Special Issue: Groups in a Dangerous Time: Virtual Work and Therapy in the COVID-19 Era

PRACTICE REVIEW

# Online Group Psychotherapy: Challenges and Possibilities During COVID-19—A Practice Review

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Weinberg, H. (2020). Online group psychotherapy: Challenges and possibilities during COVID-19—A practice review. *Group Dynamics: Theory, Research, and Practice, 24*(3), 201-211. http://dx.doi.org/10.1037/gdn0000140

## Abstract

***Background:*** Online group therapy is a relatively new modality for leading groups. There is not enough research yet to evaluate its effectiveness and no clear guidelines about how to do it well. With the outbreak of the COVID-19 pandemic it became even more crucial to provide clinicians with appropriate research review and practical guidelines. The purpose of this article was to provide practice recommendations based on or despite the limited research. ***Method:*** The article reviewed research on online therapy in general, including any on groups, followed by a summary of the obstacles in leading groups online and recommendations for creative solutions. ***Findings:*** Research on online groups is still scarce, and its quality still has many limitations. ***Discussion:*** More research is needed, especially on specific elements in online group therapy, such as the establishing of cohesion and therapeutic presence online, as well as how different the working alliance and cohesion are created online when compared to face-to-face groups. Despite limited research, the author recommends being more active and increasing self-disclosure in online groups to compensate for the challenge of being present and the lack of body-to-body interaction. Training for online group therapy is necessary.

## Highlights and Implications

1. Two of the ingredients of the therapeutic alliance, agreeing on the goals and tasks, can easily be achieved in online groups. The third one, the quality of relationship, is still questionable.

2. The absence of body-to-body interaction in online groups may be considered the main obstacle in shifting from the circle to the screen. The absence of eye contact is especially relevant for group therapists.

3. Presence is difficult to achieve through screen relations. There are too many distractions. Increasing the group therapist's self-disclosure and encouraging group members to use their imagination may be of help.

4. Moving from in-person to online group therapy requires knowledge and training, just as when moving from individual therapy to group therapy.

**KEYWORDS:**

online therapy, online group therapy, therapeutic alliance, self-disclosure, group cohesion

The 2020 world crisis of the coronavirus (COVID-19) pandemic has affected the lives of all of us. Millions of people became sick, hundreds of thousands died, people were locked in their houses for weeks deprived of physical closeness with their loved ones, and anxiety rocketed high. For example, the Centers for Disease Control and Prevention (2020) wrote: "The coronavirus disease 2019 (COVID-19) pandemic may be stressful for people. Fear and anxiety about a new disease and what could happen can be overwhelming and cause strong emotions in adults and children." Evidence has suggested that symptoms of anxiety and depression are common psychological reactions to the COVID-19 pandemic (Rajkumar, 2020).

As I wrote this article, the crisis was still continuing. At first, denial of the severity of the situation was ubiquitous. Even when it became clear that the problem was going to impact people beyond China, many thoughtful people (let alone governments) denied the threat and reacted slowly. When it became clear that this emergency situation was going to last more than a few weeks, it took time to understand the long-standing impact on our future world, such as the erosion of the illusion of stability and safety that people still had in this troubled world; the consequences for the global economy, such as closing of businesses and lost jobs; the effect on leisure time (e.g., flights and travel); and changing priorities and values for human beings. The world of psychotherapy is no different and not immune to the impact of the pandemic. Adjusting to the new situation and understanding that telehealth is now a necessary fact of professional life is not easy for many of our colleagues. Online therapy was considered sacrilegious by many who looked down on therapists working online and advocating for its usefulness (see Essig, 2010: *Be Warned: "Online Therapy" Is Not Therapy, Not Really*). Psychoanalysts claimed, "This is not psychoanalysis." For example, Gillian Russell (2015), in her excellent book *Screen Relations,* wrote: "A bed is not a couch and a car is not a consulting room." In the group therapy world, group analysts argued vehemently that online groups could not be group analysis (Tjelta, 2020). Many therapists on the International Group Analytic Society forum considered screen relations as a poor replacement for

“real” relationships. It is interesting that for technique-based cognitive behavior therapy (CBT), the shift to online therapy was much easier, because all practitioners needed to do was adjust their techniques to the Internet (see Cartreine, 2015).

When the pandemic broke out, reality forced colleagues who never dreamed that they would see clients online to move their practice to the Internet. Strangely enough, some of them found it not as distasteful as they had thought it would be. Some even enjoyed it! Within a matter of days, online therapy became the norm. A recent survey revealed that of the more than 2,000 American Psychological Association (APA) member clinicians who responded, three quarters (76%) said they are now providing solely remote services (American Psychological Association, 2020).

However, the adjustment to online *group* therapy still seemed more difficult. “How can we square the circle?” colleagues wondered (see my webinar for the Group Analytic Society, Weinberg, 2020a). Group therapists who had never thought about online groups had to move online quickly and without adequate preparation. Békés and Aafjes-van Doorn’s (2020) recent survey of therapists who moved to online therapy found higher levels of professional self-doubt among therapists after moving online. Maybe training can reduce self-doubt as well as increase skills in online work. Moving from the office circle to the screen requires new knowledge and training.

Online groups can be divided into two categories: synchronic groups (in which every participant is online at the same time) and asynchronic groups (in which participants can connect to the group at different times). Although the synchronic groups can be based on text alone, usually they are video conferences, using platforms that allow for both audio and video communication (e.g., Zoom, Vsee, Doxy.me). The asynchronic groups usually use Internet forums (e.g., Google groups), although they can also use instant message platforms (e.g., WhatsApp), and are based on text messages only. Because most group therapists moved to synchronic groups following the recent pandemic crisis, I focus more on these types of groups in this article. There is also some evidence that the quality of the research on asynchronous therapy is not high, whereas quality of research for synchronously provided therapy is good (see Varker, Brand, Ward, Terhaag, & Phelps, 2019).

My experience with online groups started 25 years ago (in 1995) when I opened an online electronic mailing list for group psychotherapists around the world. This was in the early days of the Internet revolution, but surprisingly, very quickly, 400 group therapists from 30 countries joined this forum. The format was based on e-mail exchange, meaning only text cues, and the aim of the group was to encourage the exchange of ideas among colleagues who shared interest in group psychotherapy. Soon I noticed that some of the dynamics on the forum resembled processes that were typical of small therapy groups, although it was clearly not a therapy group, whereas other dynamics reminded me

more of what happens in large groups (see Weinberg & Schneider, 2003). As a result of this experience, I wrote the first article about group dynamics in online forums, published in the *International Journal of Group Psychotherapy* in 2001 (Weinberg, 2001).

My experience with online video-based groups (mostly Zoom) started long before anyone in the mental health field knew what a Zoom platform was. I directed an international doctorate program with an online component and was looking for an appropriate platform to facilitate online classes. I also started to experiment with it for online process groups with my students, and to my surprise, it seemed to work well. People were able to open up, self-disclose, interact, relate to one another on a deep level, project, and experience transference toward the group leader and the other group members. In short—group dynamics online looked similar to what I knew from in-person groups. However, there were some caveats and obstacles to overcome.

In this article, I summarize the literature on group teletherapy and then provide clinical examples from my years of experience with online groups. The goals of this article were to provide clinicians with guidance on how to transition to online groups, how to address the limits of online groups, and how to facilitate change for members.

## Research Findings

### Individual Teletherapy: Research Findings

In general, telehealth was found appropriate in reducing the mental health burden of COVID-19 (S. Liu et al., 2020; Zhou et al., 2020). According to Pierce, Perrin, and McDonald (2020), those who were more likely to use teletherapy prior to COVID-19 practiced in Veterans Affairs Medical Centers or within an individual or group practice.

A meta-analysis on telephone-assisted therapy by Castro et al. (2020) also addressed the issue of adherence (Do clients drop out and attend at the same rate?). They found that telephone-delivered psychotherapy may be an effective strategy to reduce depression symptoms and shows adequate treatment adherence. Barak and Grohol (2011) reviewed and summarized the research in 2011 for online mental health interventions and found that there was strong evidence to support the effective use and future development of a variety of online mental health applications. In an earlier meta-analysis, Barak, Hen, Boniel-Nissim, and Shapira (2008) found that a comparison between face-to-face (f2f) and Internet intervention revealed no differences in effectiveness. A more recent meta-analysis study (Carlbring, Andersson, Cuijpers, Riper, & Hedman-Lagerlöf, 2018), comparing f2f and Internet-

based cognitive behavior therapy (ICBT) indicated that ICBT and f2f treatment produced equivalent overall effects. L. Liu et al. (2019) research findings generally suggest that cognitive processing therapy delivered via videoconferencing can be as effective as in-person for reducing the severity of posttraumatic stress disorder (PTSD) symptoms.

Videoconferencing therapy was found effective for anxiety disorders (Berryhill, Halli-Tierney, et al., 2019) and for depression (Berryhill, Culmer, et al., 2019). Varker et al. (2019) concluded that there is sufficient evidence to support video teleconference and telephone-delivered interventions for mental health conditions. Andersson (2018), a well-known researcher in this field, summarized his experience by saying that Internet interventions work for many conditions, have long-term effects, and can be as effective as f2f therapy.

## Group Teletherapy: Research Findings

As for online groups, research is scarcer. The author of this article searched PsycNET, Google Scholar, and PubMed using the term *online group* and found only a few randomized trails (only eight relevant articles on PubMed, nine in Google Scholar, two in PsycNET). For self-help groups, researchers found that clients who took part in an online support group generally felt more empowered (Barak, Boniel-Nissim, & Suler, 2008; van Uden-Kraan, Drossaert, Taal, Seydel, & van de Laar, 2009). As for video-based groups, researchers found them to be feasible and that they resulted in similar treatment outcomes to in-person groups (Banbury, Nancarrow, Dart, Gray, & Parkinson, 2018; Gentry, Lapid, Clark, & Rummans, 2019). Most of the studies about online groups focus on CBT treatment, perhaps because it is easier to measure outcomes. For example, Khatri, Marziali, Tchernikov, and Sheppard (2014) concluded that group CBT could be delivered in online videoconferencing and could meet the same professional practice standards and outcomes as f2f delivery of the intervention program. Zerwas et al. (2017) found that CBT delivered online in a group chat format appears to be an efficacious treatment for bulimia nervosa, although the trajectory of recovery may be slower than with f2f group therapy. Online group CBT was also found as effective in improving coping among persons with chronic pain as in-person groups (Mariano et al., 2019). One study about psychodynamic groups (Lemma & Fonagy, 2013) found the facilitated group appeared to show a greater decline in symptoms compared to the control groups: one without a facilitator but with self-help material and a closed virtual group space and one with only an online mental well-being site.

Comparing online video and chat groups, Varker et al.'s (2019) meta-analysis mentioned above had three studies of low quality on asynchronous or chat-type therapy but not on groups. Only one study

compared online chat groups with video-based groups (Marziali & Garcia, 2011). Both groups showed significant improvement in self-efficacy and a decline in distress related to caregiving tasks, whereas the video group showed a significantly greater improvement in mental health.

To summarize, online group therapy research is still in its infancy, and much more research is needed to determine the effectiveness of online groups for different individuals with different presenting issues. Although some of the research on online chat support groups is based on good- to medium-quality randomized controlled trials, the studies on video groups are rare and not enough based on randomized control trials (RCTs). This is not very different from the state of affairs in individual online therapy. Varker et al. (2019), for example, found only 12 RCTs of online individual therapy, and the quality of these studies varied from good to not so good. Many aspects of online group therapy work need further research. Some of the questions that should be studied are: Is group cohesion or group climate similar in online versus f2f groups? Might some patients be better off in online groups versus f2f? Is therapist empathy and therapeutic presence equivalent in online versus f2f groups? Because there is not enough good-quality research to inform clinicians, I provide impressions on the obstacles that online group therapists should overcome, based on my experiences, and I recommend that these impressions be the subject of future research.

## Clinical Implications of Online Groups

### Ethics: Confidentiality, State Licensing, Informed Consent

Before considering the legal requirements for telehealth, one must remember that cyberspace is a vast open space with loose boundaries. Group therapists cannot assume that the confidentiality that is strictly kept in the consulting office will be kept online; therefore, therapists must be much more cautious and take more measures to assure client confidentiality. Health Insurance Portability and Accountability Act (HIPAA) regulations are important sources of information on client confidentiality, but they do not exempt clinicians from being aware of the risks of online communication. Not all the video-conference platforms are HIPAA-compliant, so before using any app for online therapy, the therapist should ensure the app and version they are using is HIPAA-compliant. Among other things, using the app should include a business associate agreement between the therapist and the app company. These regulations have been waived temporarily during the time of the COVID-19 crisis by the Office for Civil Rights at the Department of Health and Human Services.

Another important requirement is that clinicians not practice across state borders in the United States. Therapists can treat clients in only the state where they are licensed, so if the therapist is licensed in California, they cannot have group members from New York, for example. Regulations vary across states, and group therapists need to check with the licensing board of the state in which the group members reside. Some states realized that these regulations are not suitable to the current circumstances and to advances in technological development, so starting July 1, 2020, telehealth across state lines became simpler for licensed psychologists, who can apply under the authority of the Psychology Interjurisdictional Compact (PSYPACT) to provide telepsychological services and/or conduct temporary in-person, f2f psychology in 12 PSYPACT states (see https://psypact.org/).

When therapists start their online practice, the APA advises that they ask their clients to sign a different informed consent that includes the risks and benefits of online therapy (see Recupero & Rainey, 2005). To be prepared for emergency situations, they should ask clients and group members for their physical locations when treating them online, so that the therapist can direct the emergency services if needed.

## Pregroup Screening and Case Example

There is substantial evidence that the quality of the therapeutic alliance is the best predictor of positive client outcome for all psychotherapies (Martin, Garske, & Davis, 2000; Flückiger, Del Re, Wampold, & Horvath, 2018). Therapeutic alliance has three components: (a) collaborative agreement on goals of therapy, (b) collaborative agreement on tasks of therapy, and (c) the emotional bond between therapist and client (Horvath & Symonds, 1991). There is no reason to doubt that therapeutic alliance can occur in remote therapy as well, as long as the therapist and client agree about the goals and tasks and they feel a sense of connection and mutual respect. Preschl, Maercker, and Wagner (2011) found that contrary to what might have been expected, the working alliance in the online group was comparable to that in the f2f group. Indeed, a review of studies (Simpson & Reid, 2014) supported the notion that therapeutic alliance can develop in video-conference psychotherapy, and clients rated the bond and therapeutic presence at least equally as strongly as in-person settings across a range of diagnostic groups (see also Dunn, 2014). Another systematic literature review and two meta-analyses of 12 studies by Norwood, Moghaddam, Malins, and Sabin-Farrell (2018) showed that working alliance in videoconferencing psychotherapy was inferior to f2f delivery but that target symptom reduction was noninferior.

Based on my clinical experience, the usual criteria for inclusion in in-person groups hold for online groups as well (Rutan & Alonso, 1982; Seligman, 1995; Yalom & Leszcz, 2020). To these f2f criteria of inclusion or exclusion, I recommend adding specific ones for online groups. Online groups may not be appropriate for people in acute crisis and for those who are easily dysregulated. Affect regulation through the body-to-body interaction is almost impossible online. Such clients usually require more time and attention that the group cannot provide, especially online, it is also problematic to reach out to them when crisis intervention is needed, given that they are not physically present. Hence, severely depressed clients with suicidal ideation should not be included in online groups.

On the other hand, there are some group members who benefit from participating in online groups more so than had they participated in f2f meetings. These might include people with intimacy problems who do not show enough improvement in the in-person group. Marmarosh, Markin, and Spiegel (2013) pointed out that individuals with a dismissive–avoidant attachment style often engage in defensive self-enhancement, resulting in less positive outcomes and more dropouts from group therapy. The latest phenomenon was also found by Tasca et al. (2006) and Kivlighan, Lo Coco, and Gullo (2012). From the writer's experience, these individuals can be less defensive online, protected by the "screen barrier," and can gain more from these groups. In addition, some group members with dissociative symptoms might engage more in the group process. F2f groups might be emotionally overwhelming for them, whereas participating in online groups allows them to lower their use of dissociative defenses. Social anxious clients may also feel a lowering of their anxiety in online groups because of the reduction in immediacy and of sense of self-consciousness that may be debilitating in f2f groups. Last but not least, Yalom and Leszcz (2020) mentioned that group therapy, compared to individual therapy, allows clients with borderline personality disorder to obtain greater distance from the therapist, thus diluting the intensity of the transference. It is possible that online groups will feel safer for them and allow these clients to work better on their relationship problems, because their core problems lie in the sphere of intimacy.

Here is a vignette that exemplifies such a case in which the client seemed to make better use of online group therapy (the details were sufficiently altered to protect the group member's privacy, and he was also shown the description and agreed to its publication).

Jim had been participating in a mixed-gender, slow-open, long-term therapy group for several years and seemed quite "stuck." In the group he was aloof, incoherent sometimes, going around in circles, almost evasive. He traveled frequently to visit his elderly mother in another state, and in the last months, since she moved to a nursing home, he missed many of the group meetings. More than that, he was almost always 5 to 10 min late for most group meetings.

Jim was married with no children, and he and his wife were experiencing serious difficulties in the marriage. His wife complained that he does not pay attention to her, makes her feel unimportant, and does not share the household tasks. When she asked him to do something, he seemed to agree but almost always found ways to sabotage it. In short, his reactions were quite passive–aggressive. She became more and more angry and aggressive, which made him more withdrawn and increased his passive–aggressive behaviors.

Jim came to the group to, among other things, work on his interpersonal issues but rarely talked about his problems with his wife. When similar issues were brought to the group by other participants, sometimes one of the group leaders invited him to join in and reflect. Jim felt pressured and complied only on the surface, usually finding a way to avoid the topic.

Over time, the group became quite irritated with him and he was severely criticized. He did his best to appease the group members, but he continued to come late and seemed not to understand how his behavior affected others in the group. The group leaders began to wonder whether he could benefit from the group meetings, because it did not seem that he took in any of the feedback.

Then came the COVID-19 crisis and the group moved online without a lot of preparation. Surprisingly, Jim's behavior online was very different from that in the f2f meetings. He came on time and was highly involved with the group. He was more interactional than before, expressed his emotions (which he rarely did in the f2f group meetings), opened up more and more, and allowed himself to touch deeper emotional issues. It became clear that he had an intense social anxiety that influenced his behavior in the f2f group. He was always afraid that he was doing something wrong and that he would be criticized by group members or the therapists. He came late to the f2f group meetings because it allowed him to avoid being the center of attention, and he tried not to be too involved to minimize the threat. He was so used to this anxiety that he could not put it into words. Moving the group online suddenly reduced the threat. The video screen barrier protected him from getting too close, from feeling the threat of intimacy, and from being too anxious about interacting with people. Paradoxically, it allowed him to become more intimate.

Other advantages of Internet-based treatments are that they can be less stigmatizing—based on the culture, ethnicity, values, or race of the individual. It would be easier to meet online if one felt ambivalent about attending therapy. Online groups save time and money as well, because one can do it from home. On the other hand, some people do not have home computers or access to technology. The older adults may feel overwhelmed by technology and the use of computers, while they are most at risk during COVID-19, given their age, health, quarantine, and limited computer experience.

## Challenges to Online Groups

Based on the writer's experience (Weinberg, 2020b), when group therapists move from the circle to the screen, or from the circle to the square (because moving online seems like squaring the circle), they need to consider four possible obstacles and to find creative ways to overcome them: managing the frame of the treatment, the disembodied environment, the question of presence, and the transparent background. These are discussed in the next four sections.

## Managing the frame of the treatment

Many articles and even books were written about the setting of the consultation meeting, especially in the psychodynamic literature (e.g., Laor, 2007; Quinodoz, 1992). Managing the setting creates a holding environment and is considered a crucial aspect in dynamic and process-oriented therapy. Usually, the therapist has some control over the setting: They choose the furniture and decoration in the office, put a tissue box in the middle of the circle, arrange for calm music in the waiting room. Taking care of the environment sends the message that therapists take care of their clients' needs. In group therapy this process is related to the concept of dynamic administration (Foulkes, 1964), involving setting up the group, dealing with issues of time and space in arranging the meetings of the group, handling boundary issues. For example, if the chairs for the group members and the group leader are not the same, sitting on a better chair can be interpreted as a symbol of status or privilege. When we move to the screen, the responsibility of establishing the appropriate setting, including ensuring the privacy of the group members, lies on the clients' shoulders. Therapists cannot take care of the environment anymore, because they do not control the environments from which the clients connect. I suggest that therapists find ways to compensate for this shortcoming.

An easy solution is to instruct group members to prepare a holding environment for themselves. The group leader can do that by adding some items to the standard agreement (e.g., "Please connect from a quiet room, with no interruptions, where your privacy is guaranteed") or discussing such issues of privacy and space in the preparation meeting that the therapist has with the group candidate. One possible result of shifting the responsibility to the client might be that it encourages more adaptive coping skills and less regression.

## The disembodied environment

In any close relationship, including the therapeutic one, the existence of the bodies of the participants in the encounter seems necessary. The interpersonal neurobiological approach claims that we regulate one another through our body interactions (Siegel, 2020): The therapist's warm gaze, their calming tone

of voice, and many other aspects of their body help the group members to feel held and to regulate their affect. Alan Schore (2009), Daniel Siegel (2010), Louis Cozolino (2006), and others have emphasized the importance of mutual regulation based on physical presence. They talk about right-brain to right-brain communication and the unconscious influence that our bodies have on one another. These affective, relational, and regulation mechanisms of change are central to psychotherapy, and they may be lost when we go online. We lose the eye-to-eye contact and the smell and the pheromones that affect our feelings of intimacy and attachment (Cozolino, 2006). The absence of eye contact is more relevant for group therapists. Eye contact is related to attachment and the parasympathetic nervous system, reducing distress and fight–flight reactions (Jarick & Bencic, 2019). Losing eye-to-eye contact affects our work with coleaders in the group as well. When coleaders work together for some time, they develop trust and can signal each other with their eyes. Online, they lose this capacity and cannot communicate the same way. Coleaders may need to find a way to overcome these barriers.

The eye-to-eye contact between coleaders that is lost may be replaced by verbal communication between the coleaders in the presence of the group members. They can exchange opinions or ask one another questions during the group process. Some coleaders send each other text messages during a session and surreptitiously read them. In my opinion, this solution has the disadvantages of both distracting the coleaders from the here-and-now and of communicating “behind the back” of the group.

Group therapists must be aware that one part of our body is seen more clearly online: the face. Facial expressions can be seen and identified much better online than in person, because we see people close up. Group therapists can train themselves to be sensitive and read facial expressions. They might get more information about clients through their faces online than in the office.

In fact, the body is not absent in online relations. Therapists still sense and feel their body, and group members still sense theirs. What is missing is the body-to-body communication or reading of body language. The therapist can ask the clients to report their body sensations or even to move in the room (e.g., to distance themselves from the screen or get closer to it) according to changing circumstances and the needs of the therapy (Ogden & Goldstein, 2020).

## The question of presence

Presence has been described as one of the most therapeutic gifts a therapist can offer a client (Geller & Greenberg, 2012). *Therapeutic presence* is defined as bringing one’s whole self to the engagement with the client and being fully in the moment with and for the client, with little self-centered purpose or

goal in mind (Craig, 1986). Therapists' presence is the ultimate state of moment-to-moment receptivity and deep relational contact. It involves *being with* the client rather than a *doing to* the client. In the group therapy literature, Grossmark (2007) wrote that the presence of the therapist involves their immersion, passion, attention, emotional involvement, reverie, and readiness to be drawn into enactments. Therapeutic presence can still be achieved online, although there are many distractions and the barrier of the screen might decrease and dilute the therapist's presence. However, just as some TV presenters can pass through the screen and transmit their presence through the ether, therapists can learn to do so as well.

Increasing the group therapist's presence may be achieved through using the therapist's self. More self-disclosure is helpful in creating presence. Yalom and Leszcz (2020) indicated that appropriate self-disclosure and transparency is centered on the here-and-now in which therapists metacommunicate about their experience of the interpersonal interactions with the client. Increasing the therapists' presence can also be achieved by therapists' taking responsibility for mistakes and for empathic failures. Here is a case vignette exemplifying a therapist's use of self to increase therapeutic presence.

In an online group using videoconferencing, one of the group members, Sheila, requested feedback from the group. She said that she is usually satisfied with her life—happy and easygoing—but is wondering whether she is denying something. Some group members said that they found it hard to believe that she is always content. Summarizing the responses, the group leader suggested to Sheila that her limited range of emotions is perceived by the group members as superficial. The leader noticed that some group members' (but not Sheila's) facial reactions online seemed shocked or irritated by this summary. After some reflection, the therapist got back to Sheila and said that he wanted to correct his previous intervention, because it might have been understood as if he were saying that Sheila is superficial, which was not his intention. He corrected himself by telling Sheila that when she expresses only joy and never any sign of irritation, dissatisfaction, or other negative emotions, it makes it difficult for him, the group leader, to feel close to Sheila. She had a strong emotional reaction to this intervention, and later on it became clear how much her parents did not allow for any strong emotional reactions and never acknowledged that they had made mistakes.

Another way to increase therapist presence is by more extensive use of imagination and by inviting the group members to use theirs as well. When a member of an online group complained that she was used to the group's being in a circle and that now it was difficult for her to get used to the squares on the screen, the group therapist suggested that she use her imagination and envision the group members sitting in a circle. He asked her which group member she would like to see sitting beside her and which member she imagined sitting across the room from her.

### The transparent background

If someone entered the room in which a therapist was leading a group, neither the group members nor the group leader would ignore such an intrusion. If someone brought a cat to the group, most group leaders would explore the dynamic meaning for the participant who brought the cat. However, when someone passes behind one of the group members when they sit in front of the computer, or when the tail of a cat suddenly appears on the screen, most of the time no one, including the group therapist, comments on it. It is as if these background details become transparent to us. Special attention and training are needed not to ignore these events.

There isn't 100 years of online group therapy tradition (and certainly no research on 100 years of online norms). Group therapy norms have developed or evolved over many years, but online group therapy norms are too new to consider what is interpretable and what is not.

## Conclusion

As explained in the introduction, the goal of this article was to review the research about online group therapy and to provide clinicians with guidelines for leading these groups, because this is a new field and because many group therapists were thrust into moving online without preparation during the COVID-19 crisis. According to current research, online group therapy seems to work, but more high-quality research is needed, especially regarding comparing outcomes, the impact on establishing cohesion online, therapeutic presence online, and the role of the therapeutic alliance in online groups. Future research on the impact of online therapy on therapists' capacity for empathy, and on therapists' self-confidence in providing group therapy online, is also needed. It might be important to study attachment to predict who will have a better alliance and outcome in groups online versus f2f. Moving from the circle to the screen requires specific knowledge, and this article tries to fill in some of this knowledge. This transition creates resistance in both therapists and clients and brings to the fore challenges and obstacles we should address and overcome. Specific training for therapists to conduct online group therapy is recommended. Such training might entail increasing therapists' self-confidence in providing online groups, especially through practicing how to establish therapeutic alliance, increase group cohesion, and create presence online by overcoming the lack of body-to-body interaction.

This article summarizes the current research, details selection considerations, and points out the main obstacles that need creative solutions. The main obstacles that we should take into consideration and

compensate for when we shift our practice to the screen are managing the setting, the disembodied environment, the question of presence, and the transparent background.

The COVID-19 crisis created a rare opportunity to compare groups that started in person and moved to the Internet. Meeting with clients via online videoconferencing illuminates the ways in which group therapists and members handle technological challenges and opportunities. Therapists should listen to the way clients react to the new therapeutic setting from a wider angle: fear of changes? enjoying new adventures? All these feelings are part of the group process. The dialogue in the therapeutic community and with our clients about moving online is important because it is characteristic of how we all cope with modern life and changing times.

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Received June 22, 2020

Revision received July 20, 2020

Accepted July 21, 2020