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INTRODUCTION

From the beginning of our training 35 years ago, we found group therapy to be fascinating, challenging, sometimes frustrating, and always compelling. On the basis of our experiences, work, and research over the years, we developed group psychodynamic-interpersonal psychotherapy (GPIP), a comprehensive model of individual case formulation and group interventions informed by contemporary psychodynamic and interpersonal theories. We value evidence-based approaches, and so we empirically tested GPIP in randomized controlled trials, effectiveness studies, and group process studies (e.g., Hewitt et al., 2015; Hewitt, Qiu, et al., 2019; Tasca et al., 2013, 2019; Tasca, Ritchie, et al., 2006). GPIP is an evidence-based treatment.

Group therapy may be daunting for some trainees and therapists because of the amount of information coming at them in a group. Yet many trainees and therapists are capable of allowing the interactional forces of a group to pull them in, while at the same time, they remain capable of stepping back and reflecting when necessary to observe and comment on the process. We found over many years of practice, teaching, research, consultation, and

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supervision that having a clear understanding of the interpersonal and intrapersonal factors that underlie each patient's problems and a good grounding in group process theory was invaluable to helping our patients. Such an understanding, which informs GPIP, has given us and our trainees the ability to effectively participate in and work with the interactions and feelings inherent in therapy groups so that patients can benefit.

Dr. Smith,[1] a White woman in her early 30s, is a newly licensed psychologist who is hardworking and conscientious and wants to provide evidence-based therapy. She took a couple of group therapy courses in graduate school, during which she learned about the ample research demonstrating that group therapy is effective for a variety of mental disorders (Burlingame & Jensen, 2017), is just as effective as individual therapy, and is more cost-effective (Burlingame et al., 2016). She ran her first therapy group during her clinical internship with her supervisor as cotherapist, and she found the work exciting and stimulating. The experience allowed her to learn more about the value of here-and-now process work, interpersonal feedback among patients, group cohesion, and other group therapeutic factors (Yalom & Leszcz, 2020). She looked forward to group therapy being part of her professional career.

A mental health clinic employed Dr. Smith after she graduated and received her license. Shortly after she started, the clinic gave her responsibility for a time-limited, evidence-based, and symptom-focused therapy group for anxiety disorders. The group therapy included highly structured and sequenced activities with many psychoeducational components. Dr. Smith understood the evidence base for this treatment, but she became increasingly dissatisfied with the therapy group. Group members wanted to share their experiences and support each other, but the group's structure left little room for that. Dr. Smith wanted to get to know better the patients, their subjective experiences, and their lives to address the issues underlying their symptoms, but she felt pressure to get through the therapy's agenda in a brief time frame. Even though the group was for patients with similar anxiety disorders, Dr. Smith struggled to provide a coherent treatment given the great diversity of patients in terms of their personality functioning, interpersonal style, coping style, culture, and motivation. As a result, she spent a good portion of each group session talking at the group, and group members spent most of their time listening, taking notes, and reviewing their homework from the previous session.

Recently, Dr. Smith ran into a former group member, Rob, an Asian American male in his late 30s, in the clinic's otherwise empty waiting room. She recalled that Rob was a pleasant group member, but he often remained quiet in her group. In passing, Dr. Smith asked Rob how he was doing, and he proceeded to tell her.

[1]Here and throughout the book, all case examples are composites of real patients, and names of therapists and patients are pseudonyms.

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ROB: I was certainly less anxious by the end of your therapy group, and I was grateful for that. I could go to the store and drive to work without worrying as much about having a panic attack. The tips and exercises you suggested were really helpful, and so I was having a better understanding of what triggered a panic attack.

DR. SMITH: But you're back here at the clinic?

ROB: Yah, well, other things in my life are still a mess. I don't think I ever told you, but my dad died around the time I was in your group [Dr. Smith remembered that Rob missed a couple of sessions], and after the end of the group, I started to feel more and more down.

DR. SMITH: Oh, I'm sorry to hear that.

ROB: Yah, well, you see, even though the anxiety was better, other things didn't really change much. I still feel taken advantage of at work by my boss, and my wife seems to have written me off. I can't seem to stand up for myself, which makes me feel like such a loser. And my relationship with my dad was pretty complicated, you know, he was so critical. Anyway, that's probably more than you want to hear.

DR. SMITH: And how's the anxiety?

ROB: That's the thing—it's starting to get worse again. I can't keep a lid on it with all of these other issues in my life. So, my family doctor referred me to see the psychiatrist this time. Maybe some medication might help.

The encounter with Rob troubled Dr. Smith. Unfortunately, this is not an uncommon story in mental health treatment. The way Dr. Smith ran the group did not allow her to get to know Rob and the important events in his life. Were his lack of assertiveness and quiet demeanor contributing to his problems with anxiety? Did others, such as his boss or wife, use him or neglect him because he was so passive? Did he expect others to take advantage of him and disrespect him? And what impact did this expectation have on his self-esteem? Why did he never mention his father's death? Did the other group members know? And how did it happen that she, Dr. Smith, missed all this?

We believe that questions like these make their way into the consciousness of mental health professionals trained exclusively in some protocol-based symptom-oriented interventions. For example, one could conceptualize an anxiety disorder, such as that experienced by Rob, as a conditioned response of a perceived threat (being in a crowded store) paired with bodily sensations (increased heart rate, sweatiness). Rob may have misinterpreted these

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bodily sensations as catastrophic and then began avoiding the perceived threatening situation. Eventually, the process and avoidance might generalize to other situations (driving, leaving his house). Interventions might include graduated exposure to the feared stimuli and challenging cognitions related to the physical sensations. But many clinicians may wonder about Rob's developmental history that made him vulnerable to anxiety in the first place, how he managed feelings like anger, and the current interpersonal and psychological factors that maintain the symptoms. And just as important may be Rob's current work and romantic relationships and the corrosive effect of his relational style on his self-esteem and self-concept. Dr. Smith might also wonder whether the group itself could have played a more prominent role in Rob's treatment. Rob's interpersonal problems were on full display in the group: He was quiet, passive, almost forgettable. However, Dr. Smith needed a way of understanding these problems, their role in maintaining Rob's symptoms, and how to use the group interactions to help Rob change his maladaptive interpersonal patterns, his means of coping, and his view of his self.

In this book, we outline a theory and practice of group psychotherapy that conceptualizes and treats those underlying transdiagnostic factors that can potentially cause or maintain many mental disorders and problems in living. We developed GPIP as a person-centered approach to treating the interpersonal and psychological factors that lead to and maintain many problems that our patients face in life. That is, we understand each patient's issues with an idiographic or personalized case formulation that is based on a developmental, interpersonal, and psychodynamic understanding of how problems evolve and what maintains them currently. For example, one can conceptualize Rob's lack of assertiveness, low self-worth, and anxiety as having developmental roots based on an insecure attachment and attendant relational behaviors. His current lack of assertiveness might be a form of avoidance to stave off potential rejection, and so group therapy may be a means of graduated exposure to interactions with others, to valuing his self, and to getting his attachment needs met in his relationships. We wrote this book for newer and more seasoned group therapists alike who are looking for a comprehensive, evidence-based way of conceptualizing patient problems and providing treatment that truly integrates individualized case formulations with group therapeutic factors to help patients live more fulfilling lives. Thus, our focus is not solely on reducing symptoms but enhancing the quality of peoples' lives by facilitating a shift in the individual's core relational pattern with both self and others.

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A TRANSDIAGNOSTIC APPROACH

In GPIP, we take a transdiagnostic approach to understanding patients' problems. By *transdiagnostic*, we mean that the treatment focuses on those variables that underlie various diagnoses and syndromes and does not focus primarily on the symptoms themselves (Blatt et al., 2006; Hewitt et al., 2008, 2015). Current diagnostic schemes such as the *Diagnostic and Statistical Manual of Mental Disorders* (fifth ed.; American Psychiatric Association, 2013) take an entirely descriptive approach to mental disorders. That is, a clinician will diagnose patients with a depressive, anxiety, or other disorder if patients display a certain number of specific symptoms or signs. However, as we saw with the earlier example, even though Dr. Smith assembled a group exclusively for individuals diagnosed with an anxiety disorder, the group composition was heterogeneous on a variety of factors that predict patient outcomes. For example, Dr. Smith included in the group some people whose level of personality functioning was relatively healthy or mildly impaired and others whose personality functioning was more severely impaired. Research shows that patients at varying levels of functional impairment and personality functioning have different needs and experience different outcomes from treatment (Harwood et al., 2011; Lingiardi & McWilliams, 2017). Similarly, her group might have included those with internalizing coping styles and others with externalizing coping styles. However, patients with varying coping styles respond differently to problem-focused versus insight-oriented interventions (Beutler et al., 2018). By relying on a purely descriptive approach to her patients' problems, Dr. Smith's therapeutic model assumed that all the patients would have similar needs and would respond uniformly. The treatment model did not allow Dr. Smith to draw on a vast body of research to adjust her interpersonal stances and interventions to patient factors (Norcross & Lambert, 2018).

A transdiagnostic approach such as the one we developed in GPIP places more emphasis on the underlying causal and maintenance factors that confer vulnerability for mental disorders, as well as other areas of dysfunction. A group treatment such as GPIP will help therapists to focus on key patient factors and provide therapists with a framework to assess individuals, compose groups, and craft interventions. The GPIP model helps therapists to individualize their interpersonal stances based on patient factors such as attachment style, interpersonal patterns, and defensive functioning. We discuss each of these factors and their roles in case formulation and group treatment in greater detail in subsequent chapters.

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A DEVELOPMENTAL APPROACH

In this book, we take a developmental approach, mainly based on attachment theory to conceptualize mental disorders and the underlying patient vulnerabilities. There is a large body of research and theory implicating the role of attachment relationships, childhood maltreatment, and the role of families in adult functioning (see Pinquart et al., 2013; Repetti et al., 2002; Teicher & Samson, 2013). The research is clear that these early experiences have an ongoing impact on adult relationships, coping style, views of self, and psychopathology (Bakermans-Kranenburg & van IJzendoorn, 2009). Beyond that, a developmental model aimed at understanding adult problems in living provides therapists and patients with a way of making sense of the problems and with a means by which patients may begin to gain a more realistic and less self-critical perspective on current difficulties.

For better or worse, early family interactions are our first group experiences and provide us with an implicit template for how individuals behave in groups and what to expect from being in a group. Understanding a patient's attachment history and expectations of relationships provides the therapist with a window into the patient's potential expectations of and behaviors in group psychotherapy (Marmarosh et al., 2013). For example, someone with a *dismissing attachment* style may see relationships as secondary, including with the group, and downplay their own emotions. Therapists treating an attachment-dismissing individual may have to emphasize subtly to the patient the potential importance of relationships and gradually help the patient to become more in touch with their emotional experiences. Someone with a *preoccupied attachment* style tends to be overly anxious about relationship loss, including within groups, and they often up-regulate their emotional experiences. Therapists treating attached preoccupied individuals may have to help them take a more reflective stance with regard to their emotions and to see relationships in a more realistic and less threatening light.

In the earlier example, Dr. Smith found out after the fact that Rob had a "complicated" relationship with his father, whom Rob perceived as critical. It also became clearer to her that Rob was generally unassertive and quiet both in the group and in relationships in general. A comprehensive assessment and individualized case formulation based on an attachment perspective might have helped Dr. Smith understand that Rob's reluctance to participate in the group was a long-standing interpersonal pattern that likely created a sense of safety for him on the one hand but also contributed greatly to problems in his current relationships, his negative view of himself, and his symptoms of anxiety on the other hand. Rob likely had a dismissing

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attachment pattern in which he downplayed his relational needs and emotions. Hence, Dr. Smith and Rob might have developed treatment goals that included using the group therapy to value rather than avoid his attachment needs, to increase his assertiveness in relationships, and to understand better his feelings about himself and others.

A PSYCHODYNAMIC-INTERPERSONAL APPROACH

The clinical perspective we developed in GPIP is based on psychodynamic and interpersonal approaches to case conceptualization and treatment (see Hewitt et al., 2017; Tasca et al., 2005). Psychodynamic theory has informed clinical practice in psychotherapy for over a century and has provided the foundation for key concepts in psychology such as attachment, defense mechanisms, transference and countertransference, unconscious processes, affect regulation, and relational styles. Contemporary psychodynamic theory emphasizes the nature and quality of relationships both past and present and the internalization of relationships into a self-concept, as well as the role of social and cultural factors. The comprehensiveness of psychodynamic theory, its developmental focus, and its emphasis on interpersonal relations make it uniquely suited to group therapy. After all, group therapy is, at its core, an interactional and relational context for working on problems with living.

For the GPIP model, we modified a classic psychodynamic model (Malan, 1979) so that it incorporates attachment theory (see a full description of the Triangle of Adaptation in Chapter 1 and Figure 1.2). Early attachment figures may have punished, dismissed, or ridiculed many of our patients' expressions of *attachment needs* (wish to be cared for, need for security). These negative experiences may lead to *affects* such as shame, anxiety, or fear that become automatic and associated with the attachment needs. As a result of the affects, patients engage in *defense mechanisms* to cope, which also denies them the expression of attachment needs. This model is consistent with contemporary psychodynamic treatments that have an evidence base (e.g., McCullough Vaillant, 1997), and it provides a strong and comprehensive understanding of the underlying dynamics of many of our patients' problems.

One of our goals in developing GPIP was to integrate intrapsychic and interpersonal aspects of functioning. Relational patterns have their genesis in early attachment experiences and generalize to other relationships. We illustrate this consistency of relationships across different contexts (from past relationships to current relationships and the therapeutic and

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group relationship) in our concept of the triangle of object relations (see Chapter 1 and Figure 1.2). In the moment-to-moment interactions that occur in a therapy group, the GPIP therapist and group directly experience the relational patterns evident in each individual's life.

A key task for a group therapist working within GPIP is to reinterpret symptomatic behavior in intrapsychic and interpersonal terms. To achieve this, we describe aspects of interpersonal patterns with the cyclical maladaptive interpersonal patterns (CMIP; Strupp & Binder, 1984) model in some detail in Chapter 1. Elements of the CMIP include (a) the *acts of self*, or one's behaviors, thoughts, and feelings in interpersonal situations to meet relational goals; (b) a client's *expectations of others*, often based on assumptions of others' intentions reinforced by a history of responses by others; (c) the *acts of others*, or how others respond to the person; and (d) the *introject*, which is the internalization of the interpersonal pattern and transactions into a self-concept (see Chapter 1 and Figure 1.3).

The interpersonal aspect of the GPIP model is particularly salient to the group therapy modality. Therapists who are capable of exploring interactions

THERAPIST TASK BOX

A TRANSDIAGNOSTIC APPROACH: ATTACHMENT AND PSYCHODYNAMICS

1. Take a transdiagnostic approach to understand the patient's problems.
   - Do not rely solely on descriptions, observations, and stated frequencies of symptoms.
   - Instead, evaluate the patient's level of personality functioning, preferred coping, and interpersonal style.
2. Consider the individual and their presenting problems within their developmental history.
   - What is the quality of the patient's past attachment relationships, current relationships, and romantic relationships, and how might this affect them now?
3. Take an interpersonal perspective on presenting problems.
   - How are current problems related to or maintained by interpersonal problems past and present?
   - How does their relationship to you and the group parallel their relationship to current or past others?

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in the group as they occur by using the triangle of object relations and the CMIP can harness a powerful means of understanding and altering interpersonal styles in their patients. Group therapists can make use of therapeutic factors such as interpersonal learning and feedback (Yalom & Leszcz, 2020). And therapists can facilitate these therapeutic factors by encouraging self-disclosure and self-reflection in patients as a means of helping them learn about themselves and others. Segalla (2012) suggested that group therapy recognizes and draws on the embeddedness of individuals within intersubjective and relational experiences, and in so doing, groups serve as vehicles for the individual to find "the self through finding the other" (p. 134). Therapists who enhance interpersonal learning in groups can help patients improve capacities such as *mentalizing*, the ability to understand one's own and others' intentions and behaviors in terms of mental states (Fonagy et al., 2002).

A CASE FORMULATION APPROACH

We are keenly aware that psychotherapy, including group therapy, requires a deep understanding of the individual and what they bring to the therapeutic context. Because of that, we take an idiographic case formulation approach to assessing patients and defining an individualized focus of treatment (Hewitt et al., 2018). To achieve this with GPIP, we describe in Chapter 2 a pre-group assessment process by which therapists and patients collaboratively develop a case formulation that informs treatment goals. We use the principles of interpersonal theory to provide a step-by-step guide to an assessment process aimed at a comprehensive understanding of the patient. The process integrates an awareness of the patient's attachment style and the unique elements of their psychodynamics and interpersonal patterns. This information is central to guiding the therapist to assume an effective interpersonal stance with patients that will facilitate their movement toward their particular goals for group therapy. For example, in Rob's case, a GPIP assessment process would have identified that Rob had underlying needs for self-assertion and self-pride and a need to be cared for. However, his father may have punished or ridiculed any expression of these attachment needs, and so over time, Rob developed automatic affects such as anxiety and shame in relation to these feelings and needs. As a means of coping with the anxiety or shame, Rob minimized his needs and self-pride by self-effacement and avoidance. These defense mechanisms may have been useful at some point in his life but currently were

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often maladaptive and not always effective to manage his anxiety. His relationships with others in the past and present, including with Dr. Smith, were characterized by passivity, fearfulness, and withdrawal.

Had Dr. Smith engaged Rob in a pre-group assessment process as we illustrate in Chapter 2, she would have been able to describe Rob's mode of adaptation in interpersonal terms using a CMIP. Rob's interpersonal behaviors were evident in his passivity or lack of assertion, his tendency to minimize his needs, and his experience of anxiety (i.e., acts of self). Others in Rob's life may be dominating and perhaps critical of Rob (i.e., acts of others), perhaps provoked by his passivity and self-criticism, which in some ways repeats his unsatisfactory relationship with his father. Rob engaged in avoidance and passivity possibly because he expected that others would ridicule or reject him (i.e., expectation of others). In response, others tended to avoid talking to him or experienced him as forgettable. As a result, Rob may have felt rejected and dismissed, thus repeating the relational issues with his father. Rob may have internalized this failure, which demonstrated yet again to him that he was not worthy and defective (i.e., introject). Rob gave Dr. Smith a hint of this when he referred to himself as a "loser." He likely saw himself as ineffective and not worthwhile, which may fuel depressive affect, anxiety, and passivity in relationships. In a sense, Rob's passivity and negative introject are also reflected in his willingness to go along with the notion that medication is what is needed to "fix" his problems because of his sense that there is something inherently wrong with him or "broken."

Such an assessment and case formulation would have been helpful to Dr. Smith and Rob as they considered how best to approach group therapy. Dr. Smith would have understood Rob not just as shy or quiet, but as someone whose interpersonal behaviors were fundamental to his relational problems, his negative self-concept, and his symptoms. In collaboration with Rob, Dr. Smith would have developed more comprehensive goals for his therapy that also addressed the underlying or maintaining aspects of his problems. She might have decided to help Rob to value rather than be anxious about his attachment needs. She would have alerted him during the assessment to be particularly attentive to his inner experience and reactions when others offer him feedback—specifically, that he might experience anxiety during group interactions in which others affirm or support him. The group's affirmation would stand in marked contrast to Rob's experience of himself and of his father's view of him. Initially, he might dismiss such feedback from the group while selectively attending to or being acutely sensitive to any signs of criticism, disapproval, or neglect.

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Dr. Smith would explain to Rob that group therapy might help him understand that his quiet manner and retiring interpersonal style may create an illusion of safety because it allows him not to reveal a self that is open to criticism and rejection. But the cost to Rob is that others may experience him as distant and dismissing of them, rather than seeing him as wanting a connection. During the therapy group, Dr. Smith would focus interventions on Rob's minimizing and avoiding coping style and highlight the cost of these defenses to his relationships, including with the group and to his sense of self.

A GROUP PSYCHOTHERAPY APPROACH

The great potential of group therapy lies in the interpersonal nature of the treatment context. Patients benefit most from groups when a therapist taps into this potential by metacommunicating about interactions in the moment during the group or what Yalom and Leszcz (2020) referred to as the here-and-now processes in the group. A here-and-now focus must have two essential components to be effective: (a) members must experience one another with spontaneity and honesty, and (b) they must be able to reflect on that experience. We developed GPIP as a group therapy precisely because it encourages therapists to make use of the transformative nature of the interpersonal context of the group. One expression of that interpersonal context is group cohesion, or the sense of belonging and attraction to a group. Cohesion is a well-known predictor of patient outcomes and is a precursor to successful groups (Burlingame et al., 2018). However, cohesion requires nurturing and development. And so, as we describe in more detail in Chapter 4, the GPIP model takes a group development approach to treatment in which nurturing and maintaining group cohesion is a key therapist task (Tuckman, 1965; Tuckman & Jensen, 1977).

Successful groups are known to go through stages of development (as do all significant relationships, including one's relationship with oneself), and therapists who are aware of the qualities of these stages and the associated tasks are better able to help the group move forward to achieve its goals. Our research identified stages of GPIP (Tasca, Balfour, et al., 2006), and we incorporate Tuckman's (1965; Tuckman & Jensen, 1977) group development model with evidence of how GPIP works. At the start or *forming* stage, therapists help groups come together to find common cause, and so therapists may knit group members together by focusing on the universality of their experiences. The next *storming* stage is possible

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after the group successfully negotiates the initial forming stage. Storming involves greater expression of individuation among members. In the *norming* stage, therapists may shape and reinforce positive therapeutic norms such as self-disclosure, self-reflection, and interpersonal feedback. It is during this stage that groups solidify their sense of cohesion, thereby allowing them to move on to the work or *performing* stage. In GPIP, the performing stage focuses on challenging a patient's CMIP and encouraging them to try unfamiliar ways of relating in the group that might generalize to relationships outside the group. The final, *adjourning* stage recognizes the universal importance and anxiety inherent in ending relationships, internalizing the group as an attachment figure, and allowing patients to take stock of their progress and come to terms with the limits inherent to all relationships.

As we illustrate in Chapters 2 and 4, one of the most useful functions of developing a good case formulation is that it allows therapists to anticipate how a client might adapt in the early stages of group and what challenges may emerge in later stages. For example, during the forming stage, a therapist might expect Rob to be quiet, and Rob may feel anxious and wonder whether he belonged in the group. The initial goal of group therapy might be to help Rob examine these feelings, develop a sense of belonging and that he is not alone, and consider that he could be a valued group member. This may require the therapist and other group members to encourage Rob to participate and for Rob to receive feedback that his participation is worthwhile, a task that is likely to give rise to anxiety because it challenges his long-held beliefs about the self. Once Rob experiences a sense of cohesion, alliance, and safety within the group, he may be capable of reducing his minimizing defenses, which may allow him to experience a sense of pride or to express attachment needs that have been dormant. That is, the performing stage of the group might be an important but difficult stage for Rob because the group might challenge him to diminish his maladaptive defenses and expose himself to the potential for shame and ridicule that he expects of others. However, the disconfirmation of this expectation will be key to Rob's future attempts in the group to behave in a way that is different from his usual passive and self-effacing manner. One outcome of this change might be that his self-concept will alter from one in which he experiences himself as a "loser" to one in which he feels more worthy.

Another important consideration of GPIP is the attention paid to group composition. At the outset, we described Dr. Smith as feeling perplexed by the wide-ranging patient characteristics in a group that was supposed to be homogeneous in terms of symptoms. Even if patients share similar

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symptoms (e.g., anxiety), they may differ in meaningful ways that may make it difficult for them to connect and feel safe with each other and to work productively together. And so, we describe in Chapter 2 a means of assessment that is attentive to group composition to increase the probability that a group will become cohesive and function optimally.

AN EVIDENCE-BASED APPROACH

Dr. Smith, like many practitioners, wants to provide evidence-based treatment to her patients. That is, she wants to practice in a manner that is consistent with and supported by research, that allows her to use her clinical experience to adjust her interventions and interpersonal stances, and that is congruent with her patients' characteristics and preferences. GPIP offers such an evidence-based practice approach to group therapy.

As we highlight in Chapter 5, we completed and have ongoing clinical trials that demonstrate the effectiveness and efficacy of GPIP to reduce symptoms (e.g., Hewitt et al., 2015; Hewitt, Qiu, et al., 2019; Tasca et al., 2013, 2019; Tasca, Ritchie, et al., 2006). In support of the GPIP transdiagnostic model, our research demonstrates that the treatment is effective not only in reducing distress and symptoms but also in reducing the level, intensity, and impact of those patient variables that maintain or cause problems in living, such as attachment insecurity, interpersonal problems, personality and relational styles, depressive affect, maladaptive defense mechanisms, and problems with mentalizing (e.g., Hewitt et al., 2015; Hewitt, Qiu, et al., 2019; Hill et al., 2015; Maxwell et al., 2018, 2014; Tasca, Ritchie, et al., 2006). Finally, our research on group processes in GPIP highlights the importance of increasing group cohesion and therapeutic alliance, the role of interpersonal learning in reducing symptoms, and the importance of developmental stages of group when planning interventions (e.g., Gallagher, Tasca, Ritchie, Balfour, & Bissada, 2014; Gallagher, Tasca, Ritchie, Balfour, Maxwell, & Bissada, 2014; Hill et al., 2015; Tasca et al., 2007; Tasca, Ritchie, et al., 2006).

Our research to date allows the conscientious group therapist to learn and apply GPIP with confidence that the treatment is effective. We geared this book to help the practitioner not only learn the clinical techniques of the psychodynamic-interpersonal approach to assessment, case formulation, and group treatment but also understand the research that supports GPIP. This will help the clinician feel comfortable and confident in the treatment and inform their patients of the treatment's efficacy to increase patients'

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expectations of a good outcome. Moreover, knowing the research support for GPIP may help clinicians inform administrators, third-party funders, and policy makers about the utility of the approach. With this evidence in hand, Dr. Smith will be able to propose an alternative approach to group therapy in her place of employment.

THERAPIST TASK BOX

GPIP CASE FORMULATION, GROUP PROCESS, AND EVIDENCE BASE

1. Use a case formulation approach to inform therapist interpersonal stances in the group.
   - Consider that symptoms are a manifestation of attachment and interpersonal patterns.
2. Think about group therapy in terms of stages of group development.
   - Different stages of the group require different therapist interpersonal stances and interventions.
   - Early stages of group therapy should focus on developing a sense of cohesion to the group and an alliance with the therapist and group.
3. Know the research evidence for GPIP, and convey this knowledge to your patients and to those who fund your practice.

ORGANIZATION OF THE BOOK

We designed this book for both new and experienced psychotherapists who want to solidify their grounding in psychodynamic or interpersonal psychotherapy theory and its impact on group therapy practice. The book provides a means to advance one's knowledge and skills in these areas and to integrate theoretical perspectives and clinical practice to understand one's patients better and to be a more effective group therapist. Our objectives are to make the content of the book user friendly and to encourage therapists to apply the knowledge and skills outlined in the text. To meet these objectives, we use several pedagogical methods to illustrate the theoretical and practical material and facilitate learning. First, we provide a number of detailed case illustrations as examples of the concepts, assessment process, case formulation, pre-group preparation, and typical group therapy interactions and therapist interventions at each stage of the development of a GPIP group. The case illustrations are composites

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of many patients that we worked with over the years (and the therapist and patient names are pseudonyms), so the information does not identify any one patient. The cases appear throughout each of the chapters to bring the concepts and practices to life. Second, we provide Therapist Task Boxes that are specific to the topic of each chapter or sections within a chapter. Therapist Task Boxes are designed to be a quick and easy reference for therapists wishing to brush up on the tasks that are germane to the theory, assessment and case formulation, pre-group preparation, and group treatment. Third, each chapter ends with Chapter Review Exercises. These are designed to help the clinician test their understanding and hone concepts or practices that need further review. Finally, we encourage the reader to view the American Psychological Association (2020) video on GPIP featuring Samuel F. Mikail and Giorgio A. Tasca. This video provides an example of many of the techniques used in the treatment, as well as a discussion with experts that refers to the therapy session itself in describing the treatment approach.

We start the book in Chapter 1 with a general description of the transdiagnostic approach to understanding patients, their interpersonal world, and the factors that underlie and maintain their problems. This is consistent with our view that, although useful, descriptive diagnoses alone are not enough to inform a clinician on how to be with and how to treat a patient. The chapter then goes into more detail about the theory of GPIP. The psychodynamic model of the triangle of adaptation, the triangle of object relations, the CMIP model, and their integration represent the core guiding framework of GPIP. Understanding these models is crucial to directing a therapist's assessment and interventions. We encourage clinicians to read Chapter 1 first to prepare for the more applied chapters to follow.

Chapter 2 focuses on assessment and case formulation using the GPIP model. In this chapter, we provide a step-by-step approach to assessing interpersonal style by using the interpersonal circumplex, attachment insecurity within a developmental approach, defensive functioning, and level of personality functioning. An idiographic person-centered assessment and case formulation is key to treatment planning, setting treatment goals, ensuring an optimal group composition, and informing the clinician on the most therapeutic interpersonal stances with each patient.

In Chapter 3, we turn to pre-group preparation and treatment planning. In this chapter, we emphasize the importance of preparing patients for group therapy and developing specific treatment goals by using the individualized case formulation for each patient. We provide specific steps and examples of how to prepare patients for group therapy.

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In Chapter 4, we highlight therapist tasks and goals during each stage of group therapy. We discuss in some detail how a therapist emphasizes the therapeutic alliance, universality, group norms, and safety in the forming stage; manages needs for patient individuation during the storming stage; solidifies cohesion and authentic engagement in the norming stage; uses group processes and interactions to change CMIPs and maladaptive defenses during the performing stage; and deals with termination during the adjourning stage.

Finally, in Chapter 5, we provide a detailed description of the evidence base for GPIP, including its effectiveness and efficacy, the impact of GPIP on transdiagnostic maintenance factors, and research on group processes in GPIP.

Our intention in writing this book on GPIP is to provide clinicians such as Dr. Smith with an evidence-based treatment option for group psychotherapy that addresses the transdiagnostic factors that maintain or cause problems in living. There is an unfortunate and increasing lack of diversity in treatments offered to patients like Rob, which limits the relevance and effectiveness of psychotherapy in general and group psychotherapy in particular. With GPIP, clinicians are equipped with an intentional, comprehensive, research-informed theory and practice that emphasizes not just symptom reduction but helping the whole person to live a more fulfilling and self-aware life.