Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Brief Interventions and Brief Therapies for Substance Abuse

Treatment Improvement Protocol (TIP) Series

34

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9 Time-Limited Group Therapy

Group psychotherapy is one of the most common modalities for treatment of substance abuse disorders. Group therapy is defined as a meeting of two or more people for a common therapeutic purpose or to achieve a common goal. It differs from family therapy in that the therapist creates open- and closed-ended groups of people previously unknown to each other. The lessons learned in therapy are practiced in the normal social network. Although efficacy research on group therapy for substance abuse disorder clients has been limited, there is substantial anecdotal and clinical evidence that it can have a dramatic impact on participating clients. In TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (CSAT, 1994a), group therapy is cited as the treatment modality of choice for a variety of reasons. In clinical practice, group psychotherapy offers individuals suffering from substance abuse disorders the opportunity to see the progression of abuse and dependency in themselves and in others; it also gives them an opportunity to experience their success and the success of other group members in an atmosphere of support and hopefulness. The curative factors associated with group psychotherapy, defined by Yalom, specifically address such issues as the instillation of hope, the universality experienced by group members as they see themselves in others, the opportunity to develop insight through relationships, and a variety of other concerns specific to the support of substance-abusing clients and their recovery (Yalom, 1995). For many years, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have recognized the importance of breaking the isolation associated with substance abuse, while at the same time connecting individuals with others whose common purpose is to dramatically change their lives through connection and community. From these perspectives, time-limited group psychotherapy offers potent opportunities to maximize the treatment energies of both therapist and client.

Research suggests that most client improvement as a result of group therapy occurs within a brief span of time—typically, 2 or 3 months (Garvin et al., 1976). This research implies that short-term therapy can be as successful as long-term therapy in promoting change. Short-term group therapy should be more goal-oriented, more structured, and more directive than long-term group therapy. Some therapists also believe the experience should be intensified through the use of high-impact techniques such as psychodrama (see discussion later in this chapter).

Appropriateness of Group Therapy

Groups can be extremely beneficial to individuals with substance abuse problems. Levine and Gallogly have noted that groups for alcohol-dependent clients

- Help reduce denial, process ambivalence, and facilitate acceptance of alcohol abuse

Group Effects

One Consensus Panelist recalls a therapy session in which a member arrived, furious and hostile, shouting, "How much longer do I have to do this stupid program? None of it works anyway!" Another group member immediately asked, "So, how does the anger keep things going for you?" In the ensuing conversation, the group learned that the angry member's ex-wife had just sent him a bottle of expensive whiskey with the following note: "Dying to get together again." This revelation, and the supportive group listening that followed, occurred largely without verbal involvement from the therapist.

- Increase motivation for sobriety and other changes
- Treat the emotional conditions that often accompany drinking (e.g., anxiety, depression, hostility)
- Increase the capacity to recognize, anticipate, and cope with situations that may precipitate drinking behavior
- Meet the intense needs of alcohol-dependent clients for social acceptance and support (Levine and Gallogly, 1985)

Many beneficial effects happen more easily in groups than in one-on-one therapy. Group members confront each other, do "reality checks," practice reflective listening, mirror each other, and help each other reframe key issues. Individuals in earlier stages of dependence can witness what later stage experiences are like (and by inference where they could progress if they do not reduce their use). Often, group members can be more effective than the therapist in confronting a participant who is not facing an important issue (e.g., the client who believes she can quit drinking and still smoke marijuana).

Group Therapy Approaches

Several kinds of groups fall under the spectrum of time-limited group therapy. In the broadest sense, two fundamental models help define categories of group interventions: the process-sensitive approach and the directive approach. The *process-sensitive* group approach finds its direction in the traditions of analytical theory and has a significant range of expression. Depending on the theoretical base and leadership style of the facilitator, a process-sensitive group can examine the unconscious processes of the group as a whole, utilizing these energies to help individuals see themselves more clearly and therefore open up the opportunity for change. This "group-as-a-whole" approach is best exemplified by the work of Bion, who sees healing as an extension of the individuals within the group as the group comes to terms with a commonly shared anxiety (Bion, 1961).

Yalom offers a significant contrast to these group-as-a-whole interventions through his interactional group process model (Yalom, 1995). By attending to the relationships within the group and helping individuals understand themselves within the relational framework, an interactional group process provides individuals with significant information about how their behavior affects others and how they are in turn affected by other members. In addition, focusing energy on the relationships within the context of group, the leader is careful not to assume a central role but, rather, recognizes that the group itself becomes the agent of change, with the leader supporting the process but not initiating it. Attention is focused on the nature and growth of the relationships manifested in the "here and now" as the group takes place.

The second approach, and one better known to alcohol and drug counselors, is a dramatically different form of group therapy, often referred to as a *directive approach.* It offers structured goals and therapist-directed interventions to enable individuals to change in desired ways. A short-term directed group may be used to address major issues of concern for clients with substance abuse disorders and to facilitate self-discovery and growth through appropriately sequential activities. Because the therapist is "central" and in charge, this type of group depends less for success on group members and their ability to create a cohesive sense of belonging.

Compared with the process-sensitive group, which sees the cohesive power of the group as a primary curative factor, the directive approach addresses specific agenda items in a logical order with greater emphasis on content as the primary source of effective change. The directive approach, therefore, is perhaps more likely to be effective with those in early recovery. A potent example of directive, time-limited group experience, developed by Maultsby and Ellis, is known as Rational Behavioral Training (RBT) (Maultsby, 1976). This cognitive–behavioral therapy takes place over 13 weeks, one session per week. It uses fundamental cognitive–behavioral interventions and the clients' growing awareness of their ability to control their own belief systems and self-talk and thus control their affective states. Clients are asked to share homework assignments and bring real-life situations into the group for exploration and examination. There is little effort in this group modality to analyze or direct energy to the relationships within the room. RBT affords a short-term intervention to develop the client's skill in controlling emotions. The inference is that individuals who experience their emotional world as controllable will no longer need to use substances to exert "external" control.

It is important to note that in any kind of group therapy, relationships are formed and process issues experienced. Even within the context of a cognitive–behavioral approach such as RBT, which is more educational than therapeutic, issues of process invariably arise. The experienced therapist can use the relationships within the group even in a psychoeducational framework to support and enhance the treatment experience. Whenever the opportunity arises, the group facilitator should help connect members to members. When shared histories are acknowledged, the sense of belonging is increased, and greater cohesion takes place. Cohesion may seem less important in a directive psychoeducational group. However, because of the very nature of substance abuse disorders, a feeling of belonging to a group committed to its own health rather than its own destruction is an important motivator for many clients.

There has been significant debate within the field regarding the pros and cons of heterogeneous and homogeneous groups. The heterogeneous group, in which members have a variety of diagnoses, offers greater complexity and more opportunities for a wide range of relationships, which can be extremely helpful to many clients. However, the homogeneous group, particularly when composed of clients with substance abuse disorders, tends to lend itself more quickly to issues of cohesion and safety. For this reason, homogeneity has particular utility in the time-limited group intervention.

An important issue within the context of the homogeneous substance abuse disorder group, whether time limited or not, is the group's tendency to bond around its history of substance abuse rather than its commitment to recovery. Although the general focus of substance abuse treatment is on the abuse itself, the focus also must include issues of living within the context of the group. Through modeling and gentle

persuasion, the group facilitator can broaden the scope of a substance abuse treatment group to include relationships, concerns about daily living, and newly discovered personal integrity. Such are the struggles of all people in all circumstances. The movement from "what is wrong with us" to "how do we build better lives?" is an important transition in the time-limited group, whether psychoeducational or process sensitive.

Group therapy can be conducted within the context of almost any theoretical framework familiar to the therapist and appropriate to group goals. Often the therapist will work with two or more models at the same time. The theoretical bases supporting both process-sensitive groups and a more directive style can be combined effectively to address substance-abusing clients.

Theories of Group Therapy

The following group therapy models are discussed in this section:

- Brief cognitive group therapy
- Cognitive–behavioral group therapy
- Strategic/interactional therapy
- Brief group humanistic and existential therapies
- Group psychodynamic therapy
- Modified dynamic group therapy (MDGT)
- Modified interactional group process (MIGP)

The first five are summarized below and discussed at greater length in Chapters 4 though 7 of this TIP. MIGP, considered a highly effective type of brief group treatment for substance abusers, is discussed in detail in this section. The 11 therapeutic factors identified by Yalom as the basis of successful group therapy are presented at the end of this section (Yalom, 1995).

Brief Cognitive Group Therapy

Cognitive techniques work well in group therapy. The group is taught the basics of the cognitive approach, then individual members take turns presenting an event or situation that tempted them to abuse substances. Other members assist the therapist in asking for more information about the client's thoughts on the event and how it did or did not lead to substance abuse (or to negative feelings that might have led to use). Finally, the group members provide the client with alternative ways of viewing the situation. Chapter 4 discusses brief cognitive therapy in more depth.

Cognitive–Behavioral Group Therapy

The cognitive–behavioral approach focuses the group's attention on self-defeating beliefs, relying on group members to identify such beliefs in each other. The therapist encourages group members to apply behavioral techniques such as homework and visualization to help participants think, feel, and behave differently. Chapter 4 discusses brief cognitive–behavioral therapy in more depth.

Strategic/Interactional Therapies

The strategic therapist uses techniques similar to those used in family therapy to challenge each group member to examine ineffective attempted solutions. The therapist encourages group members to evaluate and process these attempted solutions and recognize when they are not working, then engages the group in generating alternative solutions. The therapist also works, where appropriate, to change group members' perceptions of problems and help them understand what is happening to them. Typically, the therapist guides the process, while members offer suggestions and encouragement to each other as they identify and implement

effective solutions. To address the problem of substance abuse, the group will often be directed to examine problems that might result in substance abuse and reframe their perceptions of these problems.

The principles of solution-focused therapy are the same for group treatment as for individual therapy. These include client goal-setting through the use of the "miracle" question, use of scaling questions to monitor progress, and identification of successful strategies that work for each client. (These techniques are defined in Chapter 5 of this TIP.) The therapist works to create a group culture and dynamic that encourages and supports group members by affirming their successes. At the same time, the therapist works to restrain client digressions ("war stories") and personal attacks. The therapist tries to challenge group members—all of whom, unlike in family therapy, are seen as "customers"—to take action to create positive change. Chapter 5 discusses brief strategic/interactional therapies in more depth.

Brief Group Humanistic and Existential Therapies

Several approaches fall within this category. The transpersonal approach is useful in meditation, stress reduction, and relaxation therapy groups and can be adapted for clients who have substance abuse disorders. In dealing with issues of religion or spirituality, it is helpful to have other people talk about their perspectives. In this way, past degrading or punitive experiences related to organized religion can be redefined in a more meaningful and useful context.

Gestalt therapy in groups allows for more comprehensive integration in that each group member can provide a piece of shared personal experience. Each group member plays a role in creating the group, and all of their perceptions must be taken into account in making a change. Role-playing and dream analysis in groups are practical and relevant exercises that can help clients come to terms with themselves.

One of the most influential contemporary experts on group therapy, Irvin D. Yalom, considers himself an existentialist because he is not concerned with past behavior except as it influences the "here and now." A summary of his existential approach is presented in *The Yalom Reader* (Yalom, 1997) and consists of three sections: (1) therapeutic factors in group therapy, (2) a description of the "here and now" core concept, and (3) therapy with specialized groups, including a chapter on group therapy and alcoholism. This last chapter details specific techniques to diminish anxiety but still permit the group to maintain an interactional focus—for example, writing a candid summary of the session and mailing it to members before the next meeting. Yalom has worked closely with the National Institute on Alcohol Abuse and Alcoholism to apply basic principles of group therapy to alcohol abusers, and his ideas are applicable to those with other substance abuse disorders as well. See Chapter 6 for more discussion of humanistic and existential therapies.

Group Psychodynamic Therapy

Group psychodynamic therapy enables the group itself to become both the context and means of change through which its members stimulate each other to support, strengthen, or change attitudes, feelings, relationships, thinking, and behavior—with the assistance of the therapist.

> The context sought is one in which the group becomes an influential reference group for the individual. Participation of members according to their abilities leads to some degree of involvement of each in pursuing individual and group goals. The process of goal-setting and clarification for expectation provides an agreed upon framework for meeting of mutual needs. This, in turn,

> contributes to the building of cohesive forces (Roberts and Northen, 1976, p. 141).

Chapter 7 discusses psychodynamic therapy in more depth.

Modified Dynamic Group Therapy

On the basis of psychodynamic theory, a modified dynamic group therapy approach was defined for substance-abusing clients (Khantzian et al., 1990). Viewing substance abuse disorders as an expression of ego dysfunction, affect dysregulation, failure of self-care, and dysfunctional interpersonal relationships, MDGT falls in the intermediate length of time-limited group psychotherapy, with its basic structure defined by two meetings per week over a 26-week format. Based primarily on interventions to address cocaine addicts, MDGT focuses energy on the individuals within the group and conceptualizes the basic origins of substance abuse disorders as expressions of vulnerabilities within the characterological makeup of the client (Khantzian et al., 1990). As a supportive, expressive group experience, MDGT provides substance-abusing clients the opportunity to evaluate and change their vulnerabilities in four primary areas: (1) accessing, tolerating, and regulating feelings; (2) problems with relationships; (3) self-care failures; and (4) self-esteem deficits. Congruent with this understanding of the origins of substance abuse, MDGP emphasizes safety, comfort, and control within the group context. Group facilitation is defined primarily by the therapist's ability to engage and retain substance abusers in treatment by providing structure, continuity, and activity in an empathic atmosphere.

This supportive approach creates an atmosphere of safety, allowing the client to move away from the safety of the known behavior associated with substance abuse and into the less known world of recovery. As in other group experiences, this group theory encourages issues of universality as a means of overcoming isolation, while at the same time dealing with a common shame so often encountered in the substance-abusing client. Unlike interpersonally focused process groups, which look more at relational concerns, MDGT places greater emphasis on the clients' growing understanding of their characterological difficulties and/or deficits, not entirely dissimilar to issues identified in self-help groups such as AA and NA.

Modified Interactional Group Process

Time-limited MIGP is a synthesis of the work of several theorists (Flores, 1988; Khantzian et al., 1990; MacKenzie, 1990; Yalom, 1995). MIGP is distinguished in a variety of ways from the psychoeducational groups so important in substance abuse treatment. As referenced in TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (CSAT, 1994a), both process-sensitive and psychoeducational group learning experiences are often necessary for the substance-abusing client. Even in a short-term, intensive treatment experience, combining a psychoeducational group and a process group has significant clinical impact. The psychoeducational group is more directive, with the therapist as the central figure. However, as will be explained, it is important to utilize the energy of group process itself, even in a psychoeducational format, to enable clients to make connections and build relationships that will support their recovery.

The features that distinguish MIGP from a more traditional interactive process are the greater activity of the leader and the sensitivity to the development of a safe atmosphere that allows group members to examine relational issues without excessive emotional contagion. The atmosphere of safety is greatly enhanced by the therapist's adherence to group agreements or group norms and by the continued

reinforcement of these agreements throughout the group process. The importance of confidentiality, the group's accepting responsibility for itself, and self-disclosure are all supported by the facilitator. Procedural agreements, including beginning and ending the group session on time and ensuring that each member has a place within the circle, with any absences addressed, are part of the development of the safe environment.

In this process, the therapist helps the clients recognize that they are the primary change agents. The group becomes a safe place both to give and to receive support. Although traditionally substance abuse groups tend to be confrontative, MIGP is far more supportive. This stems from the belief that denial and other defense mechanisms become more rigid when a person is attacked. Consequently, group members are encouraged to support one another and look for areas of commonality rather than use more shame-based interactive styles that attempt to "break through denial."

Intellectualization and MIGP

Many therapists are told that clients should get in touch with their feelings and experience "what is in their gut." Although awareness of the affective life is important to everyone, it is precisely the regulation of emotions that many substance-abusing clients have difficulty addressing. Consequently, although emotional exploration is encouraged within the context of MIGP, the facilitator is constantly monitoring the affective energy within the group, taking steps to break emotional contagion should it begin. In a particularly intense group experience, the therapist may ask the group as a whole to take a step back and look at what just took place. In this way, the group not only learns from its shared life but also experiences its ability to control intense emotional responses. This consistent effort to reduce high levels of anxiety or emotional catharsis and to prevent them from dominating the group is another hallmark of MIGP.

General issues in MIGP

Following the insights of Flores and Mahon, MIGP focuses special attention in four areas of the client's life: gratification and support, vulnerability of self, regulation of affect, and self-care (Flores and Mahon, 1993). These four areas receive particular attention because they represent areas of vulnerability within the substance-abusing client that can easily lead to relapse and undermine recovery.

Gratification and support

Many clients come to treatment with profound issues of guilt and shame. Therefore, they lack the ability to give themselves gratification and support in the face of change. The active leadership style of MIGP allows group members to openly support one another and at the same time provides each group member with attention from the leader that leads to higher levels of gratification. Affirming group members' willingness to share and support one another is an essential ingredient in time-limited group work. It creates a positive atmosphere and increases levels of safety and cohesiveness, which further supports the change process.

Vulnerability of self

Substance-abusing clients often enter treatment with shattered self-esteem. Defending against this internal vulnerability can become damaging, because clients project their fears onto others. They may try to hide internal vulnerability by appearing hostile and overly self-confident. An atmosphere of safety and empathy enables clients with profound vulnerabilities to enter the process of self-disclosure, through which they become accessible not only to the group but also to themselves. The group facilitator actively encourages such self-disclosure but at the same time emphasizes that individual members need

not disclose any issue they are not yet ready to discuss. Clear boundaries and clear group agreements further support the possibility for self-disclosure.

Regulation of affect

Substance abuse disorders can be perceived as the consequences of trying to control one's emotional life with external substances. This points to a failure of internal regulation that makes the client uncomfortable when feeling emotions that others might consider commonplace. Issues of grief, loss, sadness, and joy can be so affectively charged and linked to the client's past alcohol and drug use that they threaten the client's continued recovery. As mentioned above, the leader's sensitivity to the levels of affective energy in the group is particularly important. Supporting group members to both feel what they are experiencing and at the same time move to a safer and more objective viewpoint regarding those feelings is inherent in MIGP.

Self-care

Substance-abusing clients often present to treatment unaware of internal stresses and pain, having lost sensitivity to physical cues that lead others to the normal self-care functions of daily living. These functions may be as simple as basic hygiene or more complex in terms of boundary setting and relational definitions. Setting boundaries within the group and encouraging heightened sensitivity to self-care are ways in which MIGP addresses this issue. Clients must hear a consistent message that they are worthy of the group's support and, therefore, worthy of their own attention in regard to self-care. All of the above can comfortably be addressed within the context of MIGP, with the leader actively connecting members to members, who support one another on the importance of self-monitoring and care.

Use of Psychodrama Techniques in a Group Setting

Psychodrama has long been effectively used with the substance-abusing client population in a group setting. Wegscheider-Cruse effectively integrated psychodrama as a means to heal family-of-origin issues within the context of addictive behaviors (Wegscheider-Cruse, 1989). The utility of such an intervention seems to be clinically well established. The techniques can help the group move more quickly in terms of self-understanding and relational awareness. The insights gained from the experience of family sculpting (illustrated below) can be worthwhile and potent. However, it is important to stress that psychodrama and other similar expressive therapeutic interventions bring with them a clinical potency that needs to be understood. These interventions can raise anxiety and shame to the point where some clients may be pushed toward relapse or even feel the need to leave treatment to escape the internal conflicts encountered. As with any therapeutic technique, therapists should not utilize such techniques unless they are thoroughly trained and well supervised. Any intervention that has a powerful potential for growth almost always has an equal potential for damage if poorly conducted. Training and appropriate supervision are particularly important with expressive techniques because of their clinical potency.

Psychodrama can be used with different models of group therapy. It offers persons with substance abuse disorders an opportunity to better understand past and present experiences—and how past experiences influence their present lives. This approach encourages clients to relearn forgotten skills,

imaginatively change apparent problems that block progress, rehearse new behaviors, practice empathy, and expand their emotional range by confronting feelings that have never been properly dealt with. As clients act, important concepts become real, internalized, and operational that might otherwise be purely theoretical. Changes experienced through acting become accessible to the psyche as part of the lived history of the individual.

Some therapists use psychodrama to help transform internal dynamics that maintain old patterns relevant to substance abuse. For example, one therapist invites group members to list "rules" in their family of origin. These rules may be related to substance abuse (e.g., "Don't ever say that Mother is drunk. She is taking a nap."). After a client describes a situation in which the rule would be invoked, he assigns family roles to other participants, giving them instructions for how they would behave in this situation. The client is encouraged to break the rule—in the case of the "napping" mother, by insisting on bringing the truth into the open—with the verbal encouragement of all remaining group members who are not playing assigned roles. The client's victory—which can be a transformative, powerful experience—is celebrated as the achievement it is. In this example, the individual experiences himself as a powerful truth-speaker rather than the powerless and voiceless participant he perceived himself to be in the past. This new experience can enhance his sense of self-efficacy and help foster change in his own pattern of substance abuse.

In another example of psychodrama, group participants explore "character defects" such as grandiosity or isolation associated with their pattern of substance abuse. The defects are dramatized, with half the group engaged in the dramatization and half sitting as an audience. For example, persons who experience themselves as isolated sit in the corner or under a table with a "sponsor." The therapist gives them sentences to complete, such as, "I like this corner because…." or "The first time I remember isolating is…." Finally, they are asked to complete the sentence, "I have to get out of this corner because…." The sponsors then gather in a circle and invite the persons they have been supporting to join them, saying, "I want you to join this circle because…." This experience of connection often enhances participants' motivation and ability to change.

A common use of psychodrama in treatment for substance abuse disorders is "sculpting" family members in typical roles and enacting significant situations related to substance abuse patterns. In this process, developed by Papp, family members enact a scene to graphically depict the problem (Papp, 1977, 1983). The physical arrangement of the family members illustrates emotional relationships and conflicts within the family. For example, a family may naturally break up into a triad of the mother, sister, and brother, and a dyad of the father and another sibling. In that case, the therapist might highlight the fact that the mother and father communicate through one of their children and never talk to each other directly.

In yet another form of psychodrama, one person in the group may be asked to give voice to different aspects of her own self that either help maintain dependency or speak for change (sometimes called the "disease" and "recovery" selves). The client might speak from a different chair or position for each of these voices. The intensity of psychodrama often helps compensate for the shorter time span now commonly funded for treatment. Although many participants express concern about acting, the barrier of shyness often drops completely as they enter the process with the assistance of a dynamic and committed facilitator.

Therapeutic Factors

In his classic work, *Theory and Practice of Group Psychotherapy*, Irvin Yalom identified 11 primary "therapeutic factors" in group therapy (Yalom, 1995). Each of these factors has particular importance for clients with substance abuse disorders and can be used to help explain why a group works in a particular way for this client population. These curative factors are present in all group interventions and are listed below.

Instillation of Hope

Many clients come to a treatment setting feeling defeated by life and overwhelmed by their failure to control their use of substances. They feel they have nowhere to go and no possibility for a better outcome in life. When individuals with this life view join a group of people struggling with similar problems, they have the remarkable opportunity of witnessing change in others while at the same time having their own small victories acknowledged and celebrated by group members. Through this process, hope begins to emerge. The energy of hope and the focused attention on this curative factor receive specific attention in the MIGP model.

A variety of exercises can be utilized to further instill hope within substance-abusing clients. Clients can be asked to participate in a visualization exercise where they see themselves in a life without substance use, envisioning particularly how life would be different and better under such circumstances. The group energy fuels this experience and adds the intensity of other clients' support. As with all "guided imagery exercises," the group leader must move with caution. Many substance-abusing clients may not have a picture of life without substances, and consequently such an exercise can be humiliating if not handled sensitively. If the client is unable to visualize, he once again perceives failure. To guard against such potential shaming, the group facilitator can take an active role in the creation of the image, monitoring it for issues of safety with all members of the group as the exercise develops.

Universality

Substance abuse disorders tend to impede relationships and force clients into increased isolation. In a brief group experience, the clients encounter other individuals who have faced similar problems. They become aware that they are not alone in life and can feel tremendous satisfaction in this connection. The sense that their pain is not exclusive or unique and that others with similar problems are willing to support them can be profoundly healing. It helps clients move beyond their isolation, and it gives further energy to hope, which helps to fuel the change process.

Imparting Information

The inevitable exchange of information in a group setting helps members get from one day to the next. Particularly in conjunction with formal psychoeducational groups, MIGP affords group members the opportunity to reflect on what they have learned and at the same time apply that learning within the group setting. The information shared is personal and tends to be experienced as motivational. The client struggling with issues of substance abuse can hear from others how they have dealt with difficult concerns and how they have experienced success. This mutually shared success gives positive energy to the group and encourages change.

Altruism

Fundamental to the human condition is the desire to help others when they are in trouble. Clients struggling with substance abuse disorders tend to be focused on their own difficulties and have a hard time reaching out to help those in need. Group therapy offers the members opportunities to provide assistance

and insight to one another. Particularly within the model of MIGP, the facilitator pays great attention to altruistic moves on the part of members. They are celebrated and acknowledged. As individuals recognize that they have something of value to give their fellow group members, their self-esteem rises as change and self-efficacy are supported.

Corrective Recapitulation of the Primary Family Group

This therapeutic factor pertains to the importance of relationships within the client's family of origin, which invariably finds expression within the group experience. "Recapitulation of the family group" happens when a client—both consciously and unconsciously—relates to another group member as if that person is a member of his family of origin with whom he has struggled in the past. This occurrence is clearly a projection, but it can be identified by the leader, and both group members involved can benefit as they investigate new ways of relating that break the old dysfunctional patterns of the family of origin. In a way, the group begins to serve as a substitute family. The group members are the siblings, and the group facilitator is in a parental role. Even in a time-limited group, issues of transference and countertransference may require attention. However, MIGP tends to dilute the transference by "spreading it throughout the group" rather than concentrating it within the dyadic counseling relationship.

Development of Socializing Techniques

Many substance abusers are "field-sensitive" or "field-dependent" individuals who are keenly conscious of the network of specific relationships as opposed to principles or generalizations that apply regardless of context. Group therapy can take advantage of this trait and use the energy of the relationships to facilitate change. As participants engage in relationships, they learn new social skills that can help them break through their isolation and connect with others in more meaningful ways. They also learn how to disconnect, which is equally important given the anxieties often associated with relational loss and grief. The group facilitator may at times deliberately focus on these social skills through role-playing or modeling exercises within the context of the group itself. The healing takes place as the clients take what they have learned and experienced in group and actively generalize it in their lives outside of the group.

Imitative Behaviors

Imitative behaviors are an important source of learning in group therapy. The process of modeling can be particularly important as clients learn new ways to handle difficult emotions without resorting to violence or drug use. Therapists must be acutely sensitive to the important role they play within this context; clients often look to the therapist to model new behaviors as they encounter new situations within the group context. Group members can also learn by imitating other members who are successfully dealing with difficult relational issues. It is helpful for a new group member to witness an ongoing group where people are confronting their problems appropriately, moving beyond old dysfunctional patterns, and forming new relationships that support change. The group becomes a living demonstration of these new behaviors, which facilitates and supports insight and change.

Interpersonal Learning

Groups provide an opportunity for members to learn about relationships and intimacy. The group itself is a laboratory where group members can, perhaps for the first time, honestly communicate with individuals who

will support them and provide them with respectful feedback. This interpersonal learning is facilitated by the MIGP model, in that special attention is given to relational issues within the context of group.

Group Cohesiveness

Often misunderstood, group cohesion is a sense of belonging that defines the individual not only in relation to herself but also to the group. It is a powerful feeling that one has meaning in relationships and that one is valued. Development of group cohesion is particularly important in the MIGP model, so that group members feel safe enough to take the risks of self-disclosure and change. The experience of belonging is both nurturing and empowering.

Catharsis

Sometimes group participants will gain a sudden insight through interaction with others, which can cause a significant internal shift in the way they respond to life. Such insights may be accompanied by bursts of emotion that release pain or anger associated with old psychological wounds. This process happens more easily in a group where cohesion has been developed and where the therapist can facilitate a safe environment in which emotions can be freely shared. It is important to recognize, however, that although catharsis is a genuine expression, it is not seen as curative in and of itself. High levels of emotional exchange not addressed in the group can become potential relapse triggers, which endanger the success of individual members. The therapist acknowledges the powerful emotions after the member has shared them but asks the group as well as the member to give those emotions meaning and context within the group. Thus, both the experience of the emotion and the understanding of how that emotion either interferes or supports relationships are healing.

Existential Factors

Existential factors of loss and death are often issues of great discomfort in the substance-abusing population. The brevity of a time-limited group experience forces these issues to the surface and allows members to discuss them openly in a safe environment. Time itself represents loss and also serves as a motivator, as the members face the ending of each group session and of the group treatment experience. As they become more aware of the frustrations of reality and the limits they face, clients can receive support from the group in accepting "life on life's terms" instead of their past patterns of escape.

Using Time-Limited Group Therapy

The focus of time-limited therapeutic groups varies a great deal according to the model chosen by the therapist. Yet some generalizations can be made about several dimensions of the manner in which brief group therapy is implemented.

Assessment and Preparation

Client preparation is particularly important in any time-limited group experience. Clients should be thoroughly assessed before their entry into a group for therapy. In terms of exclusionary issues, persons with severe disorders or those who cannot accept support may need to be given more individual time before a group experience. Also, persons with significant deficits in cognition may not benefit as much from a time-limited group.

Group participants should be given a thorough explanation of group expectations. For an MIGP group, for example, they need to understand their responsibility for speaking within the group and that the primary focus of

the group is relationships. A brief explanation of a "here and now" encounter is helpful—the group can become a place where feedback takes place in the "here and now," as members learn how they are affected by the others and how they in turn affect other members. This "here and now" focus brings clients into the present and allows them to deal with real issues within the group that they can then apply in their daily lives. It also distinguishes MIGP from self-help support groups, which traditionally discourage relational "here and now" interactions.

If time permits, it is particularly effective for group members as they are being assessed and prepared for group to either watch or participate in a practice group as a trial experience. A variety of group tapes are available; however, any program can videotape one of its own groups, with appropriate releases for client permission, to use for instructional purposes. This enables new clients to see what will happen in the group session and lowers anxiety. This intentional effort to make the group safe and reduce its inherent anxiety distinguishes MIGP from a more traditionally interactive process group. Introductions to group can also be provided in a psychoeducational format. Clients learn not only what is going to take place in the group but also why and how the group process brings about healing. The importance of relationships and open communications through self-disclosure and support can be explained.

It is important to recognize that although a significant amount of client preparation takes place before the client ever enters a group, client preparation itself is also a process and not an event. Through continual references to the group agreements and group contracts, the therapist continues to prepare clients as they move into the experience.

Initial Session

Opening sessions for group therapy differ according to the type of group, its specific goals, and the personal style of the therapist. In homogeneous, problem-focused groups, for example, less time is needed to define what group members have in common. Opening sessions typically include the following:

- New group members introduce themselves at the opening session, responding to a simple request such as, "Tell us what led you here." Research suggests that if groups do not explicitly address the reason for each member's participation, more members will drop out (Levine, 1967). In the context of substance abuse treatment, the therapist should therefore initially discuss with group members how substance abuse issues will be addressed so as to ensure that focus is maintained.
- The "locus of control" for the group is clarified. Clients explore whether they believe they have the ability to choose effective actions or if they think of themselves as helpless victims of circumstance. For directive groups, in which the therapist exercises greater control, this process will be shorter than for group process groups, in which group members take turns as leaders.
- Goals for the group (and often for individuals) are clarified.
- The therapist seeks to establish a safe, warm, supportive environment. There may be a need to establish rules to increase safety—for example, that members will not engage in physical contact, will not discuss what was said outside the room, and will give feedback to each other in an agreed-upon manner.
- The therapist helps group members establish connections with each other, pointing out common concerns and problems.

Some therapists ask the group to evaluate the opening session. This may be done orally or in writing. The group's success can be measured through the following questions:

- Was substance abuse discussed?
- Did group members listen to each other?
- Did members cooperate and support each other?
- Did they give feedback?

Later Sessions

Often, to enhance continuity, the therapist will begin the next session by recalling the previous one and ensuring that "leftover" items are addressed. The therapist may ask group members how lessons learned in the group have affected their daily lives. Members may have tried to implement suggestions and found they did or did not work, or they may not have tried to do so at all, which is also an important topic of discussion.

On an inpatient unit with clients going through withdrawal or struggling with coexisting psychiatric disorders, instilling hope is particularly important. For the newest clients on the unit, connecting with others who have just been through a similar difficult experience can be inspirational. Such a therapeutic encounter can also reduce issues of shame, as clients connect with others who both share and understand their journey. In addition, the inpatient group can serve as an example of what treatment will be like after discharge and allow the client to "practice" being in a group. Clients can experience the supportive nature of the group, which will reduce their anxiety about future group involvement. Underscoring the impact of brief group interventions, the inpatient process treatment group remains one of the cornerstones of continued change.

Duration of Therapy and Frequency of Sessions

The preferred timeline for time-limited group therapy is not more than two sessions per week (except in the residential settings), with as few as six sessions in all, or as many as 12, depending on the purpose and goals of the group. Sessions are typically 1½ to 2 hours in length. Residential programs usually have more frequent sessions.

Given the dramatically shortened inpatient and residential stays available under managed health care, some have questioned the utility of a process-sensitive treatment group and are focusing on directive educational groups. Even though clients often do not stay more than 3 to 5 days on an inpatient unit, much can be accomplished in this brief timeframe. As mentioned before, directive educational groups are necessary but not always sufficient. Groups with active facilitation, but adhering to process sensitivity, can build cohesion quickly and act as powerful motivators for clients to follow through with the next level of care.

Group process therapy is most effective if participants have had time to find their roles in a group, to "act" these roles, and to learn from them. The group needs time to define its identity, develop cohesion, and become a safe environment in which there is enough trust for participants to reveal themselves. (The exception is an educational group, which relies less on group process factors.) Consequently, prematurely terminated groups relying on group process may be less effective than they could be in promoting long-term change. Furthermore, participants may have to clear their systems of the most serious effects of substances before they can fully participate. Because of such factors, arbitrary time limits for groups, as opposed to timelines set according to the therapeutic goals of the particular group, can be ill advised.

Gender and Cultural Issues Within Groups

Researchers at Cornell University found that social contact with persons who have gone through the same crisis is highly beneficial (Manisses Communications Group, 1997a). Therefore, a common gender, culture and/or

sexual preference will help clients in group therapy share difficulties they may have encountered because of that common background.

Participation in group therapy may be less effective for women than men, perhaps because groups are often dominated by men and reflect their issues and style of interaction (Jarvis, 1992). At this time, however, little research is available on the relative efficacy of women-only rather than mixed-gender groups. Weitz argues that women may have to be empowered in order to remain abstinent (Weitz, 1982). Group cognitive–behavioral therapy has been found to be an effective treatment for women with posttraumatic stress disorder and a substance abuse disorder (Najavits et al., 1996) as well as for women with both a substance abuse disorder and a history of physical or sexual abuse (Manisses Communication Group, 1997).

Covington has written extensively about the importance of women-specific groups, particularly in early recovery. She accurately pointed out that the powerful role definitions within our culture tend to be played out in group and are often oppressive to women (Covington, 1997). In a mixed group, the women quickly become the "emotional containers" for the group and take care of the men. Although such activity is not defined as pathological, it expresses cultural norms wherein women's needs become secondary to those of men, with the women primarily defined as caretakers. They are uncomfortable about bringing up issues of sexuality, particularly sexual abuse, given that men have generally been the abusers (Covington, 1997).

The creation of gender-specific groups, particularly in small agencies or private practice, may pose logistical difficulties. However, there is growing consensus among therapists that, whenever possible, women need to have their own groups, particularly during early recovery (Byington, 1997). This does not suggest that women should be fully segregated from men. Participation in mutually shared psychoeducational experiences and multifamily groups is a therapeutic way of addressing gender issues (Byington, 1997).

Concerns of ethnicity and race should be handled with sensitivity. This is not to suggest that in a time-limited group, the potency of homogeneity is such that each and every ethnic or racial subgroup should be segregated in order to reap the benefits of this intervention. However, cultural issues need to be addressed openly and with sensitivity.

Cost-Effectiveness

The clinical utility of time-limited groups has clearly been demonstrated, but the cost factor is not irrelevant to a consideration of the value of these groups. Although individual work and family work will likely always remain a part of even the briefest time-limited treatment experience, acceptance and use of group interventions are slowly growing. From a cost-management perspective, the benefits are obvious. Not only can the therapist use the power of the group to support change within all group members, but one well-trained group therapist can meet the clinical needs of 8 to 12 clients in roughly the same amount of time as an individual session. When these numbers are enlarged to include more directive approaches such as cognitive–behavioral or psychoeducational groups, the cost–benefit ratio increases.

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