Group Therapy
(3 Hours/Units)

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Course Objectives: This course is designed to help you:

1. Become familiar with group therapy approaches and techniques

2. Learn the historical framework concerning the development of group therapy.

3. Learn and apply widely accepted theoretical approaches

4. Identify and distinguish between group therapy types

5. Evaluate the appropriateness and effectiveness of group therapy

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1. Definitions and History

Group psychotherapy or group therapy is a form of psychotherapy in which one or more therapists treat a small group of clients together as a group. The term can legitimately refer to any form of psychotherapy when delivered in a group format, including Cognitive behavioral therapy or Interpersonal therapy, but it is usually applied to psychodynamic group therapy where the group context and group process is explicitly utilized as a mechanism of change by developing, exploring and examining interpersonal relationships within the group. The broader concept of group therapy can be taken to include any helping process that takes place in a group, including support groups, skills training groups (such as anger management, mindfulness, relaxation training or social skills training), and psycho-education groups. The differences between psychodynamic groups, activity groups, support groups, problem-solving and psychoeducational groups are discussed by Montgomery (2002). Other, more specialized forms of group therapy would include non-verbal expressive therapies such as dance therapy, music therapy (Yalom ID: The Theory and Practice of Group Psychotherapy New York: Basic Books, 1970).

Joseph H. Pratt, Trigant Burrow and Paul Schilder were the American founders of group psychotherapy. After World War II, group psychotherapy was further developed by Jacob L. Moreno, Samuel Slavson, Hyman Spotnitz, Irvin Yalom, and Lou Ormont. Yalom's approach to group therapy has been very influential throughout the world, through his classic text "The Theory and Practice of Group Psychotherapy". Moreno developed a specific and highly structured form of group therapy known as Psychodrama (Yalom ID: The Theory and Practice of Group Psychotherapy New York: Basic Books, 1970).

In the United Kingdom group psychotherapy initially developed independently, with pioneers S. H. Foulkes and Wilfred Bion using group therapy as an approach to treating combat fatigue in the Second World War. Foulkes and Bion were psychoanalysts and incorporated psychoanalysis into
group therapy by recognizing that transference can arise not only between group members and the therapist but also among group members. Furthermore the psychoanalytic concept of the unconscious was extended with a recognition of a group unconscious, in which the unconscious processes of group members could be acted out in the form of irrational processes in group sessions. Foulkes developed the model known as Group Analysis and the Institute of Group Analysis, while Bion was influential in the development of group therapy at the Tavistock Clinic. Bion has been criticised, for example by Yalom, for his technical approach which had an exclusive focus on analysis of whole-group processes to the exclusion of any exploration of individual group members' issues. Despite this, his recognition of group defences in the "Basic Assumption Group" has been highly influential (Yalom ID: The Theory and Practice of Group Psychotherapy New York: Basic Books, 1970).

Bion's approach is comparable to Social Therapy, first developed in the United States in the late 1970s by Lois Holzman and Fred Newman, which is a group therapy in which practitioners relate to the group, not its individuals, as the fundamental unit of development. The task of the group is to "build the group" rather than focus on problem solving or "fixing" individuals.

2. Group Theory

Irvin David Yalom, M.D., was born June 13th 1931 in Washington DC and is an author of fiction and nonfiction, Emeritus Professor of Psychiatry at Stanford University, an existentialist, and accomplished psychotherapist. After graduating from Boston University School of Medicine in 1956 he went on to complete his internship at Mount Sinai Hospital in New York and his residency at the Phipps Clinic of Johns Hopkins Hospital in Baltimore and completed his training in 1960. After two years of Army service at Tripler General Hospital in Honolulu, Dr. Yalom began his academic career at Stanford University. He was appointed to the faculty in 1963 and then promoted over the next several years and granted tenure in 1968. Soon after this period he made some of his most lasting contributions by teaching about group psychotherapy and developing his model of existential psychotherapy. In addition to his scholarly, non-fiction writing, Dr. Yalom has produced a number of novels and also experimented with writing techniques. In "Everyday Gets a Little Closer" Dr. Yalom invited a patient to co-write about the experience of therapy. The book has two distinct voices which are
looking at the same experience in alternating sections. Dr. Yalom's works have been used as collegiate textbooks and standard reading for psychology students. His new and unique view of the patient/client relationship has been added to curriculum in Psychology programs at such schools as John Jay College of Criminal Justice in New York City. The American Psychiatric Association awarded Irvin Yalom the 2000 Oscar Pfister prize (for important contributions to religion and psychiatry). Yalom's therapeutic factors (originally termed curative factors but re-named therapeutic factors in the 5th edition of "The Theory and Practice of Group Psychotherapy are derived from extensive self-report research with users of group therapy (Yalom ID: The Theory and Practice of Group Psychotherapy New York: Basic Books, 1970.).

*Universality*

The recognition of shared experiences and feelings among group members and that these may be widespread or universal human concerns, serves to remove a group member's sense of isolation, validate their experiences and raise self-esteem

*Altruism*

The group is a place where members can help each other, and the experience of being able to give something to another person can lift the member's self esteem and help develop more adaptive coping styles and interpersonal skills.

*Instillation of hope*

In a mixed group which has members at various stages of development or recovery, a member can be inspired and encouraged by another member who has overcome the problems that they are still struggling with.

*Imparting information*

While this is not strictly speaking a psychotherapeutic process, members often report that it has been very helpful to learn factual information from other members in the group, for example about their treatment or about access to services.
Corrective recapitulation of the primary family experience

Members often unconsciously identify the group therapist and other group members with their own parents and siblings in a process which is a form of transference specific to group psychotherapy. The therapist's interpretations can help group members gain understanding of the impact of childhood experiences on their personality, and they may learn to avoid unconsciously repeating unhelpful past interactive patterns in present day relationships.

Development of socializing techniques

The group setting provides a safe and supportive environment for members to take risks by extending their repertoire of interpersonal behavior and improving their social skills

Imitative behavior

One way in which group members can develop social skills is through a modeling process, observing and imitating the therapist and other group members, for example sharing personal feelings, showing concern and supporting others.

Cohesiveness

It has been suggested that this is the primary therapeutic factor from which all others flow. Humans are herd animals with an instinctive need to belong to groups, and personal development can only take place in an interpersonal context. A cohesive group is one in which all members feel a sense of belonging, acceptance and validation.

Existential factors

Learning that one has to take responsibility for one's own life and the consequences of one's decisions.

Catharsis

Catharsis is the experience of relief from emotional distress through the free and uninhibited expression of emotion. When members tell their story to a supportive audience, they can obtain relief from chronic feelings of shame and guilt.
Interpersonal learning

Group members achieve a greater level of self-awareness through the process of interacting with others in the group, who give feedback on the member's behavior and impact on others.

Self-understanding

This factor overlaps with interpersonal learning but refers to the achievement of greater levels of insight into the genesis of one's problems and the unconscious motivations which underlie one's behavior.

3. Group Types

Self Help Groups

Self-help groups for mental health are voluntary associations of people who share a common desire to overcome mental illness or otherwise increase their level of cognitive or emotional wellbeing. There are several international mental health self-help organizations including Emotions Anonymous, GROW and Recovery International. Recovery International uses a cognitive therapy approach, Emotions Anonymous uses a twelve-step approach, whereas GROW incorporates a combination of cognitive therapy and twelve-step methods. Despite the different approaches, many of the psychosocial processes in the groups are the same and they share similar relationships with mental health professionals. The terms 'self-help', 'mutual-help' and 'mutual-aid' are used interchangeably in this context (Levy, Leon H., 1978. "Self-help groups viewed by mental health professionals: A survey and comments". American Journal of Community Psychology).

Self-help groups for mental health provide mutual support and peer support. Mutual support is a process by which people voluntarily come together to help each other address common problems. Peer support is social, emotional or instrumental support that is mutually offered or provided by persons with similar mental health conditions where there is some mutual agreement on what is helpful (Solomon, Phyllis, 2004. "Peer support/peer provided services underlying processes, benefits, and critical ingredients". Psychiatric rehabilitation journal).
The definitions of mutual support and peer support include many other mental health consumer non-profits and social groups. Such groups are further distinguished as either Individual Therapy (inner-focused) or Social Reform (outer-focused) groups. In the former set members seek to improve themselves, whereas the latter set encompasses advocacy organizations such as NAMA, NAMI and USPRA.

Self-help groups are subsets of mutual support and peer support groups, and have a specific purpose for mutual aid in satisfying a common need, overcoming a shared handicap or life-disrupting problem. Self-help groups are less bureaucratic and work on a more grassroots level. Self-help Organizations are national affiliates of local self-help groups or mental health consumer groups that finance research, maintain public relations or lobby for legislation in favor of those affected (Levy, Leon H., 1978. "Self-help groups viewed by mental health professionals: A survey and comments". American Journal of Community Psychology).

Effectiveness

Alcoholics Anonymous is the largest of all the twelve-step programs followed by Narcotics Anonymous, meaning a large majority of twelve-step members are recovering from addiction to drugs or alcohol. The majority of twelve-step programs, however, address illnesses other than addiction. For example, the third largest twelve-step program, Al-Anon, treats codependence. About twenty percent of twelve-step programs are for addiction recovery, the other eighty percent address a variety of problems from debt to depression. It would be an error to assume the effectiveness of twelve-step methods at treating problems in one domain translates to all or to another domain, therefore readers are directed to relevant sections in each group's articles (Alcoholics Anonymous, June 2001. Alcoholics Anonymous (4th edition ed.). Alcoholics Anonymous World Services).

Behavior Control and Stress Coping Groups

Among Individual Therapy groups, researchers distinguish between Behavior Control groups (such as Alcoholics Anonymous and TOPS) and Stress Coping groups (such as mental health support groups, cancer patient support groups, and groups of single parents). German researchers refer to Stress Coping groups as Conversation Circles. Significant differences exist between Behavioral Control groups and Stress Coping groups. Meetings of Behavior Control groups tend to be significantly larger than Stress Coping
counterparts (by more than a factor of two). Behavior Control group members have a longer average group tenure than members of Stress Coping groups (45 months compared to 11 months), and are less likely to consider their membership as temporary. While very few members of either set saw professionals concurrently while being active in their group, Stress Coping members were more likely to have previously seen professionals than Behavior Control group members. Similarly, Stress Coping groups worked closer with mental health professionals (Ronel, Natti, 2000. "From Self-Help to Professional Care: An Enhanced Application of the 12-Step Program". The Journal of Applied Behavioral Science).

Talking Groups

In Germany a specific subset of Conversation Circles are categorized as Talking Groups. Talking Groups proclaim that all members of the group have the same rights, each member is responsible only for themselves, each group is autonomous, everyone attends the group on account of their own problems, whatever is discussed in the group remains confidential, and participation is free of charge.

Affiliation and lifespan

If self-help groups are not affiliated with a national organization, professional involvement increases their life expectancy. Conversely, if particular groups are affiliated with a national organization professional involvement decreases their life expectancy. Rules enforcing self-regulation in Talking Groups are essential for the group's effectiveness.

Twelve Step

A twelve-step program is a set of guiding principles outlining a course of action for recovery from addiction, compulsion, or other behavioral problems. Originally proposed by Alcoholics Anonymous (AA) as a method of recovery from alcoholism, the Twelve Steps were first published in the book, Alcoholics Anonymous: The Story of How More Than One Hundred Men Have Recovered From Alcoholism in 1939. The method was then adapted and became the foundation of other twelve-step programs such as Narcotics Anonymous, Overeaters Anonymous, Co-Dependents Anonymous and Debtors Anonymous. The process of twelve-step recovery has been characterized by Dr. Bob - one of AA's co-founders - as "Trust God, clean
house, help others". As summarized by the American Psychological Association, the process involves the following:

- admitting that one cannot control one's addiction or compulsion;
- recognizing a greater power that can give strength;
- examining past errors with the help of a sponsor (experienced member);
- making amends for these errors;
- learning to live a new life with a new code of behavior;
- helping others that suffer from the same addictions or compulsions.

Twelve-step methods have been adopted to address a wide range of substance abuse and dependency problems. Over 200 self-help organizations, also known as fellowships, with a worldwide membership of millions, now employ twelve-step principles for recovery. Narcotics Anonymous was formed by people who did not relate to the specifics of alcohol dependency. Similar groups now exist for sufferers of cocaine addiction: Cocaine Anonymous, as well as other specific drug addictions, such as Crystal Meth Anonymous and Marijuana Anonymous. Behavioral issues such as compulsion with and/or addiction to gambling, food, and sex are addressed in fellowships such as Gamblers Anonymous, Overeaters Anonymous and Sexual Compulsives Anonymous. Fellowships such as Al-Anon - for families and friends of the person with the addiction - are responses to what is identified by some mental health professionals as the problem of addiction as a disease that flourishes in and is enabled by family systems. Other groups address problems with certain types of behaviors, including Clutterers Anonymous, Debtors Anonymous, and Workaholics Anonymous (Ronel, Natti (2000). "From Self-Help to Professional Care: An Enhanced Application of the 12-Step Program". The Journal of Applied Behavioral Science.).

Alcoholics Anonymous (AA), the first twelve-step program, was founded in 1935 by Bill Wilson and Dr. Bob Smith, known to AA members as "Bill W." and "Dr. Bob", in Akron, Ohio. As AA grew in the 1930s and 1940s, definite guiding principles began to emerge as the Twelve Traditions. A singleness of purpose emerged as tradition five: "Each group has but one primary purpose - to carry its message to the alcoholic who still suffers." Consequently, drug addicts who do not suffer from the specifics of alcoholism involved in AA hoping for recovery technically are not welcome in "closed" meetings unless they have a desire to stop drinking alcohol. The
reason for such emphasis on alcoholism as the problem is to overcome
denial and distraction. Thus the principles of AA have been used to form
many numbers of other fellowships for those recovering from various
pathologies, each of which in turn emphasizes recovery from the specific
malady which brought the sufferer into the fellowship (Ronel, Natti (2000).
"From Self-Help to Professional Care: An Enhanced Application of the 12-
Step Program". The Journal of Applied Behavioral Science.).


These are the original Twelve Steps as published by Alcoholics Anonymous:

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His Will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.
In some cases, where other twelve-step groups have adapted the AA steps as guiding principles, they have been altered to emphasize principles important to those particular fellowships, to remove gender-biased or specific religious language.

The Twelve Traditions provide guidelines for group governance. The Twelve Traditions also correspond to the Twelve Steps. Most twelve-step programs have adopted these principles for their structural governance. The Twelve Traditions of Alcoholics Anonymous are as follows.

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

Twelve-step programs symbolically represent human structure in three dimensions: physical, mental, and spiritual. The disorders and diseases the groups deal with are understood to manifest themselves in each dimension. For addicts and alcoholics the physical dimension is best described by the allergy-like bodily reaction resulting in the compulsion to continue using substances after the initial use. For groups not related to substance abuse this physical manifestation could be more varied including, but not limited to: compulsive hoarding, distractibility, eating disorders, dysfunctional enabling, hyperactivity, hypomania, insomnia, irritability, lack of motivation, laziness, mania, panic attacks, psychosomatic illnesses, poor impulse control, procrastination, self-injury and suicide attempts. The statement in the First Step that the individual is "powerless" over the substance or behavior at issue refers to the lack of control over this compulsion, which persists despite any negative consequences that may be endured as a result (Alcoholics Anonymous, June 2001. Alcoholics Anonymous, 4th edition ed. Alcoholics Anonymous World Services).

The mental obsession is described as the cognitive processes that cause the individual to repeat the compulsive behavior after some period of abstinence, either knowing that the result will be an inability to stop or operating under the delusion that the result will be different. The description in the First Step of the life of the alcoholic or addict as "unmanageable" refers to the lack of choice that the mind of the addict or alcoholic affords concerning whether to drink or use again. The illness of the spiritual dimension, or "spiritual malady," is considered in all twelve-step groups to be self-centeredness. This model is not intended to be a scientific explanation, it is only a perspective that twelve-step organizations have found useful. The process of working the steps is intended to replace self-centeredness with a growing moral consciousness and a willingness for self-sacrifice and unselfish constructive action. In twelve-step groups, this is known as a spiritual awakening or religious experience. This should not be confused with abreaction, which produces dramatic, but ephemeral, changes. In twelve-step groups, "spiritual awakening" is believed to develop, most frequently, slowly over a period of time (Alcoholics Anonymous, June 2001. Alcoholics Anonymous, 4th edition ed. Alcoholics Anonymous World Services).

Members are encouraged to regularly attend meetings with other members who share their particular recovery problem. In accordance with the First Step, twelve-step groups emphasize self-admission by members of the
problem they are recovering from. It is in this spirit that members often identify themselves along with an admission of their problem, e.g. "Hi, I'm Wendy and I'm an alcoholic." Such catchphrases are now widely associated with support groups. Some meetings are known as dual-identity groups, which limit attendance to certain demographics, so that some areas have for example, women's groups; men's groups; and gay, lesbian, transgendered groups. There are also in some areas beginner's groups as well as "old-timer" groups that limit who can share, or speak during the meeting, by the length of time the members have in that fellowship (Alcoholics Anonymous, June 2001. Alcoholics Anonymous, 4th edition ed. Alcoholics Anonymous World Services).

A sponsor is a more experienced person in recovery who guides the less-experienced aspirant ("sponsee" or variously, "sponsoree") through the program. New members in twelve-step programs are encouraged to secure a relationship with at least one sponsor. Publications from twelve-step fellowships emphasize that sponsorship is a "one on one" relationship of shared experiences focused on working the Twelve Steps. According to Narcotics Anonymous:

“Sponsors share their experience, strength, and hope with those they sponsor. A sponsor's role is not that of a legal adviser, a banker, a parent, a marriage counselor, or a social worker. Nor is a sponsor a therapist offering some sort of professional advice. A sponsor is simply another addict in recovery who is willing to share his or her journey through the Twelve Steps.

Sponsors and those they sponsor participate in activities that lead to spiritual growth. These may include practices such as literature discussion and study, meditation, and writing. Completing the Twelve Steps implies being competent to sponsor to newcomers in recovery. Sponsees typically do their Fifth Step, review their moral inventory written as part of the Fourth Step, with their sponsor. The Fifth Step, as well as the Ninth Step, have been compared to confession and penitence. Many, such as Michel Foucault, noted such practices produce intrinsic modifications in the person—exonerating, redeeming and purifying them—it unburdens them of their wrongs, liberates them, and promises their salvation.

The personal nature of the behavioral issues that lead to seeking help in twelve-step fellowships results in a strong relationship between sponsee and sponsor. As the relationship is based on spiritual principles, it is unique and not generally characterized as "friendship." Fundamentally, the sponsor has the single purpose of helping the sponsee recover from the
behavioral problem that brought the sufferer into twelve-step work, which reflexively helps the sponsor recover.

A study of sponsorship as practiced in Alcoholics Anonymous and Narcotics Anonymous found that providing direction and support to other alcoholics and addicts correlates with sustained abstinence for the sponsor, but that there were few short-term benefits for the sponsee” (Narcotics Anonymous World Services, February 23, 2007. "World Service Board of Trustees Bulletin #13: Some thoughts regarding our relationship to Alcoholics Anonymous").

Alcoholics Anonymous is the largest of all the twelve-step programs followed by Narcotics Anonymous, meaning a large majority of twelve-step members are recovering from addiction to drugs or alcohol. The majority of twelve-step programs, however, address illnesses other than addiction. For example, the third largest twelve-step program, Al-Anon, treats codependence. About twenty percent of twelve-step programs are for addiction recovery, the other eighty percent address a variety of problems from debt to depression. It would be an error to assume the effectiveness of twelve-step methods at treating problems in one domain translates to all or to another domain, therefore readers are directed to relevant sections in each group's articles.

The criticisms of twelve-step groups are as varied as the pathologies they address. People have attended twelve-step meetings, only to find success eluded them. Their varied success rate and the belief in a Higher Power suggested in them, are common criticisms of their universal applicability and efficacy.

The Twelve Traditions encourage members to practice the spiritual principle of anonymity in the public media and members are also asked to respect each other's confidentiality. However, the programs rely on 'obedience to the unenforceable' and there are no legal consequences or sanctions within the program to discourage those attending twelve-step groups from revealing information disclosed during meetings. Statutes on group therapy do not encompass those associations that lack a professional therapist or clergyman to whom confidentiality and privilege might apply. Physicians who refer patients to these groups, to avoid both civil liability and licensure problems, have been advised that they should alert their patients that, at any time, their statements made in working through the Twelve Steps might be disclosed (Solomon, Phyllis, 2004. "Peer support/peer provided services underlying
processes, benefits, and critical ingredients". Psychiatric rehabilitation journal).

One review of twelve-step programs warned of detrimental iatrogenic effects of twelve-step philosophy, and labeled the organizations as cults. However, a further study concluded that these programs bore little semblance to religious cults because the techniques used appeared beneficial. Another study found that a twelve-step program's focus on self-admission of having a problem increases deviant stigma and strips members of their previous cultural identity replacing it with the deviant identity. A survey of twelve-step group members, however, found they had a bicultural identity and saw twelve-step programs as a complement to their other national, ethnic, and religious cultures (Solomon, Phyllis, 2004. "Peer support/peer provided services underlying processes, benefits, and critical ingredients". Psychiatric rehabilitation journal).

Emotions Anonymous

Emotions Anonymous (EA) is a twelve-step program similar to Alcoholics Anonymous (AA), but for the purpose of helping its members recover from depression and other mental illnesses. EA is the largest of three organizations that have adapted AA's Twelve Steps to create a program for people suffering from mental or emotional illness, replacing the word "alcohol" with "our emotions" in the First Step. Smaller organizations include Neurotics Anonymous (N/A or NAIL) and Emotional Health Anonymous (EHA). EA is a successor organization of Neurotics Anonymous (Emotional Health Anonymous (2007-04-02). "Frequently Asked Questions).

EA and NAIL are open to anyone who desires to become emotionally well, EHA additionally requires that members are not suffering from problems that are specifically addressed by other twelve-step groups (e.g. substance abuse, eating disorders, sexual addiction, compulsive gambling, etc). According to the Twelve Traditions, EA, NAIL, and EHA groups cannot not accept outside contributions (Emotional Health Anonymous, 2007-04-02. "Frequently Asked Questions).

Recovery International

Recovery, Inc. was founded in Chicago, Illinois in 1937 by psychiatrist Abraham Low. Dr Low emphasized concepts opposite of those popularized
by psychoanalysis. During the organization's annual meeting in June of 2007 it was announced that Recovery, Inc. would thereafter be known as Recovery International. Recovery International is open to anyone identifying as "nervous" strictly encourages members to follow their physician's, social worker's, psychologist's or psychiatrist's orders; and does not operate with funding restrictions. Dr. Low claims "Adult life is not driven by instincts but guided by Will," using a definition of will opposite of Arthur Schopenhauer's (Low, Abraham A.; Recovery, Inc. (1943). The techniques of self-help in psychiatric after-care. Chicago, Illinois). Low's program is based on increasing determination to act, self-control and self-confidence. Edward Sagarin compared it to a modern, reasonable, and rational implementation of Emile Coue's psychotherapy. Recovery International is "twelve-step friendly." Members of any twelve-step group are encouraged to attend Recovery International meetings in addition to their twelve-step group participation (Low, Abraham A.; Recovery, Inc. (1943). The techniques of self-help in psychiatric after-care. Chicago, Illinois).

Professional led group psychotherapy

Self-help groups are not designed to offer involved or "deep" psychotherapy. However, the emphasis on psychosocial processes, and the understanding shared by those with the same or similar mental illnesses does achieve constructive treatment goals. Interpersonal learning, which is done through processes such as feedback and confrontation, is not usually emphasized in self-help groups. This is likely because it can be threatening, and requires training and understanding of small group processes. Similarly, reality testing, is also deemphasized. Reality testing relies on consensual validation, offering feedback, seeking feedback and confrontation. These processes seldom occur in self-help groups, though they frequently occur in professionally directed groups.

Group processes

The most essential group processes are those that meet personal and social needs in an environment of safety and simplicity. Complex theoretical formulations, systematic behavioral techniques, and complicated cognitive-restructuring methods are unnecessary.

Despite the differences, researchers have identified many psychosocial processes occurring in self-help groups related to their effectiveness. This
list includes, but is not limited too: acceptance, behavioral rehearsal, changing member's perspectives of themselves, changing member's perspectives of the world, catharsis, extinction, role modeling, learning new coping strategies, mutual affirmation, personal goal setting, instilling hope, justification, normalization, positive reinforcement, reducing social isolation, reducing stigma, self-disclosure, sharing, and showing empathy (Levy, Leon H. (1978). "Self-help groups viewed by mental health professionals: A survey and comments". American Journal of Community Psychology).

Five theoretical frameworks have been used in attempts to explain the effectiveness of self-help groups.

1. Social support: Having a community of people to give physical and emotional comfort, people who love and care, is a moderating factor in the development of psychological and physical disease.
2. Experiential knowledge: Members obtain specialized information and perspectives that other members have obtained through living with severe mental illness. Validation of their approaches to problems increases their confidence.
3. Social learning theory: Members with experience become creditable role models.
4. Social comparison theory: Individuals with similar mental illness are attracted to each other in order to establish a sense of normalcy for themselves. Comparing one another to each other is considered to provide other peers with an incentive to change for the better either through upward comparison (looking up to someone as a role model) or downward comparison (seeing an example of how debilitating mental illness can be).
5. Helper theory: Those helping each other feel greater interpersonal competence from changing other's lives for the better. The helpers feel they have gained as much as they have given to others. The helpers receive "personalized learning" from working with helpees. The helpers' self-esteem improves with the social approval received from those they have helped, putting them in a more advantageous position to help others.

A framework derived from common themes in empirical data describes recovery as a contextual nonlinear process, a trend of general improvement with unavoidable paroxysms while negotiating environmental,
socioeconomic and internal forces, motivated by a drive to move forward in one's life. The framework identified several negotiation strategies, some designed to accommodate illnesses and others designed to change thinking and behavior. The former category includes strategies such as acceptance and balancing activities. The latter includes positive thinking, increasing one's own personal agency/control and activism within the mental health system (Levy, Leon H. (1978). "Self-help groups viewed by mental health professionals: A survey and comments". American Journal of Community Psychology).

**Relationship with mental health professionals**

A 1978 survey of mental health professionals in the United States found they had a relatively favorable opinion of self-help groups and there was a hospitable climate for integration and cooperation with self-help groups in the mental health delivery system. The role of self-help groups in instilling hope, facilitating coping, and improving the quality of life of their members is now widely accepted in many areas both inside and outside of the general medical community. A survey of psychotherapists in Germany found that 50% of the respondents reported a high or very high acceptance of self-help groups and 43.2% rated their acceptance of self-help groups as moderate. Only 6.8% of respondents rated their acceptance of self-help groups as low or very low (Levy, Leon H., 1978. "Self-help groups viewed by mental health professionals: A survey and comments". American Journal of Community Psychology).

Surveys of self-help groups has shown very little evidence of antagonism towards mental health professionals. The maxim of self-help groups in the United States is "Doctors know better than we do how a sickness can be treated. We know better than doctors how sick people can be treated as humans.” (Levy, Leon H., 1978. "Self-help groups viewed by mental health professionals: A survey and comments". American Journal of Community Psychology).

**Referrals**

Professional referrals to self-help groups for mental health are less effective than arranging for prospective self-help members to meet with veterans of the self-help group. This is true even when compared to referrals from professionals familiar with the self-help group when referring clients to it.
Referrals mostly come from informal sources (e.g. family, friends, word of mouth, self). Those attending groups as a result of professional referrals account for only one fifth to one third of the population. One survey found 54% of members learned about their self-help group from the media, 40% learned about the their group from friends and relatives, and relatively few learned about them from professional referrals (Levy, Leon H. (1978). "Self-help groups viewed by mental health professionals: A survey and comments". American Journal of Community Psychology).

Effectiveness

Self-help groups are effective for helping people cope with, and recover from, a wide variety of problems. German Talking Groups have been shown to be as effective as psychoanalytically orientated group therapy. Participation in self-help groups for mental health is correlated with reductions in psychiatric hospitalizations, and shorter hospitalizations if they occur. Members demonstrate improved coping skills, greater acceptance of their illness, improved medication adherence, decreased levels of worry, higher satisfaction with their health, improved daily functioning and improved illness management. Participation in self-help groups for mental health encourages more appropriate use of professional services, making the time spent in care more efficient. The amount of time spent in the programs, and how proactive the members are in them, has also been correlated with increased benefits. Decreased hospitalization and shorter durations of hospitalization indicate that self-help groups result in financial savings for the health care system, as hospitalization is one of the most expensive mental health services. Similarly, reduced utilization of other mental health services may translate into additional savings for the system (Levy, Leon H., 1978. "Self-help groups viewed by mental health professionals: A survey and comments". American Journal of Community Psychology).

While self-help groups for mental health increase self-esteem, reduce stigma, accelerate rehabilitation, improve decision-making, decrease tendency to decompensate under stress, and improve social functioning, they are not always shown to reduce psychiatric symptomatology. The therapeutic effects are attributed to the increased social support, sense of community, education and personal empowerment. Members of self-help groups for mental health rated their perception of the group’s effectiveness on average at 4.3 on a 5-point Likert scale (Levy, Leon H., 1978. "Self-help
groups viewed by mental health professionals: A survey and comments". American Journal of Community Psychology).

4. Group Therapy Clinical Advantages

Group Therapy Program Offers Meaningful Gains for People with Borderline Personality Disorder

A 20-week group therapy program focusing on cognitive behavioral and skills training, when used in conjunction with usual care, helped reduce symptoms of borderline personality disorder and improve overall functioning, reported NIMH-funded researchers. Their findings were published online February 15, 2008 in the American Journal of Psychiatry.

Borderline personality disorder is a serious mental illness noted by unstable moods, behavior and relationships. Each year, 1.4 percent of adults in the United States have this disorder, which is widely viewed as being difficult to treat. However, recent advances in treatment research for specific symptoms of borderline personality disorder, such as dialectical behavioral therapy to reduce suicidal thinking or behavior, have shown reasons to continue exploring options for therapy.

In this study, led by Donald W. Black, M.D., of the University of Iowa, researchers tested the effectiveness of the Systems Training for Emotional Predictability and Problem Solving (STEPPS) program for treating people with borderline personality disorder. STEPPS, developed by lead author Nancee Blum, MSW, and colleagues, is a structured treatment program involving 20 weekly meetings that each last for two hours. Over the course of the program, participants learn about the disorder as well as skills for controlling problematic emotions and behaviors. Family members also receive a two-hour session to learn about the illness and best ways to interact with their loved one. STEPPS is meant to be used along with other forms of treatment, such as medication or individual therapy.

The researchers randomly assigned 165 men and women ages 18 and older to receive either STEPPS plus any other care they had previously been receiving (“treatment as usual”), or treatment as usual alone. During the 20-week treatment period, people who received STEPPS plus treatment as usual had greater and more rapid improvement in borderline-related and
depressive symptoms (which affected 78 percent of study participants) than people who received treatment as usual alone.

Also, participants in the STEPPS group continued to improve over the entire 20 weeks of the program, whereas improvements in the group that received only treatment as usual leveled off after 10 weeks.

Furthermore, people who received STEPPS plus treatment as usual were more likely to rate themselves, and to be rated by their study therapist, as “very much” or “much” improved, compared to the other group. At follow up visits during the year after the end of treatment, improvements of the STEPPS plus treatment as usual group were maintained.

Fewer participants who received STEPPS had emergency department visits, compared to the group that received treatment as usual alone. There were no significant differences between the two treatment groups in the number or frequency of suicide attempts, self-harming acts, or hospitalization. Also, similar to other studies of borderline personality disorder, there was a relatively high rate of dropout from the study from both treatment groups, roughly 25 percent of the 165 randomly assigned participants.

The researchers suggest that a relatively brief therapy program offers “real world” benefits because their study mirrored common treatment situations in which people are already receiving other types of mental health care.

Following similar results in earlier studies, STEPPS has been widely adopted in The Netherlands as the primary group treatment for borderline personality disorder. Other countries, including the United States, have been evaluating more widespread use of this program as well.

Group Therapy Research

Sponsored by:
National Institute on Drug Abuse

Background
A 1998 study by the Institute of Medicine determined that despite the availability of efficacious behavioral treatments, established research-based treatments have not been adopted widely in clinical practice. The gap between research and practice is especially evident with regard to group therapies for substance use disorders. Most substance abuse treatment in community settings is delivered in a group format, yet there is little empirical evidence to inform the development or delivery of group therapies. The unique challenges of conducting group therapy research may account for the observed disconnect between clinical science and practice. Some of the challenges inherent in group work are constituting one or more groups in the context of a research project, managing fluctuations in group membership over the course of treatment, accounting for heterogeneity in group member’s responses to treatment, choosing appropriate levels of analysis for group treatment data, and identifying key mechanisms of action of group treatment.

As part of NIDA’s ongoing efforts to develop behavioral treatments for substance abuse that are both efficacious and community-friendly, a science meeting on group therapy research was convened. The purposes of the meeting were to clarify the state of the science regarding group behavioral treatment, and to discuss the challenges of conducting group therapy and potential solutions to these challenges. These discussions were intended to inform future initiatives on group therapies, and to enhance technical assistance provided to investigators proposing group therapy research studies.

Meeting Overview
On April 29 and 30, 2003, the National Institute on Drug Abuse convened a meeting to discuss the state of the science of group therapy research for drug abuse and
dependence. The meeting brought together experts on group behavioral treatment research, both for substance-related disorders, and for other psychiatric disorders with potential relevance to the treatment of substance abuse and dependence. Over the course of the meeting, the participants evaluated the existing empirical literature regarding group treatment for substance abuse and dependence, highlighted a number of cutting-edge group therapy research projects, identified the major challenges posed by group treatment research, and discussed potential solutions to these challenges. Through funding initiatives such as targeted RFAs and NIDA’s ongoing Behavioral Therapies Development Program Announcement (see: http://grants1.nih.gov/grants/guide/pa-files/PA-03-126.html), and via dissemination of the outcomes of this meeting, NIDA hopes to advance further a program of research on group behavioral treatment.

Overview of Research on Group Therapy for Substance Abuse and Dependence
A context-setting presentation on published studies of group treatments for substance abuse and dependence acknowledged that, while group therapy is the most commonly-used treatment modality in community drug treatment settings, fewer than 20 controlled studies of group treatment for substance abuse had been published as of this meeting. Those studies that had been published addressed such a wide range of populations, target drugs of abuse, and types and intensities of group treatment, that it is difficult to draw conclusions about the efficacy of group treatment for drug abusers.

Cutting-Edge Group Therapy Research Projects
Following a brief review of existing literature on group therapy for substance abuse and dependence, presenters described recent or ongoing research projects focused on group therapy. These presentations highlighted the wealth of lessons learned through conducting group therapy research in areas outside the substance abuse field. Additionally, they generated discussion of a very basic
question: When should a group therapy project (as opposed to a different treatment modality) be conducted?

When should a group therapy project be conducted? The participants offered two answers to this question. The first emphasizes a theoretical or clinical reason to expect that a group format would be beneficial. Examples in which a group format might be beneficial are group therapy for social phobia, in which group interaction in itself may address the presenting problem (e.g., research presented by Dr. Heimberg), and treatment for adolescents, a developmental stage in which the influence of peers is especially important (e.g., research presented by Dr. Winters).

The second answer offered to this question emphasized the aim of developing treatments that are community-friendly, because the majority of community treatment occurs in a group format, and the assumption is that group therapy is cost-effective. While a group format seems intuitively less costly, there may be tradeoffs in effectiveness or other expenditures such as therapist training, supervision, and crisis management. It seems clear that more work needs to be done in establishing that group treatment is indeed cost-effective. Also, although group treatment appears to be the default “cost-effective” alternative to individual or family treatment, further research on other potentially cost-effective modalities (e.g., web-based interventions, self-paced instruction, etc.) may provide other options. Finally, if one goal of research is to develop streamlined, cost-effective treatments, it is vitally important to begin to identify and test the mechanisms of action of group therapies. Identifying therapy mechanisms of action allows for preserving those components of treatment that contribute most to outcomes when moving the treatment into community settings.

Challenges in Conducting Group Therapy Research and Potential Solutions

Closed vs. rolling groups. The meeting participants
identified several major logistical and methodological challenges in conducting group therapy research. Among the most challenging logistical issues discussed was whether to constitute closed or rolling groups. In closed groups, members are enrolled before treatment begins, and group membership stays fairly constant. In contrast, for rolling groups, membership changes as new members join and previous members “graduate”. In constituting closed groups, subject flow must be adequate to form a group in a reasonable time frame. Because risk of drop-out increases with increasing wait-times for treatment, it may be necessary to implement strategies to retain subjects. In addition, some disorders may require treatment as soon as possible, so that waiting for a closed group to fill before beginning treatment may not be clinically appropriate. In such cases, researchers might consider a baseline treatment during the waiting period. Of course, introducing additional treatment has the potential of confounding the effects of the treatment under study. One way to minimize confounding may be to offer a baseline treatment that is unrelated to the treatment under study. Also for closed groups, if too many members drop-out, this may have a deleterious effect on the remaining group members. The question of how many group members are required for effective treatment is an important one.

While constituting rolling groups avoids some of the logistical problems with wait-listing patients, it generates other problems related to group heterogeneity. Group heterogeneity is a problem to the extent that the composition of the group affects treatment process and/or outcome. For instance, if group norms are an important mediator of therapeutic outcomes, and group norms change with changing group membership, outcome for any single group member probably depends on some combination of the group norms that member experienced. Statistical strategies may help to manage such complexity. One such strategy is to treat each change in group membership as a new group, so that the number of groups becomes another variable in analyses. Another strategy is to model the
hypothesized key elements of group composition over time, and account for these in the analyses. For example, if group norms are thought to mediate outcome, assess group norms over time, and add group norms (or change in group norms) to equations predicting outcome.

*The non-independence of group members.* Another methodological challenge of group therapy research is accounting for the non-independence of group members. By definition, group members in the same group participate in the same therapy, which implies some level of interdependence. However, the experiences of individual group members in these shared group sessions are probably varied, so that the level of interdependence may be small. In general, interdependence is less of a problem in small groups, i.e., N < 6. In cases where individual group members are thought to have a great influence on other members, it may be possible to quantify the effect of those individual(s), so that change in the group can be tracked by change in that individual’s behavior. For instance, the catalyzing effect of a charismatic group organizer, or the intimidating effect of a so-called “predator”, can be quantified and modeled in predictive equations. Hierarchical linear models (HLM) or multi-level analytic strategies can account for both within-group and between-group variables, making it possible to model both those factors that make group members interdependent, and factors that distinguish one group from another. Also, statistically, the non-independence of group members influences the significance of any effect found, rather than the size of the effect. This implies that interdependence is likely to lead to premature acceptance of findings as significant, and that appropriate cautions could be taken in setting a compelling statistical significance level.

*The unit of analysis in group therapy research.* Another related issue has to do with the unit of analysis in group therapy research. Data collected from individual group members can be transformed into sums, averages, a
measure of group variability, and in other ways. In cases where group members are highly-interdependent, it may make sense to consider the group, rather than the individual, as the unit of analysis. (But preserving the individual level of analysis may be necessary for answering some research questions, such as identifying moderators of treatment effect.)

Randomization in group therapy research. Another methodological issue discussed by the meeting participants related to appropriate strategies for randomization procedures. Individuals can be randomly-assigned to different group treatments, or groups can be constituted and then randomized to treatment conditions. The latter may be especially appropriate if there are clinical indications for constituting a group of a particular composition (e.g., single-gender, day vs. evening schedules, presenting problems, etc.).

Controlled group therapy experiments. The meeting participants also discussed the possibility of conducting group therapy research through controlled, pseudo-laboratory studies similar to traditional social psychology experiments. As in some social psychology studies, confederates acting as group members might increase the degree of control in a group therapy study.

Recommendations for Future Group Therapy Research

The meeting concluded with a lively discussion about recommendations for future research in group therapy. The following are some of those recommendations:

- Encourage new investigators to develop group therapy projects

- Support translational research, e.g., from social psychology, business schools looking at work teams, behavior analysts, etc.

- Conduct secondary data analyses using new statistical strategies that account for group data
Brainstorm about methodologies for answering good questions with good methodologists

Include in group therapy research hypotheses directly related to the group aspect of the project

Include questions in research that address the unique challenges of group therapy, such as how one makes a rolling group work, and how to aggregate group data

When proposing to develop or manualize a group therapy (i.e., Stage I research), be clear about when iterations to the manual will be made

For review committees, demonstrate the feasibility of doing group therapy research, given the many challenges inherent in the work

Study the mechanisms of action of group therapy

Let the research question guide the study design and analyses, not the other way around

5. Substance Abuse and Group Therapy

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, TextRevision [DSM-IV-TR] [American Psychiatric Association 2000]). This term was chosen partly 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 pregroup 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

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• 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.

6. Outcomes

Empirical support exists for the effectiveness of group psychotherapy in treatment for depression. A meta-analysis of 48 studies revealed an effect size of 1.03, which is clinically highly significant. Similarly, a meta-analysis of five studies of group psychotherapy for adult sexual abuse survivors showed moderate to strong effect sizes, and there is also strong evidence for effectiveness with chronic traumatic stress in war veterans. There is less robust evidence of good outcomes for patients with borderline personality disorder, with some studies showing only small to moderate effect sizes. These poor outcomes might reflect a need for additional support for some patients, in addition to the group therapy. This is borne out by the impressive results obtained using Mentalization based treatment, a model which combines dynamic group psychotherapy with individual psychotherapy and case management. Most outcome research is carried out using time-limited therapy with diagnostically homogenous groups, however long-term intensive interactional group psychotherapy assumes diverse and diagnostically heterogeneous group membership, and an open-ended time scale for therapy. Good outcomes have also been demonstrated for this form of group therapy.

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