Substance Abuse Treatment: Group Therapy

A Treatment Improvement Protocol

TIP 41

Substance Abuse and Mental Health Services Administration
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

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Disclaimer

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided. When no citation is provided, the information is based on the collective clinical knowledge and experience of the consensus panel.

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Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities by providing evidence-based and best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. Field reviewers then review and critique this panel's work.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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Executive Summary

With the recognition of addiction as a major health problem in this country, demand has increased for effective treatments of substance use disorders. Because of its effectiveness and economy of scale, group therapy has gained popularity, and the group approach has come to be regarded as a source of powerful curative forces that are not always experienced by the client in individual therapy. One reason groups work so well is that they engage therapeutic forces—like affiliation, support, and peer confrontation—and these properties enable clients to bond with a culture of recovery. Another advantage of group modalities is their effectiveness in treating problems that accompany addiction, such as depression, isolation, and shame.

Groups can support individual members in times of pain and trouble, and they can help people grow in ways that are healthy and creative. Formal therapy groups can be a compelling source of persuasion, stabilization, and support. In the hands of a skilled, well-trained group leader, the potential healing powers inherent in a group can be harnessed and directed to foster healthy attachments, provide positive peer reinforcement, act as a forum for self-expression, and teach new social skills. In short, group therapy can provide a wide range of therapeutic services, comparable in efficacy to those delivered in individual therapy.

Group therapy and addiction treatment are natural allies. One reason is that people who abuse substances are often more likely to stay sober and committed to abstinence when treatment is provided in groups, apparently because of rewarding and therapeutic benefits like affiliation, confrontation, support, gratification, and identification. This capacity of group therapy to bond patients to treatment is an important asset because the greater the amount, quality, and duration of treatment, the better the client's prognosis (Leshner 1997; Project MATCH Research Group 1997).

The primary audience for this TIP is substance abuse treatment counselors; however, the TIP should be of interest to anyone who wants to learn more about group therapy. The intent of the TIP is to assist counselors in enhancing their therapeutic skills in regard to leading groups.

The consensus panel for this TIP drew on its considerable experience in the group therapy field. The panel was composed of representatives from all of the disciplines involved in group therapy and substance abuse treatment, including alcohol and drug counselors, group therapists, mental health providers, and State government representatives.

This TIP comprises seven chapters. Chapter 1 defines therapeutic groups as those with trained leaders and a primary intent to help people recover from substance abuse. It also explains why groups work so well for treating substance abuse.

Chapter 2 describes the purpose, main characteristics, leadership, and techniques of five group therapy models, three specialty groups, and groups that focus on solving a single problem.

Chapter 3 discusses the many considerations that should be weighed before placing a client in a particular group, especially keying the group to the client's stage of change and stage of recovery. This chapter also concentrates on issues that arise from client diversity.

Chapter 4 compares fixed and revolving types of therapy groups and recommends ways to prepare clients for participation: pregroup interviews, retention measures, and most important, group agreements that specify clients' expectations of each other, the leader, and the group. Chapter 4 also specifies the tasks that need to be accomplished in the early, middle, and late phases of group development.

Chapter 5 turns to the stages of treatment. In the early, middle, and late stages of treatment, clients' conditions will differ, requiring different therapeutic strategies and approaches to leadership.

Chapter 6 is the how-to segment of this TIP. It explains the characteristics, duties, and concepts important to promote effective group leadership in treating substance abuse, including how confidentiality regulations for alcohol and drug treatment apply to group therapy.

Chapter 7 highlights training opportunities available to substance abuse treatment professionals. The chapter also recommends the supervisory group as an added measure that improves group leadership and gives counselors in the group insights about how clients may experience groups.

Throughout this TIP, the term "substance abuse" has been used to refer to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* [DSM-IV-TR] [American Psychiatric Association 2000]). This term was chosen partly because substance abuse treatment professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders described by DSM-IV.

The sections that follow summarize the content in this TIP and are grouped by chapter.

Groups and Substance Abuse Treatment

Because human beings by nature are social beings, group therapy is a powerful therapeutic tool that is effective in treating substance abuse. The therapeutic groups described in this TIP are those groups that have trained leaders and a specific intent to treat substance abuse. This definition excludes self-help groups like Alcoholics Anonymous and Narcotics Anonymous.

Group therapy has advantages over other modalities. These include positive peer support; a reduction in clients' sense of isolation; real-life examples of people in recovery; help from peers in coping with substance abuse and other life problems; information and feedback from peers; a substitute family that may be healthier than a client's family of origin; social skills training and practice; peer confrontation; a way to help many clients at one time; structure and discipline often absent in the lives of people abusing substances; and finally, the hope, support, and encouragement necessary to break free from substance abuse.

Groups Commonly Used in Substance Abuse Treatment

Five group models are common in substance abuse treatment:

- Psychoeducational groups, which educate clients about substance abuse
- Skills development groups, which cultivate the skills needed to attain and sustain abstinence, such as those needed to manage anger or cope with urges to use substances
- Cognitive–behavioral groups, which alter thoughts and actions that lead to substance abuse
- Support groups, which buoy members and provide a forum to share pragmatic information about maintaining abstinence and managing day-to-day, chemical-free life
- Interpersonal process groups, which delve into major developmental issues that contribute to addiction or interfere with recovery

Three other specialized types of groups that do not fit neatly into the five-model classification nonetheless are common in substance abuse treatment. They are designed specifically to prevent relapse, to bring a specific culture's healing practices to bear on substance abuse, or to use some form of art to express thoughts that otherwise would be difficult to communicate. Groups also can be formed to help clients who share a specific problem, such as anger or shyness, that contributes to their substance abuse.

Criteria for the Placement of Clients in Groups

Not everyone is suited to every kind of group. Moreover, because recovery is a long, nonlinear process, the type of therapy chosen always should be subject to re-evaluation.

Appropriate placement begins with a thorough assessment of the client's needs, desires, and ability to participate. Evaluators rely on forms and interviews to determine the client's level of interpersonal functioning, motivation to abstain, stability, stage of recovery, and expectation of success in the group.

Most clients can function in a group that is heterogeneous, that is, members may be mixed in age, gender, culture, and so on. What is essential, however, is that all clients in a group should have similar needs. Some clients, such as those with a severe personality disorder, will need to be placed in homogeneous groups, in which members are alike in some way other than their dependence problem. Such groups may include people of a particular ethnicity, all women, or a particular age group.

Some clients probably are not suitable for certain groups, or group therapy in general, including

- People who refuse to participate
- People who cannot honor group agreements, including preserving privacy and confidentiality of group members in accordance with the Federal regulations (42 C.F.R., Part 2)
- People who make the therapist very uncomfortable
- People who are prone to dropping out or who continually violate group norms
- People in the throes of a life crisis
- People who cannot control impulses
- People who experience severe internal discomfort in groups

Professional judgment is also essential and should consider characteristics such as substances abused, duration of use, treatment setting, and the client's stage of recovery. For example, a client in a maintenance stage may need to acquire social skills for interacting in new ways, address emotional difficulties, or become reintegrated into a community or culture of origin.

Ethnicity and culture can have a profound effect on treatment. The greater the mix of

ethnicities in a group, the more likely it is that biases will emerge and require mediation. Special attention may be warranted, too, if clients do not speak English fluently because they may be unable to follow a fast-flowing discussion. Programs should ensure that group members are fluent in the language for their specific demographic area, which may or may not be English. Further, while it might be desirable to match the group leader and all group members ethnically, the reality is that it is seldom feasible. Thus, it is crucial for the group leader to understand how ethnicity affects substance abuse and group participation.

Group Development and Phase-Specific Tasks

Group membership may be fixed, with a stable and relatively small number of clients. Alternatively, membership may revolve, with new members entering a group when they are ready for the service it provides. Either type can run indefinitely or for a set time.

The preparation of clients for group participation commences when the group leader meets individually with each prospective group member to begin to form a therapeutic alliance, reach consensus on what is to be accomplished in therapy, educate the client about group therapy, allay anxiety related to joining a group, and explain the group agreement. In these pre-group interviews, it is important to be sensitive to people who differ significantly from the rest of the group whether by age, ethnicity, gender, disorder, and so on. It is important to assure clients that a difference is not a deficit and can be a source of vitality for the group.

Selection of group members is based on the client's fit with a specific group modality. Considerations include the client's

- Level of interpersonal functioning, including impulse control
- Motivation to abstain from drug or alcohol abuse
- Stability
- Stage of recovery
- Expectation of success

Throughout the initial group therapy sessions, clients are particularly vulnerable to relapse and discontinuation of treatment. The first month appears to be especially critical (Margolis and Zweben 1998). Retention rates in a group are enhanced by client preparation, maximum client involvement, feedback, prompts to encourage attendance, and the provision of wraparound services (such as child care and transportation). The timing and duration of groups also affect retention.

While group leaders have many responsibilities in preparing clients for participation in groups, clients have obligations, too. A group agreement establishes the expectations that group members have of each other, the leader, and the group itself. It specifies the circumstances under which clients may be barred from group and explains policies regarding confidentiality, physical contact, substance use, contact outside the group, group participation, financial responsibility, and termination. A group member's acceptance of the contract prior to entering a group has been described as the single most important factor contributing to the success of outpatient therapy groups.

The tasks in the beginning phase of a group include introductions, review of the group agreement, establishment of an emotionally safe environment and positive group norms, and focusing the group toward its work. In the middle phase, clients interact, rethink their behaviors, and move toward productive change. The end phase concentrates on reaching closure.

Stages of Treatment

As clients move through different stages of recovery, treatment must move with them. That is, therapeutic strategies and leadership roles will change with the condition of the clients.

In the early phase of treatment clients tend to be ambivalent about ending substance use,

rigid in their thinking, and limited in their ability to solve problems. Resistance is a challenge for the group leader at this time.

The art of treating addiction in the early phase is in the defeat of denial and resistance. Groups are especially effective at this time since people with dependencies often have had adversarial relationships with people in authority. Thus, information from peers in a group is more easily accepted than that from a lone therapist.

People with addictions remain vulnerable during the middle phase of treatment. Though cognitive capacity usually begins to return to normal, the mind can still play tricks. Clients may remember distinctly the comfort of their past use of substances, yet forget just how bad the rest of their lives were. Consequently, the temptation to relapse remains a concern. Because people with dependencies usually are isolated from healthy social groups, the group helps to acculturate clients into a culture of recovery. The leader draws attention to positive developments, points out how far clients have traveled, and affirms the possibility of increased connection and new sources of satisfaction.

In the late phase of treatment clients are stable enough to face situations that involve conflict or deep emotion. A process-oriented group may become appropriate for some clients who finally are able to confront painful realities, such as being an abused child or an abusive parent. Other clients may need groups to help them build a healthier marriage, communicate more effectively, or become a better parent. Some may want to develop new job skills to increase employability.

Group Leadership, Concepts, and Techniques

Effective group leadership requires a constellation of specific personal qualities and professional practices. The personal qualities necessary are constancy, active listening, firm identity, confidence, spontaneity, integrity, trust, humor, and empathy.

Leaders should be able to

- Adjust their professional styles to the particular needs of different groups
- Model group-appropriate behaviors
- Resolve issues within ethical dimensions
- Manage emotional contagion
- Work only within modalities for which they are trained
- Prevent the development of rigid roles in the group
- Avoid acting in different roles inside and outside the group
- Motivate clients in substance abuse treatment
- Ensure emotional safety in the group
- Maintain a safe therapeutic setting (which involves deflecting defensive behavior without shaming the offender, recognizing and countering the resumption of substance use, and protecting physical boundaries according to group agreements)
- Curtail emotion when it becomes too intense for group members to tolerate
- Stimulate communication among group members

Key concepts and techniques used in group therapy for substance abuse follow.

Interventions are any action by a leader to intentionally affect the processes of the group. Interventions may be used, for example, to clarify understanding, redirect energy, or stop a damaging sequence of interactions. Effective leaders do not overdo intervention. To do so would result in a leader-centered group, which is undesirable because in therapy groups, the healing comes from the connections forged between group members. One type of intervention, confrontation, deftly points out inconsistencies in clients' thinking.

Confidentiality restricts the information that providers can reveal about clients and that clients may reveal about each other. Group

leaders and clients should understand the exact provisions of this important boundary.

Diversity plays a highly important role in group therapy, for it may affect critical aspects of the process, such as what clients expect of the leader and how clients may interpret other clients' behavior. Clinicians should be open to learning about other belief systems, should not assume that every person from a specific group shares the same characteristics, and should avoid appearing as if they are trying to persuade clients to renounce their cultural characteristics.

Many people in treatment for substance abuse have other complex problems, such as co-occurring mental disorders, homelessness, or involvement with the criminal justice system. For many clients, group therapy may be one element in a larger plan that also marshals biopsychosocial and spiritual interventions to address important life issues and restore faith or belief in some force beyond the self.

Integrated care from diverse sources requires cooperation with other healthcare providers. For example, it is critical that all providers working with clients with multiple disorders know what medications they are taking and why.

Two aspects of group management relate to conflict and subgroups. Properly managed, conflict can promote learning about respect for different viewpoints, managing emotions, and negotiation. Part of the therapist's job as a conflict manager is to reveal covert conflicts and expose repetitive and predictable arguments. The therapist also reveals covert subgroups and intervenes to reconfigure negative subgroups that threaten the group's progress.

Various types of disruptive behavior may require the group leader's attention. Such problems include clients who talk nonstop, interrupt, flee a session, arrive late or skip sessions, decline to participate, or speak only to the problems of others. The leader also should have skills to handle people with psychological emergencies or people who are anxious about disclosing personal information.

Training and Supervision

National professional organizations are a rich source of training. Through conferences or regional chapters, national associations provide training—both experiential and direct instruction—geared to the needs of a wide range of persons, from graduate students to highly experienced therapists. More training options are usually available in large urban areas. It is likely, however, that online training will make some types of professional development accessible to a greater number of counselors in remote areas.

Clinical supervision as it pertains to group therapy often is best carried out within the context of group supervision. Group dynamics and group process facilitate learning by setting up a microcosm of a larger social environment. Each group member's style of interaction will inevitably show up in the group transactions. As this process unfolds, group members, guided by the supervisor, learn to model effective behavior in an accepting group context.

Supervisory groups reduce, rather than escalate, the level of threat that can accompany supervision. In place of isolation and alienation, group participation gives counselors a sense of community. They find that others share their worries, fears, frustrations, temptations, and ambivalence. This reassurance is of particular benefit to novice group counselors.

1 Groups and Substance Abuse Treatment

In This Chapter…

Introduction

Defining Therapeutic Groups in Substance Abuse Treatment

Advantages of Group Treatment

Modifying Group Therapy To Treat Substance Abuse

Approach of This TIP

Overview

The natural propensity of human beings to congregate makes group therapy a powerful therapeutic tool for treating substance abuse, one that is as helpful as individual therapy, and sometimes more successful. One reason for this efficacy is that groups intrinsically have many rewarding benefits—such as reducing isolation and enabling members to witness the recovery of others—and these qualities draw clients into a culture of recovery. Another reason groups work so well is that they are suitable especially for treating problems that commonly accompany substance abuse, such as depression, isolation, and shame.

Although many groups can have therapeutic effects, this TIP concentrates only on groups that have trained leaders and that are designed to promote recovery from substance abuse. Great emphasis is placed on interpersonal process groups, which help clients resolve problems in relating to other people, problems from which they have attempted to flee by means of addictive substances. While this TIP is not intended as a training manual for individuals training to be group therapists, it provides substance abuse counselors with insights and information that can improve their ability to manage the groups they currently lead.

Introduction

The lives of individuals are shaped, for better or worse, by their experiences in groups. People are born into groups. Throughout life, they join groups. They will influence and be influenced by family, religious, social, and cultural groups that constantly shape behavior, self-image, and both physical and mental health.

Groups can support individual members in times of pain and trouble, and they can help people grow in ways that are healthy and creative. However, groups also can support deviant behavior or influence an individual to act in ways that are unhealthy or destructive.

Because our need for human contact is biologically determined, we are, from the start, social creatures. This propensity to congregate is a powerful therapeutic tool. Formal therapy groups can be a compelling source of persuasion, stabilization, and support. Groups organized around therapeutic goals can enrich members with insight and guidance; and during times of crisis, groups can comfort and guide people who otherwise might be unhappy or lost. In the hands of a skilled, well-trained group leader, the potential curative forces inherent in a group can be harnessed and directed to foster healthy attachments, provide positive peer reinforcement, act as a forum for self-expression, and teach new social skills. In short, group therapy can provide a wide range of therapeutic services, comparable in efficacy to those delivered in individual therapy. In some cases, group therapy can be more beneficial than individual therapy (Scheidlinger 2000; Toseland and Siporin 1986).

> Groups provide positive peer support and pressure to abstain from substances of abuse.

Group therapy and addiction treatment are natural allies. One reason is that people who abuse substances often are more likely to remain abstinent and committed to recovery when treatment is provided in groups, apparently because of rewarding and therapeutic forces such as affiliation, confrontation, support, gratification, and identification. This capacity of group therapy to bond patients to treatment is an important asset because the greater the amount, quality, and duration of treatment, the better the client's prognosis (Leshner 1997; Project MATCH Research Group 1997).

The effectiveness of group therapy in the treatment of substance abuse also can be attributed to the nature of addiction and several factors associated with it, including (but not limited to) depression, anxiety, isolation, denial, shame, temporary cognitive impairment, and character pathology (personality disorder, structural deficits, or an uncohesive sense of self). Whether a person abuses substances or not, these problems often respond better to group treatment than to individual therapy (Kanas 1982; Kanas and Barr 1983). Group therapy is also effective because people are fundamentally relational creatures.

Defining Therapeutic Groups in Substance Abuse Treatment

All groups can be therapeutic. Anytime someone becomes emotionally attached to other group members, a group leader, or the group as a whole, the relationship has the potential to influence and change that person. Identifying a group as "therapy" does not imply that other groups are not therapeutic. In preparing this TIP, the consensus panel debated at length what constitutes "group therapy" and what distinguishes therapy groups from other types of groups.

Although many types of groups can have therapeutic elements and effects, the group types included in this TIP are based on the goals and intentions of the groups, as well as the intended audience of the TIP (especially substance abuse treatment counselors and other substance abuse treatment professionals). Thus, this TIP is limited to groups that (1) have trained leaders and (2) intend to produce some type of healing or recovery from substance abuse. This TIP describes (in chapter 2) five models of group therapy currently used in substance abuse treatment:

- Psychoeducational groups, which teach about substance abuse.

- Skills development groups, which hone the skills necessary to break free of addictions.
- Cognitive–behavioral groups, which rearrange patterns of thinking and action that lead to addiction.
- Support groups, which comprise a forum where members can debunk each other's excuses and support constructive change.
- Interpersonal process group psychotherapy (referred to hereafter as "interpersonal process groups" or "therapy groups"), which enable clients to recreate their pasts in the here-and-now of group and rethink the relational and other life problems that they have previously fled by means of addictive substances.

Treatment providers routinely use the first four models and various combinations of them. The last is not as widely used, chiefly because of the extensive training required to lead such groups and the long duration of the groups, which demands a high degree of commitment from both providers and clients. All the same, many people enter substance abuse treatment with a long history of failed relationships exacerbated by substance use. In these cases, an extended period of therapy is warranted to resolve the client's problems with relationships. The reality that extended treatment is not always feasible does not negate its desirability.

This TIP does not discuss multifamily and multicouple groups, which are discussed in TIP 39, *Substance Abuse Treatment and Family Therapy* (Center for Substance Abuse Treatment 2004). Even though multifamily and multicouple groups typically are made up of unrelated groups of families, they focus on family relations as they affect and are affected by a member with a substance use disorder. This TIP concentrates on therapy groups, which have a distinctively different focus.

Also outside the scope of this TIP is the use of peer-led self-help groups such as Alcoholics Anonymous (AA) or group activities like social events, religious services, sports, and games. Any or all may have one or more therapeutic effects, but are not specifically designed to achieve that purpose. Figure 1-1 (see p. 4) shows other differences between self-help groups and interpersonal process groups. In most aspects, the comparison would apply to the other four group models as well.

Advantages of Group Treatment

Treating adult clients in groups has many advantages, as well as some risks. Any treatment modality—group therapy, individual therapy, family therapy, and medication—can yield poor results if applied indiscriminately or administered by an unskilled or improperly trained therapist. The potential drawbacks of group therapy, however, are no greater than for any other form of treatment.

Some of the numerous advantages to using groups in substance abuse treatment are described below (Brown and Yalom 1977; Flores 1997; Garvin unpublished manuscript; Vannicelli 1992).

- *Groups provide positive peer support and pressure to abstain from substances of abuse.* Unlike AA, and, to some degree, substance abuse treatment program participation, group therapy, from the very beginning, elicits a commitment by all the group members to attend and to recognize that failure to attend, to be on time, and to treat group time as special disappoints the group and reduces its effectiveness. Therefore, both peer support and pressure for abstinence are strong.
- *Groups reduce the sense of isolation that most people who have substance abuse disorders experience.* At the same time, groups can enable participants to identify with others who are struggling with the same issues. Although AA and treatment groups of all types provide these opportunities for sharing, for some people the more formal and deliberate nature of participation in process group therapy increases their feelings of security and enhances their ability to share openly.
- *Groups enable people who abuse substances to witness the recovery of others.* From this

Figure 1-1

Differences Between 12-Step Self-Help Groups and Interpersonal Process Groups

	Self-Help Group	Interpersonal Process Group
Size	Unlimited (often large)	Small (8–15 members)
Leadership	• Peer leader or individual in recovery • Leadership is earned over time • Implicit hierarchical leadership structure	• Trained professional • Appointed leader • Formal hierarchical leadership structure
Participation	Voluntary	Voluntary and involuntary
Group Government	Self-governing	Leader governed
Content	• Environmental factors, no examination of group interaction • Emphasis on similarities among members • Here-and-now focus	• Examination of intragroup behavior and extragroup factors • Emphasis on differences and similarities among members • Here-and-now focus plus historical focus
Screening Interview	None	Always
Group Processes	Universality, empathy, affective sharing, self-disclosure (public statement of problem), mutual affirmation, morale building, catharsis, immediate positive feedback, high degree of persuasiveness	Cohesion, mutual identification, education, catharsis, use of group pressure to encourage abstinence and retention of group membership, outside socialization (depending on the group contract or agreement)
Group Goals	• Positive goal setting, behaviorally oriented • Focus on the group as a whole and the similarities among members	• Ambitious goals: immediate problem plus individual personality issues • Individual as well as group focus
Leader Activity	• Educator/role model, catalyst for learning • Less member-to-leader distance	• Responsible for directing therapeutic group experience • More member-to-leader distance
Use of Psycho-dynamic Techniques	No	Yes
Confiden-tiality	Anonymity preserved	Anonymity strongly emphasized and includes *everything* that occurs in the group, not just the identity of group members

	Self-Help Group	Interpersonal Process Group
Sponsorship Program	Yes (usually same sex)	None
Determination of Time in Group	• Members may leave group at their own choosing • Members may avoid self-disclosure or discussion of any subject	• Predetermined minimal term of group membership • Avoidance of discussion seen as possible "resistance"
Involvement in Other Therapies	Yes	Yes—eclectic models No—psychodynamic models
Time Factors	Unlimited group participation possible over years	Often time-limited group experiences
Frequency of Meetings	Active encouragement of daily participation	Meets less frequently (often once or twice weekly)

Source: Adapted from Spitz 2001. Used with permission.

inspiration, people who are addicted to substances gain hope that they, too, can maintain abstinence. Furthermore, an interpersonal process group, which is of long duration, allows a magnified witnessing of both the changes related to recovery as well as group members' intra- and interpersonal changes.

- *Groups help members learn to cope with their substance abuse and other problems by allowing them to see how others deal with similar problems.* Groups can accentuate this process and extend it to include changes in how group members relate to bosses, parents, spouses, siblings, children, and people in general.
- *Groups can provide useful information to clients who are new to recovery.* For example, clients can learn how to avoid certain triggers for use, the importance of abstinence as a priority, and how to self-identify as a person recovering from substance abuse. Group experiences can help deepen these insights. For example, self-identifying as a person recovering from substance abuse can be a complex process that changes significantly during different stages of treatment and recovery and often reveals the set of traits that makes the system of a person's self as altogether unique.
- *Groups provide feedback concerning the values and abilities of other group members.* This information helps members improve their conceptions of self or modify faulty, distorted conceptions. In terms of process groups in particular, as specific themes emerge in a client's group experience, repetitive feedback from multiple group members and the therapist can chip away at those faulty or distorted conceptions in slightly different ways until they not only are correctable, but also the very process of correction and change is revealed through the examination of the group processes.
- *Groups offer family-like experiences.* Groups can provide the support and nurturance that may have been lacking in group members' families of origin. The group also gives members the opportunity to practice healthy ways of interacting with their families.

- *Groups encourage, coach, support, and reinforce as members undertake difficult or anxiety-provoking tasks.*
- *Groups offer members the opportunity to learn or relearn the social skills they need to cope with everyday life instead of resorting to substance abuse.* Group members can learn by observing others, being coached by others, and practicing skills in a safe and supportive environment.
- *Groups can effectively confront individual members about substance abuse and other harmful behaviors.* Such encounters are possible because groups speak with the combined authority of people who have shared common experiences and common problems. Confrontation often plays a part of substance abuse treatment groups because group members tend to deny their problems. Participating in the confrontation of one group member can help others recognize and defeat their own denial.
- *Groups allow a single treatment professional to help a number of clients at the same time.* In addition, as a group develops, each group member eventually becomes acculturated to group norms and can act as a quasi-therapist himself, thereby ratifying and extending the treatment influence of the group leader.
- *Groups can add needed structure and discipline to the lives of people with substance use disorders, who often enter treatment with their lives in chaos.* Therapy groups can establish limitations and consequences, which can help members learn to clarify what is their responsibility and what is not.
- *Groups instill hope, a sense that "If he can make it, so can I."* Process groups can expand this hope to dealing with the full range of what people encounter in life, overcome, or cope with.
- *Groups often support and provide encouragement to one another outside the group setting.* For interpersonal process groups, though, outside contacts may or may not be disallowed, depending on the particular group contract or agreements.

Modifying Group Therapy To Treat Substance Abuse

Modifying group therapy to make it applicable to and effective with clients who abuse substances requires three improvements. One is specific training and education for therapists so that they fully understand therapeutic group work and the special characteristics of clients with substance use disorders. The importance of understanding the curative process that occurs in groups cannot be underestimated.

Most substance abuse counselors have responded by adapting skills used in individual therapy. Counselors have also sought direction, clinical training, and practical suggestions. Despite individual efforts, however, group therapy often is conducted as individual therapy in a group.

Individual therapy is not equivalent to group therapy. Some principles that work well with individuals are inappropriate for group therapy. Using the wrong approach may lead to several undesirable results. First, the rich potential of groups—self-understanding, psychological growth, emotional healing, and true intimacy—will be left unfulfilled. Second, group leaders who are unfamiliar with and insensitive to issues that manifest themselves in group therapy may find themselves in a difficult situation. Third, therapists who think they are doing group therapy when they actually are not may observe the poor results and conclude that group therapy is ineffective. Compounding all these difficulties is the fact that group therapy is so ubiquitous. Thus, poorly conceived approaches are being used frequently.

Group therapy also is not equivalent to 12-Step program practices. Many therapists who lack full qualifications for group work have adapted practices from AA and other 12-Step programs for use in therapeutic groups. To say that this borrowing is inadvisable is not to say that the principles of AA are inadequate. On the contrary, many people seem to be unable to recover from dependency without AA or a program

similar to it. For this reason, most effective treatment programs make attendance at AA or another 12-Step program a mandatory part of the treatment process. By the same token, AA and other 12-Step programs are not group therapy. Rather, they are complementary components to the recovery process. Twelve-Step programs can help keep the individual who abuses substances abstinent while group therapy provides opportunities for these individuals to understand and explore the emotional and interpersonal conflicts that can contribute to substance abuse.

Progress toward optimal group therapy has also been hindered by the misconception that group therapy with clients who have addictions does not require specially qualified leaders. This notion is false. Therapy groups cannot just take care of themselves. Group therapy, properly conducted, is difficult. One reason that it is challenging has to do with the nature of the clients; an addicted population poses unique problems for the group therapy leader. A second reason is the complexity of group therapy; the leader requires a vast amount of specialized knowledge and skills, including a clear understanding of group process and the stages of development of group dynamics. Such mastery only comes with extended training and experience leading groups.

Many groups led by untrained or poorly trained leaders have not fulfilled their potential and may even have had negative effects on a client's recovery. It matters little whether the inadequately trained group therapist is a person who once abused substances or someone who developed knowledge in a traditional course of academically based training. Where problems exist, they usually relate to one of two deficiencies: a lack of effective group therapy training or use of a group therapy model that is inadequate for clients who are chemically dependent. Additional training and education is needed to produce therapists who are well qualified to lead therapy groups composed primarily of individuals who are chemically dependent.

A second major improvement needed if people who have addictions are to benefit from group therapy is a clear answer to the question, "Why is group therapy so effective for people with addictions?" We already have part of the answer, and it lies in the individual with addiction, a person whose character style often involves a defensive posture commonly referred to as denial. Addiction is, in fact, frequently referred to as a disease of denial.

> Groups instill hope, a sense that "If he can make it, so can I."

The individual who is chemically dependent usually comes into treatment with an uncommonly complex set of defenses and character pathology. Any group leader who intends to help people who have addictions benefit from treatment should have a clear understanding of each group member's defensive process and character dynamics. More than 20 years ago, John Wallace (1978) wrote about this important issue in an informative essay on the defensive style of the individual who is addicted to alcohol. He referred to these character-related defensive features as the preferred defense system of the individual addicted to alcohol.

A third major modification needed is the adaptation of the group therapy model to the treatment of substance abuse. The principles of group therapy need to be tailored to meet the realities of treating clients with substance use disorders.

For the most part, group therapy has been based on a model derived from outpatient therapy for clients whose problems may or may not include substance abuse. The theoretical underpinnings and practical applications of general group therapy are not always applicable to individuals who abuse substances.

Substance abuse treatment sometimes is implemented as a grab bag of strategies, approaches, and techniques that were not tailored for people with substance use disorders. Further, the common characteristics and typical dynamics seen in this population have not always been evaluated adequately, and this lapse has inhibited the development of effective methods of treatment for these clients.

This model suitability problem is further complicated by the fact that clients with substance use disorders, and even staff members, often become confused about the different types of group treatment modalities. For instance, in the course of their treatment, clients may engage in AA, Narcotics Anonymous, other 12-Step groups, discussion groups, educational groups, continuing care groups, and support groups. Given this mix, clients often become confused about the purpose of group therapy, and the treatment staff sometimes underestimates the impact that group therapy can make on an individual's recovery.

> This TIP will help counselors expand their awareness and comprehension of dynamics occurring in their treatment groups.

The upshot of these problems has been partial or complete failure; that is, the techniques and strategies that usually work with the general psychiatric population often do not work with people abusing substances.

A further negative result is that the clients who have addictions may be unfairly viewed as poor treatment risks—people resistant to treatment and unmotivated to change.

Time also is an important factor in a person's recovery. What a group leader does in group therapy with clients in an inpatient setting in a hospital during the first few days or weeks of recovery will differ dramatically from what that same group therapist will do with the same recovering person in a continuing care group 6 months into abstinence with the expectation that the person will remain in the group at least another 6 to 12 months.

Approach of This TIP

While this TIP does not provide the training needed to become an interpersonal process group therapist, the point of view, attitudes, and considerations of these group therapists infuse the discussions throughout this TIP. The panel hopes that this TIP will help counselors expand their awareness and comprehension of dynamics that might be going on in their current substance abuse treatment groups. These insights will help counselors become better prepared to manage their groups and their individual members, inform group members' individual therapists of possible issues that need resolution, record dynamics and issues for use in treatment during later stages of recovery, and improve retention by appropriately acknowledging issues that are outside the scope of the group. The TIP will achieve its purpose to the extent that it assists counselors as they juggle immediate client needs, interactions in groups, tasks leading to recovery, and sheer human complexity.

2 Types of Groups Commonly Used in Substance Abuse Treatment

In This Chapter…

Five Group Models

Psychoeducational Groups

Skills Development Groups

Cognitive–Behavioral Groups

Support Groups

Interpersonal Process Group Psychotherapy

Specialized Groups in Substance Abuse Treatment

Relapse Prevention

Communal and Culturally Specific Groups

Expressive Groups

Groups Focused on Specific Problems

Overview

This chapter presents five models of groups used in substance abuse treatment, followed by three representative types of groups that do not fit neatly into categories, but that, nonetheless, have special significance in substance abuse treatment. Finally, groups that vary according to specific types of problems are considered. The purpose of the group, its principal characteristics, necessary leadership skills and styles, and typical techniques for these groups are described.

Introduction

Substance abuse treatment professionals employ a variety of group treatment models to meet client needs during the multiphase process of recovery. A combination of group goals and methodology is the primary way to define the types of groups used. This TIP describes five group therapy models that are effective for substance abuse treatment:

- Psychoeducational groups
- Skills development groups
- Cognitive–behavioral/problemsolving groups
- Support groups
- Interpersonal process groups

Each of the models has something unique to offer to certain populations; and in the hands of a skilled leader, each can provide powerful therapeutic experiences for group members. A model, however, has to be matched with the needs of the particular population being treated; the goals of a particular group's treatment also are an important determinant of the model that is chosen.

This chapter describes the group's purpose, principal characteristics, leadership requisites, and appropriate techniques for each type of group. Also discussed are three specialized types of groups that do not fit

into the five model categories, but that function as unique entities in the substance abuse treatment field:

- Relapse prevention treatment groups
- Communal and culturally specific treatment groups
- Expressive groups (including art therapy, dance, psychodrama)

Figure 2-1 lists some groups commonly used in substance abuse treatment and classifies them into the five-model framework used in this TIP. This list of groups is by no means exhaustive, but it demonstrates the variety of groups found in substance abuse treatment settings.

Occasionally, discussions in this TIP refer to the stages of change delineated by Prochaska and DiClemente (1984). They examined 18 psychological and behavioral theories of how change occurs, including the components of a biopsychosocial framework for understanding substance abuse. Their result was a continuum of six categories for understanding client motivation for changing substance abuse behavior. The six stages are:

- *Precontemplation.* Clients are not thinking about changing substance abuse behavior and may not consider their substance abuse to be a problem.
- *Contemplation.* Clients still use substances, but they begin to think about cutting back or quitting substance use.
- *Preparation.* Clients still use substances, but intend to stop since they have recognized the advantages of quitting and the undesirable consequences of continued use. Planning for change begins.
- *Action.* Clients choose a strategy for discontinuing substance use and begin to make the changes needed to carry out their plan. This period generally lasts 3–6 months.
- *Maintenance.* Clients work to sustain abstinence and evade relapse. From this stage, some clients may exit substance use permanently.
- *Recurrence.* Many clients will relapse and return to an earlier stage, but they may move quickly through the stages of change and may have gained new insights into problems that defeated their former attempts to quit substance abuse (such as unrealistic goals or frequenting places that trigger relapse).

For a detailed description of the stages of change, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] 1999*b*).

The client's stage of change will dictate which group models and methods are appropriate at a particular time. If the group is composed of members in the action stage who have clearly identified themselves as substance dependent, the group will be conducted far differently from one composed of people who are in the precontemplative stage. Priorities change with time and experience, too. For example, a group of people with substance use disorders on their second day of abstinence is very different from a group with 1 or 2 years of sobriety.

Theoretical orientations also have a strong impact on the tasks the group is trying to accomplish, what the group leader observes and responds to in a group, and the types of interventions that the group leader will initiate. Before a group model is applied in treatment, the group leader and the treating institution should decide on the theoretical frameworks to be used, because each group model requires different actions on the part of the group leader. Since most treatment programs offer a variety of groups for substance abuse treatment, it is important that these models be consistent with clearly defined theoretical approaches.

In practice, however, groups can, and usually do, use more than one model, as shown in Figure 2-1. For example, a therapy group in an intensive early recovery treatment setting might combine elements of psychoeducation (to show how drugs have ravaged the individual's life), skills development (to help the client maintain abstinence), and support (to teach individuals how to relate to other group members in an honest and open fashion). Therefore, the

Figure 2-1

Groups Used in Substance Abuse Treatment and Their Relation to Six Group Models

Group Types æ	Group Model or Combination of Models					
	Skills Develop-ment	Cognitive–Behavioral Therapy	Inter-personal Process	Support	Specialized Group*	Psycho-educa-tional
Anger/feelings management	•	•				•
Co-occurring disorders	•			•		
Skills-building	•	•				
Conflict resolution	•	•				•
Relapse prevention	•	•		•		•
12-Step psychoeducational					•	•
Psychoeducational						•
Trauma (abuse, violence)			•	•		•
Early recovery	•	•		•		•
Substance abuse education						•
Spirituality-based				•		
Cultural					•	•
Psychodynamic			•	•		
Ceremonial healing practices					•	
Support				•		
Family roles (psychoeducational)						•
Expressive therapy					•	
Relaxation training	•					
Meditation	•					
Multiple-family	•			•		•
Gender specific				•	•	
Life skills training	•	•				
Health and wellness						•
Cognitive–behavioral	•	•		•		
Psychodrama					•	
Adventure-based					•	
Marathon					•	
Humanistic/existential			•	•		

Source: Consensus Panel. *See "Specialized Groups in Substance Abuse Treatment" on p. 29.

descriptions of the groups in this chapter are of ideal, pure forms that rarely stand alone in practice. It must be acknowledged, too, that the terms used to describe groups are not altogether clear-cut and consistent. In different treatment settings, programs, and regions of the country, a term like "support group" may be used to refer to different types of treatment groups, including a relapse prevention group.

Despite such discrepancies between neat theory and untidy practice, little difficulty will arise if the group leader exercises sound clinical judgment regarding models and interventions to be used. One exception to this assurance, however, should be noted. Close adherence to the theory that dictates the way an interpersonal process group should be conducted has crucial implications for its success.

Five Group Models

Figure 2-2 summarizes the characteristics of five therapeutic group models used in substance abuse treatment. Variable factors include the focus of group attention, specificity of the group agenda, heterogeneity or homogeneity of group members, open-ended or determinate duration of treatment, level of facilitator or leader activity, training required for the group leader, length of sessions, and preferred arrangement of the room.

Psychoeducational Groups

Psychoeducational groups are designed to educate clients about substance abuse, and related behaviors and consequences. This type of group presents structured, group-specific content, often taught using videotapes, audiocassette, or lectures. Frequently, an experienced group leader will facilitate discussions of the material (Galanter et al. 1998). Psychoeducational groups provide information designed to have a direct application to clients' lives—to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf, such as entering a treatment program. While psychoeducational groups may inform clients about psychological issues, they do not aim at intrapsychic change, though such individual changes in thinking and feeling often do occur.

Purpose. The major purpose of psychoeducational groups is expansion of awareness about the behavioral, medical, and psychological consequences of substance abuse. Another prime goal is to motivate the client to enter the recovery-ready stage (Martin et al. 1996; Pfeiffer et al. 1991). Psychoeducational groups are provided to help clients incorporate information that will help them establish and maintain abstinence and guide them to more productive choices in their lives.

These groups also can be used to counteract clients' denial about their substance abuse, increase their sense of commitment to continued treatment, effect changes in maladaptive behaviors (such as associating with people who actively use drugs), and supporting behaviors conducive to recovery. Additionally, they are useful in helping families understand substance abuse, its treatment, and resources available for the recovery process of family members.

Some of the contexts in which psychoeducational groups may be most useful are

- Helping clients in the precontemplative or contemplative level of change to reframe the impact of drug use on their lives, develop an internal need to seek help, and discover avenues for change.
- Helping clients in early recovery learn more about their disorders, recognize roadblocks to recovery, and deepen understanding of the path they will follow toward recovery.
- Helping families understand the behavior of a person with substance use disorder in a way that allows them to support the individual in recovery and learn about their own needs for change.
- Helping clients learn about other resources that can be helpful in recovery, such as

Figure 2-2

Characteristics of Five Group Models Used in Substance Abuse Treatment

Group model	Group/ leader focus	Specificity of the group agenda	Heterogeneous or homogeneous	Open-ended/ determinate	Level of facilitator activity
Psycho-educational	Leader focused	Specific	Either	Either	High
Skills development	Leader focused	Specific	Either	Either (depending on topic)	High
Cognitive–behavioral	Mixed/ balanced	Either	Either	Either	High
Support	Group focus	Nonspecific	Either	Open	Low to moderate
Interpersonal process	Group focus	Nonspecific	Heterogeneous	Open	Low to moderate
Group model	**Level of facilitator activity**	**Duration of treatment**	**Length of session**	**Space and arrangement**	**Leader training**
Psycho-educational	High	Limited by program requirements	15 to 90 minutes	Horseshoe or circle	Basic
Skills development	High	Variable	45 to 90 minutes	Horseshoe or circle	Basic with some specialized training
Cognitive–behavioral	High	Variable and open-ended	60 to 90 minutes	Circle	Specialized training
Support	Low to moderate	Open-ended	45 to 90 minutes	Circle	Specialized training with process-oriented skills
Interpersonal Process	Low to moderate	Open-ended	1 to 2 hours	Circle	Specialized training in interpersonal process groups

meditation, relaxation training, anger management, spiritual development, and nutrition.

Principal characteristics. Psychoeducational groups generally teach clients that they need to learn to identify, avoid, and eventually master the specific internal states and external circumstances associated with substance abuse. The coping skills (such as anger management or the use of "I" statements) normally taught in a skills development group often accompany this learning.

Psychoeducational groups are considered a useful and necessary, but not sufficient, component of most treatment programs. For instance, psychoeducation might move clients

in a precontemplative or perhaps contemplative stage to commit to treatment, including other forms of group therapy. For clients who enter treatment through a psychoeducational group, programs should have clear guidelines about when members of the group are ready for other types of group treatment.

Psychoeducational groups are highly structured and often follow a manual or a preplanned curriculum.

Often, a psychoeducational group integrates skills development into its program. As part of a larger program, psychoeducational groups have been used to help clients reflect on their own behavior, learn new ways to confront problems, and increase their self-esteem (La Salvia 1993).

Psychoeducational groups should work actively to engage participants in the group discussion and prompt them to relate what they are learning to their own substance abuse. To ignore group process issues will reduce the effectiveness of the psychoeducational component.

Psychoeducational groups are highly structured and often follow a manual or a preplanned curriculum. Group sessions generally are limited to set times, but need not be strictly limited. The instructor usually takes a very active role when leading the discussion. Even though psychoeducational groups have a format different from that of many of the other types of groups, they nevertheless should meet in a quiet and private place and take into account the same structural issues (for instance, seating arrangements) that matter in other groups.

As with any type of group, accommodations may need to be made for certain populations. Clients with cognitive disabilities, for example, may need special considerations. Psychoeducational groups also have been shown to be effective with clients with co-occurring mental disorders, including clients with schizophrenia (Addington and el-Guebaly 1998; Levy 1997; Pollack and Stuebben 1998). For more information on making accommodations for clients with disabilities, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*b*).

Leadership skills and styles. Leaders in psychoeducational groups primarily assume the roles of educator and facilitator. Still, they need to have the same core characteristics as other group therapy leaders: caring, warmth, genuineness, and positive regard for others.

Leaders also should possess knowledge and skills in three primary areas. First, they should understand basic group process—how people interact within a group. Subsets of this knowledge include how groups form and develop, how group dynamics influence an individual's behavior in group, and how a leader affects group functioning. Second, leaders should understand interpersonal relationship dynamics, including how people relate to one another in group settings, how one individual can influence the behavior of others in group and some basic understanding of how to handle problematic behaviors in group (such as being withdrawn). Finally, psychoeducational group leaders need to have basic teaching skills. Such skills include organizing the content to be taught, planning for participant involvement in the learning process, and delivering information in a culturally relevant and meaningful way.

To help clients get the most out of psychoeducational sessions, leaders need basic counseling skills (such as active listening, clarifying, supporting, reflecting, attending) and a few advanced ones (such as confronting and terminating) (Brown 1998). It also helps to have leadership skills, such as helping the group get started in a session, managing (though not necessarily eliminating) conflict between group members, encouraging withdrawn group members to be more active, and making sure that

all group members have a chance to participate. As the group unfolds, it is important that group leaders are nondogmatic in their dealings with group members. Finally, the group leader should have a firm grasp of material being communicated in the psychoeducational group.

During a session, the group leader should be mindful both of the group's need and the specific needs of each member. The group leader will need to understand group member roles and how to manage problem clients. Except in unusual circumstances, efforts should be made to increase members' comfort and to reduce anxiety in the group. Leaders will use a variety of resources to impart knowledge to the group, so each session also requires preparation and familiarization with the content to be delivered.

Group leaders should have ongoing training and formal supervision. Supervision benefits all group leaders of all levels of skill and training, as it helps to assure them that people in positions of authority are interested in their development and in their work. If direct supervision is not possible (as may be the case in remote, rural areas), then Internet discussions or regular telephone contact should be used.

Techniques. Techniques to conduct psychoeducational groups are concerned with (1) how information is presented, and (2) how to assist clients to incorporate learning so that it leads to productive behavior, improved thinking, and emotional change. Adults in the midst of crises in their lives are much more likely to learn through interaction and active exploration than they are through passive listening. As a result, it is the responsibility of the group leader to design learning experiences that actively engage the participants in the learning process. Four elements of active learning can help.

First, the leader should foster an environment that supports active participation in the group and discourages passive note taking. Accordingly, leader lecturing should be limited in duration and extent. The leader should concentrate instead on facilitating group discussion, especially among clients who are withdrawn and have little to say. They need support and understanding of the content before expressing their views. Techniques such as role playing, group problemsolving exercises, and structured experiences all foster active learning.

Second, the leader should encourage group participants to take responsibility for their learning rather than passing on that responsibility to the group leader. From the outset of the group, the leader can emphasize group self-ownership by allowing members to participate in setting agreements and other group boundaries. The leader can emphasize member responsibility for honest, respectful interaction among all members and can de-emphasize the leader role in determining group life.

Third, because many people have pronounced preferences for learning through a particular sense (hearing, sight, touch/movement), it is essential to use a variety of learning methods that call for different kinds of sensory experience. Excellent material on adapting instruction to learning styles is available through the Association for Supervision and Curriculum Development Web site. To access the many articles and book chapters, enter "learning styles" into the search function and click the "Go" button.

Most people, at one time or another, have had unpleasant experiences in traditional, formal classroom environments. The resulting shame, rejection, and self-deprecation strongly motivate people to avoid situations where these experiences might be brought back into awareness. Therefore it is critically important for the group leader to be sensitive to the anxiety that can be aroused if the client is placed in an environment that replicates a disturbing scene from the past. To allay some of these concerns, leaders can acknowledge the anxieties of participants, prevent all group participants from mocking others' comments or ideas, and show sensitivity to the meaning of a participant's withdrawal in the group. Overall, leaders should create an environment where participants who are having difficulty with the psychoeducational group process can express their concerns and receive support.

Fourth, people with alcoholism and other addictive disorders are known to have subtle, neuropsychological impairments in the early stage of abstinence. Verbal skills learned long ago (that is, crystallized intelligence) are not affected, but fluid intelligence, needed to learn some kinds of new information, is impaired. As a result, clients may seem more able to learn than they actually are. Therapists who are teaching new skills should be mindful of this difficulty.

Skills Development Groups

Most skills development groups operate from a cognitive–behavioral orientation, although counselors and therapists from a variety of orientations apply skills development techniques in their practice. Many skills development groups incorporate psychoeducational elements into the group process, though skills development may remain the primary goal of the group.

Purpose. Coping skills training groups (the most common type of skills development group) attempt to cultivate the skills people need to achieve and maintain abstinence. These skills may either be directly related to substance use (such as ways to refuse offers of drugs, avoid triggers for use, or cope with urges to use) or may apply to broader areas relevant to a client's continued sobriety (such as ways to manage anger, solve problems, or relax).

Skills development groups typically emerge from a cognitive–behavioral theoretical approach that assumes that people with substance use disorders lack needed life skills. Clients who rely on substances of abuse as a method of coping with the world may never have learned important skills that others have, or they may have lost these abilities as the result of their substance abuse. Thus, the capacity to build new skills or relearn old ones is essential for recovery.

Since many of the skills that people with substance abuse problems need to develop are interpersonal in nature, group therapy becomes a natural treatment of choice for skills development. Members can practice with each other, see how different people use the same skills, and feel the positive reinforcement of a peer group (rather than that of a single professional) when they use skills effectively.

Principal characteristics. Because of the degree of individual variation in client needs, the particular skills taught to a client should depend on an assessment that takes into account individual characteristics, abilities, and background. The suitability of a client for a skills development group will depend on the unique needs of the individual along with the skills being taught. Most clients can benefit from developing or enhancing certain general skills, such as controlling powerful emotions or improving refusal skills when around people using alcohol or illicit drugs. Skills might also be highly specific to certain clients, such as relaxation training.

Skills development groups usually run for a limited number of sessions. The size of the group needs to be limited, with an ideal range of 8 to 10 participants (perhaps more, if a cofacilitator is present). The group has to be small enough for members to practice the skills being taught.

While skills development groups often incorporate elements of psychoeducation and support, the primary goal is on building or strengthening behavioral or cognitive resources to cope better in the environment. Psychoeducational groups tend to focus on developing an information base on which decisions can be made and action taken. Support groups, to be discussed later in this chapter, focus on providing the internal and environmental supports to sustain change. All are appropriate in substance abuse treatment. While a specific group may incorporate elements of two or more of these models, it is important to maintain focus on the overall goal of the group and link methodology to that goal.

Leadership skills and styles. In skills development groups, as in psychoeducation, leaders need basic group therapy knowledge and skills, such as understanding the ways that groups

grow and evolve, knowledge of the patterns that show how people relate to one another in group, skills in fostering interaction among members, managing conflict that inevitably arises among members in a group environment, and helping clients take ownership for the group.

In addition, group leaders should know and be able to demonstrate the set of skills that the participants are trying to develop. Leaders also will need significant experience in modeling behavior and helping others learn discrete elements of behavior. Other general skills, such as sensitivity to what is going on in the room and cultural sensitivity to differences in the ways people approach issues like anger or assertiveness, also will be important. Depending on the skill being taught, there may be certain educational or certification requirements. For example, a nurse might be needed to teach specific health maintenance skills, or a trained facilitator may be needed to run certain meditation or relaxation groups.

Techniques. The specific techniques used in a skills development group will vary greatly depending on the skills being taught. (For more information on the techniques used in cognitive–behavioral coping skills training see chapter 4 of TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse Treatment* [CSAT 1999*a*].)

It is useful to keep in mind that most skills, such as riding a bicycle or swimming, seem relatively simple, straightforward, and easy once incorporated into one's repertoire of behavior. The process of learning and incorporating new skills, however, may be difficult, especially if the previous approach has been used for a long time. For instance, individuals who have been passive and nonassertive throughout life may have to struggle mightily to learn to stand up for themselves. As a consequence, it is crucial for leaders of skills development groups to be sensitive to the struggles of group participants, hold positive expectations for change, and not demean or shame individuals who seem overwhelmed by the task.

Skills development groups typically emerge from a cognitive–behavioral approach.

Furthermore, many behavioral changes that seem straightforward on the surface have powerful effects at deeper levels of psychological functioning. For instance, assertiveness may touch feelings of shame and unworthiness. Thus, new assertive competence may be incompatible with and overwhelmed by deep feelings of inadequacy and low self-esteem. As a result, a client may learn a new behavior, but be unable to incorporate it into a repertoire of positive action. Counselors should not automatically assume, therefore, that a newly learned skill inevitably will translate into action. Feedback from participants on their progress since the last group is a good way to assess both learning and the incorporation of skills.

An often unstated and underrecognized difficulty in leading skills groups is that a leader teaching the same material week after week can become bored with the content. In due course, the boredom will creep into the teaching. To retain energy and teaching effectiveness, leaders can switch topics, or one leader can teach different topics over time. When feasible, it also may help to provide feedback to leaders by making video or audio recordings of their presentations.

Other specific techniques for skills development groups depend on the nature of the group, topic, and approach of the group leader. Before undertaking leadership of a skills development group, it is wise for the leader to have previously participated in the specific kind of skills development group to be led. Often special training programs are available for leaders of these kinds of groups.

Cognitive–Behavioral Groups

Cognitive–behavioral groups are a well-established part of the substance abuse treatment field and are particularly appropriate in early recovery. The term "cognitive–behavioral therapy group" covers a wide range of formats informed by a variety of theoretical frameworks, but the common thread is cognitive restructuring as the basic methodology of change.

Purpose. Cognitive–behavioral groups conceptualize dependency as a learned behavior that is subject to modification through various interventions, including identification of conditioned stimuli associated with specific addictive behaviors, avoidance of such stimuli, development of enhanced contingency management strategies, and response-desensitization (McAuliffe and Ch'ien 1986). The etiologies of dependency include neurobehavioral factors (Rawson et al. 1990), biopsychosocial (Nunes-Dinis and Barth 1993; Wallace 1990), and the disease model (Miller and Chappel 1991), in which the key etiological determinants of dependency are genetic and physiological factors, ones that the person with dependency cannot control.

Cognitive–behavioral therapy groups work to change learned behavior by changing thinking patterns, beliefs, and perceptions. The groups also work to develop social networks that support continued abstinence so the person with dependency becomes aware of behaviors that may lead to relapse and develops strategies to continue in recovery (Matano et al. 1997).

> Cognitive–behavioral groups are particularly appropriate in early recovery.

Cognitive processes include a number of different psychological elements, such as thoughts, beliefs, decisions, opinions, and assumptions. A number of thoughts and beliefs are affected by an individual's substance abuse and addiction. Some common errant beliefs of individuals entering recovery are

- "I'm a failure."
- "I'm different."
- "I'm not strong enough to quit."
- "I'm unlovable."
- "I'm a (morally) bad person." The word "morally" carries the implication of a "shame script" and feeling defective as a person. "Bad" alone refers more to behavior, or doing "bad things."

Changing such cognitions and beliefs may lead to greater opportunities to maintain sobriety and live more productively.

Principal characteristics. In cognitive–behavioral groups for people who abuse substances, the group leader focuses on providing a structured environment within which group members can examine the behaviors, thoughts, and beliefs that lead to their maladaptive behavior. Treatment manuals—providing specific protocols for intervention techniques—may be helpful in some, though not all, cognitive–behavioral groups. In any case, most cognitive–behavioral groups emphasize structure, goal orientation, and a focus on immediate problems. Problem solving groups often have a specific protocol that systematically builds problemsolving skills and resources.

One example is a model cognitive–behavioral group for women with posttraumatic stress disorder (PTSD) and substance abuse designed to

- Educate clients about the two disorders
- Promote self-control skills to manage overwhelming emotions
- Teach functional behaviors that may have deteriorated as a result of the disorders
- Provide relapse prevention training (Najavits et al. 1996)

The group format is an important element of the model, given the importance of social support for PTSD and substance use disorders. In addition, group treatment is a well-established, relatively low-cost modality, so it can successfully reach a large number of clients. Some key characteristics of this program are that it

- Uses a model designed for 24 sessions, in which 3–10 members meeting twice each week for 3 months in 90-minute group meetings
- Is early-recovery–oriented, with a strong focus on coping skills to gain control over symptoms
- Has homogeneous membership (for example, all women)
- Includes a six-session unit on relationships and themes, such as Safety and Self-protection and Reaching Out for Help
- Uses educational devices to promote rapid and sustained learning of material, such as visual aids, role preparation, memory improvement techniques, written summaries, review sessions, homework, and audiotapes of each session
- Focuses on both disorders, with instruction on stages of recovery to motivate members to achieve abstinence and control over PTSD symptoms (Najavits et al. 1996)

Another cognitive–behavioral model was employed to reduce the anger that can trigger renewed use of cocaine among 59 men and 32 women diagnosed with cocaine dependence. The model assumed that angry responses are learned behavior that can be changed. Clients in the pilot program were taught to gauge their anger levels and to use anger management strategies like time-outs and conflict resolution. During the 12 weeks of treatment, participants were able to reduce and control their anger more effectively than they had in the past, and these gains held at the follow-up 3 months after treatment. Violent behavior also decreased significantly (Reilly and Shopshire 2000).

Leadership skills and styles. Cognitive–behavioral therapies encompass a variety of methodological approaches, all focused on changing cognition (beliefs, judgments, and perceptions) and the behavior that flows from it. Some approaches focus more on behavior, others on core beliefs, still others on developing problem-solving capabilities. Regardless of the particular focus, the group therapist conducting cognitive–behavioral groups should have a solid grounding in the broader theory of cognitive–behavioral therapy. This basis is the framework from which specific interventions can be drawn and implemented. Training in cognitive–behavioral theory is available in many workshops on counseling skills and in many alcohol and drug training programs for counselors. For instance, over a 2-week period in 2002, the Rutgers Summer Schools of Alcohol and Drug Studies offered seven week-long courses that concentrated specifically on cognitive counseling theory and methods. Many books are available on the theory of cognitive–behavioral therapy (Beck 1976; Ellis and MacLaren 1998; Glasser 2000; Leahy 1996) as well as self-help manuals with a cognitive–behavioral focus (Burns 1999; Greenberger and Padesky 1995). See chapter 7 for more information about training sources.

The level of interaction by the therapist in cognitive–behavioral groups can vary from very directive and active to relatively nondirective and inactive. It also can vary from highly confrontational with group members to relatively nonconfrontational demeanor. Perhaps the most common leadership style in cognitive–behavioral groups is active engagement and a consistently directive orientation.

A cautionary note: In cognitive–behavioral groups, the leader may be tempted to become the expert in how to think, how to express that thinking behaviorally, and how to solve problems. It is important not to yield to such a temptation, but instead to allow group members to use the power of the group to develop their own capabilities in these areas.

Techniques. Specific techniques may vary based on the particular orientation of the leader, but in general, techniques include those which (1) teach group members about self-

destructive behavior and thinking that leads to maladaptive behavior, (2) focus on problem-solving and short- and long-term goal setting, and (3) help clients monitor feelings and behavior, particularly those associated with drug use. More experienced leaders will have a wider range of specific techniques to engage participants and more comfort with a wider range of client needs and expectations.

An important element of conducting cognitive–behavioral groups is recognizing that behavioral change and intellectual insight gained in the group can be provocative and upsetting for clients with a poor sense of self, low self-esteem, and fear of emotional and interpersonal inadequacy. As a result, resistance to change inevitably will occur as the group evolves and behavioral changes begin to become routine. Experienced leaders learn to recognize, respect, and work with the resistance instead of simply confronting it. Clinical supervision is quite beneficial in learning a variety of styles of working with resistance generated by growth and change.

Many specific approaches to cognitive–behavioral therapy, including rational emotive therapy (Ellis 1997), reality therapy (Glasser 1965) and the work of Aaron Beck and colleagues (1993), incorporate various techniques specific to each approach. Substance abuse treatment counselors may find it useful to explore these approaches for techniques appropriate to their specific client populations.

Support Groups

The widespread use of support groups in the substance abuse treatment field originated in the self-help tradition in the field. These groups also have roots in the realization that significant lifestyle change is the long-term goal in treatment and that support groups can play a major role in such life transitions. Self-help groups share many of the tenets of support groups—unconditional acceptance, inward reflection, open and honest interpersonal interaction, and commitment to change. These groups attempt to help people with dependencies sustain abstinence without necessarily understanding the determinants of their dependence (Cooper 1987).

The focus of support groups can range from strong leader-directed, problem-focused groups in early recovery, which focus on achieving abstinence and managing day-to-day living, to group-directed, emotionally and interpersonally focused groups in middle and later stages of recovery.

Purpose. Support groups bolster members' efforts to develop and strengthen the ability to manage their thinking and emotions and to develop better interpersonal skills as they recover from substance abuse. Support group members also help each other with pragmatic concerns, such as maintaining abstinence and managing day-to-day living. These groups are also used to improve members' general self-esteem and self-confidence. The group—or more often, the group leader—provides specific kinds of support, such as being sure to help clients avoid isolation and finding something positive to say about each participant's contribution. In some programs, support groups might be considered process (therapy) groups, but the main interest of support groups is not in the intrapsychic world, and the goal is not character change. Process issues may be involved, but support groups are less complex, more direct, and narrower in focus than process groups.

Principal characteristics. Many people with substance use disorders avoid treatment because the treatment itself threatens to increase their anxiety. Because of support groups' emphasis on emotional sustenance providing a safe environment, these groups are especially useful for apprehensive clients, indeed, for any client new to abstinence. The adjective "support" itself may be a way of destigmatizing the activity. For this reason, a "support" group may be more attractive to someone less committed to recovery than a "therapy" group.

Not all support groups, however, are intended just for clients new to recovery. Support groups

can be found for all stages of treatment in all sorts of settings (inpatient, outpatient, continuing care, etc.). While a support group always will have a clearly stated purpose, the purpose varies according to its members' motivation and stage of recovery. Many of these groups are open-ended, with a changing population of members. As new clients move into a particular stage of recovery, they may join a support group appropriate for that stage until they are ready to move on again. Groups may continue indefinitely, with new members coming in and old members leaving, and occasionally, returning. Program differences will also alter how this type of group is used. A support group will be different in a 4- to 6-week daily treatment program from the way it is used in a 1-year treatment community.

In a support group, members typically talk about their current situation and recent problems that have arisen. Discussion usually focuses on the practical matters of staying abstinent; for example, ways to deal with legal issues or avoid places that tempt people to use substances. Group members are encouraged to share and discuss their common experiences.

Issues that do not specifically relate to the focus of the group are often considered extraneous, so discussion of them is limited. Support groups provide guidance through peer feedback, and group members generally require accountability from each other. The group leader, however, will try to minimize confrontation within the group so as to keep anxiety levels low. In cohesive, highly functioning support groups, member-to-member or leader-to-member confrontation does occur.

Support groups can work from a variety of theoretical positions. Many reflect the 12-Step tradition in the substance abuse field, but other recovery tools, such as relapse prevention, can form the basis of a support group. Some support groups are based on theoretical frameworks such as cognitive therapies or spiritual paths. Programs may even design a support group by combining theories or philosophies.

Leadership skills and styles. Some support groups may be peer-generated or peer-led, but this TIP is mainly concerned with groups led by a trained, professional group leader. Support group leaders need a solid grounding in how groups grow and evolve and the ways in which people interact and change in groups. It is also critical that group leaders have a theoretical framework for counseling (such as cognitive–behavioral therapy) that informs their approach to support group development, the therapeutic goals for group members, the guidance of group members' interactions, and the leader's implementation of specific intervention methods.

> In a support group, members typically talk about their current situation and problems that have recently arisen.

Since the leader should help build connections between members and emphasize what they have in common, it is useful for the leader to have participated in a support group and to have been supervised in support group work before undertaking leadership of such a group. Training and supervision focused on how individuals develop psychologically, typical psychological conflicts, and the way these conflicts may appear in group therapy settings also may help the support group leader function more effectively, since such considerations help the leader understand individual members' behavior in the group.

The leadership style for someone running a support group typically will be less directive than for psychoeducational, skills development, or cognitive–behavioral groups because the support group is generally group-focused rather than leader-focused. The leader's primary role is to facilitate group discussion, helping group members share their experiences, grapple with their problems, and overcome difficult challenges. The group leader also provides positive reinforcement for group mem-

bers, models appropriate interactions between individuals in the group, respects individual and group boundaries, and fosters open and honest communication in the group setting. In a most general way, the leader is active but not directive.

Techniques. The techniques of leading support groups vary with group goals and member needs. In general, leaders need to actively facilitate discussion among members, maintain appropriate group boundaries, help the group work though obstacles and conflicts, and provide acceptance of and regard for members. In a support group, the leader exercises the role of modeler of appropriate behaviors. In this way, the leader helps members grow and change.

Specific group techniques may appear to be less important for the leader of a support group, since the leader is usually less active in group direction and leadership. The techniques used in support groups, however, are simply less obvious.

Interventions, for example, are likely to be more interpretive and observational and less directive than in many other groups. The observations are generally limited to support for the progress of the group and facilitating supportive interaction among group members. The goal is not to provide insight to group members, but to facilitate the evolution of support within the group.

> Process-oriented group therapy uses the process of the group as the primary change mechanism.

The support group leader is also responsible for monitoring each individual's progress in group and ensuring that individuals are participating (in their own way) and benefiting from the group experience. Understanding some of the history of each person in the group, the leader also watches to see whether the group is providing each individual with emotional and interpersonal experiences that build success and skills that apply to life arenas outside the group. In addition to monitoring individuals in the group, the leader also monitors the progress of the group as a whole, making sure that group development proceeds through its predictable stages and does not become blocked at any stage of its evolution.

Finally the leader is responsible for recognizing interpersonal blocks or struggles between group members. It is not necessarily the responsibility of the leader to resolve these blocks, or even to point them out to group members, but to ensure that such struggles do not hinder the development of the group or any member of the group.

Interpersonal Process Group Psychotherapy

The interpersonal process group model for substance abuse treatment is grounded in an extensive body of theory (Brown 1985; Brown and Yalom 1977; Flores 1988; Flores and Mahon 1993; Khantzian et al. 1990; Matano and Yalom 1991; Vannicelli 1992; Washton 1992). Even this sharply defined area of process-oriented group therapies is widely diverse. Psychodynamic group therapies can be thought of as a generic name encompassing several ways of looking at the dynamics that take place in groups. Originally, these dynamics were considered in Freudian psychoanalytic terms that placed a heavy emphasis on sexual and aggressive drives, and conflicts and attachments between parents and children. Over the past half century many researchers, such as Jung, Adler, Bion, Noreno, Rogers, Perls, Yalom, and others, expanded or changed the Freudian emphasis. As a result, current dynamic conceptualizations include heavy emphasis on the social nature of human attachment, rivalry and social hierarchies, and cultural and spiritual concerns (i.e., existential issues and questions

of faith). This therapeutic approach focuses on healing by changing basic intrapsychic (within a person) or interpersonal (between people) psychological dynamics.

Thus, a student of process-oriented group therapy, a group treatment approach that uses the process of the group as the primary change mechanism, soon learns that the way Bion (1961) taught group therapy will be far different from the way other recognized authorities, such as Wolf and Schwartz (1962), taught. These theorists in turn differ from the process-orientation exemplified by Durkin (1964) or Glatzer (1969). The many theoretical variants differ in what they pay most of their attention to as group members interact.

Purpose. Interpersonal process groups use psychodynamics, or knowledge of the way people function psychologically, to promote change and healing. The psychodynamic approach recognizes that conflicting forces in the mind, some of which may be outside one's awareness, determine a person's behavior, whether healthy or unhealthy. Attachment to others is one of the contending forces. From a psychodynamic point of view, starting in early childhood, developmental issues are a key concern, as are environmental influences, to which certain people are particularly vulnerable because of their genetic and other biological characteristics. For those people who have been drawn to substance abuse, the interpersonal process group raises and re-examines fundamental developmental issues. As faulty relationship patterns are perceived and identified, the group participant can begin to change dysfunctional, destructive patterns. The group member becomes increasingly able to form mutually satisfying relationships with other people, so alcohol and drugs lose much of their power and appeal.

Basic tenets of the psychodynamic approach include the following

- *Early experience affects later experience.* Individuals bring their histories—personal, cultural, psychological, and spiritual—to therapy.
- *Sometimes perceptions distort reality.* People often draw generalizations from their life experiences and apply the generalizations to the current environment, even when doing so is inappropriate or counterproductive. These "cognitive distortions" may serve to maintain habits people would otherwise like to change.
- *Psychological and cognitive processes outside awareness influence behavior.* As clients become conscious of some formerly subconscious processes supporting a behavior they want to change, this information can be used to alter dysfunctional relationships.
- *Behaviors are chosen to adapt to situations and protect people from harm.* A specific behavior is a person's best effort to adapt to a particular situation given individual make-up, environment, and personal history. In a sense, people come to therapy because of their solutions, not their problems.

Within the interpersonal process model, the objects of interest are the here-and-now interactions among members. Of less importance is what happens outside the group or in the past. All therapists using a "process-oriented group therapy" model continually monitor three dynamics:

- The psychological functioning of each group member (intrapsychic dynamics)
- The way people are relating to one another in the group setting (interpersonal dynamics)
- How the group as a whole is functioning (group-as-a-whole dynamics)

A group leader conducting an interpersonal process group, however, will tend to pay more attention to the interpersonal dynamics and concentrate less on each member's individual psychological dynamics and the workings of the group as a whole. The section that follows includes illustrations (Figures 2-3 to 2-6) of how groups might differ according to their focus on intrapsychic, interpersonal, and group-as-a-whole dynamics.

The experienced group leader knows that the intervention chosen at any moment in the group will have an impact on all three dynamics and

that a delicate balance must be struck in the attention given to each. A too-intense focus on group members' interaction, to the exclusion of attention to individual psychological needs or the needs of the group as a whole, blunts the effectiveness and relevance of group development.

Principal characteristics. Interpersonal process group therapy delves into major developmental issues, searching for patterns that contribute to addiction or interfere with recovery. The group becomes a microcosm of the way group members relate to people in their daily lives.

The Interpersonal Process Group Psychotherapy (IPGP) model links the abstinence-based treatment approach with current psychological principles of treatment, while still remaining compatible with 12-Step theory and practice. IPGP and substance abuse treatment both recognize that a person's capacity for healthy interpersonal relationships supports solid recovery from substance abuse. IPGP is easy to understand and adapt because it is

- *Pragmatic*. IPGP is a practical, nuts and bolts, hands-on type of group treatment. It focuses on results, not abstract concepts and all-encompassing theories, and its results-oriented nature is especially satisfying to a population that needs some swift, positive outcomes. This feature is especially important during the early phases of treatment, when the window of opportunity for influencing clients is small and open only briefly.
- *Applicable*. IPGP is a very adaptable model. Because it can so readily be modified, it can be applied in diverse sets of difficulties and under various circumstances. IPGP furnishes the group leader with a set of strategic tools that are easy to acquire and use. The IPGP model provides enough structure to prevent unproductive discussion. This is especially desirable because few will tolerate a passive group leader who waits for issues to evolve out of the flow of the group. On the other hand, many people who abuse substances will react negatively to a domineering or authoritarian leader. The IPGP model permits a group experience that is neither leader-dependent nor leader-centered. This generally egalitarian setting helps to reduce resistance.
- *Synergistic*. IPGP and substance abuse treatment complement each other, reciprocally setting the scene for the establishment of the crucial components of effective treatment. The combination of IPGP and substance abuse treatment allows the client to experience treatment as emotionally supportive. This sparing of the client's self-image enables the client to identify positively with treatment and mutes any strong reactions to the counselor. Further, the combination of these two treatment approaches can ease the client's handling of shame, the need to change aspects of self, the uncomfortable newness of the recovery period, and the therapeutic experience itself. Recovery can proceed as clients experience and re-experience deep attachment dynamics and use the experience to craft major changes in character and behavior.

Leadership skills and styles. In interpersonal process groups, content is a secondary concern. Instead, leaders focus on the present, noticing signs of people recreating their past in what is going on between and among members of the group. If, for example, a person has a problem with anger, this problem eventually will be re-enacted in the group. When an angry group member, "George," explodes at "Charlie," the therapist might say, "George, you seem to be having a strong response to Charlie right now. Who does Charlie remind you of? Does this feel familiar? Has anything like this happened to you before?"

On one hand, the interpersonal process group leader monitors how group members are relating, how each member is functioning psychologically or emotionally, and how the group as a whole is functioning. On the other hand, the interpersonal process group leader observes a variety of group dynamics, such as the stages of group development, how leadership is emerging in the group, the strengths each individual is

bringing to the group as a whole, and how individual resistances to change are interacting with and influencing group functioning. The interventions of the leader are dependent on his or her perceptions of this mix.

Since the group leader's theoretical persuasion, training, experience, and personality determine the level of intervention that takes priority at a particular time, it is rare to find two interpersonal process group leaders who will conduct a group in exactly the same manner. Even so, leaders in this type of group are not fonts of information, skill builders, problemsolving directors, or client boosters. In interpersonal process group therapy, the leader's job is to promote and probe interactions that carry a point.

Most group leaders who apply a process-oriented approach to group therapy with people who abuse substances recognize the theoretical influence of the Interactional Model (Yalom 1975). Yalom recommends an adaptable approach to group treatment, one that allows easily applied modifications across the continuum of the recovery needs of an individual who abuses substances. His model can be tightened (to have more structure) early in treatment and can subsequently be loosened (to relax structure) as more abstinent time passes, recovery is solidified, and the danger of relapse decreases.

Techniques. In practice, group leaders may use different models at various times, and may simultaneously influence more than one focus level at a time. For example, a group that focuses on changing the individual will also have an impact on the group's interpersonal relations and the group-as-a-whole. Groups will, however, have a general orientation that determines the focus the majority of the time. This focus is an entry point for the group leader, helping to provide direction when working with the group.

Specific techniques of the process group leader will vary, not only with the type of process group, but also with the developmental stage of the group. Early on in group development, process group leaders might consciously decide to be more or less active in the group life. They might also choose, based on the needs of the group, to make more or fewer interpretations of individual and group dynamics to the group as a whole. Likewise they might choose to show more warmth and supportiveness toward group members or take a more aloof position. For instance, in contrast to leading a support group, where the leader is likely to be unconditionally affirming, the process leader might make a conscious decision to allow clients to struggle to affirm themselves, rather than essentially doing it for them.

> In interpersonal process groups, leaders focus on the present.

Such choices should be based on the needs of group members and the needs of the group as a whole, rather than the style that is most comfortable for the group leader. Obviously such tactical decisions require a high degree of understanding and insight about group dynamics and individual behavior. For this reason, almost all leaders of process groups will seek supervision and consultation to guide them in making the best tactical decisions on behalf of the group and its members.

Three group dynamics in practice

When deciding on a model for a substance abuse treatment group, programs need to consider their resources, the training and theoretical orientation of group leaders, and the needs and desires of clients in order to determine what approaches are feasible. While it is beyond the scope of this TIP to provide detailed instruction on how to run each of the different models of groups, the following figures do illustrate the basic differences among the psychodynamic emphases. Figure 2-3 describes an argument drawn from a problem-focused

Figure 2-3

Group Vignette: Joe's Argument With His Roommate

Before the first meeting of a new problem-focused group, Joe had been arguing with his roommate because the roommate had forgotten to pay the phone bill the previous month. Joe had told his roommate, Mike, that he might remember to pay the bills on time if he were not smoking pot every day, and they began an angry discussion about the roommate's drug use. Joe tells the group that he wants to talk about his distrust of his roommate. Joe is not currently using drugs, but he is still struggling with attempts to control his drinking. Group members are generally supportive of Joe in his argument with his roommate. They express concern that he is living with someone who is actively using marijuana and other drugs. One group member, Jane, voices strong objections, however, to Joe's lack of trust for his roommate. Jane is struggling with her own abuse of prescription tranquilizers, and she is typically rather quiet and anxious in group. Nonetheless, she attacks Joe verbally with uncharacteristic vehemence.

Source: Adapted from Flores 1997.

group, which assists people in resolving a specific problem in their lives. (For additional information on this type of group, see the last section in this chapter. The reader also may refer to appendix B of TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT 1999*a*], for a list of resources that can provide further training and information about the theoretical orientations that influence these groups.)

Individually focused groups

The individually focused group concentrates on individual members of the group and their distinctive internal cognitive and emotional processes. How the client interacts in the world at large is not on the agenda. The group instead strives to modify clients' behavior. This model is used with a range of technical and theoretical approaches to group therapy, including cognitive therapy, expressive therapies, psychodrama, transactional analysis, redecision therapy, Gestalt, and reality therapy (see section below for further discussion of expressive therapies and psychodrama as well as the glossary in appendix D).

The group is conceived as an aggregate of individuals in which the group leader generally works sequentially with one group member at a time. While one individual's issues are addressed, the other group members serve as observers, contributors, alter egos, or significant others. Generally, however, more than one group member will be involved in the conversation at one time, and all group members will be encouraged to actively help each other and learn from each other's experiences. This model of group does not require a client to have insight into a problem but does require awareness of behavior and its immediate causes and consequences. Some individually oriented approaches will use group members in a structured/directive way, such as in a role-playing exercise.

In the more cognitively oriented approaches, clients will focus on their behaviors in relation to thoughts. The more expressive form of individually oriented groups is particularly bene-

ficial for clients who need a structured environment or have so much contained, powerful emotion that they need some creative way of releasing it.

Individually focused groups are useful to identify the first concrete steps in coping with substance abuse. They can help clients become more aware of behavior and its causes, and at the same time, they increase the client's range of options as to how to behave. The ideal end result is the client's freedom from an unproductive or destructive behavior.

Figure 2-4 describes how an individually focused group might respond to the conflict described in Figure 2-3.

Interpersonally focused groups

Interpersonally focused groups generally work from a theory of interactional group therapy, most often associated with the work of Irving Yalom (1995). Other examples of this model of group include sensitivity training, or T-groups (Bradford et al. 1964), and L. Ormont's Modern Analytic Approach (Ormont 1992). In groups that follow this model, emphasis is placed primarily on current interactions between and among group members. Clients are urged to explore how they behave, how this behavior affects others, and how others' behavior affects them.

In interpersonally focused groups, the group leader serves as a role model, but does not explicitly assess the clients' behavior. That task is left to other group members, who evaluate each other's behavior. The group leader monitors the way clients relate to one another, and reinforces therapeutic group norms, such as members responding to each other in an emphatic way. The leader also steps in to extinguish contratherapeutic norms that might damage group cohesion or to point out behavior that could inhibit empathic relationships within the group.

Figure 2-4

Joe's Case in an Individually Focused Group

The group leader in an individually focused group might work first with Joe and then Jane (or vice versa, depending on who seemed to have the more pressing issues). The group leader might ask Joe to tell the group more about his anger and how he experiences it and might ask him to say why he has difficulty trusting his roommate. Joe could be urged to see how this situation might relate to other circumstances and how his reaction to his roommate's substance abuse might help him understand his own problems with drinking. The leader might use role-playing techniques with Joe so that he can practice how he will interact with his roommate and better understand his reaction to his roommate's behavior. Jane might be asked why Joe's reaction to his roommate made her so angry. The group leader could try to help her see if Joe reminded her of anyone and whether she identified with the roommate because she too had been judged. Her fears of being judged might be related to her own substance abuse, and the group could explore that possibility.

Source: Adapted from Flores 1997.

Figure 2-5

Joe's Case in an Interpersonally Focused Group

A group leader working from an interpersonally focused group model would direct the group's attention to what is going on between Joe and Jane. The leader might ask Jane if she can tell Joe directly how his statements have made her feel, and then ask Joe to say how he feels about what she said. The group leader might also ask Joe if he sees any parallel in his response to both his roommate and Jane. The leader might ask him if Jane could have reported what she felt in a way that would make him feel less defensive. Jane might tell Joe that she is reacting to his judgmental behavior toward his roommate and his evasiveness about his own drinking. This interaction confronts Joe's denial. If Jane discloses the reasons behind her response to Joe, namely that her husband distrusts her in a similar manner, the group leader would turn the issue over to the group, perhaps asking Jane how she thinks Joe feels about her. Another group member who has worked on issues concerning trust may interpret what is really going on between Joe and Jane. The goal is to help Joe and Jane deal authentically and realistically with one another, and strengthen the attachment between them. This analysis of relationships within the group may ultimately transfer to settings outside the group and improve Joe's and Jane's relationships with others outside the group.

Source: Adapted from Flores 1997.

Figure 2-5 describes how an interpersonally focused group might respond to the conflict described in Figure 2-3.

Group-as-a-whole focused groups

The theoretical approaches most often associated with the group-as-a-whole orientation are Tavistock's Group-as-a-Whole (Bion 1961; Rice 1965), Agazarian Systems-Centered Therapy for Group (Agazarian 1992), Bion's primary assumption groups (Bion 1961), and the focal conflict model (Whitaker and Lieberman 1965). As the name suggests, in this model, the group leader focuses on the group as a single entity or system. While model variations may recognize the group as an aggregate of individuals (the Systems-Centered Therapy does, for instance), the emphasis remains on the group as a single unit with its own ways of operating in the world.

This model generally is inappropriate for clients with substance use disorders—at least as the sole approach to treatment. It can be harmful, especially to clients new to recovery, and can add to their problems without helping them manage their substance abuse. Certain techniques taken from this approach, however, may be used productively in an eclectic treatment group. For example, when the entire group seems to be sharing a mood, behavior, or viewpoint, a group leader may choose to use mass group process comments, such as "You all seem quiet today" or "Almost everyone is ganging up on Jim."

Figure 2-6 describes how a group-as-a-whole focused group might handle Joe's problem.

Figure 2-6

Joe's Case in a Group-As-A-Whole Focused Group

A group leader with a Bion orientation would notice a lot of conflict swirling around this incident and that the group is in a "fight mode." The point of interest would be the source of the tension and how it interferes with the work of the group, which is the recovery process. The leader might note that the group has become very involved in this discussion as a way of evading issues of trust common to the whole group. Is the group perhaps fleeing from dealing directly with trust? Looking at Jane's response, the group leader would consider whether Jane's response is carrying something for the group, that is, representing a group concern about whether the group will judge members for what they have to say. The discussion might be redirected toward how the group is coping with feelings of uncertainty about continued substance use.

Source: Adapted from Flores 1997.

Three cautionary notes

These vignettes illustrate the different interventions available. No single approach necessarily is more appropriate than any other. The critical question is always, "Is this approach the most likely to succeed with this particular group in substance abuse treatment?"

In addition to making the right strategic choice of approach, the interventions should be done at the right time. Treatment as a time-dependent process should be the guiding principle when working with people with addictions in group.

Finally, what works for the client without addictions will not always work with a client with addictions. Consequently, the rest of this TIP will be dedicated to exploring the modifications in group technique that need to be made when treating people with substance use disorders.

Specialized Groups in Substance Abuse Treatment

A variety of therapeutic groups that do not fit in the already-described group models may be employed in substance abuse treatment settings. Some of these specialized groups are unique to substance abuse treatment (like relapse prevention), and others are unique in format, group membership, or structure (such as culturally specific groups and expressive therapy groups). It would be impossible to describe all of the types of special groups that might be used in substance abuse treatment. The three that follow represent a cross-section of special groups.

Relapse Prevention

Relapse prevention groups focus on helping a client maintain abstinence or recover from relapse. This kind of group is appropriate for clients who have attained abstinence, but who have not necessarily established a proven track record indicating they have all the skills to maintain a drug-free state. Relapse prevention

also can be helpful for people in crisis or who are in some way susceptible to a return to substance use.

Purpose. Relapse prevention groups help clients maintain their sobriety by providing them with the skills and knowledge to "anticipate, identify, and manage high-risk situations" that lead to relapse into substance use "while also making security preparations for their future by striving for broader life balance" (Dimeff and Marlatt 1995, p. 176). Thus, relapse prevention is a double-level initiative. It aims both to upgrade a client's ability to manage risky situations and to stabilize a client's lifestyle through changes in behavior (Dimeff and Marlatt 1995).

Principal characteristics. Relapse prevention groups focus on activities, problemsolving, and skills-building. They also may take the form of psychotherapy. For instance, Khantzian et al. (1992) assert that, because the same traits in personality and character predispose people to use substances initially and to relapse during recovery, psychodynamic approaches can mitigate psychological vulnerabilities. Because relapse prevention groups may use techniques drawn from all of these types of groups, they are considered a special type of group in this TIP.

Relapse prevention groups focus on activities, problemsolving, and skills-building.

The different models for relapse prevention groups (Donovan and Chaney 1985) include those developed by Annis and Davis (1988), Daley (1989), Gorski and Miller (1982), and Marlatt (1982). All of these models are derived from principles of cognitive therapy. Some, such as that of Marlatt, classify relapse prevention as a form of skills development; other models tend to emphasize support.

These approaches share a number of basic elements, including teaching clients to recognize high-risk situations that may lead to relapse, preparing them to meet those high-risk situations, and helping them develop balance and alternative ways of coping with stressful situations. Many of these approaches also increase group members' feelings of self-control, so they feel capable of resisting relapse. (More information on the techniques of relapse prevention appears in TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT 1999*a*].)

Research has demonstrated that relapse is common and to be expected during the process of recovery (Project MATCH 1997). In a meta-analysis of 24 controlled clinical trials evaluating relapse prevention programs delivered in both group and individual formats, Carroll (1996) found that relapse prevention groups were effective in comparison to no-treatment controls for many substances of abuse; the groups were most effective for smoking cessation. Carroll also notes that relapse prevention groups seem to reduce the intensity of relapse when it occurs. Groups also appear to be more effective than other approaches for clients who have "more severe levels of substance use, greater levels of negative affect, and greater perceived deficits in coping skills" (1996, p. 52).

Research also suggests that relapse prevention can be conducted in both group and one-on-one formats, with little measurable difference in outcomes. Schmitz and colleagues (1997) compared relapse prevention for cocaine abuse delivered in group and individual formats. Both demonstrated favorable outcomes; no significant difference was detected in cocaine use as measured by urine tests. Clients treated in groups, however, reported fewer cocaine-related problems than those treated in individual sessions. Further, McKay et al. (1997) found that 6 months after intensive outpatient treatment for cocaine abuse, subjects treated in a group setting displayed higher rates

of sustained abstinence than those treated individually.

Relapse prevention carried out in group settings enables clients to explore the problems of daily life and recovery together and to work collaboratively to isolate and overcome problems. Because of these dual goals, relapse prevention groups may improve clients' quality of life. However, as Schmitz and colleagues note, it may also be the case that the group experience makes members less willing to report the severity of their problems or cause them to feel that their problems are less severe by comparison to those of others (Schmitz et al. 1997).

Leadership skills and styles. Leaders of relapse prevention groups need to have a set of skills similar to those needed for a skills development group. However, they also need experience working in relapse prevention, which requires specialized training, perhaps in a particular model of relapse prevention. Leaders also
need a well-developed ability to work on group process issues.

Group leaders need to be able to monitor client participation to determine risk for relapse, to perceive signs of environmental stress, and to know when a client needs a particular intervention. Above all, group leaders should know how to handle relapse and help the group process such an event in a nonjudgmental, nonpunitive way—clients, after all, need to feel safe in the group and in their recovery. Leaders should know how to help the group manage the abstinence violation effect, in which a single lapse leads to a major recurrence of the addiction.

Additionally, the leader of a relapse prevention group should understand the range of consequences a client faces because of relapse. These consequences can be culturally specific responses, criminal justice penalties, child protective services actions, welfare-to-work setbacks, and so on. The group leader, like any counselor, should know the confidentiality rules (42 C.F.R. Part 2) and the legal reporting requirements relating to client relapse.

Techniques. Relapse prevention groups draw on techniques used in a variety of other types of groups, especially the cognitive–behavioral, psychoeducational, skills development, and process-oriented groups. Because the purpose of a relapse prevention group is to help members develop new ways of living and relating to others, thereby undercutting the need to return to substance use or abuse, potential group members need to achieve a period of abstinence before joining a relapse prevention group.

Communal and Culturally Specific Groups

Restoring lost cultural ties or providing a sense of cultural belonging can be a powerful therapeutic force in substance abuse treatment, and in important ways, substance abuse is intimately intertwined with the cultural context in which it occurs. Cultural prohibitions against substance use and cultural patterns of permissible use define, in part, what is reasonable use and what is abuse of substances (Westermeyer 1995). Risk factors such as cultural displacement or discrimination cause substance abuse rates to rise drastically for a given population. Problems that pervade particular cultures, such as racism, poverty, and unemployment, have an impact on the incidence of substance abuse and are appropriate focuses for intervention in substance abuse treatment (Taylor and Jackson 1990; Thornton and Carter 1988).

Communal and culturally specific wellness activities and groups include a wide range of activities that use a specific culture's healing practices and adjust therapy to cultural values. For instance, Hispanics/Latinos generally share a value of personalismo, a preference for person-to-person contact. Effective substance abuse treatment providers thus build personal relationships with clients before turning to the tasks of treatment. Also, at the outset of treatment, personal relationships do not yet exist. At this point, a client's hesitation should not be mistaken for resistance (Millan and Ivory 1994).

Three common ways to integrate such strengths-focused activities into a substance abuse treatment program are

- Culturally specific group wellness activities may be used in a treatment program to help clients heal from substance abuse and problems related to it.
- Culturally specific practices or concepts can be integrated into a therapeutic group to instruct clients or assist them in some aspect of recovery. For example, a psychoeducational group formed to help clients develop a balance in their lives might use an American Indian medicine wheel diagram or the seven principles of Kwanzaa. The medicine wheel represents four dimensions of wellness: belonging, independence, mastery, and generosity. These four concepts promote wellness for the individual and collective good of the American-Indian tribal group and humanity/environments. Kwanzaa is based on a value system of seven principles called the Nguzo Saba. The Kwanzaa paradigm is a nonreligious, nonheroic ritual that has been widely embraced by the national African-American community. The Nguzo Saba and other Kwanzaa symbols and practices can be used therapeutically in the regrounding and reconnecting process for African-American clients.
- Culturally or community-specific treatment groups may be developed within a services program or in a substance abuse treatment program serving a heterogeneous population with a significant minority population of a specific type. Examples might include a group for people with cognitive disabilities, or a bilingual group for recent immigrants. Such groups typically are process- or support-oriented, though they also may have psychoeducational components. The groups help minority group members understand their own background, cope with prejudice, and resolve other problems related to minority status. Groups described in this TIP fall into this category.

Purpose. Groups and practices that accentuate cultural affinity help curtail substance abuse by using a particular culture's healing practices and tapping into the healing power of a communal and cultural heritage. Many have commented on the usefulness of these types of groups (Trepper et al. 1997; Westermeyer 1995), and clinical experience supports their utility. As this TIP is written, little research-based evidence has accumulated to confirm the effectiveness of this approach. Research is needed to evaluate the effectiveness of culturally specific groups and ascertain the primary indications for their use.

Principal characteristics. Different cultures have developed their own views of what constitutes a healthy and happy life. These ideas may prove more relevant and understandable to members of a minority culture than do the values of the dominant culture, which sometimes can alienate rather than heal. All cultures also have specific processes for promoting wellness among their members.

In using a culture's healing practices or group activities, whether in heterogeneous or homogeneous groups (that is, all one culture or a mix of cultures), treatment providers should be careful to show respect for the culture and its healing practices. As long as respect and awareness are evident, the use of such practices will not harm the members of a particular culture.

Leadership characteristics and style. Group leaders always need to strive to be culturally competent with members of the various populations who enter their programs.[1] Substance

[1] See chapter 3 of this TIP and the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (SAMHSA in development *a*) for more information on cultural competence. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*b*), contains information on being sensitive and responsive to the needs of people with disabilities, and *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001) has information on working with gay and lesbian populations.

abuse treatment counselors first need to be aware of the demographics in their program areas, and to be aware as well that there are many people from mixed ethnic backgrounds who do not necessarily know or recognize their cultural heritage. Clinicians should actively avoid stereotyping clients based on their looks, and instead allow them to self-identify. Clients should be asked what it means to them to belong to a particular group. Clinicians also should be sensitive to self-identification issues such as sexual orientation, gender identification, and disability. When in doubt, clinicians should discuss the issue privately with the client.

A group leader for a culturally specific group will need to be sensitive and creative. How much authority leaders will exercise and how interactive they will be depends on the values and practices of the cultural group. The group leader should pay attention to a number of factors, all of which should be considered in any group but which will be particularly important in culturally specific groups. Clinicians should

- Be aware of cultural attitudes and resistances toward groups.
- Understand the dominant culture's view of the cultural group or community and how that affects members of the group.
- Be able to validate and acknowledge past and current oppression, with a goal of helping to empower group members.
- Be aware of a cultural group's collective grief and anger and how it can affect countertransference issues.

Figure 2-7

The SageWind Model for Group Therapy

In programs that have the resources, the capacity to offer a variety of types of groups addressing a range of client needs is preferred. SageWind in Reno, Nevada, offers more than 100 groups each week.

To assess each client's unique needs, SageWind's comprehensive biopsychosocial assessment evaluates the severity of a client's substance abuse. In addition, the clinical team, the client, and any others concerned (such as probation or parole officers, parents or legal guardians, or social workers) determine the best course of group therapy formats.

Group intervention ranges in intensity from one group per week to more than 20. The large number of weekly groups offered in SageWind's menu of options covers a continuum of treatment options from psychoeducational to skills-building to experiential to process-oriented. In a structured program similar to that of a university, where fundamental courses are required before more advanced ones may be taken, clients attend the groups they need, then change to others and progress through the program. Clients complete groups, moving to more advanced formats until they have met discharge criteria based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria-2R (PPC-2R) (ASAM 2001).

- Focus on what is held in common among members of the group, being sensitive to differences.

The SageWind Model for group therapy, discussed in Figure 2-7 (see p. 33), provides individually tailored interventions for its clients.

Techniques. Different cultures have specific activities that can be used in a treatment setting. Some common elements in treatment include storytelling, rituals and religious practices, holiday celebrations, retreats, and rites of passage practice (these may be particularly useful for adolescent clients).

Culturally specific groups work best if all members of the population become involved in the activity, even the clients who are not familiar with their cultural heritage. In fact, the reasons for that lack of familiarity can become a topic of discussion. Helping clients understand what they have lost by being separated from their cultural heritage, whether because of substance abuse or societal forces, can provide one more reason to continue in sobriety.

Expressive Groups

This category includes a range of therapeutic activities that allow clients to express feelings and thoughts—conscious or unconscious—that they might have difficulty communicating with spoken words alone.

Purpose. Expressive therapy groups generally foster social interaction among group members as they engage either together or independently in a creative activity. These groups therefore can improve socialization and the development of creative interests. Further, by enabling clients to express themselves in ways they might not be able to in traditional talking therapies, expressive therapies can help clients explore their substance abuse, its origins, the effect it has had on their lives, and new options for coping. These groups can also help clients resolve trauma (like child abuse or domestic violence) that may have been a progenitor of their substance abuse. For example, Glover (1999) states that play therapy and art therapy are particularly useful for substance abuse treatment clients who have been incest victims. Play and art therapies enable these clients to work through their trauma and substance abuse issues using alternatives to verbal communication (Glover 1999).

Although a number of articles have theorized about the usefulness of various types of expressive therapy for clients with substance use disorders, little study on the subject has used rigorous research methods. Clinical observation, however, has suggested benefits for female clients involved in dance therapy (Goodison and Schafer 1999). Client self-reports suggest the value of psychodrama for female clients in treatment for alcoholism, particularly for highly educated women and those who are inclined to be extroverted and verbally expressive (Loughlin 1992).

As Galanter and colleagues note, expressive therapy groups—which they called "activity groups"—often can be "the source of valuable insight into patients' deficits and assets, both of which may go undetected by treatment staff members concerned with more narrowly focused treatment interventions" (Galanter et al. 1998, p. 528).

Principal characteristics. The actual characteristics of an expressive therapy group will depend on the form of expression clients are asked to use. Expressive therapy may use art, music, drama, psychodrama, Gestalt, bioenergetics, psychomotor, play (often with children) games, dance, free movement, or poetry.

Leadership characteristics and style. Expressive group leaders generally will have a highly interactive style in group. They will need to focus the group's attention on creative activities while remaining mindful of group process issues. The leader of an expressive group will need to be trained in the particular modality to be used (for example, art therapy).

Expressive therapies can require highly skilled staff, and, if a program does not have a trained staff person, it may need to hire an outside consultant to provide these services. Any con-

sultant working with the group should be in regular communication with other staff, since expressive activities need to be integrated into the overall program, and group leaders need to know about each client if they are to understand their work in the group.

Expressive therapies can stir up very powerful feelings and memories. The group leader should be able to recognize the signs of reactions to trauma and be able to contain clients' emotional responses when necessary. Group leaders need to know as well how to help clients obtain the resources they need to work though their powerful emotions.

Finally, it is important to be sensitive to a client's ability and willingness to participate in an activity. To protect participants who may be in a vulnerable emotional state, the leader should be able to set boundaries for group members' behavior. For example, in a movement therapy group, participants need to be aware of each other's personal space and understand what types of touching are not permissible.

Techniques. The techniques used in expressive groups depend on the type of expressive therapy being conducted. Generally, however, these groups set clients to work on an activity. Sometimes clients may work individually, as in the case of painting or drawing. At other times, they may work as a group to perform music. After clients have spent some time working on this activity, the group comes together to discuss the experience and receive feedback from the group leader and each other. In all expressive therapy groups, client participation is a paramount goal. All clients need to be involved in the group activity if the therapy is to exert its full effect.

Groups Focused on Specific Problems

In addition to the five *models* of therapeutic groups and three specialized *types* of groups discussed above, groups can be classified by *purpose*. The problem-focused group is a specific form of cognitive–behavioral group used to eliminate or modify a single particular problem, such as shyness, loss of a loved one, or substance abuse. In sheer numbers, these groups are the most widespread. Additionally, problemsolving groups are directed from a cognitive–behavioral framework. They focus on problems of daily life for people in early and middle recovery, helping group members learn problemsolving skills, cope with everyday difficulties, and develop the ability to give and receive support in a group setting. As clients discuss problems they face, these problems are generalized to the experience of group members, who offer support and insight.

Expressive therapy groups foster social interaction as members engage in a creative activity.

Purpose. Problem-focused groups' primary purpose is to "change, alter, or eliminate a group member's self-destructive or self-defeating target behavior. Such groups are usually short-term and historically have been used with addictive types of behavior (smoking, eating, taking drugs) as well as when the focus is on symptom reduction…or behavioral rehearsal" (Flores 1997, p. 40).

Principal characteristics. Problem-focused groups are short (commonly 10 or 12 weeks), highly structured groups of people who share a specific problem. This type of group is not intended to increase client insight, and little or no emphasis is placed on self-exploration. Instead, the group helps clients develop effective coping mechanisms to enable them to meet social obligations and to initiate recovery from substance abuse. The group's focus, for the most part, is on one symptom or behavior, and they use the cohesiveness among clients to

increase the rate of treatment compliance and change. A problem-focused group commonly is used in the early stages of recovery to help clients engage in treatment, learn new skills, and commit to sobriety. This kind of group is helpful particularly for new clients; its homogeneity and simple focus help to allay feelings of vulnerability and anxiety.

> The leader in a problem-focused group usually is active and directive.

Leadership characteristics and styles. The group leader usually is active and directive. Interaction within the group is limited typically to exchanges between individual clients and the group leader; the rest of the group acts to confront or support the client according to the leader's guidance.

Techniques. Many traditional recovery groups fall into the problem-focused category, which includes abstinence maintenance, relapse prevention, support, behavior management, and many continuing care groups. Other examples are groups that help support people with a specific problem or loss (such as breast cancer or suicide in the family), help people alter a particular behavior or trait (like overeating or shyness), or learn a new skill or behavior (for instance, conflict resolution or assertiveness training).

In practice, group leaders may use different models at various times, and may simultaneously influence more than one focus level at a time. For example, a group that focuses on changing the individual will also have an impact on the group's interpersonal relations and the group-as-a-whole. Groups will, however, have a general orientation that determines the focus the majority of the time. This focus is an entry point for the group leader, helping to provide direction when working with the group.

When deciding on a model for a substance abuse treatment group, programs will need to consider their resources, the training and theoretical orientation of group leaders, and the needs and desires of clients in order to determine what approaches are feasible. The reader may also refer to appendix B of TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999*a*), for a list of resources that can provide further training and information about the theoretical orientations that influence these groups.

3 Criteria for the Placement of Clients in Groups

In This Chapter…

Matching Clients With Groups

Assessing Client Readiness for Group

Primary Placement Considerations

Stages of Recovery

Placing Clients From Racial or Ethnic Minorities

Diversity in a Broad Sense

Leader Self-Assessment

Diversity and Placement

Ethnic and Cultural Matching

Other Considerations for Practice

Overview

Before any client is placed in a group, readiness for particular groups must be assessed. Techniques such as eco-maps and resources like American Society of Addiction Medicine (ASAM) criteria (see the "Primary Placement Considerations" section of this chapter) can be very helpful. The clinician must also determine the client's current stage of recovery and stage of change.

Culture and ethnicity considerations also are of primary importance. This chapter explains ways to facilitate the placement of people from minority cultures and ease such clients into existing groups. From this discussion, clinicians can also assess their readiness to deal with other cultures and become aware of processes that occur in multiethnic groups.

Matching Clients With Groups

Therapy groups, designed to treat substance abuse by resolving persistent life problems, are used frequently, but the individual success of this group experience depends in important respects on appropriate placement. Matching each individual with the right group is critical for success. Before placing a client in a particular group, the provider should consider

- The client's characteristics, needs, preferences, and stage of recovery
- The program's resources
- The nature of the group or groups available

The placement choice, moreover, should be considered as constantly subject to change. Recovery from substance abuse is an ongoing process and, if resources permit, treatment may continue in various forms for some time. Clients may need to move to different groups as they progress through treatment, encounter setbacks, and become more or less committed to recovery. A client may move, for example, from a psychoeducational group to a relapse prevention group to an interpersonal process group. The client also may participate in more than one group at the same time.

Assessing Client Readiness for Group

Placement should begin with a thorough assessment of the client's ability to participate in the group and the client's needs and desires regarding treatment. This assessment can begin as part of a general assessment of clients entering the program, but the evaluation process should continue after the initial interview and through as long as the first 4 to 6 weeks of group.

Assessment should inquire about all drugs used and look for cross-addictions. It also is important to match groups to clients' current needs. In addition to these and other assessment considerations, clients should be asked about the composition of their social networks, types of groups they have been in, their experience in those groups, and the roles they typically have played in those groups (Yalom 1995).

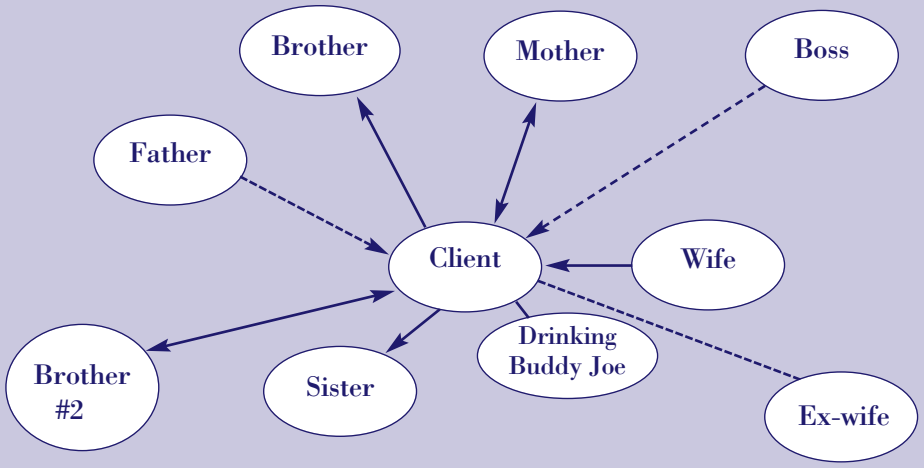
To help assess clients' relationships and their ability to participate productively in a group, the clinician can have the client draw an eco-map (see an example in Figure 3-1). An eco-map (sometimes called a sociogram) is a graphic representation that depicts interpersonal relationships (Garvin and Seabury 1997; Hartman 1978). The client occupies the center of the page. Then, circles are added to show each significant relationship. The closer the relationship, the closer it is to the center circle. A solid line between circles indicates a strong, nurturing relationship, while a dotted line depicts a conflicted connection. Arrows drawn on the lines can represent the direction of the relationship. An arrow from the center out means "I care about this person." An incoming arrow means "This person cares about me."

Clients who are inarticulate or withdrawn may welcome the opportunity to present information visually, and clinicians can gather useful information from these diagrams. If the diagram indicates few, distant, and conflicted relationships, the client may require a group that is very structured.

The eco-map is indicative, but not comprehensive. It only provides the client's viewpoint. Though it is a useful tool, leaders should be

Figure 3-1

Eco-Map



Source: Adapted from Garvin and Seabury 1997; Hartman 1978. Used with permission.

wary of basing placement decisions on this or any other single source of information. Clinical observation and judgments, information from collateral resources, and other assessment instruments all should contribute to a decision on a client's readiness and appropriateness for group treatment. Either the group leader or another trained staff person should meet with a client before assignment to a group. In this interview, it is important to evaluate how the client reacts to the group leader and to assess current and past interpersonal relationships. The group leader also may hold an orientation group (perhaps educational in nature) to observe how the client relates to others. The client also may be observed in a waiting room with other clients or in a similar social situation to gain insight into how each person relates to others.

The clinician pays such careful attention to the relationships clients can manage at their current stage of recovery because this capacity has everything to do with how able the client is to participate in a group. Whatever their diagnosis, clients in groups—especially interpersonal process groups—need to be able to engage with other people. They need motivation to change, creativity, and dogged perseverance (Brown 1991). Furthermore, the group leader should continue to assess clients as treatment progresses. The clients' needs and abilities are apt to change—change is part of successful treatment—and the appropriate type of group or the suitability for group in general may shift dramatically.

Not all clients are equally suited for all kinds of groups, nor is any group approach necessary or suitable for all clients with a history of substance abuse. For instance, a person who relapses frequently probably would be inappropriate in a support group of individuals who have attained significant abstinence and who have moved on to resolving practical life problems. It would be equally disadvantageous to place a person in the throes of acute withdrawal from crack cocaine in a group of people with alcoholism who have been abstinent for 3 months. A group usually can be heterogeneous in demographic composition, including men and women, younger and older clients, and people of different races and ethnicities, but clients should be placed in groups with people with similar needs.

People with significant character pathology (for example, a personality disorder) placed in a group of people who do not have a similar disorder almost certainly would violate the boundaries of the group and of individuals in the group. As a result, both the clients who have and who lack the character disorder would have a negative group experience and limited opportunity for growth. Clients with a personality disorder generally need a group that can place significant limits on their behavior both in and beyond the group setting. In groups treating clients with active psychoses, special adaptations would need to be made for possible psychotic symptoms, delusions, and paranoia. Once such adaptations in technique are made to fit the special circumstances of the population being treated, group therapy—in the hands of a skilled group leader—can be an effective, appropriate form of treatment.

Other types of clients who may be inappropriate for group therapy include

- Clients who refuse to participate. No one should be forced to participate in group therapy.
- People who can't honor group agreements. Sometimes, as noted, these clients may have a disqualifying pathology. In other instances, they cannot attend for logistical reasons, such as a work schedule that conflicts with that of regular group meetings.
- Clients who, for some reason, are unsuitable for group therapy. Such people might be prone to dropping out, getting and remaining stuck, or acting in ways contrary to the interests of the group.
- People in the throes of a life crisis. Such clients require more concentrated attention than groups can provide.

- People who can't control impulses. Such clients, however, may be suitable for homogeneous groups.
- People whose defenses would clash with the dynamics of a group. People who can't tolerate strong emotions or get along with others are examples.
- People who experience severe internal discomfort in groups.

Primary Placement Considerations

A formal selection process is essential if clinicians are to match clients with the groups best suited to their needs and wants. For each group, different filters are appropriate. Some groups may require only that members be participants in a particular program. Others may require a multidisciplinary panel review of the client's case history. For many groups, especially interpersonal process groups, pregroup interviews and client preparation are essential.

Client evaluators should not rely solely on the review of forms, but should meet with each candidate for group placement. The interviewer should listen carefully to the client's hopes, fears, and preferences. Ideally, clients should be offered a menu of appropriate options, since people will be more likely to remain committed to courses of treatment that they have chosen. Client choice also may strengthen the therapeutic alliance and thereby increase the likelihood of a positive treatment outcome (Emrick 1974, 1975; Miller and Rollnick 1991). Naturally, appropriate clinical guidance should also play a part in placement decisions.

After specifying the appropriate treatment level, a therapist meets with the client to identify options consistent with this level of care. More specific screens are needed to determine whether, within the appropriate level of care, the client is appropriate for treatment in a group modality. If so, further screens are needed to determine the most helpful type of group. Considerations include the following.

Women. Recent studies have shown that women do better in women-only groups than in mixed gender groups. When women have single-gender group therapy, retention is improved (Stevens et al. 1989). They also are more likely to complete their treatment programs (Grella 1999), use more services during the course of their treatment, and are more likely to feel they are doing well in treatment (Nelson-Zlupko et al. 1996).

The primary reason same-sex groups are more effective for women is that women have distinct treatment needs that are different from those of men. Women are more likely than men to have experienced traumatic events, which often lead to depression, anxiety, and posttraumatic stress disorder. About three-quarters of the women in treatment have been child or adult victims of sexual, physical, or emotional abuse (Roberts 1998). Statistically, women with substance use disorders also have experienced more severe types of abuse (such as incest), and perpetrators have abused them for longer periods of time in comparison to women without substance use disorders. The perpetrators are most often male partners, male family members, or male acquaintances. Women are less willing to disclose and discuss their victimization in mixed-gender groups (Hodgins et al. 1997).

Women further are more likely to be caretakers for minor children or elderly parents and need to balance these family responsibilities with their own treatment needs. They face greater challenges in securing employment, are more likely to have co-occurring mental illness, and encounter greater stigma for their substance use disorders than men.

Because women are relational by nature and develop a sense of self and self-worth in relation to others (Miller 1986), groups specifically for women are advisable, particularly in early treatment. Gender-specific treatment groups provide both the safety women often need to resolve the problems that fuel their substance use disorders and the healing environment they

need to develop a healthier development of self and connections to other women.

It is important to help female clients make the transition from an environment supportive of their specific needs to one that is less sensitive to them. Following treatment, they will need an effective support network in their communities to help them sustain the gains of treatment. (See the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* [Center for Substance Abuse Treatment (SAMHSA) in development *b*].)

Adolescents. Planning, designing, and operating group therapy services for adolescent clients is a complex undertaking. Adolescents are strikingly different from adults, both psychosocially and developmentally, and require decidedly different services. Local, State, and Federal laws related to confidentiality; infectious disease control; parental permissions and notifications; child abuse, neglect, and endangerment; and statutory rape all can come into play when substance abuse treatment services are delivered to minors. Add the complications related to scheduling around school and the need to include family in the treatment process, and it is no surprise that most group therapy for teens occurs in the context of an overall treatment program or as part of highly specialized, targeted programs (e.g., see the discussion of Cognitive Behavioral Therapy group sessions in Sampl and Kadden 2001). Indeed, to serve as a substance abuse counselor or clinician in the delivery of group therapy to adolescents typically requires prior training and experience with the particular age group to be served.

The complexities related to adolescents and group therapy lie outside the scope of the TIP. Suggested reading for those interested in the rationale for group therapy with adolescents includes, but is not limited to, Sampl and Kadden 2001 or textbooks such as *Group Therapy with Children and Adolescents* (Kymissis and Halperin 1996), including the chapter by Spitz and Spitz on adolescents who abuse substances, or *Adolescent Substance Abuse: Etiology, Treatment, and Prevention* (Lawson and Lawson 1992), especially the chapter on group psychotherapy with adolescents by Shaw. Last, a journal article (Pressman et al. 2001) relates the special difficulties group psychotherapy presents for adolescents with both psychiatric and substance abuse problems—another common complexity of providing group therapy for adolescents with substance abuse disorders.

In placement, both the client's and the group's best interests need to be considered.

The client's level of interpersonal functioning, including impulse control. Does the client pose a threat to others? Is the client prepared to engage in the give and take of group dynamics? The client's "level of psychological functioning and integration" should be considered, as should "the kinds of defenses [used] to maintain abstinence, and the rigidity of [those] defenses" (Vannicelli 1992, p. 31). A client who has not moved beyond sloganism, including "avoid strong feelings," may not do well in a group that has evolved more sophisticated ways to maintain abstinence (Vannicelli 1992).

Motivation to abstain. Clients with low levels of motivation to abstain should be placed in psychoeducational groups. They can help the client make the transition into the recovery-ready stage.

Stability. In placement, both the client's and group's best interests need to be considered. For example, bringing a new member who is in crisis into treatment may tax the group beyond its ability to function effectively, yet the group might easily manage a person in similar crisis who already is part of the group (Vannicelli 1992). Group stability counts as well. An ongoing group of clients who have gained insight into the management of their feelings can sup-

Every effort should be made to place the client in a group in which the client can succeed.

port a new member, helping that person solve problems without getting caught up in feelings of crisis themselves.

Stage of recovery. The five stages of Prochaska and DiClemente's transtheoretical model of change (discussed briefly in chapter 2 and in greater detail in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*b*]) map the route that a person abusing substances must travel during the transition from abuse to recovery. The stages of change are best conceived as a cycle, but movement through the cycle is not always a tidy, forward progression. Clients can—and often do—move backward as they struggle with dependence. Varying types of groups will be appropriate for clients at different stages of recovery. For example, an interpersonal process group might be overstimulating for some clients in early stages of recovery, particularly those undergoing detoxification. They would benefit most from a group with a strong primary focus on achieving and maintaining abstinence. Once abstinence and attachment to the recovery process are established, the client is ready to work on such issues as awareness and communication of feelings, conflict resolution, healthy interdependence, and intimacy.

Expectation of success. Every effort should be made to place the client in a group in which the client, and therefore, the program, can succeed.

A poor match between group and client is not always apparent at the outset. Monitoring can ensure that clients are in groups in which they can learn and grow without interfering with the learning and growth of others. Although the primary factor to consider regarding continued participation in group should be a client's ability to get something out of the experience, it is also important to determine how each person's participation affects the group as a whole. A client who, for whatever reason, cannot participate may have a profoundly adverse effect on the group's ability to coalesce and function cohesively. If a client does not interfere with group progress, however, sometimes it is appropriate to keep a nonparticipant in the group and simply allow that person to sit and listen.

A number of different assessment models can be used to allow meaningful dialog between client and program representatives during the screening and placement phase, even when resources are limited. The ASAM PPC-2R treatment criteria (ASAM 2001) commonly are used for client placement. The criteria are arranged in two sets, one for adults and one for adolescents. Each set covers five levels of service:

- Level 0.5 — Early Intervention
- Level I — Outpatient Treatment
- Level II — Intensive Outpatient Treatment/ Partial Hospitalization
- Level III — Residential/Inpatient Treatment
- Level IV — Medically Managed Intensive Inpatient Treatment

On each level of care ASAM's criteria describe appropriate treatment settings, staff and services, admission, continued service, and discharge criteria for six "dimensions":

- Potential for acute intoxication or withdrawal
- Biomedical conditions and complications
- Emotional and behavioral conditions or complications
- Treatment acceptance or resistance
- Relapse and continued use potential
- Recovery environment

On the five levels of care, ASAM also provides a brief overview of the services available for particular severities of addiction and related

problems. Another commonly used assessment tool, the Addiction Severity Index, can be found in appendix D of TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000).

Some States require providers to use the ASAM PPC-2R for patient placement, continuing stay, and discharge decisions. For placement in group therapy, a provider can also consider

- A client's stage of recovery (see next section)
- The progression of the disease
- The client's stage of readiness for change

Although no single set of criteria is sufficient to evaluate a client's proper placement, this document presents a chart (see Figure 3-2) that summarizes the types of group treatment most appropriate for clients at different stages of recovery. Clinicians can use the chart as a guide to determine the type of group most appropriate for a client.

When different dimensions of evaluation conflict in their placement indications, the clinician will need to break the impasse with clinical judgment. Actual client placement should take into account characteristics such as substances abused, duration of use, treatment setting, and the client's stage of change. For example, a client in a maintenance stage may need to acquire social skills to interact in new ways, may need to address emotional difficulties, or may need to be reintegrated into a community and culture of origin. Only an additional level of assessment will determine which of these groups (or combination of groups) is best for the client.

Stages of Recovery

A number of classification systems have been applied to the stages of recovery from substance abuse. The most common, however, classifies clients as being in an early, middle, or late stage of recovery:

- *Early recovery.* The client has moved into treatment, focusing on becoming abstinent and then on staying sober. Clients in this stage are fragile and particularly vulnerable to relapse. This stage generally will last from 1 month to 1 year.

Figure 3-2

Client Placement by Stage of Recovery

	Psycho-educa-tion	Skills-Building	Cognitive–Behavioral	Support	Inter-personal Process	Relapse Preven-tion	Ex-pressive	Culture-Specific
Early	+++	++	+	+++	+		+	*
Middle	+	++	++	++	+++	+++	+	*
Late and Maintenance			++	+	+++			*

Key:
Blank Generally not appropriate
+ Sometimes necessary
++ Usually necessary
+++ Necessary and most important

Source: Consensus Panel.

Figure 3-3

Client Placement Based on Readiness for Change

	Psycho-educa-tion	Skills-Building	Cognitive–Behavioral	Support	Inter-personal Process	Relapse Preven-tion	Ex-pressive	Culture-Specific
Precontem-plation	+		+		+			+
Contem-plation	+	+	+	+	+		+	+
Preparation	+	+	+	+	+		+	+
Action	+	+	+	+	+	+	+	+
Maintenance		+	+	+	+	+	+	+
Recurrence		+	+	+	+	+	+	+

Source: Consensus Panel; Prochaska and DiClemente 1984.

- *Middle recovery.* The client feels fairly secure in abstinence. Cravings occur but can be recognized. Nonetheless, the risk of relapse remains. The client will begin to make significant lifestyle changes and will begin to change personality traits. This stage generally will take at least a year to complete, but can last indefinitely. Some clients never progress to the late recovery/maintenance stage. Sometimes they relapse and revert to an early stage of recovery.
- *Late recovery/maintenance.* Clients work to maintain abstinence while continuing to make changes unrelated to substance abuse in their attitudes and responsive behavior. The client also may prepare to work on psychological issues unrelated to substance abuse that have surfaced in abstinence. Since recovery is an ongoing process, this phase has no end.

Figure 3-3 uses Prochaska and DiClemente's stages of change model to relate group placements to the client's level of motivation for change.

Placing Clients From Racial or Ethnic Minorities

Diversity in a Broad Sense

In all aspects of group work for substance abuse treatment, clinicians need to be especially mindful of diversity issues. Such considerations are key in any form of substance abuse treatment, but in a therapeutic group composed of many different kinds of people, diversity considerations can take on added importance. As group therapy proceeds, feelings of belonging to an ethnic group can be intensified more than in individual therapy because, in the group process, the individual may engage many peers who are different, not just a single therapist who is different (Salvendy 1999).

While the word "diversity" often is used to refer to cultural differences, it is used here in a broader sense. It is taken to mean any differences that distinguish an individual from others and that affect how an individual identifies himself and how others identify him. Considerations such as age, gender, cultural

background, sexual orientation, and ability level are all extremely important, as are less apparent factors such as social class, education level, religious background, parental status, and justice system involvement. Figure 3-4 provides several definitions around culture.

To help clinicians understand the range of diversity issues and the importance of these issues, this volume adapts a diversity wheel from Loden and Rosener (1991) (see Figure 3-5 on p. 46). The wheel depicts two kinds of characteristics that can play an important role in understanding client diversity: The inner wheel includes permanent characteristics such as age or race; the outer wheel lists a number of secondary characteristics that can be altered. Note that primary characteristics are not necessarily more important than secondary ones and that this figure does not include a comprehensive list of secondary characteristics.

It is important for clinicians to realize that diversity issues affect everyone. All individuals have unique characteristics. Further, how people view themselves and how the dominant culture may view them are frequently different. In any event, no one should be reduced to a single characteristic in an attempt to understand that person's identity. All people have multiple characteristics that define who they are.

While ideas of difference are social constructions, they do have a real-world effect. For example, members of groups tend to act in different ways when with members of their own group than they would in a heterogeneous group. Further, the dominant culture's attitudes and beliefs about people (based on age, race, sexual preference, and so on) influence everyone.

A culturally homogeneous group quite naturally will tend to adopt roles and values from its

Figure 3-4

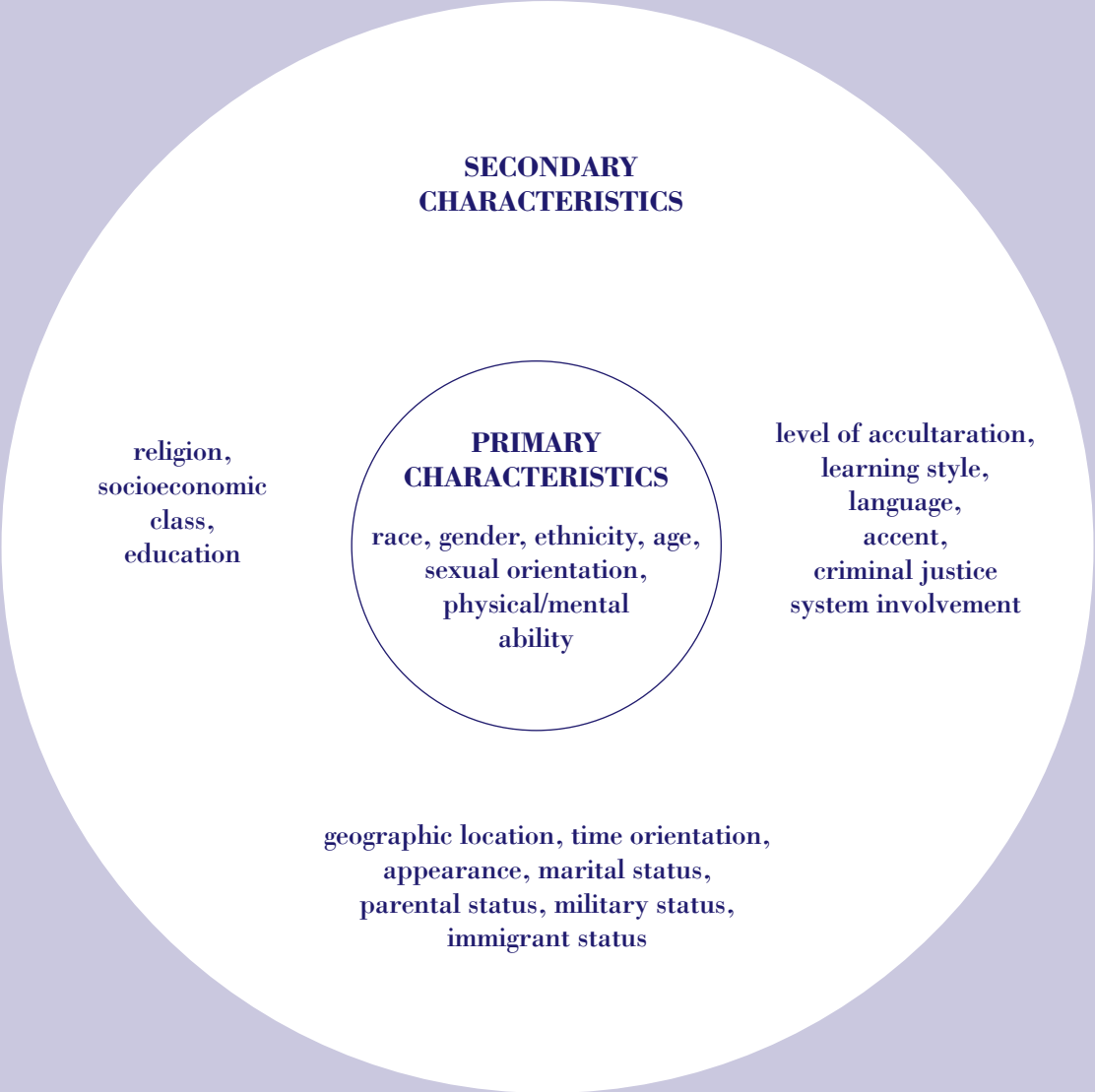
What Is Culture?

Culture: Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.
Cultural knowledge: Familiarity with selected cultural characteristics, history, values, belief systems, and behaviors of the members of another ethnic group.
Cultural awareness: Developing sensitivity to and understanding of another ethnic group. This usually involves internal changes of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness should be supplemented with cultural knowledge.
Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations.

Source: Giachello 1995; Office of Minority Health 2001.

Figure 3-5

Diversity Wheel



Source: Adapted from Loden and Rosener 1991. Used with permission.

culture of origin (Tylim 1982). These ways should be understood, accepted, respected, and used to promote healing and recovery. However, group leaders should also be aware of the possibility that these group roles and values might conflict with treatment requirements, and therefore clinicians need to be prepared to provide more direction to group members when required (Salvendy 1999). For example, a group composed of Southeast Asian refugees might give authority to older men in the group, who may never be challenged, contradicted, or disagreed with because to do so would show disrespect (Kinzie et al. 1988). These older, adult males can assist in group leadership. However, the opinions of female group members, particularly younger ones, might be ignored, and a group leader should be able to compensate for this tendency. As another example, many Hispanics/Latinos may be suspicious of rules and the people who enforce them. Consequently, group leaders regarded as authority figures (that is, not compadres) unwittingly may represent discrimination and encroachments on freedom (Torres-Rivera et al. 1999).

Cultural practices also affect communication among group members. Many traditionally raised Asians, for example, will be reluctant to disagree openly with their elders or even voice a personal opinion in their presence (Chang 2000). Gender-specific cultural roles, too, may be played out in groups. For example, women may hold emotional energy for men or nurture them. Therapists should be alert to assumptions and roles that may inhibit the development of individuals or the group as a whole.

Unfortunately, little research reveals how group therapy should be adapted to meet such differences, and many of the findings that do exist are contradictory. Further, any generalizations about cultural groups may not apply to individuals because of variance in levels of acculturation and other experiential factors. A particular Latino youth, for example, may identify with the dominant culture and not think of himself as Latino. The client is always to be considered the expert on what culture, ethnicity, and gender identity mean to that person. If a leader believes that cultural traditions might be a factor in a client's participation in group or in misunderstandings among group members, the leader should check the accuracy of that perception with the client involved. Therapists should be aware, however, that individuals may not always be able to perceive or articulate their cultural assumptions.

Group leaders should be able to anticipate a particular group's characteristics without automatically assigning them to all individuals in that group. It would be a mistake, for instance, if an institution assigned all immigrants or people of color to a single group, assuming they would be more comfortable together. Members of such groups may not have anything in common. An Asian-American woman assigned to the only Asian-American therapist in the institution might resent her placement and protest in strong terms. She would want the best therapist for her, not an automatic matchmaking based on ethnicity.

Clinicians working primarily with other cultural or ethnic groups should be open and ready to learn all they can about their clients' culture. For example, a therapist working with Salvadoran immigrants should be prepared to learn not only about the country and culture of El Salvador, but also about all the events and influences that have shaped this population's experience, including social conditions in El Salvador and the experience of immigration.

Accommodating cultural and ethnic characteristics is not a simple matter. These adaptations should be made, however, because ethnicity and culture can have a profound effect on many aspects of treatment. For instance, pressures to conform to the dominant culture represented in the group can be intense. The norms of the group may also be in painful conflict with an individual's traditional cultural values. An example is shown in Figure 3-6 (see p. 48). Figure 3-7 (see p. 48) provides three suggested resources on culture and ethnicity; however, this list is by no means exhaustive.

Figure 3-6

When Group Norms and Cultural Values Conflict

A middle-aged, single professional woman of Philippine background who, in one group session, recounted death wishes toward an elder sister whom she perceived as domineering, remained silent the following week in the group. When other members tried to engage her, wanting her to follow up, she complained of debilitating migraines and refused to talk. Months later, she was able to share with the group that she felt ashamed and disloyal to her sister, a great transgression in her culture. The client believed she was punished for her "naughtiness" with crippling headaches.

Source: Adapted from Salvendy 1999, p. 441.

Figure 3-7

Three Resources on Culture and Ethnicity

Culture and Psychotherapy: A Guide to Clinical Practice is a resource for mental health professionals treating people of widely varying cultural backgrounds. Case studies include the story of an American-Indian woman who could not escape her "spirit song," a Latina who feared "losing her soul," and an Arab woman whose psychological conflicts were related to cultural changes in her society that involved the social status of women. Other chapters describe treatment techniques for various racial and ethnic groups and models of therapy (Tseng and Streltzer 2001).

Ethnic Sensitivity in Social Work provides a section on cross-cultural orientation and one on specific cultures, including African-American, Hispanic/Latino, American-Indian, and Asian and Pacific Island cultures. The second part of the book is a psychocultural overview of several major ethnic groups in the United States. For each group, the authors discuss work and economic systems, family life and kinships, political structures and stratification, intergroup relations and ideological structures, identity, social interaction rules, and health behaviors (Winkelman 1995).

Readings in Ethnic Psychology contains several chapters on substance abuse and treatment among several ethnic and racial groups and describes culturally appropriate interventions used in therapy, including group therapy (Organista et al. 1998).

Leader Self-Assessment

Group leaders should be aware that their own ethnicities and standpoints can affect their interpretation of group members' behavior. The group leader brings to the group a sense of identity, as well as feelings, assumptions, thoughts, and reactions. Leaders should be conscious of how their own backgrounds affect their ability to work with particular populations. For example, a female therapist who has survived domestic violence may have severe difficulties working with spouse abusers. Another example is that male group leaders may be inclined to call on male members more often than female members of the group. If so, they need to make a conscious effort to call on all members equally, regardless of gender. Clinicians also need to evaluate how competent they are managing issues of cultural diversity. In cases where cultural or language barriers are very strong, a group leader may need to refer a client to another group or make special accommodations to allow the client to participate.

Reed and her colleagues (1997) have developed a list of principles for group leaders to evaluate their own attitudes about diversity (see Figure 3-8). Figure 3-9 (see pp. 50–52) is a self-assessment guide for group counselors working with diverse populations.

Figure 3-8

Guidelines for Clinicians on Evaluating Bias and Prejudice

- The processes of gaining knowledge about the workings of discrimination and oppression and for guarding against bias should be ongoing and lifelong.
- Clinicians should learn about their own culturally shaped assumptions so as to refrain from unconsciously imposing them on others and should exhibit a professional's values, standards, and actions.
- Clinicians should work harder to recognize institutionalized racism than they do to perceive individual prejudice; that is, they should recognize how bias is structured into policies, practices, and norms in program relations.
- Clinicians should question the knowledge base and theories that underlie their practice in order to eliminate prejudice and bias in that practice.
- Clinicians should look at their own feelings and reactions and listen to the feedback of others to recognize how their own ideas have been unconsciously shaped by discriminatory social dynamics.
- Clinicians can use their knowledge of how their personal characteristics are likely to affect a range of others to reduce communication problems and disputes between group members.

Source: Adapted from Reed et al. 1997. Used with permission.

Figure 3-9

Self-Assessment Guide

The questions that follow can serve as a guide and self-assessment for group leaders working with clients of diverse cultures.

Are you familiar with a broad range of special populations, particularly those in your community?

- What cultural customs and health beliefs, practices, and attitudes of ethnic/racial groups would affect treatment in a group situation?
- Would tensions within any broad cultural group—say one that includes Cubans, Mexicans, and Puerto Ricans—pose problems in therapy?
- What languages are spoken within the community?
- What are the typical communication styles, including body language, of various racial/ethnic groups? Are clients likely to speak in a group setting? Would they speak only with others of their same culture? Would they speak in an ethnically mixed group?
- How do clients think about the cultures of the world? Do they have pronounced prejudices? How do they understand the major and minor cultural subgroups that make up the community?
- How do language, social class, race/ethnicity, and gender affect the outward signs and symptoms of substance abuse, emotional distress, and mental illness?
- In any local cultures, do specific social stresses, such as homelessness or uncertain immigration status, complicate the problem of coping with substance abuse and psychiatric disorders?
- What are community views about different kinds of substances? Is alcohol more acceptable than marijuana? Marijuana more acceptable than cocaine? Are males with addictions tolerated more than females?
- How do various cultural subgroups perceive women in the community? The elderly? Lesbian, gay, and bisexual persons?

Do you understand your own thoughts, feelings, and experiences regarding other cultures?

- With what cultural groups other than your own do you have frequent contact?
- With what ethnic groups do you have contact? How frequently?
- What are some of the key characteristics of these groups?
- What do you know about the principal cultural groups in the country? In your community?
- What are the main ethnic groups in the United States?
- What are the important characteristics of your own culture?
- How does your culture affect the way you interact with others? What is your culture's style of interaction?

Figure 3-9

Self-Assessment Guide (continued)

- Do you have a personal style that differs from your culture's norms?
- Toward which cultural groups do you feel positive?

Which groups make you feel uneasy or uncomfortable?

- Are you comfortable counseling persons with sexual orientations different from yours?
- Have you worked with a variety of age groups?
- Do you have substantial knowledge of any particular population's key attributes and values regarding child rearing, marriage, financial matters, and other major matters of life?
- Do you know any other group's social and political history well enough to predict its impact on group dynamics around a given issue?

What resources in the community are available to meet the needs of special populations?

- Are cofacilitators with special expertise, such as fluency in other languages, available to assist with groups?
- Are services available in other languages? Have support groups been designed for racial/ethnic groups? Lesbians and gay men? Women? Elderly people?
- What State- and community-based organizations provide social services for people from nonmainstream cultures?

What systemic barriers and staff attitudes and beliefs inhibit cultural sensitivity and competence in your programs?

- Is cross-cultural training available to group leaders?
- Are any staff members fluent in languages spoken by potential clients in group?
- Is there someone in your agency or organization who assists clients with social services support, including Medicaid?

What are the characteristics of the person about to be placed?

- Are the client's language skills adequate to permit participation in this group?
- To what degree is the client acculturated? For example, how long has a Salvadoran been in this country?
- Is the client discriminated against?
- Does this client share traits (for example, educational attainment, socioeconomic status, motivation level) with others in the group who are not from the same population?
- How familiar is the client with the goals of therapy? With group therapy?

Figure 3-9

Self-Assessment Guide (continued)

- How does the client currently relate to the therapist? To treatment in general?
- How would the client fit into an existing group? Would the client be the only representative of that culture in the group? What is the current makeup of the group with respect to cultural diversity? What views do current members hold toward the prospective member's culture?
- How long has the person been a resident of your community? Is the client traveling from another community for therapy? How long has the person been a resident of this geographical area?
- Would the client fit in better with a homogeneous group; for example, a single-sex group for a woman who has been a victim of sexual abuse or incest?
- How does the client's family handle issues of power and control? Independence and autonomy? Trust? Communication of feelings?
- Does the culture of origin provide traditional healing practices that could be used in the group?
- Might specific cultural issues affect the recovery process?
- To what extent will the new client adapt to an existing group's norms?
- Will changes that satisfy the group's norms alienate the client from the culture of origin?
- What are the alternatives to placing the person in a specific group? What accommodations may have to be made?

Source: Adapted from Winkelman 1995. Used with permission.

Diversity and Placement

In many groups, the composition of members will be heterogeneous; for example, a majority of Caucasians placed with a minority of ethnically or racially different members. The greater the mix of ethnicities, the more likely that biases will emerge and require mediation (Brook et al. 1998). Whatever a client's belief system or origin, "neither the therapist nor the group should ask any group member to give up or renounce any ethnic/cultural beliefs, feelings, or attitudes. Rather, group members are encouraged to share these feelings and beliefs verbally and overtly, even if this may be upsetting to some or all of the group's members" (Brook et al. 1998, p. 77). Although therapists may be uncomfortable when group members talk about subjects like racism and discrimination, such expression sometimes is an important part of an individual's recovery process.

First-generation immigrants who speak little or no English usually are underrepresented in

group therapy because of their limited fluency. While an immigrant may be able to communicate adequately in individual therapy with a single healthcare professional, that newcomer may be unable to follow a fast-flowing group discussion.

As previously mentioned, before placing a client in a particular group, the therapist needs to understand the influence of culture, family structure, language, identity processes, health beliefs and attitudes, political issues, and the stigma associated with minority status for each client who is a potential candidate for a group. In addition, the therapist will need to do the following:

Address the substance abuse problem in a manner that is congruent with the client's culture. Each culture incorporates beliefs and values that guide the behavior of everyone identified with the culture and that govern experiences related to the use of substances. Some cultures, for instance, use chemical substances as part of rituals, some of them religious. This entwinement of substance use and culture does not mean that the therapist cannot discuss the issue of this substance use with a client. Some clients, of their own volition, will reduce or eliminate the use of substances once they examine their beliefs and experiences.

Appreciate that particular cultures use substances, usually in moderation, at specified types of social occasions. For many people, occasional, moderate use of substances might be part of a meaningful social/cultural ritual, but for people with substance use disorders such use, even when culturally accepted, is contraindicated because it might provoke relapse, binges, or other destructive reactions. Again, a culturally sensitive discussion of this issue with clients may result in individual decisions to abstain on these occasions, despite considerable cultural pressure to use substances of abuse. In contrast, some cultures have beliefs in direct opposition to the client's use of substances. Helping the client redirect behavior to come into accord with these beliefs may be an important treatment approach.

Assess the behaviors and attitudes of current group members to ascertain whether the new client would match the group. From the start of a multicultural therapy group, members should feel that race is a safe topic to discuss (Salvendy 1999). Because group members are less restricted to their usual social circles and customary ethnic and cultural boundaries, the group is potentially a social microcosm within which members may safely try out new ways of relating (Matsukawa 2001). Even so, potential problems between a candidate and existing group members should be identified and counteracted to prevent dropout and promote engagement cohesion among members.

Understanding the cultural characteristics of major racial and ethnic populations will permit better-informed decisions about placement.

Understand personal biases and prejudices about specific cultural groups. A group leader should be conscious of personal biases to be aware of countertransference issues, to serve as a role model for the group, and to create group norms that permit discussion of prejudice and other topics relevant to a multicultural setting.

Understanding the cultural characteristics of major racial and ethnic populations—particularly their history, acculturation level, family and community roles and relationships, health beliefs, and attitudes toward substance abuse—will permit better-informed decisions about the placement of individuals from these populations into existing therapy groups. Naturally, no group leader can know everything about every culture, but a good counselor can be aware of major characteristics of cultural groups. This knowledge can guide the placement of clients into appropriate groups and

Figure 3-10

Preparing the Group for a New Member From a Racial/Ethnic Minority

To promote cohesion, a positive group quality stemming from a sense of solidarity within the group, the group leader should

- Inform the group members in advance that people from a variety of backgrounds and racial and ethnic groups will be in the group.
- Discuss the differences at appropriate times in a sensitive way to provide an atmosphere of openness and tolerance.
- Set the tone for an open discussion of differences in beliefs and feelings.
- Help clients adapt to and cope with prejudice in effective ways, while maintaining their self-esteem.
- Integrate new clients into the group slowly, letting them set their own pace.
- When new members start to make comments about others or to accept feedback, encourage more participation.

help a leader anticipate relationships and tensions that may arise within a group.

Figure 3-10 provides tools to prepare both the group and the minority client for the client's entry and integration into an established therapeutic group.

One researcher cites four major dynamic processes that occur within a multiethnic group (Matsukawa 2001). Identifying these processes as they function in a group may help a therapist predict whether a possible placement will support a cohesive social microcosm or create a threatening and disruptive environment.

1. *Symbolism and nonverbal communication.* In some cultural groups, direct expression of thoughts and feelings is considered unseemly. Matsukawa (2001) points out that among the Japanese, a highly valued trait is the ability to sense what another person wants without explicitly stated cues. In such a culture, symbolic gestures (a gift, perhaps) or nonverbal signals (the author describes a woman who showed her craft work without comment) are used to communicate indirectly and acceptably. In such a situation, Matsukawa says, the therapeutic approach is modified to perceive and permit a Japanese-American woman to present herself tacitly without pressing for verbal elaboration. Therapists also should intervene if nonverbal communications are misinterpreted.
2. *Cultural transference of traits from one person of a certain culture to another person of that culture.* If a group member has had experiences (usually negative) with people of the same ethnicity as the therapist, the group member may transfer to the therapist the feelings and reactions developed with others of the therapist's ethnicity. In short, Matsukawa (2001) says, the group member jumps to conclusions and assigns traits to the therapist based on ethnicity alone. The therapist first should detect these miscon-

ceptions and then reveal them for what they are to dispel them.

3. *Cultural countertransference, the therapist's (often subconscious) emotional reaction to a client.* Therapists also can jump to conclusions. Countertransference of culture occurs when a therapist's response to a current group member is based on experience with a former group member of the same ethnicity as the new client. Matsukawa (2001) cautions therapists to exercise restraint when in the middle of a "countertransference storm."
4. *Ethnic prejudice.* "Stereotypes become prejudice," Matsukawa (2001, p. 256) writes, "when they are hard to modify and when one's interactions, or lack thereof, with another person are based on preconceived feelings and judgments about the person's race, without enough knowledge, understanding, or experience." In multiethnic groups, it is vital to develop an environment in which it is safe to talk about race. Not to do so will result in scapegoating or division along racial lines (Matsukawa 2001).

In practice, people connect and diverge in ways that cannot be predicted solely on the basis of ethnic or cultural identity. Two people from different ethnic backgrounds may share many other common experiences that provide a basis for identification and mutual support. All the same, it is possible to rule out some combinations. For example, two elderly men, one Korean and the other Japanese, may not blend well since their cultures have clashed in the past many times. Similarly, a single 17-year-old girl would not mix well with a group made up primarily of middle-aged males. Potentially undesirable and distracting group dynamics could easily be foreseen. Leaders are responsible for considering carefully the positions of people who are different in some way, especially when planning fixed-membership groups.

Ethnic and Cultural Matching

Although arguments for matching the ethnicity of the therapist with that of the group members treated may have some merit, the reality is that such a course seldom is feasible. Health care providers from culturally and linguistically diverse groups are underrepresented in the current service delivery system, so it is likely that a group leader will be from the mainstream culture (Cohen and Goode 1999). While it might be ideal to match all participants by ethnicity in a therapeutic group, the most important determinants of success are the values and attitudes shared by the therapist and group members (Brook et al. 1998).

It should be noted that recent research suggests that an ethnic match between therapist and client does not "consistently improve outcomes" (Salvendy 1999, p. 437). Other research (Atkinson and Lowe 1995) suggests that, while the ethnicity of the therapist is a factor that can influence treatment, it is by no means the most important factor. Culturally specific homogeneous groups should be used only when someone's "cultural, religious, or political beliefs are very different from the mainstream and they are not open to adjustments," as, for example, with recent immigrants or refugees (Brook et al. 1998; Ivey et al. 1993; Salvendy 1999, p. 457; Silverstein 1995; Takeuchi et al. 1995; Yeh et al. 1994).

If less acculturated people with limited language skills are treated in groups, the program should provide bilingual clinicians who are sensitive to gender and culture. Therapists should focus on problem-oriented, short-term treatment; should consider employing a proactive therapeutic style; and should be aware that clients may view them as authority figures (Brook et al. 1998).

In culturally specific groups, a member of the focus culture usually runs the group, although this ideal situation is not always possible. If a trained clinician who also belongs to the group is not available, it may be advantageous to add a cofacilitator who belongs to the population, understands the population's specific problems and strengths, and can serve as a role model to assist the clinician. Of course, if the program is not specifically focused on cultural or communi-

ty issues and is simply incorporating some cultural elements, the staffing requirements are not as stringent. In such cases, the presence of a member of the culture that developed the practice or knowledge is desirable, but not vital.

"Children often accompany their parents to therapeutic encounters to translate and provide support" for immigrant parents, but relying on "the children in this way actually perpetuates isolation and decreases pressure to build a network of supports. Finding an interpreter who not only speaks the language but also who may share the values and the migration experience is crucial to further the acculturation and therapy process" (Nakkab and Hernandez 1998, p. 98).

Other Considerations for Practice

Groups may include people who have varying

- Expectations of leaders
- Experience in decisionmaking and conflict resolution
- Understanding of gender roles, families, and community
- Values

All these differences, and many others, will affect individual and group experiences. Group leaders should be keenly aware of ways in which ethnicity and culture can affect participation in interactive therapy. One of the most profound ways that different cultural backgrounds may affect individuals in groups is in expectations of the leader. For example, many African Americans look to leaders as problemsolvers. In Hispanic/Latino culture, people are equals until proven otherwise—roles do not automatically constitute a supervisor/subordinate relationship (Wilbur and Roberts-Wilbur 1994).

Differences that may influence an individual's perception of a leader's role should be explored in the pregroup interview. The interviewer can explain how the leader's role may differ from what the client might expect. Later, in group, leaders need to be alert to unexpected differences in interpretation of their actions. For example, a group member who expects the leader to exercise authority might view a leader's attempt to empower the group as shirking responsibility. The leader can help by being explicit about his or her role and responsibilities in the group.

Group leaders also should be aware that people manage conflict in culturally diverse ways. A native New Yorker might have an in-your-face approach to conflict, while some Asian Americans may find a raised voice offensive. Cultural factors may frame a client's perception of conflict in a way not readily apparent to the group. For an example, see Figure 3-11.

For more detailed information on cultural diversity in client placement, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (SAMHSA in development *a*).

Once placement decisions are completed, group development begins. Chapter 4 explains this process.

Figure 3-11

Culture and the Perception of Conflict

A 33-year-old single, second-generation Chinese-Canadian woman joined a group after proper preparation. She was one of two non-Caucasians in this long-term, interpersonally focused, slow-turnover group. Unfortunately, in her first session, the group forcefully confronted an elderly man, who was emotionally abusive to his spouse and shirked responsibility for it. The new member froze throughout the session and was clearly very anxious. The therapist acknowledged her discomfort and the stressfulness of the situation for her. Nevertheless, the following day this client wanted to discontinue group, feeling very threatened by the directness of the confrontation and its target, the elderly father figure. Her anxiety was accepted as genuine and not seen as resistance by the therapist, who provided several individual sessions parallel to the group to clarify that this was not an attack on all fathers (including her own) in the group, and that it was done to help the elderly group member. This Chinese-Canadian client also was reassured that the other group members would be informed about the sociocultural reasons for her being upset, and that they would be empathic to her feelings on this matter. This intervention facilitated her integration in the group and her perception of the therapist as culturally credible and competent.

Source: Adapted from Salvendy 1999, p. 451.

4 Group Development and Phase-Specific Tasks

In This Chapter…

Fixed and Revolving Membership Groups

Fixed Membership Groups

Revolving Membership Groups

Preparing for Client Participation in Groups

Pregroup Interviews

Increasing Retention

Identifying the Need for Wraparound Services

Group Agreements

Phase-Specific Group Tasks

Beginning Phase—Preparing the Group To Begin

Middle Phase—Working Toward Productive Change

End Phase—Reaching Closure

Overview

This chapter begins by discussing the varying uses of fixed or revolving groups. Fixed groups generally stay together for a long time, while members in revolving groups remain only until they accomplish their goals. Each is used for different purposes, and each requires different leadership.

As treatment and recovery have stages, group development also changes over time. The first phase pays attention to orientation and establishing safe, effective working relationships. In the middle (and longest) phase, the actual work of the group is done. The end phase is a deliberate, positive termination of group business. Each phase requires attention to specific tasks.

Fixed and Revolving Membership Groups

The way groups are developed varies by the type of group. A wide range of therapeutic groups may be used with people who have substance use problems. For the purpose of this discussion, however, groups have been classified into two broad categories, each with the same two subcategories:

1. Fixed membership groups
   A. Time-limited
   B. Ongoing
2. Revolving membership groups
   A. Time-limited
   B. Ongoing

Fixed Membership Groups

Fixed membership groups are relatively small (not more than 15 members); membership is relatively stable. Typically, the therapist screens prospective members, who then receive formal preparation for participation. Any departure from the group occurs through a well-defined process. Two variations of this category are

- A time-limited group, in which the same group of people attend a specified number of sessions, generally starting and finishing together
- An ongoing group, in which new members fill vacancies in a group that continues over a long period of time

In time-limited groups with fixed membership, learning builds on what has taken place in prior meetings. Thus, members need to be in the group from its start. New members are admitted only in the earliest stages of group development (for example, only during the first week for a daily group or during the first month for a group that meets weekly). Ongoing fixed membership groups may be used for short-term therapy, skill building, psychoeducation, and relapse prevention.

New members enter a revolving membership group when they become ready for the service it provides.

In ongoing groups with fixed membership, the size of the group is set; new members enter only when there is a vacancy. The leader generally is less active than is the leader of a time-limited group, since the interaction among group members is more important than leader-to-member interactions. To conduct this type of group, the leader needs substantial training in group dynamics (such as individuals' boundaries and the roles different members assume) and leadership along with excellent supervisory skills. Examples in this category include interpersonal process groups and some psychoeducational therapy groups.

Fixed groups are rare because they demand a long-term commitment of resources. Most outpatient programs provide only 8–20 sessions, and most inpatient programs are limited to 2–4 weeks.

Revolving Membership Groups

New members enter a revolving membership group when they become ready for the service it provides. Revolving membership groups frequently are found in inpatient treatment programs. As clients are admitted and discharged, people come and go in the group. Consequently, revolving groups must adjust to frequent, unpredictable membership changes. The two variations of revolving membership groups are

- A time-limited group that members generally join for a set number of sessions
- An ongoing group that clients join until they accomplish their goals

Revolving membership groups can be larger than fixed membership groups. The temptation to have many members often is strong due to insufficiently trained staff and shortages of funding. While revolving membership groups have no absolute limit on the number of members, it is prudent to keep the group small enough (about 15 or fewer) for participants to feel heard and understood, for the leader to know each of them, and for members to feel a sense of connection and belonging to the group. If a group becomes too large (more than 20), group interaction breaks down and the clients become a class made up of individuals, rather than a single, cohesive, therapeutic body.

Revolving membership groups generally are more structured and require more active lead-

One advantage to revolving membership groups is the stimulation that new members provide.

ership than fixed membership groups. Participation and learning are not highly dependent on attendance at previous sessions. In some settings, new members may be brought in at fixed intervals. In a daily group, for instance, new members might enter once a week. Members who have been in the group for a substantial number of meetings often help to orient newer members.

One advantage to revolving membership groups is the stimulation that new members provide. A potential problem is that new group members may dread joining a group, feeling themselves to be at a disadvantage because existing members already know each other, how the group operates, and what has been discussed in previous sessions. For its part, the group itself may be apprehensive about the new member (Rasmussen 1999).

A related possible problem is the adverse effect that membership changes can have on group cohesion. For these reasons, preparation for revolving groups is of paramount importance: Group leaders need to pay special attention to helping new members become acclimated to the group, and clients chosen to fill a group vacancy should have the capacity to observe and adjust to the dynamics of the group (Rasmussen 1999).

In time-limited groups, each member generally is expected to attend a certain number of sessions for a certain number of weeks or months. A psychodrama group (one kind of expressive therapy group), for example, might be offered every spring. Other common examples include psychoeducational groups and some skills-building groups.

Several possible varieties of ongoing groups have revolving membership. Such groups may be (1) open-ended, with clients staying for as many sessions as they wish; (2) repeating sets of topics, with clients staying only until they have completed all of the topics; or (3) a duration-specific format, with clients attending for a set number of weeks (either consecutively or non-consecutively). An interpersonal process group as part of an intensive outpatient program is an example of an ongoing group with revolving membership. Clients enter this treatment group and attend until the work specified in the treatment plan has been completed.

Other examples of revolving membership groups include inpatient unit groups, continuing care drop-in groups, transition groups for inpatients leaving and moving to outpatient care, psychoeducational groups, expressive therapy groups, and long-term support groups, such as ongoing continuing care groups and maintenance groups. Figure 4-1 (see p. 62) provides the characteristics of fixed and revolving membership groups.

Preparing for Client Participation in Groups

Pregroup Interviews

Research shows a strong tendency toward relapse early in the substance abuse treatment process. A person early in recovery is at greater risk for returning to use than someone with 3, 6, or even 18 months of abstinence (Johnson 1973; Project MATCH 1997). The better clients are prepared for treatment, however, the longer they stay in treatment. If clinicians ensure that clients come to the group with appropriate expectations, both clinicians and clients can expect a greater degree of success.

Group leaders should conduct initial individual sessions with the candidate for group to form a therapeutic alliance, to reach consensus on what is to be accomplished in therapy, to educate the client about group therapy, to allay anxiety related to joining a group, and to

Figure 4-1

Characteristics of Fixed and Revolving Membership Groups

	Entry	Group Development	Examples
Fixed Membership Groups			
Time-limited	• New members admitted only in earliest stages of group development • Groups begin and end with same membership	• Learning built on what has happened in prior meetings	• Short-term therapy groups • Skills-building and psychoeducational groups • Relapse prevention groups
Ongoing	• Group size fixed • New members enter only after vacancy or graduation • Members expected to stay for a substantial period of time	• Dynamics of group process (such as individuals' boundaries and the roles different members assume) are the primary source of learning, healing for participants	• Ongoing interpersonal process groups • Long-term supportive therapy groups
Revolving Membership Groups			
Time-limited	• Number of sessions usually fixed	• Learning at each session relatively independent of previous group sessions	• Expressive therapy groups (dance therapy, psychodrama) • Psychoeducational groups • Some skills-building groups
Ongoing	• Clients may (1) stay as long as they wish, (2) be required to attend sessions with set topics, or (3) be required to attend set number of weeks • Usually a set maximum number of participants	• More structured • Active leadership	• Client hall groups • Day hospital check-in groups • Continuing care drop-in groups • Transition groups for clients leaving inpatient and moving to outpatient care • Psychoeducational groups • Expressive therapy groups • Long-term supportive groups, such as ongoing continuing care groups and maintenance groups

explain the group agreement. These activities may take as little as one meeting or as long as several weeks (Rutan and Stone 2001). Normally, the longer the expected duration of the group, the longer the preparation phase. Clients should have an opportunity to air any concerns, especially if they are apprehensive about their cultural status within the group. During this time, the group facilitator should learn how the client handles interpersonal functions on a day-to-day basis, how the client's family functions, and how the client's culture perceives the substance abuse problem.

The process of preparing the client for participation in group therapy begins as early as the initial contact between the client and the program. Clients' preconceptions about the group, their expectation of how the group will benefit them, their understanding of how they are expected to participate, and whether they have experienced a motivational session prior to the group will all influence members' participation.

Preparation meetings serve a dual purpose. First, they ensure that clients understand expectations and are willing and able to meet them. Second, these meetings help clients become familiar with group therapy processes. Where in-depth, one-on-one meetings are impractical because of group size or other considerations, at least some form of orientation should be provided, perhaps in the form of readings, videotape, group preparation meeting, or discussion with the primary counselor prior to attending a group.

Pregroup interviews are widely used to gather useful information about clients and prepare them for what they can expect from a group. The pregroup interview should cover clients' goals for treatment, the group contract, client behaviors that might present an obstacle to group work, and any other information that clients feel may be pertinent (Vannicelli 1992). Clients should be thoroughly informed about what group therapy will be like. In addition, client preparation should address the following:

Explain how group interactions compare to those in self-help groups, such as Alcoholics Anonymous (AA). Clients should be informed that group therapy differs from 12-Step or other similar recovery groups. In particular, the member-to-member "cross-talk" discouraged in 12-Step groups is an essential part of interactive therapy (Margolis and Zweben 1998). Although clients sometimes perceive a conflict between their AA or Al-Anon experience and group therapy due to these different formats, the therapist should know with certainty that the two are not mutually exclusive, but that they serve different functions and provide support in distinct, complementary ways (Vannicelli 1992). Therapists also should be careful to distinguish treatment groups from AA's self-help approach, which, having no formal leadership, cannot provide meaningful accountability (Vannicelli 1992; Zweben 1995).

Emphasize that treatment is a long-term process. Participants should know in advance that in group therapy, each person's attendance at each session is vital. They should also recognize that while the first 3 months of treatment after detoxification are critical, fully effective treatment takes much longer.

Let new members know they may be tempted to leave the group at times. It should be emphasized that although the work is difficult and even upsetting at times, clients gain a great deal from persistent commitment to the process and should resist any temptation to leave the group. Clients also should be encouraged to discuss thoughts about leaving the group when they arise so that the antecedents of these thoughts can be examined and resolved.

Give prospective and novice members an opportunity to express anxiety about group work, and help allay their fears with information. For some prospective members, group process work may need to be demythologized. Misperceptions should be countered to keep them from interfering with group participation. Some providers conduct a short-term group to prepare clients for upcoming participation in other kinds of groups. This approach enables

leaders to assess clients' suitability for various types of group work.

Recognize and address clients' therapeutic hopes. With help, clients can explain how they think group work can help them, identify their preferences, and articulate realistic goals. Leaders can use this information to be sure that clients are placed in groups most likely to fulfill their aspirations.

For a sample dialog that takes place in a preparation interview, see "Preparing the Patient for Group Psychotherapy" (Hoffman 1999).

In preparing prospective members for a group experience, it is important to be sensitive to people who are different from the majority of the other participants in some way. Such a person may be much older or younger than the rest of the group, the lone woman, the only member with a particular disorder, or the person from a distinctive ethnic or cultural minority. The leader should consult privately with people who stand out in the group to determine from their unique perspective how they are experiencing the group. They should always be allowed to be the experts on their own situation. Further, clients should be encouraged to define the extent of their identification with the groups to which they belong and to determine what that identification implies.

The fixed membership format provides more time to discuss issues of difference prior to joining a group. A person unlike the rest of the group may be asked by the other group members:

- How do you think you would feel in a group in which you differ from other group members?
- What would it be like to be in a group where everyone else is a strong believer in something, such as AA, and you are not?

Such questions might be coupled with positive comments that stress the benefits that a unique perspective may bring to the group.

It is important to explore issues of difference in advance of group placement. It similarly is important to acknowledge cultural or ethnic backgrounds and to emphasize that differences can be strengths that can contribute to the group. If a client believes that a particular group situation would be uncomfortable, however, the counselor may offer the client other treatment options.

The counselor also is responsible for raising the level of group members' sensitivity and empathy. It is important at times, for instance, to prepare group members for situations in which others have symptoms that could offend or repel them. The therapist can initiate discussion by asking questions such as, "What would it be like for you to be with people who sometimes cut themselves?"

While group leaders have many responsibilities to prepare clients for participation in groups, the clients have obligations, too. Their responsibilities are specified in group agreements, discussed later in this chapter.

Increasing Retention

Throughout the initial sessions of therapy, clients are particularly vulnerable to return to substance use and to discontinue treatment. The first month appears to be especially critical (Margolis and Zweben 1998). Yalom (1995) writes that premature termination usually "stems from problems caused by deviancy, subgrouping, conflicts in intimacy and disclosure, the role of the early provocateur, external stress, complications of concurrent individual and group therapy, inability to share the leader, inadequate preparation, and emotional contagion" (p. 315) (a concept discussed later in chapter 6).

Retention rates are affected positively by client preparation, maximum client involvement during the early stages of treatment, the use of feedback, prompts to encourage attendance, and the provision of wraparound services (such as child care and transportation) to make it possible or easier for clients to attend regularly.

Consideration needs to be given to the timing and length of groups, too, because these factors affect retention.

To achieve maximum involvement in group therapy during this period, motivational techniques, such as psychoeducation and attendance prompts, may be used to engage the client. Evidence suggests that if people are self-motivated, they will persist longer in behaviors consistent with recovery, and will attach more value to their quest than they would in response to external pressure. Incorporating motivational elements in pregroup preparation or offering groups that focus on motivation is likely to increase compliance with continuing care requirements (Foote et al. 1999).

Some pretreatment techniques that appear to reduce the incidence of dropping out include the following:

- *Role induction* uses formats such as interviews, lectures, and films to educate clients about the reasons for therapy, setting realistic goals for therapy, expected client behaviors, and so on.
- *Vicarious pretraining* using interviews, lectures, films, or other settings demonstrates what takes place during therapy so the client can experience the process vicariously.
- *Experiential pretraining* uses group exercises to teach client behaviors like self-disclosure and examination of emotions.
- *Motivational interviews* use specific listening and questioning strategies to help the client overcome doubt about making changes (Walitzer et al. 1999).

Prompts to remind clients of upcoming group sessions are another important way to engage group members during the first 3 months of treatment (Lash and Blosser 1999). One successful strategy increased the number of clients who began continuing care group therapy and nearly doubled the attendance at group sessions (Lash and Blosser 1999). The plan included:

- An explanation to each client of the importance of continuing care in maintaining sobriety and the use of a continuing care participation contract.
- An appointment card and an automated telephone message reminder of each upcoming group session.
- A note from the therapist following the first session saying that he was glad the client chose to attend the group and was looking forward to seeing the client at upcoming sessions.
- At least two follow-up phone calls after missed sessions (Lash and Blosser 1999).

Yalom (1995) notes that it is common practice for therapists to try to forestall premature termination by persuading clients who plan to leave group to attend just one more session. The hope is that other group members will persuade the restless member not to drop out. This tactic rarely works, however. Instead, during the preparation of clients for group, Yalom suggests emphasizing that periods of discouragement are likely to occur during therapy.

Another effective way to retain clients can be used in groups that have a few veteran members. When new members join, the old members are asked to predict which new member will be the first to drop out. This prediction paradoxically increases the probability that it will not be fulfilled (Yalom 1995).

Researchers note that these simple initiatives, which make so much difference in continuing care engagement, and the outcomes of treatment, "required minimal clinical and clerical time to conduct" (Lash and Blosser 1999, p. 58). However, while automated phone reminders might be useful for highly structured skills-building groups early

To achieve maximum involvement in group therapy during this period, motivational techniques may be used.

in recovery or for groups of low-functioning clients, in interpersonal process groups with higher functioning clients, the prompts might set up norms that place too much responsibility on the leader and too little on group members.

Identifying the Need for Wraparound Services

Practical problems, such as a lack of suitable childcare or transportation, deter many clients from participation in substance abuse counseling services. Many programs find that when they provide wraparound services to meet these and other practical needs, they retain clients in therapy longer. As a result, clients are more likely to develop new behaviors and thought processes that enable them to remain abstinent. Two examples of programs that provide such services are described in Figures 4-2 and 4-3.

The first step toward wraparound services is to document the need for them. The next step is to recognize that wraparound services seldom flourish in isolation. A thorough search of existing community resources may identify services already in place that could meet some

Figure 4-2

The Family Care Program of the Duke Addictions Program

The Family Care Program (FCP) at Duke University in Durham, North Carolina, is a substance abuse program for women who abuse substances and are pregnant and/or mothers of young children. Transportation is a major difficulty for many of the women and should be provided if their group experience is to be consistent. Using vans supplied by the county and the State, FCP uses Medicaid funding to provide transportation to and from approved medical interventions. The program schedules appropriate transportation for the mother and her children on days that therapy is provided at the Duke Addictions Program.

Viewing the mother and child dyad as the client, FCP provides wraparound services to support the involvement of the woman and her children in treatment. FCP works closely with the Department of Social Services, the Child Protection Team at Duke University Medical Center, Head Start, and Vocational Rehabilitation, thus providing a wide range of services, all coordinated through FCP.

Because women are encouraged to bring their infants to group, changing tables and diapers are available within the group space. For the physical comfort of pregnant women, particularly those in the later stages of pregnancy, rooms are furnished with chairs that move into a variety of positions.

Older children who are not yet in school are also included in the treatment program. Because these children could be upset by the subject matter that can arise in the group, they are not present when women are discussing sensitive issues. Instead, they have their own treatment programs, supported by a specially trained child treatment and intervention specialist, who works with the children on issues of self-esteem, life skills, overall adjustment, and academic performance.

Source: Jeffrey M. Georgi, Senior Clinician, Duke Addictions Program.

Figure 4-3

SageWind

SageWind in Reno, Nevada, provides a variety of wraparound services to support clients in recovery. First, it has a working agreement with the local school district's alternative high school education program, under which two teachers help clients acquire high school credits that can be transferred to other schools in the district. SageWind pays the salary of one teacher and the district pays the other. SageWind also hires two summer school teachers in order to offer clients year-round schooling. Throughout the year, college students and other adult volunteers provide tutoring.

SageWind has a full-time wellness coordinator who is a licensed substance abuse counselor. The wellness program includes a wide range of recreational activities designed to teach clients to enjoy alcohol- and drug-free experiences. Clients participate in such activities as woodshop projects, along with basketball, pool, bowling, baseball, and volleyball games.

Through a Qualified Service Organization Agreement with the county health department, SageWind offers onsite mandatory tuberculosis testing and counseling and voluntary HIV and pregnancy testing and counseling. A registered nurse teaches a weekly health class on issues ranging from communicable diseases to nutrition. Treatment technicians can provide transportation, picking up clients for treatment and returning them to work or home. When necessary, SageWind also offers bus passes.

An onsite mental health and family clinic at SageWind addresses co-occurring disorders and strengthens the family unit. Multifamily group counseling, family support groups, couples counseling, and family therapy help develop skills needed for the survival and growth of the family.

All of SageWind's primary counselors also function as case managers. If a client or the client's family needs housing, food, clothing, or medical care, counselors will provide referral information and assistance. SageWind receives donated returned items from two of the area's largest retailers. The agency maintains a clothes closet and can also help clients obtain household furnishings and similar necessities. Any remaining items are donated to other nonprofit organizations in nearby areas.

Finally, a full-time career counselor at SageWind facilitates a career track. The counselor provides individual and group services, as well as onsite monitoring of clients' job performance. The goal is to assist clients not only to gain employment, but to perform well consistently in their jobs.

Source: A Consensus Panel member.

needs. Services still needed can be provided by initiating cooperative ventures with organizations that have similar interests and complementary capabilities. Note all the cooperation between and among organizations described in Figures 4-2 and 4-3.

Group Agreements

A group agreement establishes the expectations that group members have of each other, the leader, and the group itself. For example, many leaders require that group members entering long-term fixed membership groups commit to remain in the group for a set period. Another common provision of group contracts stipulates that sessions will start and end at specific times. The leader should make sure that these time boundaries are observed, both by clients and the leader. Group members cannot be expected to abide by the group agreement if the leader does not.

A group member's acceptance of the contract before entering a group has been described as the single most important factor contributing to the success of outpatient therapy groups (Flores 1997). Consequently, it is important to present the contract in a way that causes clients to view it as a true commitment and not a mere formality. Particularly with people referred to treatment through the criminal justice system, it is important to make therapeutic contracts that are explicit and clear, and that carry a firm expectation that the agreement is to be honored by all members of the group.

> It is important to present the contract in a way that causes clients to view it as a true commitment and not a mere formality.

To reinforce the importance of the agreement as the basis for group activities, group members can be asked to recall specific agreements during the first session. To an appropriate response, the leader can reply, "Yes, that's an important one." Responses that are distorted may be referred to the group to determine how others recall the agreement (Vannicelli 1992).

The agreement provides for "a mutual understanding of the common task and the conditions under which it will be pursued. It is through the contract that the leader derives his authority to work: to propose activities, to confront a member, to make interpretations. And it is by virtue of the contract that certain other activities can be declared 'out of bounds' by either leader or member" (Singer et al. 1975, p. 147).

Sometimes, obtaining compliance to the group agreement requires flexibility and ingenuity. In some cultures, for example, time is a process, not a concept represented by a number. Of course, it remains important to maintain time boundaries. However, when many group members share a culture or ethnicity with a markedly relaxed attitude toward time, it may be appropriate to design and adhere to a structure appropriate for that group. For example, SageWind accommodates its Hispanic/Latino clients' flexible view of time and traditions of sociability. One model moves clients from a shared lunch to group. By the time group starts, all its members have arrived and are ready to begin group work. Another tactic is to schedule longer group times that enable members to move into group work from a socializing phase, usually including rituals of food or music.

The group agreement is intended to inspire clients to accept the basic rules and premises of the group and to increase their determination and ability to succeed. These agreements are not meant to provide a basis for excluding or punishing anyone. On the contrary, the leader should understand that few group members are able to meet all stipulations in the agreement throughout their recovery. When provisions of the group agreement are violated, the leader should avoid assuming an authoritarian role

Figure 4-4

Examples of Agreements About Time and Attendance

Regular and timely attendance at all sessions is expected. As a member, it is your responsibility to notify the group in advance when you know that you will be away or late for group. To emphasize the importance of each person to the group, members are also required to notify the leader when they are unable to attend. Members joining long-term groups remain as long as they find the group useful in working on important issues in their lives. We recommend at least 1 year's participation. Members are required to make an initial 3-month commitment in order to determine the usefulness of this particular group for them. In the event of an unexpected absence, group members are expected to notify the group at least 24 hours in advance to avoid being charged for the missed session.	*Attendance.* Regular attendance and punctuality increase the value of the group for each member. Such cohesiveness creates a climate of work, support, and success. In the event of a member's inability or decision not to attend a session, a telephone call to this effect is expected. Group will begin and end promptly at the designated times. Group members will agree to be in group at the time it starts and stay until it finishes. *Commitment.* Members are allowed to join the group only if they are willing to make a 6-month commitment. This agreement ensures that the group process will not be disrupted by members "dropping in" for one or two sessions and then dropping out of the group. The agreement also ensures that any person who joins the group will be making enough of a commitment to benefit from the group.
Source: Vannicelli 1992, p. 295.	*Source:* Philip J. Flores.

and instead ask questions that refer infractions to the group. The violation becomes important and useful material for group members to discuss as part of the group process. The errant behavior should be understood as a meaningful deviation and approached with interest and curiosity, not with an air of reproach. See Figures 4-4 and 4-5 (see p. 71) for examples of group agreement stipulations.

Communicating grounds for exclusion

The terms under which clients will be excluded from the group should be made explicit in the group agreement, so exclusion does not come as a surprise. Some stipulations in the group agreement might have to incorporate legal requirements since court-mandated treatment groups may have attendance criteria set by the State. If so, the State will set forth the consequences for failure to attend the requisite number of sessions.

Confidentiality

Group members should be asked not to discuss anything outside the group that could reveal the identity of other members. The leader should emphasize that confidentiality is critical and should strongly encourage group members to honor their pledge of confidentiality. The principle that "what is said in the group stays in the group" is a way of delineating group boundaries and increasing trust in the group. This atmosphere of trust is essential for group members to feel safe enough to disclose their feelings and problems.

Though group members are precluded from identifying other members of the group or discussing anything they say, members can discuss the themes of the group and what they personally have said. In fact, talking about the group with a significant other or therapist in a way that does not violate the confidentiality of others can be important to a client's growth.

Under some circumstances, as defined by the Federal confidentiality regulation or by more stringent State regulation, certain information may be shared. However, the information shared without consent is restricted by the minimum necessary clause. Refer to 42 C.F.R., Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records to identify the specific circumstances under which these exceptions apply. Group members should know what information about them might be shared and why, how, and when this sharing occurs, so they do not feel betrayed when someone outside the group knows about something said within the group.

> Group leaders need to be familiar with confidentiality requirements in their programs and their States.

Except in situations specified in Federal law, programs may not disclose information about the services a client receives without the client's written consent. The law is explained in detail in *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* (Lopez 1994).

The leader should emphasize how to structure consent and disclosure, especially through discussion of the minimum necessary principle. Only specific information can be disclosed. Legal requirements commonly require, for example, that the therapist report instances of elder or child abuse and take action when clients threaten to harm themselves or others. Actions might include the hospitalization of the prospective perpetrator and/or a warning to the intended victim. Group leaders need to be familiar with confidentiality requirements in their programs and their States. See chapter 6 for a discussion of confidentiality.

Physical contact

Touch in a group is never neutral. People have different personal histories and cultural backgrounds that lead to different interpretations of what touch means. Consequently, the leader should evaluate carefully any circumstance in which physical contact occurs, even when it is intended to be positive. In most groups, touch (handholding or hugs) as part of group rituals is not recommended, though in others (such as an expressive therapy or dance group), touch may be acceptable and normative. Naturally, group agreements always should include a clause prohibiting physical violence.

Use of mood-altering substances

Some programs, especially ones connected to the judicial system, have policies that require expulsion of group members who are using drugs of abuse. Counselors are required to report these violations. Part of client prepara-

tion and orientation is to explain all legally mandated provisions and consequences for failure to comply with group and treatment guidelines.

Many in the substance abuse treatment field believe that such rules lead to withholding of information (Vannicelli 1992). They reason that clients cannot be open and honest about substance use if their candor is punished. A reasonable requirement, many believe, is that clients "must be in an appropriate condition to participate in order to be at the group. This allows the therapist to make a clinical judgment on a case-by-case basis, as to whether or not a client who has slipped may benefit from being in the group that night" (Vannicelli 1992, pp. 59–60). Members also should pledge to discuss a return to use promptly after it occurs (providing that group rules permit and encourage such disclosures).

Contact outside the group

Generally speaking, the group agreement should discourage personal contact outside the group. The reality is, however, that clients who have bonded in group are likely to communicate outside the group and may encounter each other on occasions like AA meetings. Under some circumstances, it may even be desirable to encourage individuals who support each other's efforts to abstain from substance abuse. The group members need to be told and reminded that new intimate relationships are hazardous to early recovery and are therefore discouraged. Further, any contacts outside the group should be discussed openly in the group.

Figure 4-5

Examples of Agreements About Group Participation

Members will have a commitment to talk about important issues in their lives that cause difficulty in relating to others or in living life fully. Members will have a commitment to talk about what is going on in the group itself as a way of better understanding their own interpersonal dynamics.	To help you benefit most from your group experience, you will agree to: Talk about the issues and problems that prompted you to join the group. Tell the emotionally meaningful stories of your life. Verbally communicate your immediate thoughts and feelings about yourself, the group leaders, and the group members. Take an equal share of the total talking time. Not leave the group before you complete or resolve what you came to the group to address.
Source: Vannicelli 1992, p. 295.	*Source:* Philip J. Flores.

Participation in the life of the group

The group agreement should specify what group members are expected to divulge. For example, group members should be willing to discuss, in an honest way, the issues that brought them to the group. Instructions to participants should emphasize that they are responsible for maintaining their personal boundaries, and they should participate at the pace and level they find comfortable. They should not be required to share personal information until they feel safe enough to do so.

Financial responsibility

In the group agreement, members agree to pay their bills at a specified time. The agreement also may specify (1) a commitment to discuss any problems that occur in making payments (Vannicelli 1992) and (2) the circumstances under which a group member will be held responsible for payments. For example, group members should know ahead of time that they will be financially responsible for missed sessions if that is the agency policy.

Termination

Group agreements should specify how group members should handle termination or occasions when they are considering termination. Sometimes, a group member close to an emotionally charged issue may decide to terminate rather than to confront the uncomfortable feelings. Because group members often are tempted to leave the group prematurely instead of working toward the necessary changes in their lives, the agreement should emphasize the need to involve the group in termination decisions. Ultimately, however, the group members should make their own choice about discontinuing treatment.

> Premature termination (dropping out) may have serious consequences for some clients.

Premature termination (dropping out) may have serious consequences for some clients. Court-referred clients (those on parole, probation, and so on) must be reported if they drop out of treatment. The group agreement should clearly state all requirements for reporting and all consequences established by the referring agency. Members of the group should all clearly understand what behaviors might lead to a premature termination.

Phase-Specific Group Tasks

Every group has a beginning, middle, and end. These phases occur at different times for different types of groups. One or two sessions of a particular revolving membership group may cover all three stages of group therapy for a particular client, while for a long-term fixed membership group, several sessions may be only part of the beginning phase. Whatever the type or length of a group, the group leader is responsible for attending to certain key elements at each of these points. (Note that this discussion focuses on phases of group development, not phases of treatment.)

Beginning Phase—Preparing the Group To Begin

During the beginning phase of group therapy, issues arise around topics such as orientation, beginners' anxiety, and the role of the leader. The purpose of the group is articulated, working conditions of the group are established, members are introduced, a positive tone is set for the group, and group work begins. This phase may last from 10 minutes to a number of months. In a revolving group, this orientation will happen each time a new member joins the group.

Introductions

Even in short-term revolving membership groups, it is important for the leader to connect with each member. This joining can be as simple as a friendly smile and a one-word welcome. At this time, all members, at the very least, should have an opportunity to give their names and say something about themselves. Some leaders ask members to introduce themselves. Others let the group figure out how to get acquainted. One cautionary note, however, is that many clients treated for substance abuse also have histories of emotional and physical abuse. Merely directing attention toward them can trigger feelings of shame. Thus, while it is extremely important to make connections between and among group members and to involve them in the process, the sensitive leader will not insist on recitations. Emotional safety always should be foremost in the group leader's mind.

At the first meeting of a fixed membership group, group members also may be asked if they know anyone else in the group. If there are connections that might cause difficulties, they will be discovered at the start.

Each new member who joins the group is entering the beginning phase of the group—for that individual. It is not easy to find one's place in an already established group. The leader can help build bridges between old and new members by pointing out that it is difficult to be the new member and by encouraging old members to help the new one join the group. In long-term fixed membership groups, the group will require careful preparation to receive a new member graciously. Even in revolving membership groups, which provide less opportunity for preparation, the leader should let members know when to expect membership changes, introduce new members, and help build bridges—for example, by inviting existing members to say something about the group and how it works.

Ideally, membership changes should be held to a minimum, especially in fixed membership groups, though as members graduate, new members will need to enter to ensure survival of the group. In contrast, revolving membership groups may have frequent changes because of the demands of treatment payment guidelines or admission and discharge procedures. Careful thought should be given to the pace and timing of membership changes for particular group types.

Group agreement review

The group agreement should be reviewed in an interactive way, involving the group members in discussion of the terms. The group leader should ask members if they are aware of concerns that might require additional group agreement provisions to make the group a safe place to share and grow. Group members should have an opportunity to suggest and discuss further stipulations. In addition, the group agreement should be reviewed periodically.

Ideally, membership changes should be held to a minimum, especially in fixed membership groups.

Providing a safe, cohesive environment

During the beginning phase of the group, all members should feel that they have a part to play in the group and have something in common with other members. This cohesion, both among clients and between the clients and the group leader, will affect the productivity of work throughout the therapeutic process. Among the many components of group cohesion are "connectedness of the group demonstrated by working toward a common therapeutic goal;

acceptance, support, and identification with the group; affiliation, acceptance, and attractiveness of the group; and engagement" (Marziali et al. 1997, p. 476).

In the beginning phase, the leader ordinarily needs to be more supportive and active than will be necessary once the group gets underway. If particular members have spoken very little, it helps to let them know that their contributions are welcome. The leader might say something like, "We haven't heard much from you tonight, Jane, but perhaps next week the group will have a chance to get to know you a little bit more" (Vannicelli 1992, p. 48).

To help group members bond with each other, the leader should encourage the connections members begin to make on their own and should point out similarities. The leader might say, for instance, "It seems that Sue and Bob, and perhaps others in here as well, are struggling with very similar problems with their anger" (Vannicelli 1992, pp. 48–49).

The leader also is responsible for ensuring that early in the group, emotional expression stays at a manageable level. Otherwise, members quickly may feel emotionally overloaded and begin to withdraw. Care always should be taken not to shame group members or to allow others in the group to engage in shaming behaviors.

The leader also should bear in mind that in the beginning phase, the group is unable to withstand much conflict. Before the group develops trust and cohesion, conflict is likely to disrupt proceedings or even to threaten a group's existence, so it is unwise to permit confrontation. Instead the group leader should encourage interaction that minimizes aggression and hostility. Later, when the group is more stable, group members may be urged to risk more provocative positions (Flores 1997).

Establishing norms

It is up to the leader to make sure that healthy group norms are established and that counterproductive norms are precluded, ignored, or extinguished. The leader shapes norms not only through responses to events in the group, but also by modeling the behavior expected of others. For example, norms to be encouraged in a process group include honesty, spontaneity, a high level of attentive involvement, appropriate

Figure 4-6

Reminders for Each Group Session

Open.

Announcements: Who will be late? Absent? Does the leader plan any absences?

If there are new members, welcome them. Then explain the goals of the group. Encourage new members to express their goals.

Track process.

To refocus the direction of the group, ask:

- How are things going (or feeling) in the group?
- What is happening right now?
- Does it feel as if we are on track?

Figure 4-6

Reminders for Each Group Session (continued)

Don't fight what is hard—use it!

Capitalize on the energy of resistance (the client's defense against the pain of self-examination) by

- Noticing it
- Validating it by welcoming honesty
- Linking it to group goals

Connect before tackling. Ally before confronting or stopping behavior.

Note the speaker's positive intentions or efforts. Then ask the speaker to examine his behavior or change course.

Encourage mutual connections among members.

Underscore resonating responses, either verbal or nonverbal. Ask how others are reacting to what is being shared.

Share the work.

Use the group to help you when the going gets rough:

- Share your conflict and ask the group to help with it.
- When a problem occurs, ask the group members to share their thoughts about how to proceed. For example, "Max clearly has a lot on his mind. Do we go with that issue or stick to where we were headed a few minutes ago?"

Close.

Note that the time is up, or soon will be.

As you state the end boundary, ask if it is a hard time to end.

Source: Vannicelli, unpublished manuscript.

self-disclosure, the desire for insight into one's own behavior, nonjudgmental acceptance of others, and the determination to change unhealthy practices (Flores 1997). Unhealthy norms that could hamper a process group include a tendency to become leader-centered, one-dimensional (that is, all-loving or all-attacking), or so tightly knit that the group is hostile to new members (Flores 1997). The leader should respond quickly and clearly to habits that impede group work and that threaten to become normative.

Termination is a particularly important opportunity for members to honor the work they have done.

Initiating the work of the group

The leader facilitates the work of the group, whether by providing information in a psychoeducational group or by encouraging honest exchanges among members in other types of groups. Most leaders strive to keep the focus on the here and now as much as possible. The leader also may need to prompt a new group with questions such as, "You seem to be responding to what Jane was sharing. Can you tell us something about what was going on for you as she was talking?" (Vannicelli 1992, p. 50).

Middle Phase—Working Toward Productive Change

The group in its middle phase encounters and accomplishes most of the actual work of therapy. During this phase, the leader balances content, which is the information and feelings overtly expressed in the group, and process, which is how members interact in the group. The therapy is in both the content and process. Both contribute to the connections between and among group members, and it is those connections that are therapeutic.

Many new leaders focus strongly on content, but thoughtful attention to group process is extremely important. Even in an educational group, tension in the room, rolling eyes, or side conversations can interfere with messages that need attention. In a process group, these cues are part of the work and need to be explored actively, but even in more content-oriented groups, nonverbal cues are indicative and should not be ignored.

The group, then, is a forum where clients interact with others. In this give and take of therapy, clients receive feedback that helps them rethink their behaviors and move toward productive changes. The leader helps group members by allocating time to address the issues that arise, by paying attention to relations among group members, and by modeling a healthy interactional style that combines honesty with compassion. Figure 4-6 (p. 74) suggests some ways in which a group leader can help the group accomplish its middle-phase tasks.

End Phase—Reaching Closure

Termination is a particularly important opportunity for members to honor the work they have done, to grieve the loss of associations and friendships, and to look forward to a positive future. Group members should learn and practice saying "good-bye," understanding that it is necessary to make room in their lives for the next "hello."

"Termination," Yalom (1995, pp. 361–362) observes, "is more than the end of therapy; it is … an important force in the process of change … a stage in the individual's career of growth." The group begins this work of termination when the group as a whole reaches its agreed-upon termination point or a member determines that it is time to leave the group. In either case, termination is a time for

- Putting closure on the experience
- Examining the impact of the group on each person
- Acknowledging the feelings triggered by departure
- Giving and receiving feedback about the group experience and each member's role in it
- Completing any unfinished business

- Exploring ways to carry on the learning the group has offered

Departing clients have been classified into three groups. *Completers* have finished the work they came into group to do. *Plateauers* are not really finished, but their progress has slowed or stopped for the time being. *Fleers* feel an irresistible need to escape as rapidly as possible, often because they have encountered an upsetting reality in the group or in their lives outside the group (Vannicelli 1992).

The group may be invited to explore the proposal that a member leave the group. In addition, the leader might ask clients about to terminate to classify themselves as completers, plateauers, or fleers. If the client is a fleer, that person might be asked a hypothetical question: If you remained in group, what do you think you might work on? Such a query might bring to light the issue the fleer wants very much to avoid. To dissuade a person departing prematurely, it may also help to comment, "One of the characteristics of a good decision is that it remains a good decision even after consideration a few weeks later" (Vannicelli 1992, p. 179). Then ask the client if, by that standard, his decision to leave will be a good one.

Whatever attempts are made to dissuade premature termination, some people with substance abuse problems inevitably will leave groups abruptly, for a variety of reasons. Groups should be forewarned that sudden changes may take place, and leaders should be prepared to help group members cope with these changes.

Completing a group successfully can be an important event for group members, when they see the conclusion of a difficult but successful endeavor (Flores 1997). The termination of a group also is an opportunity for clients to practice parting, with the understanding that a departure leads to the next opportunity for connection.

Even positive, celebrated departures, however, can raise strong feelings, so soon-to-depart members of an ongoing group should give ample advance notice (perhaps 4 weeks) to give the group time to process the feelings associated with the leave-taking (Flores 1997). Group members should be given permission to examine existential issues like loss, growth, death, the shortness of time, the unfairness of life, and other thoughts that can prey on the mind (Yalom 1995). So often, clients who used drugs or alcohol to anesthetize their grief over losses come to confront their grief in early sobriety. Every group facilitator working with substance abuse therefore should understand the grief process and should be prepared to deal with grieving clients.

It is natural for individuals and groups to try to hold onto each other. "Some isolated patients may postpone termination because they have been using the therapy group for social reasons rather than as a means for developing the skills to create a social life for themselves in their home environment. The therapist should help these members focus on transfer of learning and encourage risk taking outside the group" (Yalom 1995, p. 363). Alternatively, groups (and therapists) may subtly pressure a particular group member to remain because they value the departing member's contributions and will miss him or her. When a senior member leaves, however, another ordinarily will assume the role just vacated (Yalom 1995).

> In general, the longer members have been with the group, the longer they may need to spend on termination.

Some client feelings may concern parting from the therapist. Some clients who are exquisitely sensitive to abandonment, for example, may deny the gains they have made. They need reassurance that, once they improve, they no longer will need the therapist.

In other reluctant clients, symptoms may recur. These people need help seeing the apparent setback for what it really is: fear of termination (Yalom 1995).

Under no circumstances should the therapist "collude in the denial of termination" (Yalom 1995, p. 365). The client has to come to grips with the reality of leaving and not routinely returning. The departing client and the balance of the group should face the fact that "the group will be irreversibly altered; replacements will enter the group; the present cannot be frozen; time flows on cruelly and inexorably" (Yalom 1995, p. 365).

In general, the longer members have been with the group, the longer they may need to spend on termination. The group leader plays an important role in termination, either facilitating an individual's good-bye to the group or the group's good-bye to itself (if the group is ending). Although group leaders cannot say good-bye for the group, they can encourage the group to fashion its own farewell.

5 Stages of Treatment

In This Chapter…

Adjustments To Make Treatment Appropriate

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The Late Stage of Treatment

Condition of Clients in Late-Stage Treatment

Therapeutic Strategies in Late-Stage Treatment

Leadership in Late-Stage Treatment

Overview

This chapter describes the characteristics of the early, middle, and late stages of treatment. Each stage differs in the condition of clients, effective therapeutic strategies, and optimal leadership characteristics.

For example, in early treatment, clients can be emotionally fragile, ambivalent about relinquishing chemicals, and resistant to treatment. Thus, treatment strategies focus on immediate concerns: achieving abstinence, preventing relapse, and managing cravings. Also, to establish a stable working group, a relatively active leader emphasizes therapeutic factors like hope, group cohesion, and universality. Emotionally charged factors, such as catharsis and reenactment of family of origin issues, are deferred until later in treatment.

In the middle, or action, stage of treatment, clients need the group's assistance in recognizing that their substance abuse causes many of their problems and blocks them from getting things they want. As clients reluctantly sever their ties with substances, they need help managing their loss and finding healthy substitutes. Often, they need guidance in understanding and managing their emotional lives.

Late-stage treatment spends less time on substance abuse per se and turns toward identifying the treatment gains to be maintained and risks that remain. During this stage, members may focus on the issues of living, resolving guilt, reducing shame, and adopting a more introspective, relational view of themselves.

Adjustments To Make Treatment Appropriate

As clients move through different stages of recovery, treatment must move with them, changing therapeutic strategies and leadership roles with the condition of the clients. These changes are vital since interventions that work well early in treatment may be ineffective, and even harmful, if applied in the same way later in treatment (Flores 2001).

With guidance, clients can learn to recognize the events and situations that trigger renewed substance use.

Any discussion of intervention adjustments to make treatment appropriate at each stage, however, necessarily must be oversimplified for three reasons. First, the stages of recovery and stages of treatment will not correspond perfectly for all people. Clients move in and out of recovery stages in a nonlinear process. A client may fall back, but not necessarily back to the beginning. "After a return to substance use, clients usually revert to an earlier change stage—not always to maintenance or action, but more often to some level of contemplation. They may even become precontemplators again, temporarily unwilling or unable to try to change . . . [but] a recurrence of symptoms does not necessarily mean that a client has abandoned a commitment to change" (Center for Substance Abuse Treatment 1999*b*, p. 19). See chapters 2 and 3 for a discussion of the stages of change.

A return to drug use, properly handled, can even be instructive. With guidance, clients can learn to recognize the events and situations that trigger renewed substance use and regression to earlier stages of recovery. This knowledge becomes helpful in subsequent attempts leading to eventual recovery. Client progress-regress-progress waves, however, require the counselor to constantly reevaluate where the client is in the recovery process, irrespective of the stage of treatment.

Second, adjustments in treatment are needed because progress through the stages of recovery is not timebound. There is no way to calculate how long any individual should require to resolve the issues that arise at any stage of recovery. The result is that different group members may achieve and be at different stages of recovery at the same time in the lifecycle of the group. The group leader, therefore, should use interventions that take the group as a whole into account.

Third, therapeutic interventions, meaning the acts of a clinician intended to promote healing, may not account for all (or any) of the change in a particular individual. Some people give up drugs or alcohol without undergoing treatment. Thus, it is an error to assume that an individual is moving through stages of treatment because of assistance at every point from institutions and self-help groups. To stand the best chance for meaningful intervention, a leader should determine where the individual best fits in his level of function, stance toward abstinence, and motivation to change. In short, generalizations about stages of treatment may not apply to every client in every group.

The Early Stage of Treatment

Condition of Clients in Early Treatment

In the early stage of treatment, clients may be in the precontemplation, contemplation, preparation, or early action stage of change, depending on the nature of the group. Regardless of their stage in early recovery, clients tend to be ambivalent about ending substance use. Even those who sincerely intend to remain abstinent may have a tenuous commitment to recovery. Further, cognitive impairment from substances is at its most severe in these early stages of recovery, so clients tend to be rigid in their thinking and limited in their ability to solve problems. To some scientists, it appears that the "addicted brain is abnormally conditioned, so that environmental cues surrounding drug use have become part of the addiction" (Leshner 1996, p. 47).

Typically, people who abuse substances do not enter treatment on their own. Some enter treatment due to health problems, others because they are referred or mandated by the legal system, employers, or family members (Milgram and Rubin 1992). Group members commonly are in extreme emotional turmoil, grappling with intense emotions such as guilt, shame, depression, and anger about entering treatment.

Even if clients have entered treatment voluntarily, they often harbor a desire for substances and a belief that they can return to recreational use once the present crisis subsides. At first, most clients comply with treatment expectations more from fear of consequences than from a sincere desire to stop drinking or using illicit drugs (Flores 1997; Johnson 1973).

Consequently, the group leader faces the challenge of treating resistant clients. In general, resistance presents in one of two ways. Some clients actively resist treatment. Others passively resist. They are outwardly cooperative and go to great lengths to give the impression of willing engagement in the treatment process, but their primary motivation is a desire to be free from external pressure. The group leader has the delicate task of exposing the motives behind the outward compliance.

The art of treating addiction in early treatment is in the defeat of denial and resistance, which almost all clients with addictions carry into treatment. Group therapy is considered an effective modality for

> …overcoming the resistance that characterizes addicts. A skilled group leader can facilitate members' confronting each other about their resistance. Such confrontation is useful because it is difficult for one addict to deceive another. Because addicts usually have a history of adversarial relationships with authority figures, they are more likely to accept information from their peers than a group leader. A group can also provide addicts with the opportunity for mutual aid and support; addicts who present for treatment are usually well connected to a dysfunctional subculture but socially isolated from healthy contacts (Milgram and Rubin 1992, p. 96).

Emphasis therefore is placed on acculturating clients into a new culture, the culture of recovery (Kemker et al. 1993).

Therapeutic Strategies in Early Treatment

In 1975, Irvin Yalom elaborated on earlier work and distinguished 11 therapeutic factors that contribute to healing as group therapy unfolds:

- Instilling hope—some group members exemplify progress toward recovery and support others in their efforts, thereby helping to retain clients in therapy.
- Universality—groups enable clients to see that they are not alone, that others have similar problems.
- Imparting information—leaders shed light on the nature of addiction via direct instruction.
- Altruism—group members gain greater self-esteem by helping each other.
- Corrective recapitulation of the primary family group—groups provide a family-like context in which long-standing unresolved conflicts can be revisited and constructively resolved.
- Developing socializing techniques—groups give feedback; others' impressions reveal how a client's ineffective social habits might undermine relationships.
- Imitative behavior—groups permit clients to try out new behavior of others.
- Interpersonal learning—groups correct the distorted perceptions of others.
- Group cohesiveness—groups provide a safe holding environment within which people feel free to be honest and open with each other.
- Catharsis—groups liberate clients as they learn how to express feelings and reveal what is bothering them.

- Existential factors—groups aid clients in coming to terms with hard truths, such as (1) life can be unfair; (2) life can be painful and death is inevitable; (3) no matter how close one is to others, life is faced alone; (4) it is important to live honestly and not get caught up in trivial matters; (5) each of us is responsible for the ways in which we live.

In different stages of treatment, some of these therapeutic factors receive more attention than others. For example, in the beginning of the recovery process, it is extremely important for group members to experience the therapeutic factor of universality. Group members should come to recognize that although they differ in some ways, they also share profound connections and similarities, and they are not alone in their struggles.

The therapeutic factor of hope also is particularly important in this stage. For instance, a new member facing the first day without drugs may come into a revolving membership group that includes people who have been abstinent for 2 or 3 weeks. The mere presence of people able to sustain abstinence for days—even weeks—provides the new member with hope that life can be lived without alcohol or illicit drugs. It becomes possible to believe that abstinence is feasible because others are obviously succeeding.

Attention to group cohesiveness is important early in treatment.

Imparting information often is needed to help clients learn what needs to be done to get through a day without chemicals. Psychoeducation also allows group members to learn about addiction, to judge their practices against this factual information, and to postpone intense interaction with other group members until they are ready for such highly charged work. Attention to group cohesiveness is important early in treatment because only when group members feel safety and belonging within the group will they be able to form an attachment to the group and fully experience the effects of new knowledge, universality, and hope.

Therapeutic factors such as catharsis, existential factors, or recapitulation of family groups generally receive little attention in early treatment. These factors often are highly charged with emotional energy and are better left until the group is well established.

During the initial stage of treatment, the therapist helps clients acknowledge and understand how substance abuse has dominated and damaged their lives. Drugs or alcohol, in various ways, can provide a substitute for the give-and-take of relationships and a means of surviving without a healthy adjustment to life. As substances are withdrawn or abandoned, clients give up a major source of support without having anything to put in its place (Brown 1985; Straussner 1997).

In this frightening time, counselors need to ensure that the client has a sense of safety. The group leader's task is to help group members recognize that while alcohol or illicit drugs may have provided a temporary way to cope with problems in the past, the consequences were not worth the price, and new, healthier ways can be found to handle life's problems.

In early-stage treatment, strong challenges to a client's fragile mental and emotional condition can be very harmful. Out of touch with unmedicated feelings, clients already are susceptible to wild emotional fluctuations and are prone to unpredictable responses. Interpersonal relationships are disturbed, and the effects of substances leave the client prone to use "primitive defensive operations such as denial, splitting, projective identification, and grandiosity" (Straussner 1997, p. 68).

This vulnerable time, however, is also one of opportunity. In times of crisis, "an individual's attachment system opens up" and the therapist

A Note on Attachment Theory and Substance Abuse Treatment

Attachment theory provides a comprehensive meta-theory of addiction that not only integrates diverse mental health models with the disease-concept, but also furnishes guidelines for clinical practice that are compatible with existing addiction treatment strategies including an abstinence basis and alignment with 12-Step treatment philosophy.

Attachment theory (Bowlby 1979) and self psychology (Kohut 1977*b*) provided the first compelling theories that offered a practical alternative rationale for the addiction cycle that is not only compatible with the disease concept, but expands it by providing a more complete and intellectually satisfying theoretical explanation why Alcoholic Anonymous (AA) works as it does.

According to the theory, attachment is recognized as a primary motivational force with its own dynamics, and these dynamics have far-reaching and complex consequences (Bowlby 1979). In clients with substance use disorders there is an inverse relation between their substance abuse and healthy interpersonal attachments. A person who is actively abusing substances can rarely negotiate the demands of healthy interpersonal relationships successfully.

Using this theoretical model, substance abuse can be viewed as an attachment disorder. Individuals who have difficulty establishing intimate attachments will be more inclined to substitute substances for their deficiency in intimacy. Because of their difficulty maintaining emotional closeness with others, they are more likely to substitute various behaviors (including substance abuse) to distract them from their lack of intimate interpersonal relations.

The use of substances may initially serve a compensatory function, helping those who feel uncomfortable in social situations because of inadequate interpersonal skills. However, substances of abuse will gradually compromise neurophysiological functioning and erode existing interpersonal skills. Managing relationships tends to become increasingly difficult, leading to a heightened reliance on substances, which accelerates deterioration and increases abuse and dependence. Eventually, the individual's relationship with substances of abuse becomes both an obstacle to and a substitute for interpersonal attachments. If problems in attachment are a primary cause of substance abuse, then a therapeutic process that addresses the client's interpersonal relations will be effective for long-term recovery (Flores 2001; Straussner 1993). Treatment concentrates on removing stress-inducing stimuli, teaching ways to recognize and quell environmental cues that trigger inappropriate behaviors, providing positive reinforcement and support, cultivating positive habits that endure, and developing secure and positive attachments.

has a chance to change the client's internal dynamics (Flores 2001, p. 72). Support networks that can provide feedback and structure are especially helpful at this stage. Clients also need reliable information to strengthen their motivation.

At this time, clients are solidifying their "new identity as an alcoholic with the corresponding belief in loss of control." They develop "a new logical structure" with which to assail their "former logic and behavior." They also can develop a "new story . . . the Alcoholics Anonymous drunkalogue," which recalls their experiences and compares previous events with what life is like now (Brown 1985).

Whether information is offered through skills groups, psychoeducational groups, supportive therapy groups, spiritually oriented support groups, or process groups, clients are most likely to use the information and tools provided in an environment alive with supportive human connections. All possible sources of positive forces in a client's life should be marshaled to help the client manage life's challenges instead of turning to substances or other addictive behaviors.

During early treatment, a relatively active leader seeks to engage clients in the treatment process.

Painful feelings, which clients are not yet prepared to face, can sometimes trigger relapse. If relapses occur in an outpatient setting—as they often do, because relapses occur in all chronic illnesses, including addiction—the group member should be guided through the regression. The leader encourages the client to attend self-help groups, explores the sequence of events leading to relapse, determines what cues led to relapse, and suggests changes that might enable the client to manage cravings better or avoid exposure to strong cues.

For some clients, chiefly those mandated into treatment by courts or employers, grave consequences inevitably ensue as a result of relapse. As Vannicelli (1992) points out, however, clinicians should view relapse not as failure, but as a clinical opportunity for both group leader and clients to learn from the event, integrate the new knowledge, and strengthen levels of motivation. Discussion of the relapse in group not only helps the individual who relapsed learn how to avoid future use, but it also gives other group members a chance to learn from the mistakes of others and to avoid making the same mistakes themselves.

Leadership in Early Treatment

Clients usually come to the first session of group in an anxious, apprehensive state of mind, which is intensified by the knowledge that they will soon be revealing personal information and secrets about themselves. The therapist begins by making it clear that clients have some things in common. All have met with the therapist, have acceded to identical agreements, and have set out to resolve important personal issues. Usually, the therapist then suggests that members get to know each other. One technique is to allow the members to decide exactly how they will introduce themselves. The therapist observes silently—but not impassively—watching how interaction develops (Rutan and Stone 2001).

During early treatment, a relatively active leader seeks to engage clients in the treatment process. Clients early on "usually respond more favorably to the group leader who is spontaneous, 'alive,' and engaging than they do to the group leader who adopts the more reserved stance of technical neutrality associated with the more classic approaches to group therapy" (Flores 2001, p. 72). The leader should not be overly charismatic, but should be a strong enough presence to meet clients' dependency needs during the early stage of treatment.

During early treatment, the effective leader will focus on immediate, primary concerns: achieving abstinence, preventing relapse, and learning ways to manage cravings. The leader should create an environment that enables clients to acknowledge that (1) their use of addictive substances was harmful and (2) some things they want cannot be obtained while their pattern of substance use continues. As clients take their first steps toward a life centered on healthy sources of satisfaction, they need strong support, a high degree of structure, positive human connections, and active leadership.

In process groups, the leader pays particular attention to feelings in the early stage of treatment. Many people with addiction histories are not sure what they feel and have great difficulty communicating their feelings to others. Leaders begin to help group members move toward affect regulation by labeling and mirroring feelings as they arise in group work. The leader's subtle instruction and empathy enables clients to begin to recognize and own their feelings. This essential step toward managing feelings also leads clients toward empathy with the feelings of others.

The Middle Stage of Treatment

Condition of Clients in Middle-Stage Treatment

Often, in as little as a few months, institutional and reimbursement constraints limit access to ongoing care. People with addiction histories, however, remain vulnerable for much longer and continue to struggle with dependency. They need vigorous assistance maintaining behavioral changes throughout the middle, or action, stage of treatment.

Several studies (Committee on Opportunities in Drug Abuse Research 1996; London et al. 1999; Majewska 1996; Paulus et al. 2002; Strickland et al. 1993; Volkow et al. 1988, 1992) have observed decreased blood flow and metabolic changes rates in the brains of subjects who abused stimulants (cocaine and methaphetamine). The studies also found that deficits persisted for at least 3 to 6 months after cessation of drug use. Whether these deficits predated substance abuse or not, treatment personnel should expect to see clients with impaired decision-making and impulse control manifested by difficulties in attending, concentrating, learning new material, remembering things heard or seen, producing words, and integrating visual and motor cues. For the clinician, this finding means that clients may not have the mental structures in place to enable them to make the difficult decisions faced during the action stage of treatment. If clients draw and use support from the group, however, the client's affect will re-emerge, combine with new behaviors and beliefs, and produce an increasingly stable and internalized structure (Brown 1985).

Cognitive capacity usually begins to return to normal in the middle stage of treatment.

Cognitive capacity usually begins to return to normal in the middle stage of treatment. The frontal lobe activity in a person addicted to cocaine, for example, is dramatically different after approximately 4–6 months of nonuse. Still, the mind can play tricks. Clients distinctly may remember the comfort of their substance past, yet forget just how bad the rest of their lives were and the seriousness of the consequences that loomed before they came into treatment. As a result, the temptation to relapse remains a concern.

Therapeutic Strategies in Middle-Stage Treatment

In middle-stage recovery, as the client experiences some stability, the therapeutic factors

of self-knowledge and altruism can be emphasized. Universality, identification, cohesion, and hope remain important as well.

Practitioners have stressed the need to work in alliance with the client's motivation for change. The therapist uses whatever leverage exists—such as current job or marriage concerns—to power movement toward change. The goal is to help clients perceive the causal relationship between substance abuse and current problems in their lives. Counselors should recognize and respect the client's position and the difficulty of change. The leader who leaves group members feeling that they are understood is more likely to be in a position to influence change, while sharp confrontations that arouse strong emotions and appear judgmental may trigger relapse (Flores 1997).

The goal is to help clients perceive the causal relationship between substance abuse and current problems in their lives.

Therapeutic strategies also should take into account the important role substance abuse has played in the lives of people with addictions. Often, from the client's perspective, drugs of abuse have become their best friends. They fill hours of boredom and help them cope with difficulties and disappointments. As clients move away from their relationship with their best friend, they may feel vulnerable or emotionally naked, because they have not yet developed coping mechanisms to negotiate life's inevitable problems. It is crucial that clients recognize these feelings as transient and understand that the feeling that something vital is missing can have a positive effect. It may be the impetus that clients need to adopt new behaviors that are adaptive, safe, legal, and rewarding.

As the recovering client's mental, physical, and emotional capacities grow stronger, anger, sadness, terror, and grief may be expressed more appropriately. Clients need to use the group as a means of exploring their emotional and interpersonal world. They learn to differentiate, identify, name, tolerate, and communicate feelings. Cognitive–behavioral interventions can provide clients with specific tools to help modulate feelings and to become more confident in expressing and exploring them. Interpersonal process groups are particularly helpful in the middle stage of treatment, because the authentic relationships within the group enable clients to experience and integrate a wide range of emotions in a safe environment.

When strong emotions are expressed and discussed in group, the leader needs to modulate the expression of emerging feelings, delicately balancing a tolerable degree of expression and a level so overwhelming that it inhibits positive change or leads to a desire to return to substance use to manage the intensity. It also is very important for the group leader to "sew the client up" by the end of the session. Clients should not leave feeling as if they are "bleeding" emotions that they cannot cope with or dispel. A plan for the rest of the day should be developed, and the increased likelihood of relapse should be acknowledged so group members see the importance of following the plan.

Leadership in Middle-Stage Treatment

Historically, denial has been the target of most treatment concepts. The role of the leader was primarily to confront the client in denial, thereby presumably provoking change. More recently, clinicians have stressed the fact that "confrontation, if done too punitively or if motivated by a group leader's countertransference issues, can severely damage the therapeutic alliance" (Flores 1997, p. 340). Inappropriate confrontation may even strengthen the client's resistance to change, thereby increasing the rigidity of defenses.

When it is necessary to point out contradictions in clients' statements and interpretations of reality, such confrontations should be well-timed, specific, and indisputably true. For example, author Wojciech Falkowski had a client whose medical records distinctly showed abnormal liver functions. When the client maintained that he had no drinking problem, Falkowski gently suggested that he "convince his liver of this fact." The reply created a ripple of amusement in the group, and "the client immediately changed his attitude in the desired direction" (Falkowski 1996, p. 212). Such caring confrontations made at the right time and in the right way are helpful, whether they come from group members or the leader.

Another way of understanding confrontation is to see it as an outcome rather than as a style. From this point of view, the leader helps group members see how their continued use of drugs or alcohol interferes with what they want to get out of life. This recognition, supported by the group, motivates individuals to change. It seems that people who abuse substances need someone to tell it like it is "in a realistic fashion without adopting a punitive, moralistic, or superior attitude" (Flores 1997, p. 340).

In the middle stage of treatment, the leader helps clients join a culture of recovery in which they grow and learn. The leader's task is to engage members actively in the treatment and recovery process. To prevent relapse, clients need to learn to monitor their thoughts and feelings, paying special attention to internal cues. Both negative and positive dimensions may be motivational. New or relapsed group members can remind others of how bad their former lives really were, while the group's vision of improvements in the quality of life is a distinct and immediate beam of hope.

The leader can support the process of change by drawing attention to new and positive developments, pointing out how far clients have traveled, and affirming the possibility of increased connection and new sources of satisfaction. Leaders should bear in mind, however, that people with addictions typically choose immediate gratification over long-range goals, so benefits achieved and sought after should be real, tangible, and quickly attainable.

The benefits of recovery yield little satisfaction to some clients, and for them, the task of staying on course can be difficult. Their lives in recovery seem worse, not better. Many experience depression, lassitude, agitation, or anhedonia (that is, a condition in which formerly satisfying activities are no longer pleasurable). Eventually, their lives seem devoid of any meaningful purpose, and they stop caring about recovery.

These clients may move quickly from "I don't care" to relapse, so the group leader should be vigilant and prepared to intervene when a client is doing all that should be done in the recovery process, yet continues to feel bleak. Such clients need attention and accurate diagnosis. Do they have an undiagnosed co-occurring disorder? Do they need antidepressants? Do they need more intensive, frequent, adjuncts to therapy, such as more Alcoholics Anonymous or Narcotics Anonymous meetings and additional contacts with a sponsor?

Leaders need to help group members understand and accept that many forms of therapy outside the group can promote recovery. Group members should be encouraged to support each other's efforts to recover, however much their needs and treatment options may differ.

The leader helps individuals assess the degree of structure and connection they need as recovery progresses. Some group members find that participation in religious or faith groups meets their needs for affiliation and support. For

In the middle stage of treatment, the leader helps clients join a culture of recovery in which they grow and learn.

long-term, chronically impaired people with addictive histories, highly intensive participation in 12-Step groups is usually essential for an extended period of time.

The Late Stage of Treatment

Condition of Clients in Late-Stage Treatment

During the late (also referred to as ongoing or maintenance) stage of treatment, clients work to sustain the attainments of the action stage, but also learn to anticipate and avoid tempting situations and triggers that set off renewed substance use. To deter relapse, the systems that once promoted drinking and drug use are sought out and severed.

Despite efforts to forestall relapse, many clients, even those who have reached the late stage of treatment, do return to substance use and an earlier stage of change. In these cases, the efforts to guard against relapse were not all in vain. Clients who return to substance abuse do so with new information. With it, they may be able to discover and acknowledge that some of the goals they set are unrealistic, certain strategies attempted are ineffective, and environments deemed safe are not at all conducive to successful recovery. With greater insight into the dynamics of their substance abuse, clients are better equipped to make another attempt at recovery, and ultimately, to succeed.

> During the late stage of treatment, clients work to sustain the attainments of the action stage.

As the substance abuse problem fades into the background, significant underlying issues often emerge, such as poor self-image, relationship problems, the experience of shame, or past trauma. For example, an unusually high percentage of substance and alcohol abuse occurs among men and women who have survived sexual or emotional abuse. Many such cases warrant an exploration of dissociative defenses and evaluation by a knowledgeable mental health professional.

When the internalized pain of the past is resolved, the client will begin to understand and experience healthy mutuality, resolving conflicts without the maladaptive influence of alcohol or drugs. If the underlying conflicts are left unresolved, however, clients are at increased risk of other compulsive behavior, such as excessive exercise, overeating, gambling, or excessive sexual activity.

Therapeutic Strategies in Late-Stage Treatment

In the early and middle stages of treatment, clients necessarily are so focused on maintaining abstinence that they have little or no capacity to notice or solve other kinds of problems. In late-stage treatment, however, the focus of group interaction broadens. It attends less to the symptoms of drug and alcohol abuse and more to the psychology of relational interaction.

In late-stage treatment, clients begin to learn to engage in life. As they begin to manage their emotional states and cognitive processes more effectively, they can face situations that involve conflict or cause emotion. A process-oriented group may become appropriate for some clients who are finally able to confront painful realities, such as being an abused child or abusive parent. Other clients may need groups to help them build a healthier marriage, communicate more effectively, or become a better parent. Some may want to develop new job skills to increase employability.

Some clients may need to explore existential concerns or issues stemming from their family of origin. These emphases do not deny the continued importance of universality, hope, group

cohesion and other therapeutic factors. Instead it implies that as group members become more and more stable, they can begin to probe deeper into the relational past. The group can be used in the here and now to settle difficult and painful old business.

Leadership in Late-Stage Treatment

The leader plays a very different role in late-stage treatment, which refocuses on helping group members expose and eliminate personal deficits that endanger recovery. Gradually, the leader shifts toward interventions that call upon people who are chemically dependent to take a cold, hard look at their inner world and system of defenses, which have prevented them from accurately perceiving their self-defeating behavioral patterns. To become adequately resistant to substance abuse, clients should learn to cope with conflict without using chemicals to escape reality, self-soothe, or regulate emotions (Flores 1997).

As in the early and middle stages, the leader helps group members sustain abstinence and makes sure the group provides enough support and gratification to prevent acting out and premature termination. While early- and middle-stage interventions strive to reduce or modulate affect, late-stage interventions permit more intense exchanges. Thus, in late treatment, clients no longer are cautioned against feeling too much. The leader no longer urges them to apply slogans like "Turn it over" and "One day at a time." Clients finally should manage the conflicts that dominate their lives, predispose them to maladaptive behaviors, and endanger their hard-won abstinence. The leader allows clients to experience enough anxiety and frustration to bring out destructive and maladaptive characterological patterns and coping styles. These characteristics provide abundant grist for the group mill.

As group members become more and more stable, they can begin to probe deeper into the relational past.

6 Group Leadership, Concepts, and Techniques

In This Chapter…

The Group Leader
Personal Qualities
Leading Groups

Concepts, Techniques, and Considerations
Interventions
Transference and Countertransference
Resistance in Group
Confidentiality
Biopsychosocial and Spiritual Framework—Treating the Whole Person
Integrating Care
Management of the Group
Managing Other Common Problems

Overview

This chapter describes desirable leader traits and behaviors, along with the concepts and techniques vital to process groups—though many of the ideas can apply in other types of groups. Most of the ideas seem perfectly logical, too, once they are brought to mind.

For instance, consistency in manner and procedure helps to provide a safe and stable environment for the newly recovering person with a substance use disorder. When the upheaval in the lives of people recovering from addictions is considered, it becomes clear how important it is to keep as many factors as possible both constant and predictable.

The pages that follow discuss issues such as

- How to convert conflict and resistance into positive energy that powers the group
- How to deal with disruptive group members, such as clients who talk incessantly or bolt from a session
- How to cool down runaway affect or turn a crisis into an opportunity

People who abuse substances are a broad and diverse population, one that spans all ages and ethnic groups and encompasses people with a wide variety of co-occurring conditions and personal histories. In working with people who have substance use disorders, an effective leader uses the same skills, qualities, styles, and approaches needed in any kind of therapeutic group. The adjustments needed to treat substance abuse are simply that—adjustments within the bounds of good practice. The particular personal and cultural characteristics of the clients in group also will influence the therapist's tailoring of therapeutic strategies to fit the particular needs of the group.

The Group Leader

Personal Qualities

Although the attributes of an effective interpersonal process group leader treating substance abuse are not strikingly different from traits needed to work successfully with other client populations, some of the variations in approach make a big difference. Clients, for example, will respond to a warm, empathic, and life-affirming manner. Flores (1997) states that "many therapists do not fully appreciate the impact of their personalities or values on addicts or alcoholics who are struggling to identify some viable alternative lifestyle that will allow them to fill up the emptiness or deadness within them" (p. 456). For this reason, it is important for group leaders to communicate and share the joy of being alive. This life-affirming attitude carries the unspoken message that a full and vibrant life is possible without alcohol or drugs.

In addition, because many clients with substance abuse histories have grown up in homes that provided little protection, safety, and support, the leader should be responsive and affirming, rather than distant or judgmental. The leader should recognize that group members have a high level of vulnerability and are in need of support, particularly in the early stage of treatment. A discussion of other essential characteristics for a group leader follows. Above all, it is important for the leader of any group to understand that he or she is responsible for making a series of choices as the group progresses. The leader chooses how much leadership to exercise, how to structure the group, when to intervene, how to effect a successful intervention, how to manage the group's collective anxiety, and the means of resolving numerous other issues. It is essential for any group leader to be aware of the choices made and to remember that all choices concerning the group's structure and her leadership will have consequences (Pollack and Slan 1995).

> Excellent listening skills are the keystone of any effective therapy.

Constancy

An environment with small, infrequent changes is helpful to clients living in the emotionally turbulent world of recovery. Group facilitators can emphasize the reality of constancy and security through a variety of specific behaviors. For example, group leaders always should sit in the same place in the group. Leaders also need to respond consistently to particular behaviors. They should maintain clear and consistent boundaries, such as specific start and end times, standards for comportment, and ground rules for speaking. Even dress matters. The setting and type of group will help determine appropriate dress, but whatever the group leader chooses to wear, some predictability is desirable throughout the group experience. The group leader should not come dressed in a suit and tie one day and in blue jeans the next.

Active listening

Excellent listening skills are the keystone of any effective therapy. Therapeutic interventions require the clinician to perceive and to understand both verbal and nonverbal cues to meaning and metaphorical levels of meaning. In addition, leaders need to pay attention to the context from which meanings come. Does it pertain to the here-and-now of what is occurring in the group or the then-and-there history of the specific client?

Firm identity

A firm sense of their own identities, together with clear reflection on experiences in group, enables leaders to understand and manage their own emotional lives. For example,

therapists who are aware of their own capacities and tendencies can recognize their own defenses as they come into play in the group. They might need to ask questions such as: "Am I cutting off discussions that could lead to verbal expression of anger because I am uncomfortable with anger? Have I blamed clients for the group's failure to make progress?"

Group work can be extremely intense emotionally. Leaders who are not in control of their own emotional reactions can do significant harm—particularly if they are unable to admit a mistake and apologize for it. The leader also should monitor the process and avoid being seduced by content issues that arouse anger and could result in a loss of the required professional stance or distance. A group leader also should be emotionally healthy and keenly aware of personal emotional problems, lest they become confused with the urgent issues faced by the group as a whole. The leader should be aware of the boundary between personal and group issues (Pollack and Slan 1995).

Confidence

Effective group leaders operate between the certain and the uncertain. In that zone, they cannot rely on formulas or supply easy answers to clients' complex problems. Instead, leaders have to model the consistency that comes from self-knowledge and clarity of intent, while remaining attentive to each client's experience and the unpredictable unfolding of each session's work. This secure grounding enables the leader to model stability for the group.

Spontaneity

Good leaders are creative and flexible. For instance, they know when and how to admit a mistake, instead of trying to preserve an image of perfection. When a leader admits error appropriately, group members learn that no one has to be perfect, that they—and others—can make and admit mistakes, yet retain positive relationships with others.

Integrity

Largely due to the nature of the material group members are sharing in process groups, it is all but inevitable that ethical issues will arise. Leaders should be familiar with their institution's policies and with pertinent laws and regulations. Leaders also need to be anchored by clear internalized standards of conduct and able to maintain the ethical parameters of their profession.

Good leaders are creative and flexible.

Trust

Group leaders should be able to trust others. Without this capacity, it is difficult to accomplish a key aim of the group: restoration of group members' faith and trust in themselves and their fellow human beings (Flores 1997).

Humor

The therapist needs to be able to use humor appropriately, which means that it is used only in support of therapeutic goals and never is used to disguise hostility or wound anyone.

Empathy

Empathy, one of the cornerstones of successful group treatment for substance abuse, is the ability to identify someone else's feelings while remaining aware that the feelings of others are distinct from one's own. Through these "transient identifications" we make with others, we feel less alone. "Identification is the antidote to loneliness, to the feeling of estrangement that seems inherent in the human condition" (Ormont 1992, p. 147).

For the counselor, the ability to project empathy is an essential skill. Without it, little can be

accomplished. Empathic listening requires close attention to everything a client says and the formation of hypotheses about the underlying meaning of statements (Miller and Rollnick 1991). An empathic substance abuse counselor

- Communicates respect for and acceptance of clients and their feelings
- Encourages a nonjudgmental, collaborative relationship
- Is supportive and knowledgeable
- Sincerely compliments rather than denigrates or diminishes another person
- Tells less and listens more
- Gently persuades, while understanding that the decision to change is the client's
- Provides support throughout the recovery process (Center for Substance Abuse Treatment [CSAT] 1999*b*, p. 41)

One of the great benefits of group therapy is that as clients interact, they learn from one another. For interpersonal interaction to be beneficial, it should be guided, for the most part, by empathy. The group leader should be able to model empathic interaction for group members, especially since people with substance use disorders often cannot identify and communicate their feelings, let alone appreciate the emotive world of others. The group leader teaches group members to understand one another's subjective world, enabling clients to develop empathy for each other (Shapiro 1991). The therapist promotes growth in this area simply by asking group members to say what they think someone else is feeling and by pointing out cues that indicate what another person may be feeling.

> The group leader should be able to model empathic interaction for group members.

One of the feelings that the group leader needs to be able to empathize with is shame, which is common among people with substance abuse histories. Shame is so powerful that it should be addressed whenever it becomes an issue. When shame is felt, the group leader should look for it and recognize it (Gans and Weber 2000). The leader also should be able to empathize with it, avoid arousing more shame, and help group members identify and process this painful feeling. Figure 6-1 discusses shame and group therapy.

Leading Groups

Group therapy with clients who have histories of substance abuse or dependence requires active, responsive leaders who keep the group lively and on task, and ensure that members are engaged continuously and meaningfully with each other. Leaders, however, should not make themselves the center of attention. The leader should be aware of the differing personalities of the group members, while always searching for common themes in the group. Themes to focus on, for example, might include loss, abandonment, and self-value (Pollack and Slan 1995).

Leaders vary therapeutic styles with the needs of clients

As explained in chapter 5, group leaders should modify their styles to meet clients' needs at different times. During the early and middle stages of treatment, the therapist is more active, becoming less so in the late stage. Moreover, during the late stage of treatment, the therapist should offer less support and gratification. This keeps the group at an "optimal level of anxiety," one that would be intolerable and counterproductive in the early or middle stages of treatment (Flores 1997).

To determine the type of leadership required to support a client in treatment, the clinician

Figure 6-1

Shame

Often failed attachments in childhood and failed relationships thereafter result in shame, an internalized sense of being inferior, not good enough, or worthless. Shame flares whenever clients encounter the discrepancy between their drug-affected behavior and personal or social values. In group therapy, feelings of shame may be intensified because feelings of self-consciousness are elevated and other group members are present. The presence of other group members "often stimulates regressive longings" (Gans and Weber 2000, p. 385). Furthermore, group members have a marked tendency to compare themselves with one another (Gans and Weber 2000). In the past, when group facilitators used highly confrontational efforts to break through denial and resistance, an undesirable side effect was intensified shame, which increased the likelihood that group members would relapse or leave treatment. Shame interferes dramatically with attempts to heighten a client's self-esteem, which in turn is important to recovery (Alonso and Rutan 1988).

Clients with addictions often are exquisitely sensitive and prone to project their shame onto relationships within the group. Often, at an unconscious level, they anticipate disapproval or hostility when none was intended. In this way, clients may demote themselves to the role of secondary player in the group.

One way to neutralize unintentionally shame-provoking comments is to reframe member-to-member communications. For example, if a group member asks, "Sally, where were you last week? You didn't come to group." Sally may interpret the question as a criticism or even an implication that she has returned to active use. The group facilitator may choose to reframe this member-to-member communication by speaking to the concern that the questioner really has for Sally's well-being.

This reframing would begin with the group leader asking why the group member wanted to know where Sally had been, adding something like, "I suspect your question reflects the feeling that you missed Sally last week and find group more enjoyable when she is here."

By focusing on positive interactions that reveal competency, the group facilitator helps move clients from shame to an affirmative image of themselves. The group leader should pay attention to member-to-member interaction, looking for instances of relational competence and support. The leader's supportive interactions eventually develop into group norms that combat the shame attached to addictive illness.

Source: Consensus Panel.

should consider the client's capacity to manage affect, level of functioning, social supports, and stability, since these factors have some bearing upon alcohol or illicit drug use. These considerations are essential to determine the type of group best suited to meet the client's needs. For example, a client at the beginning stage of treatment who is high functioning and used to working in groups generally will require a less active therapist and less structure. On the other hand, a lower-functioning client who has little or no group experience and is just beginning treatment would best be placed in a structured, task-oriented group. Such a person also would benefit from a clinician who more actively expresses warmth and acceptance, thus helping to engage the client.

Cotherapy is extremely powerful when carried out skillfully.

Leaders model behavior

It is more useful for the therapist to model group-appropriate behaviors than to assume the role of mentor, showing how to "do recovery." For example, the therapist can model the way to listen actively, give accurate feedback, and display curiosity about apparent discrepancies in behavior and intent.

Therapists should be aware that self-disclosure is always going on, whether consciously or unconsciously. They intentionally should use self-disclosure only to meet the task-related needs of the group, and then only after thoughtful consideration, perhaps including a discussion with a supervisor.

Both therapists and their institutions should have a thoughtful policy about self-disclosure, including disclosure of a therapist's past experiences with substance abuse or addiction. Too often, self-disclosure occurs to meet the therapist's own needs (for example, for affiliation and approval) or to gratify clients. When personal questions are asked, group leaders need to consider the motivation behind the question. Often clients are simply seeking assurance that the therapist is able to understand and assist them (Flores 1997).

Leaders can be cotherapists

Cotherapy is an effective way to blend the diverse skills, resources, and therapeutic perspectives that two therapists can bring to a group. In addition, cotherapy is beneficial because, if properly carried out, it can provide

- The opportunity to watch "functional, adaptive behavior in the co-leader pair"
- Additional opportunities for family transferences when the leaders are of different genders
- An opportunity for "two sets of eyes to view the situation" (Vannicelli 1992, p. 238)

Cotherapy, also called coleadership, is extremely powerful when carried out skillfully. A male–female cotherapy team may be especially helpful, for a number of reasons. It allows clients to explore their conscious and subconscious reactions to the presence of a parental dyad, or pair. It shows people of opposite sexes engaging in a healthy, nonexploitative relationship. It presents two different gender role models. It demonstrates role flexibility, as clients observe the variety of roles possible for a male or a female in a relationship. It provides an opportunity for clients to discover and work through their gender distortions (Kahn 1996).

Frequently, however, cotherapy is not done well, and the result is destructive. At times, a supervisor and a subordinate act as cotherapists, and power differentials result. Alternatively, cotherapists are put together out of convenience, rather than their potential to work well together and improve and facilitate group process. True cotherapy takes place

between clinicians of equal authority and mutual regard. (Naturally, the foregoing does not apply to training opportunities in which a trainee sits in with a seasoned group therapist. In such a setting, the trainee functions as an observer, not a cotherapist.)

Problems also may arise because institutions and leaders fail to allow enough time for cotherapists to prepare for group together and to process what has happened after the group has met. Some suggest that cotherapists confer for as much time outside the group as the length of the group itself, that is, 45 minutes of consultation for each 45-minute group session. While this amount of time may be ideal, the realities of most organizations do not make this level of commitment feasible. At the least, however, cotherapists should have a minimum of 15 minutes before and after each group meets.

Personal conflict or professional disagreements can be a third source of negative effects on the group. Thus, cotherapists should carefully work out their own conflicts and develop a leadership style suitable for the group before engaging in the therapeutic process. Cotherapists also should work out important theoretical differences before taking on a group, reaching full agreement on their view of the group and appropriate ways to facilitate the group's development (Wheelan 1997). Achieving a healthy, collaborative, and productive cotherapy team will require a "(1) commitment of time and sharing, (2) the development of [mutual] respect…and (3) use of supervision to work out differences and identify…problems" (Kahn 1996, p. 443).

Inevitably, cotherapist relationships will grow and evolve over time. The relationship between the cotherapists and the group, too, will evolve. Both the cotherapists and the group should recognize this process and be ready to adapt to constant change and growth (Dugo and Beck 1997). The most successful cotherapy is carried out "by partners who make a commitment to an ongoing relationship, who reason with each other, and who accept responsibility to work on the evolution of their relationship" (Dugo and Beck 1997, p. 2). The development of a healthy relationship between cotherapists will have a positive effect on their relationship to the group, relationships among members of the group, and on individuals within the group as they experience the continuous changes and growth of the group (Dugo and Beck 1997).

Leaders are sensitive to ethical issues

Group therapy by nature is a powerful type of intervention. As the group process unfolds, the group leader needs to be alert, always ready to perceive and resolve issues with ethical dimensions. Some typical situations with ethical concerns follow.

Overriding group agreements

Group agreements give the group definition and clarity, and are essential for group safety. In rare situations, however, it would be unethical not to bend the rules to meet the needs of an individual. For example, group rules may say that failure to call in before an absence from group is cause for reporting the infraction to a referring agency. If the client can demonstrate that an unavoidable emergency prevented calling in, the group leader may agree that the offense does not merit a report. Furthermore, the needs of the group may sometimes override courtesies shown to an individual. For example, a group may have made an agreement not to discuss any group member when that member is not present. If, however, a member should relapse, become seriously ill, or experience some other dire problem, the no-discussion rule has to be set aside if the group leader is to allow the

Group agreements give the group definition and clarity, and are essential for group safety.

members to express their concerns for the missing member and to consider how that person's problem affects the group as a whole.

Informing clients of options

Even when group participation is mandated, clients should be informed clearly of the options open to them. For example, the client deserves the option to discuss with program administrators any forms of treatment or leadership style that the client believes to be inappropriate. In such an instance, issues of cultural competence should be kept in mind, because what is appropriate for an individual or a group is by no means universal.

Preventing enmeshment

Leaders should be aware that the power of groups can have a dark side. Although cohesion is a positive outcome to be sought and supported, the strong desire for affiliation also can place undue pressure on group members who already are in the throes of a major transition from substance abuse to abstinent lives. The need to belong is so strong that it can sometimes cause a client to act in a way that is not genuine or consistent with personal ethics. Regardless of the kind of group, the leader needs to be aware of this possibility and to monitor group sharing to ensure that clients are not drawn into situations that violate their privacy or integrity. The leader is obligated to foster cohesion while respecting the rights and best interests of individuals.

The leader is obligated to foster cohesion while respecting the rights and best interests of individuals.

Acting in each client's best interest

It is possible that the group collectively may validate a particular course of action that may not be in a client's best interest. For example, if there is stress in one group member's marriage, other group members might support a course of action that could have dangerous or harmful consequences. Similarly, the group might engage in problem solving in some area of a member's life and recommend a course of action that would clearly be undesirable.

It is the responsibility of the group facilitator to challenge the group's conclusions or recommendations when they deny individual autonomy or could lead to serious negative consequences. Any such challenge, however, should come in a nonshaming fashion, primarily through the review of other options.

Handling emotional contagion

Another's sharing, such as an agonized account of sexual abuse, can stir frightening memories and intense emotions in listeners. In this powerful and emotional atmosphere, the spreading excitement of the moment, or emotional contagion, requires the leader to

- *Protect individuals.* The group leader should guard the right of each member to refrain from involvement. The leader makes it clear that each group member has a right to private emotions and feelings. When the group pressures a member to disclose information, the leader should remind the group that members need only reveal information about themselves at levels with which they are comfortable.
- *Protect boundaries.* Group pressure or the group leader's interest should not obligate anyone to disclose intimate details that the client prefers not to share. At the same time, clients are responsible for managing their feelings in the face of the group's power and deciding what they will and won't share.
- *Regulate affect.* At all times, the therapist should be mindful of the need to modulate

affect (emotionality), always keeping it at a level that enables the work of the group to continue. Yalom (1995) suggests an intervention that group leaders could use to limit conflict or almost any unacceptable escalation of affect: "We've been expressing some intense feelings here today….To prevent us from overload, it might be valuable to stop what we're doing and try together to understand what's been happening and where all these powerful feelings come from" (p. 350).

Working within professional limitations

Group leaders never should attempt to use group techniques or modalities for which they are not trained. When new techniques are used with any group, leaders should be certain to have appropriate training and the supervision of experts familiar with the techniques to be employed. Therapists likewise should decline to work with any population or in any situation for which they are unprepared. For example, an addiction counselor who has never run a long-term therapy group and has not learned how to do so should not accept an assignment to lead such a group. Further, a counselor cannot read about psychodrama and, using a workbook, successfully apply this highly charged technique with clients in an early stage of treatment. Such a misguided effort could have serious psychological consequences.

Ensuring role flexibility

Different group members may assume particular roles within the group. Natural leaders may emerge, as may a member who expresses anger for the group and someone who provides support. One client may take on a scapegoat role and then blame the group.

Playing different roles and examining their dynamics can provide a corrective emotional and interpersonal experience for the group. On the other hand, rigid roles can restrict group work. If, for example, a group consistently places individuals in particular roles, they may use their placements as defense mechanisms, thereby avoiding powerfully charged issues. It is easier, for example, to deal with the problems of being a scapegoat than it is to work on recovery from addiction.

While it is natural for group members to assume certain roles—there are, after all, natural leaders—individual members benefit from the opportunity to experience different aspects of themselves. Role variation also keeps the group lively and dynamic. These benefits will be lost if the same group members consistently assume the same roles in group. It is important for the group facilitator to support role sharing within the membership.

In all therapeutic settings, the clinician should be sensitive to issues of dual relationships.

Avoiding role conflict

In all therapeutic settings, the clinician should be sensitive to issues of dual relationships. A group leader's responsibilities outside the group that place him in a different relationship to group participants should not be allowed to compromise the leader's in-group role. For example, a client's group leader should not also be that client's Alcoholics Anonymous (AA) sponsor. Both roles and functions are important, but should not be performed by the same person. If the leader happens to be in recovery and is attending self-help meetings at which group members are present, this possible role conflict should be discussed with supervisors.

Ethical behavior is absolutely essential to group leadership. As the best practice guidelines (1998) from the Association for Specialists in Group Work (ASGW) declare, "ASGW views ethical process as being integral to group work and views Group Workers as ethical agents."

The ASGW statement is regarded as so important that the entire text is reproduced in appendix E.

Leaders improve motivation

Client motivation is a vital factor in the success of treatment for substance use disorders. Motivation-boosting techniques have been shown to increase both treatment participation and outcomes (Chappel 1994; Easton et al. 2000; Foote et al. 1999). Motivation generally improves when

- Clients are engaged at the appropriate stage of change.
- Clients receive support for change efforts.
- The therapist explores choices and their consequences with the client.
- The therapist honestly and openly communicates care and concern for group members.
- The therapist points out the client's competencies.
- Steps toward positive change are noted within the group and further encouragement is provided.

The therapist helps clients enjoy their triumphs with questions such as, "What's it like, Bill, to communicate your thoughts so clearly to Claire and to have her understand you so well?" or "What was it like to be able to communicate your frustration so directly?"

One effective motivational tool is the FRAMES approach, which uses the six key elements of Feedback, Responsibility, Advice, Menus (of change options), Empathic therapy, and Self-efficacy (Miller and Sanchez 1994). This approach engages clients in their own treatment and motivates them to change in ways that are the least likely to trigger resistance. The FRAMES approach is discussed in detail in chapter 2 of TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

When this kind of supportive technique is employed, however, a client's stage of change should be taken into account (see chapters 2 and 3 for more detailed discussions of the stages of change). Techniques to enhance motivation that are appropriate at one stage of change may not be useful at another stage and may even trigger treatment resistance or noncompliance (CSAT 1999*b*). For example, clients in the contemplation stage are weighing the pros and cons of continued substance abuse. An intervention for the action stage is appropriate for a client who has already made a commitment to change. If such an intervention is used too early, the client understandably may fail to cooperate.

Leaders overcome resistance

Resistance is especially strong among clients referred by the courts. It generally arises as a defense against the pain that therapy and examining one's own behavior usually brings. In group therapy, resistance appears at both the individual and the group level. The group leader should have a repertoire of means to overcome the resistance that prevents successful substance abuse treatment in groups (Milgram and Rubin 1992).

The group therapist should be prepared to work effectively against intense resistance to "experiencing, expressing, and understanding emotions" (Cohen 1997, p. 443). In order to overcome resistance to the experience of emotion, "the group members should experience feelings at a level of arousal wherein feelings are undeniable, but not to the extent that the group member is overcome" (Cohen 1997, p. 445).

Leaders defend limits

Providing a safe, therapeutic frame for clients and maintaining firm boundaries are among the most important functions of the group leader. For many group members, a properly conducted group will be the first opportunity to interact with others in a safe, supportive, and substance-free environment.

The boundaries established should be mutually agreed upon in a specific contract. When leaders point out boundaries and boundary violations, they should do so in a nonshaming,

nonjudgmental, matter-of-fact way. Some possible ways of dealing with this situation might be

- "This is a hard place to end, but . . ."
- "I know how angry you're feeling, but we have agreed . . ."

When boundary violations occur, group members should be reminded of agreements and given an opportunity to discuss the meaning and implication of the limit-breaking behavior as they see it. For example, if three group members are coming in late, the leader might say, "It's interesting that although everyone who joined the group agreed to arrive on time, many members are having a difficult time meeting this agreement." Or the leader might ask, "How would this group be different if everyone came on time?"

The group members may respond, for example, that they would not be obliged to repeat what already has been said to help latecomers catch up and, thus, get more out of each session. This group involvement in limit setting is crucial. It transmits power and responsibility to the group, and the leader avoids the isolated role of enforcer. While leaders inevitably will be regarded as authority figures, they certainly want to avoid creating the image of an insensitive, punitive authority.

Leaders maintain a safe therapeutic setting

Emotional aspects of safety

Group members should learn to interact in positive ways. In the process, leaders should expect that people with substance abuse histories will have learned an extensive repertoire of intimidating, shaming, and other harmful behaviors. Because such conduct can make group members feel unsafe, the leader should use interventions that deflect the offensive behavior without shaming the shamer.

Shame is not a point, but a range, some researchers argue. "Healthy" shame "helps to regulate a person's behavior in the service of preserving self-esteem, values, and personal connection" at one end of the continuum (Gans and Weber 2000, p. 382). At the other end is "unmetabolized shame," or shame that "in a narcissistically vulnerable person produces its pathological variants…Whereas guilt is a response to a thought or deed, shame connotes a more pervasive (self) condemnation" (Gans and Weber 2000, p. 382). It is thus potentially harmful to group members who are struggling to be honest with themselves and with the other group members.

The boundaries established should be mutually agreed upon in a specific contract.

The group needs to feel safe without blaming or scapegoating an individual member. If a member makes an openly hostile comment, the leader's response should state clearly what has happened and set a firm boundary for the group that makes clear that group members are not to be attacked. Sometimes, the leader simply may need to state what has occurred in a factual manner: "Debby, you may not have intended this effect, but that last remark came across as really hurtful."

When group members' responses lack empathy or treat one group member as a scapegoat, this targeted individual represents "a disowned part of other members of the group." Members may fault Sally repeatedly for her critical nature and lack of openness. The leader may intervene with a comment such as, "We've taken up time dealing with Sally's problems. My guess is that part of the reason the group is so focused on this is that it's something everybody in here knows a little about and that this issue has a lot of meaning for the group. Perhaps the group is trying to kick this characteristic down and beat it out because it's too close to home and simply cannot be ignored" (Vannicelli 1992, p. 125).

It is the therapist's responsibility to maintain the appropriate level of emotion and stimulation in the group.

When individual group members are verbally abusive and other group members are too intimidated to name the problem, the leader should find a way to provide "a safe environment in which such interactions can be productively processed and understood—not only by the attacking group member but also by the other members (who need to understand what is motivating their reluctance to respond)" (Vannicelli 1992, p. 165). To accomplish this goal, the leader may intervene with statements such as:

- *To the group as a whole:* "John has been pretty forthright with some of his feelings this evening. It seems as if others in here are having more difficulty sharing their feelings. Perhaps we can understand what it is about what John has shared or the way in which he shared it that makes it hard to respond" (Vannicelli 1992, p. 165).
- *To John:* "John, how do you suppose Mary might be feeling just now about your response to her?" or "If you had just received the kind of feedback that you gave to Mary, how do you suppose you'd be feeling right now?" (Vannicelli 1992, pp. 165–166).

Whatever intervention is used should show the group "that it is appropriate to let people know how you feel, and that people can learn in the group how to do this in a way that doesn't push others away" (Vannicelli 1992, p. 166).

A client can be severely damaged by emotional overstimulation. It is the therapist's responsibility to maintain the appropriate level of emotion and stimulation in the group. This will "prevent a too sudden or too intense mobilization of feeling that cannot be adequately expressed in language" (Rosenthal 1999*a*, p. 159). The therapist can achieve this control by warning potential group members of the emotional hazards of revealing their feelings to a group of strangers and by helping new members regulate the amount of their self-disclosure.

Substance use

In a group of people trying to maintain abstinence, the presence of someone in the group who is intoxicated or actively using illicit drugs is a powerful reality that will upset many members. In this situation, the leader should intervene decisively. The leader will make it as easy as possible for the person who has relapsed to seek treatment, but a disruptive member should leave the group for the present. The leader also will help group members explore their feelings about the relapse and reaffirm the primary importance of members' agreement to remain abstinent. Some suggestions follow for situations involving relapse:

- *If clients come to sessions under the influence of alcohol or drugs,* the leader should ensure that the individual does not drive home. Even a person walking home sometimes should be escorted to prevent falls, pedestrian accidents, and so on.
- If a client obviously is intoxicated at the beginning of the group, that person should be asked to leave and return for the next session in a condition appropriate for participation (Vannicelli 1992).

Vannicelli (1992) addresses several other situations that commonly occur:

Signs indicate that the client is not abstinent, but the client will not admit using alcohol or drugs. When signs (such as bloodshot eyes) indicate that the client is using substances repeatedly before coming to the group, but the client does not admit the infraction, the leader might:

- Use empathy to join with the client, letting the member know that the leader understands why it's hard to acknowledge substance use to the group.

- Describe the impasse, namely, that it is important that both client and therapist feel that they are in a credible relationship, but the way things are shaping up, it must be increasingly difficult for the client to come in week after week knowing that the therapist doubts him.
- Brainstorm, permitting the group to solve the problem and get past the impasse (Vannicelli 1992).

A client has been using alcohol or drugs, but will not acknowledge it. If other group members do not confront clients who are using substances, the leader should raise the issue in an empathic manner designed to encourage honesty, such as, "It must be hard for you, Sandy, to find yourself in a group in which you don't feel safe enough to talk about your drinking" (Vannicelli 1992, p. 65).

A client defiantly acknowledges using substances. A client who uses substances and clearly has no intention of stopping should be asked to leave the group. In contrast, a client who slips repeatedly needs an intervention that invites the group's help in setting conditions for continued participation: "It is clear, Maria, that you feel it is appropriate for you to stop using and yet, so far, the ways that you have been dealing with the problem have not been adequate. Since it is important that your behavior, as well as your words, support the group norm, we need to find ways that will be more effective in supporting abstinence." The group may then help set up specific requirements for Maria that will help her maintain abstinence. Suggestions might include increased AA participation, the development of a relapse prevention plan, increased supportive social contact, or the use of medications (like Antabuse for alcoholism) (Vannicelli 1992, p. 68).

Many outpatient groups have mandated clients who are required to submit to urine tests. The counselor is required to report infractions or test failures. These stipulations should appear in the group agreement, so they do not come as a surprise to anyone.

Boundaries and physical contact

When physical boundaries are breached in the group, and no one in the group raises the issue, the leader should call the behavior to the group's attention. The leader should remind members of the terms of agreement, call attention to the questionable behavior in a straightforward, factual way, and invite group input with a comment such as, "Joe, you appear to be communicating something nonverbally by putting your hand on Mary's shoulder. Could you please put your actions into words?"

Most agencies have policies related to violent behavior; all group leaders should know what they are. In groups, threatening behavior should be intercepted decisively. If necessary, the leader may have to stand in front of a group member being physically threatened. Some situations require help, so a lone leader should never conduct a group session without other staff nearby. On occasion, police intervention may be necessary, which could be expected to disrupt the group experience completely.

The leader should not suggest touching, holding hands, or group hugs without first discussing this topic in group. This tactic will convey the message that strong feelings should be talked about, not avoided. In general, though, group members should be encouraged to put their thoughts and feelings into words, not actions.

Whenever the therapist invites the group to participate in any form of physical contact (for example, in psychodrama or dance therapy), individuals should be allowed to opt out without any negative perceptions within the group. All members uncomfortable with

A group may need to set up specific requirements to help a member maintain abstinence.

physical contact should be assured of permission to refrain from touching or having anyone touch them.

Group leaders carefully monitor the level of emotional intensity in the group.

Leaders also should make sure that suggestions to touch are intended to serve the clients' best interests and not the needs of the therapist. Under no circumstances should a counselor ask for or initiate physical contact. Like their clients, counselors need to learn that such impulses affect them as well. Nothing is wrong with feeling attracted to a client. It is wrong, however, for group leaders to allow these feelings to dictate or influence their behavior.

Leaders help cool down affect

Group leaders carefully monitor the level of emotional intensity in the group, recognizing that too much too fast can bring on extremely uncomfortable feelings that will interfere with progress—especially for those in the earlier stages of recovery. When emotionally loaded topics (such as sexual abuse or trauma) come up and members begin to share the details of their experiences, the level of emotion may rapidly rise to a degree some group members are unable to tolerate.

At this point, the leader should give the group the opportunity to pause and determine whether or not to proceed. The leader might ask, "Something very powerful is going on right now. What is happening? How does it feel? Do we want to go further at this time?"

At times, when a client floods the room with emotional information, the therapist should mute the disturbing line of discussion. The leader should not express discomfort with the level of emotion or indicate a wish to avoid hearing what was being said. Leaders can say something such as

- "As I ask you to stop, there's a danger that what you hear is, 'I don't want to hear you.' It's not that. It's just that for now, I'm concerned that you may come to feel as if you have shared more than you might wish."
- "I'm wondering how useful it would be for you to continue with what you're doing right now." This intervention teaches individuals how to regulate their expression of emotions and provides an opportunity for the group to comment.
- "Let's pause for a moment and every few minutes from now. How are you feeling right now? Let me know when you're ready to move on."

A distinction needs to be made whether the strong feelings are related to there-and-then material or to here-and-now conduct. It is far less unsettling for someone to express anger—even rage—at a father who abused her 20 years ago than it is to have a client raging at and threatening to kill another group member. Also, the amount of appropriate affect will differ according to the group's purpose. Much stronger emotions are appropriate in psychodrama or gestalt groups than in psychoeducational or support groups.

For people who have had violence in their lives, strong negative emotions like anger can be terrifying. When a group member's rage adversely affects the group process, the leader may use an intervention such as

- "Bill, stop for a moment and hear how what you're doing is affecting other people."
- "Bill, maybe it would be helpful for you to hear what other people have been thinking while you've been speaking."
- "Bill, as you've been talking, have you noticed what's been happening in the group?"

The thrust of such interventions is to modulate the expression of intense rage and encourage the angry person and others affected by the anger to pay attention to what has happened. Vannicelli (1992) suggests two other ways to modulate a highly charged situation:

- Switch from emotion to cognition. The leader can introduce a cognitive element by asking clients about their thoughts or observations or about what has been taking place.
- Move in time, from a present to a past focus or from past to present.

When intervening to control runaway affect, the leader always should be careful to support the genuine expressions of emotion that are appropriate for the group and the individual's stage of change.

Leaders encourage communication within the group

In support and interpersonal process groups, the leader's primary task is stimulating communication among group members, rather than between individual members and the leader. This function also may be important on some occasions in psychoeducational and skills-building groups. Some of the many appropriate interventions used to help members engage in meaningful dialog with each other are

- Praising good communication when it happens.
- Noticing a member's body language, and without shaming, asking that person to express the feeling out loud.
- Building bridges between members with remarks such as, "It sounds as if both you and Maria have something in common . . ."
- Helping the group complete unfinished business with questions such as, "At the end of our session last time, Sally and Joan were sharing some very important observations. Do you want to go back and explore those further?"
- When someone has difficulty expressing a thought, putting the idea in words and asking, "Have I got it right?"
- Helping members with difficulty verbalizing know that their contributions are valuable and putting them in charge of requesting assistance. The leader might ask, "I can see that you are struggling, Bert. My guess is that you are carrying a truth that's important for the group. Do you have any sense of how they can help you say it?"

In support and interpersonal process groups, the leader's primary task is stimulating communication among group members.

In general, group leaders should speak often, but briefly, especially in time-limited groups. In group, the best interventions usually are the ones that are short and simple. Effective leadership demands the ability to make short, simple, cogent remarks.

Concepts, Techniques, and Considerations

Interventions

Interventions may be directed to an individual or the group as a whole. They can be used to clarify what is going on or to make it more explicit, redirect energy, stop a process that is not helpful, or help the group make a choice about what should be done. A well-timed, appropriate intervention has the power to

- Help a client recognize blocks to connection with other people
- Discover connections between the use of substances and inner thoughts and feelings
- Understand attempts to regulate feeling states and relationships
- Build coping skills

- Perceive the effect of substance abuse on one's life
- Notice meaningful inconsistencies among thoughts, feelings, and behavior
- Perceive discrepancies between stated goals and what is actually being done

> A process group that remains leader focused limits the potential for learning and growth.

Any verbal intervention may carry important nonverbal elements. For example, different people would ascribe a variety of meanings to the words, "I am afraid that you have used again," and the interpretation will vary further with the speaker's tone of voice and body language. Leaders should therefore be careful to avoid conveying an observation in a tone of voice that could create a barrier to understanding or response in the mind of the listener.

Avoiding a leader-centered group

Generally a counselor leads several kinds of groups. Leadership duties may include a psychoeducational group, in which a leader usually takes charge and teaches content, and then a process group, in which the leader's role and responsibilities should shift dramatically. A process group that remains leader-focused limits the potential for learning and growth, yet all too often, interventions place the leader at the center of the group. For example, a common sight in a leader-centered group is a series of one-on-one interactions between the leader and individual group members. These sequential interventions do not use the full power of the group to support experiential change, and especially to build authentic, supportive interpersonal relationships. Some ways for a leader to move away from center stage:

- In addition to using one's own skills, build skills in participants. Avoid doing for the group what it can do for itself.
- Encourage the group to learn the skills necessary to support and encourage one another because too much or too frequent support from the clinician can lead to approval seeking, which blocks growth and independence. Supporting each other, of course, is a skill that should develop through group phases. Thus, in earlier phases of treatment, the leader may need to model ways of communicating support. Later, if a client is experiencing loss and grief, for example, the leader does not rush in to assure the client that all will soon be well. Instead, the leader would invite group members to empathize with each other's struggles, saying something like, "Joanne, my guess is at least six other people here are experts on this type of feeling. What does this bring up for others here?"
- Refrain from taking on the responsibility to repair anything in the life of the clients. To a certain extent, they should be allowed to struggle with what is facing them. It would be appropriate, however, for the leader to access resources that will help clients resolve problems.

Confrontation

Confrontation is one form of intervention. In the past, therapists have used confrontation aggressively to challenge clients' defenses of their substance abuse and related untoward behaviors. In recent years, however, clinicians have come to recognize that when "confrontation" is equivalent to "attack," it can have an adverse effect on the therapeutic alliance and process, ultimately leading to failure. Trying to force the client to share the clinician's view of a situation accomplishes no therapeutic purpose and can get in the way of the work.

A more useful way to think about confrontation is "pointing out inconsistencies," such as disconnects between behaviors and stated goals. William R. Miller explains:

> The linguistic roots of the verb "to confront" mean to come face to face. When you think about it that way, confrontation is precisely what we are trying to accomplish: to allow our clients to come face to face with a difficult and often threatening reality, to "let it in" rather than "block it out," and to allow this reality to change them. That makes confrontation a goal of counseling rather than a particular style or technique. . . [T]hen the question becomes, What is the best way to achieve that goal? Evidence is strong that direct, forceful, aggressive approaches are perhaps the least effective way to help people consider new information and change their perceptions (CSAT 1999*b*, p. 10).

Confrontation in this light is a part of the change process, and therefore part of the helping process. Its purpose is to help clients see and accept reality so they can change accordingly (Miller and Rollnick 1991). With this broader understanding of what interventions that "confront" the client really mean, it is not useful to divide therapy into "supportive" and "confrontative" categories.

Transference and Countertransference

Transference means that people project parts of important relationships from the past into relationships in the present. For example, Heather may find that Juan reminds her of her judgmental father. When Juan voices his suspicion that she has been drinking, Heather feels the same feelings she felt when her father criticized all her supposed failings. Within the microcosm of the group, this type of incident not only relates the here-and-now to the past, but also offers Heather an opportunity to learn a different, more self-respecting way of responding to a remark that she perceives as criticism.

The emotion inherent in groups is not limited to clients. The groups inevitably stir up strong feelings in leaders. The therapist's emotional response to a group member's transference is referred to as countertransference. Vannicelli (2001) describes three forms of countertransference:

- *Feelings of having been there.* Leaders with family or personal histories with substance abuse have a treasure in their extraordinary ability to empathize with clients who abuse substances. If that empathy is not adequately understood and controlled, however, it can become a problem, particularly if the therapist tries to act as a role model or sponsor, or discloses too much personal information.
- *Feelings of helplessness when the therapist is more invested in the treatment than the client is.* Treating highly resistant populations, such as clients referred to treatment by the courts, can cause leaders to feel powerless, demoralized, or even angry. The best way to deal with this type of countertransference may be to use the energy of the resistance to fuel the session. (See "Resistance in Group," next section.)
- *Feelings of incompetence due to unfamiliarity with culture and jargon.* It is helpful for leaders to be familiar with 12-Step programs, cultures, and languages. If a group member uses unfamiliar terms, however, the leader should ask the client to explain what the term means to that person, using a question like, "'Letting go' means something a bit different to each person. Can you say a little more about how this relates to your situation?" (Vannicelli 2001, p. 58).

When countertransference occurs, the clinician needs to bring all feelings associated with it to

> The therapist's emotional response to a group member's transference is referred to as countertransference.

awareness and manage them appropriately. Good supervision can be really helpful. Countertransference is not bad. It is inevitable, and with the help of supervision, the group leader can use countertransference to support the group process (Vannicelli 2001).

Resistance in Group

Resistance arises as an often unconscious defense to protect the client from the pain of self-examination. These processes within the client or group impede the open expression of thoughts and feelings, or block the progress of an individual or group. The effective leader will neither ignore resistance nor attempt to override it. Instead, the leader helps the individual and group understand what is getting in the way, welcoming the resistance as an opportunity to understand something important going on for the client or the group. Further, resistance may be viewed as energy that can be harnessed and used in a variety of ways, once the therapist has helped the client and group understand what is happening and what the resistant person or persons actually want (Vannicelli 2001).

In groups that are mandated to enter treatment, members often have little interest in being present, so strong resistance is to be expected. Even this resistance, however, can be incorporated into treatment. For example, the leader may invite the group members to talk about the difficulties experienced in coming to the session or to express their outrage at having been required to come. The leader can respond to this anger by saying, "I am impressed by how open people have been in sharing their feelings this evening and in being so forthcoming about really speaking up. My hope is that people will continue to be able to talk in this open way to make our time together as useful as possible" (Vannicelli 2001, p. 55).

For the group leader, strict adherence to confidentiality regulations builds trust.

Leaders should recognize that clients are not always aware that their reasons for nonattendance or lateness may be resistance. The most helpful attitude on the clinician's part is curiosity and an interest in exploring what is happening and what can be learned from it. Leaders need not battle resistance. It is not the enemy. Indeed, it is usually the necessary precursor to change.

It would be a serious mistake, however, to imagine that resistance always melts away once someone calls attention to it. "Resistance is always there for a reason, and the group members should not be expected to give it up until the emotional forces held in check by it are sufficiently discharged or converted, so that they are no longer a danger to the safety of the group or its members" (Flores 1997, p. 538).

When a group (rather than an individual) is resistant, the leader may have contributed to the creation of this phenomenon and efforts need to be made to understand the leader's role in the problem. Sometimes, "resistance can be induced by leaders who are passive, hostile, ineffective, guarded, weak, or in need of constant admiration and excessive friendliness" (Flores 1997, p. 538).

Confidentiality

For the group leader, strict adherence to confidentiality regulations builds trust. If the bounds of confidentiality are broken, grave legal and personal consequences may result. All group leaders should be thoroughly familiar with Federal laws on confidentiality (42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records; see Figure 6-2) and relevant agency policies. Confidentiality is recognized as "a central tenet of the practice of psychotherapy" (Parker et al. 1997, p. 157), yet a

vast majority of States either have vague statutes dealing with confidentiality in group therapy or have no statutes at all. Even where a privilege of confidentiality does exist in law, enforcement of the law that protects it is often difficult (Parker et al. 1997). Clinicians should be aware of this legal problem and should warn clients that what they say in group may not be kept strictly confidential. Some studies indicate that a significant number of therapists do not advise group members that confidentiality has limits (Parker et al. 1997).

One set of confidentiality issues has to do with the use of personal information in a group session. Group leaders have many sources of information on a client, including the names of the client's employer and spouse, as well as any ties to the court system. A group leader should be clear about how information from these sources may and may not be used in group.

Clinicians consider the bounds of confidentiality as existing around the treatment enterprise, not around a particular treatment group. Clients should know that everyone on the treatment team has access to relevant information. In addition, clinicians should make it clear to clients that confidentiality cannot be used to conceal continued substance abuse, and the therapist will not be drawn into colluding with the client to hide substance use infractions. Clinicians also should advise clients of the exact circumstances under which therapists are legally required to break confidentiality (see Figure 6-2).

A second set of confidentiality issues has to do with the group leader's relationships with clients and clients with one another. When counseling a client in both individual therapy and a group context, for example, the leader should know exactly how information learned in individual therapy may be used in the group context. In almost every case, it is more beneficial for the client to divulge such information than for the clinician to reveal it. In an individual session, the therapist and the client can plan how the issue will be brought up in group. This preparation gives clients ample time to decide what to say and what they want from the group. The therapist can prompt clients to share information in the group with a comment like, "I wonder if the group understands what a hard time you've been having over the last 2 weeks?" On the other hand, therapists should reserve the right to determine what information will be discussed in group. A leader may say firmly, "Understand that whatever you tell me may or may not be introduced in group. I will not keep important information from the group, if I feel that withholding the information will impede your progress or interfere with your recovery."

> Clinicians should warn clients that what they say in group may not be kept strictly confidential.

Still other confidentiality issues arise when clients discuss information from the group beyond its bounds. Violations of confidentiality among members should be managed in the same way as other boundary violations; that is, empathic joining with those involved followed by a factual reiteration of the agreement that has been broken and an invitation to group members to discuss their perceptions and feelings. In some cases, when this boundary is violated, the group may feel a need for additional clarification or addenda to the group agreement. The leader may ask, both at the beginning of the group or when issues arise, whether the group feels it needs additional agreements in order to work safely. Such amendments, however, should not seek to renegotiate the terms of the original group agreement. See Figure 6-2 (see p. 110) for helpful information on confidentiality and the law.

Because a group facilitator generally is part of the larger substance abuse treatment program, it is recommended that the group facilitator take a practical approach to exceptions. This

Figure 6-2

Confidentiality and 42 C.F.R., Part 2

Confidentiality is both an ethical and a legal issue. Federal law (Title 42, Part 2 or 42 C.F.R., Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records) guarantees strict confidentiality of information about all people receiving substance abuse prevention and/or treatment services. Clients should be fully informed regarding issues of confidentiality, and group leaders should do all they can to build respect for confidentiality and anonymity within groups.

There are six conditions under which limited disclosure is permitted under the regulations. These exceptions are

- The group member has signed a Release of Information document that allows the group facilitator to communicate with another professional and/or agency.
- A group member threatens imminent harm to him- or herself, and the group facilitator believes that the client may act on this threat.
- A client threatens imminent harm to another named person, and the group facilitator believes that there is a reasonable likelihood that the client will act on the threat.
- A medical emergency requires that a client's drug and alcohol status be revealed in order to ensure that the client gets appropriate medical attention.
- A client is suspected of child neglect and/or abuse, as defined by the laws of the State in which the substance abuse treatment services are being provided.
- A direct court order mandates the release of specific information related to a client's history and/or treatment. However, an authorizing court order alone does not compel disclosure—for example, if the person authorized to disclose confidential information does not elect to make the disclosure, he or she cannot be forced to do so unless there is a valid subpoena (i.e., the subpoena has not expired) or other compulsory process introduced that would then compel disclosure. An appropriate judge issues a court order. It specifies the exact information to be provided about a particular client and is properly signed and dated.

More detailed discussions of confidentiality can be found in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*); TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (CSAT 1994*a*); TAP 13, *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* (Lopez 1994); and TAP 18, *Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance* (CSAT 1996).

Source: Consensus Panel.

practical approach is to have the group facilitator discuss the potential application of the exceptions with the program director or member of the program staff who is the lead on the confidentiality regulation.

Biopsychosocial and Spiritual Framework—Treating the Whole Person

Substance use disorders include a wide range of symptoms with different levels of associated disability. Clients always bring into treatment vulnerabilities other than their alcohol or illicit drug dependencies. Group interventions may be needed to resolve psychological problems, physical ailments, social stresses, and perhaps, spiritual emptiness or bankruptcy. In short, successful treatment for substance use disorders should address the whole person, including that person's spiritual growth.

While the group experience is a powerful tool in the treatment of substance use disorders, it is not the only tool. Other interventions, such as individual therapy, psychological interventions, pharmacological supports, and intensive case management, may all be necessary to achieve long-term remission from the symptoms of addictive disorders.

For example, people who are homeless with a co-occurring mental disorder have three complicated sets of problems that require a continuous and comprehensive care system—one that integrates or coordinates interventions in (1) the mental health system, (2) the addiction system, and (3) the social service system for homeless persons. In group therapy, each condition should be regarded as a primary interactive problem; that is, one in which each problem develops independently but contributes to both of the others (Minkoff and Drake 1992).

One model offered for treating homeless persons with substance use disorder is a modified training group designed to accommodate a large number of members whenever a traditional small group is not possible. In this model, participants meet in a large group with the clinician and then break into smaller groups to discuss, practice, or role-play the particular topic.

Each group has a client leader, and the clinician circulates among the groups to ensure that the topic is understood and that discussion is proceeding. The clinician does not participate in the groups. Researchers describing this model note that because the clinicians step back from assuming leadership roles in the groups, the clients become empowered to take group sessions in the necessary direction and demonstrate feelings and insights that might not occur in a group formally led by a clinician (Goldberg and Simpson 1995).

Successful treatment for substance use disorders should address the whole person.

It is well known that 12-Step programs are an important part of many therapeutic programs (Page and Berkow 1998). While 12-Step programs have a proven record of success in helping people overcome substance use disorders, there is a basic conflict inherent in them that group therapists need to reconcile. In the 12-Step program, people are urged to cede control to a higher power. Yet, in group, the clinician is prompting clients to take control of their emotions, behavior, and lives.

As a result, some researchers have stated that it is "impossible to integrate psychotherapy and AA approaches dealing with addictions without compromising one approach or the other" (Page and Berkow 1998, pp. 1–2). Another researcher has argued that "the AA approach is consistent with existential philosophy" because both stress that people should accept their "human limitations and security-seeking behaviors" (Page and Berkow 1998, p. 2). Although the literature currently has few straightforward discussions of spirituality and

Recent research has clearly demonstrated the ability of self-help groups to improve outcomes.

its role in the dynamics of group therapy, most clinicians would agree that the spiritual well-being of the client is essential to breaking free of substance abuse.

When clients join self-help groups, they sometimes hear from individuals who strongly oppose the use of any medication. Some people in 12-Step programs erroneously believe, for example, that the use of pharmacological adjuncts to therapy is a violation of the program's principles. They consequently oppose methadone maintenance, the use of Antabuse, or the use of medications needed to control co-occurring disorders.

Clinicians should be prepared to handle these misapprehensions. One way to help would be to refer apprehensive clients to the pamphlet, *The AA Member—Medications and Other Drugs: A Report from a Group of Physicians in AA* (Alcoholics Anonymous World Services 1984). It stresses the value of appropriate medication prescribed by a physician who understands addictive disorders and reassures clients that such use of medication is wholly consistent with AA and Narcotics Anonymous' 12-Step programs.

Many clients enrolled in a process group for persons with substance use disorders are likely participating in a 12-Step program or other self-help groups as well. On occasion, apparently conflicting messages can be an issue. For instance, many people with addiction histories try to use AA and its jargon as material for resistance. Such problems can readily be managed, provided the therapist is thoroughly familiar with the self-help group. Matano and Yalom (1991) strongly recommend that group leaders become thoroughly familiar with AA's language, steps, and traditions because misconceptions about the program, whether by the client or therapist, can raise barriers to recovery.

Recent research has clearly demonstrated the ability of self-help groups to improve outcomes (Tonigan et al. 1996). Research also has shown that clients receiving mental health services as well as participating in 12-Step meetings have an even better prognosis (Ouimette et al. 1998). Marilyn Freimuth's research on integrating group psychotherapy and 12-Step work has shown that "if mere co-participation in psychotherapy and 12-Step groups supports a client's recovery, it is reasonable to expect that a more integrated approach will provide further benefits" (Freimuth 2000, p. 298). Both activities "support abstinence and emotional growth" (Freimuth 2000, p. 301). Together, the two modalities supply multiple relationship models, potentially of immense value to the client.

Some suggestions for maximizing the therapeutic potential of participation in both process and 12-Step groups follow:

Orientation should prepare new group members who are also members of 12-Step groups for differences in the two groups. A key difference will be the fact that members interact with each other. Such "cross talk" is discouraged at 12-Step meetings. "The new psychotherapy group member may need to be told that the topic of conversation is much wider than the 12-Step meeting's focus on addiction and recovery, and that it includes feelings and reactions toward other group members" (Freimuth 2000, p. 300; see also Vannicelli 1992).

During early recovery, it is particularly important to avoid making the 12-Step program's encouragement of "unquestioning acceptance" a focus of analysis in group therapy. Too critical an interpretation offered too early may disrupt the 12-Step program's status as an "ideal object," belief in which "is critical to

maintaining early abstinence" (Dodes 1988; Freimuth 2000, p. 305).

Sometimes clients experience "splitting"—seeing "the [12-Step] program as the all-good parent and all others, including the therapist/group as the all-bad/ambivalent object." Later, the split may be just the opposite (Freimuth 2000). The group leader should be attuned to this potential and should be prepared to work through these perceptions and the feelings underlying them. Further, when the process group is perceived as the "less than" modality and the client enthusiastically quotes insights from a 12-Step group, the therapist should watch for possible countertransference and bear in mind the benefits the client is receiving from both programs.

Sponsors of 12-Step members may distrust therapy and discourage group member from continuing in treatment. The leader should be prepared to respond to a variety of potential issues in ways that avoid appearing to compete with the self-help group. For example, if a client says, "In my AA group, they say I don't need to be here. As long as I'm not drinking, my life is fine." The therapist might acknowledge the importance of continued sobriety, but remind the client of depression experienced before the onset of heavy drinking.

Group leaders should beware of their possible biases against 12-Step groups that may be based on inaccurate information. For example, it is not true that the 12-Step philosophy opposes therapy and medication, as AA World Service pamphlets clarify. It also is a misconception that 12-Step programs encourage people to abdicate responsibility for substance use. AA, however, does urge people with addiction problems to attend meetings in the early stages of recovery, even though they may still be using alcohol or illicit drugs. Finally, some clinicians believe that 12-Step programs discourage strong negative emotions. On the contrary, "there is no unilateral discouragement of negative affects within [12-Step] program philosophy; only when anger threatens sobriety is it considered necessary to circumvent negative feelings" (Freimuth 2000, p. 308).

The following vignette illustrates a typical intervention intended to clarify and harmonize appropriate participation in 12-Step and process groups:

> The group leader knew that Henry, who was well along in recovery but new to group, had not expressed his anger at Jenna for having cut him off for the third time. When asked how he experienced Jenna, he simply replied that according to the program you are not to take another person's inventory. The leader took the opportunity to say that in group therapy it is important to consider one's feelings about what others say and do even if [the feelings] are negative. Expressing one's own feelings is different from focusing on another's character (taking his inventory) (Freimuth 2000, p. 308).

No matter what the modality, however, group therapy is sure to remain an integral part of substance abuse treatment.

Addressing life issues

Substance abuse affects every aspect of life: home, family, friends, job, health, emotional well-being, and beliefs. As clients move into recovery, the wide range of issues they should face may overwhelm them. Leaders need to help clients rank the importance of the challenges, taking care to make the best possible use of the resources the client and the leader can bring to bear.

Naturally, clients will vary in their ability to address many concerns simultaneously; capacity for change also is variable. For example, some individuals with cognitive impairments will have a much harder time

Naturally, clients will vary in their ability to address many concerns simultaneously.

The leader should explore the importance of spiritual life with the group.

than others engaging in a change process. In the early stage of treatment, such clients need simple ideas, structures, and principles.

As the client moves forward, the clinician can keep in mind the issues that a client is not ready or able to manage. As this process goes on, the leader should remember that the client's priorities matter more than what the leader thinks ought to come next. Unless both client and leader operate in the same motivational framework the leader will not be able to help the client make progress.

No matter what is missing—even if it is a roof over the client's head—it is possible to engage the client in treatment. A client never should be told to come back after problems other than substance abuse have been resolved. On some front, constructive work can always be done. Of course, this assertion does not mean that critical needs can be ignored until treatment for substance abuse is well underway. The therapist should recognize that a client preoccupied with the need to find a place to sleep will not be able to engage fully in treatment until urgent, practical needs are met.

Life issues facing the client provide two powerful points of therapeutic leverage that leaders can use to motivate the client to pursue recovery. First, group leaders should be aware that people with alcoholism and other addictions will not give up their substance use until the pain it brings outweighs the pleasure it produces. Consequently, they should be helped to see the way alcohol and drugs affect important areas of their lives. Second, early in treatment, group leaders should learn what is important to each client that continued substance abuse might jeopardize. For some individuals, it is their job. For others, it is their spouse, health, family, or self-respect. In some cases, it might be the threat of incarceration. Such knowledge can be used to encourage, and even coerce, individuals to utilize the tools of treatment, group, or AA (Flores 1997).

Incorporating faith

While spirituality and faith may offer to some the hope, nurturing, sense of purpose and meaning, and support needed to move toward recovery, people obviously interpret spiritual matters in diverse ways. It is important not to confuse spirituality with religion. Even if clients are not religious, their spiritual life is important. Some clinicians mistakenly conclude that their own understanding of spirituality will help the client. Other clinicians err in the opposite direction and are overly reluctant to address spiritual beliefs. Actually, a middle ground is preferable. The leader should explore the importance of spiritual life with the group, and if the search for spiritual meaning is important, the clinician can incorporate it into group discussions.

For clients who lack meaningful connection to anything beyond themselves, the group may be the first step toward a search for meaning or a feeling of belonging to something greater than the self. The clinician's role in group therapy simply is to create an environment within which such ego-transcending connections can be experienced.

Integrating Care

Interaction with other health care professionals

Professionals within the entire healthcare network need to become more aware of the role of group therapy for people abusing substances. To build the understanding needed to support people in recovery, group leaders should educate others serving this population as often as opportunities arise, such as when clinicians

from different sectors of the healthcare system work together on a case. Similar needs for understanding exist with probation officers, families, and primary care physicians.

Integration of group therapy and other forms of therapy

It is common for a client to be in both individual and group therapy simultaneously. The dual relationship creates both problems and opportunities. Skilled therapists can use what they discover in group about the client's style of relatedness to enhance individual therapy. Conversely, the individual alliance can help the client use the group effectively. So long as the therapist does not collude consciously or unconsciously with the client to keep what is said as a secret between them, most obstacles can be overcome.

In conjoint treatment, that is, a situation in which one therapist sees a client individually while another therapist treats the same client in a group, the therapists should be in close communication with each other. Clinicians should coordinate the treatment plan, keeping important interpersonal issues alive in both settings. The client should know that this collaboration routinely occurs for the client's benefit.

Medication knowledge base

Clinicians need general knowledge of common medications used to assist in recovery, relapse prevention, and co-occurring disorders. Group leaders should be aware of various medication needs of clients, the type of medications prescribed, and potential side effects. Prescribing medication involves striking a balance between therapeutic and detrimental pharmacological effects. For example, benzodiazepines can reduce anxiety, but they can be sedating and might lead to dependency.

The pregroup interview for long-term groups should ask what medications group members are taking and the names of prescribing physicians so cooperative treatment is possible. For example, if a client is awake all night with drug cravings, the therapist might talk with the physician to determine whether appropriate medication could help the client through the difficult period following substance abuse cessation. Therapists should be wary, however. From former days of active substance abuse, clients may have ties to careless physicians who enabled addiction by providing cross-addictive medications. If an evaluation of prescription medications is needed, counselors should refer the client to a consulting physician working with the agency or to a physician knowledgeable about chemical dependency. Attention needs to be paid to medications prescribed for physical illnesses as well. For example, it would be important for the group leader to know that a group member has diabetes and requires medication.

Conflict in group therapy is normal, healthy, and unavoidable.

Management of the Group

Handling conflict in group

Conflict in group therapy is normal, healthy, and unavoidable. When it occurs, the therapist's task is to make the most of it as a learning opportunity. Conflict can present opportunities for group members to find meaningful connections with each other and within their own lives.

Handling anger, developing empathy for a different viewpoint, managing emotions, and working through disagreements respectfully are all major and worthwhile tasks for recovering clients. The leader's judgment and management are crucial as these tasks are handled. It is just as unhelpful to clients to let the conflict

After a conflict, it is important for the group leader to speak privately with group members and see how each is feeling.

go too far as it is to shut down a conflict before it gets worked through. The therapist must gauge the verbal and nonverbal reactions of every group member to ensure that everyone can manage the emotional level of the conflict.

The clinician also facilitates interactions between members in conflict and calls attention to subtle, sometimes unhealthy patterns. For example, a group may have a member, Mary, who frequently disagrees with others. Group peers regard Mary as a source of conflict, and some of them have even asked Mary (the scapegoat) to leave so that they can get on with group work. In such a situation, the therapist might ask, "Do you think this group would learn more about handling this type of situation if Mary left the group or stayed in the group?" An alternative tack would be, "I think the group members are avoiding a unique opportunity to learn something about yourselves. Giving in to the fantasy of getting rid of Mary would rob each of you of the chance to understand yourself better. It would also prevent you from learning how to deal with people who upset you."

Conflicts within groups may be overt or covert. The therapist helps the group to label covert conflicts and bring them into the open. The observation that a conflict exists and that the group needs to pay attention to it actually makes group members feel safer. The therapist is not responsible, however, for resolving conflicts. Once the conflict is observed, the decision to explore it further is made based on whether such inquiry would be productive for the group as a whole. In reaching this decision, the therapist should consider the function the conflict is serving for the group. It actually may be the most useful current opportunity for growth in the group.

On the other hand, as Vannicelli (1992) points out, conflicts can be repetitive and predictable. When two members are embroiled in an endless loop of conflict, Vannicelli suggests that the leader may handle the situation by asking, "John, did you know what Sally was likely to say when you said X?" and "Sally, did you know what John was likely to say when you said Y?" "Since both participants are likely to answer, 'Yes, of course,' the therapist would then inquire what use it might serve for them to engage in this dialogue when the expected outcome is so apparent to both of them (as well as to other members of the group). This kind of distraction activity or defensive maneuver should come to signal to group members that something important is being avoided. It is the leader's task to help the group figure out what that might be and then to move on" (Vannicelli 1992, p. 121).

Group leaders also should be aware that many conflicts that appear to scapegoat a group member are actually displaced anger that a member feels toward the therapist. When the therapist suspects this kind of situation, the possibility should be forthrightly presented to the group with a comment such as, "I notice, Joe, that you have been upset with Jean quite a bit lately. I also know that you have been a little annoyed with me a since couple weeks ago about the way I handled that phone call from your boss. Do you think some of your anger belongs with me?"

Individual responses to particular conflicts can be complex, and may resonate powerfully according to a client's personal values and beliefs, family, and culture. Therefore, after a conflict, it is important for the group leader to speak privately with group members and see how each is feeling. Leaders also often use the last 5 minutes of a session in which a conflict has occurred to give group members an opportunity to express their concerns.

Subgroup management

In any group, subgroups inevitably will form. Individuals always will feel more affinity and more potential for alliance with some members than with others. One key role for the therapist in such cases is to make covert alliances overt. The therapist can involve the group in identifying subgroups by saying, "I notice Jill and Mike are finding they have a good deal in common. Who else is in Jill and Mike's subgroup?"

Subgroups can sometimes provoke anxiety, especially when a therapy group is made up of individuals acquainted before becoming group members. Group members may have used drugs together, slept together, worked together, or experienced residential substance abuse treatment together. Obviously, such connections are potentially disruptive, so when groups are formed, group leaders should consider whether subgroups would exist.

When subgroups somehow stymie full participation in the group, the therapist may be able to reframe what the subgroup is doing. At other times, a change in the room arrangement may be able to reconfigure undesirable combinations. On occasion, however, subtle approaches fail. For instance, adolescents talking among themselves or making obscene gestures during the session should be told factually and firmly that what they are doing is not permissible. The group leader might say, "We can't do our work with distractions going on. Your behavior is disrespectful and it attempts to shame others in the group. I won't tolerate any abuse of members in this group."

Subgroups are not always negative. The leader for example may intentionally foster a subgroup that helps marginally connected clients move into the life of the group. This gambit might involve a question like, "Juanita, do you think it might help Joe if you talked some about your experience with this issue?" Further, to build helpful connections between group members, a group member might be asked, "Bob, who else in this group do you think might know something about what you've just said?"

Responding to disruptive behavior

Clients who cannot stop talking

When a client talks on and on, he or she may not know what is expected in a therapy group. The group leader might ask the verbose client, "Bob, what are you hoping the group will learn from what you have been sharing?" If Bob's answer is, "Huh, well nothing really," it might be time to ask more experienced group members to give Bob a sense of how the group works. At other times, clients tend to talk more than their share because they are not sure what else to do. It may come as a relief to have their monolog interrupted (Vannicelli 1992, p. 167).

If group members exhibit no interest in stopping a perpetually filibustering client, it may be appropriate to examine this silent cooperation. The group may be all too willing to allow the talker to ramble on, to avoid examining their own past failed patterns of substance abuse and forge a more productive future. When this motive is suspected, the leader should explore what group members have and have not done to signal the speaker that it is time to yield the floor. It also may be advisable to help the talker find a more effective strategy for being heard and understood (Vannicelli 1992).

> In managing subgroups, one key role for the therapist is to make covert alliances overt.

Clients who interrupt

Interruptions disrupt the flow of discussion in the group, with frustrating results. The client who interrupts is often someone new to the group and not yet accustomed to its norms and rhythms. The leader may invite the group to comment by saying, "What just happened?" If

Sometimes, clients are unable to participate in ways consistent with group agreements.

the group observes, "Jim seemed real anxious to get in right now," the leader might intervene with, "You know, Jim, my hunch is that you don't know us well enough yet to be certain that the group will pay adequate attention to your issues; thus, at this point, you feel quite a lot of pressure to be heard and understood. My guess is that when other people are speaking you are often so distracted by your worries that it may even be hard to completely follow what is going on" (Vannicelli 1992, p. 170).

Clients who flee a session

Clients who run out of a session often are acting on an impulse that others share. It would be productive in such instances to discuss these feelings with the group and to determine what members can do to talk about these feelings when they arise. The leader should stress the point that no matter what is going on in the group, the therapeutic work requires members to remain in the room and talk about problems instead of attempting to escape them (Vannicelli 1992). If a member is unable to meet this requirement, reevaluation of that person's placement in the group is indicated.

Contraindications for continued participation in group

Sometimes, clients are unable to participate in ways consistent with group agreements. They may attend irregularly, come to the group intoxicated, show little or no impulse control, or fail to take medication to control a co-occurring disorder. Though removing someone from the group is very serious and should never be done without careful thought and consultation, it is sometimes necessary. It may be required because of a policy of the institution, because the therapist lacks the skills needed to deal with a particular problem or condition, or because an individual's behavior threatens the group in some significant and insupportable way.

Though groups do debate many issues, the decision to remove an individual is not one the group makes. On the contrary, the leader makes the decision and explains to the group in a clear and forthright manner why the action was taken. Members then are allotted time to work through their responses to what is bound to be a highly charged event. Anger at the group leader for acting without group input or acting too slowly is common in expulsion situations, and should be explored.

Managing Other Common Problems

Coming late or missing sessions

Sometimes, addiction counselors view the client who comes to group late as a person who, in some sense, is behaving badly. It is more productive to see this kind of boundary violation as a message to be deciphered. Sometimes this attempt will fail, and the clinician may decide the behavior interferes with the group work too much to be tolerated.

Silence

A group member who is silent is conveying a message as clearly as one who speaks. Silent messages should be heard and understood, since nonresponsiveness may provide clues to clients' difficulties in connecting with their own inner lives or with others (Vannicelli 1992).

Special consideration is sometimes necessary for clients who speak English as a second language (ESL). Such clients may be silent, or respond only after a delay, because they need

time to translate what has just been said into their first language. Experiences involving strong feelings can be especially hard to translate, so the delay can be longer. Further, when feelings are running high, even fluent ESL speakers may not be able to find the right words to say what they mean or may be unable to understand what another group member is saying about an intense experience.

Tuning out

When the group is in progress and clients seem present in body but not in mind, it helps to tune into them just as they are tuning out. The leader should explore what was happening as an individual became inattentive. Perhaps the person was escaping from specific difficult material or was having more general difficulties connecting with other people. It may be helpful to involve the group in giving feedback to clients whose attention falters. It also is possible, however, that the group as a whole is sidestepping matters that have to do with connectedness. The member who tunes out might be carrying this message for the group (Vannicelli 1992).

Participating only around the issues of others

Even when group members are disclosing little about themselves, they may be gaining a great deal from the group experience, remaining engaged around issues that others bring up. To encourage a member to share more, however, a leader might introduce the topic of how well members know each other and how well they want to be known. This topic could be explored in terms of percentages. For instance, a man might estimate that group members know about 35 percent about him, and he would eventually like them to know 75 percent. Such a discussion would yield important information about how much individuals wish to be known by others (Vannicelli 1992).

Fear of losing control

As Vannicelli (1992) notes, sometimes clients avoid opening up because they are afraid they might break down in front of others—a fear particularly common in the initial phases of groups. When this restraint becomes a barrier to clients feeling acute pain, the therapist should help them remember ways that they have handled strong feelings in the past.

For example, if a female client says she might "cry forever" once she begins, the leader might gently inquire, "Did that ever happen?" Clients are often surprised to realize that tears generally do not last very long. The therapist can further assist this client by asking, "How were you able to stop?" (Vannicelli 1992, p. 152).

> A group member who is silent is conveying a message as clearly as one who speaks.

When a client's fears of breaking down or becoming unable to function may be founded in reality (for example, when a client has recently been hospitalized), the therapist should validate the feelings of fear, and should concentrate on the strength of the person's adaptive abilities (Vannicelli 1992).

Fragile clients with psychological emergencies

Since clients know that the group leader is contractually bound to end the group's work on time, they often wait intentionally until the last few minutes of group to share emotionally charged information. They may reveal something particularly sad or difficult for them to deal with. It is important for the leader to recognize they have deliberately chosen this time to share this information. The timing is the

Clients may feel great anxiety after disclosing something important.

client's way of limiting the group's responses and avoiding an onslaught of interest. All the same, the group members or leader should point out this self-defeating behavior and encourage the client to change it.

Near the end of a session, for example, a group leader has an exchange with a group member named Lan, who has been silent throughout the session:

Leader: Lan, you've been pretty quiet today. I hope we will hear more about what is happening with you next week.

Lan: I don't think you'll see me next week.

Further exploration reveals that Lan intends to kill herself that night. In view of the approaching time boundary, what should the leader do?

In such a situation, the group leader has dual responsibilities. First, the leader should respond to Lan's crisis. Second, the incident should be handled in a way that reassures other group members and preserves the integrity of the group. Group members will have a high level of anxiety about such a situation. Because of their concern, some group leaders are willing to extend the time boundary for that session only, provided that all members are willing and able to stay. Others feel strongly that the time boundary should be maintained and that the leader should pledge to work with Lan individually right after the session. Whatever the decision and subsequent action, the leader should not simply drift casually and quietly over the time boundary. The important message is that boundaries should be honored and that Lan will get the help she needs. The group leader can say explicitly that Lan's needs will be addressed after group.

Figure 6-3 shows that group leaders should be prepared to deal not only with substance abuse issues, but with co-occurring psychiatric concerns as well.

Anxiety and resistance after self-disclosure

Clients may feel great anxiety after disclosing something important, such as the fact that they are gay or incest victims. Often, they wonder about two possibilities: "Does this mean that I have to keep talking about it? Does this mean that if new people come into the group, I have to tell them too?" (Vannicelli 1992, p. 160).

To the first question, the therapist can respond with the assurance, "People disclose in here when they are ready." To the second, the member who has made the disclosure can be assured of not having to reiterate the disclosure when new clients enter. Further, the disclosing member is now at a different stage of development, so the group leader could say, "Perhaps the fact that you have opened up the secret a little bit suggests that you are not feeling that it is so important to hide it any more. My guess is that this, itself, will have some bearing on how you conduct yourself with new members who come into the group" (Vannicelli 1992, p. 160 & p. 161).

Figure 6-3

Jody's Arm

A long-term outpatient interpersonal process group meets in 90-minute sessions to support sustained recovery. The group, which includes five women and four men, is relatively stable and successfully abstinent. Many of the clients, however, still struggle with profound psychological concerns that require ongoing attention.

In one group session, all members are present except Jody, a 43-year-old client who is opioid-dependent and has co-occurring psychiatric difficulties. Jody walks in approximately 35 minutes late, apologizing for her lateness. The group facilitator makes a mental note that Jody is wearing several sweatshirts, despite weather too mild to justify the need for layered clothing.

Approximately 15 minutes before the close of group, blood seeps through the top layer of clothing covering Jody's left arm. The group leader asks Jody if her injured arm is making some statement to the group members. Is there something specific that she wants from the group at this particular moment? The leader is confident that Jody is saying something very important not only to, but for, the group as a whole.

Jody indicates that the previous week she felt diminished by comments from a number of members in the group. In an effort to deal with the anxiety and shame associated with returning to the group, she has cut herself before attending.

A number of group members quickly share their concern for her and hopes that their comments of the previous week could be revisited and revised to be more supportive. Jody shows the group the cut on her forearm, which has all but stopped bleeding. She explains how deep her pain is and her desire for the group not to judge her for that pain.

Because Jody appears to be in no imminent danger, the leader chooses to continue with the group process, ending it at the regularly scheduled time. The group meets at a major medical center, so the leader is able to walk with Jody to the emergency room. The leader assures the group that Jody will receive the medical attention she needs.

The next week, the entire group makes substantial gains. They carefully examine their judgment and willingness to allow Jody to be the primary spokeswoman for the profound emotional pain that each of them feels. The dramatic and unexpected situation the previous week has not interrupted the group process. It has instead been used adroitly to make the group even more productive.

7 Training and Supervision

In This Chapter...

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Overview

Substance abuse counselors come to the field from a variety of backgrounds, education, and experience. Many have not had specific training and supervision in the special skills needed to be an effective group therapist. Counselors may be promoted to positions of supervision without the additional training in the skills needed to perform supervisory tasks, which are

- Administrative
- Evaluative
- Clinical
- Supportive

This chapter describes the skills group therapy clinicians need, the purpose and value of clinical supervision, and how to get the training necessary to be a top-flight group clinician or supervisor of clinicians.

Training

In a brief article, Geoffrey Greif lists "Ten Common Errors Beginning Substance Abuse Workers Make in Group Treatment." He contends that these errors are common because people who abuse substances are supremely adept at helping group leaders make mistakes. Some of these are

- Impatience with the clients' slow pace of dealing with change
- Inability to drop the mask of professionalism
- Failure to recognize countertransference issues
- Not clarifying group rules
- Conducting individual therapy rather than using the entire group effectively
- Failure to integrate new members effectively into the group (Greif 1996)

A group leader for people in substance abuse treatment requires competencies in both group work and addiction.

Training and education for group therapists working in the substance abuse field can alleviate or eliminate such errors. Simultaneously, additional training is becoming even more critical because (1) the traditionally separate fields of mental health and substance abuse counseling increasingly overlap, requiring more and more cross-knowledge; and (2) an ever younger pool of clients is presenting with more cognitive deficits, abuse issues, and co-occurring disorders.

A group leader for people in substance abuse treatment requires competencies in both areas: group work and addiction. For example, facilitators should understand group process, group dynamics, and the stages of group development; they need to understand that group therapy is not individual therapy in a group setting. Further, facilitators should be aware that although Alcoholics Anonymous (AA) or other 12-Step programs are complementary to substance abuse treatment, these modalities are distinct from group therapy.

As trends move toward integrated mental and substance abuse treatment, counselors already adept at working with groups of clients with substance abuse problems may need specific training to manage mental disorders such as depression, which often co-occur with substance abuse. Further, counselors in recovery may be familiar with the stages of addiction treatment but lack a background in group therapy.

On the other hand, group counselors who have treated clients without addictions may not always have sufficient skills to combat addiction and its effect on a group therapy situation. Therapists need to become well versed in the substance abuse treatment philosophy, its terminology, and techniques of recovery, including the self-help approaches (Kemker et al. 1993).

A group therapist with roots in the mental health field planning to become more competent in group work for the treatment of substance abuse will need to make a number of adjustments. First, the therapist working with clients with substance use disorders should be able to screen and assess for substance abuse problems. On this subject, see TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (Center for Substance Abuse Treatment [CSAT] 1994*b*); TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997*a*); and TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*c*). Second, the therapist will need to recognize the importance of abstinence. Third, the therapist will need to be sensitive to a client's anxiety and shame, especially in early stages of treatment for substance abuse. In a modified interpersonal process group, for example, the group leader should create a safe, supportive environment free from the stigma of addiction while promoting a client's attachment to other group members, self-help groups, therapy, and the entire healing community of which the group is a part.

Group therapists who move into the treatment of clients who are chemically dependent typically need staff development in:

- *Theories and techniques.* Theories may include traditional psychodynamic methods, cognitive–behavioral modes, and systems theory. From such theoretical bases are drawn applications that pertain to a wide variety of settings and particular client populations.
- *Observation.* The observer can sit in on group therapy sessions, study videotapes of senior therapists leading group sessions (ordinarily followed by a discussion), or watch groups live through one-way mirrors as experienced therapists lead groups.

- *Experiential learning.* With this approach, a therapist may participate in a training group offered by an agency, become a member of a personal therapy group (these are often process-oriented), or join in group experiences at conferences, such as those offered at the Institute of the American Group Psychotherapy Association's annual conference. (For more on experiential training, see the section on "Experiential Learning" later in this chapter.)
- *Supervision.* A large part of this type of training is ongoing work with groups under the supervision of an experienced therapist. Supervision may be dyadic, that is, supervisor and supervisee, but while simple and easy, this setting does not allow opportunities for actual group work. Supervision of group therapists ideally is conducted in a supervisory group format. Supervision in a group enables therapists to obtain first-hand experience and helps them better understand what is happening in groups that they will eventually lead. Several other important benefits accrue as well. The supervisory group creates a safe place for trainees to reveal themselves and the skills they need to develop. It provides support from peers and a chance to learn from their experience. It stimulates dialog around theory and technique and encourages a healthy kind of competition. It expands the capacity for empathy (Alonso 1993). Finally, this kind of supervision provides an opportunity for trainees to explore sensitive issues, such as child abuse, sexual abuse, and prostitution. (For more on supervisory groups, see the "Supervision" section later in this chapter.)

Before leaving the matter of what group leaders treating substance abuse should know, it is desirable to assess the importance of the group facilitator's being a person who is in recovery. There is some tension around this issue. Culbreth (2000) reviewed 16 relevant studies and concluded that while clients do not perceive differences in treatment related to a therapist being in recovery or not, and no differences in treatment outcomes could be discerned, recovering and nonrecovering therapists do not perceive substance abuse problems the same way, use different methods to treat substance abuse, and differ in personality and attitudinal traits.

Some people dismiss the notion that all people with addictions prefer to work with a group leader who is in recovery. They insist that, on the contrary, some people with addictions prefer not to work with recovering leaders, fearing that leaders in recovery will share the issues and problems of people with addictions and thus will not be in a position to help them with these issues.

Others say that a staff of group leaders should include people in recovery. Those holding this point of view reason that people with addictions are highly skilled at manipulating people and situations. With both recovering and nonrecovering group leaders, a clinical team will be best positioned to see and treat the whole client—and not be duped by agreeable, but false, façades.

In group therapy with clients with substance use disorders, it can be challenging to establish and maintain credibility with all group clients. Facilitators not in recovery will need to anticipate and respond to group members' questions about their experience with substances and will need skills to handle group dynamics focused on this issue. On the other hand, leaders who are in recovery may tend to focus too much on themselves. Group leaders emotionally invested in acting as models of recovering perfection are easy marks for clients.

Of course, the main issue is not whether the leader is in recovery. What matters most is whether the counselor knows the fields of group therapy and addiction treatment and has

Supervision in a group enables therapists to obtain first-hand experience.

good judgment and leadership skills (see Figure 7-1). Helping the group explore why the recovery status of the group leader is important can be discussed if and when the issue is raised.

Training Opportunities

National professional organizations are a rich source of training. Through conferences or regional chapters, national associations provide training—both experiential and direct instruction—geared to the needs of a wide range of professionals, from the novice to the highly experienced therapist. More training options are usually available in large urban areas. It is likely, however, that online training will make some types of professional development accessible to a greater number of counselors in remote areas. A number of professional organizations that provide a variety training settings are listed below. Inclusion in the list does not imply endorsement by the Substance Abuse and Mental Health Services Administration (SAMHSA). Note that not all of these organizations approach substance abuse treatment through group therapy.

Professional associations

American Group Psychotherapy Association (AGPA)

AGPA, founded in 1942, has more than 4,000 members and 33 local and regional affiliate societies, which provide a broad range of professional, educational, and social support for group therapists in the United States and abroad. The organization publishes *The International Journal of Group Psychotherapy* and *The Group Circle.*

AGPA's Special Interest Groups (SIGs) share ideas and knowledge through interaction with colleagues. Some SIGs focus on substance abuse; children and adolescents; cotherapy; diversity; gay, lesbian, and bisexual clients; the medically ill; the severe and persistent mentally ill; and women in group therapy. SIGs are open to nonmembers of AGPA.

At its annual conferences, AGPA offers training institutes for individuals. Three of these institutes focus on substance abuse training. The association can also provide in-house training to agency staff at a very low cost. Further, AGPA has developed basic and

Figure 7-1

How Important Is It for a Substance Abuse Group Leader To Be In Recovery?

A leader who is in recovery will probably elicit trust more quickly from group members, especially people with hard-core addictive backgrounds, because such clients often assume—correctly or not—that a person in recovery can empathize with the pain of addiction. Such group leaders, as success stories, have the added advantage of serving as role models for group members struggling against temptations and cravings in the early stages of recovery.

A leader having personally recovered, however, does not automatically make that person an effective therapist. Many counselors in recovery cannot make the switch from self- to client-centered approaches and hold rigid views of how to manage the recovery process.

Source: Consensus Panel.

advanced core courses. They tend to be practical in nature, and they contribute to certification. The certified group therapy program is available through the regional affiliates.

American Psychiatric Association (APA)

The American Psychiatric Association is a medical specialty society recognized world-wide. Its more than 35,000 U.S. and international member physicians work together to ensure humane care and effective treatment for all persons with mental disorder, including mental retardation and substance-related disorders. To its members, the APA offers board certification and continuing medical education from online sources as well as at annual meetings.

American Psychological Association (APA)

The APA College of Professional Psychology offers a Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders. This certificate is a uniform nationally recognized credential offered exclusively to licensed psychologists who meet specific criteria related to experience in substance abuse treatment, including completion of an APA examination.

Two of APA's 55 subgroups may be of special interest. Division 49, Group Psychology and Group Psychotherapy, serves psychologists' interest in research, teaching, and the practice of group psychology and group therapy. Division 50, Addictions, centers on research, professional training, and clinical practice dealing with a broad range of addictive behaviors. Both divisions publish a newsletter and journal, and both have annual meetings and award programs.

APA has extensive resources on cultural diversity and ethnic/racial issues related to therapy, including online brochures, a quarterly journal, *Cultural Diversity and Ethnic Minority Psychology*, and an Office of Ethnic Minority Affairs that provides publications and information. Recent APA books on this topic describe relationships among Asian-American women and health-promoting and health-compromising behaviors among minority adolescents.

American Society of Addiction Medicine (ASAM)

One of ASAM's goals is educating health professionals about addiction. The organization develops credentialing guidelines and publishes the comprehensive and influential volume, *Principles of Addiction Medicine* (Graham et al. 2003), among other books and journals. The society has also developed patient placement criteria called PPC-2R (published in 2001), as well as screening and assessment tools. Each year, ASAM hosts several conferences and training meetings on various aspects of addiction medicine. ASAM offers audiotapes of its conferences for continuing medical education credit. Physicians certified by the society in addiction medicine are listed in an ASAM directory.

Association for the Advancement of Social Work with Groups (AASWG)

This international professional organization has developed standards that reflect the distinguishing features of group work, as well as the unique perspective that social workers bring to their practice with groups. These standards are applicable to the types of groups that social workers encounter in the various settings in which they practice and allow the practitioner to apply a variety of relevant group work models. AASWG has also collected a 29-page bibliography of books, monographs, and videos available for practitioners, educators, and researchers.

Association for Specialists in Group Work (ASGW)

A division of the American Counseling Association, the ASGW was founded to promote high quality in group work training, practice, and research, both nationally and internationally. The organization has developed Best Practice Guidelines, Principles for Diversity-Competent Group Workers, and Professional Standards for the Training of Group Workers. These criteria are available on the organization's Web site: http://asgw.org. The Web site also provides resources, including products, institutes, and links to other Web pages, along with a calendar describing upcoming conferences and professional development activities of interest to a broad spectrum of group leaders.

National Association of Alcohol and Drug Abuse Counselors (NAADAC)

NAADAC is the largest national organization for alcoholism and drug abuse professionals across the country. The association offers opportunities for professional development, such as workshops, seminars, and education programs for members. In addition to a bimonthly magazine, *The Counselor*, NAADAC provides an Educational Resources Guide that lists colleges and universities offering degree and certification programs in addiction counseling and a listing of approved education providers for trainers in each State. Through its national certification program, including the National Certified Addiction Counselor and the Masters Addiction Counselor designation, NAADAC recognizes counselors with advanced skill levels.

National Association of Black Social Workers (NABSW)

NABSW offers national and international education conferences, as well as projects and mentoring programs to support the work of African-American social workers.

National Association of Social Workers (NASW)

NASW is the world's largest organization of professional social workers. The association has developed practice standards and clinical indicators, a credentialing program, continuing education courses on national and State levels, and numerous publications for members and nonmembers.

Distance learning courses are listed on NASW's Web site. Many topics are relevant to addiction counselors, such as Chemical Dependency and the African American: Counseling Strategies and Community Issues, Dual Diagnosis, HIV/AIDS and Substance Abuse, and Multicultural Counseling—The New Paradigm for Substance Abuse Professionals.

National Registry of Certified Group Psychotherapists

In an effort to maintain the highest standards for group therapy practice, the National Registry certifies group therapists according to nationally accepted criteria and promotes these criteria among mental health professionals, employers, insurers, education personnel, and clients. The registry has developed guidelines that are clinically based, client-focused service indicators to be used in discussions with accrediting organizations regarding appropriate standards of quality. The guidelines also apply in discussions with employers regarding delivery of mental health services in groups, as well as managed care and health maintenance organizations. The registry's newsletter, *The Group Solution*, provides up-to-date information on the use of group therapy in the current behavioral health care atmosphere.

Frequent continuing education seminars are given by local affiliate societies and at the annual meeting of the parent group, AGPA.

Other sources of training

Many agencies mandate a certain number of trainings each year and provide in-house training that draws on the resources of credentialed senior management. Each of the States has a department of alcohol and drug abuse services, and some may provide substance abuse training for group therapy. Training in mental health issues is often available through the mental health division of government agencies, professional associations, and psychological and psychiatric organizations. Most colleges, universities, and community colleges offer relevant courses, many of them certified by professional organizations.

Several Federal entities offer resources for training. SAMHSA provides a number of resources, including publications for substance abuse treatment professionals. These include the Technical Assistance Publication (TAP) series. TAP 21 is relevant to training: *Addiction Counselor Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT 1998*a*).

In addition, SAMHSA's Treatment Improvement Protocol (TIP) series includes more than 40 publications to assist therapists and counselors in treating people with substance abuse problems. To view TAPs and TIPs online, go to http://www.kap.samhsa.gov and click on "Publications."

These publications also are available free through the SAMHSA Store at 1-877-726-4727. The SAMHSA Store can also provide a catalog of other resources and publications on addiction counseling and treatment. One of them, for example, is the National Institute on Drug Abuse, which provides information on research and treatment.

The National Mental Health Information Center (NMHIC) at SAMHSA provides a wealth of information for the public and for treatment professionals. A search for "training" on its Web site resulted in a list of numerous opportunities for training and technical assistance on a variety of topics as well as bibliographies, publications, and links.

Training Opportunities in Types of Group Therapy

Experiential learning

For the therapist in training, the experience of being in a group is particularly important for both the development of skills and the level of comfort with one's developing leadership style. Whether this experience is acquired through a process group, a supervision group, or experiences offered through organizations like the AGPA, experiential opportunities afford learners not only insight into their personal growth, but a first-person appreciation for the healing power of group therapy.

Experienced group therapists are able to lead process groups because training in this area is part of the preparation program for mental health professionals. In these groups, members study their own behavior to learn about group dynamics, individual dynamics, boundaries, and interpersonal communications. In addition,

SAMHSA provides a number of resources, including publications for substance abuse professionals.

leadership of process groups provides one of the best continuing education tools available to senior clinicians (Swiller et al. 1993). One experienced supervisor of training groups for therapists in training has found that "one of the most striking aspects of the supervision of group therapists in the group setting is its effectiveness in bringing about the identification, emotional recognition, and resolution of…untherapeutic behaviors, which we term counterresistances" (Rosenthal 1999*b*, p. 201).

A great many institutions and individuals offer workshops and courses in conducting group therapy. One of these is the A.K. Rice Institute and its affiliate societies, which provides group relations training based on the Tavistock model, which originated at the Tavistock Institute in England. The training, offered in weekend or longer conferences, is a model of experiential training that focuses exclusively on group-level dynamics.

The A.K. Rice Institute
Anne-Marie Kirkpatrick, R.N., Administrator
P.O. Box 1776
Jupiter, Florida 33468-1776
Phone: (561) 744-1350
Fax: (561) 744-5998

Expressive therapies

A wide range of expressive therapies (therapy based on an artist's working process) is often used in substance abuse treatment. Expressive therapy groups may use dance, music, art, writing, psychodrama, drama, role playing, adventure, and gestalt. Training in these areas is available through AGPA, ASGW, and APA. The Gestalt Institute has training centers in most large cities and offers a certification in psychodrama.

The National Institute of Expressive Psychotherapy offers a 2-year online program for those who have participated annually in the institute's 2-day residency. Professionals are required to participate as a member of a role-playing or drama group before attending classes in techniques and learning how to apply them with a population that has substance abuse problems. The National Expressive Therapy Association offers conferences, professional education, and in affiliation with the National Institute of Expressive Therapy, continuing education units, credentialing, and board certification.

Cross-training

Though group therapists work in the field of mental health, they generally have little training in the specifics of substance abuse treatment. This situation will have to change if the fields of substance abuse treatment and mental health are to integrate their activities.

To supplement courses that professional organizations offer individuals, agencies can use a case study approach. Case studies that include educational materials on diagnosis, symptoms, and treatment serve as a good foundation for cross-training. The cases that cause counselors to struggle the most could be analyzed. What strategies were used? What were the outcomes? What alternatives did other staff recommend? Case conferences can be conducted at weekly staff development sessions, as part of regular meetings, or (more quickly) at morning feedback meetings on clinical topics. A case conference might involve counselors, social workers, and psychologists.

Legal issues

It is important for therapists to know Federal regulations and the laws of their States, especially those concerning "duty to warn" stipulations regarding the abuse of children or elders, commitment procedures for psychiatric clients, and confidentiality laws pertaining to HIV/AIDS, adolescents, and managed care. Practitioners should be familiar with the Federal confidentiality regulation, 42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. In addition, there are State laws that also guide the confidentiality of

alcohol and drug abuse information, and whichever is more restrictive (i.e., State law or Federal law) governs. Professional and legal organizations usually address these topics in their coursework. It is best to find such courses at the regional or State level, so that attendees can grasp the laws governing residents in their specific geographical areas.

Videos

While impersonal media cannot replace the relationships between supervisors and trainees, videos can be used to explain theoretical principles, provide information on various types of drugs, and support skills-building activities.

Distance learning

Distance learning systems, which often communicate via cable or satellite, can assist with explaining concepts, theories, and case studies. Like videos, distance learning may lack the close personal relationship with a supervisor, but interactive forms of distance learning do permit questions, comments, and requests for clarification.

Group therapy for trainees using an online chat room is an interesting possibility and could be especially helpful to people in remote settings. Licensing boards, however, would first need to resolve any potential legal issues regarding confidentiality. Also, some critics have worried that computerized communication would interfere with attachment (one of the most powerful therapeutic factors). This problem does not seem to occur in educational seminars conducted online (see Figure 7-2 on p. 132).

Every State has a credentialing process for substance abuse treatment professionals, and NAADAC lists all the particulars at http://www.NAADAC.org. At the same address, NAADAC posts training calendars and a great deal of other information on training opportunities.

The 14 regional Addiction Technology Transfer Centers (ATTCs), launched by SAMHSA's CSAT in 1993, connect substance abuse treatment professionals to a wide variety of useful information. ATTCs

- Provide State-by-State credentialing information
- Post news in the field
- List new resources, including publications
- Translate technical and academic journal articles into easy-to-read language
- List alcohol and other drug treatment programs in each State
- Provide a worldwide catalog of online courses

To tap into ATTC's lode of professional development information, log onto http://www.nattc.org.

Supervision

Supervisory oversight is a significant training requirement for group therapists. Powell (1993) defines clinical supervision as "a disciplined, tutorial process wherein principles are transformed into practical skills with four overlapping foci—administrative, evaluative, clinical, and supportive." Powell's description points out that the clinical supervisor has an administrative task, namely the development of an appropriate supervision plan for clinician trainees. This task includes planning, coordination, and delegation of responsibilities; determining appropriate staff assignments; and helping to define administrative polcies and procedures.

In addition, the clinical supervisor has duties in the sphere of evaluation. As the skills and knowledge of new group facilitators begin to grow, they need consistent, useful feedback that will direct their work and will support professional growth. In the early stages of

Every State has a credentialing process for substance abuse treatment professionals.

Figure 7-2

Does Online Communication Impede Attachment?

As a faculty member with the Fielding Graduate Institute, a distance learning program, I teach psychology in both on- and offline formats. In many of the online seminars, students post their papers and comment on the contributions of others. The students are dispersed around the country, so few (if any) know each other prior to the seminar.

Even though the students' interactions are asynchronous (that is, not in real time; a lag separates comment and response), a group of learners develops that is indistinguishable from learners sitting in the same room together. Alliances develop between students who share similar ideas, and disagreements take place between opposing positions. The attachments that develop through the written word outside of real time seem as genuine as any other relationships.

In the online seminars, some students find in cyberspace a safer format than traditional classes. Not having to confront all the verbal cues that may distract people in a face-to-face conversation, learners are freer to be genuine. Several of my students who were involved in a seminar with in-person and online components were more interactive and spontaneous in the online segment.

I don't see why these dynamics would be different in supervisory groups. I don't know of any online therapy groups, but some AA meetings are conducted online.

Further, Haim Weinberg operates a discussion list that includes about 400 group therapists from more than 30 countries. This arena for exchanging ideas about group therapy behaves very much like any large group, with a few surprising departures. Among them:

- In this highly diverse group representing many schools of thought, conflicts do not arise over differing theoretical stances or the appropriateness of interventions. Instead, "word wars," (commonly called "flaming") break out due to impatience or personal attitudes and exchanges. One member wrote, for example, "I thought you either have to be very young and inexperienced or very rude and insulting." Some of the flaming seems to stem from misunderstandings that in turn result from having only words as cues. What is meant in jest, for example, may be taken seriously (Weinberg 2002).
- Traditionally, the larger the group, the more impersonal it was, but Weinberg finds startling self-disclosure and intimacy over the Internet. For example, a man whose newborn son had died wrote, "My heart is broken. Words can't convey the grief, and I realize only now that the depth of this pain is beyond comprehension. I feel waves of horrible sadness and utter bewilderment." Messages of condolence flooded back to the distraught father (Weinberg 2002).

Source: A Consensus Panel member.

group facilitation, answers to the question, "How am I doing?" are extremely important, but unfortunately, the question often goes unanswered. Appropriate clinical supervision will not only keep this question in mind, but also provide clear, cogent responses to trainees. Figure 7-3 gives an example of group experiential training.

Figure 7-3

Group Experiential Training

Through the Mountain Area Health Education Center in Asheville, North Carolina, I conducted an 18-month intensive group training and supervision experience, which is one of many ways to provide clinicians with an expanded knowledge base and the opportunity to sense the power of group therapy. The group met one Saturday a month from 9:00 a.m. to 6:00 p.m.

The model had three main components. The first, conducted in a direct instruction format, communicated basic, intermediate, and eventually advanced group skills. It also highlighted the role of failed attachment in the expression of addictive disease and the theoretical means by which groups address these concerns.

The trainees' experiential group process, the second component, took place three times throughout the day. In these 1-hour sessions, trainees participated in a training group. From the outset, it was made clear that this training group was not therapy. Although personal information inevitably was shared, the primary purpose of the experience was trainees' encounter with the here-and-now aspects of interpersonal group process, while being exposed to the same anxieties, excitement, and achievements that clients feel within the context of group. At the end of each experiential group process, trainees evaluated not only the group process, but also reflected on aspects of the supervisor's leadership style, commenting on its facilitation of the process or difficulties it presented.

The third aspect of this training and supervision experience was an in-depth evaluation of the clinical experiences of the trainees. At each session, group members brought in clinical issues that occurred in their practice for comment, discussion, and review. They received information not only from the group supervisor, but also from peers. This opportunity enabled trainees to integrate a theory base with practice, thus satisfying one of Powell's key components of clinical supervision, that is, "a tutorial process wherein principles are transformed into practical skills" (Powell 1993).

After leading this intensive experience, as well as many less intensive 30-hour training courses in group therapy, the need for such continuing training opportunities is clear to us. We can say with some authority that the continued advancement of one's personal skills is essential, from initiation into the field throughout the trajectory of a professional's career.

Source: A Consensus Panel member.

The supervisory alliance is needed to teach the trainee the skills and knowledge required to lead groups effectively.

The *clinical* function that the supervisor fulfills is the development of a basic core of knowledge and skills, which includes an in-depth understanding of addictive disease, an integrated model of group process, group dynamics, and the stages of group development.

The interaction between supervisory personnel and trainees has a *supportive* function, which is vital to the growth of trainees. When they begin to apply their newly acquired knowledge is the time that they need the most support and the most discerning supervision.

Clinical supervision, as it pertains to group therapy, often is best carried out within the context of group supervision. Group dynamics and group process facilitate learning by setting up a microcosm of a larger social environment. Each group member's style of interaction will inevitably show up in the group transactions. Given enough time, all the people in the supervisory group will interact with group members just as they interact with others in wider social and clinical spheres, and every person will create in the group the same interpersonal universe inhabited outside the group. As this process unfolds, group members, guided by the supervisor, learn to model effective behavior in an accepting group context.

For the beginning counselor, supervisory groups reduce, rather than escalate, the level of threat that can accompany supervision. In place of isolation and alienation, group participation gives counselors a sense of community. They find that others share their worries, fears, frustrations, temptations, and ambivalence. This reassurance is especially beneficial to novice counselors. Further,

- Group disclosure increases the potential for self-disclosure and confirmation, creating opportunities for growth.
- Empathy and sharing of interests are available to a greater extent than in individual supervision.
- Working together over time, a group can reinforce its members' personal growth.
- Alternative clinical approaches and methods of helping are available to a far greater extent than in dyadic supervision. As a result, group members acquire a broad perspective on counseling styles.
- Each counselor can do reality testing, presenting perceptions for peer scrutiny, and possibly, validation.
- The potential for critique is greatly expanded (Powell 1993).

For treatment facilities, group supervision is attractive in its efficiency and effectiveness:

- It provides a cost-effective way of supervising more people in the same amount of time.
- The diversity of people in the group increases opportunities for learning. The number of group members (up to the desired limit of four to six members) exponentially expands the range of learning opportunities.
- Group supervision creates a working alliance among counselors, engendering a sense of psychological safety and reducing self-defeating behavior (Powell 1993).

The Supervisor's Essential Skills

A supervisor should be competent in several content areas, including substance abuse treatment, group training, cultural competence, and diagnosis of co-occurring conditions. A supervisor may be an administrator, an in-house trainer, or a therapist from another agency.

A recent survey of members of NAADAC indicates that many counselors receive and are

satisfied with weekly clinical supervision. However, a significant percentage of the respondents (who were not differentiated as to whether they work with individuals or groups) indicated they receive no clinical supervision (Culbreth 1999). This finding is disturbing considering the benefits of clinical supervision for the delivery of high-quality service to clients and the professional development of counselors. Other findings from the NAADAC survey have clear implications for supervisory training. For example, respondents preferred a supervisor who is a knowledgeable professional in the field and supervision that is more proactive and intentional than reactive (Culbreth 1999).

The Supervisory Alliance

Some training experts believe the key to effective group therapy supervision is the development of the supervisory alliance. This positive working relationship between the supervisor and trainee is a unique and appropriate setting within which a new therapist can develop skills in group analysis and refine an ability to develop appropriate treatment strategies.

The supervisory alliance is needed to teach the trainee the skills and knowledge required to lead groups effectively and to make sure that the group accomplishes its purpose. The supervisor helps by establishing an open and collaborative climate, identifying the unique learning needs and styles of the supervisory group members, formulating a responsive supervisory contract, and pinpointing any problems that emerge within the alliance (Kleinberg 1999). Supervision also includes encouraging and mentoring students from specific cultural groups, since it is difficult to locate well-trained therapists to treat certain populations.

Assessment of trainee skills

The supervisor should be able to assess the various domains that trainees are required to master.

- Clinical skills (from selecting prospective group members and designing treatment strategies to planning and managing termination)
- Comprehensive knowledge of substance abuse, which, depending upon the treatment setting, could entail broad general knowledge of, or a thorough facility with, a particular field
- Knowledge of the preferred theoretical approach
- Knowledge of psychodynamic theory
- Knowledge of group dynamics theory
- Knowledge of the institution's preferred theoretical approaches
- Diagnostic skills for determining co-occurring disorders
- Capacity for self-reflection, such as recognizing one's own vulnerability and, when this problem arises, the ability to monitor and govern behavioral and emotional reactions
- Consultation skills, such as the ability to consult with a referring therapist, provide feedback, and coordinate treatment in both individual and group modes
- Capacity to be supervised; for example, openness in supervision, setting goals for training, and discussing with supervisor one's learning style and preferences (Kleinberg 1999)

Planning ways to train new counselors

In planning a training approach, a supervisor needs to consider the characteristics of the supervisory team, that is, the supervisor plus the trainees. Variables to be considered include

- The sophistication of trainees' knowledge and skills
- The supervisory setting
- The characteristics of the client population
- The nature of the supervised treatment
- The personality fit of the members on the supervisory team
- The format of the supervision
- The theoretical compatibility of the supervisory team (Kleinberg 1999)

After weighing all these variables, the supervisor discusses the focus and goals of the work with the team. The particulars will take shape as the supervisory contract. The necessary mastery of specified clinical subjects, as well as the skills associated with them, can be developed through reading assignments, video presentations, written assessments, and both direct and indirect supervision.

Funding for Training and Supervision Programs

Given the time and financial resources needed to create formal academic preparation programs, it is a challenge to provide extended training (beyond 1- and 2-day seminars) that is well grounded in theory and application and that addresses the needs of substance abuse counselors, especially those leading therapy groups. The best way to fund such training is to incorporate it into an agency or organization budget. These outlays should be viewed as investments that pay handsome dividends. For instance, opportunities for training can help attract new, highly motivated employees.

One alternative source of funding is a Federal or State grant. Such funds are often available, though frequently they require a great deal of administrative work and strict adherence to specific guidelines for project direction, staffing, and evaluation. Grants are also available to agencies and individuals through certain professional and training organizations. For example, AGPA gives scholarships to students who wish to attend its annual meetings and training conferences.

> It is a challenge to provide extended training that is well grounded in theory and application.

Other options can be found through the Foundation Center, a nonprofit library system that

- Collects and disseminates information on sources of funding
- Conducts and promotes research on trends in philanthropy
- Provides education on grant seeking
- Publishes The Foundation Directory, available on CD-ROM through *The Foundation Center*

The five foundation libraries (located in Atlanta, Cleveland, New York, San Francisco, and Washington) provide many resources with information on grants for projects related to health and education. The center has recently designed a virtual classroom to assist in

- Researching philanthropy
- Writing proposals
- Identifying nearby corporations, government agencies, and other sources of funds in specific geographical areas
- Training in fundraising
- Online fundraising

The Foundation Center can be reached at http://www.fdncenter.org. The Frequently Asked Questions section on this Web site is a useful introduction to the center's services.

As with training, an inherent cost is associated with high-quality clinical supervision, both in financial commitment and clinical time. Despite the positive returns that stem from good, better, or best clinical supervision, staff resources, agency or organizational requirements, and the needs of the leader in training often dictate the specific type of supervision available.

Every agency providing services to clients abusing substances should take clinical supervision seriously and direct appropriate resources toward constant improvement through the clinical supervision process.

Appendix A: Bibliography

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Appendix B: Adult Patient Placement Criteria

Adult Patient Placement Criteria For the Treatment of Psychoactive Substance Use Disorders

Levels of Care Criteria → ↓	Dimensions	Level I Outpatient Treatment	Level II Intensive Outpatient Treatment	Level III Medically Monitored Intensive Inpatient Treatment
1 Acute Intoxication and/or Withdrawal Potential	Level IV	Medically Managed Intensive Inpatient Treatment	No withdrawal risk.	Minimal withdrawal risk.
2 Biomedical Conditions and Complications	Severe withdrawal risk but manageable in Level III.	Severe withdrawal risk.	None or very stable.	None or nondistracting from addiction treatment and manageable in Level II.
3 Emotional and Behavioral Conditions and Complications	Requires medical monitoring but not intensive treatment.	Requires 24-hour medical, nursing care. None or very stable.	Mild severity with potential to distract from recovery.	Moderate severity needing a 24-hour structured setting.
4 Treatment Acceptance and Resistance	Severe problems requiring 24-hour psychiatric care with concomitant addiction treatment.	Willing to cooperate but needs motivating and monitoring strategies.	Resistance high enough to require structured program, but not so high as to render outpatient treatment ineffective.	Resistance high despite negative consequences and needs intensive motivating strategies in 24-hour structure.

(continued on next page)

Adult Patient Placement Criteria For the Treatment of Psychoactive Substance Use Disorders (continued)

Levels of Care Criteria → Dimensions ↓	Level I Outpatient Treatment	Level II Intensive Outpatient Treatment	Level III Medically Monitored Intensive Inpatient Treatment	Level IV Medically Managed Intensive Inpatient Treatment
5 Relapse Potential	Able to maintain abstinence and recovery goals with minimal support.	Intensification of addiction symptoms and high likelihood of relapse without close monitoring and support.	Unable to control use despite active participation in less intensive care and needs 24-hour structure.	Problems in this dimension do not qualify patient for Level IV treatment.
6 Recovery Environment	Supportive recovery environment and/or patient has skills to cope.	Environment unsupportive but with structure or support, the patient can cope.	Environment dangerous for recovery necessitating removal from the environment; logistical impediments to outpatient treatment.	Problems in this dimension do not qualify patient for Level IV treatment.

Source: American Society of Addiction Medicine 2001.

Appendix C: Sample Group Agreement

Appleton Outpatient Psychotherapy Group Ground Rules

The following is excerpted from Vannicelli 1992, pp. 295–296.

The behavior and feelings of members of the therapy group mirror in important ways behavior and feelings in other important relationships. Consequently, the group provides a setting in which to examine patterns of behavior in relationships. The group also provides a context in which members learn to identify, understand, and express their feelings. The therapist's role is to facilitate this group process.

To foster these goals, we believe that several group ground rules are important. These are as follows:

1. Members joining long-term groups remain as long as they find the group useful in working on important issues in their lives. We recommend at least a year. Members are required to make an initial 3-month commitment in order to determine the usefulness of this particular group for them.

2. Regular and timely attendance at all sessions is expected. As a member, it is your responsibility to notify the group in advance when you know that you will be away or late for group. In the event of an unexpected absence, you should notify the group at least 24 hours in advance to avoid being charged for the missed session.

3. Members of Appleton substance abuse groups are committed to maintaining abstinence. If a relapse does occur, it must be discussed promptly in the group—as must thoughts or concerns about resuming drug/alcohol use. Members of ACOA (Adult Children of Alcoholics) and family groups are asked to be reflective about their own substance use and to bring up changes in patterns of use or concerns that may be associated with use.

4. Members will notify the group if they are considering leaving the group. Because leaving the group is a process, just as joining is, members are expected to see this process through for at least 3 weeks following notification of termination.

5. Members will have a commitment to talk about important issues in their lives that cause difficulty in relating to others or in living life fully.

6. Members will also have a commitment to talk about what is going on in the group itself as a way of better understanding their own interpersonal dynamics.

7. Members will treat matters that occur in the group with utmost confidentiality. To that end, members are expected not to discuss what happens in the group with people who are not members of the group.

8. Outside-of-group contact often has considerable impact on the group's therapeutic effectiveness. Therefore, any relevant interactions between members which occur outside the group should be brought back into the next meeting and shared with the entire group.

9. What you share in the group will be shared with other members of the treatment team when we feel that it is important to your treatment to do so.

10. Payments for group are due at the last meeting of the month unless other arrangements are discussed and explicitly worked out in the group. If for any reason timely payment becomes problematic, members are expected to discuss this in the group.

Appendix D: Glossary

AA

Alcoholics Anonymous, the best known of the 12-Step self-help organizations.

ASAM

The American Society of Addiction Medicine is a national specialty society of the American Medical Association and is dedicated to educating physicians and improving the treatment of individuals with alcoholism and other addictions. ASAM publishes the *Patient Placement Criteria for the Treatment of Substance-Related Disorders: ASAM PPC-2R* (2001), a widely used system of criteria for placing clients in appropriate treatment settings.

Basic teaching skills

Organizing the content to be taught, planning for participant involvement in the learning process, and delivering information in a culturally relevant and meaningful way.

Cognitive–behavioral groups

Groups formed to change learned patterns of thinking and behavior that lead to substance abuse or other psychological and interpersonal disorders.

Cognitive therapy

Attempts to modify maladaptive behavior by influencing a client's beliefs, schemas, self-statements, and problemsolving strategies. Assumes that emotional problems are largely caused by irrational or maladaptive thinking and that restructuring these cognitions will be therapeutic.

Cohesion

A positive quality of groups denoting a sense of enthusiastic solidarity within the group; Yalom (1995, p. 48) notes that cohesive groups "have a higher rate of attendance, participation, and mutual support," and that members "will defend the group standards much more than groups with less esprit de corps."

Communal and culturally specific groups

Groups formed to use the sense of belonging to a culture to reduce or eliminate drug abuse and other negative behaviors.

Conflict

A basic dynamic in groups in which members have opposing views, beliefs, or emotions; conflict can be constructive by (1) assisting members to consider and respect other opinions, (2) generating energy and investment in the group, and (3) creating a variety of options for change; conflict is detrimental when (1) it distracts members' attention or allows them to avoid issues in the group, (2) any group member feels his or her beliefs or world views are not understood or viewed as valid, or (3) the conflict leads to destructive behaviors, such as denigration or other verbal abuse.

Confrontation

A form of intervention that literally means "coming face to face" or "pointing out inconsistencies" that keep clients from facing unpleasant realities (CSAT 1999*b*, p. 10).

Content

Information and feelings expressed in group; its complement is process.

Culture

Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group (Giachello 1995; Office of Minority Health 2001).

Eco-map, or sociogram

A graphic that clients construct to represent their important social relationships.

Expressive groups

Groups formed to use some kind of creative activity (such as painting, dance, play therapy, or psychodrama) to help clients explore their substance abuse, its origins and effects, and new coping options; expressive groups may be especially effective for clients who have difficulty verbalizing thoughts and feelings.

Diversity

As used in this TIP, diversity refers to any difference that distinguishes one individual from another and that affects how clients identify themselves and are identified by others.

Emotional contagion

Rapid and intense escalation of excitement in a group, which if uncontrolled, can threaten boundaries and an individual's sense of well-being, potentially leading to premature termination of treatment.

Fixed membership groups

Relatively small group with a set number of members who stay together over a long period of time; people in time-limited fixed membership groups start and stay together, while ongoing fixed membership groups bring in new members if a vacancy occurs.

Gestalt therapy

Developed by Friedrich S. and Laura Perls, gestalt therapy aims to enhance clients' awareness, which frees them to grow in their own consciously guided ways. It seeks to reestablish stalled growth processes by helping clients become aware of feelings they have disowned but that are a genuine part of them, and recognize feelings and values that they think are a genuine part of them but are borrowed from other people.

Group agreement

A contract between provider and client stipulating the responsibilities of clients and their expectations of other group members, the leader, and the group; group agreements typically specify grounds for exclusion from group, expectations of confidentiality, restrictions on physical contact, consequences for returns to substance use, boundaries on contact outside the group, expectations for participation in group, financial responsibilities, and procedures for termination (leaving the group).

Group dynamics

Forces at work among small groups of interacting people; collectively, group dynamics are a complex amalgam of individual personalities and actions combined with the overarching properties of the group as a whole; put another way, group dynamics are the collective impact of individual members on the group and the impact the group has on each individual.

Group process

How events take place in group, in contrast to content, which is what takes place; if, for example, a question is raised, a process-oriented group leader might silently note circumstances such as voice quality, facial expression, what came before and after the question, and how the question was directed (to the leader? the group? to an individual? away from someone?); overall, process concerns include (1) the impact and quality of interaction among group members, (2) the impact of group on individuals, and (3) the life phases of the group.

Heterogeneous groups

Groups made up of a mixture of clients whose only similarity is the need they share for a particular kind of group.

Homogeneous groups

Groups made up of clients who are alike in some respect other than a common substance use problem; homogeneous groups may include, for example, only women, only adolescents or elderly people, or only people from a certain cultural heritage.

IPGP

Interpersonal process group psychotherapy, shortened in this TIP to interpersonal process groups.

Interpersonal process groups

Formed to use group interactions to promote change and healing; such groups are used after abstinence is well established; they delve into major developmental issues that contribute to addiction and interfere with recovery; the primary interest is how clients recreate past experiences in the here-and-now microcosm of the group; interpersonal process groups attend more to process (how people act and talk) and less to content (what people do and say).

Interpersonal relationship dynamics

How people relate to one another in group settings and how one individual can influence the behavior of others in group, such as by giving and receiving feedback from each other.

Interventions

Words or actions with a therapeutic purpose; interventions may clarify what is happening in group, redirect energy, stop unhelpful processes, or present the group with a choice.

Intrapsychic

Relating to events occurring within the psyche, mind, or personality; that is, internally without reference to any external factors.

Leadership skills

Include helping the group get started in a session, managing (though not necessarily eliminating) conflict between group members, helping withdrawn members of the group become more active, and making sure that all group members have a roughly equal chance to participate.

Problem-focused groups

Groups formed to address a particular problem that contributes to substance abuse or limits recovery options; problem-focused groups also look at the process of problemsolving so members can generalize their experience in group to other life areas.

Process

How members interact in the group; its complement is content.

Process-oriented therapy

An approach to group therapy that emphasizes group interaction as the healing agent; the role of the leader is the promotion of interaction among group members.

Projective identification
Involves projecting one's disowned attributes onto another person (Yalom 1995).

Psychodynamic emphases
The dynamic interplay of psychological forces conceptualized using psychodynamic theories. Within an individual these forces influence behavior, interaction with others, and emotions.

Psychodynamic therapy, psychodynamic approach
An approach to psychological growth and change that emphasizes the evolution and adaptation of the psychological structure within an individual. Psychodynamic therapy often focuses on changing behavior in the present by re-examining and revising a person's understandings and reactions to events in the past.

Psychotherapy (or therapy) groups
Groups formed to reduce or eliminate substance abuse or other problematic behaviors by changing long-standing relational and intrapsychic difficulties. Psychotherapy groups differ from other groups traditionally used for substance abuse treatment, such as problem-solving or support groups, in that the group (1) has a relatively long-term contract; (2) focuses more on psychodynamic issues (rather than education, support, or problem solving); (3) begins in later stages of treatment and recovery; (4) tolerates the expression of more emotion; and (5) stresses process over content.

Psychoeducational groups
Groups formed to educate clients about substance abuse, related behaviors, and the behavioral, medical, and psychological consequences of use, abuse, and dependency; psychoeducational groups provide information important for achieving abstinence and maintaining recovery.

Reality therapy
Developed by William Glasser, the basic principle of reality therapy is that we are responsible for what we choose to do. Reality therapy focuses on solving problems and on coping with the demands of reality in society by making more effective choices.

Redecision therapy
Is aimed at helping people challenge themselves to discover ways in which they perceive themselves in victimlike roles and to take charge of their lives by deciding for themselves how they will change.

Relapse prevention groups
Groups formed to help clients maintain abstinence or minimize the impact and duration of relapse.

Resistance to therapy
An often subconscious defense against the pain of examining one's own behavior, perceptions, beliefs, and feelings; resistance can appear in many disguises: continual claims to be too upset to work on issues in group, missing group or coming late, or aversion to strong emotions, such as anger. Resistance is a natural part of any change process, but if it is not dealt with, it impedes growth and blocks the progress of individuals and groups.

Revolving membership groups
Somewhat larger than fixed membership groups, revolving membership groups acquire new members when they become ready for its services; time-limited revolving membership groups keep a member for a specified period of time, while ongoing revolving membership groups may have clients who (1) stay as long as they wish, (2) enter a group with a repeating cycle of topics and stay until they have completed all the topics, or (3) attend for a set time (either consecutively or nonconsecutively).

Skills development groups

Groups formed to bring about or improve the skills needed to achieve and maintain abstinence; such skills may relate directly to substance abuse (such as ways to refuse drugs or cope with urges to use them), or they may be designed to reduce or eliminate general life problems that imperil recovery (such as inadequate anger management or an inability to relax).

Splitting

A divide-and-conquer tactic used to come between cotherapists (Yalom 1995).

Stages of change

Prochaska and DiClemente's (1984) continuum that describes the stages a client moves through to achieve lasting recovery: precontemplation, contemplation, preparation, action, maintenance, and recurrence (for definitions, see chapter 2); the stage a client is in helps to determine what group treatment models and methods are appropriate for that person.

Stages (or phases) of group development

In the *beginning* phase, the group is prepared to begin its work. Tasks in this period involve introductions, a review of the group agreement, and the establishment of a safe environment and healthy norms. The *middle* phase, or actual work of the group, is the time for here-and-now interactions that help clients rethink behaviors and undertake changes. The *end* phase is a mixture of recognition and celebration of work done and goals achieved, mourning for the loss of the attachments formed in group, and reorientation toward the future.

Stages of recovery

In *early* recovery, clients establish abstinence. During this period, they are fragile and highly prone to relapse. In *middle* recovery, abstinence becomes stable enough so that the client can begin to work on life problems. In *late* recovery, clients continue working to maintain abstinence and make life changes, but may also confront and modify deeply ingrained relational problems and other psychological issues. A client's stage of recovery is one determinant of placement.

Stages of treatment

In *early* treatment, clients are ambivalent about relinquishing substance abuse, so heavy emphasis is placed on drawing clients into a culture of recovery and helping them get through each day without substances. Strong challenges to the mental and emotional state are set aside until later in treatment. In the *middle* stage, clients' mental and emotional condition improves, but they have an acute need for satisfying new directions that can fulfill the role that substance abuse once played in their lives. In *late* treatment, clients sustain earlier gains, but learn to anticipate temptations and triggers for relapse. Also, the client may need to address issues like poor self-image, relationship problems, shame, or trauma.

Support groups

Groups formed to (1) develop and strengthen clients' abilities to manage their own thinking and emotions (2) improve interpersonal skills, (3) manage day-to-day life more effectively, and (4) boost self-esteem and self-confidence.

Transactional analysis

Is both a theory of personality and an organized system of interactional therapy. Its basic assumption is that people make current decisions based on past premises that were at one time appropriate to survival but may no longer be valid. Transactional analysis emphasizes the cognitive, rational, and behavioral aspects of the therapeutic process.

Transference and countertransference

Transference is a perceptual distortion in which the characteristics of one person are attributed to another; in other words, parts of past relationships are projected onto relationships in the present; if, for example, group member A reminds member B of a dour, narrow-minded father,

member B may transfer the attributes of his father to member A and react to him in group with extraordinary and irrational hostility. In a narrow sense, countertransference occurs when clients' transference evokes (often unconscious) emotional responses in therapists. In recent years, the concept has widened to include any emotional reaction in a therapist brought on by a client.

12-Step programs

Self-help programs that are based on mastering a set of steps to achieve and maintain abstinence; they are often loosely organized around a drug of abuse: Alcoholics Anonymous (alcohol), Narcotics Anonymous (opioids and illicit drugs), Cocaine Anonymous.

Appendix E: Association for Specialists in Group Work Best Practice Guidelines

Approved by the ASGW Executive Board, March 29, 1998

Prepared by: Lynn Rapin and Linda Keel, ASGW Ethics Committee Co-Chairs

The Association for Specialists in Group Work (ASGW) is a division of the American Counseling Association whose members are interested in and specialize in group work. We value the creation of community; service to our members, clients, and the profession; and leadership as a process to facilitate the growth and development of individuals and groups.

The Association for Specialists in Group Work recognizes the commitment of its members to the Code of Ethics and Standards of Practice (as revised in 1995) of its parent organization, the American Counseling Association (ACA), and nothing in this document shall be construed to supplant that code. These Best Practice Guidelines are intended to clarify the application of the ACA Code of Ethics and Standards of Practice to the field of group work by defining Group Workers' responsibility and scope of practice involving those activities, strategies, and interventions that are consistent and current with effective and appropriate professional ethical and community standards. ASGW views ethical process as being integral to group work and views Group Workers as ethical agents. Group Workers, by their very nature in being responsible and responsive to their group members, necessarily embrace a certain potential for ethical vulnerability. It is incumbent upon Group Workers to give considerable attention to the intent and context of their actions because the attempts of Group Workers to influence human behavior through group work always have ethical implications. These Best Practice Guidelines address Group Workers' responsibilities in planning, performing, and processing groups.

Section A: Best Practice in Planning

A.1. Professional Context and Regulatory Requirements

Group Workers actively know, understand, and apply the ACA Code of Ethics and Standards of Best Practice, the ASGW Professional Standards for the Training of Group Workers, these ASGW Best Practice Guidelines, the ASGW diversity competencies, the ACA Multicultural Guidelines, relevant State laws, accreditation requirements, relevant National Board for Certified Counselors Codes and Standards, their organizations' standards, and insurance requirements impacting the practice of group work.

A.2. Scope of Practice and Conceptual Framework

Group Workers define the scope of practice related to the core and specialization competencies defined in the ASGW Training Standards. Group Workers are aware of personal strengths and weaknesses in leading groups. Group Workers develop and are able to articulate a general conceptual framework to guide practice and a rationale for use of techniques that are to be used. Group Workers limit their practice to those areas for which they meet the training criteria established by the ASGW Training Standards.

A.3. Assessment

a. Assessment of self. Group Workers actively assess their knowledge and skills related to the specific group(s) offered. Group Workers assess their values, beliefs, and theoretical orientation and how these impact upon the group, particularly when working with a diverse and multicultural population.

b. Ecological assessment. Group Workers assess community needs, agency or organization resources, sponsoring organization mission, staff competency, attitudes regarding group work, professional training levels of potential group leaders regarding group work, client attitudes regarding group work, and multicultural and diversity considerations. Group Workers use this information as the basis for making decisions related to their group practice, or to the implementation of groups for which they have supervisory, evaluation, or oversight responsibilities.

A.4. Program Development and Evaluation

a. Group Workers identify the type(s) of group(s) to be offered and how they relate to community needs.

b. Group Workers concisely state in writing the purpose and goals of the group. Group Workers also identify the role of the group members in influencing or determining the group goals.

c. Group Workers set fees consistent with the organization's fee schedule, taking into consideration the financial status and locality of prospective group members.

d. Group Workers choose techniques and a leadership style appropriate to the type(s) of group(s) being offered.

e. Group Workers have an evaluation plan consistent with regulatory, organization and insurance requirements, where appropriate.

f. Group Workers take into consideration current professional guidelines when using technology, including but not limited to Internet communication.

A.5. Resources

Group Workers coordinate resources related to the kind of group(s) and group activities to be provided, such as: adequate funding; the appropriateness and availability of a trained co-leader; space and privacy requirements for the type(s) of group(s) being offered; marketing and recruiting; and appropriate collaboration with other community agencies and organizations.

A.6. Professional Disclosure Statement

Group Workers have a professional disclosure statement which includes information on confidentiality and exceptions to confidentiality, theoretical orientation, information on the nature, purpose(s) and goals of the group, the group services that can be provided, the role and responsibility of group members and leaders, qualifications to conduct the specific group(s), specific licenses, certifications and professional affiliations, and address of licensing/credentialing body.

A.7. Group and Member Preparation

a. Group Workers screen prospective group members if appropriate to the type of group being offered. When selection of group members is appropriate, Group Workers identify group members whose needs and goals are compatible with the goals of the group.

b. Group Workers facilitate informed consent. Group Workers provide in oral and written form to prospective members (when appropriate to group type): the professional disclosure statement; group purpose and goals; group participation expectations including voluntary and involuntary membership; role expectations of members and leader(s); policies related to entering and exiting the group; policies governing substance use; policies and procedures governing mandated groups (where relevant); documentation requirements; disclosure of information to others; implications of out-of-group contact or involvement among members; procedures for consultation between group leader(s) and group member(s); fees and time parameters; and potential impacts of group participation.

c. Group Workers obtain the appropriate consent forms for work with minors and other dependent group members.

d. Group Workers define confidentiality and its limits (for example, legal and ethical exceptions and expectations, waivers implicit with treatment plans, documentation and insurance usage). Group Workers have the responsibility to inform all group participants of the need for confidentiality, potential consequences of breaching confidentiality and that legal privilege does not apply to group discussions (unless provided by State statute).

A.8. Professional Development

Group Workers recognize that professional growth is a continuous, ongoing, developmental process throughout their career.

a. Group Workers remain current and increase knowledge and skill competencies through activities such as continuing education, professional supervision, and participation in personal and professional development activities.

b. Group Workers seek consultation and/or supervision regarding ethical concerns that interfere with effective functioning as a group leader. Supervisors have the responsibility to keep abreast of consultation, group theory, process, and adhere to related ethical guidelines.

c. Group Workers seek appropriate professional assistance for their own personal problems or conflicts that are likely to impair their professional judgment or work performance.

d. Group Workers seek consultation and supervision to ensure appropriate practice whenever working with a group for which all knowledge and skill competencies have not been achieved.

e. Group Workers keep abreast of group research and development.

A.9. Trends and Technological Changes

Group Workers are aware of and responsive to technological changes as they affect society and the profession. These include but are not limited to changes in mental health delivery systems; legislative and insurance industry reforms; shifting population demographics and

client needs; and technological advances in Internet and other communication and delivery systems. Group Workers adhere to ethical guidelines related to the use of developing technologies.

Section B: Best Practice in Performing

B.1. Self Knowledge

Group Workers are aware of and monitor their strengths and weaknesses and the effects these have on group members.

B.2. Group Competencies

Group Workers have a basic knowledge of groups and the principles of group dynamics, and are able to perform the core group competencies, as described in the ASGW Professional Standards for the Training of Group Workers. Additionally, Group Workers have adequate understanding and skill in any group specialty area chosen for practice (psychotherapy, counseling, task, psychoeducation, as described in the ASGW Training Standards).

B.3. Group Plan Adaptation

a. Group Workers apply and modify knowledge, skills, and techniques appropriate to group type and stage, and to the unique needs of various cultural and ethnic groups.

b. Group Workers monitor the group's progress toward the group goals and plan.

c. Group Workers clearly define and maintain ethical, professional, and social relationship boundaries with group members as appropriate to their role in the organization and the type of group being offered.

B.4. Therapeutic Conditions and Dynamics

Group Workers understand and are able to implement appropriate models of group development, process observation, and therapeutic conditions.

B.5. Meaning

Group Workers assist members in generating meaning from the group experience.

B.6. Collaboration

Group Workers assist members in developing individual goals and respect group members as co-equal partners in the group experience.

B.7. Evaluation

Group Workers include evaluation (both formal and informal) between sessions and at the conclusion of the group.

B.8. Diversity

Group Workers practice with broad sensitivity to client differences including but not limited to ethnic, gender, religious, sexual, psychological maturity, economic class, family history, physical characteristics or limitations, and geographic location. Group Workers continuously seek information regarding the cultural issues of the diverse population with whom they are working both by interaction with participants and from using outside resources.

B.9. Ethical Surveillance

Group Workers employ an appropriate ethical decisionmaking model in responding to ethical challenges and issues and in determining courses of action and behavior for self and group members. In addition, Group Workers employ applicable standards as promulgated by ACA, ASGW, or other appropriate professional organizations.

Section C: Best Practice in Group Processing

C.1. Processing Schedule

Group Workers process the workings of the group with themselves, group members, supervisors, or other colleagues, as appropriate. This may include assessing progress on group and member goals, leader behaviors and techniques, group dynamics and interventions,

developing understanding, and acceptance of meaning. Processing may occur both within sessions and before and after each session, at time of termination, and later follow up, as appropriate.

C.2. Reflective Practice

Group Workers attend to opportunities to synthesize theory and practice and to incorporate learning outcomes into ongoing groups. Group Workers attend to session dynamics of members and their interactions and also attend to the relationship between session dynamics and leader values, cognition, and affect.

C.3. Evaluation and Follow-Up

a. Group Workers evaluate process and outcomes. Results are used for ongoing program planning, improvement and revisions of current group, and/or to contribute to professional research literature. Group Workers follow all applicable policies and standards in using group material for research and reports.

b. Group Workers conduct follow-up contact with group members, as appropriate, to assess outcomes or when requested by a group member(s).

C.4. Consultation and Training With Other Organizations

Group Workers provide consultation and training to organizations in and out of their setting, when appropriate. Group Workers seek out consultation as needed with competent professional persons knowledgeable about group work.

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Appendix F: Resource Panel

Note: The information given indicates each participant's affiliation during the time the panel was convened and may no longer reflect the individual's current affiliation.

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