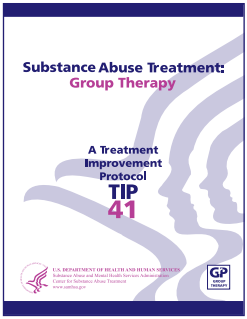
Quick Guide

For Clinicians

Based on TIP 41

Substance Abuse Treatment: Group Therapy



GROUP THERAPY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Quick Guide

For Clinicians

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Substance Abuse Treatment: Group Therapy

This Quick Guide is based entirely on information contained in TIP 41, published in 2005, and based on information updated through September 2004. No additional research has been conducted to update this topic since publication of the TIP.

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WHY A QUICK GUIDE?

This Quick Guide was developed to accompany *Substance Abuse Treatment: Group Therapy*, Number 41 in the Treatment Improvement Protocol (TIP) series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). This Quick Guide is based entirely on TIP 41 and is designed to meet the needs of the busy clinician for concise, easily accessed how-to information.

The Guide is divided into eight sections (see *Contents*) to help readers quickly locate relevant material. Terms related to group therapy are listed beginning on page 50 in the *Glossary*.

For more information on the topics in this Quick Guide, readers are referred to TIP 41.

WHAT IS A TIP?

The TIP series has been in production since 1991. This series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital current interest.

TIP 41, *Substance Abuse Treatment: Group Therapy*

- Presents an overview of the role and efficacy of group therapy in substance abuse treatment planning
- Offers recent research and clinical findings
- Describes effective types of group therapy
- Offers a theoretical basis for group therapy's effectiveness in the treatment of substance use disorders

See the inside back cover for information on how to order TIPs and other related products.

INTRODUCTION

Group therapy can be a powerful therapeutic tool for treating substance abuse. In many cases, it is as effective as individual therapy because groups intrinsically have many rewarding traits, such as reducing isolation and enabling members to witness the recovery of others. These qualities can draw clients into a culture of recovery.

Although many types of groups can have therapeutic elements and effects, the group therapy models included in TIP 41 and this Quick Guide are appropriate for groups that (1) have trained leaders and (2) are intended to produce some type of healing or recovery from substance abuse.

Advantages of Group Therapy

There are many advantages to using group therapy in substance abuse treatment. Groups can

- Provide useful information to clients who are new to recovery.
- Allow a single treatment professional to help a number of clients at the same time.
- Provide positive peer support and pressure for abstinence from substances of abuse.

- Help members learn to cope with problems related to substance abuse by allowing them to see how others deal with similar problems.
- Provide feedback concerning the values and abilities of group members.
- Help clients overcome past harmful family experiences.
- Encourage, coach, support, and reinforce members as they undertake difficult or anxiety-provoking tasks.
- Offer members the opportunity to learn or relearn the social skills they need to cope with everyday life instead of resorting to substance abuse.
- Effectively confront individual members about substance abuse and other harmful behaviors.
- Add needed structure and discipline to the lives of people with substance use disorders, who often enter treatment with their lives in chaos.
- Instill hope, a sense that "If they can make it, so can I."
- Support and provide encouragement to one another outside the group setting.

GROUPS COMMONLY USED IN SUBSTANCE ABUSE TREATMENT

Substance abuse treatment professionals employ a variety of group treatment forms, which TIP 41 divides according to their *model*, *type*, or *purpose*. In the hands of a skilled leader, each form of group treatment can provide powerful therapeutic experiences for group members.

Five Group Therapy Models

TIP 41 describes five *models* of group therapy that are effective for substance abuse treatment:

- Psychoeducational Groups
- Skills Development Groups
- Cognitive–Behavioral/Problem-Solving Groups
- Support Groups
- Interpersonal Process Groups

1. 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 by means of videotapes, audiocassette, or lectures.

Psychoeducational groups provide information that aims to have a direct application to clients' lives, such as instilling self-awareness, suggesting

options for growth and change, and prompting people using substances to take action on their own behalf.

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

- Helping clients in the precontemplative or contemplative stage of change to reframe the impact of substance use on their lives, develop an internal need to seek help, and discover avenues for change. (For more information on the stages of change, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment*.)
- 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 a 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 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.

Leadership skills and styles. Leaders in psychoeducational groups primarily assume the roles of educator and facilitator.

Techniques. Techniques for conducting 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.

2. Skills Development Groups

Skills development groups teach skills that help clients maintain abstinence, such as

- Refusal skills
- Social skills
- Communication skills
- Anger management skills
- Parenting skills
- Money management skills

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.

Leadership skills and styles. In skills development groups, as in psychoeducation, leaders need basic group therapy knowledge and skills, knowledge of the patterns that show how people relate to one another in groups, skills in fostering interaction among members and managing conflict that inevitably arises among members in a group environment, and helping clients take ownership for the group.

Techniques. The specific techniques used in a skills development group will vary depending on the skills being taught.

3. Cognitive–Behavioral Groups

Cognitive–behavioral groups are a well-established part of the substance abuse treatment field and are particularly appropriate in early recovery.

Cognitive processes include a number of different psychological activities, 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."

Principal characteristics. Cognitive–behavioral therapy groups work to change learned behavior by changing thinking patterns, beliefs, and perceptions. 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.

For example, one model of a cognitive–behavioral group for individuals with posttraumatic stress disorder (PTSD) and substance abuse is 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

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 relatively low-cost modality, so it can reach a larger number of clients.

Leadership skills and styles. Some cognitive–behavioral approaches focus more on behavior, others on core beliefs, still others on developing problem-solving capabilities. The level of interaction by the counselor in cognitive–behavioral groups can vary from quite directive to relatively inactive. Perhaps the most common leadership style in such groups is active engagement and a consistently directive orientation.

Techniques. Specific techniques may vary by the specific orientation of the leader but, in general, include the ability to (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 substance use.

4. Support Groups

Many people with substance use disorders avoid treatment because the treatment itself threatens to increase their anxiety. Support groups bolster members' efforts to develop and strengthen their ability to manage their own thinking and emotions and to develop better interpersonal skills as they recover from substance abuse.

Principal characteristics. 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.

Leadership skills and styles. Support group leaders need a solid grounding in how groups grow and evolve and the ways in which people interact and change in groups. The leader facilitates group discussion and helps group members share their experiences and overcome difficult challenges. The counselor provides positive reinforcement for group members, models appropriate interactions between individuals in the group, respects individual and group boundaries, and fosters open and honest communication.

Techniques. Counselor interventions in support groups are likely to be more interpretive and observational and less directive than in many other groups. The goal is not to provide insight to group members, but to facilitate the evolution of support within the group.

5. Interpersonal Process Groups

Interpersonal process groups use psychodynamics, or knowledge of the way people function psychologically, to promote change and healing. 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)

Principal characteristics. Interpersonal process group therapy delves into major developmental issues, searching for patterns that contribute to addiction or interfere with recovery.

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.

Techniques. In practice, group leaders may use different models at various times and may simultaneously influence more than one focus level at a time.

Three variations of the interpersonal process group are

- *Individually focused groups*. This group concentrates on individual members of the group and their distinctive internal cognitive and emotional processes.
- *Interpersonally focused groups*. In these groups, members evaluate each other's behavior. The group leader monitors the way clients relate to one another, reinforces therapeutic group norms, and works to prevent contratherapeutic norms.
- *Group-as-a-whole focused groups*. In this group, the group leader focuses on the group as a single entity or system.

For more information on these group models, see Chapter 2 of TIP 41.

Three Group Therapy Types

There are three specialized *types* of groups that do not fit into the five model categories, but which function as unique entities in the substance abuse treatment field:

- Relapse Prevention Groups
- Communal and Culturally Specific Groups
- Expressive Groups

1. Relapse Prevention Groups

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.

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 can lead to relapse while also making security preparations for their future by striving for broader life balance.

Principal characteristics. Relapse prevention groups focus on activities, problem-solving, and skill building. They may also take the form of psychotherapy.

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, along with 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, when a group member does relapse, the leader should be able to help the group process the event in a nonjudgmental, nonpunitive way.

Techniques. Relapse prevention groups draw upon techniques used in a variety of other types of groups, including the cognitive–behavioral, psychoeducational, skills development, and process-oriented groups.

2. Communal and Culturally Specific Groups

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. Such strengths-focused activities can be integrated into a substance abuse treatment program in several ways:

- 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, Hispanics/Latinos generally

share a value of *personalismo*, a preference for person-to-person contact. Alternately, a psychoeducational group formed to help clients develop a balance in their lives might use an American Indian medicine wheel diagram.

- 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.

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.

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

Leadership characteristics and style. 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.
- Focus on what is held in common among group members, while being sensitive to differences.

Techniques. Different cultures have specific activities that can be used in a treatment setting. Some common elements in treatment include story telling, rituals and religious practices, holiday celebrations, retreats, and rites of passage practices.

3. 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.

Principal characteristics. Expressive therapy may use art, music, drama, psychodrama, Gestalt, bioenergetics, psychomotor, games, dance, free movement, or poetry.

Leadership characteristics and style. Expressive group leaders will generally 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.

Techniques. The techniques used in expressive groups depend on the type of expressive therapy being conducted. Generally, these groups set clients to work on an activity, and client participation is a paramount goal if the therapy is to exert its full effect.

Groups Focused on a Specific Purpose

In addition to the five *models* of therapeutic groups and three specialized *types* of groups discussed above, groups can be classified by *purpose.* The purpose-focused group is a specific form of cognitive–behavioral therapy used to eliminate or modify a single problem, such as shyness, loss of a loved one, or substance abuse.

Purpose. The primary purpose of a group focused on a specific problem is to target, alter, and eliminate a group member's self-destructive or self-defeating behavior. Such groups are usually short-term and historically have been used with addictive types of behavior (smoking, eating, substance use) as well as when the focus is on symptom reduction or behavioral rehearsal.

Principal characteristics. Groups focused on a purpose are short (commonly 10 or 12 weeks), highly structured groups of people who share a specific problem. 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. These groups are particularly helpful for new clients; their focus helps to allay feelings of vulnerability and anxiety.

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

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.

CRITERIA FOR THE PLACEMENT OF CLIENTS IN GROUPS

Matching Clients With Groups

The success of a group therapy experience for the individual can depend on appropriate placement. 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 (e.g., should the program administrator consider developing specialty groups, such as a women-only group?)
- The nature of the group or groups available

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 work to become committed to recovery.

Assessing Client Readiness for Group

Placement should begin with a thorough assessment of the client's ability to participate in a group and the client's needs and desires regarding treatment.

Not all clients are suited for all kinds of groups, nor is any group approach necessary or suitable for all clients with a history of substance abuse. Clients who may be unsuited to group therapy include

- People who refuse to participate
- People who cannot honor group agreements
- People in the throes of a life crisis
- People who cannot control impulses
- People whose defenses would clash with the dynamics of a group
- 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 many groups, especially interpersonal process groups, pre-group interviews and client preparation are essential.

After specifying the appropriate treatment level, a therapist meets with the client to identify options consistent with this level of care. More specific screens might be needed to determine whether, within the appropriate level of care, the client is suited to treatment in a group modality.

Considerations include the following:

- *Women*. Recent studies have shown that some women do better in same-sex groups than in mixed gender groups.
- *Adolescents.* The complexities related to adolescents and group therapy lie outside the scope of TIP 41. Suggested reading includes *Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions* (CSAT 2001), *Group Therapy with Children and Adolescents* (American Psychiatric Press 1996), and *Adolescent Substance Abuse: Etiology, Treatment, and Prevention* (Aspen Publishers 1992).
- *Clients' 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?
- *Motivation to abstain.* Clients with low levels of motivation to abstain generally should be placed in psychoeducational groups.
- *Stability.* In placement, both the client's and group's best interests need to be considered.
- *Expectation of success.* Every effort should be made to place the client in a group in which the client (and, therefore, the group) can succeed.
- *Stage of recovery.* For a summary of the types of group treatment that are most appropriate for clients at different stages of recovery, see the Figures on the following page.

Client Placement by Stage of Recovery								
	Psycho-education	Skill Building	Cognitive–Behavioral	Support	Interpersonal Process	Relapse Prevention	Expressive	Culture-Specific
Early	+++	++	+	+++	+		+	*
Middle	+	++	++	++	+++	+++	+	*
Late and Maintenance			++	+	+++			*

Key:

Blank Generally not appropriate
+ Sometimes necessary
++ Usually necessary
+++ Necessary and most important
* Depends on the culture and the context of treatment

Client Placement Based on Readiness for Change								
	Psycho-education	Skill Building	Cognitive–Behavioral	Support	Interpersonal Process	Relapse Prevention	Expressive	Culture
Precontemplation	+		+		+			+
Contemplation	+	+	+	+	+		+	+
Preparation	+	+	+	+	+		+	+
Action	+	+	+	+	+	+	+	+
Maintenance		+	+	+	+	+	+	+
Recurrence		+	+	+	+	+	+	+

Placing Clients From Racial or Ethnic Minorities

In all aspects of group work for substance abuse treatment, clinicians need to be especially mindful of diversity issues.

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 backgrounds affect their ability to work with particular populations.

For a self-assessment guide for group counselors working with diverse populations, see Figure 3-9 in TIP 41.

Diversity and Placement

In many groups, the 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 it will be that biases will emerge and require mediation.

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.

To help ensure 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, races, and ethnicities will be in the group.
- Model sensitivity and openness in order to create an atmosphere of 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.
- Encourage new members to participate.

When working with group members from different cultural or ethnic backgrounds, a group leader should consider the following:

- *Symbolism and nonverbal communication.* In some cultural groups, direct expression of thoughts and feelings is considered inappropriate.
- *Cultural transference.* If a group member has had experiences 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.
- *Cultural countertransference.* Countertransference of culture occurs when a therapist's response to a current group member is based on a previous experience with a member of the same ethnicity.
- *Ethnic prejudice.* In multiethnic groups, it is vital to develop an environment in which it is safe to talk about race. Not to do so may result in division along racial lines.

GROUP DEVELOPMENT AND PHASE-SPECIFIC TASKS

Group Development

The way groups are developed varies according to the type of group. For the purpose of TIP 41 and this Quick Guide, however, groups have been classified into two broad categories, each with the same two subcategories:

- Fixed membership groups
  - — Time-limited
  - — Ongoing
- Revolving membership groups
  - — Time-limited
  - — Ongoing

Fixed Membership Groups

Fixed membership groups generally have no more than 15 members, and the membership is relatively stable. Typically, the therapist screens prospective members, and group members receive formal preparation for group 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 can fill vacancies in a group that continues over a long period of time

In time-limited groups with fixed membership, learning in the group builds on what has happened in prior meetings, so members need to be in the group from its start.

In ongoing groups with fixed membership, the size of the group is set and new members enter only when there is a vacancy.

Revolving Membership Groups

New members enter a revolving membership group when they become ready for the service it provides. Revolving membership groups are frequently found in inpatient treatment programs. The two variations of revolving membership groups are

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

Revolving membership groups can be larger than fixed membership groups. They are generally more structured and require more active leadership. In time-limited groups, each member is generally expected to attend a certain number of sessions

for a certain number of weeks or months. Examples of time-limited groups include psychoeducational groups, skills building groups, and psychodrama groups.

Several possible varieties of ongoing groups have revolving membership. Such groups may be

- Open-ended, with clients staying for as many sessions as they wish
- A repeating set of topics, with clients staying only until they have completed all of the topics
- A format that is not topic-specific, which clients attend for a set number of weeks (either consecutively or nonconsecutively)

Figure 4-1 in TIP 41 provides the characteristics of fixed and revolving membership groups.

Preparing for Client Participation in Groups

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.

Pre-group interviews are a widely used means of gathering useful information about clients and preparing them for what they can expect from a group. Clients should be thoroughly informed about what group therapy will be like. In addition, client preparation should

- Explain how group interactions compare to those in self-help groups, such as Alcoholics Anonymous (AA).
- Emphasize that treatment is a long-term process.
- Let new members know that they may be tempted to leave the group at times, but that they can gain a great deal from persistent commitment to the process.
- Give prospective and novice members an opportunity to express anxiety about group work, and help allay their fears with information.
- Recognize and address clients' therapeutic hopes.

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 (e.g., much older or younger than the rest, the lone woman, the only member with a particular disorder, or the only person from a distinctive ethnic or cultural minority).

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

- 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.

Increasing Retention

To make it possible or easier for clients to attend regularly, retention rates in a group are positively affected by

- Client preparation
- Maximum client involvement during the early stages of treatment
- The use of feedback
- Prompts to encourage attendance
- The provision of wraparound services (such as child care and transportation)
- The timing and length of the group

A number of pre-treatment techniques have been shown to reduce incidence of dropout:

- *Role induction* uses formats like interviews, lectures, and films to educate clients about the reasons for therapy, setting realistic goals for therapy, expected client behaviors, and so on.
- *Vicarious pre-training* via interviews, lectures, films, or other settings demonstrates what takes place during therapy so that the client can experience the process without actually committing to group membership.
- *Experiential pre-training* uses group exercises to teach the client behaviors such as self-disclosure and examination of emotions.
- *Motivational interviews* use specific listening and questioning strategies to help the client overcome doubt about making changes.

One 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.

Group Agreements

A group agreement establishes the expectations that group members have of each other, the leader, and the group itself.

A group member's acceptance of the agreement prior to entering a group has been described as the single most important factor contributing to the success of outpatient therapy groups. To reinforce the importance of the agreement as the basis for group activities, group members can be asked to recall specifics of the agreement during the first session.

The agreement provides for a mutual understanding of the common task and the conditions under which it will be pursued. It is through the agreement that the leader derives his or her authority to work, to propose activities, and to confront a member to make interpretations.

The group agreement is intended to inspire clients to accept the basic rules and premises of the group and increase their determination and ability to succeed. These agreements are not meant to provide a basis for excluding or punishing anyone. Rather, violations can be useful material for group members to discuss as part of the group process.

When provisions of the group agreement are violated, the leader should ask questions that refer infractions to the group. For examples of group treatment stipulations, see Figures 4-4 and 4-5 in TIP 41.

The following issues should be taken into consideration when developing a group agreement:

- Communicating grounds for exclusion
- Confidentiality
- Physical contact
- Use of mood altering substances
- Contact outside the group
- Participation in the life of the group
- Financial responsibility
- Termination

For more detail regarding the elements of a group agreement, see pages 70–75 of TIP 41.

Phase-Specific Group Tasks

Every group goes through three phases; a beginning, middle, and end. These phases occur at different times for different types of groups. The group leader is responsible for attending to certain key elements at each of these points.

Beginning Phase: Preparing the Group to Begin

During the beginning phase of group therapy, issues arise around topics such as

- Orientation
- Beginners' anxiety
- The role of the leader

During the beginning phase

- The purpose of the group is articulated.
- Working conditions of the group are established.
- A positive tone is set for the group.
- Members are introduced.
- The group agreement is reviewed.
- A safe, cohesive environment is ensured.
- Norms are established.
- The work of the group begins.

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* (the information and feelings overtly expressed in the group) and *process* (how members interact in the group over time).

Some ways in which a group leader can help the group accomplish its middle-phase tasks include

- Opening the session
- Tracking the process
- Capitalizing on the energy of resistance
- Connecting before tackling issues

- Encouraging mutual connections between members
- Sharing the work
- Closing the session

For more information on these tasks, see Figure 4-6 in TIP 41.

End Phase: Reaching Closure

Termination is a particularly important opportunity for members to honor the work they have done, grieve the loss of associations and friendships, and look forward to a positive future.

The group begins the 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

GROUP LEADERSHIP: CONCEPTS AND TECHNIQUES

Several desirable leadership traits and behaviors, along with specific concepts and techniques, can make process groups successful. Leaders should know how to

- Convert conflict and resistance into positive energy that powers the group.
- Manage disruptive group members, such as clients who talk incessantly or leave abruptly
- Turn a crisis into an opportunity.

Personal Qualities

The personal qualities that an effective group leader should have are

- *Constancy*. The ability to promote an environment with small, infrequent changes can be very helpful to a client in recovery.
- *Active listening*. Strong listening skills are the keystone of any effective therapy.
- *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.

- *Confidence*. Leaders should be a model of the consistency that comes from self-knowledge and clarity of intent while remaining attentive to each client's experience. This secure grounding enables the leader to model stability for the group.
- *Spontaneity*. Good leaders are creative and flexible.
- *Integrity*. Leaders should be aware of ethical issues that arise.
- *Trust*. Group leaders should be able to trust others, and vice versa.
- *Humor*. The therapist needs to be able to use humor appropriately.
- *Empathy*. The ability to project empathy is an essential skill for the counselor.

For more information on these personal qualities, see pages 93–95 of TIP 41.

Leading Groups

Group therapy with clients who have histories of substance abuse or addiction requires active, responsive leaders who keep the group lively and ensure that members are continuously and meaningfully engaged with each other. The following behaviors and abilities are important when leading groups:

- Leaders are able to vary therapeutic styles based on the needs of clients.

- Leaders model behavior.
- Leaders can be co-therapists.
- Leaders are sensitive to ethical issues.
- Leaders are able to work within professional limitations.
- Leaders are flexible.
- Leaders avoid role conflict.
- Leaders improve motivation and overcome resistance.
- Leaders defend limits and group agreements.
- Leaders maintain a safe therapeutic setting.
- Leaders encourage communication within the group.

For more information on these issues, see pages 96--106 of TIP 41.

Interventions

Interventions may be directed to an individual or the group as a whole. A well-timed, appropriate intervention has the power to help clients

- 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 their lives
- Notice meaningful inconsistencies among thoughts, feelings, and behavior
- Perceive discrepancies between stated goals and what is actually being done

Management of the Group

Handling Conflict

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. In many cases, 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.

Subgroup Management

In any group, subgroups inevitably will form. 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 people who were 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 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 reconfigure undesirable combinations.

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, “Bob, what are you hoping the group will learn from what you have been sharing?” If Bob's answer is, “Well, nothing really,” it might be time to ask more experienced group members to give Bob a sense of how the group works.

If group members exhibit no interest in stopping a perpetually filibustering client, it may be appropriate to examine this silent cooperation, as well. The group may be all too willing to allow the talker to ramble on in order to avoid examining their own past. 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.

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 on the interruption as a form of intervention.

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.

Other Common Problems

Coming late or missing sessions. Sometimes, addiction counselors view a client who comes to group late as a person who 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, however, 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 a client's difficulties in connecting with his or her own inner life or with others.

Special consideration is sometimes necessary for clients who speak English as a second language. 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.

Tuning out. When a group member seems 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 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.

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, a leader might introduce the topic of how well members know each other and how well they want to be known.

Fear of losing control. 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.

When a client's fears of breaking down or becoming unable to function may be founded in reality (e.g., 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.

Fragile clients with psychological emergencies. Some clients wait until the last few minutes of group to share emotionally charged information. It is important for the leader to recognize that the client may have deliberately chosen this time to share this information. The timing is the client's way of limiting the group's responses and avoiding an onslaught of interest. The group members or leader should point out this self-defeating behavior and encourage the client to change it.

Anxiety and resistance after self-disclosure. Clients may feel great anxiety after disclosing something important, such as the fact that they are gay or victims of sexual abuse. 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?"

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."

For more information on group management issues, see pages 116--122 of TIP 41.

GLOSSARY

Cohesion: A positive quality of groups denoting a sense of enthusiastic solidarity within the group.

Communal and Culturally Specific Groups: Groups formed in order to use the sense of belonging to a culture to reduce or eliminate substance abuse and other negative behaviors.

Conflict: A basic dynamic in groups in which members have opposing views, beliefs, or emotions.

Content: Information and feelings expressed in group; its complement is process.

Expressive Groups: Groups formed to use some kind of creative activity (i.e., painting, dance, psychodrama) to help clients explore their substance abuse, its origins and effects, and new coping options.

Fixed Membership Groups: Relatively small groups 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.

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 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 over-arching properties of the group as a whole.

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?).

Heterogeneous Groups: Groups made up of a mixture of clients.

Homogeneous Groups: Groups made up of clients who are alike in some respect other than a common substance use problem (i.e., all women, all elderly, or all from a specific culture).

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. Interpersonal process groups attend more to process and less to content.

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.

Intrapsychic: Relating to events occurring within the psyche, mind, or personality; that is, internally without reference to any external factors.

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 problem-solving 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 to promote of interaction among group members.

Psychodynamic Therapy (or 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.

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 non-consecutively).

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, or they may be designed to reduce or eliminate general life problems that imperil recovery.

Stages (or Phases) of Group Development: In the ***beginning*** phase, the group is prepared to begin its work. 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.

Ordering Information

TIP 41
Substance Abuse Treatment: Group Therapy

TIP 41-RELATED PRODUCTS

Training Manual

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