejected her.
14. Suggest that her preoccupation with being rejected is a way of not having to consider her own participation in the breakup.

15. Talk about her problems with her ***partner*** ~~boyfriend~~, leading perhaps to a general exploration of her problems with intimacy.
16. Encourage her to relate this to her family relationships and past experiences.
17. Encourage her to discuss her problem in behavioral terms.
18. Use a nonverbal procedure to get at her underlying feelings.
19. Use a role-playing or psychodrama procedure to obtain a more here-and-now expression of what happens with her ***partner*** ~~boyfriend~~.
20. Make a comment about societal expectations for women to be partnered.

Situation 8: The Late Arrival

It is the fourth meeting, one ~~wo~~man makes a dramatic entrance 15 minutes late. Although ~~s~~he has done this before, no one says anything about it. What do you do?

l. Do nothing.
2. Ask why no one says anything about ~~her~~***him*** coming late.
3. Give ~~her~~***him*** attention and express interest in ~~her~~***him***.
4. Continue as if nothing out of the ordinary were happening.
5. Suggest that ~~s~~he try to get to group on time.
6. Accuse ~~her~~***him*** of acting like a ~~*prima donna*~~***celebrity***- coming to group late so that ~~s~~he can make a dramatic entrance with everyone watching.
7. Ask ~~her~~***him*** and the rest of the group how they feel about ~~her~~***him*** coming late.
8. Say how you are feeling.
9. Share a similar experience in your own life.
10. Ask ~~her~~***him*** why ~~s~~he comes late.
11. Ask how ~~her~~***him*** coming late might be related to what has been going on in the group as a whole.
12. Mention that ~~s~~he has been late several times.
13. Suggest that ~~her~~***his*** role in the group involves making a grand entrance with everyone watching.
14. Suggest that ~~s~~he comes to group late in order to deny the important role that it plays in ~~her~~***his*** life.
15. Ask if ~~s~~he usually comes late to things (perhaps this is the way ~~s~~he deals with situations).
16. Encourage ~~her~~***him*** to relate this to ~~her~~***his*** family relationships and past experiences.
17. Encourage ~~her~~***him*** to use this situation to consider behavior ~~s~~he may wish to change.
18. Use a nonverbal procedure to get at the underlying feeling.
19. Ask another member to role-play ~~her~~***his*** entrance.
20. Ask them what cultural factors about him or other group members may be causing them to ignore his behavior.

Situation 9: The Monopolizer

For several meetings now the conversation has been monopolized by one of the women. Her monologues and interruptions interfere with the development of any kind of meaningful interchange. It is now part way into the fourth meeting. She has had the floor for most of this ***session*** ~~hour~~ also. What do you do?

1. Do nothing.
2. Ask why they are letting her monopolize.
3. Talk in an approving way about the freedom with which she is able to assert herself in the group.
4. Direct remarks to others in an attempt to increase their participation.
5. Suggest that she limit her comments for a while to give others a chance.
6. Describe her as a longwinded and insensitive bore who always has to be in the spotlight.
7. Ask how they feel about one person doing most of the talking.
8. Say how you are feeling (example: irritated with her).
9. Share a similar experience in your own life.
10. Ask her why she is monopolizing.
11. Ask how they would describe what has been going on this meeting.
12. Comment on the group's attitude of passive resignation to what is going on.
13. Describe what is going on as a two party interaction where she monopolizes while the others allow and perhaps even encourage her to do it.
14. Describe her need to control as a defense against her fear of being controlled or overwhelmed.
15. Ask if this kind of thing happens with her outside the group.
16. Encourage her to relate this behavior to her family relationships and past experiences.
17. Encourage her and the rest of the group to use this event to consider behavior they may wish to change.
18. Use a nonverbal or gestalt therapy procedure to get beyond her verbal defenses.
19. Ask another member to role-play how she behaves in the group.
20. Ask them to consider how cultural messages about interrupting may contribute to the current situation.

Situation 10: The Quiet Member

One of the men has said very little throughout the meetings, although he seems to follow with interest everything that has been happening. It is now the middle of the fourth session and some of the others are finally beginning to question him about his silence. He remains basically uncommunicative, however, and the group seems uncertain how to pursue the matter. What do you do?

1. Do nothing.
2. Even if they look to you for help, leave it to the group to deal with the situation.
3. Say that each person is free to decide when he wants to talk, adding that you would like to hear from him when he does feel like talking.
4. Encourage him to speak but without making a point of his silence (example: ask for his opinion about the group).
5. Tell him that he is not going to get much out of the group if he does not put much into it.
6. Try to get him to react (example: accuse him of being a parasite, sitting back and living off others).
7. Ask how he feels about what the group is saying to him and ask how they feel about his reaction to their remarks.

8. Say how you are feeling.
9. Share a similar experience in your own life.
10. Ask him why he has been silent and ask the others why they object to his silence.
11. Ask how they would describe what has been going on in the group today.
12. Describe how the group seems uncertain about how to discuss this with him.
13. Describe the nonverbal ways in which he interacts with others- eye contact, laughter, attentive expression.
14. Interpret his silence as an expression of tenseness and anxiety about the group.
15. Encourage him to talk about himself (example: ask if he is usually quiet in group situations).
16. Encourage him to relate his behavior to his family relationships and past experiences.
17. Encourage him to use this situation to consider behavior he may wish to change.
18. Encourage him to express himself nonverbally.
19. Ask him to role-play an important situation in his life.
20. Comment on the negative messages men and boys often receive regarding personal and emotional expression.

Situation 11: A Threat to Quit

Near the beginning of the fifth meeting, one of the women announces that she is going to quit the group. The others are upset by this and try to talk her out of it. She remains resolute, however, and stands up to leave. She pauses briefly at the door, as if waiting to see if anyone has any final comments. The others just sit there, not knowing what to do. What do you do?

1. Do nothing.
2. Ask what they want to do about the situation.
3. Say that you have enjoyed her being in the group and would be sorry if she left.
4. Draw her into a conversation without making an issue of the fact that she was about to leave.
5. Suggest that she give the group more of a try before making any final decisions.
6. Accuse her of using an obvious play to get the attention of the group.
7. Ask her and the group how they feel about her leaving.
8. Say how you are feeling (example: abandoned).
9. Share a similar experience in your own life.
10. Ask why she wants to leave now, right in the middle of the meeting.
11. Ask how her wanting to leave might be related to what is happening in the group as a whole.
12. Describe how everyone seems confused and uncertain what to do.
13. Interpret their concern and confusion about her leaving as a fear that this may be the beginning of the dissolution of the whole group.
14. Suggest that she wants to stop because she is afraid of becoming involved in the group.
15. Ask if this kind of thing has happened with her before (perhaps quitting is her way of dealing with threatening situations).
16. Encourage her to relate her desire to quit to her family relationships and past experiences (perhaps the group reminds her of her family situation).
17. Encourage her and the others to use this event to consider behavior they may wish to change.
18. Ask her to express nonverbally how she feels toward each member.
19. Use a role-playing or psychodrama procedure.
20. Ask her whether any cultural dynamics in the group are contributing to her desire to leave.

Situation 12: Marital Problem

Later in this fifth meeting, one of the men talks about his marital problems. The others offer numerous suggestions. He listens to each of them one at a time and then explains why that particular suggestion will not work. What do you do?

1. Do nothing.
2. If they ask your opinion, reflect the question back to the group.
3. Show interest in him and express concern about his difficulties.
4. Seeing the interaction as a stalemate, bring up another issue for discussion.
5. Describe the interaction as a stalemate and suggest that they talk about something else.
6. Criticize him for not seriously considering his problem and wasting the group's time.
7. Ask how he feels about the group response to his problem and ask how they feel about his reaction to their suggestions.
8. Say how you are feeling.
9. Share a similar experience in your own life.
10. Ask him why he rejects all their suggestions and ask them why they are giving so much advice.
11. Ask what they think is going on in the group today.
12. Describe the eagerness with which they are giving him advice.
13. Describe how he asks for help and then rejects all the suggestions.
14. Describe how he is the focus around which all the other members are projecting their own problems – suggest that their advice may have more to do with them than it does with him.
15. Try to help him understand what happens between him and his ***spouse*** ~~wife~~.
16. Encourage him to relate this to his family relationships and past experiences (perhaps his difficulties with his ***spouse*** ~~wife~~ have something to do with his feelings toward ***a parent*** ~~his mother~~).
17. Encourage him to talk about the problem in behavioral terms.
18. Use a nonverbal procedure.
19. Use a role-playing or psychodrama procedure to obtain a more here-and-now expression of what happens with his ***spouse*** ~~wife~~.
20. Comment on cultural differences that exist in the group and how these may be impacting the dynamics of the advice-giving and his reactions.

Situation 13: The Return of the Absent Member

A member who had been absent the two previous meetings arrives on time for the sixth meeting. It is now well into this meeting and neither ***s***he nor any of the others has mentioned ~~his~~***her*** absences. What do you do?

1. Do nothing.
2. Ask why no one has said anything about ~~his~~***her*** absences.
3. Say that it is good to see ~~him~~***her*** again, that you were concerned when ***s***he missed two meetings that ***s***he might have dropped out of the group entirely.

4. Seeing ~~his~~***her*** absences as a sign of lack of involvement with the group, try to draw ~~him~~***her*** into the group conversation, but without referring to these absences.
5. Talk about the importance of coming to every meeting.
6. Comment on ~~his~~***her*** halfhearted commitment to the group ***by saying***~~—say~~ that you doubt that ***s***he has ever really been committed to anything.
7. Ask ~~him~~***her*** and the others how they feel about ~~his~~***her*** returning after missing two meetings.
8. Say how you are feeling.
9. Share a similar experience in your own life.
10. Ask ~~him~~***her*** why ***s***he missed these two meetings.
11. Ask how ~~his~~***her*** missing two meetings might be related to what has been going on in the group as a whole.
12. Mention that ***s***he missed the two previous meetings.
13. Say that there seems to be an unspoken ~~compact~~ ***pact*** among the members not to talk about such events.
14. Interpret ~~his~~***her*** absence as an expression of anxiety about the group.
15. Ask ~~him~~***her*** what is happening in ~~his~~***her*** life which may have caused ~~him~~***her*** to miss those two meetings.
16. Encourage ~~him~~***her*** to relate ~~his~~***her*** absences to ~~his~~***her*** family relationships and past experiences.
17. Encourage ~~him~~***her*** to use this event to consider behavior ***s***he may wish to change.
18. Use a nonverbal procedure to get at the underlying feelings.
19. Ask ~~him~~***her*** to role-play an important situation in ~~his~~***her*** life.
20. Explore how cultural messages regarding conflict avoidance may be contributing to the group's reluctance to address the issue.

Situation 14: A Member Cries

It is the middle of the sixth meeting. A ~~wo~~man who had been unusually silent for the first half of this meeting makes a brief attempt to fight back tears and then begins to cry. No one says anything about it. What do you do?

1. Do nothing.
2. Ask why no one has said anything about the fact that someone is crying.
3. Express concern and reassurance.
4. Continue as if nothing out of the ordinary were happening.
5. Suggest that it might be more useful for ~~her~~***him*** to talk than just to cry.
6. Accuse ~~her~~***him*** of putting on a show.
7. Ask about feelings (examples: encourage ~~her~~***him*** to give words to ~~her~~***his*** feelings; ask the members how they feel about ~~her~~***his*** crying).
8. Say how you are feeling (examples: moved, embarrassed).
9. Share a similar experience in your own life.
10. Ask ~~her~~***him*** why ~~s~~he is crying (ask what's the matter).
11. Ask them to describe what is happening at that meeting.
12. Say that someone in the group is crying.
13. Describe ~~her~~***his*** crying as an act of involvement in the group and a willingness to share ~~her~~***his*** more private feelings with them.

14. Suggest that ~~s~~he may feel that the only time people are willing to listen and pay attention to ~~her~~***him*** is when ~~s~~he is crying.
15. Encourage ~~her~~***him*** to talk about the events in ~~her~~***his*** life which may be upsetting ~~her~~***him***.
16. Encourage ~~her~~***him*** to relate what ~~s~~he is feeling to ~~her~~***his*** family relationships and past experiences.
17. Encourage ~~her~~***him*** to talk about ~~her~~***his*** difficulties in behavioral terms.
18. Use a nonverbal procedure to explore the rich emotional experience of crying.
19. Ask ~~her~~***him*** to role-play the situation ***about*** which ~~her~~***he is*** crying.
20. Say that you wonder whether cultural messages about men crying is preventing them from attending to a group member.

Situation 15: The Grumpy Group

Meeting seven is characterized by a general mood of irritability and negativism. A person can hardly start talking before another interrupts to say, “I am bored.” No one seems pleased about anything. The warm, involved mood at the end of the previous meeting seems completely forgotten. What do you do?

1. Do nothing.
2. Ask if they are satisfied with how the group is going today.
3. Reassure them that most groups have occasional meetings like this one.
4. Try to emphasize more positive feelings, both in your own remarks and those of others.
5. Suggest that they use the time more constructively.
6. Describe them as a group of irritable old men.
7. Ask how they feel about the meeting.
8. Say how you are feeling.
9. Share a similar experience in your own life.
10. Ask why everyone is being negative.
11. Ask what they think might be going on in the group today.
12. Describe the group's mood of negativism and irritability.
13. Say that there seems to be an unspoken understanding among the members to disagree with everything.
14. Describe their irritability as a reaction to the warm involvement of the previous meeting.
15. Encourage them to relate their grumpy mood to what is happening in their lives outside the group.
16. Encourage them to relate their behavior to their family relationships and past experiences.
17. Encourage them to use this situation to consider behavior they may wish to change.
18. Use a nonverbal procedure to get at the underlying feeling.
19. Use a role-playing or psychodrama procedure.
20. Ask them to consider how cultural differences within the group may be influencing what is occurring.

Situation 16: The Polite Group

The eighth meeting begins in a mood of superficial agreeableness. Everyone is being super-polite. Rambling remarks, evasive comments, behavior which ordinarily would immediately be

challenged is being tolerated. It is clear that the group is protecting itself against any possible expression of aggressive feeling. What do you do?

1. Do nothing.
2. Ask if they are satisfied with how the group is going today.
3. Join in on whatever they are discussing.
4. Try to draw them into a more meaningful discussion.
5. Suggest that they get down to real feelings.
6. Be aggressive yourself – criticize the group for ***wasting everyone's time***~~pussyfooting around~~.
7. Ask how they feel about what has been going on.
8. Say how you are feeling.
9. Share similar experiences in your own life.
10. Ask why everyone is being so polite.
11. Ask what they think might be going on in the group today.
12. Describe the group mood of politeness.
13. Say that there seems to be an unspoken agreement among the members to be polite and avoid anything that might rock the boat.
14. Suggest that all this politeness is a reaction against the anger of the previous meeting.
15. Encourage them to relate this to what is happening in their lives outside the group.
16. Lead into a discussion of their family relationships and past experiences.
17. Encourage them to use the situation to consider behavior they may wish to change.
18. Use a nonverbal procedure to get at the underlying feeling.
19. Use a role-playing or psychodrama procedure.
20. ***Make a comment about culturally-embedded expectations of politeness.***

Situation 17: A Group Attack

Throughout the meetings one of the ***wo***men had been insisting that ***s***he has no problems. In the middle of this eighth meeting, the group attacks ~~him~~***her*** for "hiding behind a mask." At the present moment the whole interaction seems to be gaining in intensity – ***s***he responds to their accusations by increasing ~~his~~***her*** denial; they respond to ~~his~~***her*** denial by increasing their attack. You are not sure how ***s***he is being affected by it. What do you do?

l. Do nothing.
2. Even if they ask for your advice, let whatever happens happen.
3. Say that ***all people***~~each person~~ ha***ve***~~s~~ the right to be the kind of person ***they***~~he~~ want~~s~~ to be.
4. Direct attention away from their attack by bringing up another issue.
5. Say that ***s***he is not going to get anything out of group if ***s***he does not put anything into it.
6. Join in on the attack.
7. Ask how ***s***he feels about what they are saying and how they feel about what ***s***he is saying.
8. Say how you are feeling.
9. Share an experience in your own life.
10. Ask why they are attacking and why ***s***he is denying.
11. Ask what they think might be going on in the group today.
12. Comment on the intensity of the argument between ~~him~~***her*** and the rest of the group.

13. Describe the interaction as a standoff – they respond to ~~his~~***her*** intellectualizing with increased attack, and ***s***he responds to their attack with increased intellectualizing.
14. Describe ~~his~~***her*** denial as resistance to becoming involved in the group and describe the group's attack as an attempt to force ~~him~~***her*** to become involved.
15. Ask if the kind of thing happening in the group now ever occurs in ~~his~~***her*** life outside the group.
16. Encourage ~~him~~***her*** to relate these group events to ~~his~~***her*** family relationships and past experiences.
17. Encourage ~~him~~***her*** and the others to use this event to consider behavior they may wish to change.
18. Ask ~~him~~***her*** and the others to express nonverbally how they feel toward each other.
19. Suggest that ***s***he and another member role-play each other's side in the argument.
20. Ask them to consider how cultural differences within the group may be influencing what is occurring.

Situation 18: A Member Comes Drunk

A man who has been relatively quiet in the two previous meetings comes to session nine drunk. He is mildly disruptive, laughing and singing to himself, and occasionally breaking in when others are talking. What do you do?

l. Do nothing.
2. Ask what they want to do about the situation.
3. Show interest in him and express concern about his difficulties (say that he must have been feeling pretty lonely and depressed).
4. Continue as if nothing out of the ordinary were happening.
5. Ask him to leave and come back when he isn't drunk.
6. Accuse him of behaving like a baby.
7. Ask how they feel about what is happening.
8. Say how you are feeling.
9. Share a similar experience in your own life.
10. Ask him why he came to the meeting drunk.
11. Ask how they would describe what has been going on in the meeting.
12. Describe his effect on the mood of the group.
13. Suggest that he may be trying to tell the group something that he could not say in other ways.
14. Describe his behavior as an expression of anxiety about what has been happening in the group.
15. Encourage him to talk about the events in his life which may be troubling him.
16. Encourage him to relate his behavior to his family relationships and past experiences.
17. Encourage him to talk about his difficulties in behavioral terms.
18. Ask him to express nonverbally how he feels about you and the others.
19. Ask another member to role-play the drunk member's behavior.
20. Suggest that someone call him a cab.
21. Ask if they would let any member get away with this behavior or if there's something unique about this member's identities that protects him from comment.

Situation 19: A Side Conversation

The group had been spending much of this ninth meeting talking about one ***member*** ~~of the women~~, when another woman turns to ***the person*** ~~a man~~ sitting next to her and, disregarding the main conversation, starts a competing side conversation. Her talking is a discourtesy and interferes with the main discussion. She continues for several minutes and gives no sign of stopping. What do you do?

l. Do nothing.
2. Ask why no one has said anything about the two conversations.
3. Talk in an approving way about the engaged, intense, and spirited quality of the group interaction.
4. Draw her into the main discussion by inviting her to tell the whole group what she is talking about.
5. Ask that there be only one conversation at a time.
6. Say that it sounds like a nursery school- everyone wants to talk and no one wants to listen.
7. Ask how they feel when there are two conversations going on.
8. Say how you are feeling.
9. Share a similar experience in your own life.
10. Ask her why she is starting a second conversation.
11. Ask how they would describe what has been going on.
12. Say that there are two conversations going on.
13. Describe her side conversation as an expression of jealousy.
14. Describe her interruption as the expression of an underlying fear of being ignored and abandoned.
15. Encourage the interrupting member to talk about herself (perhaps her behavior is a reflection of difficulties she is having in her life outside the group).
16. Encourage her to relate these group events to her family relationships and past experiences (perhaps she felt left out in her family).
17. Encourage her to use this event to consider behavior she may wish to change.
18. Ask her to express nonverbally how she feels toward each person.
19. Ask them to exchange roles and repeat the interaction.
20. Inquire about what cultural message suggested it was okay to begin a side conversation during group.

Situation 20: The Fight

Later in this ninth session, two men get into a heated argument over a minor point. The real reason for the argument appears to be their rivalry for the attention of one of the women. Finally one of the men jumps up enraged and threatens to hit the other. What do you do?

l. Do nothing.
2. Ask the members what they want to do about the situation.
3. Comment on the willingness with which these men are able to accept their aggressive feelings.
4. Defuse the situation by redirecting the group's attention to another issue.
5. Say that physical violence is not allowed in group.

6. Tell him to sit down, shut up, and stop acting like a child.
7. Ask about feelings (examples: ask the two men and the woman how they feel about each other; ask the members how they feel about what is going on).
8. Say how you are feeling.
9. Share a similar experience in your own life.
10. Ask the two why they are doing what they are doing.
11. Ask what they think might be going on between these two men.
12. Describe the mood of tension in the group.
13. Attribute the argument to competition between the two men for the attention of this woman.
14. Describe his aggressive behavior as a defense against his more passive and dependent feelings.
15. Encourage the threatening member to talk about himself (perhaps his behavior is a reflection of difficulties he is having in his life outside the group).
16. Encourage him to relate these group events to his family relationships and past experiences.
17. Encourage him and the rest of the group to use this event to consider behavior they may wish to change.
18. ***Ask them to express nonverbally (but non-violently) how they feel towards one another.*** ~~Use a nonverbal procedure (example: arm wrestling).~~
19. Ask other members to role-play the interaction between the two men.
20. Make a comment about the objectification of the woman in this situation.

Situation 21: The Sexualized Meeting

The tenth meeting begins in a mood of seductiveness. At the center of the interaction is a ***woman*** ~~girl~~ who, for several meetings now, has repeated a pattern of flirting with ***other group members*** ~~a man~~ ***just*** until ***they*** ~~he~~ begin~~s~~ to show interest in her. In the present meeting, she has just stopped flirting with one ***person*** ~~man~~ and has begun with another. Everyone seems to be taking part in the sexual mood, if not as an active participant, at least as a fascinated observer. What do you do?

1. Do nothing.
2. Ask if they are satisfied with how the group is going today.
3. Talk in an approving way about the intensity with which everyone seems to be involved.
4. Seeing the interaction as a stalemate, lead the group in another direction.
5. Suggest that they talk about what is going on rather than simply continuing to do it.
6. Accuse her of being a flirt ~~who is basically afraid of men~~.
7. Ask about feelings (examples: ask the three major participants how they feel about each other; ask the members how they feel about what is going on).
8. Say how you are feeling (example: fascinated).
9. Share a similar experience in your own life.
10. Ask her why she is flirting the way she is.
11. Ask what they think might be going on among these three.
12. Describe the mood of seductiveness in the group.
13. Describe how the whole group seems to be fascinated by the interaction among the three.
14. Suggest that she flirts with different ***people*** ~~men~~ because she is afraid of involvement with any one.

15. Ask if this is the way she relates to ***people*** ~~men~~ outside the group.
16. Encourage her and the others to relate these group events to their family relationships and past experiences.
17. Encourage them to use this event to consider behavior they may wish to change.
18. Ask them to express nonverbally how they feel about each other.
19. Suggest that the three change roles and repeat the interaction.
20. Make a comment about the possible function of flirting as claiming power for those who feel powerlessness and invite her to discuss how she would like to be seen in the group.

Appendix G

Demographics Questionnaire- Phase 1 & Phase 2, Experts

1. With which gender do you most identify?
    a. Man
    b. Woman
    c. Non-binary gender identity (agender, bigender, genderfluid, genderqueer, etc.)
    d. Prefer not to answer
2. Do you identify as transgender?
    a. Yes (my current gender is different than my gender assigned at birth)
    b. No (my current gender is the same as my gender assigned at birth)
    c. Neither answer applies or I prefer not to answer
3. What is your age? ____
4. With which racial or ethnic group do you most closely identify?
    a. Asian, Pacific Islander, or Asian-American
    b. Black or African-American (non-Hispanic)
    c. Latino/a or Hispanic
    d. Native American
    e. White or Caucasian (non-Hispanic)
    f. Biracial or Multiracial
    g. Other identity ____
    h. Prefer not to answer
5. Which of the regions below do you most consider "home?"
    a. Midwest (US)
    b. Northeast (US)
    c. Pacific (US)
    d. South (US)
    e. West (US)
    f. Outside of United States
    g. Prefer not to answer
6. What is your sexual orientation?
    a. Bisexual
    b. Gay/Lesbian
    c. Heterosexual
    d. Other identity ____
    e. Prefer not to answer
7. With which religion do you most closely identify?
    a. Agnostic
    b. Atheist
    c. Buddhist
    d. Christian
    e. Hindu
    f. Jewish
    g. Muslim
    h. Other organized religion ____

i. Other identity ______________________________________
j. Prefer not to answer

8. Years of experience providing group therapy, including pre-doctoral leadership or co-leadership (estimate if needed): ______________________
9. Over the past year, please indicate how many process-oriented group sessions you have led or co-led, on average.
   a. Less than biweekly or a limited portion of the year
   b. Biweekly or more, but less than 1 per week
   c. 1-2 sessions per week
   d. More than 2 sessions per week
10. What is your highest degree?
   a. Ed.D.
   b. M.D.
   c. Ph.D.
   d. Psy.D.
   e. Masters degree or equivalent
   f. Bachelors degree or equivalent
   g. Other ______________________________________
11. In which year did you earn said degree? ______________________________________
12. If applicable, what year did you earn your CGP certification? ____________________
13. If applicable, what year did you earn your ABPP in Group Psychology? ____________
14. What is your mental health discipline?
   a. Alcoholism and Drug Abuse Counseling
   b. Clinical Mental Health Counseling
   c. Occupational Therapy
   d. Pastoral Counseling
   e. Psychiatry
   f. Psychology
   g. School Counseling
   h. Social Work
   i. Other ______________________________________
15. What is your current work setting?
   a. Community Mental Health
   b. Hospital
   c. Independent Practice
   d. Prison/Jail/Forensic Setting
   e. University Academic Department
   f. University Counseling Center
   g. Veteran's Administration Facility
   h. Other ______________________________________
16. Considering your overall practice (not limited to group), which best describes your primary theoretical orientation?
   a. Behavioral
   b. Biological
   c. Cognitive Behavioral
   d. Eclectic and/or Integrative

e. Feminist and/or Multicultural
f. Humanistic/Existential
g. Interpersonal
h. Psychodynamic/Psychoanalytic
i. Systems
j. Other ____

17. Did you carefully read and pay attention to each item while completing this survey?

a. Yes
b. No

Appendix H

Information Letter- Phase 1

AUBURN UNIVERSITY DEPARTMENT OF SPECIAL EDUCATION, REHABILITATION, AND COUNSELING

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT.)
INFORMATION LETTER for a dissertation research study entitled "Measuring Leadership Competence in Group Therapy: Development of an Adapted Version of the Group Leadership Questionnaire"
You are invited to participate in a research study to investigate group therapists' perceptions of therapy vignettes and potential responses. The study is being conducted by Ms. Erin Crozier, under the supervision of Randy Pipes, Ph.D., both in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You were selected as a possible participant because you are an experienced group therapist with a specialty certification in group psychology or group therapy.
What will be involved if you participate? If you decide to participate in this research study, you will read 21 vignettes, rate potential responses to each vignette, and answer some questions about your demographics and professional experience. Your total time commitment will be approximately 45 minutes.
Are there any risks or discomforts? There are no known risks to participating in this study. Minor discomfort may arise as you think about situations that may occur in group therapy.
Are there any benefits to yourself or others? There are no direct benefits to you for participating.
Will you receive compensation for participating? To thank you for your time, you will be offered $50 compensation at the conclusion of your participation. You will be directed to a separate survey where you may enter your physical address to be mailed a check or your email address to be compensated electronically via PayPal. You may decline compensation by not providing your information in this separate survey. Although you may withdraw at any time without penalty as outlined below, I am only able to provide compensation for those who complete the study.

Are there any costs? There are no costs for you to participate in this study.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling, the Department of Psychology, Erin Crozier, or Randy Pipes, Ph.D.

Any data obtained in connection with this study will remain anonymous. In addition, your contact information gathered for the purposes of compensation will be kept separate from any data you provide and will only be accessible to the primary investigator and dissertation supervisor. Information collected through your participation may be published in a professional journal, and/or presented at a professional meeting.

If you have questions about this study, please contact Erin Crozier at elf0003@auburn.edu or Randy Pipes, Ph.D. at pipesrb@auburn.edu. Please print a copy of this document to keep for your records. If you choose not to do so at this time, you may contact Erin Crozier for a copy of this document at any time.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334)-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

Erin F. Crozier September 12, 2016

The Auburn University Institutional Review Board has approved this document for use from September 11, 2016 to September 10, 2019. Protocol #16-307 EX 1609.

Appendix I

Four Scenarios with Reduced Response Options Eventually Dropped from the GLCQ

Categorization agreement levels from the initial expert sample from Phase 1 are included with each response option.

Situation 1: Starting the Group

You are the leader in a group which is meeting today for the first time. All eight members, young adults, are present as you enter the room and sit down. You introduce yourself and the members introduce themselves. Then everyone turns and looks at you expectantly. There is silence. What do you do?

Excellent:
5. Describe the purposes and procedures of the group. (70%)
7. Ask how they feel in this first meeting (about being in the group or about each other). (60%)

Moderate:
17. Encourage them to discuss their goals in behavioral terms. (60%)

Poor:
6. Say that everyone seems so uptight that you wonder if the group is going to get off the ground. (90%)
9. Share an experience in your own life. (90%)

Situation 2: Personal Questions

Near the beginning of the first meeting, the members ask you personal questions about your family and background. What do you do?

Excellent:
3. Say that you can understand why they might be curious about you. (60%)
16. Lead into a discussion of their family relationships and past experiences (example: ask if they would like to answer these same questions about themselves). (60%)

Moderate:
14. Suggest that they may be asking about you to avoid talking about their own thoughts and feelings. (70%)

Poor:
6. Say that it is none of their business. (100%)
19. Ask one of the members to role-play your position in the group. (90%)

Situation 4: A Filibuster

The group spends much of the second session talking about politics. No one appears displeased with the discussion, and it looks like it may continue for the remainder of the meeting. What do you do?

Excellent:
13. Suggest that their interest in politics may have something to do with their concern about the interrelationship – or "politics" – within the group. (80%)
4. Try to draw them into a more meaningful discussion without criticizing what they were doing. (60%)

Moderate:
20. Make a comment about how differences in political opinions are being handled by the group. (60%)

Poor:
3. Join in on the discussion. (90%)
9. Share an experience in your own life. (100%)

Situation 7: A Distressed Woman

Later in this third meeting, one of the women describes how her partner just ended their relationship. She seems quite upset, skipping from one idea to another, and returning repetitively to the same few despairing thoughts. She has been looking directly at you from the beginning of her remarks, ignoring the rest of the group. When she finishes talking, she asks for your comments. What do you do?

Excellent:
2. Redirect her question to the group (ask how the group might be able to help her). (70%)
7. Ask the members how they feel about what is going on. (60%)

Moderate:
16. Encourage her to relate this to her family relationships and past experiences. (70%)

Poor:
6. Accuse her of basking in self-pity. (100%)
20. Make a comment about societal expectations for women to be partnered. (100%)

Appendix J

Group Leadership Competency Questionnaire (GLCQ)

Directions

This questionnaire presents 10 situations which sometimes occur in human interaction groups and asks you to indicate how you would respond if you were the leader in the group. Please imagine that you are the leader of a heterogenous, interpersonal process therapy group when you respond to the questionnaire.

A list of five alternative responses is provided for each situation. Please consider the ideal actions of the leader faced with this particular situation and select the two best response options for each situation.

It is okay if you are not familiar with this type of group therapy or how to lead such a group. Please do the best you can.

Situation 1(3): The Chairperson

~~Later in this~~ ***In the*** first session, someone suggests that the group appoint a chairperson to conduct the meetings. This idea is received enthusiastically. They explain that this will permit the group to function in a more orderly fashion. Everyone appears to agree with the idea. What do you do?

3. Agree that it is worth a try.
4. Direct attention away from this idea by bringing up another issue.
10. Ask why it is important for the group to function "in an orderly fashion."
1l. Say, "What happened that made us decide we need a chairperson?"
12. Describe the group's feeling of enthusiasm about the idea.

Situation 2(5): An Attack upon the Leader

After spending much of ~~this~~ ***the*** second meeting talking about dieting and politics, the group suddenly turns on you, accusing you of being uninvolved, distant, and uncaring. What do you do?

3. Talk in an approving way about the directness and honesty with which they are able to say how they feel.
4. Direct attention away from their attack by bringing up another issue.
5. Defend yourself – say that you do not see yourself as uninvolved and uncaring.
13. Suggest that they are disappointed that you are not the inspirational and protective leader that they had wanted you to be.
16. Lead into a discussion of their family relationships and past experiences (example: suggest that you may be reminding them of people they have known).

Situation 3(6): A Group Silence

The third meeting begins with a silence. Several minutes pass and still no one says anything. It is beginning to look like the silence might continue for some time. What do you do?

5. Say that they are wasting time.
6. Remark that they look pretty foolish, sitting around waiting for someone else to say something.
7. Ask how they feel when everyone is silent.
11. Ask what they think might be going on in the group today.
15. Encourage them to talk about themselves.

Situation 4(8): The Late Arrival

It is the fourth meeting, one man makes a dramatic entrance 15 minutes late. Although he has done this before, no one says anything about it. What do you do?

2. Ask why no one says anything about him coming late.
6. Accuse him of acting like a celebrity- coming to group late so that he can make a dramatic entrance with everyone watching.
7. Ask him and the rest of the group how they feel about him coming late.
9. Share a similar experience in your own life.
15. Ask if he usually comes late to things (perhaps this is the way he deals with situations).

Situation 5(10): The Quiet Member

One of the men has said very little throughout the meetings, although he seems to follow with interest everything that has been happening. It is now the middle of the fourth session and some of the others are finally beginning to question him about his silence. He remains basically uncommunicative, however, and the group seems uncertain how to pursue the matter. What do you do?

3. Say that each person is free to decide when he wants to talk, adding that you would like to hear from him when he does feel like talking.
5. Tell him that he is not going to get much out of the group if he does not put much into it.
6. Try to get him to react (example: accuse him of being a parasite, sitting back and living off others).
7. Ask how he feels about what the group is saying to him and ask how they feel about his reaction to their remarks.
11. Ask how they would describe what has been going on in the group today.

Situation 6(12): Marital Problem

~~Later in this~~ ***In the*** fifth meeting, one of the men talks about his marital problems. The others offer numerous suggestions. He listens to each of them one at a time and then explains why that particular suggestion will not work. What do you do?

3. Show interest in him and express concern about his difficulties.
4. Seeing the interaction as a stalemate, bring up another issue for discussion.
6. Criticize him for not seriously considering his problem and wasting the group's time.
10. Ask him why he rejects all their suggestions and ask them why they are giving so much advice.
11. Ask what they think is going on in the group today.

Situation 7(17): A Group Attack

Throughout the meetings one of the women had been insisting that she has no problems. In the middle of this eighth meeting, the group attacks her for "hiding behind a mask." At the present moment the whole interaction seems to be gaining in intensity – she responds to their accusations by increasing her denial; they respond to her denial by increasing their attack. You are not sure how she is being affected by it. What do you do?

3. Say that all people have the right to be the kind of person they want to be.
5. Say that she is not going to get anything out of group if she does not put anything into it.
7. Ask how she feels about what they are saying and how they feel about what she is saying.
9. Share an experience in your own life.
12. Comment on the intensity of the argument between her and the rest of the group.

Situation 8(18): A Member Comes Drunk

A man who has been relatively quiet in the two previous meetings comes to session nine drunk. He is mildly disruptive, laughing and singing to himself, and occasionally breaking in when others are talking. What do you do?

3. Show interest in him and express concern about his difficulties (say that he must have been feeling pretty lonely and depressed).
4. Continue as if nothing out of the ordinary were happening.
7. Ask how they feel about what is happening.
9. Share a similar experience in your own life.
13. Suggest that he may be trying to tell the group something that he could not say in other ways.

Situation 9(19): A Side Conversation

The group had been spending much of this ninth meeting talking about one member, when another woman turns to the person sitting next to her and, disregarding the main conversation, starts a competing side conversation. Her talking is a discourtesy and interferes with the main discussion. She continues for several minutes and gives no sign of stopping. What do you do?

2. Ask why no one has said anything about the two conversations.
3. Talk in an approving way about the engaged, intense, and spirited quality of the group interaction.
5. Ask that there be only one conversation at a time.

11. Ask how they would describe what has been going on.
13. Describe her side conversation as an expression of jealousy.

Situation 10(21): The Sexualized Meeting

The tenth meeting begins in a mood of seductiveness. At the center of the interaction is a woman who, for several meetings now, has repeated a pattern of flirting with other group members just until they begin to show interest in her. In the present meeting, she has just stopped flirting with one person and has begun with another. Everyone seems to be taking part in the sexual mood, if not as an active participant, at least as a fascinated observer. What do you do?

4. Seeing the interaction as a stalemate, lead the group in another direction.
6. Accuse her of being a flirt.
11. Ask what they think might be going on among these three.
12. Describe the mood of seductiveness in the group.
15. Ask if this is the way she relates to people outside the group.

Appendix K

Recruitment Email- Phase 2, Experts

Dear Group Therapist,

My name is Erin Crozier, and I am a doctoral candidate in counseling psychology in the College of Education at Auburn University. I am currently conducting a dissertation study that seeks to examine individuals' responses to vignettes about group therapy. If you choose to participate, you will be asked to read a series of clinical vignettes and rate potential response options to each situation in the vignettes. The study will be completed online and is estimated to take 15-20 minutes to complete. **At the end of the study, you will have the option to enter a drawing for one of four $25 Amazon gift cards.**

In order to participate, you must (a) be currently certified as a Certified Group Psychotherapist and/or Diplomate in Group Psychology from the American Board of Professional Psychology; (b) have conducted at least one therapy group in the past year from a general interpersonal process approach. Please note that those from any mental health discipline who meet these qualifications are welcome to participate.

In another phase of this dissertation, a similar email was disseminated seeking a small sample of experienced group therapists to take a longer version of this survey in exchange for $50 in compensation. If you participated in that study, please DO NOT participate in this round of data collection.

I know that many of you receiving this email are passionate about group therapy, and it is this same passion that led me to conduct my dissertation in this area. This study has the potential to make a significant contribution to the areas of training and competency in group therapy, and I hope you can find time to help with these efforts. Even if you do not qualify for the study, **please forward this email to others who may qualify**.

If you would like to participate in our study, please click on the link below and you will be directed to the online survey, beginning with the informed consent document: INSERT LINK HERE

Thank you very much for your time! If you have any question about this study, please feel free to contact me or my dissertation chair using the contact information below. This research study has been approved by the Auburn University Institutional Review Board (IRB# 16-307 EX 1609).

Sincerely,

Erin F. Crozier
Principle Investigator
Doctoral Candidate
Auburn University
elf0003@auburn.edu

Randy Pipes, Ph.D.
Dissertation Chairperson
Professor
Auburn University
pipesrb@auburn.edu

Appendix L

Recruitment Email- Phase 2, Trainees

Dear [Director of Training],

For my dissertation, I am seeking responses of clinical and counseling psychology doctoral students to vignettes about group therapy and am providing compensation as outlined below. I would be very grateful if you would forward this information to your current doctoral students. Thank you for your assistance!

Dear Graduate Student,

My name is Erin Crozier, and I am a doctoral candidate in counseling psychology in the College of Education at Auburn University. I am currently conducting a dissertation study that seeks to examine individuals' responses to vignettes about group therapy. If you choose to participate, you will be asked to read a series of clinical vignettes and rate potential response options to each situation in the vignettes. The study will be completed online and is estimated to take 15-20 minutes to complete. **At the end of the study, you will have the option to enter a drawing for one of four $25 Amazon gift cards.**

In order to participate, you must **(a) be a doctoral student in a clinical or counseling psychology Ph.D. or Psy.D. program**, **(b) have taken a graduate-level course in group therapy, AND (c) have led or co-led at least one process-oriented therapy group**. Even if you do not qualify for the study or do not have time to participate, **please forward this email to others who may qualify**.

If you would like to participate in our study, please click on the link below and you will be directed to the online survey, beginning with the informed consent document: INSERT LINK HERE

Thank you very much for your time! If you have any question about this study, please feel free to contact me or my dissertation chair using the contact information below. This research study has been approved by the Auburn University Institutional Review Board (IRB# 16-307 EX 1609).

Sincerely,

Erin F. Crozier
Principle Investigator
Doctoral Candidate
Auburn University
elf0003@auburn.edu

Randy Pipes, Ph.D.
Dissertation Chairperson
Professor
Auburn University
pipesrb@auburn.edu

Appendix M

Demographics Questionnaire- Phase 2, Trainees

1. With which gender do you most identify?
    a. Man
    b. Woman
    c. Non-binary gender identity (agender, bigender, genderfluid, genderqueer, etc.)
    d. Prefer not to answer
2. Do you identify as transgender?
    a. Yes (my current gender is different than my gender assigned at birth)
    b. No (my current gender is the same as my gender assigned at birth)
    c. Neither answer applies or I prefer not to answer
3. What is your age? ________________________________
4. With which racial or ethnic group do you most closely identify?
    a. Asian, Pacific Islander, or Asian-American
    b. Black or African-American (non-Hispanic)
    c. Latino/a or Hispanic
    d. Native American
    e. White or Caucasian (non-Hispanic)
    f. Biracial or Multiracial
    g. Other identity ________________________________
    h. Prefer not to answer
5. Which of the regions below do you most consider "home?"
    a. Midwest (US)
    b. Northeast (US)
    c. Pacific (US)
    d. South (US)
    e. West (US)
    f. Outside of United States
    g. Prefer not to answer
6. What is your sexual orientation?
    a. Bisexual
    b. Gay/Lesbian
    c. Heterosexual
    d. Other identity ________________________________
    e. Prefer not to answer
7. With which religion do you most closely identify?
    a. Agnostic
    b. Atheist
    c. Buddhist
    d. Christian
    e. Hindu
    f. Jewish
    g. Muslim
    h. Other organized religion ________________________________

i. Other identity ______________________________________
j. Prefer not to answer

8. Which academic degree are you seeking?
   a. Ph.D.
   b. Psy.D.
   c. Other ______________________________________
9. What is your academic discipline?
   a. Clinical psychology
   b. Counseling psychology
   c. Other _____________________________________
10. What is your highest degree?
    a. Masters degree or equivalent
    b. Bachelors degree or equivalent
    c. Other ______________________________________
11. Considering your overall practice (not limited to group), which best describes your primary theoretical orientation?
    a. Behavioral
    b. Biological
    c. Cognitive Behavioral
    d. Eclectic and/or Integrative
    e. Feminist and/or Multicultural
    f. Humanistic/Existential
    g. Interpersonal
    h. Psychodynamic/Psychoanalytic
    i. Systems
    j. Other ____
12. What is your current year of study in your program?
    a. 1st year
    b. 2nd year
    c. 3rd year
    d. 4th year
    e. 5th year
    f. 6th year or beyond
13. Which of the following best describes your stage in your program?
    a. I have not yet begun my pre-doctoral internship.
    b. I am currently on internship.
    c. I have completed all degree requirements except for dissertation.
14. Please estimate your total number of hours of process-oriented group therapy provision.
    a. 10 or fewer
    b. 11-50
    c. 51-100
    d. More than 100
15. In your career ahead, do you intend to seek specialty certification in group psychotherapy?
    a. Yes
    b. No

c. I am unsure.

16. Did you carefully read and pay attention to each item while completing this survey?
    a. Yes
    b. No

Appendix N

Demographics Questionnaire- Phase 2, Novices

1. With which gender do you most identify?
    a. Man
    b. Woman
    c. Non-binary gender identity (agender, bigender, genderfluid, genderqueer, etc.)
    d. Prefer not to answer
2. Do you identify as transgender?
    a. Yes (my current gender is different than my gender assigned at birth)
    b. No (my current gender is the same as my gender assigned at birth)
    c. Neither answer applies or I prefer not to answer
3. What is your age? ___________________________________
4. With which racial or ethnic group do you most closely identify?
    a. Asian, Pacific Islander, or Asian-American
    b. Black or African-American (non-Hispanic)
    c. Latino/a or Hispanic
    d. Native American
    e. White or Caucasian (non-Hispanic)
    f. Biracial or Multiracial
    g. Other identity ___________________________________
    h. Prefer not to answer
5. Which of the regions below do you most consider "home?"
    a. Midwest (US)
    b. Northeast (US)
    c. Pacific (US)
    d. South (US)
    e. West (US)
    f. Outside of United States
    g. Prefer not to answer
6. What is your sexual orientation?
    a. Bisexual
    b. Gay/Lesbian
    c. Heterosexual
    d. Other identity ___________________________________
    e. Prefer not to answer
7. With which religion do you most closely identify?
    a. Agnostic
    b. Atheist
    c. Buddhist
    d. Christian
    e. Hindu
    f. Jewish
    g. Muslim
    h. Other organized religion ___________________________________

i. Other identity ______________________________________
j. Prefer not to answer

8. What is your class standing?
   a. Freshman
   b. Sophomore
   c. Junior
   d. Senior
   e. Second-year senior or beyond
9. Which of the following best describes your academic major?
   a. Business
   b. Education
   c. Psychology, social work, or other mental health field
   d. Other liberal arts or humanities field
   e. Other science/technical field
   f. My major does not fit any of these categories.
10. Have you ever been a counseling or therapy client?
    a. Yes
    b. No
    c. Prefer not to answer
11. Have you ever been in a client in group therapy?
    a. Yes
    b. No
    c. Prefer not to answer
12. Have you ever taken a psychology course in which group therapy was covered?
    a. Yes
    b. No
    c. I do not remember
13. Did you carefully read and pay attention to each item while completing this survey?
    a. Yes
    b. No

Appendix O

Recruitment Post Information for Sona System- Phase 2, Novices

Study Name: Development of Group Leadership Competence Questionnaire

Brief Abstract: This is a brief online study about group therapy vignettes. Knowledge of group therapy is NOT required.

Detailed Description: This is a dissertation study of individuals' responses to vignettes about group therapy. If you choose to participate, you will be asked to read a series of clinical vignettes and rate potential response options to each situation in the vignettes. **Knowledge of group therapy is NOT needed to participate in this study!** In fact, for this portion of the study, we are interested in the responses of people who know little to nothing about group therapy. You will also answer some general questions about yourself. Participation will take 15-20 minutes and you will receive 0.5 Sona credit by giving your name in a separate survey.

Eligibility Requirements: Must be age 18 or older

Appendix P

Information Letter- Phase 2, Experts and Trainees

AUBURN UNIVERSITY DEPARTMENT OF SPECIAL EDUCATION, REHABILITATION, AND COUNSELING

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT.)
INFORMATION LETTER for a dissertation research study entitled "Measuring Leadership Competence in Group Therapy: Development of an Adapted Version of the Group Leadership Questionnaire"
You are invited to participate in a research study to investigate group therapists' perceptions of therapy vignettes and potential responses. The study is being conducted by Ms. Erin Crozier, under the supervision of Randy Pipes, Ph.D., both in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You were selected as a possible participant because you are either (a) an experienced group therapist with a specialty certification in group psychology or group therapy or (b) a doctoral student in clinical or counseling psychology with some training and experience in group therapy.
What will be involved if you participate? If you decide to participate in this research study, you will read 10 vignettes, rate potential responses to each vignette, and answer some questions about your demographics and professional experience. Your total time commitment will be approximately 15 to 20 minutes.
Are there any risks or discomforts? There are no known risks to participating in this study. Minor discomfort may arise as you think about situations that may occur in group therapy.
Are there any benefits to yourself or others? There are no direct benefits to you for participating.
Will you receive compensation for participating? To thank you for your time, you will be offered the opportunity to enter to win a $25 Amazon gift card at the conclusion of your participation. Although you may withdraw at any time without penalty as outlined below, I am only able to provide the gift card drawing for those who complete the study.

Are there any costs? There are no costs for you to participate in this study.
If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling, the Department of Psychology, Erin Crozier, or Randy Pipes, Ph.D.
Any data obtained in connection with this study will remain anonymous. In addition, your email address will be gathered via a separate survey solely for the purposes of compensation. It will be kept separate from any other data you provide and will only be accessible to the primary investigator and dissertation supervisor. Information collected through your participation may be published in a professional journal, and/or presented at a professional meeting.
If you have questions about this study, please contact Erin Crozier at elf0003@auburn.edu or Randy Pipes, Ph.D. at pipesrb@auburn.edu. Please print a copy of this document to keep for your records. If you choose not to do so at this time, you may contact Erin Crozier for a copy of this document at any time.
If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334)-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.
HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.
Erin F. Crozier September 12, 2016 **The Auburn University Institutional Review Board has approved this document for use from September 11, 2016 to September 10, 2019. Protocol #16-307 EX 1609.**

Appendix Q

Information Letter- Phase 2, Novices

AUBURN UNIVERSITY DEPARTMENT OF SPECIAL EDUCATION, REHABILITATION, AND COUNSELING

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT.)
INFORMATION LETTER for a dissertation research study entitled "Measuring Leadership Competence in Group Therapy: Development of an Adapted Version of the Group Leadership Questionnaire"
You are invited to participate in a research study to investigate individuals' perceptions of the best potential responses to group therapy vignettes. The study is being conducted by Ms. Erin Crozier, under the supervision of Randy Pipes, Ph.D., both in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You were selected as a possible participant because you are an undergraduate student age 18 or older and are enrolled in a class using the Sona system within the College of Education at Auburn University.
What will be involved if you participate? If you decide to participate in this research study, you will read 10 vignettes, rate potential responses to each vignette, and answer some questions about your demographics and educational or professional experience. Your total time commitment will be approximately 15 to 20 minutes.
Are there any risks or discomforts? There are no known risks to participating in this study. Minor discomfort may arise as you think about situations that may occur in group therapy.
Are there any benefits to yourself or others? There are no direct benefits to you for participating.
Will you receive compensation for participating? To thank you for your time, you will be offered one half Sona credit at the conclusion of your participation. You will be directed to a separate survey to enter your name and email for Sona verification. Please note that you must provide this information in order to receive credit. Although you may withdraw at any time without penalty as outlined below, I am only able to provide Sona credit for those who complete the study.

Are there any costs? There are no costs for you to participate in this study.
If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling, the Department of Psychology, Erin Crozier, or Randy Pipes, Ph.D.
Any data obtained in connection with this study will remain anonymous. In addition, your name, collected for the purposes of Sona verification only, will be kept separate from any data you provide and will only be accessible to the primary investigator and dissertation supervisor. Please note that you must provide this information in a separate survey in order to receive Sona credit. Information collected through your participation may be published in a professional journal, and/or presented at a professional meeting.
If you have questions about this study, please contact Erin Crozier at elf0003@auburn.edu or Randy Pipes, Ph.D. at pipesrb@auburn.edu. Please print a copy of this document to keep for your records. If you choose not to do so at this time, you may contact Erin Crozier for a copy of this document at any time.
If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334)-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.
HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.
Erin F. Crozier September 12, 2016 **The Auburn University Institutional Review Board has approved this document for use from September 11, 2016 to September 10, 2019. Protocol #16-307 EX 1609.**

Appendix R

Qualification Questions- Phase 2

Experts

Are you at least 18 years of age?

- Yes, I am 18 years of age or older
- *No*
- *I prefer not to answer*

Please respond to the following statement:

I have led or co-led at least one group in the past year utilizing a general interpersonal process approach.

- True, this statement describes me
- *False, this statement does not accurately describe me*
- *I don't know if this describes me, or I prefer not to answer*

Which of the following group credentials do you hold?

- Certified Group Psychotherapist (CGP)
- American Board of Professional Psychology Diploma in Group Psychology (ABPP)
- Both CGP and ABPP in Group Psychology
- *Neither of these*

Trainees

Are you at least 18 years of age?

- Yes, I am 18 years of age or older
- *No*
- *I prefer not to answer*

Have you taken a graduate-level course in group therapy?

- Yes
- *No*

Have you led or co-led a process-oriented therapy group? Please exclude any groups composed strictly for training purposes and any that were solely psychoeducational. If you do not know what we mean by "process-oriented group," please answer "no."

- Yes
- *No*

Novices

Are you at least 18 years of age?

- Yes, I am 18 years of age or older
- *No*
- *I prefer not to answer*

Responses in italics will be included in regular font in the survey, but any such responses will lead to an alternate end of survey screen informing participants that they do not qualify for the study.