

**Group Therapy Treatment for
Substance Abuse
(Revised)
Part 1**

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Executive Summary

With the recognition of addiction as a major health problem in this country, demand has increased for effective treatments of substance use disorders. Because of its effectiveness and economy of scale, group therapy has gained popularity, and the group approach has come to be regarded as a source of powerful curative forces that are not always experienced by the client in individual therapy. One reason groups work so well is that they engage therapeutic forces—like affiliation, support, and peer confrontation—and these properties enable clients to bond with a culture of recovery. Another advantage of group modalities is their effectiveness in treating problems that accompany addiction, such as depression, isolation, and shame.

Groups can support individual members in times of pain and trouble, and they can help people grow in ways that are healthy and creative. Formal therapy groups can be a compelling source of persuasion, stabilization, and support. In the hands of a skilled, well-trained group leader, the potential healing powers inherent in a group can be harnessed and directed to foster healthy attachments, provide positive peer reinforcement, act as a forum for self-expression, and teach new social skills. In short, group therapy can provide a wide range of therapeutic services, comparable in efficacy to those delivered in individual therapy.

Group therapy and addiction treatment are natural allies. One reason is that people who abuse substances are often more likely to stay sober and committed to abstinence when treatment is provided in groups, apparently because of rewarding and therapeutic benefits like affiliation, confrontation, support, gratification, and identification. This capacity of group therapy to bond patients to treatment is an important asset because the greater the amount, quality, and duration of treatment, the better the client's prognosis (Leshner 1997; Project MATCH Research Group 1997).

The primary audience for this TIP is substance abuse treatment counselors; however, the TIP should be of interest to anyone who wants to learn more about group therapy. The intent of the TIP is to assist counselors in enhancing their therapeutic skills in regard to leading groups.

The consensus panel for this TIP drew on its considerable experience in the group therapy field. The panel was composed of representatives from all of the disciplines involved in group therapy and substance abuse treatment, including alcohol and drug counselors, group therapists, mental health providers, and State government representatives.

This TIP comprises seven chapters. Chapter 1 defines therapeutic groups as those with trained leaders and a primary intent to help people recover from substance abuse. It also explains why groups work so well for treating substance abuse.

Chapter 2 describes the purpose, main characteristics, leadership, and techniques of five group therapy models, three specialty groups, and groups that focus on solving a single problem.

Chapter 3 discusses the many considerations that should be weighed before placing a client in a particular group, especially keying the group to the client's stage of change and stage of recovery. This chapter also concentrates on issues that arise from client diversity.

Chapter 4 compares fixed and revolving types of therapy groups and recommends ways to prepare clients for participation: pregroup interviews, retention measures, and most important, group agreements that specify clients' expectations of each other, the leader, and the group. Chapter 4 also specifies the tasks that need to be accomplished in the early, middle, and late phases of group development.

Chapter 5 turns to the stages of treatment. In the early, middle, and late stages of treatment, clients' conditions will differ, requiring different therapeutic strategies and approaches to leadership.

Chapter 6 is the how-to segment of this TIP. It explains the characteristics, duties, and concepts important to promote effective group leadership in treating substance abuse, including how confidentiality regulations for alcohol and drug treatment apply to group therapy.

Chapter 7 highlights training opportunities available to substance abuse treatment professionals. The chapter also recommends the supervisory group as an added measure that improves group leadership and gives counselors in the group insights about how clients may experience groups.

Throughout this TIP, the term “substance abuse” has been used to refer to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* [DSM-IV-TR] [American Psychiatric Association 2000]). This term was chosen part-

ly because substance abuse treatment professionals commonly use the term “substance abuse” to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders described by DSM-IV.

The sections that follow summarize the content in this TIP and are grouped by chapter.

Groups and Substance Abuse Treatment

Because human beings by nature are social beings, group therapy is a powerful therapeutic tool that is effective in treating substance abuse. The therapeutic groups described in this TIP are those groups that have trained leaders and a specific intent to treat substance abuse. This definition excludes self-help groups like Alcoholics Anonymous and Narcotics Anonymous.

Group therapy has advantages over other modalities. These include positive peer support; a reduction in clients' sense of isolation; real-life examples of people in recovery; help from peers in coping with substance abuse and other life problems; information and feedback from peers; a substitute family that may be healthier than a client's family of origin; social skills training and practice; peer confrontation; a way to help many clients at one time; structure and discipline often absent in the lives of people abusing substances; and finally, the hope, support, and encouragement necessary to break free from substance abuse.

Groups Commonly Used in Substance Abuse Treatment

Five group models are common in substance abuse treatment:

- Psychoeducational groups, which educate clients about substance abuse
- Skills development groups, which cultivate the skills needed to attain and sustain abstinence, such as those needed to manage anger or cope with urges to use substances
- Cognitive-behavioral groups, which alter thoughts and actions that lead to substance abuse
- Support groups, which buoy members and provide a forum to share pragmatic information about maintaining abstinence and managing day-to-day, chemical-free life
- Interpersonal process groups, which delve into major developmental issues that contribute to addiction or interfere with recovery

Three other specialized types of groups that do not fit neatly into the five-model classification nonetheless are common in substance abuse treatment. They are designed specifically to prevent relapse, to bring a specific culture's healing practices to bear on substance abuse, or to use some form of art to express thoughts that otherwise would be difficult to communicate. Groups also can be formed to help clients who share a specific problem, such as anger or shyness, that contributes to their substance abuse.

Criteria for the Placement of Clients in Groups

Not everyone is suited to every kind of group. Moreover, because recovery is a long, nonlinear process, the type of therapy chosen always should be subject to re-evaluation.

Appropriate placement begins with a thorough assessment of the client's needs, desires, and ability to participate. Evaluators rely on forms and interviews to determine the client's level of interpersonal functioning, motivation to abstain, stability, stage of recovery, and expectation of success in the group.

Most clients can function in a group that is heterogeneous, that is, members may be mixed in age, gender, culture, and so on. What is essential, however, is that all clients in a group should have similar needs. Some clients, such as those with a severe personality disorder, will need to be placed in homogeneous groups, in which members are alike in some way other than their dependence problem. Such groups may include people of a particular ethnicity, all women, or a particular age group.

Some clients probably are not suitable for certain groups, or group therapy in general, including

- People who refuse to participate
- People who cannot honor group agreements, including preserving privacy and confidentiality of group members in accordance with the Federal regulations (42 C.F.R., Part 2)
- People who make the therapist very uncomfortable
- People who are prone to dropping out or who continually violate group norms
- People in the throes of a life crisis
- People who cannot control impulses
- People who experience severe internal discomfort in groups

Professional judgment is also essential and should consider characteristics such as substances abused, duration of use, treatment setting, and the client's stage of recovery. For example, a client in a maintenance stage may need to acquire social skills for interacting in new ways, address emotional difficulties, or become reintegrated into a community or culture of origin.

Ethnicity and culture can have a profound effect on treatment. The greater the mix of

ethnicities in a group, the more likely it is that biases will emerge and require mediation. Special attention may be warranted, too, if clients do not speak English fluently because they may be unable to follow a fast-flowing discussion. Programs should ensure that group members are fluent in the language for their specific demographic area, which may or may not be English. Further, while it might be desirable to match the group leader and all group members ethnically, the reality is that it is seldom feasible. Thus, it is crucial for the group leader to understand how ethnicity affects substance abuse and group participation.

Group Development and Phase-Specific Tasks

Group membership may be fixed, with a stable and relatively small number of clients. Alternatively, membership may revolve, with new members entering a group when they are ready for the service it provides. Either type can run indefinitely or for a set time.

The preparation of clients for group participation commences when the group leader meets individually with each prospective group member to begin to form a therapeutic alliance, reach consensus on what is to be accomplished in therapy, educate the client about group therapy, allay anxiety related to joining a group, and explain the group agreement. In these pre-group interviews, it is important to be sensitive to people who differ significantly from the rest of the group whether by age, ethnicity, gender, disorder, and so on. It is important to assure clients that a difference is not a deficit and can be a source of vitality for the group.

Selection of group members is based on the client's fit with a specific group modality. Considerations include the client's

- Level of interpersonal functioning, including impulse control
- Motivation to abstain from drug or alcohol abuse

- Stability
- Stage of recovery
- Expectation of success

Throughout the initial group therapy sessions, clients are particularly vulnerable to relapse and discontinuation of treatment. The first month appears to be especially critical (Margolis and Zweben 1998). Retention rates in a group are enhanced by client preparation, maximum client involvement, feedback, prompts to encourage attendance, and the provision of wraparound services (such as child care and transportation). The timing and duration of groups also affect retention.

While group leaders have many responsibilities in preparing clients for participation in groups, clients have obligations, too. A group agreement establishes the expectations that group members have of each other, the leader, and the group itself. It specifies the circumstances under which clients may be barred from group and explains policies regarding confidentiality, physical contact, substance use, contact outside the group, group participation, financial responsibility, and termination. A group member's acceptance of the contract prior to entering a group has been described as the single most important factor contributing to the success of outpatient therapy groups.

The tasks in the beginning phase of a group include introductions, review of the group agreement, establishment of an emotionally safe environment and positive group norms, and focusing the group toward its work. In the middle phase, clients interact, rethink their behaviors, and move toward productive change. The end phase concentrates on reaching closure.

Stages of Treatment

As clients move through different stages of recovery, treatment must move with them. That is, therapeutic strategies and leadership roles will change with the condition of the clients.

In the early phase of treatment clients tend to be ambivalent about ending substance use,

rigid in their thinking, and limited in their ability to solve problems. Resistance is a challenge for the group leader at this time.

The art of treating addiction in the early phase is in the defeat of denial and resistance. Groups are especially effective at this time since people with dependencies often have had adversarial relationships with people in authority. Thus, information from peers in a group is more easily accepted than that from a lone therapist.

People with addictions remain vulnerable during the middle phase of treatment. Though cognitive capacity usually begins to return to normal, the mind can still play tricks. Clients may remember distinctly the comfort of their past use of substances, yet forget just how bad the rest of their lives were. Consequently, the temptation to relapse remains a concern. Because people with dependencies usually are isolated from healthy social groups, the group helps to acculturate clients into a culture of recovery. The leader draws attention to positive developments, points out how far clients have traveled, and affirms the possibility of increased connection and new sources of satisfaction.

In the late phase of treatment clients are stable enough to face situations that involve conflict or deep emotion. A process-oriented group may become appropriate for some clients who finally are able to confront painful realities, such as being an abused child or an 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.

Group Leadership, Concepts, and Techniques

Effective group leadership requires a constellation of specific personal qualities and professional practices. The personal qualities necessary are constancy, active listening, firm

identity, confidence, spontaneity, integrity, trust, humor, and empathy.

Leaders should be able to

- Adjust their professional styles to the particular needs of different groups
- Model group-appropriate behaviors
- Resolve issues within ethical dimensions
- Manage emotional contagion
- Work only within modalities for which they are trained
- Prevent the development of rigid roles in the group
- Avoid acting in different roles inside and outside the group
- Motivate clients in substance abuse treatment
- Ensure emotional safety in the group
- Maintain a safe therapeutic setting (which involves deflecting defensive behavior without shaming the offender, recognizing and countering the resumption of substance use, and protecting physical boundaries according to group agreements)
- Curtail emotion when it becomes too intense for group members to tolerate
- Stimulate communication among group members

Key concepts and techniques used in group therapy for substance abuse follow.

Interventions are any action by a leader to intentionally affect the processes of the group. Interventions may be used, for example, to clarify understanding, redirect energy, or stop a damaging sequence of interactions. Effective leaders do not overdo intervention. To do so would result in a leader-centered group, which is undesirable because in therapy groups, the healing comes from the connections forged between group members. One type of intervention, confrontation, deftly points out inconsistencies in clients' thinking.

Confidentiality restricts the information that providers can reveal about clients and that clients may reveal about each other. Group

leaders and clients should understand the exact provisions of this important boundary.

Diversity plays a highly important role in group therapy, for it may affect critical aspects of the process, such as what clients expect of the leader and how clients may interpret other clients' behavior. Clinicians should be open to learning about other belief systems, should not assume that every person from a specific group shares the same characteristics, and should avoid appearing as if they are trying to persuade clients to renounce their cultural characteristics.

Many people in treatment for substance abuse have other complex problems, such as co-occurring mental disorders, homelessness, or involvement with the criminal justice system. For many clients, group therapy may be one element in a larger plan that also marshals biopsychosocial and spiritual interventions to address important life issues and restore faith or belief in some force beyond the self.

Integrated care from diverse sources requires cooperation with other healthcare providers. For example, it is critical that all providers working with clients with multiple disorders know what medications they are taking and why.

Two aspects of group management relate to conflict and subgroups. Properly managed, conflict can promote learning about respect for different viewpoints, managing emotions, and negotiation. Part of the therapist's job as a conflict manager is to reveal covert conflicts and expose repetitive and predictable arguments. The therapist also reveals covert subgroups and intervenes to reconfigure negative subgroups that threaten the group's progress.

Various types of disruptive behavior may require the group leader's attention. Such problems include clients who talk nonstop, interrupt, flee a session, arrive late or skip sessions, decline to participate, or speak only to the problems of others. The leader also should have skills to handle people with psychological emergencies or people who are anxious about disclosing personal information.

Training and Supervision

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 persons, from graduate students to highly experienced therapists. 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.

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. As this process unfolds, group members, guided by the supervisor, learn to model effective behavior in an accepting group context.

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 of particular benefit to novice group counselors.

1 Groups and Substance Abuse Treatment

In This Chapter...

Introduction

Defining
Therapeutic
Groups in
Substance Abuse
Treatment

Advantages of
Group Treatment

Modifying Group
Therapy To Treat
Substance Abuse

Approach of
This TIP

Overview

The natural propensity of human beings to congregate makes group therapy a powerful therapeutic tool for treating substance abuse, one that is as helpful as individual therapy, and sometimes more successful. One reason for this efficacy is that groups intrinsically have many rewarding benefits—such as reducing isolation and enabling members to witness the recovery of others—and these qualities draw clients into a culture of recovery. Another reason groups work so well is that they are suitable especially for treating problems that commonly accompany substance abuse, such as depression, isolation, and shame.

Although many groups can have therapeutic effects, this TIP concentrates only on groups that have trained leaders and that are designed to promote recovery from substance abuse. Great emphasis is placed on interpersonal process groups, which help clients resolve problems in relating to other people, problems from which they have attempted to flee by means of addictive substances. While this TIP is not intended as a training manual for individuals training to be group therapists, it provides substance abuse counselors with insights and information that can improve their ability to manage the groups they currently lead.

Introduction

The lives of individuals are shaped, for better or worse, by their experiences in groups. People are born into groups. Throughout life, they join groups. They will influence and be influenced by family, religious, social, and cultural groups that constantly shape behavior, self-image, and both physical and mental health.

Groups can support individual members in times of pain and trouble, and they can help people grow in ways that are healthy and creative. However, groups also can support deviant behavior or influence an individual to act in ways that are unhealthy or destructive.

Because our need for human contact is biologically determined, we are, from the start, social creatures. This propensity to congregate is a powerful therapeutic tool. Formal therapy groups can be a compelling source of persuasion, stabilization, and support. Groups organized around therapeutic goals can enrich members with insight and guidance; and during times of crisis, groups can comfort and guide people who otherwise might be unhappy or lost. In the hands of a skilled, well-trained group leader, the potential curative forces inherent in a group can be harnessed and directed to foster healthy attachments, provide

Groups provide positive peer support and pressure to abstain from substances of abuse.

positive peer reinforcement, act as a forum for self-expression, and teach new social skills. In short, group therapy can provide a wide range of therapeutic services, comparable in efficacy to those delivered in individual therapy. In some cases, group therapy can be more beneficial than individual therapy (Scheidlinger 2000; Toseland and Siporin 1986).

Group therapy and addiction treatment are natural allies. One reason is that people who abuse substances often are more likely to remain abstinent and committed to recovery when treatment is provided in groups, apparently because of rewarding and therapeutic forces such as affiliation, confrontation, support, gratification, and identification. This capacity of group therapy to bond patients to treatment is an important asset because the greater the amount, quality, and duration of treatment, the better the client's prognosis (Leshner 1997; Project MATCH Research Group 1997).

The effectiveness of group therapy in the treatment of substance abuse also can be attributed to the nature of addiction and several factors associated with it, including (but not limited to) depression, anxiety, isolation, denial, shame, temporary cognitive impairment, and character pathology (personality disorder, structural deficits, or an uncohesive sense of self).

Whether a person abuses substances or not, these problems often respond better to group treatment than to individual therapy (Kanas 1982; Kanas and Barr 1983). Group therapy is also effective because people are fundamentally relational creatures.

Defining Therapeutic Groups in Substance Abuse Treatment

All groups can be therapeutic. Anytime someone becomes emotionally attached to other group members, a group leader, or the group as a whole, the relationship has the potential to influence and change that person. Identifying a group as "therapy" does not imply that other groups are not therapeutic. In preparing this TIP, the consensus panel debated at length what constitutes "group therapy" and what distinguishes therapy groups from other types of groups.

Although many types of groups can have therapeutic elements and effects, the group types included in this TIP are based on the goals and intentions of the groups, as well as the intended audience of the TIP (especially substance abuse treatment counselors and other substance abuse treatment professionals). Thus, this TIP is limited to groups that (1) have trained leaders and (2) intend to produce some type of healing or recovery from substance abuse. This TIP describes (in chapter 2) five models of group therapy currently used in substance abuse treatment:

- Psychoeducational groups, which teach about substance abuse.

- Skills development groups, which hone the skills necessary to break free of addictions.
- Cognitive-behavioral groups, which rearrange patterns of thinking and action that lead to addiction.
- Support groups, which comprise a forum where members can debunk each other's excuses and support constructive change.
- Interpersonal process group psychotherapy (referred to hereafter as "interpersonal process groups" or "therapy groups"), which enable clients to recreate their pasts in the here-and-now of group and rethink the relational and other life problems that they have previously fled by means of addictive substances.

Treatment providers routinely use the first four models and various combinations of them. The last is not as widely used, chiefly because of the extensive training required to lead such groups and the long duration of the groups, which demands a high degree of commitment from both providers and clients. All the same, many people enter substance abuse treatment with a long history of failed relationships exacerbated by substance use. In these cases, an extended period of therapy is warranted to resolve the client's problems with relationships. The reality that extended treatment is not always feasible does not negate its desirability.

This TIP does not discuss multifamily and multicouple groups, which are discussed in TIP 39, *Substance Abuse Treatment and Family Therapy* (Center for Substance Abuse Treatment 2004). Even though multifamily and multicouple groups typically are made up of unrelated groups of families, they focus on family relations as they affect and are affected by a member with a substance use disorder. This TIP concentrates on therapy groups, which have a distinctively different focus.

Also outside the scope of this TIP is the use of peer-led self-help groups such as Alcoholics Anonymous (AA) or group activities like social events, religious services, sports, and games. Any or all may have one or more therapeutic effects, but are not specifically designed to

achieve that purpose. Figure 1-1 (see p. 4) shows other differences between self-help groups and interpersonal process groups. In most aspects, the comparison would apply to the other four group models as well.

Advantages of Group Treatment

Treating adult clients in groups has many advantages, as well as some risks. Any treatment modality—group therapy, individual therapy, family therapy, and medication—can yield poor results if applied indiscriminately or administered by an unskilled or improperly trained therapist. The potential drawbacks of group therapy, however, are no greater than for any other form of treatment.

Some of the numerous advantages to using groups in substance abuse treatment are described below (Brown and Yalom 1977; Flores 1997; Garvin unpublished manuscript; Vannicelli 1992).

- *Groups provide positive peer support and pressure to abstain from substances of abuse.* Unlike AA, and, to some degree, substance abuse treatment program participation, group therapy, from the very beginning, elicits a commitment by all the group members to attend and to recognize that failure to attend, to be on time, and to treat group time as special disappoints the group and reduces its effectiveness. Therefore, both peer support and pressure for abstinence are strong.
- *Groups reduce the sense of isolation that most people who have substance abuse disorders experience.* At the same time, groups can enable participants to identify with others who are struggling with the same issues. Although AA and treatment groups of all types provide these opportunities for sharing, for some people the more formal and deliberate nature of participation in process group therapy increases their feelings of security and enhances their ability to share openly.
- *Groups enable people who abuse substances to witness the recovery of others.* From this

Figure 1-1

Differences Between 12-Step Self-Help Groups and Interpersonal Process Groups

	Self-Help Group	Interpersonal Process Group
Size	Unlimited (often large)	Small (8–15 members)
Leadership	<ul style="list-style-type: none"> • Peer leader or individual in recovery • Leadership is earned over time • Implicit hierarchical leadership structure 	<ul style="list-style-type: none"> • Trained professional • Appointed leader • Formal hierarchical leadership structure
Participation	Voluntary	Voluntary and involuntary
Group Government	Self-governing	Leader governed
Content	<ul style="list-style-type: none"> • Environmental factors, no examination of group interaction • Emphasis on similarities among members • Here-and-now focus 	<ul style="list-style-type: none"> • Examination of intragroup behavior and extragroup factors • Emphasis on differences and similarities among members • Here-and-now focus plus historical focus
Screening Interview	None	Always
Group Processes	Universality, empathy, affective sharing, self-disclosure (public statement of problem), mutual affirmation, morale building, catharsis, immediate positive feedback, high degree of persuasiveness	Cohesion, mutual identification, education, catharsis, use of group pressure to encourage abstinence and retention of group membership, outside socialization (depending on the group contract or agreement)
Group Goals	<ul style="list-style-type: none"> • Positive goal setting, behaviorally oriented • Focus on the group as a whole and the similarities among members 	<ul style="list-style-type: none"> • Ambitious goals: immediate problem plus individual personality issues • Individual as well as group focus
Leader Activity	<ul style="list-style-type: none"> • Educator/role model, catalyst for learning • Less member-to-leader distance 	<ul style="list-style-type: none"> • Responsible for directing therapeutic group experience • More member-to-leader distance
Use of Psycho-dynamic Techniques	No	Yes
Confidentiality	Anonymity preserved	Anonymity strongly emphasized and includes <i>everything</i> that occurs in the group, not just the identity of group members

	Self-Help Group	Interpersonal Process Group
Sponsorship Program	Yes (usually same sex)	None
Determination of Time in Group	<ul style="list-style-type: none"> • Members may leave group at their own choosing • Members may avoid self-disclosure or discussion of any subject 	<ul style="list-style-type: none"> • Predetermined minimal term of group membership • Avoidance of discussion seen as possible “resistance”
Involvement in Other Therapies	Yes	Yes—eclectic models No—psychodynamic models
Time Factors	Unlimited group participation possible over years	Often time-limited group experiences
Frequency of Meetings	Active encouragement of daily participation	Meets less frequently (often once or twice weekly)
<i>Source: Adapted from Spitz 2001. Used with permission.</i>		

inspiration, people who are addicted to substances gain hope that they, too, can maintain abstinence. Furthermore, an interpersonal process group, which is of long duration, allows a magnified witnessing of both the changes related to recovery as well as group members’ intra- and interpersonal changes.

- *Groups help members learn to cope with their substance abuse and other problems by allowing them to see how others deal with similar problems.* Groups can accentuate this process and extend it to include changes in how group members relate to bosses, parents, spouses, siblings, children, and people in general.
- *Groups can provide useful information to clients who are new to recovery.* For example, clients can learn how to avoid certain triggers for use, the importance of abstinence as a priority, and how to self-identify as a person recovering from substance abuse. Group experiences can help deepen these insights. For example, self-identifying as a person recovering from substance abuse can be a complex process that changes signifi-

cantly during different stages of treatment and recovery and often reveals the set of traits that makes the system of a person’s self as altogether unique.

- *Groups provide feedback concerning the values and abilities of other group members.* This information helps members improve their conceptions of self or modify faulty, distorted conceptions. In terms of process groups in particular, as specific themes emerge in a client’s group experience, repetitive feedback from multiple group members and the therapist can chip away at those faulty or distorted conceptions in slightly different ways until they not only are correctable, but also the very process of correction and change is revealed through the examination of the group processes.
- *Groups offer family-like experiences.* Groups can provide the support and nurturance that may have been lacking in group members’ families of origin. The group also gives members the opportunity to practice healthy ways of interacting with their families.

- *Groups encourage, coach, support, and reinforce as members undertake difficult or anxiety-provoking tasks.*
- *Groups offer members the opportunity to learn or relearn the social skills they need to cope with everyday life instead of resorting to substance abuse.* Group members can learn by observing others, being coached by others, and practicing skills in a safe and supportive environment.
- *Groups can effectively confront individual members about substance abuse and other harmful behaviors.* Such encounters are possible because groups speak with the combined authority of people who have shared common experiences and common problems. Confrontation often plays a part of substance abuse treatment groups because group members tend to deny their problems. Participating in the confrontation of one group member can help others recognize and defeat their own denial.
- *Groups allow a single treatment professional to help a number of clients at the same time.* In addition, as a group develops, each group member eventually becomes acculturated to group norms and can act as a quasi-therapist himself, thereby ratifying and extending the treatment influence of the group leader.
- *Groups can add needed structure and discipline to the lives of people with substance use disorders, who often enter treatment with their lives in chaos.* Therapy groups can establish limitations and consequences, which can help members learn to clarify what is their responsibility and what is not.
- *Groups instill hope, a sense that “If he can make it, so can I.”* Process groups can expand this hope to dealing with the full range of what people encounter in life, overcome, or cope with.
- *Groups often support and provide encouragement to one another outside the group setting.* For interpersonal process groups, though, outside contacts may or may not be disallowed, depending on the particular group contract or agreements.

Modifying Group Therapy To Treat Substance Abuse

Modifying group therapy to make it applicable to and effective with clients who abuse substances requires three improvements. One is specific training and education for therapists so that they fully understand therapeutic group work and the special characteristics of clients with substance use disorders. The importance of understanding the curative process that occurs in groups cannot be underestimated.

Most substance abuse counselors have responded by adapting skills used in individual therapy. Counselors have also sought direction, clinical training, and practical suggestions. Despite individual efforts, however, group therapy often is conducted as individual therapy in a group.

Individual therapy is not equivalent to group therapy. Some principles that work well with individuals are inappropriate for group therapy. Using the wrong approach may lead to several undesirable results. First, the rich potential of groups—self-understanding, psychological growth, emotional healing, and true intimacy—will be left unfulfilled. Second, group leaders who are unfamiliar with and insensitive to issues that manifest themselves in group therapy may find themselves in a difficult situation. Third, therapists who think they are doing group therapy when they actually are not may observe the poor results and conclude that group therapy is ineffective. Compounding all these difficulties is the fact that group therapy is so ubiquitous. Thus, poorly conceived approaches are being used frequently.

Group therapy also is not equivalent to 12-Step program practices. Many therapists who lack full qualifications for group work have adapted practices from AA and other 12-Step programs for use in therapeutic groups. To say that this borrowing is inadvisable is not to say that the principles of AA are inadequate. On the contrary, many people seem to be unable to recover from dependency without AA or a program

similar to it. For this reason, most effective treatment programs make attendance at AA or another 12-Step program a mandatory part of the treatment process. By the same token, AA and other 12-Step programs are not group therapy. Rather, they are complementary components to the recovery process. Twelve-Step programs can help keep the individual who abuses substances abstinent while group therapy provides opportunities for these individuals to understand and explore the emotional and interpersonal conflicts that can contribute to substance abuse.

Progress toward optimal group therapy has also been hindered by the misconception that group therapy with clients who have addictions does not require specially qualified leaders. This notion is false. Therapy groups cannot just take care of themselves. Group therapy, properly conducted, is difficult. One reason that it is challenging has to do with the nature of the clients; an addicted population poses unique problems for the group therapy leader. A second reason is the complexity of group therapy; the leader requires a vast amount of specialized knowledge and skills, including a clear understanding of group process and the stages of development of group dynamics. Such mastery only comes with extended training and experience leading groups.

Many groups led by untrained or poorly trained leaders have not fulfilled their potential and may even have had negative effects on a client's recovery. It matters little whether the inadequately trained group therapist is a person who once abused substances or someone who developed knowledge in a traditional course of academically based training. Where problems exist, they usually relate to one of two deficiencies: a lack of effective group therapy training or use of a group therapy model that is inadequate for clients who are chemically dependent. Additional training and education is needed to produce therapists who are well qualified to lead therapy groups composed primarily of individuals who are chemically dependent.

A second major improvement needed if people who have addictions are to benefit from group therapy is a clear answer to the question, "Why is group therapy so effective for people with addictions?" We already have part of the answer, and it lies in the individual with addiction, a person whose character style often involves a defensive posture commonly referred to as denial. Addiction is, in fact, frequently referred to as a disease of denial.

The individual who is chemically dependent usually comes into treatment with an uncommonly complex set of defenses and character pathology. Any group leader who intends to help people who have addictions benefit from treatment should have a clear understanding of each group member's defensive process and character dynamics. More than 20 years ago, John Wallace (1978) wrote about this important issue in an informative essay on the defensive style of the individual who is addicted to alcohol. He referred to these character-related defensive features as the preferred defense system of the individual addicted to alcohol.

A third major modification needed is the adaptation of the group therapy model to the treatment of substance abuse. The principles of group therapy need to be tailored to meet the realities of treating clients with substance use disorders.

For the most part, group therapy has been based on a model derived from outpatient therapy for clients whose problems may or may not include substance abuse. The theoretical underpinnings and practical applications of general group therapy are not always applicable to individuals who abuse substances.

Groups instill hope, a sense that "If he can make it, so can I."

Substance abuse treatment sometimes is implemented as a grab bag of strategies, approaches, and techniques that were not tailored for people with substance use disorders. Further, the common characteristics and typical dynamics seen in this population have not always been evaluated adequately, and this lapse has inhibited the development of effective methods of treatment for these clients.

This model suitability problem is further complicated by the fact that clients with substance use disorders, and even staff members, often become confused about the different types of group treatment modalities. For instance, in the course of their treatment, clients may engage in AA, Narcotics Anonymous, other 12-Step groups, discussion groups, educational groups, continuing care groups, and support groups. Given this mix, clients often become

confused about the purpose of group therapy, and the treatment staff sometimes underestimates the impact that group therapy can make on an individual's recovery.

The upshot of these problems has been partial or complete failure; that is, the techniques and strategies that usually work with the general psychiatric population often do not work with people abusing substances.

A further negative result is that the clients who have addictions may be unfairly viewed as poor treatment risks—people resistant to treatment and unmotivated to change.

Time also is an important factor in a person's recovery. What a group leader does in group therapy with clients in an inpatient setting in a hospital during the first few days or weeks of recovery will differ dramatically from what that same group therapist will do with the same recovering person in a continuing care group 6 months into abstinence with the expectation that the person will remain in the group at least another 6 to 12 months.

Approach of This TIP

While this TIP does not provide the training needed to become an interpersonal process group therapist, the point of view, attitudes, and considerations of these group therapists infuse the discussions throughout this TIP. The panel hopes that this TIP will help counselors expand their awareness and comprehension of dynamics that might be going on in their current substance abuse treatment groups. These insights will help counselors become better prepared to manage their groups and their individual members, inform group members' individual therapists of possible issues that need resolution, record dynamics and issues for use in treatment during later stages of recovery, and improve retention by appropriately acknowledging issues that are outside the scope of the group. The TIP will achieve its purpose to the extent that it assists counselors as they juggle immediate client needs, interactions in groups, tasks leading to recovery, and sheer human complexity.

This TIP will help counselors expand their awareness and comprehension of dynamics occurring in their treatment groups.

2 Types of Groups Commonly Used in Substance Abuse Treatment

In This Chapter...

Five Group Models

Psychoeducational Groups

Skills Development Groups

Cognitive–Behavioral
Groups

Support Groups

Interpersonal Process
Group Psychotherapy

Specialized Groups in Substance Abuse Treatment

Relapse Prevention

Communal and
Culturally Specific Groups

Expressive Groups

Groups Focused on Specific Problems

Overview

This chapter presents five models of groups used in substance abuse treatment, followed by three representative types of groups that do not fit neatly into categories, but that, nonetheless, have special significance in substance abuse treatment. Finally, groups that vary according to specific types of problems are considered. The purpose of the group, its principal characteristics, necessary leadership skills and styles, and typical techniques for these groups are described.

Introduction

Substance abuse treatment professionals employ a variety of group treatment models to meet client needs during the multiphase process of recovery. A combination of group goals and methodology is the primary way to define the types of groups used. This TIP describes five group therapy models that are effective for substance abuse treatment:

- Psychoeducational groups
- Skills development groups
- Cognitive–behavioral/problemsolving groups
- Support groups
- Interpersonal process groups

Each of the models has something unique to offer to certain populations; and in the hands of a skilled leader, each can provide powerful therapeutic experiences for group members. A model, however, has to be matched with the needs of the particular population being treated; the goals of a particular group's treatment also are an important determinant of the model that is chosen.

This chapter describes the group's purpose, principal characteristics, leadership requisites, and appropriate techniques for each type of group. Also discussed are three specialized types of groups that do not fit

into the five model categories, but that function as unique entities in the substance abuse treatment field:

- Relapse prevention treatment groups
- Communal and culturally specific treatment groups
- Expressive groups (including art therapy, dance, psychodrama)

Figure 2-1 lists some groups commonly used in substance abuse treatment and classifies them into the five-model framework used in this TIP. This list of groups is by no means exhaustive, but it demonstrates the variety of groups found in substance abuse treatment settings.

Occasionally, discussions in this TIP refer to the stages of change delineated by Prochaska and DiClemente (1984). They examined 18 psychological and behavioral theories of how change occurs, including the components of a biopsychosocial framework for understanding substance abuse. Their result was a continuum of six categories for understanding client motivation for changing substance abuse behavior. The six stages are:

- *Precontemplation.* Clients are not thinking about changing substance abuse behavior and may not consider their substance abuse to be a problem.
- *Contemplation.* Clients still use substances, but they begin to think about cutting back or quitting substance use.
- *Preparation.* Clients still use substances, but intend to stop since they have recognized the advantages of quitting and the undesirable consequences of continued use. Planning for change begins.
- *Action.* Clients choose a strategy for discontinuing substance use and begin to make the changes needed to carry out their plan. This period generally lasts 3–6 months.
- *Maintenance.* Clients work to sustain abstinence and evade relapse. From this stage, some clients may exit substance use permanently.

- *Recurrence.* Many clients will relapse and return to an earlier stage, but they may move quickly through the stages of change and may have gained new insights into problems that defeated their former attempts to quit substance abuse (such as unrealistic goals or frequenting places that trigger relapse).

For a detailed description of the stages of change, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] 1999b).

The client's stage of change will dictate which group models and methods are appropriate at a particular time. If the group is composed of members in the action stage who have clearly identified themselves as substance dependent, the group will be conducted far differently from one composed of people who are in the precontemplative stage. Priorities change with time and experience, too. For example, a group of people with substance use disorders on their second day of abstinence is very different from a group with 1 or 2 years of sobriety.

Theoretical orientations also have a strong impact on the tasks the group is trying to accomplish, what the group leader observes and responds to in a group, and the types of interventions that the group leader will initiate. Before a group model is applied in treatment, the group leader and the treating institution should decide on the theoretical frameworks to be used, because each group model requires different actions on the part of the group leader. Since most treatment programs offer a variety of groups for substance abuse treatment, it is important that these models be consistent with clearly defined theoretical approaches.

In practice, however, groups can, and usually do, use more than one model, as shown in Figure 2-1. For example, a therapy group in an intensive early recovery treatment setting might combine elements of psychoeducation (to show how drugs have ravaged the individual's life), skills development (to help the client maintain abstinence), and support (to teach individuals how to relate to other group members in an honest and open fashion). Therefore, the

Figure 2-1

Groups Used in Substance Abuse Treatment and Their Relation to Six Group Models

Group Types æ	Group Model or Combination of Models					
	Skills Development	Cognitive-Behavioral Therapy	Inter-personal Process	Support	Specialized Group*	Psycho-educational
Anger/feelings management	•	•				•
Co-occurring disorders	•			•		
Skills-building	•	•				
Conflict resolution	•	•				•
Relapse prevention	•	•		•		•
12-Step psychoeducational					•	•
Psychoeducational						•
Trauma (abuse, violence)			•	•		•
Early recovery	•	•		•		•
Substance abuse education						•
Spirituality-based				•		
Cultural					•	•
Psychodynamic			•	•		
Ceremonial healing practices					•	
Support				•		
Family roles (psychoeducational)						•
Expressive therapy					•	
Relaxation training	•					
Meditation	•					
Multiple-family	•			•		•
Gender specific				•	•	
Life skills training	•	•				
Health and wellness						•
Cognitive-behavioral	•	•		•		
Psychodrama					•	
Adventure-based					•	
Marathon					•	
Humanistic/existential			•	•		

Source: Consensus Panel. *See “Specialized Groups in Substance Abuse Treatment” on p. 29.

descriptions of the groups in this chapter are of ideal, pure forms that rarely stand alone in practice. It must be acknowledged, too, that the terms used to describe groups are not altogether clear-cut and consistent. In different treatment settings, programs, and regions of the country, a term like “support group” may be used to refer to different types of treatment groups, including a relapse prevention group.

Despite such discrepancies between neat theory and untidy practice, little difficulty will arise if the group leader exercises sound clinical judgment regarding models and interventions to be used. One exception to this assurance, however, should be noted. Close adherence to the theory that dictates the way an interpersonal process group should be conducted has crucial implications for its success.

Five Group Models

Figure 2-2 summarizes the characteristics of five therapeutic group models used in substance abuse treatment. Variable factors include the focus of group attention, specificity of the group agenda, heterogeneity or homogeneity of group members, open-ended or determinate duration of treatment, level of facilitator or leader activity, training required for the group leader, length of sessions, and preferred arrangement of the room.

Psychoeducational Groups

Psychoeducational groups are designed to educate clients about substance abuse, and related behaviors and consequences. This type of group presents structured, group-specific content, often taught using videotapes, audiocassette, or lectures. Frequently, an experienced group leader will facilitate discussions of the material (Galanter et al. 1998). Psychoeducational groups provide information designed to have a direct application to clients’ lives—to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and

prompt people using substances to take action on their own behalf, such as entering a treatment program. While psychoeducational groups may inform clients about psychological issues, they do not aim at intrapsychic change, though such individual changes in thinking and feeling often do occur.

Purpose. The major purpose of psychoeducational groups is expansion of awareness about the behavioral, medical, and psychological consequences of substance abuse. Another prime goal is to motivate the client to enter the recovery-ready stage (Martin et al. 1996; Pfeiffer et al. 1991). Psychoeducational groups are provided to help clients incorporate information that will help them establish and maintain abstinence and guide them to more productive choices in their lives.

These groups also can be used to counteract clients’ denial about their substance abuse, increase their sense of commitment to continued treatment, effect changes in maladaptive behaviors (such as associating with people who actively use drugs), and supporting behaviors conducive to recovery. Additionally, they are useful in helping families understand substance abuse, its treatment, and resources available for the recovery process of family members.

Some of the contexts in which psychoeducational groups may be most useful are

- Helping clients in the precontemplative or contemplative level of change to reframe the impact of drug use on their lives, develop an internal need to seek help, and discover avenues for change.
- Helping clients in early recovery learn more about their disorders, recognize roadblocks to recovery, and deepen understanding of the path they will follow toward recovery.
- Helping families understand the behavior of a person with substance use disorder in a way that allows them to support the individual in recovery and learn about their own needs for change.
- Helping clients learn about other resources that can be helpful in recovery, such as

Figure 2-2

Characteristics of Five Group Models Used in Substance Abuse Treatment

Group model	Group/leader focus	Specificity of the group agenda	Heterogeneous or homogeneous	Open-ended/determinate	Level of facilitator activity
Psycho-educational	Leader focused	Specific	Either	Either	High
Skills development	Leader focused	Specific	Either	Either (depending on topic)	High
Cognitive-behavioral	Mixed/balanced	Either	Either	Either	High
Support	Group focus	Nonspecific	Either	Open	Low to moderate
Interpersonal process	Group focus	Nonspecific	Heterogeneous	Open	Low to moderate
Group model	Level of facilitator activity	Duration of treatment	Length of session	Space and arrangement	Leader training
Psycho-educational	High	Limited by program requirements	15 to 90 minutes	Horseshoe or circle	Basic
Skills development	High	Variable	45 to 90 minutes	Horseshoe or circle	Basic with some specialized training
Cognitive-behavioral	High	Variable and open-ended	60 to 90 minutes	Circle	Specialized training
Support	Low to moderate	Open-ended	45 to 90 minutes	Circle	Specialized training with process-oriented skills
Interpersonal Process	Low to moderate	Open-ended	1 to 2 hours	Circle	Specialized training in interpersonal process groups

meditation, relaxation training, anger management, spiritual development, and nutrition.

Principal characteristics. Psychoeducational groups generally teach clients that they need to learn to identify, avoid, and eventually master the specific internal states and external circumstances associated with substance abuse. The

copied skills (such as anger management or the use of “I” statements) normally taught in a skills development group often accompany this learning.

Psychoeducational groups are considered a useful and necessary, but not sufficient, component of most treatment programs. For instance, psychoeducation might move clients

in a precontemplative or perhaps contemplative stage to commit to treatment, including other forms of group therapy. For clients who enter treatment through a psychoeducational group, programs should have clear guidelines about when members of the group are ready for other types of group treatment.

Psychoeducational groups are highly structured and often follow a manual or a preplanned curriculum.

Often, a psychoeducational group integrates skills development into its program. As part of a larger program, psychoeducational groups have been used to help clients reflect on their own behavior, learn new ways to confront problems, and increase their self-esteem (La Salvia 1993).

Psychoeducational groups should work actively to engage

participants in the group discussion and prompt them to relate what they are learning to their own substance abuse. To ignore group process issues will reduce the effectiveness of the psychoeducational component.

Psychoeducational groups are highly structured and often follow a manual or a preplanned curriculum. Group sessions generally are limited to set times, but need not be strictly limited. The instructor usually takes a very active role when leading the discussion. Even though psychoeducational groups have a format different from that of many of the other types of groups, they nevertheless should meet in a quiet and private place and take into account the same structural issues (for instance, seating arrangements) that matter in other groups.

As with any type of group, accommodations may need to be made for certain populations. Clients with cognitive disabilities, for example,

may need special considerations. Psychoeducational groups also have been shown to be effective with clients with co-occurring mental disorders, including clients with schizophrenia (Addington and el-Guebaly 1998; Levy 1997; Pollack and Stuebben 1998). For more information on making accommodations for clients with disabilities, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998b).

Leadership skills and styles. Leaders in psychoeducational groups primarily assume the roles of educator and facilitator. Still, they need to have the same core characteristics as other group therapy leaders: caring, warmth, genuineness, and positive regard for others.

Leaders also should possess knowledge and skills in three primary areas. First, they should understand basic group process—how people interact within a group. Subsets of this knowledge include how groups form and develop, how group dynamics influence an individual's behavior in group, and how a leader affects group functioning. Second, leaders should understand interpersonal relationship dynamics, including how people relate to one another in group settings, how one individual can influence the behavior of others in group and some basic understanding of how to handle problematic behaviors in group (such as being withdrawn). Finally, psychoeducational group leaders need to have basic teaching skills. Such skills include organizing the content to be taught, planning for participant involvement in the learning process, and delivering information in a culturally relevant and meaningful way.

To help clients get the most out of psychoeducational sessions, leaders need basic counseling skills (such as active listening, clarifying, supporting, reflecting, attending) and a few advanced ones (such as confronting and terminating) (Brown 1998). It also helps to have leadership skills, such as helping the group get started in a session, managing (though not necessarily eliminating) conflict between group members, encouraging withdrawn group members to be more active, and making sure that

all group members have a chance to participate. As the group unfolds, it is important that group leaders are nondogmatic in their dealings with group members. Finally, the group leader should have a firm grasp of material being communicated in the psychoeducational group.

During a session, the group leader should be mindful both of the group's need and the specific needs of each member. The group leader will need to understand group member roles and how to manage problem clients. Except in unusual circumstances, efforts should be made to increase members' comfort and to reduce anxiety in the group. Leaders will use a variety of resources to impart knowledge to the group, so each session also requires preparation and familiarization with the content to be delivered.

Group leaders should have ongoing training and formal supervision. Supervision benefits all group leaders of all levels of skill and training, as it helps to assure them that people in positions of authority are interested in their development and in their work. If direct supervision is not possible (as may be the case in remote, rural areas), then Internet discussions or regular telephone contact should be used.

Techniques. Techniques to conduct psychoeducational groups are concerned with (1) how information is presented, and (2) how to assist clients to incorporate learning so that it leads to productive behavior, improved thinking, and emotional change. Adults in the midst of crises in their lives are much more likely to learn through interaction and active exploration than they are through passive listening. As a result, it is the responsibility of the group leader to design learning experiences that actively engage the participants in the learning process. Four elements of active learning can help.

First, the leader should foster an environment that supports active participation in the group and discourages passive note taking. Accordingly, leader lecturing should be limited in duration and extent. The leader should concentrate instead on facilitating group discussion, especially among clients who are withdrawn and have little to say. They need support and under-

standing of the content before expressing their views. Techniques such as role playing, group problemsolving exercises, and structured experiences all foster active learning.

Second, the leader should encourage group participants to take responsibility for their learning rather than passing on that responsibility to the group leader. From the outset of the group, the leader can emphasize group self-ownership by allowing members to participate in setting agreements and other group boundaries. The leader can emphasize member responsibility for honest, respectful interaction among all members and can de-emphasize the leader role in determining group life.

Third, because many people have pronounced preferences for learning through a particular sense (hearing, sight, touch/movement), it is essential to use a variety of learning methods that call for different kinds of sensory experience. Excellent material on adapting instruction to learning styles is available through the Association for Supervision and Curriculum Development Web site. To access the many articles and book chapters, enter "learning styles" into the search function and click the "Go" button.

Most people, at one time or another, have had unpleasant experiences in traditional, formal classroom environments. The resulting shame, rejection, and self-deprecation strongly motivate people to avoid situations where these experiences might be brought back into awareness. Therefore it is critically important for the group leader to be sensitive to the anxiety that can be aroused if the client is placed in an environment that replicates a disturbing scene from the past. To allay some of these concerns, leaders can acknowledge the anxieties of participants, prevent all group participants from mocking others' comments or ideas, and show sensitivity to the meaning of a participant's withdrawal in the group. Overall, leaders should create an environment where participants who are having difficulty with the psychoeducational group process can express their concerns and receive support.

Fourth, people with alcoholism and other addictive disorders are known to have subtle, neuropsychological impairments in the early stage of abstinence. Verbal skills learned long ago (that is, crystallized intelligence) are not affected, but fluid intelligence, needed to learn some kinds of new information, is impaired. As a result, clients may seem more able to learn than they actually are. Therapists who are teaching new skills should be mindful of this difficulty.

Skills Development Groups

Most skills development groups operate from a cognitive–behavioral orientation, although counselors and therapists from a variety of orientations apply skills development techniques in their practice. Many skills development groups incorporate psychoeducational elements into the group process, though skills development may remain the primary goal of the group.

Purpose. Coping skills training groups (the most common type of skills development group) attempt to cultivate the skills people need to achieve and maintain abstinence. These skills may either be directly related to substance use (such as ways to refuse offers of drugs, avoid triggers for use, or cope with urges to use) or may apply to broader areas relevant to a client’s continued sobriety (such as ways to manage anger, solve problems, or relax).

Skills development groups typically emerge from a cognitive–behavioral theoretical approach that assumes that people with substance use disorders lack needed life skills. Clients who rely on substances of abuse as a method of coping with the world may never have learned important skills that others have, or they may have lost these abilities as the result of their substance abuse. Thus, the capacity to build new skills or relearn old ones is essential for recovery.

Since many of the skills that people with substance abuse problems need to develop are interpersonal in nature, group therapy

becomes a natural treatment of choice for skills development. Members can practice with each other, see how different people use the same skills, and feel the positive reinforcement of a peer group (rather than that of a single professional) when they use skills effectively.

Principal characteristics. Because of the degree of individual variation in client needs, the particular skills taught to a client should depend on an assessment that takes into account individual characteristics, abilities, and background. The suitability of a client for a skills development group will depend on the unique needs of the individual along with the skills being taught. Most clients can benefit from developing or enhancing certain general skills, such as controlling powerful emotions or improving refusal skills when around people using alcohol or illicit drugs. Skills might also be highly specific to certain clients, such as relaxation training.

Skills development groups usually run for a limited number of sessions. The size of the group needs to be limited, with an ideal range of 8 to 10 participants (perhaps more, if a cofacilitator is present). The group has to be small enough for members to practice the skills being taught.

While skills development groups often incorporate elements of psychoeducation and support, the primary goal is on building or strengthening behavioral or cognitive resources to cope better in the environment. Psychoeducational groups tend to focus on developing an information base on which decisions can be made and action taken. Support groups, to be discussed later in this chapter, focus on providing the internal and environmental supports to sustain change. All are appropriate in substance abuse treatment. While a specific group may incorporate elements of two or more of these models, it is important to maintain focus on the overall goal of the group and link methodology to that goal.

Leadership skills and styles. In skills development groups, as in psychoeducation, leaders need basic group therapy knowledge and skills, such as understanding the ways that groups

grow and evolve, knowledge of the patterns that show how people relate to one another in group, skills in fostering interaction among members, managing conflict that inevitably arises among members in a group environment, and helping clients take ownership for the group.

In addition, group leaders should know and be able to demonstrate the set of skills that the participants are trying to develop. Leaders also will need significant experience in modeling behavior and helping others learn discrete elements of behavior. Other general skills, such as sensitivity to what is going on in the room and cultural sensitivity to differences in the ways people approach issues like anger or assertiveness, also will be important. Depending on the skill being taught, there may be certain educational or certification requirements. For example, a nurse might be needed to teach specific health maintenance skills, or a trained facilitator may be needed to run certain meditation or relaxation groups.

Techniques. The specific techniques used in a skills development group will vary greatly depending on the skills being taught. (For more information on the techniques used in cognitive-behavioral coping skills training see chapter 4 of TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse Treatment* [CSAT 1999a].)

It is useful to keep in mind that most skills, such as riding a bicycle or swimming, seem relatively simple, straightforward, and easy once incorporated into one's repertoire of behavior. The process of learning and incorporating new skills, however, may be difficult, especially if the previous approach has been used for a long time. For instance, individuals who have been passive and nonassertive throughout life may have to struggle mightily to learn to stand up for themselves. As a consequence, it is crucial for leaders of skills development groups to be sensitive to the struggles of group participants, hold positive expectations for change, and not demean or shame individuals who seem overwhelmed by the task.

Furthermore, many behavioral changes that seem straightforward on the surface have powerful effects at deeper levels of psychological functioning. For instance, assertiveness may touch feelings of shame and unworthiness. Thus, new assertive competence may be incompatible with and overwhelmed by deep feelings of inadequacy and low self-esteem. As a result, a client may learn a new behavior, but be unable to incorporate it into a repertoire of positive action. Counselors should not automatically assume, therefore, that a newly learned skill inevitably will translate into action. Feedback from participants on their progress since the last group is a good way to assess both learning and the incorporation of skills.

An often unstated and underrecognized difficulty in leading skills groups is that a leader teaching the same material week after week can become bored with the content. In due course, the boredom will creep into the teaching. To retain energy and teaching effectiveness, leaders can switch topics, or one leader can teach different topics over time. When feasible, it also may help to provide feedback to leaders by making video or audio recordings of their presentations.

Other specific techniques for skills development groups depend on the nature of the group, topic, and approach of the group leader. Before undertaking leadership of a skills development group, it is wise for the leader to have previously participated in the specific kind of skills development group to be led. Often special training programs are available for leaders of these kinds of groups.

Skills development groups typically emerge from a cognitive-behavioral approach.

Cognitive–Behavioral Groups

Cognitive–behavioral groups are a well-established part of the substance abuse treatment field and are particularly appropriate in early recovery. The term “cognitive–behavioral therapy group” covers a wide range of formats informed by a variety of theoretical frameworks, but the common thread is cognitive restructuring as the basic methodology of change.

Purpose. Cognitive–behavioral groups conceptualize dependency as a learned behavior that is subject to modification through various interventions, including identification of conditioned stimuli associated with specific addictive behaviors, avoidance of such stimuli, development of enhanced contingency management strategies, and response-desensitization (McAuliffe and Ch’ien 1986). The etiologies of dependency include neurobehavioral factors (Rawson et al. 1990), biopsychosocial (Nunes-Dinis and Barth 1993; Wallace 1990), and the disease model (Miller and Chappel 1991), in which the key etiological determinants of dependency are genetic and physiological factors, ones that the person with dependency cannot control.

Cognitive–behavioral therapy groups work to change learned behavior by changing thinking patterns, beliefs, and perceptions. The groups also work to develop social networks that support continued abstinence so the person with dependency becomes aware of behaviors that may lead to relapse and develops strategies to continue in recovery (Matano et al. 1997).

Cognitive processes include a number of different psychological elements, such as thoughts, beliefs,

decisions, opinions, and assumptions. A number of thoughts and beliefs are affected by an individual’s substance abuse and addiction. Some common errant beliefs of individuals entering recovery are

- “I’m a failure.”
- “I’m different.”
- “I’m not strong enough to quit.”
- “I’m unlovable.”
- “I’m a (morally) bad person.” The word “morally” carries the implication of a “shame script” and feeling defective as a person. “Bad” alone refers more to behavior, or doing “bad things.”

Changing such cognitions and beliefs may lead to greater opportunities to maintain sobriety and live more productively.

Principal characteristics. In cognitive–behavioral groups for people who abuse substances, the group leader focuses on providing a structured environment within which group members can examine the behaviors, thoughts, and beliefs that lead to their maladaptive behavior. Treatment manuals—providing specific protocols for intervention techniques—may be helpful in some, though not all, cognitive–behavioral groups. In any case, most cognitive–behavioral groups emphasize structure, goal orientation, and a focus on immediate problems. Problem solving groups often have a specific protocol that systematically builds problemsolving skills and resources.

One example is a model cognitive–behavioral group for women with posttraumatic stress disorder (PTSD) and substance abuse designed to

- Educate clients about the two disorders
- Promote self-control skills to manage overwhelming emotions
- Teach functional behaviors that may have deteriorated as a result of the disorders
- Provide relapse prevention training (Najavits et al. 1996)

Cognitive–
behavioral groups
are particularly
appropriate in
early recovery.

The group format is an important element of the model, given the importance of social support for PTSD and substance use disorders. In addition, group treatment is a well-established, relatively low-cost modality, so it can successfully reach a large number of clients. Some key characteristics of this program are that it

- Uses a model designed for 24 sessions, in which 3–10 members meeting twice each week for 3 months in 90-minute group meetings
- Is early-recovery-oriented, with a strong focus on coping skills to gain control over symptoms
- Has homogeneous membership (for example, all women)
- Includes a six-session unit on relationships and themes, such as Safety and Self-protection and Reaching Out for Help
- Uses educational devices to promote rapid and sustained learning of material, such as visual aids, role preparation, memory improvement techniques, written summaries, review sessions, homework, and audiotapes of each session
- Focuses on both disorders, with instruction on stages of recovery to motivate members to achieve abstinence and control over PTSD symptoms (Najavits et al. 1996)

Another cognitive-behavioral model was employed to reduce the anger that can trigger renewed use of cocaine among 59 men and 32 women diagnosed with cocaine dependence. The model assumed that angry responses are learned behavior that can be changed. Clients in the pilot program were taught to gauge their anger levels and to use anger management strategies like time-outs and conflict resolution. During the 12 weeks of treatment, participants were able to reduce and control their anger more effectively than they had in the past, and these gains held at the follow-up 3 months after treatment. Violent behavior also decreased significantly (Reilly and Shopshire 2000).

Leadership skills and styles. Cognitive-behavioral therapies encompass a variety of methodological approaches, all focused on changing

cognition (beliefs, judgments, and perceptions) and the behavior that flows from it. Some approaches focus more on behavior, others on core beliefs, still others on developing problem-solving capabilities. Regardless of the particular focus, the group therapist conducting cognitive-behavioral groups should have a solid grounding in the broader theory of cognitive-behavioral therapy. This basis is the framework from which specific interventions can be drawn and implemented. Training in cognitive-behavioral theory is available in many workshops on counseling skills and in many alcohol and drug training programs for counselors. For instance, over a 2-week period in 2002, the Rutgers Summer Schools of Alcohol and Drug Studies offered seven week-long courses that concentrated specifically on cognitive counseling theory and methods. Many books are available on the theory of cognitive-behavioral therapy (Beck 1976; Ellis and MacLaren 1998; Glasser 2000; Leahy 1996) as well as self-help manuals with a cognitive-behavioral focus (Burns 1999; Greenberger and Padesky 1995). See chapter 7 for more information about training sources.

The level of interaction by the therapist in cognitive-behavioral groups can vary from very directive and active to relatively nondirective and inactive. It also can vary from highly confrontational with group members to relatively nonconfrontational demeanor. Perhaps the most common leadership style in cognitive-behavioral groups is active engagement and a consistently directive orientation.

A cautionary note: In cognitive-behavioral groups, the leader may be tempted to become the expert in how to think, how to express that thinking behaviorally, and how to solve problems. It is important not to yield to such a temptation, but instead to allow group members to use the power of the group to develop their own capabilities in these areas.

Techniques. Specific techniques may vary based on the particular orientation of the leader, but in general, techniques include those which (1) teach group members about self-

destructive behavior and thinking that leads to maladaptive behavior, (2) focus on problem-solving and short- and long-term goal setting, and (3) help clients monitor feelings and behavior, particularly those associated with drug use. More experienced leaders will have a wider range of specific techniques to engage participants and more comfort with a wider range of client needs and expectations.

An important element of conducting cognitive-behavioral groups is recognizing that behavioral change and intellectual insight gained in the group can be provocative and upsetting for clients with a poor sense of self, low self-esteem, and fear of emotional and interpersonal inadequacy. As a result, resistance to change inevitably will occur as the group evolves and behavioral changes begin to become routine. Experienced leaders learn to recognize, respect, and work with the resistance instead of simply confronting it. Clinical supervision is quite beneficial in learning a variety of styles of working with resistance generated by growth and change.

Many specific approaches to cognitive-behavioral therapy, including rational emotive therapy (Ellis 1997), reality therapy (Glasser 1965) and the work of Aaron Beck and colleagues (1993), incorporate various techniques specific to each approach. Substance abuse treatment counselors may find it useful to explore these approaches for techniques appropriate to their specific client populations.

Support Groups

The widespread use of support groups in the substance abuse treatment field originated in the self-help tradition in the field. These groups also have roots in the realization that significant lifestyle change is the long-term goal in treatment and that support groups can play a major role in such life transitions. Self-help groups share many of the tenets of support groups—unconditional acceptance, inward reflection, open and honest interpersonal interaction, and commitment to change. These groups attempt to help people with dependen-

cies sustain abstinence without necessarily understanding the determinants of their dependence (Cooper 1987).

The focus of support groups can range from strong leader-directed, problem-focused groups in early recovery, which focus on achieving abstinence and managing day-to-day living, to group-directed, emotionally and interpersonally focused groups in middle and later stages of recovery.

Purpose. Support groups bolster members' efforts to develop and strengthen the ability to manage their thinking and emotions and to develop better interpersonal skills as they recover from substance abuse. Support group members also help each other with pragmatic concerns, such as maintaining abstinence and managing day-to-day living. These groups are also used to improve members' general self-esteem and self-confidence. The group—or more often, the group leader—provides specific kinds of support, such as being sure to help clients avoid isolation and finding something positive to say about each participant's contribution. In some programs, support groups might be considered process (therapy) groups, but the main interest of support groups is not in the intrapsychic world, and the goal is not character change. Process issues may be involved, but support groups are less complex, more direct, and narrower in focus than process groups.

Principal characteristics. Many people with substance use disorders avoid treatment because the treatment itself threatens to increase their anxiety. Because of support groups' emphasis on emotional sustenance providing a safe environment, these groups are especially useful for apprehensive clients, indeed, for any client new to abstinence. The adjective "support" itself may be a way of destigmatizing the activity. For this reason, a "support" group may be more attractive to someone less committed to recovery than a "therapy" group.

Not all support groups, however, are intended just for clients new to recovery. Support groups

can be found for all stages of treatment in all sorts of settings (inpatient, outpatient, continuing care, etc.). While a support group always will have a clearly stated purpose, the purpose varies according to its members' motivation and stage of recovery. Many of these groups are open-ended, with a changing population of members. As new clients move into a particular stage of recovery, they may join a support group appropriate for that stage until they are ready to move on again. Groups may continue indefinitely, with new members coming in and old members leaving, and occasionally, returning. Program differences will also alter how this type of group is used. A support group will be different in a 4- to 6-week daily treatment program from the way it is used in a 1-year treatment community.

In a support group, members typically talk about their current situation and recent problems that have arisen. Discussion usually focuses on the practical matters of staying abstinent; for example, ways to deal with legal issues or avoid places that tempt people to use substances. Group members are encouraged to share and discuss their common experiences.

Issues that do not specifically relate to the focus of the group are often considered extraneous, so discussion of them is limited. Support groups provide guidance through peer feedback, and group members generally require accountability from each other. The group leader, however, will try to minimize confrontation within the group so as to keep anxiety levels low. In cohesive, highly functioning support groups, member-to-member or leader-to-member confrontation does occur.

Support groups can work from a variety of theoretical positions. Many reflect the 12-Step tradition in the substance abuse field, but other recovery tools, such as relapse prevention, can form the basis of a support group. Some support groups are based on theoretical frameworks such as cognitive therapies or spiritual paths. Programs may even design a support group by combining theories or philosophies.

Leadership skills and styles. Some support groups may be peer-generated or peer-led, but

this TIP is mainly concerned with groups led by a trained, professional group leader. Support group leaders need a solid grounding in how groups grow and evolve and the ways in which people interact and change in groups. It is also critical that group leaders have a theoretical framework for counseling (such as cognitive-behavioral therapy) that informs their approach to support group development, the therapeutic goals for group members, the guidance of group members' interactions, and the leader's implementation of specific intervention methods.

Since the leader should help build connections between members and emphasize what they have in common, it is useful for the leader to have participated in a support group and to have been supervised in support group work before undertaking leadership of such a group.

Training and supervision focused on how individuals develop psychologically, typical psychological conflicts, and the way these conflicts may appear in group therapy settings also may help the support group leader function more effectively, since such considerations help the leader understand individual members' behavior in the group.

The leadership style for someone running a support group typically will be less directive than for psychoeducational, skills development, or cognitive-behavioral groups because the support group is generally group-focused rather than leader-focused. The leader's primary role is to facilitate group discussion, helping group members share their experiences, grapple with their problems, and overcome difficult challenges. The group leader also provides positive reinforcement for group mem-

In a support group, members typically talk about their current situation and problems that have recently arisen.

bers, models appropriate interactions between individuals in the group, respects individual and group boundaries, and fosters open and honest communication in the group setting. In a most general way, the leader is active but not directive.

Techniques. The techniques of leading support groups vary with group goals and member needs. In general, leaders need to actively facilitate discussion among members, maintain appropriate group boundaries, help the group work through obstacles and conflicts, and provide acceptance of and regard for members. In a support group, the leader exercises the role of modeler of appropriate behaviors. In this way, the leader helps members grow and change.

Specific group techniques may appear to be less important for the leader of a support group, since the leader is usually less active in group direction and leadership. The techniques used in support groups, however, are simply less obvious.

Interventions, for example, are likely to be more interpretive and observational and less directive than in many other groups. The observations are generally limited to support for the progress of the group and facilitating supportive interaction among group members. The goal is not to provide insight to group members, but to facilitate the evolution of support within the group.

The support group leader is also responsible for monitoring each individual's progress in group and ensuring that individuals are participating (in their own way) and benefiting from the group

experience. Understanding some of the history of each person in the group, the leader also watches to see whether the group is providing each individual with emotional and interpersonal experiences that build success and skills that apply to life arenas outside the group. In addition to monitoring individuals in the group, the leader also monitors the progress of the group as a whole, making sure that group development proceeds through its predictable stages and does not become blocked at any stage of its evolution.

Finally the leader is responsible for recognizing interpersonal blocks or struggles between group members. It is not necessarily the responsibility of the leader to resolve these blocks, or even to point them out to group members, but to ensure that such struggles do not hinder the development of the group or any member of the group.

Interpersonal Process Group Psychotherapy

The interpersonal process group model for substance abuse treatment is grounded in an extensive body of theory (Brown 1985; Brown and Yalom 1977; Flores 1988; Flores and Mahon 1993; Khantzian et al. 1990; Matano and Yalom 1991; Vannicelli 1992; Washton 1992). Even this sharply defined area of process-oriented group therapies is widely diverse. Psychodynamic group therapies can be thought of as a generic name encompassing several ways of looking at the dynamics that take place in groups. Originally, these dynamics were considered in Freudian psychoanalytic terms that placed a heavy emphasis on sexual and aggressive drives, and conflicts and attachments between parents and children. Over the past half century many researchers, such as Jung, Adler, Bion, Noreno, Rogers, Perls, Yalom, and others, expanded or changed the Freudian emphasis. As a result, current dynamic conceptualizations include heavy emphasis on the social nature of human attachment, rivalry and social hierarchies, and cultural and spiritual concerns (i.e., existential issues and questions

Process-oriented group therapy uses the process of the group as the primary change mechanism.

of faith). This therapeutic approach focuses on healing by changing basic intrapsychic (within a person) or interpersonal (between people) psychological dynamics.

Thus, a student of process-oriented group therapy, a group treatment approach that uses the process of the group as the primary change mechanism, soon learns that the way Bion (1961) taught group therapy will be far different from the way other recognized authorities, such as Wolf and Schwartz (1962), taught. These theorists in turn differ from the process-orientation exemplified by Durkin (1964) or Glatzer (1969). The many theoretical variants differ in what they pay most of their attention to as group members interact.

Purpose. Interpersonal process groups use psychodynamics, or knowledge of the way people function psychologically, to promote change and healing. The psychodynamic approach recognizes that conflicting forces in the mind, some of which may be outside one's awareness, determine a person's behavior, whether healthy or unhealthy. Attachment to others is one of the contending forces. From a psychodynamic point of view, starting in early childhood, developmental issues are a key concern, as are environmental influences, to which certain people are particularly vulnerable because of their genetic and other biological characteristics. For those people who have been drawn to substance abuse, the interpersonal process group raises and re-examines fundamental developmental issues. As faulty relationship patterns are perceived and identified, the group participant can begin to change dysfunctional, destructive patterns. The group member becomes increasingly able to form mutually satisfying relationships with other people, so alcohol and drugs lose much of their power and appeal.

Basic tenets of the psychodynamic approach include the following

- *Early experience affects later experience.* Individuals bring their histories—personal, cultural, psychological, and spiritual—to therapy.

- *Sometimes perceptions distort reality.* People often draw generalizations from their life experiences and apply the generalizations to the current environment, even when doing so is inappropriate or counterproductive. These “cognitive distortions” may serve to maintain habits people would otherwise like to change.
- *Psychological and cognitive processes outside awareness influence behavior.* As clients become conscious of some formerly subconscious processes supporting a behavior they want to change, this information can be used to alter dysfunctional relationships.
- *Behaviors are chosen to adapt to situations and protect people from harm.* A specific behavior is a person's best effort to adapt to a particular situation given individual make-up, environment, and personal history. In a sense, people come to therapy because of their solutions, not their problems.

Within the interpersonal process model, the objects of interest are the here-and-now interactions among members. Of less importance is what happens outside the group or in the past. All therapists using a “process-oriented group therapy” model continually monitor three dynamics:

- The psychological functioning of each group member (intrapsychic dynamics)
- The way people are relating to one another in the group setting (interpersonal dynamics)
- How the group as a whole is functioning (group-as-a-whole dynamics)

A group leader conducting an interpersonal process group, however, will tend to pay more attention to the interpersonal dynamics and concentrate less on each member's individual psychological dynamics and the workings of the group as a whole. The section that follows includes illustrations (Figures 2-3 to 2-6) of how groups might differ according to their focus on intrapsychic, interpersonal, and group-as-a-whole dynamics.

The experienced group leader knows that the intervention chosen at any moment in the group will have an impact on all three dynamics and

that a delicate balance must be struck in the attention given to each. A too-intense focus on group members' interaction, to the exclusion of attention to individual psychological needs or the needs of the group as a whole, blunts the effectiveness and relevance of group development.

Principal characteristics. Interpersonal process group therapy delves into major developmental issues, searching for patterns that contribute to addiction or interfere with recovery. The group becomes a microcosm of the way group members relate to people in their daily lives.

The Interpersonal Process Group Psychotherapy (IPGP) model links the abstinence-based treatment approach with current psychological principles of treatment, while still remaining compatible with 12-Step theory and practice. IPGP and substance abuse treatment both recognize that a person's capacity for healthy interpersonal relationships supports solid recovery from substance abuse. IPGP is easy to understand and adapt because it is

- **Pragmatic.** IPGP is a practical, nuts and bolts, hands-on type of group treatment. It focuses on results, not abstract concepts and all-encompassing theories, and its results-oriented nature is especially satisfying to a population that needs some swift, positive outcomes. This feature is especially important during the early phases of treatment, when the window of opportunity for influencing clients is small and open only briefly.
- **Applicable.** IPGP is a very adaptable model. Because it can so readily be modified, it can be applied in diverse sets of difficulties and under various circumstances. IPGP furnishes the group leader with a set of strategic tools that are easy to acquire and use. The IPGP model provides enough structure to prevent unproductive discussion. This is especially desirable because few will tolerate a passive group leader who waits for issues to evolve out of the flow of the group. On the other hand, many people who abuse substances will react negatively to a domineering

or authoritarian leader. The IPGP model permits a group experience that is neither leader-dependent nor leader-centered. This generally egalitarian setting helps to reduce resistance.

- **Synergistic.** IPGP and substance abuse treatment complement each other, reciprocally setting the scene for the establishment of the crucial components of effective treatment. The combination of IPGP and substance abuse treatment allows the client to experience treatment as emotionally supportive. This sparing of the client's self-image enables the client to identify positively with treatment and mutes any strong reactions to the counselor. Further, the combination of these two treatment approaches can ease the client's handling of shame, the need to change aspects of self, the uncomfortable newness of the recovery period, and the therapeutic experience itself. Recovery can proceed as clients experience and re-experience deep attachment dynamics and use the experience to craft major changes in character and behavior.

Leadership skills and styles. In interpersonal process groups, content is a secondary concern. Instead, leaders focus on the present, noticing signs of people recreating their past in what is going on between and among members of the group. If, for example, a person has a problem with anger, this problem eventually will be re-enacted in the group. When an angry group member, "George," explodes at "Charlie," the therapist might say, "George, you seem to be having a strong response to Charlie right now. Who does Charlie remind you of? Does this feel familiar? Has anything like this happened to you before?"

On one hand, the interpersonal process group leader monitors how group members are relating, how each member is functioning psychologically or emotionally, and how the group as a whole is functioning. On the other hand, the interpersonal process group leader observes a variety of group dynamics, such as the stages of group development, how leadership is emerging in the group, the strengths each individual is

bringing to the group as a whole, and how individual resistances to change are interacting with and influencing group functioning. The interventions of the leader are dependent on his or her perceptions of this mix.

Since the group leader's theoretical persuasion, training, experience, and personality determine the level of intervention that takes priority at a particular time, it is rare to find two interpersonal process group leaders who will conduct a group in exactly the same manner. Even so, leaders in this type of group are not fonts of information, skill builders, problemsolving directors, or client boosters. In interpersonal process group therapy, the leader's job is to promote and probe interactions that carry a point.

Most group leaders who apply a process-oriented approach to group therapy with people who abuse substances recognize the theoretical influence of the Interactional Model (Yalom 1975). Yalom recommends an adaptable approach to group treatment, one that allows easily applied modifications across the continuum of the recovery needs of an individual who abuses substances. His model can be tightened (to have more structure) early in treatment and can subsequently be loosened (to relax structure) as more abstinent time passes, recovery is solidified, and the danger of relapse decreases.

Techniques. In practice, group leaders may use different models at various times, and may simultaneously influence more than one focus level at a time. For example, a group that focuses on changing the individual will also have an impact on the group's interpersonal relations and the group-as-a-whole. Groups will, however, have a general orientation that determines the focus the majority of the time. This focus is an entry point for the group leader, helping to provide direction when working with the group.

Specific techniques of the process group leader will vary, not only with the type of process group, but also with the developmental stage of the group. Early on in group development, process group leaders might consciously decide

to be more or less active in the group life. They might also choose, based on the needs of the group, to make more or fewer interpretations of individual and group dynamics to the group as a whole. Likewise they might choose to show more warmth and supportiveness toward group members or take a more aloof position. For instance, in contrast to leading a support group, where the leader is likely to be unconditionally affirming, the process leader might make a conscious decision to allow clients to struggle to affirm themselves, rather than essentially doing it for them.

Such choices should be based on the needs of group members and the needs of the group as a whole, rather than the style that is most comfortable for the group leader. Obviously such tactical decisions require a high degree of understanding and insight about group dynamics and individual behavior. For this reason, almost all leaders of process groups will seek supervision and consultation to guide them in making the best tactical decisions on behalf of the group and its members.

Three group dynamics in practice

When deciding on a model for a substance abuse treatment group, programs need to consider their resources, the training and theoretical orientation of group leaders, and the needs and desires of clients in order to determine what approaches are feasible. While it is beyond the scope of this TIP to provide detailed instruction on how to run each of the different models of groups, the following figures do illustrate the basic differences among the psychodynamic emphases. Figure 2-3 describes an argument drawn from a problem-focused

In interpersonal process groups, leaders focus on the present.

Figure 2-3

Group Vignette: Joe's Argument With His Roommate

Before the first meeting of a new problem-focused group, Joe had been arguing with his roommate because the roommate had forgotten to pay the phone bill the previous month. Joe had told his roommate, Mike, that he might remember to pay the bills on time if he were not smoking pot every day, and they began an angry discussion about the roommate's drug use. Joe tells the group that he wants to talk about his distrust of his roommate. Joe is not currently using drugs, but he is still struggling with attempts to control his drinking. Group members are generally supportive of Joe in his argument with his roommate. They express concern that he is living with someone who is actively using marijuana and other drugs. One group member, Jane, voices strong objections, however, to Joe's lack of trust for his roommate. Jane is struggling with her own abuse of prescription tranquilizers, and she is typically rather quiet and anxious in group. Nonetheless, she attacks Joe verbally with uncharacteristic vehemence.

Source: Adapted from Flores 1997.

group, which assists people in resolving a specific problem in their lives. (For additional information on this type of group, see the last section in this chapter. The reader also may refer to appendix B of TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT 1999a], for a list of resources that can provide further training and information about the theoretical orientations that influence these groups.)

Individually focused groups

The individually focused group concentrates on individual members of the group and their distinctive internal cognitive and emotional processes. How the client interacts in the world at large is not on the agenda. The group instead strives to modify clients' behavior. This model is used with a range of technical and theoretical approaches to group therapy, including cognitive therapy, expressive therapies, psychodrama, transactional analysis, redecision therapy, Gestalt, and reality therapy (see section below for further discussion of expressive therapies

and psychodrama as well as the glossary in appendix D).

The group is conceived as an aggregate of individuals in which the group leader generally works sequentially with one group member at a time. While one individual's issues are addressed, the other group members serve as observers, contributors, alter egos, or significant others. Generally, however, more than one group member will be involved in the conversation at one time, and all group members will be encouraged to actively help each other and learn from each other's experiences. This model of group does not require a client to have insight into a problem but does require awareness of behavior and its immediate causes and consequences. Some individually oriented approaches will use group members in a structured/directive way, such as in a role-playing exercise.

In the more cognitively oriented approaches, clients will focus on their behaviors in relation to thoughts. The more expressive form of individually oriented groups is particularly bene-

ficial for clients who need a structured environment or have so much contained, powerful emotion that they need some creative way of releasing it.

Individually focused groups are useful to identify the first concrete steps in coping with substance abuse. They can help clients become more aware of behavior and its causes, and at the same time, they increase the client's range of options as to how to behave. The ideal end result is the client's freedom from an unproductive or destructive behavior.

Figure 2-4 describes how an individually focused group might respond to the conflict described in Figure 2-3.

Interpersonally focused groups

Interpersonally focused groups generally work from a theory of interactional group therapy, most often associated with the work of Irving Yalom (1995). Other examples of this model of

group include sensitivity training, or T-groups (Bradford et al. 1964), and L. Ormont's Modern Analytic Approach (Ormont 1992). In groups that follow this model, emphasis is placed primarily on current interactions between and among group members. Clients are urged to explore how they behave, how this behavior affects others, and how others' behavior affects them.

In interpersonally focused groups, the group leader serves as a role model, but does not explicitly assess the clients' behavior. That task is left to other group members, who evaluate each other's behavior. The group leader monitors the way clients relate to one another, and reinforces therapeutic group norms, such as members responding to each other in an emphatic way. The leader also steps in to extinguish contratherapeutic norms that might damage group cohesion or to point out behavior that could inhibit empathic relationships within the group.

Figure 2-4

Joe's Case in an Individually Focused Group

The group leader in an individually focused group might work first with Joe and then Jane (or vice versa, depending on who seemed to have the more pressing issues). The group leader might ask Joe to tell the group more about his anger and how he experiences it and might ask him to say why he has difficulty trusting his roommate. Joe could be urged to see how this situation might relate to other circumstances and how his reaction to his roommate's substance abuse might help him understand his own problems with drinking. The leader might use role-playing techniques with Joe so that he can practice how he will interact with his roommate and better understand his reaction to his roommate's behavior. Jane might be asked why Joe's reaction to his roommate made her so angry. The group leader could try to help her see if Joe reminded her of anyone and whether she identified with the roommate because she too had been judged. Her fears of being judged might be related to her own substance abuse, and the group could explore that possibility.

Source: Adapted from Flores 1997.

Figure 2-5

Joe's Case in an Interpersonally Focused Group

A group leader working from an interpersonally focused group model would direct the group's attention to what is going on between Joe and Jane. The leader might ask Jane if she can tell Joe directly how his statements have made her feel, and then ask Joe to say how he feels about what she said. The group leader might also ask Joe if he sees any parallel in his response to both his roommate and Jane. The leader might ask him if Jane could have reported what she felt in a way that would make him feel less defensive. Jane might tell Joe that she is reacting to his judgmental behavior toward his roommate and his evasiveness about his own drinking. This interaction confronts Joe's denial. If Jane discloses the reasons behind her response to Joe, namely that her husband distrusts her in a similar manner, the group leader would turn the issue over to the group, perhaps asking Jane how she thinks Joe feels about her. Another group member who has worked on issues concerning trust may interpret what is really going on between Joe and Jane. The goal is to help Joe and Jane deal authentically and realistically with one another, and strengthen the attachment between them. This analysis of relationships within the group may ultimately transfer to settings outside the group and improve Joe's and Jane's relationships with others outside the group.

Source: Adapted from Flores 1997.

Figure 2-5 describes how an interpersonally focused group might respond to the conflict described in Figure 2-3.

Group-as-a-whole focused groups

The theoretical approaches most often associated with the group-as-a-whole orientation are Tavistock's Group-as-a-Whole (Bion 1961; Rice 1965), Agazarian Systems-Centered Therapy for Group (Agazarian 1992), Bion's primary assumption groups (Bion 1961), and the focal conflict model (Whitaker and Lieberman 1965). As the name suggests, in this model, the group leader focuses on the group as a single entity or system. While model variations may recognize the group as an aggregate of individuals (the Systems-Centered Therapy does, for instance), the emphasis remains on the group

as a single unit with its own ways of operating in the world.

This model generally is inappropriate for clients with substance use disorders—at least as the sole approach to treatment. It can be harmful, especially to clients new to recovery, and can add to their problems without helping them manage their substance abuse. Certain techniques taken from this approach, however, may be used productively in an eclectic treatment group. For example, when the entire group seems to be sharing a mood, behavior, or viewpoint, a group leader may choose to use mass group process comments, such as “You all seem quiet today” or “Almost everyone is gang-ing up on Jim.”

Figure 2-6 describes how a group-as-a-whole focused group might handle Joe's problem.

Figure 2-6

Joe's Case in a Group-As-A-Whole Focused Group

A group leader with a Bion orientation would notice a lot of conflict swirling around this incident and that the group is in a “fight mode.” The point of interest would be the source of the tension and how it interferes with the work of the group, which is the recovery process. The leader might note that the group has become very involved in this discussion as a way of evading issues of trust common to the whole group. Is the group perhaps fleeing from dealing directly with trust? Looking at Jane’s response, the group leader would consider whether Jane’s response is carrying something for the group, that is, representing a group concern about whether the group will judge members for what they have to say. The discussion might be redirected toward how the group is coping with feelings of uncertainty about continued substance use.

Source: Adapted from Flores 1997.

Three cautionary notes

These vignettes illustrate the different interventions available. No single approach necessarily is more appropriate than any other. The critical question is always, “Is this approach the most likely to succeed with this particular group in substance abuse treatment?”

In addition to making the right strategic choice of approach, the interventions should be done at the right time. Treatment as a time-dependent process should be the guiding principle when working with people with addictions in group.

Finally, what works for the client without addictions will not always work with a client with addictions. Consequently, the rest of this TIP will be dedicated to exploring the modifications in group technique that need to be made when treating people with substance use disorders.

Specialized Groups in Substance Abuse Treatment

A variety of therapeutic groups that do not fit in the already-described group models may be employed in substance abuse treatment settings. Some of these specialized groups are unique to substance abuse treatment (like relapse prevention), and others are unique in format, group membership, or structure (such as culturally specific groups and expressive therapy groups). It would be impossible to describe all of the types of special groups that might be used in substance abuse treatment. The three that follow represent a cross-section of special groups.

Relapse Prevention

Relapse prevention groups focus on helping a client maintain abstinence or recover from relapse. This kind of group is appropriate for clients who have attained abstinence, but who have not necessarily established a proven track record indicating they have all the skills to maintain a drug-free state. Relapse prevention

also can be helpful for people in crisis or who are in some way susceptible to a return to substance use.

Purpose. Relapse prevention groups help clients maintain their sobriety by providing them with the skills and knowledge to “anticipate, identify, and manage high-risk situations” that lead to relapse into substance use “while also making security preparations for their future by striving for broader life balance” (Dimeff and Marlatt 1995, p. 176). Thus, relapse prevention is a double-level initiative. It aims both to upgrade a client’s ability to manage risky situations and to stabilize a client’s lifestyle through changes in behavior (Dimeff and Marlatt 1995).

Principal characteristics. Relapse prevention groups focus on activities, problemsolving, and skills-building. They also may take the form of psychotherapy. For instance, Khantzian et al. (1992) assert that, because the same traits in personality and character predispose people to use substances initially and to relapse during recovery, psychodynamic approaches can mitigate psychological vulnerabilities. Because relapse prevention groups may use techniques drawn from all of these types of groups, they are considered a special type of group in this TIP.

Relapse prevention groups focus on activities, problemsolving, and skills-building.

The different models for relapse prevention groups (Donovan and Chaney 1985) include those developed by Annis and Davis (1988), Daley (1989), Gorski and Miller (1982), and Marlatt (1982). All of these models are derived from principles of cognitive therapy. Some, such as that of Marlatt, classify relapse prevention as a form of

skills development; other models tend to emphasize support.

These approaches share a number of basic elements, including teaching clients to recognize high-risk situations that may lead to relapse, preparing them to meet those high-risk situations, and helping them develop balance and alternative ways of coping with stressful situations. Many of these approaches also increase group members’ feelings of self-control, so they feel capable of resisting relapse. (More information on the techniques of relapse prevention appears in TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT 1999a].)

Research has demonstrated that relapse is common and to be expected during the process of recovery (Project MATCH 1997). In a meta-analysis of 24 controlled clinical trials evaluating relapse prevention programs delivered in both group and individual formats, Carroll (1996) found that relapse prevention groups were effective in comparison to no-treatment controls for many substances of abuse; the groups were most effective for smoking cessation. Carroll also notes that relapse prevention groups seem to reduce the intensity of relapse when it occurs. Groups also appear to be more effective than other approaches for clients who have “more severe levels of substance use, greater levels of negative affect, and greater perceived deficits in coping skills” (1996, p. 52).

Research also suggests that relapse prevention can be conducted in both group and one-on-one formats, with little measurable difference in outcomes. Schmitz and colleagues (1997) compared relapse prevention for cocaine abuse delivered in group and individual formats. Both demonstrated favorable outcomes; no significant difference was detected in cocaine use as measured by urine tests. Clients treated in groups, however, reported fewer cocaine-related problems than those treated in individual sessions. Further, McKay et al. (1997) found that 6 months after intensive outpatient treatment for cocaine abuse, subjects treated in a group setting displayed higher rates

of sustained abstinence than those treated individually.

Relapse prevention carried out in group settings enables clients to explore the problems of daily life and recovery together and to work collaboratively to isolate and overcome problems. Because of these dual goals, relapse prevention groups may improve clients' quality of life. However, as Schmitz and colleagues note, it may also be the case that the group experience makes members less willing to report the severity of their problems or cause them to feel that their problems are less severe by comparison to those of others (Schmitz et al. 1997).

Leadership skills and styles. Leaders of relapse prevention groups need to have a set of skills similar to those needed for a skills development group. However, they also need experience working in relapse prevention, which requires specialized training, perhaps in a particular model of relapse prevention. Leaders also need a well-developed ability to work on group process issues.

Group leaders need to be able to monitor client participation to determine risk for relapse, to perceive signs of environmental stress, and to know when a client needs a particular intervention. Above all, group leaders should know how to handle relapse and help the group process such an event in a nonjudgmental, nonpunitive way—clients, after all, need to feel safe in the group and in their recovery. Leaders should know how to help the group manage the abstinence violation effect, in which a single lapse leads to a major recurrence of the addiction.

Additionally, the leader of a relapse prevention group should understand the range of consequences a client faces because of relapse. These consequences can be culturally specific responses, criminal justice penalties, child protective services actions, welfare-to-work setbacks, and so on. The group leader, like any counselor, should know the confidentiality rules (42 C.F.R. Part 2) and the legal reporting requirements relating to client relapse.

Techniques. Relapse prevention groups draw on techniques used in a variety of other types of groups, especially the cognitive-behavioral, psychoeducational, skills development, and process-oriented groups. Because the purpose of a relapse prevention group is to help members develop new ways of living and relating to others, thereby undercutting the need to return to substance use or abuse, potential group members need to achieve a period of abstinence before joining a relapse prevention group.

Communal and Culturally Specific Groups

Restoring lost cultural ties or providing a sense of cultural belonging can be a powerful therapeutic force in substance abuse treatment, and in important ways, substance abuse is intimately intertwined with the cultural context in which it occurs. Cultural prohibitions against substance use and cultural patterns of permissible use define, in part, what is reasonable use and what is abuse of substances (Westermeyer 1995). Risk factors such as cultural displacement or discrimination cause substance abuse rates to rise drastically for a given population. Problems that pervade particular cultures, such as racism, poverty, and unemployment, have an impact on the incidence of substance abuse and are appropriate focuses for intervention in substance abuse treatment (Taylor and Jackson 1990; Thornton and Carter 1988).

Communal and culturally specific wellness activities and groups include a wide range of activities that use a specific culture's healing practices and adjust therapy to cultural values. For instance, Hispanics/Latinos generally share a value of *personalismo*, a preference for person-to-person contact. Effective substance abuse treatment providers thus build personal relationships with clients before turning to the tasks of treatment. Also, at the outset of treatment, personal relationships do not yet exist. At this point, a client's hesitation should not be mistaken for resistance (Millan and Ivory 1994).

Three common ways to integrate such strengths-focused activities into a substance abuse treatment program are

- Culturally specific group wellness activities may be used in a treatment program to help clients heal from substance abuse and problems related to it.
- Culturally specific practices or concepts can be integrated into a therapeutic group to instruct clients or assist them in some aspect of recovery. For example, a psychoeducational group formed to help clients develop a balance in their lives might use an American Indian medicine wheel diagram or the seven principles of Kwanzaa. The medicine wheel represents four dimensions of wellness: belonging, independence, mastery, and generosity. These four concepts promote wellness for the individual and collective good of the American-Indian tribal group and humanity/environments. Kwanzaa is based on a value system of seven principles called the Nguzo Saba. The Kwanzaa paradigm is a nonreligious, nonheroic ritual that has been widely embraced by the national African-American community. The Nguzo Saba and other Kwanzaa symbols and practices can be used therapeutically in the regrounding and reconnecting process for African-American clients.
- Culturally or community-specific treatment groups may be developed within a services program or in a substance abuse treatment program serving a heterogeneous population with a significant minority population of a specific type. Examples might include a group for people with cognitive disabilities, or a bilingual group for recent immigrants. Such groups typically are process- or support-oriented, though they also may have psychoeducational components. The groups help minority group members understand

their own background, cope with prejudice, and resolve other problems related to minority status. Groups described in this TIP fall into this category.

Purpose. Groups and practices that accentuate cultural affinity help curtail substance abuse by using a particular culture's healing practices and tapping into the healing power of a communal and cultural heritage. Many have commented on the usefulness of these types of groups (Trepper et al. 1997; Westermeyer 1995), and clinical experience supports their utility. As this TIP is written, little research-based evidence has accumulated to confirm the effectiveness of this approach. Research is needed to evaluate the effectiveness of culturally specific groups and ascertain the primary indications for their use.

Principal characteristics. Different cultures have developed their own views of what constitutes a healthy and happy life. These ideas may prove more relevant and understandable to members of a minority culture than do the values of the dominant culture, which sometimes can alienate rather than heal. All cultures also have specific processes for promoting wellness among their members.

In using a culture's healing practices or group activities, whether in heterogeneous or homogeneous groups (that is, all one culture or a mix of cultures), treatment providers should be careful to show respect for the culture and its healing practices. As long as respect and awareness are evident, the use of such practices will not harm the members of a particular culture.

Leadership characteristics and style. Group leaders always need to strive to be culturally competent with members of the various populations who enter their programs.¹ Substance

¹ See chapter 3 of this TIP and the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (SAMHSA in development a) for more information on cultural competence. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998b), contains information on being sensitive and responsive to the needs of people with disabilities, and *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001) has information on working with gay and lesbian populations.

abuse treatment counselors first need to be aware of the demographics in their program areas, and to be aware as well that there are many people from mixed ethnic backgrounds who do not necessarily know or recognize their cultural heritage. Clinicians should actively avoid stereotyping clients based on their looks, and instead allow them to self-identify. Clients should be asked what it means to them to belong to a particular group. Clinicians also should be sensitive to self-identification issues such as sexual orientation, gender identification, and disability. When in doubt, clinicians should discuss the issue privately with the client.

A group leader for a culturally specific group will need to be sensitive and creative. How much authority leaders will exercise and how interactive they will be depends on the values

and practices of the cultural group. The group leader should pay attention to a number of factors, all of which should be considered in any group but which will be particularly important in culturally specific groups. Clinicians should

- Be aware of cultural attitudes and resistances toward groups.
- Understand the dominant culture's view of the cultural group or community and how that affects members of the group.
- Be able to validate and acknowledge past and current oppression, with a goal of helping to empower group members.
- Be aware of a cultural group's collective grief and anger and how it can affect countertransference issues.

Figure 2-7

The SageWind Model for Group Therapy

In programs that have the resources, the capacity to offer a variety of types of groups addressing a range of client needs is preferred. SageWind in Reno, Nevada, offers more than 100 groups each week.

To assess each client's unique needs, SageWind's comprehensive biopsychosocial assessment evaluates the severity of a client's substance abuse. In addition, the clinical team, the client, and any others concerned (such as probation or parole officers, parents or legal guardians, or social workers) determine the best course of group therapy formats.

Group intervention ranges in intensity from one group per week to more than 20. The large number of weekly groups offered in SageWind's menu of options covers a continuum of treatment options from psychoeducational to skills-building to experiential to process-oriented. In a structured program similar to that of a university, where fundamental courses are required before more advanced ones may be taken, clients attend the groups they need, then change to others and progress through the program. Clients complete groups, moving to more advanced formats until they have met discharge criteria based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria-2R (PPC-2R) (ASAM 2001).

- Focus on what is held in common among members of the group, being sensitive to differences.

The SageWind Model for group therapy, discussed in Figure 2-7 (see p. 33), provides individually tailored interventions for its clients.

Techniques. Different cultures have specific activities that can be used in a treatment setting. Some common elements in treatment include storytelling, rituals and religious practices, holiday celebrations, retreats, and rites of passage practice (these may be particularly useful for adolescent clients).

Culturally specific groups work best if all members of the population become involved in the activity, even the clients who are not familiar with their cultural heritage. In fact, the reasons for that lack of familiarity can become a topic of discussion. Helping clients understand what they have lost by being separated from their cultural heritage, whether because of substance abuse or societal forces, can provide one more reason to continue in sobriety.

Expressive Groups

This category includes a range of therapeutic activities that allow clients to express feelings and thoughts—conscious or unconscious—that they might have difficulty communicating with spoken words alone.

Purpose. Expressive therapy groups generally foster social interaction among group members as they engage either together or independently in a creative activity. These groups therefore can improve socialization and the development of creative interests. Further, by enabling clients to express themselves in ways they might not be able to in traditional talking therapies, expressive therapies can help clients explore their substance abuse, its origins, the effect it has had on their lives, and new options for coping. These groups can also help clients resolve trauma (like child abuse or domestic violence) that may have been a progenitor of their substance abuse. For example, Glover (1999)

states that play therapy and art therapy are particularly useful for substance abuse treatment clients who have been incest victims. Play and art therapies enable these clients to work through their trauma and substance abuse issues using alternatives to verbal communication (Glover 1999).

Although a number of articles have theorized about the usefulness of various types of expressive therapy for clients with substance use disorders, little study on the subject has used rigorous research methods. Clinical observation, however, has suggested benefits for female clients involved in dance therapy (Goodison and Schafer 1999). Client self-reports suggest the value of psychodrama for female clients in treatment for alcoholism, particularly for highly educated women and those who are inclined to be extroverted and verbally expressive (Loughlin 1992).

As Galanter and colleagues note, expressive therapy groups—which they called “activity groups”—often can be “the source of valuable insight into patients’ deficits and assets, both of which may go undetected by treatment staff members concerned with more narrowly focused treatment interventions” (Galanter et al. 1998, p. 528).

Principal characteristics. The actual characteristics of an expressive therapy group will depend on the form of expression clients are asked to use. Expressive therapy may use art, music, drama, psychodrama, Gestalt, bioenergetics, psychomotor, play (often with children) games, dance, free movement, or poetry.

Leadership characteristics and style.

Expressive group leaders generally will have a highly interactive style in group. They will need to focus the group’s attention on creative activities while remaining mindful of group process issues. The leader of an expressive group will need to be trained in the particular modality to be used (for example, art therapy).

Expressive therapies can require highly skilled staff, and, if a program does not have a trained staff person, it may need to hire an outside consultant to provide these services. Any con-

sultant working with the group should be in regular communication with other staff, since expressive activities need to be integrated into the overall program, and group leaders need to know about each client if they are to understand their work in the group.

Expressive therapies can stir up very powerful feelings and memories. The group leader should be able to recognize the signs of reactions to trauma and be able to contain clients' emotional responses when necessary. Group leaders need to know as well how to help clients obtain the resources they need to work through their powerful emotions.

Finally, it is important to be sensitive to a client's ability and willingness to participate in an activity. To protect participants who may be in a vulnerable emotional state, the leader should be able to set boundaries for group members' behavior. For example, in a movement therapy group, participants need to be aware of each other's personal space and understand what types of touching are not permissible.

Techniques. The techniques used in expressive groups depend on the type of expressive therapy being conducted. Generally, however, these groups set clients to work on an activity. Sometimes clients may work individually, as in the case of painting or drawing. At other times, they may work as a group to perform music. After clients have spent some time working on this activity, the group comes together to discuss the experience and receive feedback from the group leader and each other. In all expressive therapy groups, client participation is a paramount goal. All clients need to be involved in the group activity if the therapy is to exert its full effect.

Groups Focused on Specific Problems

In addition to the five *models* of therapeutic groups and three specialized *types* of groups discussed above, groups can be classified by *purpose*. The problem-focused group is a spe-

cific form of cognitive-behavioral group used to eliminate or modify a single particular problem, such as shyness, loss of a loved one, or substance abuse. In sheer numbers, these groups are the most widespread.

Additionally, problemsolving groups are directed from a cognitive-behavioral framework. They focus on problems of daily life for people in early and middle recovery, helping group members learn problemsolving skills, cope with everyday difficulties, and develop the ability to give and receive support in a group setting. As clients discuss problems they face, these problems are generalized to the experience of group members, who offer support and insight.

Purpose. Problem-focused groups' primary purpose is to "change, alter, or eliminate a group member's self-destructive or self-defeating target behavior. Such groups are usually short-term and historically have been used with addictive types of behavior (smoking, eating, taking drugs) as well as when the focus is on symptom reduction...or behavioral rehearsal" (Flores 1997, p. 40).

Principal characteristics. Problem-focused groups are short (commonly 10 or 12 weeks), highly structured groups of people who share a specific problem. This type of group is not intended to increase client insight, and little or no emphasis is placed on self-exploration. Instead, the group helps clients develop effective coping mechanisms to enable them to meet social obligations and to initiate recovery from substance abuse. The group's focus, for the most part, is on one symptom or behavior, and they use the cohesiveness among clients to

Expressive
therapy groups
foster social
interaction as
members engage
in a creative
activity.

increase the rate of treatment compliance and change. A problem-focused group commonly is used in the early stages of recovery to help clients engage in treatment, learn new skills, and commit to sobriety. This kind of group is helpful particularly for new clients; its homogeneity and simple focus help to allay feelings of vulnerability and anxiety.

The leader in a problem-focused group usually is active and directive.

Leadership characteristics and styles. The group leader usually is active and directive. Interaction within the group is limited typically to exchanges between individual clients and the group leader; the rest of the group acts to confront or support

the client according to the leader's guidance.

Techniques. Many traditional recovery groups fall into the problem-focused category, which includes abstinence maintenance, relapse prevention, support, behavior management, and many continuing care groups. Other examples are groups that help support people with a spe-

cific problem or loss (such as breast cancer or suicide in the family), help people alter a particular behavior or trait (like overeating or shyness), or learn a new skill or behavior (for instance, conflict resolution or assertiveness training).

In practice, group leaders may use different models at various times, and may simultaneously influence more than one focus level at a time. For example, a group that focuses on changing the individual will also have an impact on the group's interpersonal relations and the group-as-a-whole. Groups will, however, have a general orientation that determines the focus the majority of the time. This focus is an entry point for the group leader, helping to provide direction when working with the group.

When deciding on a model for a substance abuse treatment group, programs will need to consider their resources, the training and theoretical orientation of group leaders, and the needs and desires of clients in order to determine what approaches are feasible. The reader may also refer to appendix B of TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999a), for a list of resources that can provide further training and information about the theoretical orientations that influence these groups.

3 Criteria for the Placement of Clients in Groups

In This Chapter...

Matching Clients With Groups

Assessing Client Readiness for Group

Primary Placement Considerations
Stages of Recovery

Placing Clients From Racial or Ethnic Minorities

Diversity in a Broad Sense

Leader Self-Assessment

Diversity and Placement

Ethnic and Cultural Matching

Other Considerations for Practice

Overview

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

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

Matching Clients With Groups

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

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

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

Assessing Client Readiness for Group

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

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

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

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

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

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

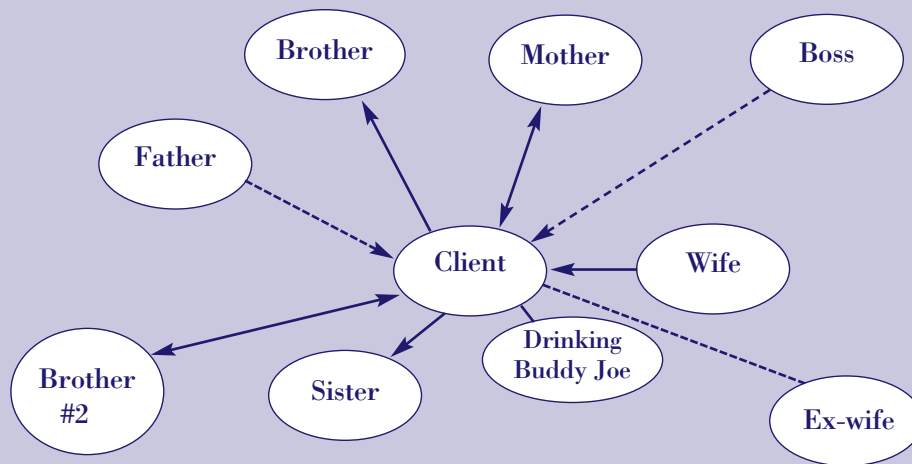


Figure 3-1

Eco-Map

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

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

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

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

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

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

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

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

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

Primary Placement Considerations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In placement,
both the client's
and the group's
best interests need
to be considered.

Every effort should be made to place the client in a group in which the client can succeed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stages of Recovery

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

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

Figure 3-2

Client Placement by Stage of Recovery

	Psycho-education	Skills-Building	Cognitive-Behavioral	Support	Inter-personal Process	Relapse Prevention	Ex-pressive	Culture-Specific
Early	+++	++	+	+++	+		+	*
Middle	+	++	++	++	+++	+++	+	*
Late and Maintenance			++	+	+++			*

Key:
 Blank Generally not appropriate
 + Sometimes necessary
 ++ Usually necessary
 +++ Necessary and most important

Source: Consensus Panel.

Figure 3-3

Client Placement Based on Readiness for Change

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

Source: Consensus Panel; Prochaska and DiClemente 1984.

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

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

Placing Clients From Racial or Ethnic Minorities

Diversity in a Broad Sense

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

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

Considerations such as age, gender, cultural

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

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

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

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

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

Figure 3-4

What Is Culture?

Culture: Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.

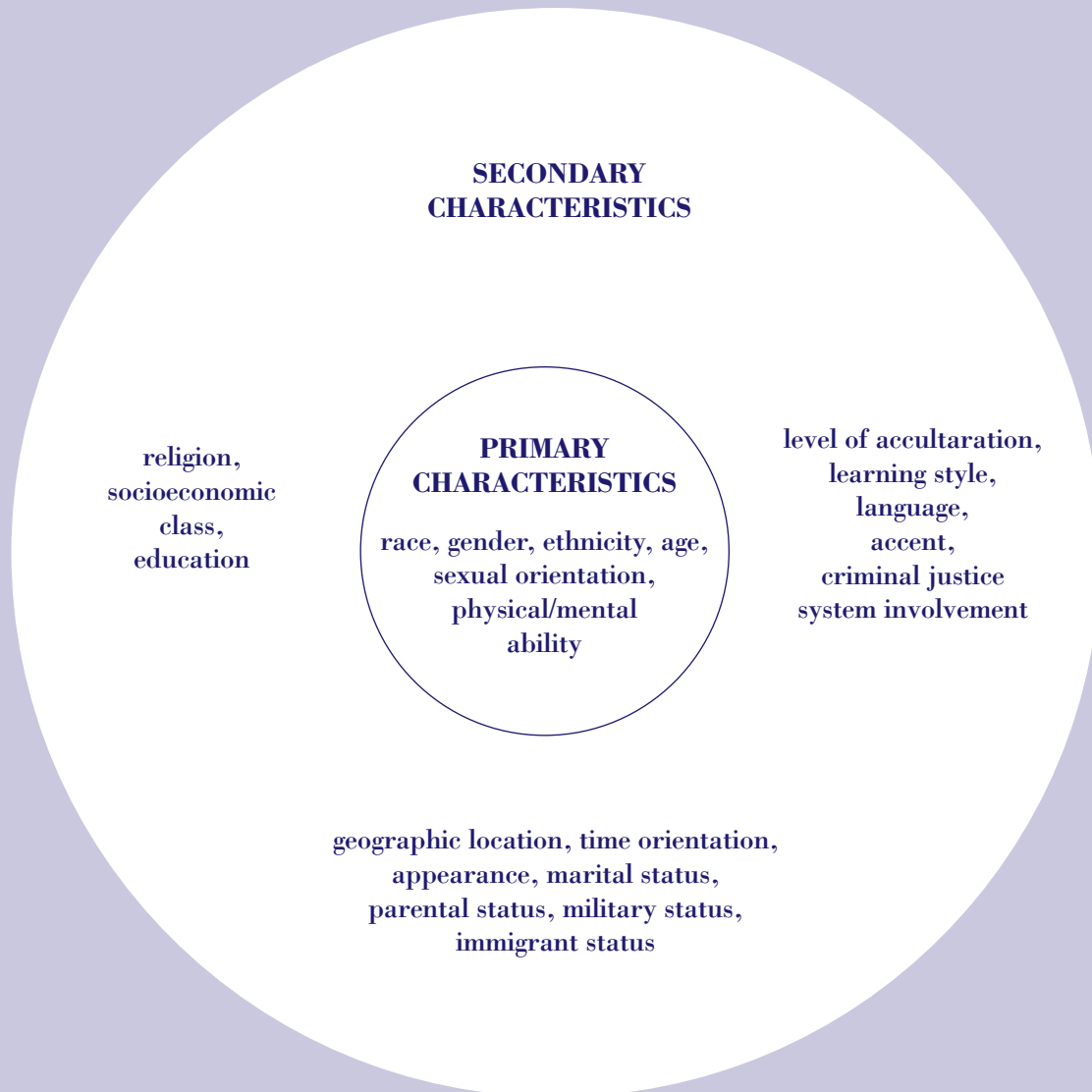
Cultural knowledge: Familiarity with selected cultural characteristics, history, values, belief systems, and behaviors of the members of another ethnic group.

Cultural awareness: Developing sensitivity to and understanding of another ethnic group. This usually involves internal changes of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness should be supplemented with cultural knowledge.

Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations.

Source: Giachello 1995; Office of Minority Health 2001.

Figure 3-5
Diversity Wheel



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

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

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

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

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

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

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

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

Figure 3-6

When Group Norms and Cultural Values Conflict

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

Source: Adapted from Salvendy 1999, p. 441.

Figure 3-7

Three Resources on Culture and Ethnicity

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

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

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

Leader Self-Assessment

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

all members equally, regardless of gender. Clinicians also need to evaluate how competent they are managing issues of cultural diversity. In cases where cultural or language barriers are very strong, a group leader may need to refer a client to another group or make special accommodations to allow the client to participate.

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

Figure 3-8

Guidelines for Clinicians on Evaluating Bias and Prejudice

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

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

Figure 3-9

Self-Assessment Guide

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

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

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

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

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

Figure 3-9

Self-Assessment Guide (continued)

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

Which groups make you feel uneasy or uncomfortable?

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

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

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

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

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

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

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

Figure 3-9

Self-Assessment Guide (continued)

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

Source: Adapted from Winkelman 1995. Used with permission.

Diversity and Placement

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

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

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

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

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

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

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

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

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

Because group members are less restricted to their usual social circles and customary ethnic and cultural boundaries, the group is potentially a social microcosm within which members may

safely try out new ways of relating (Matsukawa 2001). Even so, potential problems between a candidate and existing group members should be identified and counteracted to prevent dropout and promote engagement cohesion among members.

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

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

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

Figure 3-10

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

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

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

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

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

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

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

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

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

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

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

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

Ethnic and Cultural Matching

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

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

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

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

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

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

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

Other Considerations for Practice

Groups may include people who have varying

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

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

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

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

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

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

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

Figure 3-11

Culture and the Perception of Conflict

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

Source: Adapted from Salvendy 1999, p. 451.

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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