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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Acknowledgments

This publication was produced under the Knowledge Application Program (KAP) contract number 270-99-7072 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Karl D. White, Ed.D., and Andrea Kopstein, Ph.D., M.P.H., served as the Center for Substance Abuse Treatment (CSAT) Government Project Officers. Christina Currier served as the CSAT TIPs Task Leader.

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Recommended Citation

Center for Substance Abuse Treatment. *Substance Abuse Treatment: Group Therapy*. Treatment Improvement Protocol (TIP) Series, No. 41. HHS Publication No. (SMA) 15-3991. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Originating Office

Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

HHS Publication No. (SMA) 15-3991
Printed 2005
Revised 2009, 2011, 2012, 2014, and 2015

6 Group Leadership, Concepts, and Techniques

In This Chapter...

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.

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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.

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