

# Substance Abuse Treatment: Group Therapy

A Treatment  
Improvement  
Protocol

**TIP**  
**41**



# **Substance Abuse Treatment: Group Therapy**

## **A Treatment Improvement Protocol**

# **TIP 41**

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

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## Acknowledgments

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

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## Recommended Citation

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

## Originating Office

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

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

# 5 Stages of Treatment

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## Overview

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

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

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

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

## Adjustments To Make Treatment Appropriate

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

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

Any discussion of intervention adjustments to make treatment appropriate at each stage, however, necessarily must be oversimplified for three reasons. First, the stages of recovery and stages of treatment will not correspond perfectly for all people. Clients move in and out of recovery stages in a nonlinear process. A client may fall back, but not necessarily back to the beginning. “After a return to substance use,

clients usually revert to an earlier change stage—not always to maintenance or action, but more often to some level of contemplation. They may even become precontemplators again, temporarily unwilling or unable to try to change . . . [but] a recurrence of symptoms does not necessarily mean that a client has abandoned a commitment to change” (Center for Substance Abuse Treatment 1999*b*, p. 19). See chapters 2 and 3 for a discussion of the stages of change.

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

Second, adjustments in treatment are needed because progress through the stages of recovery is not timebound. There is no way to calculate how long any individual should require to

resolve the issues that arise at any stage of recovery. The result is that different group members may achieve and be at different stages of recovery at the same time in the lifecycle of the group. The group leader, therefore, should use interventions that take the group as a whole into account.

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

## The Early Stage of Treatment

### Condition of Clients in Early Treatment

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

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

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

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

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

...overcoming the resistance that characterizes addicts. A skilled group leader can facilitate members' confronting each other about their resistance. Such confrontation is useful because it is difficult for one addict to deceive another. Because addicts usually have a history of adversarial relationships with authority figures, they are more likely to accept information from their peers than a group leader. A group can also provide addicts with the opportunity for mutual aid and support; addicts who present for treatment are usually well

connected to a dysfunctional subculture but socially isolated from healthy contacts (Milgram and Rubin 1992, p. 96).

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

## Therapeutic Strategies in Early Treatment

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

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

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

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

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

Attention to group cohesiveness is important early in treatment.

Imparting information often is needed to help clients learn what needs to be done to get through a day without chemicals. Psychoeducation also allows group members to learn about addiction, to judge their practices against this factual information, and to postpone intense interaction with other group members until they

are ready for such highly charged work. Attention to group cohesiveness is important early in treatment because only when group members feel safety and belonging within the group will they be able to form an attachment to the group and fully experience the effects of new knowledge, universality, and hope.

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

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

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

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

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



## ***A Note on Attachment Theory and Substance Abuse Treatment***

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

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

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

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

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



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

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

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

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

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

gests changes that might enable the client to manage cravings better or avoid exposure to strong cues.

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

## Leadership in Early Treatment

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

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

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

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

## The Middle Stage of Treatment

### Condition of Clients in Middle-Stage Treatment

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

Several studies (Committee on Opportunities in Drug Abuse Research 1996; London et al. 1999; Majewska 1996; Paulus et al. 2002; Strickland et al. 1993; Volkow et al. 1988, 1992) have observed decreased blood flow and metabolic changes rates in the brains of

subjects who abused stimulants (cocaine and methamphetamine). The studies also found that deficits persisted for at least 3 to 6 months after cessation of drug use. Whether these deficits predated substance abuse or not, treatment personnel should expect to see clients with impaired decision-making and impulse control manifested by difficulties in attending, concentrating, learning new material, remembering things heard or seen, producing words, and integrating visual and motor cues. For the clinician, this finding means that clients may not have the mental structures in place to enable them to make the difficult decisions faced during the action stage of treatment. If clients draw and use support from the group, however, the client's affect will re-emerge, combine with new behaviors and beliefs, and produce an increasingly stable and internalized structure (Brown 1985).

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

### Therapeutic Strategies in Middle-Stage Treatment

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

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

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

Practitioners have stressed the need to work in alliance with the client's motivation for change. The therapist uses whatever leverage exists—such as current job or marriage concerns—to power movement toward change. The goal is to help clients perceive the causal relationship between substance abuse and

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

current problems in their lives. Counselors should recognize and respect the client's position and the difficulty of change. The leader who leaves group members feeling that they are understood is more likely to be in a position to influence change, while sharp confrontations that arouse strong emotions and appear judgmental may trigger relapse (Flores 1997).

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

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

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

## Leadership in Middle-Stage Treatment

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

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

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

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

The leader can support the process of change by drawing attention to new and positive developments, pointing out how far clients have traveled, and affirming the possibility of increased connection and new sources of satisfaction. Leaders should bear in mind, however, that people with addictions typically choose

immediate gratification over long-range goals, so benefits achieved and sought after should be real, tangible, and quickly attainable.

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

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

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

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

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

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

## The Late Stage of Treatment

### Condition of Clients in Late-Stage Treatment

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

Despite efforts to forestall relapse, many clients, even those who have reached the late stage of treatment, do return to substance use and an earlier stage of change. In these cases, the efforts to guard against relapse were not all in vain. Clients who return to substance abuse do so with new information. With it, they may be able to discover and acknowledge that some of the goals they set are unrealistic, certain

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

strategies attempted are ineffective, and environments deemed safe are not at all conducive to successful recovery. With greater insight into the dynamics of their substance abuse, clients are better equipped to make another attempt at recovery, and ultimately, to succeed.

As the substance abuse problem fades into the background, significant underly-

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

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

### Therapeutic Strategies in Late-Stage Treatment

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

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

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



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

## Leadership in Late-Stage Treatment

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

As in the early and middle stages, the leader helps group members sustain abstinence and makes sure the group provides enough support and gratification to prevent acting out and

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

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

# 7 Training and Supervision

## In This Chapter...

### Training

Training Opportunities  
Training Opportunities in  
Types of Group Therapy

### Supervision

The Supervisor's Essential  
Skills  
The Supervisory Alliance  
Funding for Training and  
Supervision Programs

## Overview

Substance abuse counselors come to the field from a variety of backgrounds, education, and experience. Many have not had specific training and supervision in the special skills needed to be an effective group therapist. Counselors may be promoted to positions of supervision without the additional training in the skills needed to perform supervisory tasks, which are

- Administrative
- Evaluative
- Clinical
- Supportive

This chapter describes the skills group therapy clinicians need, the purpose and value of clinical supervision, and how to get the training necessary to be a top-flight group clinician or supervisor of clinicians.

## Training

In a brief article, Geoffrey Greif lists “Ten Common Errors Beginning Substance Abuse Workers Make in Group Treatment.” He contends that these errors are common because people who abuse substances are supremely adept at helping group leaders make mistakes. Some of these are

- Impatience with the clients' slow pace of dealing with change
- Inability to drop the mask of professionalism
- Failure to recognize countertransference issues
- Not clarifying group rules
- Conducting individual therapy rather than using the entire group effectively
- Failure to integrate new members effectively into the group (Greif 1996)



A group leader for people in substance abuse treatment requires competencies in both group work and addiction.

Training and education for group therapists working in the substance abuse field can alleviate or eliminate such errors. Simultaneously, additional training is becoming even more critical because (1) the traditionally separate fields of mental health and substance abuse counseling increasingly overlap, requiring more and more cross-knowledge; and (2) an ever younger pool of clients is presenting

with more cognitive deficits, abuse issues, and co-occurring disorders.

A group leader for people in substance abuse treatment requires competencies in both areas: group work and addiction. For example, facilitators should understand group process, group dynamics, and the stages of group development; they need to understand that group therapy is not individual therapy in a group setting. Further, facilitators should be aware that although Alcoholics Anonymous (AA) or other 12-Step programs are complementary to substance abuse treatment, these modalities are distinct from group therapy.

As trends move toward integrated mental and substance abuse treatment, counselors already adept at working with groups of clients with substance abuse problems may need specific training to manage mental disorders such as depression, which often co-occur with substance abuse. Further, counselors in recovery may be familiar with the stages of addiction treatment but lack a background in group therapy.

On the other hand, group counselors who have treated clients without addictions may not always have sufficient skills to combat addiction and its effect on a group therapy situation.

Therapists need to become well versed in the substance abuse treatment philosophy, its terminology, and techniques of recovery, including the self-help approaches (Kemker et al. 1993).

A group therapist with roots in the mental health field planning to become more competent in group work for the treatment of substance abuse will need to make a number of adjustments. First, the therapist working with clients with substance use disorders should be able to screen and assess for substance abuse problems. On this subject, see TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (Center for Substance Abuse Treatment [CSAT] 1994b); TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997a); and TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999c). Second, the therapist will need to recognize the importance of abstinence. Third, the therapist will need to be sensitive to a client's anxiety and shame, especially in early stages of treatment for substance abuse. In a modified interpersonal process group, for example, the group leader should create a safe, supportive environment free from the stigma of addiction while promoting a client's attachment to other group members, self-help groups, therapy, and the entire healing community of which the group is a part.

Group therapists who move into the treatment of clients who are chemically dependent typically need staff development in:

- *Theories and techniques.* Theories may include traditional psychodynamic methods, cognitive-behavioral modes, and systems theory. From such theoretical bases are drawn applications that pertain to a wide variety of settings and particular client populations.
- *Observation.* The observer can sit in on group therapy sessions, study videotapes of senior therapists leading group sessions (ordinarily followed by a discussion), or watch groups live through one-way mirrors as experienced therapists lead groups.

- *Experiential learning.* With this approach, a therapist may participate in a training group offered by an agency, become a member of a personal therapy group (these are often process-oriented), or join in group experiences at conferences, such as those offered at the Institute of the American Group Psychotherapy Association’s annual conference. (For more on experiential training, see the section on “Experiential Learning” later in this chapter.)
- *Supervision.* A large part of this type of training is ongoing work with groups under the supervision of an experienced therapist. Supervision may be dyadic, that is, supervisor and supervisee, but while simple and easy, this setting does not allow opportunities for actual group work. Supervision of group therapists ideally is conducted in a supervisory group format. Supervision in a group enables therapists to obtain first-hand experience and helps them better understand what is happening in groups that they will eventually lead. Several other important benefits accrue as well. The supervisory group creates a safe place for trainees to reveal themselves and the skills they need to develop. It provides support from peers and a chance to learn from their experience. It stimulates dialog around theory and technique and encourages a healthy kind of competition. It expands the capacity for empathy (Alonso 1993). Finally, this kind of supervision provides an opportunity for trainees to explore sensitive issues, such as child abuse, sexual abuse, and prostitution. (For more on supervisory groups, see the “Supervision” section later in this chapter.)

Before leaving the matter of what group leaders treating substance abuse should know, it is desirable to assess the importance of the group facilitator’s being a person who is in recovery. There is some tension around this issue. Culbreth (2000) reviewed 16 relevant studies and concluded that while clients do not perceive differences in treatment related to a therapist being in recovery or not, and no differences in treatment outcomes could be discerned, recovering and nonrecovering thera-

pists do not perceive substance abuse problems the same way, use different methods to treat substance abuse, and differ in personality and attitudinal traits.

Some people dismiss the notion that all people with addictions prefer to work with a group leader who is in recovery. They insist that, on the contrary, some people with addictions prefer not to work with recovering leaders, fearing that leaders in recovery will share the issues and problems of people with addictions and thus will not be in a position to help them with these issues.

Others say that a staff of group leaders should include people in recovery. Those holding this point of view reason that people with addictions are highly skilled at manipulating people and situations. With both recovering and non-recovering group leaders, a clinical team will be best positioned to see and treat the whole client—and not be duped by agreeable, but false, façades.

In group therapy with clients with substance use disorders, it can be challenging to establish and maintain credibility with all group clients. Facilitators not in recovery will need to anticipate and respond to group members’ questions about their experience with substances and will need skills to handle group dynamics focused on this issue. On the other hand, leaders who are in recovery may tend to focus too much on themselves. Group leaders emotionally invested in acting as models of recovering perfection are easy marks for clients.

Of course, the main issue is not whether the leader is in recovery. What matters most is whether the counselor knows the fields of group therapy and addiction treatment and has

Supervision in a group enables therapists to obtain first-hand experience.

good judgment and leadership skills (see Figure 7-1). Helping the group explore why the recovery status of the group leader is important can be discussed if and when the issue is raised.

## Training Opportunities

National professional organizations are a rich source of training. Through conferences or regional chapters, national associations provide training—both experiential and direct instruction—geared to the needs of a wide range of professionals, from the novice to the highly experienced therapist. More training options are usually available in large urban areas. It is likely, however, that online training will make some types of professional development accessible to a greater number of counselors in remote areas. A number of professional organizations that provide a variety training settings are listed below. Inclusion in the list does not imply endorsement by the Substance Abuse and Mental Health Services Administration (SAMHSA). Note that not all of these organizations approach substance abuse treatment through group therapy.

## Professional associations

### *American Group Psychotherapy Association (AGPA)*

AGPA, founded in 1942, has more than 4,000 members and 33 local and regional affiliate societies, which provide a broad range of professional, educational, and social support for group therapists in the United States and abroad. The organization publishes *The International Journal of Group Psychotherapy* and *The Group Circle*.

AGPA's Special Interest Groups (SIGs) share ideas and knowledge through interaction with colleagues. Some SIGs focus on substance abuse; children and adolescents; cotherapy; diversity; gay, lesbian, and bisexual clients; the medically ill; the severe and persistent mentally ill; and women in group therapy. SIGs are open to nonmembers of AGPA.

At its annual conferences, AGPA offers training institutes for individuals. Three of these institutes focus on substance abuse training. The association can also provide in-house training to agency staff at a very low cost. Further, AGPA has developed basic and

**Figure 7-1**

### ***How Important Is It for a Substance Abuse Group Leader To Be In Recovery?***

A leader who is in recovery will probably elicit trust more quickly from group members, especially people with hard-core addictive backgrounds, because such clients often assume—correctly or not—that a person in recovery can empathize with the pain of addiction. Such group leaders, as success stories, have the added advantage of serving as role models for group members struggling against temptations and cravings in the early stages of recovery.

A leader having personally recovered, however, does not automatically make that person an effective therapist. Many counselors in recovery cannot make the switch from self- to client-centered approaches and hold rigid views of how to manage the recovery process.

*Source:* Consensus Panel.

advanced core courses. They tend to be practical in nature, and they contribute to certification. The certified group therapy program is available through the regional affiliates.

### *American Psychiatric Association (APA)*

The American Psychiatric Association is a medical specialty society recognized world-wide. Its more than 35,000 U.S. and international member physicians work together to ensure humane care and effective treatment for all persons with mental disorder, including mental retardation and substance-related disorders. To its members, the APA offers board certification and continuing medical education from online sources as well as at annual meetings.

### *American Psychological Association (APA)*

The APA College of Professional Psychology offers a Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders. This certificate is a uniform nationally recognized credential offered exclusively to licensed psychologists who meet specific criteria related to experience in substance abuse treatment, including completion of an APA examination.

Two of APA's 55 subgroups may be of special interest. Division 49, Group Psychology and Group Psychotherapy, serves psychologists' interest in research, teaching, and the practice of group psychology and group therapy. Division 50, Addictions, centers on research, professional training, and clinical practice dealing with a broad range of addictive behaviors. Both divisions publish a newsletter and journal, and both have annual meetings and award programs.

APA has extensive resources on cultural diversity and ethnic/racial issues related to therapy, including online brochures, a quarterly journal, *Cultural Diversity and Ethnic Minority*

*Psychology*, and an Office of Ethnic Minority Affairs that provides publications and information. Recent APA books on this topic describe relationships among Asian-American women and health-promoting and health-compromising behaviors among minority adolescents.

### *American Society of Addiction Medicine (ASAM)*

One of ASAM's goals is educating health professionals about addiction. The organization develops credentialing guidelines and publishes the comprehensive and influential volume, *Principles of Addiction Medicine* (Graham et al. 2003), among other books and journals. The society has also developed patient placement criteria called PPC-2R (published in 2001), as well as screening and assessment tools. Each year, ASAM hosts several conferences and training meetings on various aspects of addiction medicine. ASAM offers audiotapes of its conferences for continuing medical education credit. Physicians certified by the society in addiction medicine are listed in an ASAM directory.

### *Association for the Advancement of Social Work with Groups (AASWG)*

This international professional organization has developed standards that reflect the distinguishing features of group work, as well as the unique perspective that social workers bring to their practice with groups. These standards are applicable to the types of groups that social workers encounter in the various settings in which they practice and allow the practitioner to apply a variety of relevant group work models. AASWG has also collected a 29-page bibliography of books, monographs, and videos available for practitioners, educators, and researchers.

### ***Association for Specialists in Group Work (ASGW)***

A division of the American Counseling Association, the ASGW was founded to promote high quality in group work training, practice, and research, both nationally and internationally. The organization has developed Best Practice Guidelines, Principles for Diversity-Competent Group Workers, and Professional Standards for the Training of Group Workers. These criteria are available on the organization's Web site: <http://asgw.org>. The Web site also provides resources, including products, institutes, and links to other Web pages, along with a calendar describing upcoming conferences and professional development activities of interest to a broad spectrum of group leaders.

### ***National Association of Alcohol and Drug Abuse Counselors (NAADAC)***

NAADAC is the largest national organization for alcoholism and drug abuse professionals across the country. The association offers opportunities for professional development, such as workshops, seminars, and education programs for members. In addition to a bimonthly magazine, *The Counselor*, NAADAC provides an Educational Resources Guide that lists colleges and universities offering degree and certification programs in addiction counseling and a listing of approved education providers for trainers in each State. Through its national certification program, including the National Certified Addiction Counselor and the Masters Addiction Counselor designation, NAADAC recognizes counselors with advanced skill levels.

### ***National Association of Black Social Workers (NABSW)***

NABSW offers national and international education conferences, as well as projects and

mentoring programs to support the work of African-American social workers.

### ***National Association of Social Workers (NASW)***

NASW is the world's largest organization of professional social workers. The association has developed practice standards and clinical indicators, a credentialing program, continuing education courses on national and State levels, and numerous publications for members and nonmembers.

Distance learning courses are listed on NASW's Web site. Many topics are relevant to addiction counselors, such as Chemical Dependency and the African American: Counseling Strategies and Community Issues, Dual Diagnosis, HIV/AIDS and Substance Abuse, and Multicultural Counseling—The New Paradigm for Substance Abuse Professionals.

### ***National Registry of Certified Group Psychotherapists***

In an effort to maintain the highest standards for group therapy practice, the National Registry certifies group therapists according to nationally accepted criteria and promotes these criteria among mental health professionals, employers, insurers, education personnel, and clients. The registry has developed guidelines that are clinically based, client-focused service indicators to be used in discussions with accrediting organizations regarding appropriate standards of quality. The guidelines also apply in discussions with employers regarding delivery of mental health services in groups, as well as managed care and health maintenance organizations. The registry's newsletter, *The Group Solution*, provides up-to-date information on the use of group therapy in the current behavioral health care atmosphere.



Frequent continuing education seminars are given by local affiliate societies and at the annual meeting of the parent group, AGPA.

### **Other sources of training**

Many agencies mandate a certain number of trainings each year and provide in-house training that draws on the resources of credentialed senior management. Each of the States has a department of alcohol and drug abuse services, and some may provide substance abuse training for group therapy. Training in mental health issues is often available through the mental health division of government agencies, professional associations, and psychological and psychiatric organizations. Most colleges, universities, and community colleges offer relevant courses, many of them certified by professional organizations.

Several Federal entities offer resources for training. SAMHSA provides a number of resources, including publications for substance abuse treatment professionals. These include the Technical Assistance Publication (TAP) series. TAP 21 is relevant to training: *Addiction Counselor Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT 1998a).

In addition, SAMHSA's Treatment Improvement Protocol (TIP) series includes more than 40 publications to assist therapists and counselors in treating people with substance abuse problems. To view TAPs and TIPs online, go to <http://www.kap.samhsa.gov> and click on "Publications."

These publications also are available free through the SAMHSA Store at 1-877-726-4727. The SAMHSA Store can also provide a catalog of other resources and publications on addiction counseling and treatment. One of them, for example, is the National

Institute on Drug Abuse, which provides information on research and treatment.

The National Mental Health Information Center (NMHIC) at SAMHSA provides a wealth of information for the public and for treatment professionals. A search for "training" on its Web site resulted in a list of numerous opportunities for training and technical assistance on a variety of topics as well as bibliographies, publications, and links.

### **Training Opportunities in Types of Group Therapy**

#### **Experiential learning**

For the therapist in training, the experience of being in a group is particularly important for both the development of skills and the level of comfort with one's developing leadership style. Whether this experience is acquired through a process group, a supervision group, or experiences offered through organizations like the AGPA, experiential opportunities afford learners not only insight into their personal growth, but a first-person appreciation for the healing power of group therapy.

Experienced group therapists are able to lead process groups because training in this area is part of the preparation program for mental health professionals. In these groups, members study their own behavior to learn about group dynamics, individual dynamics, boundaries, and interpersonal communications. In addition,

SAMHSA provides a number of resources, including publications for substance abuse professionals.

leadership of process groups provides one of the best continuing education tools available to senior clinicians (Swiller et al. 1993). One experienced supervisor of training groups for therapists in training has found that “one of the most striking aspects of the supervision of group therapists in the group setting is its effectiveness in bringing about the identification, emotional recognition, and resolution of...untherapeutic behaviors, which we term counterresistances” (Rosenthal 1999b, p. 201).

A great many institutions and individuals offer workshops and courses in conducting group therapy. One of these is the A.K. Rice Institute and its affiliate societies, which provides group relations training based on the Tavistock model, which originated at the Tavistock Institute in England. The training, offered in weekend or longer conferences, is a model of experiential training that focuses exclusively on group-level dynamics.

The A.K. Rice Institute  
Anne-Marie Kirkpatrick, R.N., Administrator  
P.O. Box 1776  
Jupiter, Florida 33468-1776  
Phone: (561) 744-1350  
Fax: (561) 744-5998

## ***Expressive therapies***

A wide range of expressive therapies (therapy based on an artist’s working process) is often used in substance abuse treatment. Expressive therapy groups may use dance, music, art, writing, psychodrama, drama, role playing, adventure, and gestalt. Training in these areas is available through AGPA, ASGW, and APA. The Gestalt Institute has training centers in most large cities and offers a certification in psychodrama.

The National Institute of Expressive Psychotherapy offers a 2-year online program for those who have participated annually in the institute’s 2-day residency. Professionals are required to participate as a member of a role-playing or drama group before attending

classes in techniques and learning how to apply them with a population that has substance abuse problems. The National Expressive Therapy Association offers conferences, professional education, and in affiliation with the National Institute of Expressive Therapy, continuing education units, credentialing, and board certification.

## ***Cross-training***

Though group therapists work in the field of mental health, they generally have little training in the specifics of substance abuse treatment. This situation will have to change if the fields of substance abuse treatment and mental health are to integrate their activities.

To supplement courses that professional organizations offer individuals, agencies can use a case study approach. Case studies that include educational materials on diagnosis, symptoms, and treatment serve as a good foundation for cross-training. The cases that cause counselors to struggle the most could be analyzed. What strategies were used? What were the outcomes? What alternatives did other staff recommend? Case conferences can be conducted at weekly staff development sessions, as part of regular meetings, or (more quickly) at morning feedback meetings on clinical topics. A case conference might involve counselors, social workers, and psychologists.

## ***Legal issues***

It is important for therapists to know Federal regulations and the laws of their States, especially those concerning “duty to warn” stipulations regarding the abuse of children or elders, commitment procedures for psychiatric clients, and confidentiality laws pertaining to HIV/AIDS, adolescents, and managed care.

Practitioners should be familiar with the Federal confidentiality regulation, 42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. In addition, there are State laws that also guide the confidentiality of



alcohol and drug abuse information, and whichever is more restrictive (i.e., State law or Federal law) governs. Professional and legal organizations usually address these topics in their coursework. It is best to find such courses at the regional or State level, so that attendees can grasp the laws governing residents in their specific geographical areas.

## **Videos**

While impersonal media cannot replace the relationships between supervisors and trainees, videos can be used to explain theoretical principles, provide information on various types of drugs, and support skills-building activities.

## **Distance learning**

Distance learning systems, which often communicate via cable or satellite, can assist with explaining concepts, theories, and case studies. Like videos, distance learning may lack the close personal relationship with a supervisor, but interactive forms of distance learning do permit questions, comments, and requests for clarification.

Group therapy for trainees using an online chat room is an interesting possibility and could be especially helpful to people in remote settings. Licensing boards, however, would first need to resolve any potential legal issues regarding confidentiality. Also, some critics have worried that computerized communication would interfere with attachment (one of the most powerful therapeutic factors). This problem does not seem to occur in educational seminars conducted online (see Figure 7-2 on p. 132).

Every State has a credentialing process for substance abuse treatment professionals, and NAADAC lists all the particulars at <http://www.NAADAC.org>. At the same address, NAADAC posts training calendars and a great deal of other information on training opportunities.

The 14 regional Addiction Technology Transfer Centers (ATTCs), launched by SAMHSA's CSAT in 1993, connect substance abuse

treatment professionals to a wide variety of useful information. ATTCs

- Provide State-by-State credentialing information
- Post news in the field
- List new resources, including publications
- Translate technical and academic journal articles into easy-to-read language
- List alcohol and other drug treatment programs in each State
- Provide a worldwide catalog of online courses

To tap into ATTC's lode of professional development information, log onto <http://www.nattc.org>.

## **Supervision**

Supervisory oversight is a significant training requirement for group therapists. Powell (1993) defines clinical supervision as "a disciplined, tutorial process wherein principles are transformed into practical skills with four overlapping foci—administrative, evaluative, clinical, and supportive." Powell's description points out that the clinical supervisor has an administrative task, namely the development of an appropriate supervision plan for clinician trainees. This task includes planning, coordination, and delegation of responsibilities; determining appropriate staff assignments; and helping to define administrative policies and procedures.

In addition, the clinical supervisor has duties in the sphere of evaluation. As the skills and knowledge of new group facilitators begin to grow, they need consistent, useful feedback that will direct their work and will support professional growth. In the early stages of

Every State has a credentialing process for substance abuse treatment professionals.

### ***Does Online Communication Impede Attachment?***

As a faculty member with the Fielding Graduate Institute, a distance learning program, I teach psychology in both on- and offline formats. In many of the online seminars, students post their papers and comment on the contributions of others. The students are dispersed around the country, so few (if any) know each other prior to the seminar.

Even though the students' interactions are asynchronous (that is, not in real time; a lag separates comment and response), a group of learners develops that is indistinguishable from learners sitting in the same room together. Alliances develop between students who share similar ideas, and disagreements take place between opposing positions. The attachments that develop through the written word outside of real time seem as genuine as any other relationships.

In the online seminars, some students find in cyberspace a safer format than traditional classes. Not having to confront all the verbal cues that may distract people in a face-to-face conversation, learners are freer to be genuine. Several of my students who were involved in a seminar with in-person and online components were more interactive and spontaneous in the online segment.

I don't see why these dynamics would be different in supervisory groups. I don't know of any online therapy groups, but some AA meetings are conducted online.

Further, Haim Weinberg operates a discussion list that includes about 400 group therapists from more than 30 countries. This arena for exchanging ideas about group therapy behaves very much like any large group, with a few surprising departures. Among them:

- In this highly diverse group representing many schools of thought, conflicts do not arise over differing theoretical stances or the appropriateness of interventions. Instead, "word wars," (commonly called "flaming") break out due to impatience or personal attitudes and exchanges. One member wrote, for example, "I thought you either have to be very young and inexperienced or very rude and insulting." Some of the flaming seems to stem from misunderstandings that in turn result from having only words as cues. What is meant in jest, for example, may be taken seriously (Weinberg 2002).
- Traditionally, the larger the group, the more impersonal it was, but Weinberg finds startling self-disclosure and intimacy over the Internet. For example, a man whose newborn son had died wrote, "My heart is broken. Words can't convey the grief, and I realize only now that the depth of this pain is beyond comprehension. I feel waves of horrible sadness and utter bewilderment." Messages of condolence flooded back to the distraught father (Weinberg 2002).

*Source:* A Consensus Panel member.

group facilitation, answers to the question, “How am I doing?” are extremely important, but unfortunately, the question often goes unanswered. Appropriate clinical supervision

will not only keep this question in mind, but also provide clear, cogent responses to trainees. Figure 7-3 gives an example of group experiential training.

**Figure 7-3**

### **Group Experiential Training**

Through the Mountain Area Health Education Center in Asheville, North Carolina, I conducted an 18-month intensive group training and supervision experience, which is one of many ways to provide clinicians with an expanded knowledge base and the opportunity to sense the power of group therapy. The group met one Saturday a month from 9:00 a.m. to 6:00 p.m.

The model had three main components. The first, conducted in a direct instruction format, communicated basic, intermediate, and eventually advanced group skills. It also highlighted the role of failed attachment in the expression of addictive disease and the theoretical means by which groups address these concerns.

The trainees’ experiential group process, the second component, took place three times throughout the day. In these 1-hour sessions, trainees participated in a training group. From the outset, it was made clear that this training group was not therapy. Although personal information inevitably was shared, the primary purpose of the experience was trainees’ encounter with the here-and-now aspects of interpersonal group process, while being exposed to the same anxieties, excitement, and achievements that clients feel within the context of group. At the end of each experiential group process, trainees evaluated not only the group process, but also reflected on aspects of the supervisor’s leadership style, commenting on its facilitation of the process or difficulties it presented.

The third aspect of this training and supervision experience was an in-depth evaluation of the clinical experiences of the trainees. At each session, group members brought in clinical issues that occurred in their practice for comment, discussion, and review. They received information not only from the group supervisor, but also from peers. This opportunity enabled trainees to integrate a theory base with practice, thus satisfying one of Powell’s key components of clinical supervision, that is, “a tutorial process wherein principles are transformed into practical skills” (Powell 1993).

After leading this intensive experience, as well as many less intensive 30-hour training courses in group therapy, the need for such continuing training opportunities is clear to us. We can say with some authority that the continued advancement of one’s personal skills is essential, from initiation into the field throughout the trajectory of a professional’s career.

*Source:* A Consensus Panel member.

The supervisory alliance is needed to teach the trainee the skills and knowledge required to lead groups effectively.

The *clinical* function that the supervisor fulfills is the development of a basic core of knowledge and skills, which includes an in-depth understanding of addictive disease, an integrated model of group process, group dynamics, and the stages of group development.

The interaction between supervisory personnel and trainees has a *supportive* function, which is vital to the growth of trainees.

When they begin to apply their newly acquired knowledge is the time that they need the most support and the most discerning supervision.

Clinical supervision, as it pertains to group therapy, often is best carried out within the context of group supervision. Group dynamics and group process facilitate learning by setting up a microcosm of a larger social environment. Each group member's style of interaction will inevitably show up in the group transactions. Given enough time, all the people in the supervisory group will interact with group members just as they interact with others in wider social and clinical spheres, and every person will create in the group the same interpersonal universe inhabited outside the group. As this process unfolds, group members, guided by the supervisor, learn to model effective behavior in an accepting group context.

For the beginning counselor, supervisory groups reduce, rather than escalate, the level of threat that can accompany supervision. In place of isolation and alienation, group participation gives counselors a sense of community. They find that others share their worries, fears, frustrations, temptations, and ambiva-

lence. This reassurance is especially beneficial to novice counselors. Further,

- Group disclosure increases the potential for self-disclosure and confirmation, creating opportunities for growth.
- Empathy and sharing of interests are available to a greater extent than in individual supervision.
- Working together over time, a group can reinforce its members' personal growth.
- Alternative clinical approaches and methods of helping are available to a far greater extent than in dyadic supervision. As a result, group members acquire a broad perspective on counseling styles.
- Each counselor can do reality testing, presenting perceptions for peer scrutiny, and possibly, validation.
- The potential for critique is greatly expanded (Powell 1993).

For treatment facilities, group supervision is attractive in its efficiency and effectiveness:

- It provides a cost-effective way of supervising more people in the same amount of time.
- The diversity of people in the group increases opportunities for learning. The number of group members (up to the desired limit of four to six members) exponentially expands the range of learning opportunities.
- Group supervision creates a working alliance among counselors, engendering a sense of psychological safety and reducing self-defeating behavior (Powell 1993).

## The Supervisor's Essential Skills

A supervisor should be competent in several content areas, including substance abuse treatment, group training, cultural competence, and diagnosis of co-occurring conditions. A supervisor may be an administrator, an in-house trainer, or a therapist from another agency.

A recent survey of members of NAADAC indicates that many counselors receive and are

satisfied with weekly clinical supervision. However, a significant percentage of the respondents (who were not differentiated as to whether they work with individuals or groups) indicated they receive no clinical supervision (Culbreth 1999). This finding is disturbing considering the benefits of clinical supervision for the delivery of high-quality service to clients and the professional development of counselors. Other findings from the NAADAC survey have clear implications for supervisory training. For example, respondents preferred a supervisor who is a knowledgeable professional in the field and supervision that is more proactive and intentional than reactive (Culbreth 1999).

## **The Supervisory Alliance**

Some training experts believe the key to effective group therapy supervision is the development of the supervisory alliance. This positive working relationship between the supervisor and trainee is a unique and appropriate setting within which a new therapist can develop skills in group analysis and refine an ability to develop appropriate treatment strategies.

The supervisory alliance is needed to teach the trainee the skills and knowledge required to lead groups effectively and to make sure that the group accomplishes its purpose. The supervisor helps by establishing an open and collaborative climate, identifying the unique learning needs and styles of the supervisory group members, formulating a responsive supervisory contract, and pinpointing any problems that emerge within the alliance (Kleinberg 1999). Supervision also includes encouraging and mentoring students from specific cultural groups, since it is difficult to locate well-trained therapists to treat certain populations.

## **Assessment of trainee skills**

The supervisor should be able to assess the various domains that trainees are required to master.

- Clinical skills (from selecting prospective group members and designing treatment

strategies to planning and managing termination)

- Comprehensive knowledge of substance abuse, which, depending upon the treatment setting, could entail broad general knowledge of, or a thorough facility with, a particular field
- Knowledge of the preferred theoretical approach
- Knowledge of psychodynamic theory
- Knowledge of group dynamics theory
- Knowledge of the institution's preferred theoretical approaches
- Diagnostic skills for determining co-occurring disorders
- Capacity for self-reflection, such as recognizing one's own vulnerability and, when this problem arises, the ability to monitor and govern behavioral and emotional reactions
- Consultation skills, such as the ability to consult with a referring therapist, provide feedback, and coordinate treatment in both individual and group modes
- Capacity to be supervised; for example, openness in supervision, setting goals for training, and discussing with supervisor one's learning style and preferences (Kleinberg 1999)

## **Planning ways to train new counselors**

In planning a training approach, a supervisor needs to consider the characteristics of the supervisory team, that is, the supervisor plus the trainees. Variables to be considered include

- The sophistication of trainees' knowledge and skills
- The supervisory setting
- The characteristics of the client population
- The nature of the supervised treatment
- The personality fit of the members on the supervisory team
- The format of the supervision
- The theoretical compatibility of the supervisory team (Kleinberg 1999)



After weighing all these variables, the supervisor discusses the focus and goals of the work with the team. The particulars will take shape as the supervisory contract. The necessary mastery of specified clinical subjects, as well as the skills associated with them, can be developed through reading assignments, video presentations, written assessments, and both direct and indirect supervision.

## Funding for Training and Supervision Programs

Given the time and financial resources needed to create formal academic preparation programs, it is a challenge to provide extended training (beyond 1- and 2-day seminars) that is well grounded in theory and application and that addresses the needs of substance abuse counselors, especially those leading therapy groups. The best way to fund such training is to incorporate it into an agency or organization budget. These outlays should be viewed as investments that pay handsome dividends. For instance, opportunities for training can help attract new, highly motivated employees.

One alternative source of funding is a Federal or State grant. Such funds are often available, though frequently they require a great deal of administrative work and strict adherence to specific guidelines for project direction, staffing, and evaluation. Grants are also available to agencies and individuals through certain professional and training organizations. For example, AGPA gives scholarships to students who wish to attend its annual meetings and training conferences.

It is a challenge to provide extended training that is well grounded in theory and application.

Other options can be found through the Foundation Center, a nonprofit library system that

- Collects and disseminates information on sources of funding
- Conducts and promotes research on trends in philanthropy
- Provides education on grant seeking
- Publishes *The Foundation Directory*, available on CD-ROM through *The Foundation Center*

The five foundation libraries (located in Atlanta, Cleveland, New York, San Francisco, and Washington) provide many resources with information on grants for projects related to health and education. The center has recently designed a virtual classroom to assist in

- Researching philanthropy
- Writing proposals
- Identifying nearby corporations, government agencies, and other sources of funds in specific geographical areas
- Training in fundraising
- Online fundraising

The Foundation Center can be reached at <http://www.fdncenter.org>. The Frequently Asked Questions section on this Web site is a useful introduction to the center's services.

As with training, an inherent cost is associated with high-quality clinical supervision, both in financial commitment and clinical time. Despite the positive returns that stem from good, better, or best clinical supervision, staff resources, agency or organizational requirements, and the needs of the leader in training often dictate the specific type of supervision available.

Every agency providing services to clients abusing substances should take clinical supervision seriously and direct appropriate resources toward constant improvement through the clinical supervision process.

# Appendix A: Bibliography

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