

ETHICAL PRACTICE OF GROUP EXPERIENTIAL PSYCHOTHERAPY

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Ethical issues related to the practice of group experiential therapy are discussed. Particular emphasis is given to ethical considerations associated with group psychotherapy versus individual psychotherapy, therapist competency in the use of experiential techniques, leader power issues, and aftercare. The “Ethical Principles of Psychologists and Code of Conduct” of the American Psychological Association (2002) and the “Association for Specialists in Group Work Best Practice Guidelines” (L. Rapin & L. Keel, 1998) are referenced to highlight ethical principles and guidelines as they relate to this discussion.

The experiential therapies offer unique and powerful interventions that can be used in a multitude of settings with a myriad of presenting problems. Research on the experiential therapies has shown “effects across a range of disorders and treatment varieties” (Greenberg, Elliot, & Lietaer, 1993, p. 532). Experiential techniques are often used in a group-therapy context. According to Corey, Corey, Callanan, & Russell (1982), the reputation of group work has been compromised by irresponsible practitioners who use such techniques in gimmicky or inappropriate ways. The nature and inherent power in experiential techniques make them vulnerable to such abuses and misapplications. As such, there is a need for the group experiential therapist to consider specific

ethical principles and guidelines related to the application of experiential techniques, in order to provide safe and effective interventions.

There are many types of therapy combinations that fall within what is commonly referred to as experiential therapy. To varying degrees, they are linked to an existential–humanistic theory of humanity and use direct experience as the major route to psychotherapeutic change (Mahrer, 1983). Some of the psychotherapies belonging to the experiential family include feeling–expressive therapy, Gestalt therapy, intense feeling therapy, encounter therapy, cathartic therapy, emotional-flooding therapy, psycho-imagination therapy, symbolic-experiential family therapy, Mahrer’s experiential psychotherapy, multimodal group experiential therapy, psychodrama, process group therapy, aromatherapy, and metaphoric therapy (Dayton, 1994; Elliot & Greenberg, 1995; Kaye, Dichter, & Keith, 1986; Klontz, 1999; Klontz, Wolf, & Bivens 2001; Mahrer, 1983, 1996; Yalom, 1995). Although all of these psychotherapies are related in regard to their primary vehicle of change, in many cases, they differ significantly in terms of how they conceptualize therapy and how they utilize experiential techniques. As such, there may be unique ethical issues of concern that are specific to each approach.

For the purpose of this discussion, the term *experiential therapy* will be used to refer to those approaches and techniques that incorporate the use of psychodrama and role-playing and that use group therapy as their primary context of intervention (Dayton, 1994; Klontz, 1999; Klontz et al., 2001; Wegsneider-Cruse, Cruse, & Bougher, 1990; Wegsneider-Cruse, Higby, Klontz, & Rainey, 1994). Whether in reference to classical psychodrama or an integrative experiential approach using psychodramatic concepts and techniques, it is argued that these powerful forms of group therapy warrant special ethical consider-

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ation. However, many of the principles discussed below can be applied to all therapeutic approaches in which the major route to change is through direct experience.

What follows is a discussion of ethical considerations related to (a) group psychotherapy versus individual psychotherapy, (b) therapist competence in the use of experiential techniques, (c) leader power issues, and (d) aftercare. The “Ethical Principles of Psychologists and Code of Conduct” of the American Psychological Association (APA, 2002) and the “Best Practice Guidelines” of the Association for Specialists in Group Work (ASGW; Rapin & Keel, 1998) are referenced to highlight established ethical principals and guidelines as they relate to this discussion.

Group Psychotherapy Versus Individual Psychotherapy

Group psychotherapy offers a powerful and influential therapeutic dynamic when used in conjunction with experiential methods (Wegscheider-Cruse et al., 1990), and experiential tools are often used in a group-therapy context. As such, many of the important ethical issues that arise when conducting this type of experiential therapy do so in the context of the ethical practice of group therapy in general.

The same factors and dynamics that make group therapy such a powerful medium of emotional and behavioral change make group therapy such a high ethical risk (Lakin, 1994). A survey of specialists in group psychotherapy shows that there is a general dissatisfaction with the ethical standards used to address many of the dilemmas unique to group psychotherapy (Roback, Purdon, Ochoa, & Block, 1992). This suggests that group therapists agree that a careful examination of factors and dynamics unique to group therapies is important in identifying and addressing areas of potential ethical concern. Ethical issues in group psychotherapy are complex and differ from individual psychotherapy with regard to the types of ethical dilemmas that are encountered. Keith-Spiegel and Koocher (1985) highlighted some of these differences and concluded that in group therapy there is (a) less control over the content and direction of the therapy session, (b) greater potential for adverse experiences, (c) greater potential for stress that might result from confrontation and criticism from other group members, and (d) the possibility of a client growing dependent on the group.

One consistent area of tension that exists when conducting group psychotherapy is an evaluation of “whether group interest is great enough to justify the compromise of individual interest” (J. D. Moreno, 1991, p. 68). In practice, the group leader must quickly evaluate issues of beneficence and nonmaleficence through the course of therapy as they relate to the individual and the collective. He or she is often forced to make a quick assessment of benefits and risks associated with different courses of action and to lead the group in one direction or another, in an effort to maintain a delicate balance of help and harm of the individual and the other group members. For example, when doing a particular piece of psychodramatic work with a group member, it is not uncommon to observe several other members responding to the individual’s work in an emotionally intense manner. These emotional responses can range from moderate levels of discomfort to full abreaction. The group facilitator must immediately assess the individual and collective benefits and liabilities of putting the individual’s work on hold, thus allowing the facilitator to address the needs of other group members. Regulating the “pace and intensity” of emotionally charged material to ensure a positive outcome for all group members can be a challenging task for the group therapist (Glass, 1998, p. 98).

Confidentiality is a special area of concern, given that there are more threats to confidentiality in group therapy than in individual therapy. The ethics code that has been developed for professionals may have limited relevance in principle when applied to a group of individuals in nonprofessional roles (J. D. Moreno, 1991), because group members are not bound by the same confidentiality standards as are mental health professionals. Furthermore, most state laws regarding confidentiality and privileged communication do not mention the applicability of this concept in group contexts (Parker, Clevenger, & Sherman, 1997). Groups are social by nature, and there is often incentive for group members to gossip about what they have heard or witnessed in a group-therapy session (Lakin, 1986). To help protect clients’ rights to privacy, the APA’s Ethical Standard 10.03 advises clinicians to “describe at the onset the roles and responsibilities of all parties and the limitations of confidentiality” when providing services in a group setting (p. 1072). In particular, it is important for group therapists to warn members about the importance

of keeping confidences, inform group members about the dilemma of confidentiality in a group-therapy setting, inform clients of the possible risks associated with breaches in confidentiality, and take steps to set forth rules of confidentiality to be adhered to by the group (Lakin, 1986; J. D. Moreno, 1991). In addition, ASGW Best Practices Guideline A.7.d. advises group workers to explain to members that unless a specific state statute indicates otherwise, legal privilege does not apply to group discussions (Rapin & Keel, 1998).

Another important ethical dilemma lies in the social power inherent in therapy groups. This power is often one of the reasons group therapy is so effective. In writing about experiential group therapy, Wegscheider-Cruse et al. (1990) asserted,

the dynamic of group therapy helps to get beneath the denial as a person responds emotionally to the work of another group member. It is difficult for cognitive blocking to persist in one person when emotional healing is taking place in other group members. (p. 70)

Just as the social power of the group can be an important driving therapeutic force, it can also harm group members if not closely monitored. According to Lakin (1986), social pressure to conform to norms in the group could interfere with an individual's ability to make rational and informed decisions, and the group could create a reality that might never have been accepted by the individual were he or she not a member of the group. As such, the group leader must be aware of how to moderate the influence of group pressure in ways that maximize therapeutic effectiveness and minimize the potential to cause harm. In addition, although cathartic disclosures and the expression of intense affect may be beneficial for some group members, other group members might feel overwhelmed or threatened (Glass, 1998). As such, the therapist should inform clients of this potential and should provide a structure in which clients feel empowered to ask for help or to take steps to care for themselves in the event that overwhelming feelings arise.

Therapist Competence in the Use of Experiential Techniques

Experiential therapy often makes use of psychodrama techniques and typically follows psychodrama's warm-up, action, and sharing phases. Psychodrama is an action-oriented group-

psychotherapy technique developed by J. L. Moreno (1994) in 1921. It is an approach "in which the client acts out or dramatizes past, present, or anticipated life situations and roles in an attempt to gain deeper understanding, achieve catharsis, and develop behavioral skills" (Corey, 1990, p. 221). A survey of certified psychodrama practitioners and trainers revealed that 55% of the respondents believe existing professional codes of ethics are inadequate for use in the psychodrama community (Kranz & Lund, 1995). Furthermore, 94% of the respondents endorsed the idea of developing a formal written code of ethics for the psychodrama profession, including mandatory standards in psychodrama training and ethical standards relating to credentialing psychodrama practitioners and trainers (Kranz & Lund, 1995). These findings suggest that members of the psychodrama community are aware of ethical dilemmas that are specific to their model of practice and seem to exist outside the realm of established ethics codes.

Corey (1990), in a review of the literature around the ethical issues in using psychodrama techniques, identified personal and professional competence on the part of the therapist as a significant concern. APA's Ethical Standards 2.01 and 2.06 suggest that practitioners only provide services within the boundaries of their competence and that those who plan to provide services new to them undertake relevant training and supervised experience. This clearly illustrates the necessity for clinicians to receive proper training and supervision in psychodrama and experiential therapy prior to applying psychodramatic and experiential techniques. The ASGW recommends that in addition to the 20 hr of core training in group work through the observation of or participation in a group experience, those seeking to conduct groups receive an additional 60 clock hours of supervised specialty training prior to independent practice (Wilson, Rapin, & Haley-Banez, 2000). In an effort to protect clients from possible harm associated with the misapplication of techniques, in addition to extensive supervised practice, it is a standard in the field of psychodrama and experiential therapy for clinicians to spend many hours as a client in the therapeutic process prior to using the techniques with clients. The importance of the therapist working through his or her unresolved issues prior to attempting to assist others is addressed in more depth in the next section.

In addition to achieving competence through proper, specialized training and spending adequate time in the role of the client, clinicians should also be aware of the limitations of these techniques with regard to client populations. On the basis of his review of the literature, Corey (1990) suggested that psychodrama, if used at all, should be used with great care when treating severely disturbed and psychopathic populations as well as when treating individuals who are acting out. Experiential techniques facilitating emotional catharsis may also not be best suited for use with individuals who are actively abusing substances or individuals who (a) are heavily medicated, (b) have dissociative or psychotic disorders, or (c) have labile mood or difficulty regulating affective states.

Experiential techniques can be very powerful interventions, and, as such, several authors have suggested guidelines to reduce the likelihood of the misapplication of these techniques. Corey and Corey (2002) supported the use of the following guidelines to avoid abusing techniques in group therapy: (a) techniques are used to work with emotional issues raised by group members, not used to stir up emotions; (b) techniques are not used to cover up the leader's discomfort or incompetence; (c) techniques are used in a sensitive and timely manner; (d) the member's background is taken into consideration when techniques are used; (e) techniques are abandoned if they are ineffective; and (f) group members are invited to participate but are also given the option of not participating in certain techniques. Another important issue of concern in the application of experiential techniques involves emotional catharsis. The expression of emotions is often an important goal in experiential therapy (Dayton, 1994; Wegscheider-Cruse et al., 1990). However, it is important for therapists to minimize social pressure to express emotions. According to Lakin (1986), the group could produce pressure to disclose information prematurely, and individuals might attempt to conform to group pressure with "excessive emotional reactions" (p. 457). Lakin (1986) cited research that suggests that there are a multitude of negative effects that can stem from emotionally coercive techniques and interventions. Drawing from his own conclusions and the ethics codes of various professional associations, he suggested that with these issues in mind, group leaders must (a) assess members' capacity for emotional expression, (b) keep members safe

from coercion on the part of the therapist and members of the group, (c) evaluate the value being placed on emotional release, (d) inform group members that participation is voluntary, (e) inform group members of the goals of the group as well as the procedures that will be used, and (f) refrain from pushing their own agendas, needs, and values on other group members.

Leader Power Issues

Because of potential social pressure on clients to express emotions and participate in experiential exercises in experiential therapy groups, therapists must take care to avoid pressuring or coercing clients to engage in an experiential activity in which they are not ready, willing, or able to participate. This is paramount to the ethical practice of experiential therapy. Greenberg et al. (1993) asserted that one of the most important factors that might hinder the effectiveness of experiential techniques is that of "therapist intrusiveness or pressure" (p. 532). Research has confirmed this view and has shown that directive and confrontational therapeutic efforts evoke client noncompliance and resistance (Patterson & Forgatch, 1985) and that a directive-confrontational therapy style can lead to poor therapeutic outcomes (Miller, Benefield, & Tonigan, 1993). Corey (1990) suggested that there is high potential of harm to clients if clinicians push clients past a point that is therapeutic, use psychodrama techniques to fill egotistical needs, or rush clients because of impatience on the part of the clinician.

In truth, experiential therapy is defined by action-oriented techniques, and whether spoken or unspoken, there is value placed on people participating in action-oriented experiences. However, in keeping with its existential-humanistic roots, experiential therapy places great value on an individual's right to self-determination and personal choice. As such, the approach was built on a foundation of trust and respect of a client's natural processes and movements toward and away from growth. Endorsement of this philosophy by the therapist, and promotion of this philosophy as a foundation of the group's values and norms, should be a primary goal at the onset of a group therapy to protect clients from being pressured to disclose information, participate in experiential exercises, or express emotions. Although the therapist values the experiential techniques, he or she must strike a balance between

inviting a client to engage in a particular experience and taking care to not coerce the individual to engage in a process in which he or she is not ready to participate. At best, such coercion might lead to a half-hearted, empty, and uncomfortable attempt by the client to please the therapist or other group members by conforming. At worse, it could be a traumatizing, discounting, and alienating experience for the client, which could lead to a poor therapeutic outcome. Because of the danger inherent in this conflict, the experiential therapist must continually assess his or her values and be vigilant to the need to respect a client's right to self-determination. Therapists must create a climate that encourages participation, emotional expression, and cognitive and behavioral change, while also encouraging and supporting a client's right to not express emotions or participate.

To meet this end in experiential therapy, the therapist must follow the client's lead during therapeutic exercises. Research has shown that therapist behaviors consistent with a supportive and facilitative style—as opposed to efforts to confront and teach—reduce the incidence of client resistance and noncompliance (Patterson & Forgatch, 1985). To prevent unintentional coercion of a client in an experiential exercise, the therapist should give the client as much power and freedom to set up the exercise as is feasible. The therapist, while providing structure and guidance, empowers the client to take the role of the expert throughout the exercise. In the example of a psychodramatic vignette including role players, the client may be asked to identify an issue he or she would like to explore. The client may then be asked to identify relevant roles, choose role players from the group, and, if appropriate, set the scene by physical placement of role players and objects in the room. Only with great hesitancy and care should the therapist suggest the possibility of including additional roles or symbols into the vignette, as such behavior on the part of the therapist might be experienced as directive and confrontational. At these points in the process, in which the therapist offers suggestions, insights, or wisdom, any resistance on the part of the client should be taken as a sign that the therapist has created tension in the therapeutic relationship. At these moments, the therapist's response to the client's resistance can determine whether the client becomes more or less resistant and could have significant impact on the thera-

peutic outcome for the client (Patterson & Forgatch, 1985; Miller et al., 1993). Miller & Rollnick (2002) presented a philosophy and practical approach that uses a collaborative interpersonal style to evoke clients' intrinsic motivation for change while respecting clients' autonomy and right for self-direction. They suggested the following therapist responses at moments of client resistance, to help create a climate of change and avoid creating more resistance: (a) using a simple reflection, (b) using an amplified reflection, (c) reflecting both sides of the client's ambivalence, (d) shifting focus away from what is impeding progress, (e) providing new information through reframing, (f) offering agreement with a change of direction, (g) emphasizing personal choice and control, and (h) siding with the client's argument against change.

While participating in an experiential exercise, clients' expressions of resistance are encouraged. Clients are encouraged to disagree with therapist input if it is not congruent with the clients' experience. Such moments of disagreement offer the client a chance to clarify and assist the therapist in getting a better understanding of the client's subjective reality. A simple "no" or "that doesn't fit" voiced by the client should always be sufficient, and no further explanation on the part of the client should be mandated by the therapist. Rather, the therapist can use this moment as a springboard to encourage the client to identify and elaborate on his or her truth regarding the situation. When the client is uncertain where he or she should proceed, the therapist may invite him or her to engage in the vignette in various manners, but always with respect for the client's right to decline, make adjustments in the exercise, or stop participation completely. It is important for the therapist to proactively invite and encourage the client to change, adjust, or stop the exercise at any time.

The therapist can also support an individual's right to decline participation in a given activity by pointing out at the onset of treatment the value of both "public" and "private" therapeutic work in the group. J. L. Moreno (as cited in Drew, 1990) stressed the importance of paying as much attention to those individuals who are excluded from interactions as to those who are more engaged in the group. Drew (1990) suggested that one way to assure individuals feel good about their less active roles is to remind members that learning happens for observers as well as for ac-

tive participants. It is not uncommon for group members to experience insight and emotional catharsis just by watching other people engage in such exercises. With this goal in mind, prior to beginning a group, the therapist should give permission for group members to limit their participation and let the group know that treatment gains can be made just by participating in the group, whether or not an individual is the focus of a psychodramatic vignette or chooses to participate in any or all experiential exercises. This practice establishes that participation in an exercise is not essential to achieve therapeutic gains and may decrease the chances that clients feel coerced. Group members who do not wish to be the focus of a psychodramatic vignette might be willing to share their thoughts and feelings verbally or assist other group members by participating as a role player for other members' work. These experiences can also provide individuals with therapeutic insights and experiences that can be of great value.

Perhaps the most important way to assure that a therapist is careful to not push a client into expressing emotions, disclosing information, or taking part in experiences that put the individual at risk of harm is for the therapist to have a clear understanding of his or her own psychological issues and how they might interfere with the natural healing process of his or her clients. Of particular importance is the practitioner's ability to deal effectively with what surfaces for him or her as the result of a particular experiential exercise. On a personal level, it is critical that practitioners become aware of their personal problems, needs, unresolved conflicts, and countertransference issues and how they might interfere with their functioning as the group therapist. In this vein, the APA's Ethical Standard 2.06(a) states, "Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner." Standard 2.06(b) goes on to suggest that when these issues interfere with their work, practitioners obtain "professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties" (p. 1064). The ASGW's Guideline A.8.c. states, "Group workers seek appropriate professional assistance for their own personal problems or conflicts that are likely to impair their profes-

sional judgment or work performance" (Rapin & Keel, 1998, p. 241). Corey (1990) recommended that directors of psychodrama have experience in personal psychotherapy to help counteract any possible abuse of the techniques as a result of countertransference.

The ethically practicing experiential therapist is one who is aware of his or her own emotional and psychological "buttons" and watches closely for possible circumstances in which his or her unfinished business could negatively impact therapy. Once a problem is identified, the therapist takes care to pursue a personal resolution through supervision or personal therapy or may choose to avoid practicing in circumstances in which the issue is likely to surface. The nature of experiential techniques in a group setting will often move the client's work in an unpredictable direction, with a variety of issues arising. It is critical that a clinician in this line of work has the ability to remain appropriately objective throughout the course of therapy. To the degree that this end can be achieved, the clinician will have the ability to exercise good judgment with regard to structuring interventions, will be better able to follow the client's lead, and will allow proper time for closure around sensitive issues that arise through the course of treatment.

Aftercare

Whether between sessions in an ongoing weekly group or at the cessation of a short-term intensive group experience, it is good practice to spend sufficient time assisting clients in generalizing their experience to their real-world settings. Group sessions often offer clients a place where they feel unconditional love and support, sometimes for the first time in their lives. They may also have done some intense cathartic work and may be feeling open and vulnerable. To assist them in making the transition to environments outside of group therapy, therapists can provide clients with specific instructions aiding them in a successful return to their daily lives.

Often, it is suggested to clients that they consider limiting the degree to which they talk openly about the specific details of their group experience with those who have not had similar experiences or with those who may feel threatened by the clients' experience. Corey and Corey (2002) also suggested that clients should be cautioned to refrain from saying in person everything

they said symbolically to a significant other in a role play. When it would be appropriate to do so, the group leader might assist the client in determining what needs to be communicated, and the client can practice doing so in the safety of the group. The client can then receive feedback from the group leader and group members, to increase the probability of a successful outcome.

Another way to assist clients who are grieving the end of a group experience in which they have felt loved and supported is to remind them that they created this experience through a combination of risk-taking, openness, mutual support, and trust. The group therapist might offer suggestions as to how clients can recreate these feelings in their own lives and relationships. It may also be important to assist clients in developing a formal plan to help maintain and further specific treatment gains. Such a plan might include a referral for ongoing individual, group, couples, or family therapy; participation in a support group; selection of a mentor; commitment to specific self-care or leisure activities; commitment to time with significant others; exercise goals; limits around problematic behaviors (e.g., reducing hours at work); or commitment to sharing information with significant others (e.g., making amends or setting limits).

Conclusion

As is true with any form of psychotherapy, a close examination of ethical issues is essential to help assure that clients are receiving services in a fair and just manner. Although generally established ethical principles address many of the issues facing mental health professionals, there are certain areas of practice in which ethical issues arise that have not been formally addressed in an established ethics code. One such area is the practice of group experiential therapy. Experiential therapy offers powerful techniques that can be of great benefit to clients. However, the techniques used in this modality may also put clients at greater risk of harm if it is not practiced in an ethically sound manner. An understanding of the ethical issues related to group experiential therapy is essential to assure client safety and therapeutic integrity in the practice of this modality.

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