

# **Substance Abuse Treatment: Group Therapy**

## **A Treatment Improvement Protocol TIP 41**



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

1 Choke Cherry Road  
Rockville, MD 20857

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# 3 Criteria for the Placement of Clients in Groups

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## Overview

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

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

## Matching Clients With Groups

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

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

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

## Assessing Client Readiness for Group

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

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

To help assess clients' relationships and their ability to participate productively in a group, the clinician can have the client draw an eco-map (see an example in Figure 3-1). An

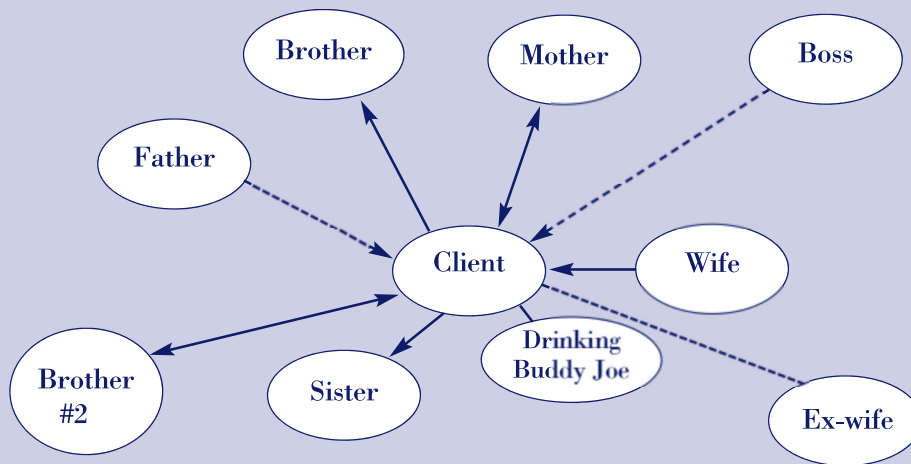
eco-map (sometimes called a sociogram) is a graphic representation that depicts interpersonal relationships (Garvin and Seabury 1997; Hartman 1978). The client occupies the center of the page. Then, circles are added to show each significant relationship. The closer the relationship, the closer it is to the center circle. A solid line between circles indicates a strong, nurturing relationship, while a dotted line depicts a conflicted connection. Arrows drawn on the lines can represent the direction of the relationship. An arrow from the center out means "I care about this person." An incoming arrow means "This person cares about me."

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

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

**Figure 3-1**

**Eco-Map**



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

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

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

Not all clients are equally suited for all kinds of groups, nor is any group approach necessary or suitable for all clients with a history of substance abuse. For instance, a person who relapses frequently probably would be inappropriate in a support group of individuals who have attained significant abstinence and who have moved on to resolving practical life problems. It would be equally disadvantageous to place a person in the throes of acute withdrawal from crack cocaine in a group of people with alcoholism who have been abstinent for 3

months. A group usually can be heterogeneous in demographic composition, including men and women, younger and older clients, and people of different races and ethnicities, but clients should be placed in groups with people with similar needs.

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

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

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

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

## Primary Placement Considerations

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

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

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

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

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

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

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



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

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

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

The complexities related to adolescents and group therapy lie outside the scope of the TIP. Suggested reading for those interested in the rationale for group therapy with adolescents includes, but is not limited to, Sampl and Kadden 2001 or textbooks such as *Group Therapy with Children and Adolescents* (Kymissis and Halperin 1996), including the chapter by Spitz and Spitz on adolescents who abuse substances, or *Adolescent Substance Abuse: Etiology, Treatment, and Prevention*

(Lawson and Lawson 1992), especially the chapter on group psychotherapy with adolescents by Shaw. Last, a journal article (Pressman et al. 2001) relates the special difficulties group psychotherapy presents for adolescents with both psychiatric and substance abuse problems—another common complexity of providing group therapy for adolescents with substance abuse disorders.

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

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

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

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

**Stage of recovery.** The five stages of Prochaska and DiClemente's trans-theoretical model of change (discussed briefly in chapter 2 and in greater detail in TIP 35, *Enhancing Motivation for Change in Substance Abuse*

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

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

A poor match between group and client is not always apparent at the outset. Monitoring can ensure that clients are in groups in which they can learn and grow without interfering with the learning and growth of others. Although the pri-

mary factor to consider regarding continued participation in group should be a client's ability to get something out of the experience, it is also important to determine how each person's participation affects the group as a whole. A client who, for whatever reason, cannot participate may have a profoundly adverse effect on the group's ability to coalesce and function cohesively. If a client does not interfere with group progress, however, sometimes it is appropriate to keep a nonparticipant in the group and simply allow that person to sit and listen.

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

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

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

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

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

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

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

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

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

When different dimensions of evaluation conflict in their placement indications, the clinician will need to break the impasse with clinical

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

## Stages of Recovery

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

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

Figure 3-2

Client Placement by Stage of Recovery

	Psycho- educa- tion	Skills- Building	Cognitive- Behavioral	Support	Inter- personal Process	Relapse Preven- tion	Ex- pressive	Culture- Specific
Early	+++	++	+	+++	+		+	*
Middle	+	++	++	++	+++	+++	+	*
Late and Maintenance			++	+	+++			*
<b>Key:</b> Blank Generally not appropriate + Sometimes necessary ++ Usually necessary +++ Necessary and most important								

Source: Consensus Panel.

**Figure 3-3**

**Client Placement Based on Readiness for Change**

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

Source: Consensus Panel; Prochaska and DiClemente 1984.

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

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

## Placing Clients From Racial or Ethnic Minorities

### Diversity in a Broad Sense

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

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

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

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

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

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

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

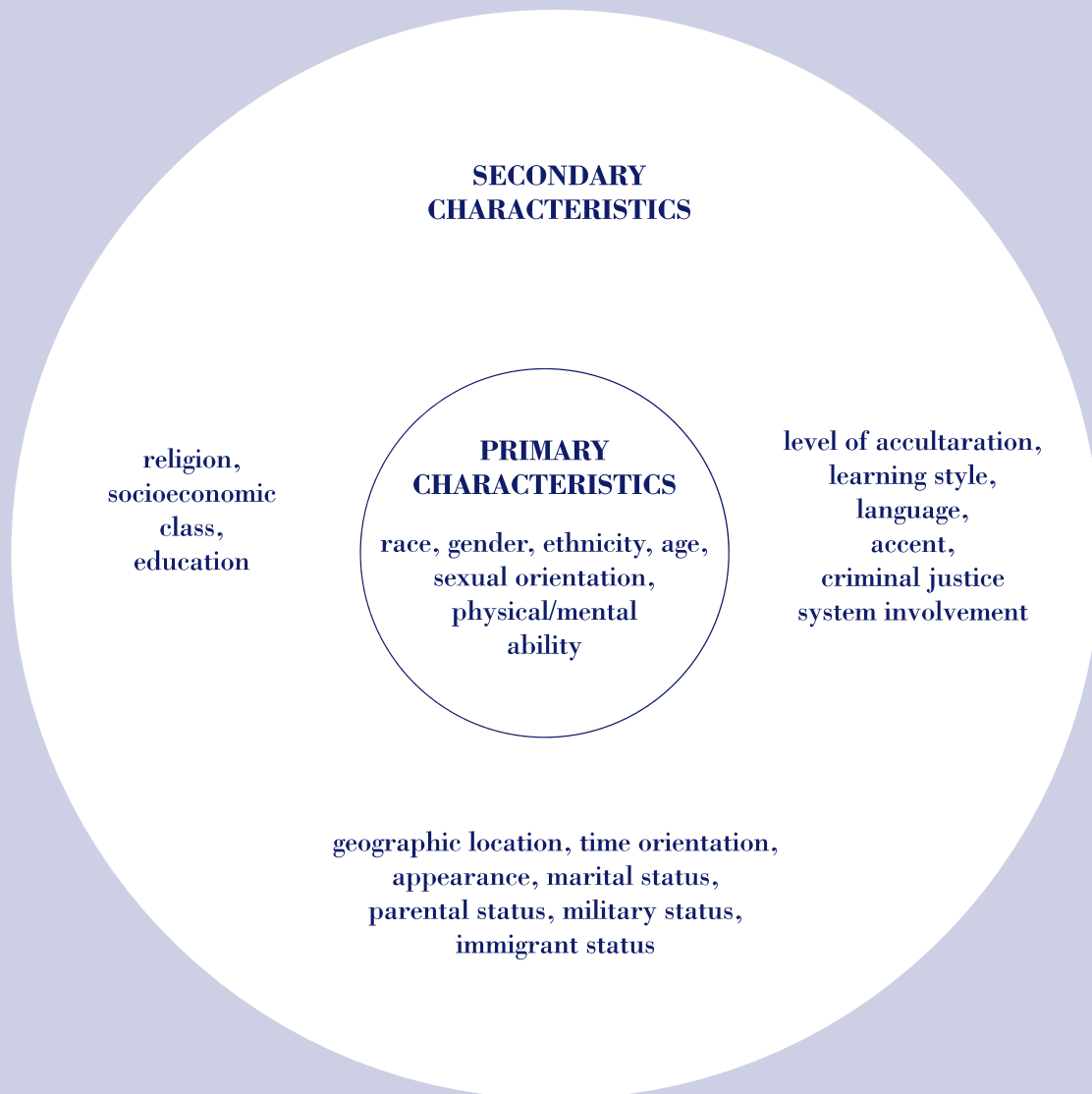
**Figure 3-4**

### ***What Is Culture?***

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

*Source:* Giachello 1995; Office of Minority Health 2001.

**Figure 3-5**  
**Diversity Wheel**



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

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

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

Unfortunately, little research reveals how group therapy should be adapted to meet such differences, and many of the findings that do exist are contradictory. Further, any generalizations about cultural groups may not apply to individuals because of variance in levels of acculturation and other experiential factors. A particular Latino youth, for example, may identify with the dominant culture and not think of himself as Latino. The client is always to be considered the expert on what culture,

ethnicity, and gender identity mean to that person. If a leader believes that cultural traditions might be a factor in a client's participation in group or in misunderstandings among group members, the leader should check the accuracy of that perception with the client involved. Therapists should be aware, however, that individuals may not always be able to perceive or articulate their cultural assumptions.

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

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

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



**Figure 3-6**

***When Group Norms and Cultural Values Conflict***

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

*Source:* Adapted from Salvendy 1999, p. 441.

**Figure 3-7**

***Three Resources on Culture and Ethnicity***

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

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

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

## Leader Self-Assessment

Group leaders should be aware that their own ethnicities and standpoints can affect their interpretation of group members' behavior. The group leader brings to the group a sense of identity, as well as feelings, assumptions, thoughts, and reactions. Leaders should be conscious of how their own backgrounds affect their ability to work with particular populations. For example, a female therapist who has survived domestic violence may have severe difficulties working with spouse abusers. Another example is that male group leaders may be inclined to call on male members more often than female members of the group. If so, they need to make a conscious effort to call on

all members equally, regardless of gender.

Clinicians also need to evaluate how competent they are managing issues of cultural diversity.

In cases where cultural or language barriers are very strong, a group leader may need to refer a client to another group or make special accommodations to allow the client to participate.

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

**Figure 3-8**

### ***Guidelines for Clinicians on Evaluating Bias and Prejudice***

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

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

**Figure 3-9**

**Self-Assessment Guide**

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

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

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

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

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

**Figure 3-9**

***Self-Assessment Guide (continued)***

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

*Which groups make you feel uneasy or uncomfortable?*

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

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

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

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

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

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

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

**Figure 3-9**

**Self-Assessment Guide (continued)**

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

*Source:* Adapted from Winkelman 1995. Used with permission.

## **Diversity and Placement**

In many groups, the composition of members will be heterogeneous; for example, a majority of Caucasians placed with a minority of ethnically or racially different members. The greater the mix of ethnicities, the more likely that biases will emerge and require mediation (Brook et al. 1998). Whatever a client's belief system or origin, "neither the therapist nor the group should ask any group member to give up or renounce any ethnic/cultural beliefs, feel-

ings, or attitudes. Rather, group members are encouraged to share these feelings and beliefs verbally and overtly, even if this may be upsetting to some or all of the group's members" (Brook et al. 1998, p. 77). Although therapists may be uncomfortable when group members talk about subjects like racism and discrimination, such expression sometimes is an important part of an individual's recovery process.

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

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

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

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

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

*Assess the behaviors and attitudes of current group members to ascertain whether the new client would match the group.*

From the start of a multicultural therapy group, members should feel that race is a safe topic to discuss (Salvendy 1999).

Because group members are less restricted to their usual social circles and customary ethnic and cultural boundaries, the group is potentially a social microcosm within which members may safely try out new ways of relating (Matsukawa 2001). Even so, potential problems between a candidate and existing group members should be identified and counteracted to prevent dropout and promote engagement cohesion among members.

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

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

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



**Figure 3-10**

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

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

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

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

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

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

1. *Symbolism and nonverbal communication.* In some cultural groups, direct expression of thoughts and feelings is considered unseemly. Matsukawa (2001) points out that among the Japanese, a highly valued trait is the ability to sense what another person wants without explicitly stated cues. In such a culture, symbolic gestures (a gift, perhaps) or nonverbal signals (the author describes a

woman who showed her craft work without comment) are used to communicate indirectly and acceptably. In such a situation, Matsukawa says, the therapeutic approach is modified to perceive and permit a Japanese-American woman to present herself tacitly without pressing for verbal elaboration. Therapists also should intervene if nonverbal communications are misinterpreted.

2. *Cultural transference of traits from one person of a certain culture to another person of that culture.* If a group member has had experiences (usually negative) with people of the same ethnicity as the therapist, the group member may transfer to the therapist the feelings and reactions developed with others of the therapist's ethnicity. In short, Matsukawa (2001) says, the group member jumps to conclusions and assigns traits to the therapist based on ethnicity alone. The therapist first should detect these miscon-

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

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

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

## Ethnic and Cultural Matching

Although arguments for matching the ethnicity of the therapist with that of the group members

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

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

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

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

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

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

## Other Considerations for Practice

Groups may include people who have varying

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

All these differences, and many others, will affect individual and group experiences. Group leaders should be keenly aware of ways in which ethnicity and culture can affect participation in interactive therapy. One of the most profound ways that different cultural backgrounds may affect individuals in groups is in expectations of the leader. For example, many African

Americans look to leaders as problemsolvers. In Hispanic/Latino culture, people are equals until proven otherwise—roles do not automatically constitute a supervisor/subordinate relationship (Wilbur and Roberts-Wilbur 1994).

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

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

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

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

**Figure 3-11**

***Culture and the Perception of Conflict***

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

*Source:* Adapted from Salvendy 1999, p. 451.



# 4 Group Development and Phase-Specific Tasks

## In This Chapter...

### Fixed and Revolving Membership Groups

Fixed Membership Groups

Revolving Membership Groups

### Preparing for Client Participation in Groups

Pregroup Interviews

Increasing Retention

Identifying the Need for Wraparound Services

Group Agreements

### Phase-Specific Group Tasks

Beginning Phase—  
Preparing the Group To Begin

Middle Phase—Working  
Toward Productive  
Change

End Phase—Reaching  
Closure

## Overview

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

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

## Fixed and Revolving Membership Groups

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

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



## Fixed Membership Groups

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

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

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

In ongoing groups with fixed membership, the size of the group is set; new members enter only when there is a vacancy. The leader generally is less active than is the leader of a time-limited group, since the interaction among group members is more important than leader-to-member interactions. To conduct this type of group, the leader needs substantial

training in group dynamics (such as individuals' boundaries and the roles different members assume) and leadership along with excellent supervisory skills. Examples in this category include interpersonal process groups and some psychoeducational therapy groups.

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

## Revolving Membership Groups

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

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

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

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

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

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

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

One advantage to revolving membership

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

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

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

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

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

## Preparing for Client Participation in Groups

### Pregroup Interviews

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

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

**Figure 4-1**

**Characteristics of Fixed and Revolving Membership Groups**

Entry		Group Development	Examples
<b>Fixed Membership Groups</b>			
<b>Time-limited</b>	<ul style="list-style-type: none"> <li>• New members admitted only in earliest stages of group development</li> <li>• Groups begin and end with same membership</li> </ul>	<ul style="list-style-type: none"> <li>• Learning built on what has happened in prior meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Short-term therapy groups</li> <li>• Skills-building and psychoeducational groups</li> <li>• Relapse prevention groups</li> </ul>
<b>Ongoing</b>	<ul style="list-style-type: none"> <li>• Group size fixed</li> <li>• New members enter only after vacancy or graduation</li> <li>• Members expected to stay for a substantial period of time</li> </ul>	<ul style="list-style-type: none"> <li>• Dynamics of group process (such as individuals' boundaries and the roles different members assume) are the primary source of learning, healing for participants</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing interpersonal process groups</li> <li>• Long-term supportive therapy groups</li> </ul>
<b>Revolving Membership Groups</b>			
<b>Time-limited</b>	<ul style="list-style-type: none"> <li>• Number of sessions usually fixed</li> </ul>	<ul style="list-style-type: none"> <li>• Learning at each session relatively independent of previous group sessions</li> </ul>	<ul style="list-style-type: none"> <li>• Expressive therapy groups (dance therapy, psychodrama)</li> <li>• Psychoeducational groups</li> <li>• Some skills-building groups</li> </ul>
<b>Ongoing</b>	<ul style="list-style-type: none"> <li>• Clients may (1) stay as long as they wish, (2) be required to attend sessions with set topics, or (3) be required to attend set number of weeks</li> <li>• Usually a set maximum number of participants</li> </ul>	<ul style="list-style-type: none"> <li>• More structured</li> <li>• Active leadership</li> </ul>	<ul style="list-style-type: none"> <li>• Client hall groups</li> <li>• Day hospital check-in groups</li> <li>• Continuing care drop-in groups</li> <li>• Transition groups for clients leaving inpatient and moving to outpatient care</li> <li>• Psychoeducational groups</li> <li>• Expressive therapy groups</li> <li>• Long-term supportive groups, such as ongoing continuing care groups and maintenance groups</li> </ul>

explain the group agreement. These activities may take as little as one meeting or as long as several weeks (Rutan and Stone 2001).

Normally, the longer the expected duration of the group, the longer the preparation phase. Clients should have an opportunity to air any concerns, especially if they are apprehensive about their cultural status within the group. During this time, the group facilitator should learn how the client handles interpersonal functions on a day-to-day basis, how the client's family functions, and how the client's culture perceives the substance abuse problem.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Increasing Retention

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

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



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

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

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

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

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

- An explanation to each client of the importance of continuing care in maintaining

sobriety and the use of a continuing care participation contract.

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

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

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

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

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



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

## Identifying the Need for Wraparound Services

Practical problems, such as a lack of suitable childcare or transportation, deter many clients from participation in substance abuse counseling services. Many programs find that when

they provide wraparound services to meet these and other practical needs, they retain clients in therapy longer. As a result, clients are more likely to develop new behaviors and thought processes that enable them to remain abstinent. Two examples of programs that provide such services are described in Figures 4-2 and 4-3.

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

**Figure 4-2**

### ***The Family Care Program of the Duke Addictions Program***

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

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

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

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

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

**Figure 4-3**

**SageWind**

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

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

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

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

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

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

*Source:* A Consensus Panel member.

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

## Group Agreements

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

A group member's acceptance of the contract before entering a group has been described as the single most important factor contributing to the success of outpatient therapy groups (Flores 1997). Consequently, it is important to

present the contract in a way that causes clients to view it as a true commitment and not a mere formality. Particularly with people referred to treatment through the criminal justice system, it is important to make therapeutic contracts that are explicit and clear, and that carry a firm expectation that the agreement is to be honored by all members of the group.

To reinforce the importance of the

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

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

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

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

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

**Figure 4-4**

**Examples of Agreements About Time and Attendance**

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

*Source:* Philip J. Flores.

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

**Communicating grounds for exclusion**

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

## Confidentiality

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

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

Under some circumstances, as defined by the Federal confidentiality regulation or by more stringent State regulation, certain information may be shared.

However, the information shared without consent is restricted by the minimum necessary clause. Refer to 42 C.F.R., Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records to identify the specific circumstances under which these exceptions apply. Group members should know what information about them might be shared and why, how, and when this sharing occurs, so they do not feel

betrayed when someone outside the group knows about something said within the group.

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

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

## Physical contact

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

## Use of mood-altering substances

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

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

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

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

viding that group rules permit and encourage such disclosures).

**Contact outside the group**

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

**Figure 4-5**

**Examples of Agreements About Group Participation**

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

Source: Philip J. Flores.



## ***Participation in the life of the group***

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

## ***Financial responsibility***

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

## ***Termination***

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

should emphasize the need to involve the group in termination decisions. Ultimately, however, the group members should make their own choice about discontinuing treatment.

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

## **Phase-Specific Group Tasks**

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

### **Beginning Phase—Preparing the Group To Begin**

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

Premature  
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(dropping out)  
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consequences for  
some clients.



## ***Introductions***

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

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

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

Ideally, membership changes should be held to a minimum, especially in fixed membership groups, though as members graduate, new

members will need to enter to ensure survival of the group. In contrast, revolving membership groups may have frequent changes because of the demands of treatment payment guidelines or admission and discharge procedures. Careful thought should be given to the pace and timing of membership changes for particular group types.

## ***Group agreement review***

The group agreement should be reviewed in an interactive way, involving the group members in discussion of the

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

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

## ***Providing a safe, cohesive environment***

During the beginning phase of the group, all members should feel that they have a part to play in the group and have something in common with other members. This cohesion, both among clients and between the clients and the group leader, will affect the productivity of work throughout the therapeutic process.

Among the many components of group cohesion are “connectedness of the group demonstrated by working toward a common therapeutic goal;

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

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

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

The leader also is responsible for ensuring that early in the group, emotional expression stays at a manageable level. Otherwise, members quickly may feel emotionally overloaded and

begin to withdraw. Care always should be taken not to shame group members or to allow others in the group to engage in shaming behaviors.

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

### ***Establishing norms***

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

**Figure 4-6**

#### ***Reminders for Each Group Session***

*Open.*

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

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

Track process.

To refocus the direction of the group, ask:

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

**Figure 4-6**

***Reminders for Each Group Session (continued)***

*Don't fight what is hard—use it!*

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

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

*Connect before tackling. Ally before confronting or stopping behavior.*

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

*Encourage mutual connections among members.*

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

*Share the work.*

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

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

*Close.*

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

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

*Source:* Vannicelli, unpublished manuscript.

self-disclosure, the desire for insight into one's own behavior, nonjudgmental acceptance of others, and the determination to change unhealthy practices (Flores 1997). Unhealthy norms that could hamper a process group include a tendency to become leader-centered, one-dimensional (that is, all-loving or all-attacking), or so tightly knit that the group is

hostile to new members (Flores 1997). The leader should respond quickly and clearly to habits that impede group work and that threaten to become normative.

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

### ***Initiating the work of the group***

The leader facilitates the work of the group, whether by providing information in a psychoeducational group or by encouraging honest exchanges among members in other types of

groups. Most leaders strive to keep the focus on the here and now as much as possible. The leader also may need to prompt a new group with questions such as, “You seem to be responding to what Jane was sharing. Can you tell us something about what was going on for you as she was talking?” (Vannicelli 1992, p. 50).

### **Middle Phase—Working Toward Productive Change**

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

Many new leaders focus strongly on content, but thoughtful attention to group process is extremely important. Even in an educational group, tension in the room, rolling eyes, or side conversations can interfere with messages that need attention. In a process group, these cues are part of the work and need to be explored

actively, but even in more content-oriented groups, nonverbal cues are indicative and should not be ignored.

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

### **End Phase—Reaching Closure**

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

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

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

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

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

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

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

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

Even positive, celebrated departures, however, can raise strong feelings, so soon-to-depart members of an ongoing group should give

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

It is natural for individuals and groups to try to hold onto each other. “Some isolated patients may postpone termination because they have been using the therapy group for social reasons rather than as a means for developing the skills to create a social life for themselves in their home environment. The therapist should help these members focus on transfer of learning and encourage risk taking outside the group” (Yalom 1995, p. 363).

Alternatively, groups (and therapists) may subtly pressure a particular group member to remain because they value the departing member’s contributions and will miss him or her. When a senior member leaves, however, another ordinarily will assume the role just vacated (Yalom 1995).

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

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

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

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

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

# Appendix A:

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