Group Therapy Treatment for Substance Abuse (Revised) Part 2

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Overview

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

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

Fixed and Revolving Membership Groups

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

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

Fixed Membership Groups

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

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

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

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

In ongoing groups with fixed membership, the size of the group is set; new members enter only when there is a vacancy. The leader generally is less active than is the leader of a time-limited group, since the interaction among group members is more important than leader-to-member interactions. To conduct this type of group, the leader needs substantial training in group dynamics (such as individuals' boundaries and the roles different members assume) and leadership along with excellent supervisory skills. Examples in this category include interpersonal process groups and some psychoeducational therapy groups.

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

Revolving Membership Groups

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

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

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

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

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

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

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

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

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

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

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

Preparing for Client Participation in Groups

Pregroup Interviews

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

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

Figure 4-1

Characteristics of Fixed and Revolving Membership Groups

	Entry	Group Development	Examples
Fixed Membership Groups			
Time-limited	• New members admitted only in earliest stages of group development • Groups begin and end with same membership	• Learning built on what has happened in prior meetings	• Short-term therapy groups • Skills-building and psychoeducational groups • Relapse prevention groups
Ongoing	• Group size fixed • New members enter only after vacancy or graduation • Members expected to stay for a substantial period of time	• Dynamics of group process (such as individuals' boundaries and the roles different members assume) are the primary source of learning, healing for participants	• Ongoing interpersonal process groups • Long-term supportive therapy groups
Revolving Membership Groups			
Time-limited	• Number of sessions usually fixed	• Learning at each session relatively independent of previous group sessions	• Expressive therapy groups (dance therapy, psychodrama) • Psychoeducational groups • Some skills-building groups
Ongoing	• Clients may (1) stay as long as they wish, (2) be required to attend sessions with set topics, or (3) be required to attend set number of weeks • Usually a set maximum number of participants	• More structured • Active leadership	• Client hall groups • Day hospital check-in groups • Continuing care drop-in groups • Transition groups for clients leaving inpatient and moving to outpatient care • Psychoeducational groups • Expressive therapy groups • Long-term supportive groups, such as ongoing continuing care groups and maintenance groups

explain the group agreement. These activities may take as little as one meeting or as long as several weeks (Rutan and Stone 2001). Normally, the longer the expected duration of the group, the longer the preparation phase. Clients should have an opportunity to air any concerns, especially if they are apprehensive about their cultural status within the group. During this time, the group facilitator should learn how the client handles interpersonal functions on a day-to-day basis, how the client's family functions, and how the client's culture perceives the substance abuse problem.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Increasing Retention

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

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

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

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

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

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

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

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

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

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

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

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

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

Identifying the Need for Wraparound Services

Practical problems, such as a lack of suitable childcare or transportation, deter many clients from participation in substance abuse counseling services. Many programs find that when they provide wraparound services to meet these and other practical needs, they retain clients in therapy longer. As a result, clients are more likely to develop new behaviors and thought processes that enable them to remain abstinent. Two examples of programs that provide such services are described in Figures 4-2 and 4-3.

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

Figure 4-2

The Family Care Program of the Duke Addictions Program

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

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

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

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

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

Figure 4-3

SageWind

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

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

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

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

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

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

Source: A Consensus Panel member.

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

Group Agreements

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

A group member's acceptance of the contract before entering a group has been described as the single most important factor contributing to the success of outpatient therapy groups (Flores 1997). Consequently, it is important to present the contract in a way that causes clients to view it as a true commitment and not a mere formality. Particularly with people referred to treatment through the criminal justice system, it is important to make therapeutic contracts that are explicit and clear, and that carry a firm expectation that the agreement is to be honored by all members of the group.

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

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

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

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

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

Figure 4-4

Examples of Agreements About Time and Attendance

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

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

Communicating grounds for exclusion

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

Confidentiality

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

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

Under some circumstances, as defined by the Federal confidentiality regulation or by more stringent State regulation, certain information may be shared. However, the information shared without consent is restricted by the minimum necessary clause. Refer to 42 C.F.R., Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records to identify the specific circumstances under which these exceptions apply. Group members should know what information about them might be shared and why, how, and when this sharing occurs, so they do not feel betrayed when someone outside the group knows about something said within the group.

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

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

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

Physical contact

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

Use of mood-altering substances

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

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

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

Contact outside the group

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

Figure 4-5

Examples of Agreements About Group Participation

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

Participation in the life of the group

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

Financial responsibility

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

Termination

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

Premature termination (dropping out) may have serious consequences for some clients.

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

Phase-Specific Group Tasks

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

Beginning Phase—Preparing the Group To Begin

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

Introductions

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

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

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

Ideally, membership changes should be held to a minimum, especially in fixed membership groups, though as members graduate, new members will need to enter to ensure survival of the group. In contrast, revolving membership groups may have frequent changes because of the demands of treatment payment guidelines or admission and discharge procedures. Careful thought should be given to the pace and timing of membership changes for particular group types.

Group agreement review

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

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

Providing a safe, cohesive environment

During the beginning phase of the group, all members should feel that they have a part to play in the group and have something in common with other members. This cohesion, both among clients and between the clients and the group leader, will affect the productivity of work throughout the therapeutic process. Among the many components of group cohesion are "connectedness of the group demonstrated by working toward a common therapeutic goal;

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

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

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

The leader also is responsible for ensuring that early in the group, emotional expression stays at a manageable level. Otherwise, members quickly may feel emotionally overloaded and begin to withdraw. Care always should be taken not to shame group members or to allow others in the group to engage in shaming behaviors.

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

Establishing norms

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

Figure 4-6

Reminders for Each Group Session

Open.

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

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

Track process.

To refocus the direction of the group, ask:

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

Figure 4-6

Reminders for Each Group Session (continued)

Don't fight what is hard—use it!

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

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

Connect before tackling. Ally before confronting or stopping behavior.

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

Encourage mutual connections among members.

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

Share the work.

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

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

Close.

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

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

Source: Vannicelli, unpublished manuscript.

self-disclosure, the desire for insight into one's own behavior, nonjudgmental acceptance of others, and the determination to change unhealthy practices (Flores 1997). Unhealthy norms that could hamper a process group include a tendency to become leader-centered, one-dimensional (that is, all-loving or all-attacking), or so tightly knit that the group is hostile to new members (Flores 1997). The leader should respond quickly and clearly to habits that impede group work and that threaten to become normative.

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

Initiating the work of the group

The leader facilitates the work of the group, whether by providing information in a psychoeducational group or by encouraging honest exchanges among members in other types of groups. Most leaders strive to keep the focus on the here and now as much as possible. The leader also may need to prompt a new group with questions such as, "You seem to be responding to what Jane was sharing. Can you tell us something about what was going on for you as she was talking?" (Vannicelli 1992, p. 50).

Middle Phase—Working Toward Productive Change

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

Many new leaders focus strongly on content, but thoughtful attention to group process is extremely important. Even in an educational group, tension in the room, rolling eyes, or side conversations can interfere with messages that need attention. In a process group, these cues are part of the work and need to be explored actively, but even in more content-oriented groups, nonverbal cues are indicative and should not be ignored.

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

End Phase—Reaching Closure

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

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

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

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

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

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

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

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

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

It is natural for individuals and groups to try to hold onto each other. "Some isolated patients may postpone termination because they have been using the therapy group for social reasons rather than as a means for developing the skills to create a social life for themselves in their home environment. The therapist should help these members focus on transfer of learning and encourage risk taking outside the group" (Yalom 1995, p. 363). Alternatively, groups (and therapists) may subtly pressure a particular group member to remain because they value the departing member's contributions and will miss him or her. When a senior member leaves, however, another ordinarily will assume the role just vacated (Yalom 1995).

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

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

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

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

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

5 Stages of Treatment

In This Chapter...

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 unmedicated 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 suggests 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 methaphetamine). 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.

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

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 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).

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

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 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.

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

As the substance abuse problem fades into the background, significant underlying 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.

6 Group Leadership, Concepts, and Techniques

In This Chapter…

Overview

This chapter describes desirable leader traits and behaviors, along with the concepts and techniques vital to process groups—though many of the ideas can apply in other types of groups. Most of the ideas seem perfectly logical, too, once they are brought to mind.

For instance, consistency in manner and procedure helps to provide a safe and stable environment for the newly recovering person with a substance use disorder. When the upheaval in the lives of people recovering from addictions is considered, it becomes clear how important it is to keep as many factors as possible both constant and predictable.

The pages that follow discuss issues such as

- How to convert conflict and resistance into positive energy that powers the group
- How to deal with disruptive group members, such as clients who talk incessantly or bolt from a session
- How to cool down runaway affect or turn a crisis into an opportunity

People who abuse substances are a broad and diverse population, one that spans all ages and ethnic groups and encompasses people with a wide variety of co-occurring conditions and personal histories. In working with people who have substance use disorders, an effective leader uses the same skills, qualities, styles, and approaches needed in any kind of therapeutic group. The adjustments needed to treat substance abuse are simply that—adjustments within the bounds of good practice. The particular personal and cultural characteristics of the clients in group also will influence the therapist's tailoring of therapeutic strategies to fit the particular needs of the group.

The Group Leader

Personal Qualities

Although the attributes of an effective interpersonal process group leader treating substance abuse are not strikingly different from traits needed to work successfully with other client populations, some of the variations in approach make a big difference. Clients, for example, will respond to a warm, empathic, and life-affirming manner. Flores (1997) states that "many therapists do not fully appreciate the impact of their personalities or values on addicts or alcoholics who are struggling to identify some viable alternative lifestyle that will allow them to fill up the emptiness or deadness within them" (p. 456). For this reason, it is important for group leaders to communicate and share the joy of being alive. This life-affirming attitude carries the unspoken message that a full and vibrant life is possible without alcohol or drugs.

In addition, because many clients with substance abuse histories have grown up in homes that provided little protection, safety, and support, the leader should be responsive and affirming, rather than distant or judgmental. The leader should recognize that group members have a high level of vulnerability and are in need of support, particularly in the early stage of treatment. A discussion of other essential characteristics for a group leader follows. Above all, it is important for the leader of any group to understand that he or she is responsible for making a series of choices as the group progresses. The leader chooses how much leadership to exercise, how to structure the group, when to intervene, how to effect a successful intervention, how to manage the group's collective anxiety, and the means of resolving numerous other issues. It is essential for any group leader to be aware of the choices made and to remember that all choices concerning the group's structure and her leadership will have consequences (Pollack and Slan 1995).

Excellent listening skills are the keystone of any effective therapy.

Constancy

An environment with small, infrequent changes is helpful to clients living in the emotionally turbulent world of recovery. Group facilitators can emphasize the reality of constancy and security through a variety of specific behaviors. For example, group leaders always should sit in the same place in the group. Leaders also need to respond consistently to particular behaviors. They should maintain clear and consistent boundaries, such as specific start and end times, standards for comportment, and ground rules for speaking. Even dress matters. The setting and type of group will help determine appropriate dress, but whatever the group leader chooses to wear, some predictability is desirable throughout the group experience. The group leader should not come dressed in a suit and tie one day and in blue jeans the next.

Active listening

Excellent listening skills are the keystone of any effective therapy. Therapeutic interventions require the clinician to perceive and to understand both verbal and nonverbal cues to meaning and metaphorical levels of meaning. In addition, leaders need to pay attention to the context from which meanings come. Does it pertain to the here-and-now of what is occurring in the group or the then-and-there history of the specific client?

Firm identity

A firm sense of their own identities, together with clear reflection on experiences in group, enables leaders to understand and manage their own emotional lives. For example,

therapists who are aware of their own capacities and tendencies can recognize their own defenses as they come into play in the group. They might need to ask questions such as: "Am I cutting off discussions that could lead to verbal expression of anger because I am uncomfortable with anger? Have I blamed clients for the group's failure to make progress?"

Group work can be extremely intense emotionally. Leaders who are not in control of their own emotional reactions can do significant harm—particularly if they are unable to admit a mistake and apologize for it. The leader also should monitor the process and avoid being seduced by content issues that arouse anger and could result in a loss of the required professional stance or distance. A group leader also should be emotionally healthy and keenly aware of personal emotional problems, lest they become confused with the urgent issues faced by the group as a whole. The leader should be aware of the boundary between personal and group issues (Pollack and Slan 1995).

Confidence

Effective group leaders operate between the certain and the uncertain. In that zone, they cannot rely on formulas or supply easy answers to clients' complex problems. Instead, leaders have to model the consistency that comes from self-knowledge and clarity of intent, while remaining attentive to each client's experience and the unpredictable unfolding of each session's work. This secure grounding enables the leader to model stability for the group.

Spontaneity

Good leaders are creative and flexible. For instance, they know when and how to admit a mistake, instead of trying to preserve an image of perfection. When a leader admits error appropriately, group members learn that no one has to be perfect, that they—and others—can make and admit mistakes, yet retain positive relationships with others.

Integrity

Largely due to the nature of the material group members are sharing in process groups, it is all but inevitable that ethical issues will arise. Leaders should be familiar with their institution's policies and with pertinent laws and regulations. Leaders also need to be anchored by clear internalized standards of conduct and able to maintain the ethical parameters of their profession.

Good leaders are creative and flexible.

Trust

Group leaders should be able to trust others. Without this capacity, it is difficult to accomplish a key aim of the group: restoration of group members' faith and trust in themselves and their fellow human beings (Flores 1997).

Humor

The therapist needs to be able to use humor appropriately, which means that it is used only in support of therapeutic goals and never is used to disguise hostility or wound anyone.

Empathy

Empathy, one of the cornerstones of successful group treatment for substance abuse, is the ability to identify someone else's feelings while remaining aware that the feelings of others are distinct from one's own. Through these "transient identifications" we make with others, we feel less alone. "Identification is the antidote to loneliness, to the feeling of estrangement that seems inherent in the human condition" (Ormont 1992, p. 147).

For the counselor, the ability to project empathy is an essential skill. Without it, little can be

accomplished. Empathic listening requires close attention to everything a client says and the formation of hypotheses about the underlying meaning of statements (Miller and Rollnick 1991). An empathic substance abuse counselor

- Communicates respect for and acceptance of clients and their feelings
- Encourages a nonjudgmental, collaborative relationship
- Is supportive and knowledgeable
- Sincerely compliments rather than denigrates or diminishes another person
- Tells less and listens more
- Gently persuades, while understanding that the decision to change is the client's
- Provides support throughout the recovery process (Center for Substance Abuse Treatment [CSAT] 1999*b*, p. 41)

One of the great benefits of group therapy is that as clients interact, they learn from one another. For interpersonal interaction to be beneficial, it should be guided, for the most part, by empathy. The group leader should be able to model empathic interaction for group members, especially since people with substance use disorders often cannot identify and communicate their feelings, let alone appreciate the emotive world of others. The group leader teaches group members to understand one another's subjective world, enabling clients to develop empathy for each other (Shapiro 1991). The therapist promotes growth in this area simply by asking group members to say what they think someone else is feeling and by pointing out cues that indicate what another person may be feeling.

The group leader should be able to model empathic interaction for group members.

One of the feelings that the group leader needs to be able to empathize with is shame, which is common among people with substance abuse histories. Shame is so powerful that it should be addressed whenever it becomes an issue. When shame is felt, the group leader should look for it and recognize it (Gans and Weber 2000). The leader also should be able to empathize with it, avoid arousing more shame, and help group members identify and process this painful feeling. Figure 6-1 discusses shame and group therapy.

Leading Groups

Group therapy with clients who have histories of substance abuse or dependence requires active, responsive leaders who keep the group lively and on task, and ensure that members are engaged continuously and meaningfully with each other. Leaders, however, should not make themselves the center of attention. The leader should be aware of the differing personalities of the group members, while always searching for common themes in the group. Themes to focus on, for example, might include loss, abandonment, and self-value (Pollack and Slan 1995).

Leaders vary therapeutic styles with the needs of clients

As explained in chapter 5, group leaders should modify their styles to meet clients' needs at different times. During the early and middle stages of treatment, the therapist is more active, becoming less so in the late stage. Moreover, during the late stage of treatment, the therapist should offer less support and gratification. This keeps the group at an "optimal level of anxiety," one that would be intolerable and counterproductive in the early or middle stages of treatment (Flores 1997).

To determine the type of leadership required to support a client in treatment, the clinician

Figure 6-1

Shame

Often failed attachments in childhood and failed relationships thereafter result in shame, an internalized sense of being inferior, not good enough, or worthless. Shame flares whenever clients encounter the discrepancy between their drug-affected behavior and personal or social values. In group therapy, feelings of shame may be intensified because feelings of self-consciousness are elevated and other group members are present. The presence of other group members "often stimulates regressive longings" (Gans and Weber 2000, p. 385). Furthermore, group members have a marked tendency to compare themselves with one another (Gans and Weber 2000). In the past, when group facilitators used highly confrontational efforts to break through denial and resistance, an undesirable side effect was intensified shame, which increased the likelihood that group members would relapse or leave treatment. Shame interferes dramatically with attempts to heighten a client's self-esteem, which in turn is important to recovery (Alonso and Rutan 1988).

Clients with addictions often are exquisitely sensitive and prone to project their shame onto relationships within the group. Often, at an unconscious level, they anticipate disapproval or hostility when none was intended. In this way, clients may demote themselves to the role of secondary player in the group.

One way to neutralize unintentionally shame-provoking comments is to reframe member-to-member communications. For example, if a group member asks, "Sally, where were you last week? You didn't come to group." Sally may interpret the question as a criticism or even an implication that she has returned to active use. The group facilitator may choose to reframe this member-to-member communication by speaking to the concern that the questioner really has for Sally's well-being.

This reframing would begin with the group leader asking why the group member wanted to know where Sally had been, adding something like, "I suspect your question reflects the feeling that you missed Sally last week and find group more enjoyable when she is here."

By focusing on positive interactions that reveal competency, the group facilitator helps move clients from shame to an affirmative image of themselves. The group leader should pay attention to member-to-member interaction, looking for instances of relational competence and support. The leader's supportive interactions eventually develop into group norms that combat the shame attached to addictive illness.

Source: Consensus Panel.

should consider the client's capacity to manage affect, level of functioning, social supports, and stability, since these factors have some bearing upon alcohol or illicit drug use. These considerations are essential to determine the type of group best suited to meet the client's needs. For example, a client at the beginning stage of treatment who is high functioning and used to working in groups generally will require a less active therapist and less structure. On the other hand, a lower-functioning client who has little or no group experience and is just beginning treatment would best be placed in a structured, task-oriented group. Such a person also would benefit from a clinician who more actively expresses warmth and acceptance, thus helping to engage the client.

Cotherapy is extremely powerful when carried out skillfully.

Leaders model behavior

It is more useful for the therapist to model group-appropriate behaviors than to assume the role of mentor, showing how to "do recovery." For example, the therapist can model the way to listen actively, give accurate feedback, and display curiosity about apparent discrepancies in behavior and intent.

Therapists should be aware that self-disclosure is always going on, whether consciously or unconsciously. They intentionally should use self-disclosure only to meet the task-related needs of the group, and then only after thoughtful consideration, perhaps including a discussion with a supervisor.

Both therapists and their institutions should have a thoughtful policy about self-disclosure, including disclosure of a therapist's past experiences with substance abuse or addiction. Too often, self-disclosure occurs to meet the therapist's own needs (for example, for affiliation and approval) or to gratify clients. When personal questions are asked, group leaders need to consider the motivation behind the question. Often clients are simply seeking assurance that the therapist is able to understand and assist them (Flores 1997).

Leaders can be cotherapists

Cotherapy is an effective way to blend the diverse skills, resources, and therapeutic perspectives that two therapists can bring to a group. In addition, cotherapy is beneficial because, if properly carried out, it can provide

- The opportunity to watch "functional, adaptive behavior in the co-leader pair"
- Additional opportunities for family transferences when the leaders are of different genders
- An opportunity for "two sets of eyes to view the situation" (Vannicelli 1992, p. 238)

Cotherapy, also called coleadership, is extremely powerful when carried out skillfully. A male–female cotherapy team may be especially helpful, for a number of reasons. It allows clients to explore their conscious and subconscious reactions to the presence of a parental dyad, or pair. It shows people of opposite sexes engaging in a healthy, nonexploitative relationship. It presents two different gender role models. It demonstrates role flexibility, as clients observe the variety of roles possible for a male or a female in a relationship. It provides an opportunity for clients to discover and work through their gender distortions (Kahn 1996).

Frequently, however, cotherapy is not done well, and the result is destructive. At times, a supervisor and a subordinate act as cotherapists, and power differentials result. Alternatively, cotherapists are put together out of convenience, rather than their potential to work well together and improve and facilitate group process. True cotherapy takes place

between clinicians of equal authority and mutual regard. (Naturally, the foregoing does not apply to training opportunities in which a trainee sits in with a seasoned group therapist. In such a setting, the trainee functions as an observer, not a cotherapist.)

Problems also may arise because institutions and leaders fail to allow enough time for cotherapists to prepare for group together and to process what has happened after the group has met. Some suggest that cotherapists confer for as much time outside the group as the length of the group itself, that is, 45 minutes of consultation for each 45-minute group session. While this amount of time may be ideal, the realities of most organizations do not make this level of commitment feasible. At the least, however, cotherapists should have a minimum of 15 minutes before and after each group meets.

Personal conflict or professional disagreements can be a third source of negative effects on the group. Thus, cotherapists should carefully work out their own conflicts and develop a leadership style suitable for the group before engaging in the therapeutic process. Cotherapists also should work out important theoretical differences before taking on a group, reaching full agreement on their view of the group and appropriate ways to facilitate the group's development (Wheelan 1997). Achieving a healthy, collaborative, and productive cotherapy team will require a "(1) commitment of time and sharing, (2) the development of [mutual] respect…and (3) use of supervision to work out differences and identify…problems" (Kahn 1996, p. 443).

Inevitably, cotherapist relationships will grow and evolve over time. The relationship between the cotherapists and the group, too, will evolve. Both the cotherapists and the group should recognize this process and be ready to adapt to constant change and growth (Dugo and Beck 1997). The most successful cotherapy is carried out "by partners who make a commitment to an ongoing relationship, who reason with each other, and who accept responsibility to work on the evolution of their relationship" (Dugo and Beck 1997, p. 2). The development of a healthy relationship between cotherapists will have a positive effect on their relationship to the group, relationships among members of the group, and on individuals within the group as they experience the continuous changes and growth of the group (Dugo and Beck 1997).

Leaders are sensitive to ethical issues

Group therapy by nature is a powerful type of intervention. As the group process unfolds, the group leader needs to be alert, always ready to perceive and resolve issues with ethical dimensions. Some typical situations with ethical concerns follow.

Overriding group agreements

Group agreements give the group definition and clarity, and are essential for group safety. In rare situations, however, it would be unethical not to bend the rules to meet the needs of an individual. For example, group rules may say that failure to call in before an absence from group is cause for reporting the infraction to a referring agency. If the client can demonstrate that an unavoidable emergency prevented calling in, the group leader may agree that the offense does not merit a report. Furthermore, the needs of the group may sometimes override courtesies shown to an individual. For example, a group may have made an agreement not to discuss any group member when that member is not present. If, however, a member should relapse, become seriously ill, or experience some other dire problem, the no-discussion rule has to be set aside if the group leader is to allow the

Group agreements give the group definition and clarity, and are essential for group safety.

members to express their concerns for the missing member and to consider how that person's problem affects the group as a whole.

Informing clients of options

Even when group participation is mandated, clients should be informed clearly of the options open to them. For example, the client deserves the option to discuss with program administrators any forms of treatment or leadership style that the client believes to be inappropriate. In such an instance, issues of cultural competence should be kept in mind, because what is appropriate for an individual or a group is by no means universal.

Preventing enmeshment

Leaders should be aware that the power of groups can have a dark side. Although cohesion is a positive outcome to be sought and supported, the strong desire for affiliation also can place undue pressure on group members who already are in the throes of a major transition from substance abuse to abstinent lives. The need to belong is so strong that it can sometimes cause a client to act in a way that is not genuine or consistent with personal ethics. Regardless of the kind of group, the leader needs to be aware of this possibility and to monitor group sharing to ensure that clients are not drawn into situations that violate their privacy or integrity. The leader is obligated to foster cohesion while respecting the rights and best interests of individuals.

The leader is obligated to foster cohesion while respecting the rights and best interests of individuals.

Acting in each client's best interest

It is possible that the group collectively may validate a particular course of action that may not be in a client's best interest. For example, if there is stress in one group member's marriage, other group members might support a course of action that could have dangerous or harmful consequences. Similarly, the group might engage in problem solving in some area of a member's life and recommend a course of action that would clearly be undesirable.

It is the responsibility of the group facilitator to challenge the group's conclusions or recommendations when they deny individual autonomy or could lead to serious negative consequences. Any such challenge, however, should come in a nonshaming fashion, primarily through the review of other options.

Handling emotional contagion

Another's sharing, such as an agonized account of sexual abuse, can stir frightening memories and intense emotions in listeners. In this powerful and emotional atmosphere, the spreading excitement of the moment, or emotional contagion, requires the leader to

- *Protect individuals.* The group leader should guard the right of each member to refrain from involvement. The leader makes it clear that each group member has a right to private emotions and feelings. When the group pressures a member to disclose information, the leader should remind the group that members need only reveal information about themselves at levels with which they are comfortable.
- *Protect boundaries.* Group pressure or the group leader's interest should not obligate anyone to disclose intimate details that the client prefers not to share. At the same time, clients are responsible for managing their feelings in the face of the group's power and deciding what they will and won't share.
- *Regulate affect.* At all times, the therapist should be mindful of the need to modulate

affect (emotionality), always keeping it at a level that enables the work of the group to continue. Yalom (1995) suggests an intervention that group leaders could use to limit conflict or almost any unacceptable escalation of affect: "We've been expressing some intense feelings here today….To prevent us from overload, it might be valuable to stop what we're doing and try together to understand what's been happening and where all these powerful feelings come from" (p. 350).

Working within professional limitations

Group leaders never should attempt to use group techniques or modalities for which they are not trained. When new techniques are used with any group, leaders should be certain to have appropriate training and the supervision of experts familiar with the techniques to be employed. Therapists likewise should decline to work with any population or in any situation for which they are unprepared. For example, an addiction counselor who has never run a long-term therapy group and has not learned how to do so should not accept an assignment to lead such a group. Further, a counselor cannot read about psychodrama and, using a workbook, successfully apply this highly charged technique with clients in an early stage of treatment. Such a misguided effort could have serious psychological consequences.

Ensuring role flexibility

Different group members may assume particular roles within the group. Natural leaders may emerge, as may a member who expresses anger for the group and someone who provides support. One client may take on a scapegoat role and then blame the group.

Playing different roles and examining their dynamics can provide a corrective emotional and interpersonal experience for the group. On the other hand, rigid roles can restrict group work. If, for example, a group consistently places individuals in particular roles, they may use their placements as defense mechanisms, thereby avoiding powerfully charged issues. It is easier, for example, to deal with the problems of being a scapegoat than it is to work on recovery from addiction.

While it is natural for group members to assume certain roles—there are, after all, natural leaders—individual members benefit from the opportunity to experience different aspects of themselves. Role variation also keeps the group lively and dynamic. These benefits will be lost if the same group members consistently assume the same roles in group. It is important for the group facilitator to support role sharing within the membership.

In all therapeutic settings, the clinician should be sensitive to issues of dual relationships.

Avoiding role conflict

In all therapeutic settings, the clinician should be sensitive to issues of dual relationships. A group leader's responsibilities outside the group that place him in a different relationship to group participants should not be allowed to compromise the leader's in-group role. For example, a client's group leader should not also be that client's Alcoholics Anonymous (AA) sponsor. Both roles and functions are important, but should not be performed by the same person. If the leader happens to be in recovery and is attending self-help meetings at which group members are present, this possible role conflict should be discussed with supervisors.

Ethical behavior is absolutely essential to group leadership. As the best practice guidelines (1998) from the Association for Specialists in Group Work (ASGW) declare, "ASGW views ethical process as being integral to group work and views Group Workers as ethical agents."

The ASGW statement is regarded as so important that the entire text is reproduced in appendix E.

Leaders improve motivation

Client motivation is a vital factor in the success of treatment for substance use disorders. Motivation-boosting techniques have been shown to increase both treatment participation and outcomes (Chappel 1994; Easton et al. 2000; Foote et al. 1999). Motivation generally improves when

- Clients are engaged at the appropriate stage of change.
- Clients receive support for change efforts.
- The therapist explores choices and their consequences with the client.
- The therapist honestly and openly communicates care and concern for group members.
- The therapist points out the client's competencies.
- Steps toward positive change are noted within the group and further encouragement is provided.

The therapist helps clients enjoy their triumphs with questions such as, "What's it like, Bill, to communicate your thoughts so clearly to Claire and to have her understand you so well?" or "What was it like to be able to communicate your frustration so directly?"

One effective motivational tool is the FRAMES approach, which uses the six key elements of Feedback, Responsibility, Advice, Menus (of change options), Empathic therapy, and Self-efficacy (Miller and Sanchez 1994). This approach engages clients in their own treatment and motivates them to change in ways that are the least likely to trigger resistance. The FRAMES approach is discussed in detail in chapter 2 of TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

When this kind of supportive technique is employed, however, a client's stage of change should be taken into account (see chapters 2 and 3 for more detailed discussions of the stages of change). Techniques to enhance motivation that are appropriate at one stage of change may not be useful at another stage and may even trigger treatment resistance or noncompliance (CSAT 1999*b*). For example, clients in the contemplation stage are weighing the pros and cons of continued substance abuse. An intervention for the action stage is appropriate for a client who has already made a commitment to change. If such an intervention is used too early, the client understandably may fail to cooperate.

Leaders overcome resistance

Resistance is especially strong among clients referred by the courts. It generally arises as a defense against the pain that therapy and examining one's own behavior usually brings. In group therapy, resistance appears at both the individual and the group level. The group leader should have a repertoire of means to overcome the resistance that prevents successful substance abuse treatment in groups (Milgram and Rubin 1992).

The group therapist should be prepared to work effectively against intense resistance to "experiencing, expressing, and understanding emotions" (Cohen 1997, p. 443). In order to overcome resistance to the experience of emotion, "the group members should experience feelings at a level of arousal wherein feelings are undeniable, but not to the extent that the group member is overcome" (Cohen 1997, p. 445).

Leaders defend limits

Providing a safe, therapeutic frame for clients and maintaining firm boundaries are among the most important functions of the group leader. For many group members, a properly conducted group will be the first opportunity to interact with others in a safe, supportive, and substance-free environment.

The boundaries established should be mutually agreed upon in a specific contract. When leaders point out boundaries and boundary violations, they should do so in a nonshaming,

nonjudgmental, matter-of-fact way. Some possible ways of dealing with this situation might be

- "This is a hard place to end, but . . ."
- "I know how angry you're feeling, but we have agreed . . ."

When boundary violations occur, group members should be reminded of agreements and given an opportunity to discuss the meaning and implication of the limit-breaking behavior as they see it. For example, if three group members are coming in late, the leader might say, "It's interesting that although everyone who joined the group agreed to arrive on time, many members are having a difficult time meeting this agreement." Or the leader might ask, "How would this group be different if everyone came on time?"

The group members may respond, for example, that they would not be obliged to repeat what already has been said to help latecomers catch up and, thus, get more out of each session. This group involvement in limit setting is crucial. It transmits power and responsibility to the group, and the leader avoids the isolated role of enforcer. While leaders inevitably will be regarded as authority figures, they certainly want to avoid creating the image of an insensitive, punitive authority.

Leaders maintain a safe therapeutic setting

Emotional aspects of safety

Group members should learn to interact in positive ways. In the process, leaders should expect that people with substance abuse histories will have learned an extensive repertoire of intimidating, shaming, and other harmful behaviors. Because such conduct can make group members feel unsafe, the leader should use interventions that deflect the offensive behavior without shaming the shamer.

Shame is not a point, but a range, some researchers argue. "Healthy" shame "helps to regulate a person's behavior in the service of preserving self-esteem, values, and personal connection" at one end of the continuum (Gans and Weber 2000, p. 382). At the other end is "unmetabolized shame," or shame that "in a narcissistically vulnerable person produces its pathological variants…Whereas guilt is a response to a thought or deed, shame connotes a more pervasive (self) condemnation" (Gans and Weber 2000, p. 382). It is thus potentially harmful to group members who are struggling to be honest with themselves and with the other group members.

The boundaries established should be mutually agreed upon in a specific contract.

The group needs to feel safe without blaming or scapegoating an individual member. If a member makes an openly hostile comment, the leader's response should state clearly what has happened and set a firm boundary for the group that makes clear that group members are not to be attacked. Sometimes, the leader simply may need to state what has occurred in a factual manner: "Debby, you may not have intended this effect, but that last remark came across as really hurtful."

When group members' responses lack empathy or treat one group member as a scapegoat, this targeted individual represents "a disowned part of other members of the group." Members may fault Sally repeatedly for her critical nature and lack of openness. The leader may intervene with a comment such as, "We've taken up time dealing with Sally's problems. My guess is that part of the reason the group is so focused on this is that it's something everybody in here knows a little about and that this issue has a lot of meaning for the group. Perhaps the group is trying to kick this characteristic down and beat it out because it's too close to home and simply cannot be ignored" (Vannicelli 1992, p. 125).

It is the therapist's responsibility to maintain the appropriate level of emotion and stimulation in the group.

When individual group members are verbally abusive and other group members are too intimidated to name the problem, the leader should find a way to provide "a safe environment in which such interactions can be productively processed and understood—not only by the attacking group member but also by the other members (who need to understand what is motivating their reluctance to respond)" (Vannicelli 1992, p. 165). To accomplish this goal, the leader may intervene with statements such as:

- *To the group as a whole:* "John has been pretty forthright with some of his feelings this evening. It seems as if others in here are having more difficulty sharing their feelings. Perhaps we can understand what it is about what John has shared or the way in which he shared it that makes it hard to respond" (Vannicelli 1992, p. 165).
- *To John:* "John, how do you suppose Mary might be feeling just now about your response to her?" or "If you had just received the kind of feedback that you gave to Mary, how do you suppose you'd be feeling right now?" (Vannicelli 1992, pp. 165–166).

Whatever intervention is used should show the group "that it is appropriate to let people know how you feel, and that people can learn in the group how to do this in a way that doesn't push others away" (Vannicelli 1992, p. 166).

A client can be severely damaged by emotional overstimulation. It is the therapist's responsibility to maintain the appropriate level of emotion and stimulation in the group. This will "prevent a too sudden or too intense mobilization of feeling that cannot be adequately expressed in language" (Rosenthal 1999*a*, p. 159). The therapist can achieve this control by warning potential group members of the emotional hazards of revealing their feelings to a group of strangers and by helping new members regulate the amount of their self-disclosure.

Substance use

In a group of people trying to maintain abstinence, the presence of someone in the group who is intoxicated or actively using illicit drugs is a powerful reality that will upset many members. In this situation, the leader should intervene decisively. The leader will make it as easy as possible for the person who has relapsed to seek treatment, but a disruptive member should leave the group for the present. The leader also will help group members explore their feelings about the relapse and reaffirm the primary importance of members' agreement to remain abstinent. Some suggestions follow for situations involving relapse:

- *If clients come to sessions under the influence of alcohol or drugs,* the leader should ensure that the individual does not drive home. Even a person walking home sometimes should be escorted to prevent falls, pedestrian accidents, and so on.
- If a client obviously is intoxicated at the beginning of the group, that person should be asked to leave and return for the next session in a condition appropriate for participation (Vannicelli 1992).

Vannicelli (1992) addresses several other situations that commonly occur:

Signs indicate that the client is not abstinent, but the client will not admit using alcohol or drugs. When signs (such as bloodshot eyes) indicate that the client is using substances repeatedly before coming to the group, but the client does not admit the infraction, the leader might:

- Use empathy to join with the client, letting the member know that the leader understands why it's hard to acknowledge substance use to the group.

- Describe the impasse, namely, that it is important that both client and therapist feel that they are in a credible relationship, but the way things are shaping up, it must be increasingly difficult for the client to come in week after week knowing that the therapist doubts him.
- Brainstorm, permitting the group to solve the problem and get past the impasse (Vannicelli 1992).

A client has been using alcohol or drugs, but will not acknowledge it. If other group members do not confront clients who are using substances, the leader should raise the issue in an empathic manner designed to encourage honesty, such as, "It must be hard for you, Sandy, to find yourself in a group in which you don't feel safe enough to talk about your drinking" (Vannicelli 1992, p. 65).

A client defiantly acknowledges using substances. A client who uses substances and clearly has no intention of stopping should be asked to leave the group. In contrast, a client who slips repeatedly needs an intervention that invites the group's help in setting conditions for continued participation: "It is clear, Maria, that you feel it is appropriate for you to stop using and yet, so far, the ways that you have been dealing with the problem have not been adequate. Since it is important that your behavior, as well as your words, support the group norm, we need to find ways that will be more effective in supporting abstinence." The group may then help set up specific requirements for Maria that will help her maintain abstinence. Suggestions might include increased AA participation, the development of a relapse prevention plan, increased supportive social contact, or the use of medications (like Antabuse for alcoholism) (Vannicelli 1992, p. 68).

Many outpatient groups have mandated clients who are required to submit to urine tests. The counselor is required to report infractions or test failures. These stipulations should appear in the group agreement, so they do not come as a surprise to anyone.

Boundaries and physical contact

When physical boundaries are breached in the group, and no one in the group raises the issue, the leader should call the behavior to the group's attention. The leader should remind members of the terms of agreement, call attention to the questionable behavior in a straightforward, factual way, and invite group input with a comment such as, "Joe, you appear to be communicating something nonverbally by putting your hand on Mary's shoulder. Could you please put your actions into words?"

Most agencies have policies related to violent behavior; all group leaders should know what they are. In groups, threatening behavior should be intercepted decisively. If necessary, the leader may have to stand in front of a group member being physically threatened. Some situations require help, so a lone leader should never conduct a group session without other staff nearby. On occasion, police intervention may be necessary, which could be expected to disrupt the group experience completely.

The leader should not suggest touching, holding hands, or group hugs without first discussing this topic in group. This tactic will convey the message that strong feelings should be talked about, not avoided. In general, though, group members should be encouraged to put their thoughts and feelings into words, not actions.

Whenever the therapist invites the group to participate in any form of physical contact (for example, in psychodrama or dance therapy), individuals should be allowed to opt out without any negative perceptions within the group. All members uncomfortable with

A group may need to set up specific requirements to help a member maintain abstinence.

physical contact should be assured of permission to refrain from touching or having anyone touch them.

Group leaders carefully monitor the level of emotional intensity in the group.

Leaders also should make sure that suggestions to touch are intended to serve the clients' best interests and not the needs of the therapist. Under no circumstances should a counselor ask for or initiate physical contact. Like their clients, counselors need to learn that such impulses affect them as well. Nothing is wrong with feeling attracted to a client. It is wrong, however, for group leaders to allow these feelings to dictate or influence their behavior.

Leaders help cool down affect

Group leaders carefully monitor the level of emotional intensity in the group, recognizing that too much too fast can bring on extremely uncomfortable feelings that will interfere with progress—especially for those in the earlier stages of recovery. When emotionally loaded topics (such as sexual abuse or trauma) come up and members begin to share the details of their experiences, the level of emotion may rapidly rise to a degree some group members are unable to tolerate.

At this point, the leader should give the group the opportunity to pause and determine whether or not to proceed. The leader might ask, "Something very powerful is going on right now. What is happening? How does it feel? Do we want to go further at this time?"

At times, when a client floods the room with emotional information, the therapist should mute the disturbing line of discussion. The leader should not express discomfort with the level of emotion or indicate a wish to avoid hearing what was being said. Leaders can say something such as

- "As I ask you to stop, there's a danger that what you hear is, 'I don't want to hear you.' It's not that. It's just that for now, I'm concerned that you may come to feel as if you have shared more than you might wish."
- "I'm wondering how useful it would be for you to continue with what you're doing right now." This intervention teaches individuals how to regulate their expression of emotions and provides an opportunity for the group to comment.
- "Let's pause for a moment and every few minutes from now. How are you feeling right now? Let me know when you're ready to move on."

A distinction needs to be made whether the strong feelings are related to there-and-then material or to here-and-now conduct. It is far less unsettling for someone to express anger—even rage—at a father who abused her 20 years ago than it is to have a client raging at and threatening to kill another group member. Also, the amount of appropriate affect will differ according to the group's purpose. Much stronger emotions are appropriate in psychodrama or gestalt groups than in psychoeducational or support groups.

For people who have had violence in their lives, strong negative emotions like anger can be terrifying. When a group member's rage adversely affects the group process, the leader may use an intervention such as

- "Bill, stop for a moment and hear how what you're doing is affecting other people."
- "Bill, maybe it would be helpful for you to hear what other people have been thinking while you've been speaking."
- "Bill, as you've been talking, have you noticed what's been happening in the group?"

The thrust of such interventions is to modulate the expression of intense rage and encourage the angry person and others affected by the anger to pay attention to what has happened. Vannicelli (1992) suggests two other ways to modulate a highly charged situation:

- Switch from emotion to cognition. The leader can introduce a cognitive element by asking clients about their thoughts or observations or about what has been taking place.
- Move in time, from a present to a past focus or from past to present.

When intervening to control runaway affect, the leader always should be careful to support the genuine expressions of emotion that are appropriate for the group and the individual's stage of change.

Leaders encourage communication within the group

In support and interpersonal process groups, the leader's primary task is stimulating communication among group members, rather than between individual members and the leader. This function also may be important on some occasions in psychoeducational and skills-building groups. Some of the many appropriate interventions used to help members engage in meaningful dialog with each other are

- Praising good communication when it happens.
- Noticing a member's body language, and without shaming, asking that person to express the feeling out loud.
- Building bridges between members with remarks such as, "It sounds as if both you and Maria have something in common . . ."
- Helping the group complete unfinished business with questions such as, "At the end of our session last time, Sally and Joan were sharing some very important observations. Do you want to go back and explore those further?"
- When someone has difficulty expressing a thought, putting the idea in words and asking, "Have I got it right?"
- Helping members with difficulty verbalizing know that their contributions are valuable and putting them in charge of requesting assistance. The leader might ask, "I can see that you are struggling, Bert. My guess is that you are carrying a truth that's important for the group. Do you have any sense of how they can help you say it?"

In support and interpersonal process groups, the leader's primary task is stimulating communication among group members.

In general, group leaders should speak often, but briefly, especially in time-limited groups. In group, the best interventions usually are the ones that are short and simple. Effective leadership demands the ability to make short, simple, cogent remarks.

Concepts, Techniques, and Considerations

Interventions

Interventions may be directed to an individual or the group as a whole. They can be used to clarify what is going on or to make it more explicit, redirect energy, stop a process that is not helpful, or help the group make a choice about what should be done. A well-timed, appropriate intervention has the power to

- Help a client recognize blocks to connection with other people
- Discover connections between the use of substances and inner thoughts and feelings
- Understand attempts to regulate feeling states and relationships
- Build coping skills

- Perceive the effect of substance abuse on one's life
- Notice meaningful inconsistencies among thoughts, feelings, and behavior
- Perceive discrepancies between stated goals and what is actually being done

A process group that remains leader focused limits the potential for learning and growth.

Any verbal intervention may carry important nonverbal elements. For example, different people would ascribe a variety of meanings to the words, "I am afraid that you have used again," and the interpretation will vary further with the speaker's tone of voice and body language. Leaders should therefore be careful to avoid conveying an observation in a tone of voice that could create a barrier to understanding or response in the mind of the listener.

Avoiding a leader-centered group

Generally a counselor leads several kinds of groups. Leadership duties may include a psychoeducational group, in which a leader usually takes charge and teaches content, and then a process group, in which the leader's role and responsibilities should shift dramatically. A process group that remains leader-focused limits the potential for learning and growth, yet all too often, interventions place the leader at the center of the group. For example, a common sight in a leader-centered group is a series of one-on-one interactions between the leader and individual group members. These sequential interventions do not use the full power of the group to support experiential change, and especially to build authentic, supportive interpersonal relationships. Some ways for a leader to move away from center stage:

- In addition to using one's own skills, build skills in participants. Avoid doing for the group what it can do for itself.
- Encourage the group to learn the skills necessary to support and encourage one another because too much or too frequent support from the clinician can lead to approval seeking, which blocks growth and independence. Supporting each other, of course, is a skill that should develop through group phases. Thus, in earlier phases of treatment, the leader may need to model ways of communicating support. Later, if a client is experiencing loss and grief, for example, the leader does not rush in to assure the client that all will soon be well. Instead, the leader would invite group members to empathize with each other's struggles, saying something like, "Joanne, my guess is at least six other people here are experts on this type of feeling. What does this bring up for others here?"
- Refrain from taking on the responsibility to repair anything in the life of the clients. To a certain extent, they should be allowed to struggle with what is facing them. It would be appropriate, however, for the leader to access resources that will help clients resolve problems.

Confrontation

Confrontation is one form of intervention. In the past, therapists have used confrontation aggressively to challenge clients' defenses of their substance abuse and related untoward behaviors. In recent years, however, clinicians have come to recognize that when "confrontation" is equivalent to "attack," it can have an adverse effect on the therapeutic alliance and process, ultimately leading to failure. Trying to force the client to share the clinician's view of a situation accomplishes no therapeutic purpose and can get in the way of the work.

A more useful way to think about confrontation is "pointing out inconsistencies," such as disconnects between behaviors and stated goals. William R. Miller explains:

> The linguistic roots of the verb "to confront" mean to come face to face. When you think about it that way, confrontation is precisely what we are trying to accomplish: to allow our clients to come face to face with a difficult and often threatening reality, to "let it in" rather than "block it out," and to allow this reality to change them. That makes confrontation a goal of counseling rather than a particular style or technique. . . [T]hen the question becomes, What is the best way to achieve that goal? Evidence is strong that direct, forceful, aggressive approaches are perhaps the least effective way to help people consider new information and change their perceptions (CSAT 1999*b*, p. 10).

Confrontation in this light is a part of the change process, and therefore part of the helping process. Its purpose is to help clients see and accept reality so they can change accordingly (Miller and Rollnick 1991). With this broader understanding of what interventions that "confront" the client really mean, it is not useful to divide therapy into "supportive" and "confrontative" categories.

Transference and Countertransference

Transference means that people project parts of important relationships from the past into relationships in the present. For example, Heather may find that Juan reminds her of her judgmental father. When Juan voices his suspicion that she has been drinking, Heather feels the same feelings she felt when her father criticized all her supposed failings. Within the microcosm of the group, this type of incident not only relates the here-and-now to the past, but also offers Heather an opportunity to learn a different, more self-respecting way of responding to a remark that she perceives as criticism.

The emotion inherent in groups is not limited to clients. The groups inevitably stir up strong feelings in leaders. The therapist's emotional response to a group member's transference is referred to as countertransference. Vannicelli (2001) describes three forms of countertransference:

- *Feelings of having been there.* Leaders with family or personal histories with substance abuse have a treasure in their extraordinary ability to empathize with clients who abuse substances. If that empathy is not adequately understood and controlled, however, it can become a problem, particularly if the therapist tries to act as a role model or sponsor, or discloses too much personal information.
- *Feelings of helplessness when the therapist is more invested in the treatment than the client is.* Treating highly resistant populations, such as clients referred to treatment by the courts, can cause leaders to feel powerless, demoralized, or even angry. The best way to deal with this type of countertransference may be to use the energy of the resistance to fuel the session. (See "Resistance in Group," next section.)
- *Feelings of incompetence due to unfamiliarity with culture and jargon.* It is helpful for leaders to be familiar with 12-Step programs, cultures, and languages. If a group member uses unfamiliar terms, however, the leader should ask the client to explain what the term means to that person, using a question like, "'Letting go' means something a bit different to each person. Can you say a little more about how this relates to your situation?" (Vannicelli 2001, p. 58).

When countertransference occurs, the clinician needs to bring all feelings associated with it to

The therapist's emotional response to a group member's transference is referred to as countertransference.

awareness and manage them appropriately. Good supervision can be really helpful. Countertransference is not bad. It is inevitable, and with the help of supervision, the group leader can use countertransference to support the group process (Vannicelli 2001).

Resistance in Group

Resistance arises as an often unconscious defense to protect the client from the pain of self-examination. These processes within the client or group impede the open expression of thoughts and feelings, or block the progress of an individual or group. The effective leader will neither ignore resistance nor attempt to override it. Instead, the leader helps the individual and group understand what is getting in the way, welcoming the resistance as an opportunity to understand something important going on for the client or the group. Further, resistance may be viewed as energy that can be harnessed and used in a variety of ways, once the therapist has helped the client and group understand what is happening and what the resistant person or persons actually want (Vannicelli 2001).

In groups that are mandated to enter treatment, members often have little interest in being present, so strong resistance is to be expected. Even this resistance, however, can be incorporated into treatment. For example, the leader may invite the group members to talk about the difficulties experienced in coming to the session or to express their outrage at having been required to come. The leader can respond to this anger by saying, "I am impressed by how open people have been in sharing their feelings this evening and in being so forthcoming about really speaking up. My hope is that people will continue to be able to talk in this open way to make our time together as useful as possible" (Vannicelli 2001, p. 55).

For the group leader, strict adherence to confidentiality regulations builds trust.

Leaders should recognize that clients are not always aware that their reasons for nonattendance or lateness may be resistance. The most helpful attitude on the clinician's part is curiosity and an interest in exploring what is happening and what can be learned from it. Leaders need not battle resistance. It is not the enemy. Indeed, it is usually the necessary precursor to change.

It would be a serious mistake, however, to imagine that resistance always melts away once someone calls attention to it. "Resistance is always there for a reason, and the group members should not be expected to give it up until the emotional forces held in check by it are sufficiently discharged or converted, so that they are no longer a danger to the safety of the group or its members" (Flores 1997, p. 538).

When a group (rather than an individual) is resistant, the leader may have contributed to the creation of this phenomenon and efforts need to be made to understand the leader's role in the problem. Sometimes, "resistance can be induced by leaders who are passive, hostile, ineffective, guarded, weak, or in need of constant admiration and excessive friendliness" (Flores 1997, p. 538).

Confidentiality

For the group leader, strict adherence to confidentiality regulations builds trust. If the bounds of confidentiality are broken, grave legal and personal consequences may result. All group leaders should be thoroughly familiar with Federal laws on confidentiality (42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records; see Figure 6-2) and relevant agency policies. Confidentiality is recognized as "a central tenet of the practice of psychotherapy" (Parker et al. 1997, p. 157), yet a

vast majority of States either have vague statutes dealing with confidentiality in group therapy or have no statutes at all. Even where a privilege of confidentiality does exist in law, enforcement of the law that protects it is often difficult (Parker et al. 1997). Clinicians should be aware of this legal problem and should warn clients that what they say in group may not be kept strictly confidential. Some studies indicate that a significant number of therapists do not advise group members that confidentiality has limits (Parker et al. 1997).

One set of confidentiality issues has to do with the use of personal information in a group session. Group leaders have many sources of information on a client, including the names of the client's employer and spouse, as well as any ties to the court system. A group leader should be clear about how information from these sources may and may not be used in group.

Clinicians consider the bounds of confidentiality as existing around the treatment enterprise, not around a particular treatment group. Clients should know that everyone on the treatment team has access to relevant information. In addition, clinicians should make it clear to clients that confidentiality cannot be used to conceal continued substance abuse, and the therapist will not be drawn into colluding with the client to hide substance use infractions. Clinicians also should advise clients of the exact circumstances under which therapists are legally required to break confidentiality (see Figure 6-2).

A second set of confidentiality issues has to do with the group leader's relationships with clients and clients with one another. When counseling a client in both individual therapy and a group context, for example, the leader should know exactly how information learned in individual therapy may be used in the group context. In almost every case, it is more beneficial for the client to divulge such information than for the clinician to reveal it. In an individual session, the therapist and the client can plan how the issue will be brought up in group. This preparation gives clients ample time to decide what to say and what they want from the group. The therapist can prompt clients to share information in the group with a comment like, "I wonder if the group understands what a hard time you've been having over the last 2 weeks?" On the other hand, therapists should reserve the right to determine what information will be discussed in group. A leader may say firmly, "Understand that whatever you tell me may or may not be introduced in group. I will not keep important information from the group, if I feel that withholding the information will impede your progress or interfere with your recovery."

Clinicians should warn clients that what they say in group may not be kept strictly confidential.

Still other confidentiality issues arise when clients discuss information from the group beyond its bounds. Violations of confidentiality among members should be managed in the same way as other boundary violations; that is, empathic joining with those involved followed by a factual reiteration of the agreement that has been broken and an invitation to group members to discuss their perceptions and feelings. In some cases, when this boundary is violated, the group may feel a need for additional clarification or addenda to the group agreement. The leader may ask, both at the beginning of the group or when issues arise, whether the group feels it needs additional agreements in order to work safely. Such amendments, however, should not seek to renegotiate the terms of the original group agreement. See Figure 6-2 (see p. 110) for helpful information on confidentiality and the law.

Because a group facilitator generally is part of the larger substance abuse treatment program, it is recommended that the group facilitator take a practical approach to exceptions. This

Figure 6-2

Confidentiality and 42 C.F.R., Part 2

Confidentiality is both an ethical and a legal issue. Federal law (Title 42, Part 2 or 42 C.F.R., Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records) guarantees strict confidentiality of information about all people receiving substance abuse prevention and/or treatment services. Clients should be fully informed regarding issues of confidentiality, and group leaders should do all they can to build respect for confidentiality and anonymity within groups.

There are six conditions under which limited disclosure is permitted under the regulations. These exceptions are

- The group member has signed a Release of Information document that allows the group facilitator to communicate with another professional and/or agency.
- A group member threatens imminent harm to him- or herself, and the group facilitator believes that the client may act on this threat.
- A client threatens imminent harm to another named person, and the group facilitator believes that there is a reasonable likelihood that the client will act on the threat.
- A medical emergency requires that a client's drug and alcohol status be revealed in order to ensure that the client gets appropriate medical attention.
- A client is suspected of child neglect and/or abuse, as defined by the laws of the State in which the substance abuse treatment services are being provided.
- A direct court order mandates the release of specific information related to a client's history and/or treatment. However, an authorizing court order alone does not compel disclosure—for example, if the person authorized to disclose confidential information does not elect to make the disclosure, he or she cannot be forced to do so unless there is a valid subpoena (i.e., the subpoena has not expired) or other compulsory process introduced that would then compel disclosure. An appropriate judge issues a court order. It specifies the exact information to be provided about a particular client and is properly signed and dated.

More detailed discussions of confidentiality can be found in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*); TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (CSAT 1994*a*); TAP 13, *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* (Lopez 1994); and TAP 18, *Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance* (CSAT 1996).

Source: Consensus Panel.

practical approach is to have the group facilitator discuss the potential application of the exceptions with the program director or member of the program staff who is the lead on the confidentiality regulation.

Biopsychosocial and Spiritual Framework—Treating the Whole Person

Substance use disorders include a wide range of symptoms with different levels of associated disability. Clients always bring into treatment vulnerabilities other than their alcohol or illicit drug dependencies. Group interventions may be needed to resolve psychological problems, physical ailments, social stresses, and perhaps, spiritual emptiness or bankruptcy. In short, successful treatment for substance use disorders should address the whole person, including that person's spiritual growth.

While the group experience is a powerful tool in the treatment of substance use disorders, it is not the only tool. Other interventions, such as individual therapy, psychological interventions, pharmacological supports, and intensive case management, may all be necessary to achieve long-term remission from the symptoms of addictive disorders.

For example, people who are homeless with a co-occurring mental disorder have three complicated sets of problems that require a continuous and comprehensive care system—one that integrates or coordinates interventions in (1) the mental health system, (2) the addiction system, and (3) the social service system for homeless persons. In group therapy, each condition should be regarded as a primary interactive problem; that is, one in which each problem develops independently but contributes to both of the others (Minkoff and Drake 1992).

One model offered for treating homeless persons with substance use disorder is a modified training group designed to accommodate a large number of members whenever a traditional small group is not possible. In this model, participants meet in a large group with the clinician and then break into smaller groups to discuss, practice, or role-play the particular topic.

Each group has a client leader, and the clinician circulates among the groups to ensure that the topic is understood and that discussion is proceeding. The clinician does not participate in the groups. Researchers describing this model note that because the clinicians step back from assuming leadership roles in the groups, the clients become empowered to take group sessions in the necessary direction and demonstrate feelings and insights that might not occur in a group formally led by a clinician (Goldberg and Simpson 1995).

Successful treatment for substance use disorders should address the whole person.

It is well known that 12-Step programs are an important part of many therapeutic programs (Page and Berkow 1998). While 12-Step programs have a proven record of success in helping people overcome substance use disorders, there is a basic conflict inherent in them that group therapists need to reconcile. In the 12-Step program, people are urged to cede control to a higher power. Yet, in group, the clinician is prompting clients to take control of their emotions, behavior, and lives.

As a result, some researchers have stated that it is "impossible to integrate psychotherapy and AA approaches dealing with addictions without compromising one approach or the other" (Page and Berkow 1998, pp. 1–2). Another researcher has argued that "the AA approach is consistent with existential philosophy" because both stress that people should accept their "human limitations and security-seeking behaviors" (Page and Berkow 1998, p. 2). Although the literature currently has few straightforward discussions of spirituality and

Recent research has clearly demonstrated the ability of self-help groups to improve outcomes.

its role in the dynamics of group therapy, most clinicians would agree that the spiritual well-being of the client is essential to breaking free of substance abuse.

When clients join self-help groups, they sometimes hear from individuals who strongly oppose the use of any medication. Some people in 12-Step programs erroneously believe, for example, that the use of pharmacological adjuncts to therapy is a violation of the program's principles. They consequently oppose methadone maintenance, the use of Antabuse, or the use of medications needed to control co-occurring disorders.

Clinicians should be prepared to handle these misapprehensions. One way to help would be to refer apprehensive clients to the pamphlet, *The AA Member—Medications and Other Drugs: A Report from a Group of Physicians in AA* (Alcoholics Anonymous World Services 1984). It stresses the value of appropriate medication prescribed by a physician who understands addictive disorders and reassures clients that such use of medication is wholly consistent with AA and Narcotics Anonymous' 12-Step programs.

Many clients enrolled in a process group for persons with substance use disorders are likely participating in a 12-Step program or other self-help groups as well. On occasion, apparently conflicting messages can be an issue. For instance, many people with addiction histories try to use AA and its jargon as material for resistance. Such problems can readily be managed, provided the therapist is thoroughly familiar with the self-help group. Matano and Yalom (1991) strongly recommend that group leaders become thoroughly familiar with AA's language, steps, and traditions because misconceptions about the program, whether by the client or therapist, can raise barriers to recovery.

Recent research has clearly demonstrated the ability of self-help groups to improve outcomes (Tonigan et al. 1996). Research also has shown that clients receiving mental health services as well as participating in 12-Step meetings have an even better prognosis (Ouimette et al. 1998). Marilyn Freimuth's research on integrating group psychotherapy and 12-Step work has shown that "if mere co-participation in psychotherapy and 12-Step groups supports a client's recovery, it is reasonable to expect that a more integrated approach will provide further benefits" (Freimuth 2000, p. 298). Both activities "support abstinence and emotional growth" (Freimuth 2000, p. 301). Together, the two modalities supply multiple relationship models, potentially of immense value to the client.

Some suggestions for maximizing the therapeutic potential of participation in both process and 12-Step groups follow:

Orientation should prepare new group members who are also members of 12-Step groups for differences in the two groups. A key difference will be the fact that members interact with each other. Such "cross talk" is discouraged at 12-Step meetings. "The new psychotherapy group member may need to be told that the topic of conversation is much wider than the 12-Step meeting's focus on addiction and recovery, and that it includes feelings and reactions toward other group members" (Freimuth 2000, p. 300; see also Vannicelli 1992).

During early recovery, it is particularly important to avoid making the 12-Step program's encouragement of "unquestioning acceptance" a focus of analysis in group therapy. Too critical an interpretation offered too early may disrupt the 12-Step program's status as an "ideal object," belief in which "is critical to

maintaining early abstinence" (Dodes 1988; Freimuth 2000, p. 305).

Sometimes clients experience "splitting"—seeing "the [12-Step] program as the all-good parent and all others, including the therapist/group as the all-bad/ambivalent object." Later, the split may be just the opposite (Freimuth 2000). The group leader should be attuned to this potential and should be prepared to work through these perceptions and the feelings underlying them. Further, when the process group is perceived as the "less than" modality and the client enthusiastically quotes insights from a 12-Step group, the therapist should watch for possible countertransference and bear in mind the benefits the client is receiving from both programs.

Sponsors of 12-Step members may distrust therapy and discourage group member from continuing in treatment. The leader should be prepared to respond to a variety of potential issues in ways that avoid appearing to compete with the self-help group. For example, if a client says, "In my AA group, they say I don't need to be here. As long as I'm not drinking, my life is fine." The therapist might acknowledge the importance of continued sobriety, but remind the client of depression experienced before the onset of heavy drinking.

Group leaders should beware of their possible biases against 12-Step groups that may be based on inaccurate information. For example, it is not true that the 12-Step philosophy opposes therapy and medication, as AA World Service pamphlets clarify. It also is a misconception that 12-Step programs encourage people to abdicate responsibility for substance use. AA, however, does urge people with addiction problems to attend meetings in the early stages of recovery, even though they may still be using alcohol or illicit drugs. Finally, some clinicians believe that 12-Step programs discourage strong negative emotions. On the contrary, "there is no unilateral discouragement of negative affects within [12-Step] program philosophy; only when anger threatens sobriety is it considered necessary to circumvent negative feelings" (Freimuth 2000, p. 308).

The following vignette illustrates a typical intervention intended to clarify and harmonize appropriate participation in 12-Step and process groups:

> The group leader knew that Henry, who was well along in recovery but new to group, had not expressed his anger at Jenna for having cut him off for the third time. When asked how he experienced Jenna, he simply replied that according to the program you are not to take another person's inventory. The leader took the opportunity to say that in group therapy it is important to consider one's feelings about what others say and do even if [the feelings] are negative. Expressing one's own feelings is different from focusing on another's character (taking his inventory) (Freimuth 2000, p. 308).

No matter what the modality, however, group therapy is sure to remain an integral part of substance abuse treatment.

Addressing life issues

Substance abuse affects every aspect of life: home, family, friends, job, health, emotional well-being, and beliefs. As clients move into recovery, the wide range of issues they should face may overwhelm them. Leaders need to help clients rank the importance of the challenges, taking care to make the best possible use of the resources the client and the leader can bring to bear.

Naturally, clients will vary in their ability to address many concerns simultaneously; capacity for change also is variable. For example, some individuals with cognitive impairments will have a much harder time

Naturally, clients will vary in their ability to address many concerns simultaneously.

The leader should explore the importance of spiritual life with the group.

than others engaging in a change process. In the early stage of treatment, such clients need simple ideas, structures, and principles.

As the client moves forward, the clinician can keep in mind the issues that a client is not ready or able to manage. As this process goes on, the leader should remember that the client's priorities matter more than what the leader thinks ought to come next. Unless both client and leader operate in the same motivational framework the leader will not be able to help the client make progress.

No matter what is missing—even if it is a roof over the client's head—it is possible to engage the client in treatment. A client never should be told to come back after problems other than substance abuse have been resolved. On some front, constructive work can always be done. Of course, this assertion does not mean that critical needs can be ignored until treatment for substance abuse is well underway. The therapist should recognize that a client preoccupied with the need to find a place to sleep will not be able to engage fully in treatment until urgent, practical needs are met.

Life issues facing the client provide two powerful points of therapeutic leverage that leaders can use to motivate the client to pursue recovery. First, group leaders should be aware that people with alcoholism and other addictions will not give up their substance use until the pain it brings outweighs the pleasure it produces. Consequently, they should be helped to see the way alcohol and drugs affect important areas of their lives. Second, early in treatment, group leaders should learn what is important to each client that continued substance abuse might jeopardize. For some individuals, it is their job. For others, it is their spouse, health, family, or self-respect. In some cases, it might be the threat of incarceration. Such knowledge can be used to encourage, and even coerce, individuals to utilize the tools of treatment, group, or AA (Flores 1997).

Incorporating faith

While spirituality and faith may offer to some the hope, nurturing, sense of purpose and meaning, and support needed to move toward recovery, people obviously interpret spiritual matters in diverse ways. It is important not to confuse spirituality with religion. Even if clients are not religious, their spiritual life is important. Some clinicians mistakenly conclude that their own understanding of spirituality will help the client. Other clinicians err in the opposite direction and are overly reluctant to address spiritual beliefs. Actually, a middle ground is preferable. The leader should explore the importance of spiritual life with the group, and if the search for spiritual meaning is important, the clinician can incorporate it into group discussions.

For clients who lack meaningful connection to anything beyond themselves, the group may be the first step toward a search for meaning or a feeling of belonging to something greater than the self. The clinician's role in group therapy simply is to create an environment within which such ego-transcending connections can be experienced.

Integrating Care

Interaction with other health care professionals

Professionals within the entire healthcare network need to become more aware of the role of group therapy for people abusing substances. To build the understanding needed to support people in recovery, group leaders should educate others serving this population as often as opportunities arise, such as when clinicians

from different sectors of the healthcare system work together on a case. Similar needs for understanding exist with probation officers, families, and primary care physicians.

Integration of group therapy and other forms of therapy

It is common for a client to be in both individual and group therapy simultaneously. The dual relationship creates both problems and opportunities. Skilled therapists can use what they discover in group about the client's style of relatedness to enhance individual therapy. Conversely, the individual alliance can help the client use the group effectively. So long as the therapist does not collude consciously or unconsciously with the client to keep what is said as a secret between them, most obstacles can be overcome.

In conjoint treatment, that is, a situation in which one therapist sees a client individually while another therapist treats the same client in a group, the therapists should be in close communication with each other. Clinicians should coordinate the treatment plan, keeping important interpersonal issues alive in both settings. The client should know that this collaboration routinely occurs for the client's benefit.

Medication knowledge base

Clinicians need general knowledge of common medications used to assist in recovery, relapse prevention, and co-occurring disorders. Group leaders should be aware of various medication needs of clients, the type of medications prescribed, and potential side effects. Prescribing medication involves striking a balance between therapeutic and detrimental pharmacological effects. For example, benzodiazepines can reduce anxiety, but they can be sedating and might lead to dependency.

The pregroup interview for long-term groups should ask what medications group members are taking and the names of prescribing physicians so cooperative treatment is possible. For example, if a client is awake all night with drug cravings, the therapist might talk with the physician to determine whether appropriate medication could help the client through the difficult period following substance abuse cessation. Therapists should be wary, however. From former days of active substance abuse, clients may have ties to careless physicians who enabled addiction by providing cross-addictive medications. If an evaluation of prescription medications is needed, counselors should refer the client to a consulting physician working with the agency or to a physician knowledgeable about chemical dependency. Attention needs to be paid to medications prescribed for physical illnesses as well. For example, it would be important for the group leader to know that a group member has diabetes and requires medication.

Conflict in group therapy is normal, healthy, and unavoidable.

Management of the Group

Handling conflict in group

Conflict in group therapy is normal, healthy, and unavoidable. When it occurs, the therapist's task is to make the most of it as a learning opportunity. Conflict can present opportunities for group members to find meaningful connections with each other and within their own lives.

Handling anger, developing empathy for a different viewpoint, managing emotions, and working through disagreements respectfully are all major and worthwhile tasks for recovering clients. The leader's judgment and management are crucial as these tasks are handled. It is just as unhelpful to clients to let the conflict

After a conflict, it is important for the group leader to speak privately with group members and see how each is feeling.

go too far as it is to shut down a conflict before it gets worked through. The therapist must gauge the verbal and nonverbal reactions of every group member to ensure that everyone can manage the emotional level of the conflict.

The clinician also facilitates interactions between members in conflict and calls attention to subtle, sometimes unhealthy patterns. For example, a group may have a member, Mary, who frequently disagrees with others. Group peers regard Mary as a source of conflict, and some of them have even asked Mary (the scapegoat) to leave so that they can get on with group work. In such a situation, the therapist might ask, "Do you think this group would learn more about handling this type of situation if Mary left the group or stayed in the group?" An alternative tack would be, "I think the group members are avoiding a unique opportunity to learn something about yourselves. Giving in to the fantasy of getting rid of Mary would rob each of you of the chance to understand yourself better. It would also prevent you from learning how to deal with people who upset you."

Conflicts within groups may be overt or covert. The therapist helps the group to label covert conflicts and bring them into the open. The observation that a conflict exists and that the group needs to pay attention to it actually makes group members feel safer. The therapist is not responsible, however, for resolving conflicts. Once the conflict is observed, the decision to explore it further is made based on whether such inquiry would be productive for the group as a whole. In reaching this decision, the therapist should consider the function the conflict is serving for the group. It actually may be the most useful current opportunity for growth in the group.

On the other hand, as Vannicelli (1992) points out, conflicts can be repetitive and predictable. When two members are embroiled in an endless loop of conflict, Vannicelli suggests that the leader may handle the situation by asking, "John, did you know what Sally was likely to say when you said X?" and "Sally, did you know what John was likely to say when you said Y?" "Since both participants are likely to answer, 'Yes, of course,' the therapist would then inquire what use it might serve for them to engage in this dialogue when the expected outcome is so apparent to both of them (as well as to other members of the group). This kind of distraction activity or defensive maneuver should come to signal to group members that something important is being avoided. It is the leader's task to help the group figure out what that might be and then to move on" (Vannicelli 1992, p. 121).

Group leaders also should be aware that many conflicts that appear to scapegoat a group member are actually displaced anger that a member feels toward the therapist. When the therapist suspects this kind of situation, the possibility should be forthrightly presented to the group with a comment such as, "I notice, Joe, that you have been upset with Jean quite a bit lately. I also know that you have been a little annoyed with me a since couple weeks ago about the way I handled that phone call from your boss. Do you think some of your anger belongs with me?"

Individual responses to particular conflicts can be complex, and may resonate powerfully according to a client's personal values and beliefs, family, and culture. Therefore, after a conflict, it is important for the group leader to speak privately with group members and see how each is feeling. Leaders also often use the last 5 minutes of a session in which a conflict has occurred to give group members an opportunity to express their concerns.

Subgroup management

In any group, subgroups inevitably will form. Individuals always will feel more affinity and more potential for alliance with some members than with others. One key role for the therapist in such cases is to make covert alliances overt. The therapist can involve the group in identifying subgroups by saying, "I notice Jill and Mike are finding they have a good deal in common. Who else is in Jill and Mike's subgroup?"

Subgroups can sometimes provoke anxiety, especially when a therapy group is made up of individuals acquainted before becoming group members. Group members may have used drugs together, slept together, worked together, or experienced residential substance abuse treatment together. Obviously, such connections are potentially disruptive, so when groups are formed, group leaders should consider whether subgroups would exist.

When subgroups somehow stymie full participation in the group, the therapist may be able to reframe what the subgroup is doing. At other times, a change in the room arrangement may be able to reconfigure undesirable combinations. On occasion, however, subtle approaches fail. For instance, adolescents talking among themselves or making obscene gestures during the session should be told factually and firmly that what they are doing is not permissible. The group leader might say, "We can't do our work with distractions going on. Your behavior is disrespectful and it attempts to shame others in the group. I won't tolerate any abuse of members in this group."

Subgroups are not always negative. The leader for example may intentionally foster a subgroup that helps marginally connected clients move into the life of the group. This gambit might involve a question like, "Juanita, do you think it might help Joe if you talked some about your experience with this issue?" Further, to build helpful connections between group members, a group member might be asked, "Bob, who else in this group do you think might know something about what you've just said?"

Responding to disruptive behavior

Clients who cannot stop talking

When a client talks on and on, he or she may not know what is expected in a therapy group. The group leader might ask the verbose client, "Bob, what are you hoping the group will learn from what you have been sharing?" If Bob's answer is, "Huh, well nothing really," it might be time to ask more experienced group members to give Bob a sense of how the group works. At other times, clients tend to talk more than their share because they are not sure what else to do. It may come as a relief to have their monolog interrupted (Vannicelli 1992, p. 167).

If group members exhibit no interest in stopping a perpetually filibustering client, it may be appropriate to examine this silent cooperation. The group may be all too willing to allow the talker to ramble on, to avoid examining their own past failed patterns of substance abuse and forge a more productive future. When this motive is suspected, the leader should explore what group members have and have not done to signal the speaker that it is time to yield the floor. It also may be advisable to help the talker find a more effective strategy for being heard and understood (Vannicelli 1992).

In managing subgroups, one key role for the therapist is to make covert alliances overt.

Clients who interrupt

Interruptions disrupt the flow of discussion in the group, with frustrating results. The client who interrupts is often someone new to the group and not yet accustomed to its norms and rhythms. The leader may invite the group to comment by saying, "What just happened?" If

Sometimes, clients are unable to participate in ways consistent with group agreements.

the group observes, "Jim seemed real anxious to get in right now," the leader might intervene with, "You know, Jim, my hunch is that you don't know us well enough yet to be certain that the group will pay adequate attention to your issues; thus, at this point, you feel quite a lot of pressure to be heard and understood. My guess is that when other people are speaking you are often so distracted by your worries that it may even be hard to completely follow what is going on" (Vannicelli 1992, p. 170).

Clients who flee a session

Clients who run out of a session often are acting on an impulse that others share. It would be productive in such instances to discuss these feelings with the group and to determine what members can do to talk about these feelings when they arise. The leader should stress the point that no matter what is going on in the group, the therapeutic work requires members to remain in the room and talk about problems instead of attempting to escape them (Vannicelli 1992). If a member is unable to meet this requirement, reevaluation of that person's placement in the group is indicated.

Contraindications for continued participation in group

Sometimes, clients are unable to participate in ways consistent with group agreements. They may attend irregularly, come to the group intoxicated, show little or no impulse control, or fail to take medication to control a co-occurring disorder. Though removing someone from the group is very serious and should never be done without careful thought and consultation, it is sometimes necessary. It may be required because of a policy of the institution, because the therapist lacks the skills needed to deal with a particular problem or condition, or because an individual's behavior threatens the group in some significant and insupportable way.

Though groups do debate many issues, the decision to remove an individual is not one the group makes. On the contrary, the leader makes the decision and explains to the group in a clear and forthright manner why the action was taken. Members then are allotted time to work through their responses to what is bound to be a highly charged event. Anger at the group leader for acting without group input or acting too slowly is common in expulsion situations, and should be explored.

Managing Other Common Problems

Coming late or missing sessions

Sometimes, addiction counselors view the client who comes to group late as a person who, in some sense, is behaving badly. It is more productive to see this kind of boundary violation as a message to be deciphered. Sometimes this attempt will fail, and the clinician may decide the behavior interferes with the group work too much to be tolerated.

Silence

A group member who is silent is conveying a message as clearly as one who speaks. Silent messages should be heard and understood, since nonresponsiveness may provide clues to clients' difficulties in connecting with their own inner lives or with others (Vannicelli 1992).

Special consideration is sometimes necessary for clients who speak English as a second language (ESL). Such clients may be silent, or respond only after a delay, because they need

time to translate what has just been said into their first language. Experiences involving strong feelings can be especially hard to translate, so the delay can be longer. Further, when feelings are running high, even fluent ESL speakers may not be able to find the right words to say what they mean or may be unable to understand what another group member is saying about an intense experience.

Tuning out

When the group is in progress and clients seem present in body but not in mind, it helps to tune into them just as they are tuning out. The leader should explore what was happening as an individual became inattentive. Perhaps the person was escaping from specific difficult material or was having more general difficulties connecting with other people. It may be helpful to involve the group in giving feedback to clients whose attention falters. It also is possible, however, that the group as a whole is sidestepping matters that have to do with connectedness. The member who tunes out might be carrying this message for the group (Vannicelli 1992).

Participating only around the issues of others

Even when group members are disclosing little about themselves, they may be gaining a great deal from the group experience, remaining engaged around issues that others bring up. To encourage a member to share more, however, a leader might introduce the topic of how well members know each other and how well they want to be known. This topic could be explored in terms of percentages. For instance, a man might estimate that group members know about 35 percent about him, and he would eventually like them to know 75 percent. Such a discussion would yield important information about how much individuals wish to be known by others (Vannicelli 1992).

Fear of losing control

As Vannicelli (1992) notes, sometimes clients avoid opening up because they are afraid they might break down in front of others—a fear particularly common in the initial phases of groups. When this restraint becomes a barrier to clients feeling acute pain, the therapist should help them remember ways that they have handled strong feelings in the past.

For example, if a female client says she might "cry forever" once she begins, the leader might gently inquire, "Did that ever happen?" Clients are often surprised to realize that tears generally do not last very long. The therapist can further assist this client by asking, "How were you able to stop?" (Vannicelli 1992, p. 152).

A group member who is silent is conveying a message as clearly as one who speaks.

When a client's fears of breaking down or becoming unable to function may be founded in reality (for example, when a client has recently been hospitalized), the therapist should validate the feelings of fear, and should concentrate on the strength of the person's adaptive abilities (Vannicelli 1992).

Fragile clients with psychological emergencies

Since clients know that the group leader is contractually bound to end the group's work on time, they often wait intentionally until the last few minutes of group to share emotionally charged information. They may reveal something particularly sad or difficult for them to deal with. It is important for the leader to recognize they have deliberately chosen this time to share this information. The timing is the

Clients may feel great anxiety after disclosing something important.

client's way of limiting the group's responses and avoiding an onslaught of interest. All the same, the group members or leader should point out this self-defeating behavior and encourage the client to change it.

Near the end of a session, for example, a group leader has an exchange with a group member named Lan, who has been silent throughout the session:

Leader: Lan, you've been pretty quiet today. I hope we will hear more about what is happening with you next week.

Lan: I don't think you'll see me next week.

Further exploration reveals that Lan intends to kill herself that night. In view of the approaching time boundary, what should the leader do?

In such a situation, the group leader has dual responsibilities. First, the leader should respond to Lan's crisis. Second, the incident should be handled in a way that reassures other group members and preserves the integrity of the group. Group members will have a high level of anxiety about such a situation. Because of their concern, some group leaders are willing to extend the time boundary for that session only, provided that all members are willing and able to stay. Others feel strongly that the time boundary should be maintained and that the leader should pledge to work with Lan individually right after the session. Whatever the decision and subsequent action, the leader should not simply drift casually and quietly over the time boundary. The important message is that boundaries should be honored and that Lan will get the help she needs. The group leader can say explicitly that Lan's needs will be addressed after group.

Figure 6-3 shows that group leaders should be prepared to deal not only with substance abuse issues, but with co-occurring psychiatric concerns as well.

Anxiety and resistance after self-disclosure

Clients may feel great anxiety after disclosing something important, such as the fact that they are gay or incest victims. Often, they wonder about two possibilities: "Does this mean that I have to keep talking about it? Does this mean that if new people come into the group, I have to tell them too?" (Vannicelli 1992, p. 160).

To the first question, the therapist can respond with the assurance, "People disclose in here when they are ready." To the second, the member who has made the disclosure can be assured of not having to reiterate the disclosure when new clients enter. Further, the disclosing member is now at a different stage of development, so the group leader could say, "Perhaps the fact that you have opened up the secret a little bit suggests that you are not feeling that it is so important to hide it any more. My guess is that this, itself, will have some bearing on how you conduct yourself with new members who come into the group" (Vannicelli 1992, p. 160 & p. 161).

Figure 6-3

Jody's Arm

A long-term outpatient interpersonal process group meets in 90-minute sessions to support sustained recovery. The group, which includes five women and four men, is relatively stable and successfully abstinent. Many of the clients, however, still struggle with profound psychological concerns that require ongoing attention.

In one group session, all members are present except Jody, a 43-year-old client who is opioid-dependent and has co-occurring psychiatric difficulties. Jody walks in approximately 35 minutes late, apologizing for her lateness. The group facilitator makes a mental note that Jody is wearing several sweatshirts, despite weather too mild to justify the need for layered clothing.

Approximately 15 minutes before the close of group, blood seeps through the top layer of clothing covering Jody's left arm. The group leader asks Jody if her injured arm is making some statement to the group members. Is there something specific that she wants from the group at this particular moment? The leader is confident that Jody is saying something very important not only to, but for, the group as a whole.

Jody indicates that the previous week she felt diminished by comments from a number of members in the group. In an effort to deal with the anxiety and shame associated with returning to the group, she has cut herself before attending.

A number of group members quickly share their concern for her and hopes that their comments of the previous week could be revisited and revised to be more supportive. Jody shows the group the cut on her forearm, which has all but stopped bleeding. She explains how deep her pain is and her desire for the group not to judge her for that pain.

Because Jody appears to be in no imminent danger, the leader chooses to continue with the group process, ending it at the regularly scheduled time. The group meets at a major medical center, so the leader is able to walk with Jody to the emergency room. The leader assures the group that Jody will receive the medical attention she needs.

The next week, the entire group makes substantial gains. They carefully examine their judgment and willingness to allow Jody to be the primary spokeswoman for the profound emotional pain that each of them feels. The dramatic and unexpected situation the previous week has not interrupted the group process. It has instead been used adroitly to make the group even more productive.

7 Training and Supervision

In This Chapter...

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] 1994*b*); TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997*a*); and TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*c*). 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 therapists 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 nonrecovering 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 1998*a*).

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 1999*b*, 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 polcies 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.

Figure 7-2

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 ambivalence. 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 B: Adult Patient Placement Criteria

Adult Patient Placement Criteria For the Treatment of Psychoactive Substance Use Disorders

Levels of Care Criteria → ↓	Dimensions	Level I Outpatient Treatment	Level II Intensive Outpatient Treatment	Level III Medically Monitored Intensive Inpatient Treatment
1 Acute Intoxication and/or Withdrawal Potential	Level IV	Medically Managed Intensive Inpatient Treatment	No withdrawal risk.	Minimal withdrawal risk.
2 Biomedical Conditions and Complications	Severe withdrawal risk but manageable in Level III.	Severe withdrawal risk.	None or very stable.	None or nondistracting from addiction treatment and manageable in Level II.
3 Emotional and Behavioral Conditions and Complications	Requires medical monitoring but not intensive treatment.	Requires 24-hour medical, nursing care. None or very stable.	Mild severity with potential to distract from recovery.	Moderate severity needing a 24-hour structured setting.
4 Treatment Acceptance and Resistance	Severe problems requiring 24-hour psychiatric care with concomitant addiction treatment.	Willing to cooperate but needs motivating and monitoring strategies.	Resistance high enough to require structured program, but not so high as to render outpatient treatment ineffective.	Resistance high despite negative consequences and needs intensive motivating strategies in 24-hour structure.

(continued on next page)

Adult Patient Placement Criteria For the Treatment of Psychoactive Substance Use Disorders (continued)

Levels of Care Criteria → Dimensions ↓	Level I Outpatient Treatment	Level II Intensive Outpatient Treatment	Level III Medically Monitored Intensive Inpatient Treatment	Level IV Medically Managed Intensive Inpatient Treatment
5 Relapse Potential	Able to maintain abstinence and recovery goals with minimal support.	Intensification of addiction symptoms and high likelihood of relapse without close monitoring and support.	Unable to control use despite active participation in less intensive care and needs 24-hour structure.	Problems in this dimension do not qualify patient for Level IV treatment.
6 Recovery Environment	Supportive recovery environment and/or patient has skills to cope.	Environment unsupportive but with structure or support, the patient can cope.	Environment dangerous for recovery necessitating removal from the environment; logistical impediments to outpatient treatment.	Problems in this dimension do not qualify patient for Level IV treatment.

Source: American Society of Addiction Medicine 2001.

Appendix C: Sample Group Agreement

Appleton Outpatient Psychotherapy Group Ground Rules

The following is excerpted from Vannicelli 1992, pp. 295–296.

The behavior and feelings of members of the therapy group mirror in important ways behavior and feelings in other important relationships. Consequently, the group provides a setting in which to examine patterns of behavior in relationships. The group also provides a context in which members learn to identify, understand, and express their feelings. The therapist's role is to facilitate this group process.

To foster these goals, we believe that several group ground rules are important. These are as follows:

1. Members joining long-term groups remain as long as they find the group useful in working on important issues in their lives. We recommend at least a year. Members are required to make an initial 3-month commitment in order to determine the usefulness of this particular group for them.

2. Regular and timely attendance at all sessions is expected. As a member, it is your responsibility to notify the group in advance when you know that you will be away or late for group. In the event of an unexpected absence, you should notify the group at least 24 hours in advance to avoid being charged for the missed session.

3. Members of Appleton substance abuse groups are committed to maintaining abstinence. If a relapse does occur, it must be discussed promptly in the group—as must thoughts or concerns about resuming drug/alcohol use. Members of ACOA (Adult Children of Alcoholics) and family groups are asked to be reflective about their own substance use and to bring up changes in patterns of use or concerns that may be associated with use.

4. Members will notify the group if they are considering leaving the group. Because leaving the group is a process, just as joining is, members are expected to see this process through for at least 3 weeks following notification of termination.

5. Members will have a commitment to talk about important issues in their lives that cause difficulty in relating to others or in living life fully.

6. Members will also have a commitment to talk about what is going on in the group itself as a way of better understanding their own interpersonal dynamics.

7. Members will treat matters that occur in the group with utmost confidentiality. To that end, members are expected not to discuss what happens in the group with people who are not members of the group.

8. Outside-of-group contact often has considerable impact on the group's therapeutic effectiveness. Therefore, any relevant interactions between members which occur outside the group should be brought back into the next meeting and shared with the entire group.

9. What you share in the group will be shared with other members of the treatment team when we feel that it is important to your treatment to do so.

10. Payments for group are due at the last meeting of the month unless other arrangements are discussed and explicitly worked out in the group. If for any reason timely payment becomes problematic, members are expected to discuss this in the group.

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

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