Group Cohesion

Empirical Evidence From Group Psychotherapy for Those Studying Other Areas of Group Work

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Group cohesion not only facilitates group therapy, but it also is a key component of all groups—including groups that function to serve the country, achieve a business goal, or participate in a sport. This chapter explores how we define and measure group cohesion, how cohesion relates to group process and outcome, how member factors influence cohesion, and how leaders can foster or hinder cohesion. Most important, we consider how this research can apply to other areas of group work, particularly social, organizational, health, military, and sport psychology groups.

DEFINING COHESION

Defining cohesion is a challenge within the many fields examining group dynamics, including both clinical and social psychology. Although commonly understood experientially, cohesion has remained difficult to put into words in ways that encapsulate a multifaceted experience felt within a member (Yalom & Leszcz, 2005). Definitions of the construct have ranged from the very general (e.g., a force that keeps members connected to the group; Dion, 2000) to the more precise (e.g., alliance, interpersonal liking, tolerance for space; Burlingame, McClendon, & Alonso, 2011; Yalom & Leszcz, 2005). Research examining cohesion has also endured criticism for its construct variability between different research studies (for a review, see Marmarosh & Van Horn, 2011).

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Over the years, however, narrow definitions of cohesion have been discarded for more complex and multidimensional conceptions, essentially transitioning cohesion from a “single-celled” organism to a paradigm reflecting a “multi-celled” experience (Marmarosh & Van Horn, 2011). In essence, researchers began to conceive of cohesion as a phenomenon arising from many distinct parts.

Group Cohesion: A Unidimensional Construct

Originally, group psychotherapists borrowed a definition for cohesion from social psychologists and group dynamics researchers (Festinger, Schachter, & Back, 1950; Hogg, 1992; Lewin, 1947). This conception of group-cohesion centered on a mechanism or force that holds group members together, keeping them connected to the group (Dion, 2000). Group therapists described it as an experience of connectedness, as “we-ness,” or as being part of a whole (Yalom & Leszcz, 2005). In this sense, cohesion is a collaborative force, constructed through shared dedication to the group’s pursuit of common goals (Budman et al., 1989). Other group clinicians emphasized the bond between group members and the attraction group members feel toward the group and to its leader(s) (Evans & Jarvis, 1980; Joyce, Piper, & Ogrodniczuk, 2007; Piper, Marrache, Lacroix, Richardsen, & Jones, 1983). These bonds create systems of relationships, forming a structure from which cohesion can emerge. This begins to illustrate the most common view of cohesion used in group therapy research today, in which cohesion represents the main component of the therapeutic relationship within group psychotherapy. Under this definition, cohesion facilitates a sense of unity, belonging, and safety, even during times of within-group stress and conflict (Marmarosh & Van Horn, 2011).

Group Cohesion: A Multidimensional Construct

One way to understand cohesion is to examine the different relationships that contribute to it. Bliese and Halverson (1996) were two of the first researchers to differentiate between vertical and horizontal cohesion in work groups. They defined vertical relationships as those between group member and leader and horizontal relationships as those between members. Burlingame et al. (2011) elaborated on this theory and applied it to group therapy, believing that research most firmly supported two implicit dimensions of cohesion: relationship structure and relationship quality. This concept of “structure” referred to the direction and function of relationships within a group, whereas “quality” referred to the alliance, climate, and level of belonging within these relationships (Burlingame, MacKenzie, & Strauss, 2004). Within this paradigm, two types of cohesion exist: task cohesion, which reflects a group’s adherence to accomplishing a common goal; and affective cohesion, reflecting a group’s experience of emotional safety due to the affective support provided by the group (Dion, 2000; Marmarosh & Van Horn, 2011). Burlingame et al. (2011) also
understood the multiple relationships within the therapy group and noted that each member perceives cohesion through three structural components: member to member, member to group, and member to leader. The group leader’s perspective included two more structural components: leader to group and leader to coleader.

The overlap between constructs describing group alliance, group identity, group engagement, and group climate may lead one to conflate these constructs, and many studies have attempted to explore the relationship among these overlapping factors to prevent inappropriate conceptual fusion (Marmarosh & Van Horn, 2011). In general, cohesion is the sense of unity and attachment to the group, whereas group climate is the overall perception of the group environment (Marmarosh & Van Horn, 2011). Both of these constructs mediate the likelihood of members engaging with the group and facilitate the emergence of a group identity.

**EMPIRICALLY IDENTIFYING FACTORS CONTRIBUTING TO COHESION**

The pursuit of understanding cohesion’s many dimensions drew clinical researchers to compare the concept to potential, overlapping constructs that are often essential in group therapy (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005). For example, both alliance and cohesion are highly correlated, and both address the quality of the relationship between patient and therapist (Gillaspy, Wright, Campbell, Stokes, & Adinoff, 2002; Johnson et al., 2005; Joyce et al., 2007; Marziali, Munroe-Blum, & McCleary, 1997; Yalom & Leszcz, 2005). Although a body of research has established that the constructs of alliance and cohesion are correlated and distinct (Bakali, Baldwin, & Lorentzen, 2009; Johnson et al., 2005; Taft, Murphy, King, Musser, & DeDeyn, 2003), there is a growing consensus that group alliance and cohesion are overlapping constructs that both relate to the system of relationships within the group (Marmarosh & Van Horn, 2011).

In order to understand the complex relationship among group therapy factors and cohesion, Johnson et al. (2005) administered measures of cohesion, group climate, working alliance, and empathy to 662 group members from 111 counseling centers; they found that the correlation between factors was high enough to indicate that they were measuring overlapping constructs. However, after further analysis, Johnson and colleagues found that the factors did not load into one singular group factor but instead to three separate factors: positive bond, positive work, and negative relationship (Burlingame et al., 2011; Johnson et al., 2005). These three factors explain how group members perceived the quality of relationships in groups, which then influenced the perception of constructs, such as alliance, climate, and cohesion (Burlingame et al., 2011; Johnson et al., 2005). Positive bond described the affective relationship members experienced among each other, as well as between themselves and the leader (Johnson et al., 2005), whereas the factor of positive work captured shared tasks and goals of the group. The negative
relationship factor captured conflict and the leaders’ empathic failures. This discovery indicated that cohesion, engagement, and leader empathy were important aspects of positive relationships within groups, but that task-oriented aspects of the relationship were distinct constructs.

Perhaps most important, Johnson et al. (2005) found that a lack of empathy by leaders or members related to perceived negative relationships within the group. Unlike prior studies that focused on clients ranking curative factors facilitating change, this study shed light on lack of empathy as a factor that hinders a group from becoming a positive force for change. Leader empathy is an important contribution that has the potential to influence all types of groups, not just psychotherapy groups.

GROUP COHESION: TREATMENT PROCESS AND OUTCOME

A meta-analysis of 40 studies examining the relationship between cohesion and treatment outcome indicated that cohesion significantly relates to outcome in both inpatient and outpatient settings (Burlingame, McClendon, & Yang, 2018). Several studies have indicated that cohesion positively correlates with an elevation in member self-esteem, reduced symptoms across diagnoses, and higher rates of goal attainment (Braaten, 1989; Budman et al., 1989; Tschuschke & Dies, 1994).

Group cohesion is not only critical in interpersonal process groups, it is also related to treatment outcome in groups designed to address specific problems, such as smoking cessation (Etringer, Gregory, & Lando, 1984) and men in treatment for domestic violence (Taft et al., 2003). For example, Taft et al. (2003) found that member-rated group cohesion, rated early and late in treatment, was related to less physical and emotional abuse for men who were in group therapy for domestic violence.

Some studies stand out because they empirically examine the difference between treatment as usual, where leaders run the groups without focusing specifically on developing cohesion, and cohesion-enhanced treatment, where leaders emphasize cohesion in addition to the standard treatment. For example, Hand, Lamontagne, and Marks (1974) found that members with agoraphobia in cognitive behavioral therapy groups where cohesiveness was emphasized (i.e., the group leader used interventions to increase and foster group members’ connection to one another) felt more helped by the groups compared to those in groups where the treatment focused only on symptom reduction. Those members who were in the cohesion-focused groups continued to improve even after treatment ended, whereas the members in groups that did not receive the cohesion intervention began to relapse after termination. Similar findings were reported in group treatment for smoking cessation (Etringer et al., 1984). In Chapter 7 of this volume, we see similar findings with cohesion relating to outcomes in team performance.
Explaining the Variability in Findings

Variability in the strength of the relationship between group therapy cohesion and group process and outcome indicates that the benefits of cohesion depend on many factors. Burlingame et al. (2018) found a number of moderator variables that significantly predicted the magnitude of the correlation between cohesion and outcome. For instance, interpersonally oriented therapies showed the highest cohesion to outcome relationship, whereas other types of therapy (e.g., cognitive–behavioral, psychodynamic, supportive) showed significant, but lower, associations between cohesion and outcome. In fact, any group therapy that focused greater attention on group process or that facilitated interactions among members was associated with higher correlations between cohesion and outcome. The size of the group also affected the relationship between cohesion and patient improvement; groups containing from five to nine members posted the largest correlation, and groups with more than nine members showed the smallest correlation (Burlingame et al., 2018). In addition, the number of group sessions also affected this relationship between group cohesion and outcome; groups lasting 20 or more sessions demonstrated a stronger relationship between cohesion and outcomes, followed by groups lasting 13 to 19 sessions, and then by groups lasting fewer than 13 sessions (Burlingame et al., 2011). This finding suggests that the effects of cohesion may increase over time and, the longer the group, the more cohesion relates to achieving treatment goals.

There are several, additional, hypotheses as to why the relationship between cohesion and outcomes can be so variable between groups. Kipnes, Piper, and Joyce (2002) proposed that cohesion might mediate other group factors, creating an environment where positive change more easily manifests within the group (Alonso, 2011). For example, there is evidence suggesting that cohesion increases: (a) member attendance (Ogrodniczuk, Piper, & Joyce, 2006), (b) decisions to stay in the group (Hand et al., 1974), (c) participation in the group (Budman et al., 1993), (d) tolerance of conflict (Alonso, 2011), and (e) the quality of member listening and empathy (Alonso, 2011). Thus, group cohesion creates a group environment that is conducive to improving psychological symptoms and increasing positive outcomes overall.

Member Interpersonal Styles and Cohesion

Although member mental-health diagnosis does not always influence the strength of the relationship between cohesion and positive outcomes in a group (Burlingame et al., 2011), the characteristics and disorders of group members can influence group cohesion (Woody & Adessky, 2002). For instance, members with longstanding interpersonal difficulties can bring maladapted patterns into the group and struggle with developing a sense of closeness and positive alliance to both group members and leaders (Marmarosh & Van Horn, 2011). Behaviorally, members can exhibit difficulty coping with
emotions or inappropriate reactions to group processes (Hilbert et al., 2007). These group members often perceive less cohesion than their healthier peers. However, despite trouble participating in the therapy groups, lower-functioning group members in inpatient hospital settings reported perceived group cohesion to be one of the curative factors in their treatment (Butler & Fuhriman, 1983).

One of the most important findings in the clinical arena is that group cohesion is not helpful to the therapeutic outcomes for all individuals who attend group therapy. German researchers investigating how member interpersonal styles moderate the correlation between cohesion and patient outcomes in depressed patients found that patients who were perceived as “too friendly” improved more when their experience of cohesion decreased during group therapy. Inversely, in the same study, patients perceived as cold or hostile improved most when their experience of cohesion increased during group (Schauenburg, Sammet, Rabung, & Strack, 2001).

In essence, there may be a false sense of cohesion both for those members who are trying too hard to fit in and belong in the group and for those who are detached and avoidant of intimacy. Group therapists often try to understand what individual factors contribute to successful group processes (see Burlingame, Fuhriman, & Johnson, 2001, 2002), and one theory that links both these friendly and detached behaviors in the group is attachment theory.

**Member Attachment and Group Cohesion**

Member attachment styles (i.e., internal working model of relationships based on their lifelong relational experiences) influence group cohesion and how group cohesion relates to treatment process and outcome (Marmarosh, Markin, & Spiegel, 2013). Shechtman and Dvir (2006) found that adolescents with avoidant attachment styles, those who avoided intimacy, also avoided self-disclosure and devalued disclosures by others more than their peers devalued such disclosures. Chen and Mallinckrodt (2002) studied attachment styles within group therapy in a graduate school environment and found that, members who were high in attachment anxiety, evidenced by their fearfulness of being abandoned or rejected, displayed problematic behaviors in the group (e.g., passivity, vindictiveness, intrusiveness). They also found that avoidant attachment negatively correlated with measures of group working alliance (e.g., group attraction) within group treatment. Other researchers have also found that members with greater attachment avoidance have greater rates of dropping out of group therapy (Tasca et al., 2006; Tasca, Taylor, Ritchie, & Balfour, 2004) and are more likely repelled by the pressures to be more intimate in the group (Iilling, Tasca, Balfour, & Bissada, 2011).

There is also some evidence that individuals who exhibit patterns of avoidant or anxious attachment styles have the most to gain from cohesion in psychotherapy. In Gallagher, Tasca, Ritchie, Balfour, and Bissada’s (2014)
research on group therapy and binge-eating disorder, they found that attachment anxiety at study baseline moderated the relationship between growth in group cohesion and change in symptoms of binge eating. An increase in cohesion was associated with better outcomes, but only for those who were high in attachment anxiety at the beginning of the study.

Kivlighan, Lo Coco, and Gullo (2012) examined the interactions of attachment styles within the group as they related to group climate (which is related to cohesion). Using actor–partner interdependence modeling, they found that aggregated anxiety and avoidance, summing all the attachment of all of the members in the group, related to individual members’ perceptions of group conflict and group climate. In essence, members created a unique attachment within the group that influenced how each individual member perceived the group. Insecure groups, groups with more members who were anxious or avoidant, had members with less cohesion and more perceived conflict. These findings are important for leaders who are considering the composition of the group and how the members will influence each other over time. In Chapter 8 of this book, the authors review how attachment mediates the relationship between cohesion and outcome in group treatment. Future research is needed to determine how attachment in group therapy is similar or different for groups that are shorter in length or for members with different mental health diagnoses. There is a large literature linking attachment insecurity to addictive disorders, eating disorders, mood and anxiety disorders, and personality disorders (see Mikulincer & Shaver, 2016).

**Member Diversity and Group Cohesion**

Group therapists value the impact of race, culture, ethnicity, gender, religion, and economic status on group process and outcome (Delucia-Waack, 2011). We know that the group is a social microcosm, and that hatred, microaggressions, prejudice, and stereotypes are likely to become a part of the group process. Leaders who are not able to help the group examine and resolve conflicts around diversity will have members experience discrimination and hatred in the group that is likely to erode group cohesion. In Chapter 3, the authors review how factors relate to group cohesion in nonclinical groups. For example, researchers have found that diversity can facilitate or impede cohesion during the initial stages of group formation (Kozlowski & Chao, 2012).

Researchers within the field of organizational psychology indicate that diversity is most likely to impede cohesion during the initial stages of group formation (Kozlowski & Chao, 2012). Kozlowski and Chao (2012) suggested that first impressions serve as the initial feedback for other group members to adapt and respond to each other as the group relationship evolves. These initial interactions are more likely to be based on surface-level identities, such as race, age, and gender (Harrison, Price, Gavin, & Florey, 2002; Kozlowski & Chao, 2012). Kozlowski and Chao hypothesized that when a group is homogeneous, surface level attributes form a foundation for member attraction
towards the group. However, in heterogeneous groups, the authors posited that surface-level differences cause fault lines that initially fracture groups, reducing feelings of unity (Kozłowski & Chao, 2012; Lau & Murnighan, 1998). As interactions continue, however, group members become less aware of superficial differences, and a matrix of cohesion emerges through transcending commonalities that connect individual members into nets of belonging (Kozłowski & Chao, 2012). This hypothesis suggests that, although diversity within the group impacts levels of cohesion early in the group process, the impact is less as surface level bonds are replaced with deeper understandings of one another.

Research on social integration also reflects this conclusion. Social integration, as defined by social and organizational psychologists, is the extent to which individuals from different backgrounds are able to become psychologically linked in the pursuit of a common task or objective (Harrison, Price, & Bell, 1998; Harrison et al., 2002; O’Reilly, Caldwell, & Barnett, 1989). Within this research, cohesion is described as the “primary affective dimension” of social integration, connecting individual members through affective bonds (Harrison et al., 1998, p. 96). Research by Harrison and colleagues (1998) examined the relationship between surface-level diversity (i.e., differences defined by physical characteristics, such as age, sex, and race) and deep-level diversity (i.e., differences based on psychological characteristics, values, and beliefs) and found that negative forces on cohesiveness due to surface-level differences dissipated over time and were replaced by connections based on deep-level similarity. This suggests that, for groups interacting regularly over time, intergroup differences in deep-level characteristics may be more harmful to cohesion than surface-level diversity (Harrison et al., 1998).

**IMMATURE AND MATURE COHESION**

Group therapists would agree that true cohesion deepens over time and that the immediate liking and agreeableness found within a group form the beginnings of cohesion (see Burlingame et al., 2001, 2002). Yalom and Leszcz (2005) argued that group therapy cohesion does not just happen but is the result of resolved conflict and risk taking. They argued that “it would be a mistake to equate cohesiveness with comfort” (p. 63). If this is true, then measuring cohesion at the very beginning of group can be misleading.

Miles (1953) described how immediate cohesion can be a mixed blessing, because immediately cohesive groups can foster dependence and reduce the likelihood that members will engage in constructive conflict. An over-emphasis on group solidarity can inhibit the importance of risk taking, conflict, and true intimacy in the group. Hartmann (1981) not only addressed the negative side effects of cohesion but also described pathological cohesion in groups, where the pressure to belong within the group causes members to regress. During this regression, members lose their sense of self and are unable...
to engage in the group process. Fears of group cohesion are not surprising and parallel the fears of groups documented in social psychology. “Groupthink,” social loafing, conformity, and deindividuation are all negative phenomena attributed to groups.

However, Karau and Hart (1998) studied the impact of cohesiveness on social loafing and found that group cohesion actually eliminated social loafing (i.e., group members doing less in the group or slacking off). They stated that group members who are in cohesive groups and have the opportunity to make positive contributions to group outcomes engage in less social loafing. They suggested that building cohesion and focusing on common goals can reduce social loafing in groups.

Robbins (2003) argued that not all cohesion is the same, and that there are specific populations in which early cohesion may inhibit growth and positive outcome. Roether and Peters (1972) studied the relationship between cohesion in groups for male sex offenders. They found not only that cohesion was not significantly related to positive outcome but also that sex offenders’ ratings of cohesion were related to their tendency to reoffend. The greater the member rated group cohesion, the greater he rated the likelihood to engage in sexual offenses in the future. Robbins (2003) argued that certain populations, such as sex offenders, are more likely to be at risk for immature cohesion and have more difficulty moving to mature cohesion. The group situation (e.g., a prison setting) where members are in mandated treatment, have leaders who are part of the system, are concerned about being evaluated, and are already mistrustful of the establishment does not facilitate or encourage honest disclosure. He argued that the combination of these factors with greater character pathology and externalizing defenses commonly seen among sex offenders can lead to members developing rapid solidarity in their group without encouraging risk taking, painful disclosure, conflict, or true intimacy. According to Robbins (2003), the assessment of cohesion early in treatment in these groups is more indicative of playing it safe and bolstering the self than engaging in therapeutic change.

The research shows us that there are developmental levels of cohesion: (a) immature cohesion, based on anxiety and perceived compatibility and similarity; and (b) mature cohesion, based on intimacy that occurs when members expose vulnerability, take risks, and truly know each other. For groups to be cohesive, the leader has a lot to do to make the group safe and move the members from immature connections to more mature relationships within the group.

**LEADER FACTORS THAT LEAD TO MATURE GROUP COHESION**

Researchers have shown that leaders who promote interpersonal interaction, regardless of their theoretical orientations, facilitate a stronger relationship between cohesion and outcomes within groups than leaders who do not focus on the interpersonal process (Burlingame et al., 2018). In addition,
leaders who actively prioritize the cultivation of cohesion have a stronger relationship between cohesion and outcomes within their groups (Burlingame et al., 2018).

**Leaders’ Orientation**

The theoretical orientation of the group leader often indicates how likely it is for a leader to emphasize interpersonal interaction (Burlingame et al., 2018). Burlingame et al. (2018) showed that leaders with an interpersonal orientation had groups that showed the highest correlation between cohesion and outcomes in their groups, whereas psychodynamic and cognitive–behavioral orientations showed weaker, although still significant, correlations. This makes sense because the interpersonal orientation often emphasizes interactions within the group over didactic and linking present to past interventions.

Meta-analyses indicate that cohesion to outcome correlations are significantly higher in groups where cohesion is prioritized when compared with groups where it is not prioritized (see Burlingame et al., 2018). Conversely, group cohesion is hindered when group leaders lack the skill to model appropriate self-disclosure as well as other interpersonal skills that facilitate growth and healthy group dynamics. Cohesion also suffers when leaders inhibit group members from expressing negative feelings towards other group members or the group leader, preventing the group from metabolizing conflict (Marmarosh & Van Horn, 2011; Yalom & Leszcz, 2005).

**Leaders’ Ability to Facilitate Safety**

One of the most inhibiting leadership factors in the development of cohesion is the leader’s inability to tolerate emotional reactions (Mikulincer & Shaver, 2007). Failure to be able to express or accept caring, to address conflict, or to explore client’s avoidant behaviors (e.g., missed sessions/tardy behavior) will almost always negatively influence the development of cohesion within a group (Yalom & Leszcz, 2005).

Smokowski, Rose, Todar, and Reardon (1999) demonstrated that dropout increases when group members feel that the group leaders are not adequately supporting or protecting them within the group environment. This indicates that a feeling of safety within the group is vital to establishing group cohesion. MacNair-Semands (2002) stated that one way to support members is to provide pregroun screening to help set the stage for the upcoming group process. This is empirically associated with both higher rates of attendance and decreased rates of premature termination, which is important because preventing turnover in groups enables group members to feel a sense of commitment to the group.

Social psychologists have studied the impact of military leaders’ capacity to support group members through the lens of attachment theory, and they found that the attachment style of the leader relates to group processes
Leadership Behaviors That Facilitate Cohesion

Because group therapists are aware of the leader’s powerful impact on group outcomes, they often emphasize the training of leaders. Burlingame et al. (2001, 2002) developed a list of empirically based, leader behaviors that engender cohesive groups. These behaviors are captured empirically based principles that focus on group leader factors that contribute and foster group cohesion. These principles address how the leader can foster cohesion via planning/pregroup preparation, verbal interactions that offer structure, and facilitation of emotional intimacy in the group. Leaders should model real-time observations and guide interpersonal interactions with a moderate amount of authority and control to facilitate safety. Burlingame et al. (2001) described how group leaders need to manage their own struggles to remain present within the group in the service of engagement and to help group members express their feelings and find a shared meaning.

It is no small task to foster a cohesive group; it is one that requires specialized training in group work. When beginning a group, leaders need to engage in behaviors so that members feel safe, choose to participate, and remain in the group. Lack of these leadership behaviors is often due to insufficient education in group dynamics and group therapy. A group facilitated by a leader with limited training, expertise, and knowledge is more likely to struggle to model appropriate self-disclosure, feedback, and communication skills to members (Bernard et al., 2008). Group members who seek the group experience because they lack these skills are less likely to be able to connect or interact with other members in a positive way without leader support and modeling. A leader who does not demonstrate empathy and engage in here and now feedback will have group members who likely to continue to struggle and reenact their problematic interpersonal interactions in the group.

GROUP PSYCHOTHERAPY: METHODS USED TO ASSESS COHESION

Because cohesion is such an important construct within group therapy, researchers have developed many measures of and ways to assess cohesion (for review, see Marmarosh & Van Horn, 2011). In this chapter, we mainly focus on trends that are more recent and methods that may be useful to those wanting to measure cohesion in their groups.
**Measures of Group Cohesion**

Burlingame et al. (2018) identified nine most studied measures of cohesion and assessed each measure for the structural and affective/task components of cohesion. Although all of the measures assessed the relationship between members and the group, fewer than half focused on the relationship between group members and the leader. The affective bond, or the emotional connection, between members in the group was assessed by all of the cohesion measures. However, cocommitment to a task, which was characterized by agreeing on what needs to happen within the group, was assessed by only a third of the measures. Burlingame and colleagues concluded that the measure one uses is critical when examining the relationship between cohesion and outcome because one can tap into different aspects of cohesion via different measures.

Based on their research, Burlingame and colleagues (2018) described their new measure, the Group Questionnaire (GQ), which taps into two main aspects of cohesion: structure and quality. **Structure** refers to how the member views the group leader’s competence and warmth and their view of other members in the group. **Quality** is more complex and taps into (a) the member’s sense of belonging within the group and (b) the working aspect of the group, such as the alliance and the group climate. We reviewed the items on the GQ and found that many of the items would be applicable to non-therapy groups. For example, similar to the working alliance items, there are items that assess the bond between the member and the leader, the agreement on group goals, and the sense that the leader is helping the member do the tasks needed to be successful in the group. Other items assess how the member feels about conflict within the group meeting, how withdrawn members are during a meeting, and how well members cooperate during the meeting. All of these items could apply to an organizational group, an athletic team, or to military groups.

The American Group Psychotherapy Association published a guide for group therapists, called the CORE Battery-Revised (see Burlingame et al., 2006), that lists measures that are useful when assessing group members at different points in treatment. The battery describes empirically supported measures, including the GQ (see Burlingame et al., 2016) and Lese and MacNair-Semands’s (2000) Therapeutic Factors Inventory, which assesses group members’ perceptions of important curative mechanisms within the group (e.g., cohesion). Many of these measures could be applied to other group settings and help leaders understand how the group is functioning and how to intervene in a way that facilitates group cohesion and outcome. There are similar measures developed to assess sport team cohesion (e.g., Group Environment Questionnaire, Team Cohesion Questionnaire; see Carron, Widmeyer, & Brawley, 1985); however, these measures are much older and have less empirical support. One of the challenges across disciplines when studying cohesion is the number of measures that are out there and the lack of research using and validating them. It appears that people who study groups like to develop new
measures of cohesion instead of using them in ongoing studies to understand how cohesion influences the process and outcome of different groups. The group therapy literature provides newer reliable and valid measures based on strong psychometrics.

**Feedback Monitoring: Assessing Group Member Cohesion After Sessions**

Burlingame and his colleagues (2016) focused on how collecting feedback from group members after each therapy session can positively affect group members and help leaders facilitate the group process. He and his colleagues developed a tracking system that allows group leaders to monitor each member and alerts leaders to members who were struggling regarding their perceptions of cohesion and engagement. After a session, a group leader can have a visual display of how each group member is doing when compared with the rest of the group and how that member was doing during prior sessions (Burlingame et al., 2016; Janis, Burlingame, & Olsen, 2018). The group leader receives a notice indicating that there has been reliable deterioration in the quality of the member’s relationship to the group. This is an excellent way to detect cohesion ruptures in the group and to track the repair of those ruptures over time.

**APPLICATIONS TO OTHER AREAS OF GROUP WORK**

The work of group psychotherapists and researchers on cohesion in therapy groups may have useful applications to other group areas, such as sport psychology, social psychology, organizational psychology, and even health psychology. The May 2018 issue of *American Psychologist* was devoted to the science of teamwork, such as in military health care, but only one article out of 22 mentioned cohesion as an important component of teams (Goodwin, Blacksmith, & Coats, 2018). In that article, Goodwin, Blacksmith, and Coats (2018) described how group cohesion is often overlooked but influences how well teammates perform on a task.

We hope that this chapter is useful to anyone working with groups in organizations, sports, and other areas, because the findings are relevant to leaders who want to promote a well-functioning group. Below are recommendations gleaned from the group therapy literature that could inform group practice and research in other areas of group work.

Group leaders can best instill group cohesion when they plan ahead for their groups/teams. They can foster cohesion even before the group/team begins by screening members who may not be ready to participate in the group, preparing members regarding the group process, discussing boundaries and explaining how they will be valuable members, and providing appropriate information about group structure and goals. The CORE Battery-Revised (Burlingame et al., 2006) offers multiple measures that can be used to screen...
and prepare group/team members for a group experience. Leaders can decide what factors are important to examine for their particular group. For example, military groups have screened soldiers for posttraumatic stress disorder and trauma and found that it does have an impact on group cohesion with some soldiers needing more support before returning to the group after deployment (Whealin et al., 2007). Studies could continue to explore how cohesion moderates group members’ traumatic experience, not only in war but also for emergency response teams, police officers, and firefighters. Are there ways that being in a secure group can provide some resilience to the impact of traumatic events?

In addition, group therapists have relied on sophisticated statistical analyses that allow them to examine the impact of individuals on one another (i.e., actor–partner interdependence modeling). Using these data analytic techniques, researchers have learned that the way in which an individual group member compares with other members on a specific attitude or quality can make them more or less at risk for being dissatisfied with the group process. For example, Kivlighan et al. (2012) found that a member who was significantly more avoidantly attached compared with other group members made him/her more likely to perceive a more negative group climate. Leaders of all groups may want to pay attention to a group member being an outlier or too different from the rest of the group, as this may negatively influence cohesion. These sophisticated analyses could easily be applied to other types of groups, such as work groups, military groups, or teams.

Group leaders need to be aware that cohesion based on a false sense of unity, without the ability to tolerate healthy disagreement and honesty, may inhibit individual growth and the successful functioning of groups. Group leaders have the responsibility to provide the safety needed so that group members can be most productive. For example, Greene-Shortridge and colleagues (2007) recommended that military leaders model openness to mental health issues, so that soldiers will reveal more vulnerability and seek out mental health care when needed. Studies need to measure both group-think, leader style, and cohesion at the same time, so that we can examine the influence of conformity on cohesion and see how it influences the work environment. It would be interesting to see how “false cohesion”—cohesion based on fear and conformity—relates to turnover, productivity, and work satisfaction. On the other side, it would be important to see what types of interventions facilitate more secure attachment in settings where “false cohesion” is likely to occur. For example, in prison settings, is it better to have a leader who is not part of the prison system nor evaluating the prisoners to reduce the “false cohesion” often found. Does reducing “false cohesion” provide better outcomes for these group members?

Group leaders can educate themselves as to the impact of race, ethnicity, and culture, and they can explore how this impact influences group members’ needs in the group and the group’s sense of safety within the group (DeLucia-Waack, 2011). Leaders who are not able to help the group examine and resolve
conflicts around diversity will have members experience discrimination and hatred in the group that is likely to erode group cohesion. It is important for leaders to remember that Puck, Neyer, and Dennerlein (2010) found that the organizational context in which teams are operating influences the diversity–conflict relationship, and that organizational supportiveness and openness influence the diversity–conflict relationship. Over time, group members become less aware of superficial differences, and surface level bonds are replaced with deeper understandings of one another. Training group leaders to expect conflict and facilitate open dialogues about differences can help groups be more productive and foster more cohesion based on less superficial similarities.

Researchers can study the impact of diversity training for group leaders to see how it facilitates both group process and group outcomes in a variety of settings.

Group leaders need to address behaviors in individual members that discourage group cohesion, such as avoidance, lateness, missed sessions, dropouts, lack of disclosure, and risk taking (see Yalom & Leszcz, 2005). One way leaders can identify at-risk members is to monitor how members in their group are doing. Collecting member feedback over time can be extremely useful for leaders who may be able to identify members who are struggling and then intervene to facilitate group cohesion and enhance group performance. For example, a member may miss sessions because she is dissatisfied with the group. She may not say anything during the group session, but she might be willing to disclose her unhappiness if she is asked to rate cohesion after the sessions. Burlingame and colleagues (2016) described the impact of feedback monitoring on therapy groups, but we could not find similar research on process or outcome monitoring in military groups, organizational groups, or sport teams. For example, researchers could examine how tracking members of military groups leads to early detection of depression and reduces suicide attempts in soldiers.

Group leaders can facilitate better outcome when they are sensitive to the importance of relationship factors in group (e.g., the alliance, group climate, cohesion). The perception of safety and trust members have within the group/team can hinder or facilitate performance. Even in groups where it is not apparent that cohesion/group climate is influencing the group (e.g., sport teams, doctors and nurses collaborating in the intensive care unit), cohesion does play a role. For example, research on emergency medical technicians found that job stress is alleviated if more attention was given to the work environment (Revicki & Gershon, 1996). Revicki and Gershon (1996) found that decreasing work stress decreases psychological stress, and they recommended interventions that foster group cohesion in medical settings. Studies have also shown that, for team sports, group cohesion relates positively to self-reported performance (Brawley, Carron, & Widmeyer, 1987). Researchers can continue to study how facilitating cohesion in their groups and work settings relates to satisfaction and outcome.
Group leadership requires specialized training in the area of group dynamics and group treatment. One cannot assume leaders have the skills to run a successful group based on their experience with individuals alone. We have seen how the lack of leader empathy can hinder group therapy (Johnson et al., 2005), and how military leaders with a dismissing style can erode well-being in soldiers (Davidovitz et al., 2007). Within organizations, leader sensitivity has been linked to employee well-being (Kuoppala, Lamminpää, Liira, & Vainio, 2008; Skakon, Nielsen, Borg, & Guzman, 2010), with unhealthy leadership linked to increased stress and anxiety, less satisfaction, and less involvement in work (Hudson, 2013). Barlow (2013) described the training that is needed for group leaders, such as a basic understanding of group dynamics, leadership theory, a capacity to regulate emotions, and an ability to facilitate intimate interactions including conflict resolution. The ability of the leader to be sensitive to the group members’ needs and facilitate safety appears to be a common thread across diverse groups. We need research that identifies the best ways to train leaders (didactic vs. experiential learning), what qualities can one easily develop (set group agendas), and which ones are more challenging to teach (empathizing with group members). Studies are needed that examine the impact of training group leaders in diverse settings, such as the military, health fields, and organizations.

SUGGESTED READINGS


This important book describes group therapy as a specialty and reviews why groups are distinct from individual work. It also describes the unique training required of group leaders.


This is an excellent review of the group therapy cohesion literature.


This book reviews attachment theory and the ways in which group leader and group member personalities influence group cohesion, group process, and outcome.

REFERENCES


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