Exercise on Identifying Triggers
**Individual and Group Session 2**

Part of this program involves completing readings and homework exercises prior to your sessions. These are intended to help you:

- Prepare for your sessions
- Take an active role in changing your behavior
- Evaluate your progress

In the first exercise you weighed the costs and benefits of changing. Now we want to help you identify what is triggering or associated with the behavior you want to change.

**THINGS TO CONSIDER WHEN COMPLETING THIS EXERCISE**

Because the behavior you want to change has come to play a major or large role in your life, you may need to make some lifestyle changes. Take a look at the following areas in your life:

- **Availability**: If the things that prompt your behavior are readily available, you may want to change your environment.
- **Activities**: If you spend a lot of time engaging in the behavior, you may need to find other ways to spend your time.
- **Relationships with peers**: In some cases, a change in social relationships may be necessary to change behaviors. If you decide that associating with certain people is too risky, then you might decide that a change in your circle of friends is necessary.

The following questions and general categories of triggers are intended to help you complete this exercise.

**Questions:**

- Where and when does your behavior occur?
- What other people are present on these occasions and how do they affect your behavior?
- What do you accomplish by engaging in the behavior? That is, what purpose does it serve for you?

**General Categories of Triggers:**

- **Emotional State** (e.g., angry, depressed, happy, sad)
- **Physical State** (e.g., relaxed, tense, tired, aroused)
- **Presence of Others** (e.g., when the behavior occurs are certain people present?)
- **Availability**
- **Physical Setting** (e.g., work, party, ex-spouse’s house)
- **Social Pressure** (e.g., are you forced or coerced into doing things you don’t want to?)
- **Activities** (e.g., work, working at home, playing sports, watching TV, playing cards)
- **Thoughts** (e.g., remember times you engaged in the behavior)

**You are now ready to complete this exercise!**

(cont.)
Exercise on Identifying Triggers (page 2 of 3)

EXERCISE

Describe **two general types of situations** that have triggered the behavior you want to change.

One thing that can help you to identify triggers and consequences related to changing is to think about real experiences you have had.

**TRIGGER SITUATION 1**

Briefly describe **ONE** of your **high-risk trigger situations**.

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Describe the types of **CONSEQUENCES** usually associated with this situation. Consider both **NEGATIVE** and **POSITIVE** consequences, and whether they occur right away or are delayed.

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( cont.)
Exercise on Identifying Triggers  (page 3 of 3)

TRIGGER SITUATION 2

Briefly describe ONE of your high-risk trigger situations.

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Describe the types of CONSEQUENCES usually associated with this situation. Consider both NEGATIVE and POSITIVE consequences, and whether they occur right away or are delayed.
CLINIC HANDOUT 4.7

Sample BSCQ Alcohol or Drug Use Profile from the Assessment

*Individual and Group Session 2*

YOUR SELF-CONFIDENCE PROFILE

The following graph shows your confidence that you could resist drinking heavily or resist urges to use drugs in different situations. Situations in which you have low confidence are more likely to pose a risk for you. You may find it particularly helpful to think of ways to identify and plan for these situations in advance. For example, if you have little confidence that you can resist drinking heavily or using drugs in social pressure situations, you may want to avoid such situations or deal with them differently. You can also look at your daily alcohol or drug use calendar to see if your heavier drinking days or drug use occurred when you had trouble resisting urges to drink heavily or resisting urges to use drugs.

**How Confident Are You?**

The three situations in which you indicated you had the lowest confidence in your ability to resist drinking heavily or resist using drugs are highlighted in **BLACK** below.
CLIENT HANDBOUT 4.8

Exercise on Developing New Options and Plans

*Individual and Group Session 3*

In this exercise you will develop new options and action plans for the high-risk trigger situations you described in the exercise on *Identifying Triggers*.

**TRIGGER SITUATION 1**

**Describe two** options and their likely consequences for your **first trigger situation** in the exercise on *Identifying Triggers*.

- Be as **specific** as possible in describing your options, all of which should be **feasible**.
- **For each option**, describe what you think would happen if you used that option.
- Consider both **negative and positive** consequences.
- Finally, **decide which option** would be your best and second-best option for dealing with this trigger situation.

1. **Option 1:**
   Likely Consequences:

2. **Option 2:**
   Likely Consequences:

(cont.)
Exercise on Developing New Options and Plans (page 2 of 4)

CHANGE PLAN

You have selected two options for your Trigger Situation 1. For each option, describe what you need to do to achieve that option.

- Your Change Plan should describe in some detail how you could put your option into practice.
- It helps to break your plan into smaller steps.

**Option # 1 Change Plan**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Option # 2 Change Plan**

________________________________________________________________________
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(cont.)
TRIGGER SITUATION 2

Describe two options and their likely consequences for your second trigger situation in the exercise on Identifying Triggers.

- Be as specific as possible in describing your options, all of which should be feasible.
- For each option, describe what you think would happen if you used that option.
- Consider both negative and positive consequences.
- Finally, decide which option would be your best and second-best option for dealing with this trigger situation.

- Option 1: __________________________________________
  Likely Consequences: __________________________________
  ____________________________________________________
  ____________________________________________________
  ____________________________________________________
  ____________________________________________________
  ____________________________________________________

- Option 2: __________________________________________
  Likely Consequences: __________________________________
  ____________________________________________________
  ____________________________________________________
  ____________________________________________________
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  ____________________________________________________

(cont.)
CHANGE PLAN

You have selected two options for your Trigger Situation 1. For each option, describe what you need to do to achieve that option.

- Your Change Plan should describe in some detail how you could put your option into practice.
- It helps to break your plan into smaller steps.

• Option # 1 Change Plan

• Option # 2 Change Plan
How Confident Are You?

The following graph shows your confidence that you could resist drinking heavily or resist urges to use drugs in different situations. The GRAY bars show your confidence when you started the program and the BLACK bars show how confident you are now. Situations in which you have low confidence are more likely to pose a risk for you. Remember, you may need to avoid situations in which you still have low confidence that you can resist drinking heavily or resist urges to use drugs, or learn to deal with them differently.
Request for Additional Sessions

Individual and Group Session 4

- This treatment program allows you to request additional individual sessions beyond the first four sessions.

- The program is designed to be individualized. Some people will need more sessions than others; some may need more now, some may need more later.

- Consistent with being a program that allows each individual to guide his or her own change, if you feel you require additional sessions, you need only to ask your therapist.

- In addition, your therapist will be contacting you by phone one month after your last session. This contact allows your therapist to find out how you are doing and also allows you an opportunity to discuss any issues or problems you are concerned about or request additional sessions.

- Please check the option below that reflects what you feel you need at the present time and give this form to your therapist at the beginning of your next session.

  a. ______ I do not feel I need any further sessions beyond the next session, but I understand I can call and request additional sessions at any time in the future.

  b. ______ I feel I need ____________ additional sessions at this time, for the following reasons:

     ______________________________________________________________________

     ______________________________________________________________________

  c. ______ I would like to discuss the issue of whether I need additional sessions with my therapist at the next treatment session.
Integrating Motivational Interviewing and Cognitive-Behavioral Techniques into Group Therapy

Although some CBT [cognitive-behavioral therapy] groups do currently employ group processes, little attention had been focused on how a CBT group can systematically use group power to maximize efficacy or how CBT interventions might impact upon group process.
—SATTERFIELD (1994, p. 185)

A pure motivational interviewing psychotherapy group [original emphasis] could be developed in which a skillful counselor utilized motivational interviewing techniques and adhered to motivational interviewing principles within the group.
—INGERSSOLL, WAGNER, AND GHARIB (2002, p. 52)

This chapter discusses issues concerning difficulties that others have encountered when attempting to extend cognitive-behavioral and motivational interviewing methods to a group therapy context. It also includes a brief review of the few RCTs that have been conducted comparing individual and group treatments for SUDs.

Motivational interviewing is designed to develop a collaborative relationship between clients and therapists in which clients’ resistance is minimized and their commitment to change is strengthened and sustained. In addition to treating SUDs, studies using motivational interviewing have had impressive outcomes across a variety of health and mental health problems (Britt et al., 2003; Burke et al., 2003; Heather, 2005; Miller, 2005; Resnicow et al., 2002; Wright, 2004). However, most studies have only involved treatment delivered in an individual setting. The successful adaptation of motivational interviewing to group therapy, in contrast, has been difficult (Walters, Bennett, & Miller, 2000; Walters, Ogle, & Martin, 2002). In their review of motivational interviewing in groups, Walters and colleagues (2002) found that when motivational interviewing was used in the context of providing psychoeducational feedback to participants in groups it was not successful. Often this involved a single session done in a non–motivational interviewing manner to correct deficient knowledge. In many ways, such psychoeducational efforts are better characterized as lecturing or as conducting individual therapy in a group setting.
setting compared with group psychotherapy that utilizes group processes to facilitate behavior change.

In their review of failed group motivational interviewing studies, Walters and colleagues (2000) may have inadvertently provided an explanation for the limited success of motivational interviewing group studies:

Unlike patient education, motivational interviewing is more a navigation process than a transmission of information: Behavior change happens when the individual weighs relevant reasons in relation to the short-term rewards of the behavior. Because of the complexity of interactions in a group, there is more potential for discrepancy diffusion, non-participation, resistance, and collective argumentation. (p. 381)

Another way of understanding why motivational interviewing does not adapt particularly well to psychoeducational and many support groups is to realize that although “the group is a vehicle for delivering a particular package of theoretical material, the nature of the member interaction is not the prime focus” (MacKenzie, 1994, pp. 47–48). In traditional group psychotherapy, MacKenzie (1994) says that the members’ interactional experience is the primary learning vehicle. In a related regard, Ingersoll and her colleagues (2002), in recognizing that their motivational group model was psychoeducational in nature, stated that “A pure motivational interviewing psychotherapy group could be developed in which a skillful counselor utilized motivational interviewing techniques and adhered to motivational interviewing principles within the group” (p. 52, original emphasis).

THE POWER OF THE GROUP: CAPITALIZING ON GROUP PROCESSES

Almost all cognitive-behavioral treatments are evidence-based and have been shown to be effective with a host of clinical disorders in an individual setting (see Bieling, McCabe, & Antony, 2006; Satterfield, 1994). Although cognitive-behavioral therapies have traditionally been conducted in an individual format, an increasing number of studies have extended these treatments to a group setting. Despite this expansion, as discussed shortly, RCTs comparing group and individual treatments, particularly the same treatment, have been few in number (Tucker & Oei, 2007). Two reviews, published over a decade apart, have compared cognitive-behavioral therapy in group versus individual settings and both reviews concluded that the results were mixed or inconsistent (Satterfield, 1994; Tucker & Oei, 2007). Satterfield (1994) suggested that many group cognitive-behavioral treatment studies have “deemphasized group dynamics” (p. 187).

Two major problems that have plagued cognitive-behavioral group treatments are (1) their failure to systematically use group processes, which Satterfield (1994) says “dilutes their power” (p. 192), and (2) their failure to integrate cognitive-behavioral techniques with group processes. These concerns, articulated 15 years ago (Satterfield, 1994), were reiterated recently in a book on this topic (Bieling et al., 2006). In his 1994 review, Satterfield argued that most cognitive-behavioral therapy groups seemed to view group dynamics as “epiphenomenal or minimize the importance of group processes to varying degrees” (p. 185), and, “although interpersonal exchanges do occur in CBT [cognitive-behavioral therapy] groups, interventions usually focus
on treating the individual in a group rather than through the group” (Satterfield, 1994, p. 185). In addition, both Satterfield and Bieling and colleagues have asserted that when cognitive-behavioral groups target the intervention to individuals in the group, they ignore the power of the group.

For example, in a behavioral study involving social skills training groups, Monti and colleagues (1989) reported that their groups were intended “to educate clients rather than explore feelings” (p. 126). They further commented, “in the context of behavioral skills training groups, ‘process’ can have a somewhat different meaning than it does when it is used in more traditional group psychotherapy” (p. 125). Similarly, in describing how to deliver cognitive-behavioral treatment for social phobia in a group setting, Heimberg and Becker (2002) cautioned that in terms of their group instruction many of the activities “focus on the interaction of the therapist(s) with a single client” (p. 268). As with Monti and colleagues’ study, Heimberg and Becker’s skills training groups for social phobia can be viewed as dyadic interactions conducted in a group context rather than as reflecting true group processes. In summary, cognitive-behavioral studies typically have been highly structured, and they often have involved a therapist working with one client at a time while other group members observe the interaction. This, of course, is very different from using interactions among group members as a force for change.

Satterfield (1994) suggested that attention to group processes and structure could enhance the outcomes of cognitive-behavioral therapy studies. In looking at some of the key group process variables identified by Satterfield (e.g., group cohesion, group norms, isomorphism), it is easy to understand why successful cognitive-behavioral interventions and motivational interviewing techniques conducted in an individual setting have not readily generalized to a group setting. For example, group cohesion, discussed in detail in Chapter 6, is defined as the extent to which a group is reinforcing to its members. Cohesive groups are characterized as having a positive group atmosphere, a culture in which members take personal responsibility for group work and for group changes. Cohesive groups also have an absence of interpersonal tension. Thus groups that fail to use group processes are more likely to have low levels of cohesion, a characteristic that research has found to be associated with poorer treatment outcomes (MacKenzie, 1997; Satterfield, 1994).

A group setting provides a basis for influencing group members’ behavior in terms of social support and social pressure to change, something not possible in individual therapy. When group dynamics are operating, interactions are occurring on multiple levels, as well as within the entire group. One reason that group psychotherapy is viewed as complex and challenging is that a therapist has to operate on multiple levels (Dies, 1994; Yalom & Leszcz, 2005): (1) as a member of the group; (2) as a therapist directing the group toward goals and addressing resistive or challenging members; and (3) as discussed in Chapter 6, as an orchestra conductor getting the group members to work in harmony to produce a sound not achievable by any single instrument.

**ADAPTATION OF THE GSC TREATMENT MODEL**

The preceding chapter described how to conduct GSC treatment using an individual therapy model and contained four individual treatment session outlines for therapists. In contrast, this
chapter describes the adaptation of the GSC treatment model to group therapy. This adaptation involves integrating cognitive-behavioral and motivational interviewing strategies and techniques into a group format. As in Chapter 4, at the end of this chapter there are four session handouts for the group leaders (Group Therapist Handouts 5.1–5.4), which describe session objectives, session procedures, client handouts, and pregroup planning. In addition, each group handout presents several round-robin discussions, the format used to conduct the clinical intervention in a therapy group. This discussion format is designed to get support, feedback, and advice emanating primarily from group members rather than the group leaders. Within each round-robin discussion are sample dialogues and clinical examples that allow group leaders to integrate the cognitive-behavioral and motivational interviewing techniques, strategies, and homework exercises into a group format. To avoid redundancy, descriptions of the GSC measures and other session details, explained at length in Chapters 3 and 4, are not repeated here. Rather, reference is made to their having been described in other chapters.

**Composition and Structure of the GSC Groups**

As described in Chapter 1 (see Table 1.2), several evidence-based studies have evaluated the GSC treatment model. Except for the study described in this book (L. C. Sobell et al., 2009), the other studies were conducted using an individual therapy format. In terms of composition and structure, the GSC group intervention, like its individual counterpart, is a cognitive-behavioral intervention that uses a motivational counseling style and strategies throughout treatment. Because the intervention is time-limited (i.e., assessment and four semistructured sessions), a closed-group format is used (i.e., no members added after the first session).

The client mix can be heterogeneous and include males and females, as well as individuals with different substance abuse problems. The ideal number of members for such groups is six to eight (in addition to the leaders). Group sessions are scheduled once a week for 2 hours. Group members are phoned the day before each meeting to remind them of the upcoming group. Because the GSC group treatment model uses group processes to avoid conducting one-on-one therapy in a group setting, the group leaders (cotherapists) need training in how to use group processes. The same homework exercises, readings, and self-monitoring logs used for conducting individual GSC therapy are used in the group version of the treatment, with the main difference being that the group discussions are conducted using a round-robin discussion format, which is described shortly.

Before starting the group, clients are assessed individually, and the upcoming group is discussed with them. As part of the assessment, they are given a brochure (Client Handout 5.1) that describes the benefits of group therapy and the expectations of group members. Before and after every group, the group leaders meet for 10–15 minutes for pregroup preparation and postgroup discussions. Although there are only four structured sessions, clients can request additional sessions that would be conducted as individual therapy sessions. In our clinical experience, it has worked well for one of the group leaders to be the therapist for members who request further sessions. Finally, all clients are informed that one of the group leaders will call them about 1 month after their last group session to inquire about their progress, to be supportive of changes, and to schedule additional sessions if needed.
Preparing to Lead Groups

As is discussed in Chapters 7 and 8, conducting therapy groups (vs. process or psychoeducational groups) is complex and can present challenges. There are several reasons that group therapy is seen as more complex than individual therapy. The first is that multiple clients must be handled simultaneously. Second, as is discussed in Chapter 9, many group therapists have had little to no formal group training. To meet the challenges of group work and to provide appropriate care for patients, experts in the field of group psychotherapy feel that specialized training is essential (Bieling et al., 2006; Dies, 1994; Markus & King, 2003; Thorn, 2004; Yalom & Leszcz, 2005). Because many of the skills needed to conduct individual therapy do not generalize to group therapy (Dies, 1994), even the best individual therapists will need training to effectively use and apply group processes. Finally, a major reason that it has been difficult to integrate cognitive-behavioral and motivational interventions, especially components such as homework exercises and personalized feedback, into group therapy has been an insufficient appreciation for group processes (Bieling et al., 2006).

Concerns When Adapting Motivational Interviewing and Cognitive-Behavioral Techniques and Strategies into a Group Format

For the reasons just discussed, extending any evidence-based treatment delivered as individual therapy to a group format requires serious adaptations. As discussed in Chapter 1, when we decided to extend the GSC treatment model to a group format, it took considerable planning and work. One of the adaptations involved recognizing the need to understand the dynamics of running groups using group processes. The primary reason for this is that, unlike individual therapy, in which there is a dyadic interaction, in groups there are multiple and complex interactions that need to be managed. A sine qua non of successfully running groups is for group leaders to understand how to use the interactions of the group to guide members toward behavior change (Yalom & Leszcz, 2005) and to “rigorously and responsibly use group processes” (Satterfield, 1994, p. 192).

We had three major concerns when incorporating cognitive-behavioral and motivational interviewing techniques into a group format. The first was ensuring that the treatment would make use of the group format rather than simply being an arena for observing dyadic interactions. In this regard, Satterfield (1994) has asserted that “although interpersonal exchanges do occur in cognitive-behavioral groups, interventions usually focus on treating the individual in the group rather than through the group” (p. 185, original emphasis). Our second concern was to make sure that group processes were utilized to facilitate change. The third major concern was to integrate motivational and cognitive-behavioral strategies into the group format in a way that would retain their therapeutic impact and effectiveness.

The first two concerns can be addressed if therapists receive adequate training in group processes. In terms of the integration of motivational interviewing and cognitive-behavioral strategies into a group format, which is the main focus of this chapter, we first reviewed the literature on group therapy to learn how to create an effective integration that would capitalize on group processes. We also arranged for experts in group therapy to train the staff. This experience demonstrated to us that therapists with little group experience could be successfully
trained in group processes (i.e., outcomes for the group and individual treatment conditions in our study were very similar, and both demonstrated significant pre- to posttreatment changes; L. C. Sobell et al., 2009).

At the same time that we were determining how to integrate cognitive-behavioral and motivational interviewing strategies into a group format, we also had to address constraints inherent in group therapy. The major constraint we faced was including all members in the group discussions within the time limits of the group. In this regard, we decided to use what we have termed round-robin discussions. Thus, for many of the GSC procedures (e.g., personalized feedback, review of homework exercises), the primary way the group sessions differ from the individual sessions is that the groups use a round-robin discussion format.

**ROUND-ROBIN DISCUSSIONS**

Round-robin discussions are used throughout the GSC group sessions as a way of including all group members in the discussion of all major topics and exercises. Table 5.1 contains descriptions of the several round-robin discussions used in the four GSC group sessions (L. C. Sobell et al., 2009). The four Group Therapist Handouts (5.1–5.4) at the end of this chapter include specific suggestions for how to focus each round-robin discussion and examples of ways the group leaders can initiate and maintain the discussions. In addition, the handouts contain notes for group leaders related to managing the discussions. Table 5.2 provides examples of statements group leaders can make to bring members and topics into the group discussion (e.g., address sensitive issues raised by a member, get all members to comment on a particular topic).

**Round-Robin Discussions: A Way for Members to Share Time in Groups**

Although group members cannot receive as much attention (e.g., homework answers) as in individual therapy, the round-robin discussions provide an opportunity for all group members to discuss some aspect of each topic or assignment and to receive feedback and support from their peers. At the first session, the following key aspects of group are discussed: expectations of members, group rules, the need for regular participation, and group members’ need to act as agents of change (i.e., providing support and reinforcement to one another). Last, for round-robin discussions to work effectively, group leaders need to manage the time so that all members get an opportunity to participate and all topics scheduled for each session are covered (e.g., personalized feedback, discussions of homework).

Group leaders also explain to the group that they are looking for balanced participation and that one way to ensure this is to use round-robin discussions. Although each group member always gets an opportunity to discuss each assignment and his or her weekly self-monitoring logs, each is asked to select one example from the homework (e.g., in Client Handout 4.6, one of the two high-risk trigger situations) rather than discussing everything in each assignment. Over the years, we have found that if the rationale for round-robin discussions is presented to the group, they understand and quickly become accustomed to the procedure.

At every group session, members are asked to share their experiences and to comment on other members’ behaviors and assignments. In this way, commonalities among members can be
TABLE 5.1. Round Robin Discussion Topics Used in the GSC Group Treatment

SESSION 1

- **Introductory Discussion:** Includes normalizing members' feelings about groups and discussing group rules, what members expect out of treatment, and why they come to treatment
- **Self-Monitoring Logs:** Discussion of clients' completed logs for alcohol or drug use since the assessment interview (Alcohol: Client Handout 3.2; Drug: Client Handout 3.3)
- **Goal Evaluations:** Review of clients' completed goal evaluations for abstinence or low-risk, limited drinking, including their goal importance and confidence ratings (Abstinence: Client Handout 3.4; Goal Choice: Client Handout 3.5)
- **Personalized Feedback:** Discussion of the personalized feedback handouts (i.e., summaries of pretreatment alcohol and drug use; where their alcohol or drug use fits in with respect to national norms; scores on the AUDIT or DAST-10 evaluating the seriousness of their pretreatment substance use (Alcohol: Client Handout 4.1; Drug: Client Handout 4.2)
- **Decisional Balance:** Discussion of good and less good things about changing alcohol or drug use using the decisional balance exercise (Client Handout 3.1)
- **End of Session:** Wrap-Up and what stood out

SESSION 2

- **Self-Monitoring Logs:** Discussion of clients' completed logs for alcohol or drug use since Session 1 (Alcohol: Client Handout 3.2; Drug: Client Handout 3.3)
- **High-Risk Trigger Situations:** Discussion of the reading and exercise on identification of high-risk trigger situations for alcohol and drug use, including how to take a realistic perspective on change (i.e., Mt. Recovery) and how to view slips as learning experiences (Reading: Client Handout 4.5; Exercise: Client Handout 4.6)
- **BSCQ:** Review of the personalized profiles of high-risk situations for alcohol or drug use using the BSCQ clients completed at assessment; includes a discussion of the relationship of the BSCQ profile to their high-risk triggers homework exercise (Client Handout 4.7)
- **Where Are You Now Scale:** Review of clients' completed Where Are You Now scale (Client Handout 3.6)
- **End of Session:** Wrap-Up and what stood out

SESSION 3

- **Self-Monitoring Logs:** Discussion of clients' completed logs for alcohol or drug use since Session 2 (Alcohol: Client Handout 3.2; Drug: Client Handout 3.3)
- **Developing New Options and Action Plans:** Discussion of the homework exercise on developing new options and action plans to deal with the high-risk trigger situations identified in Session 2 (Client Handout 4.8)
- **End of Session:** Wrap-Up and what stood out

SESSION 4

- **Self-Monitoring Logs:** Discussion of clients' completed logs for alcohol or drug use since Session 3 (Alcohol: Client Handout 3.2; Drug: Client Handout 3.3)
- **Personalized Comparative Feedback about Alcohol or Drug Changes:** Discussion of personalized feedback about changes in alcohol or drug use from the assessment session through Session 3 (Client Handouts 4.3 and 4.4, respectively)
- **Comparative Goal Evaluations:** Comparative evaluation of clients' first (assessment) and second (Session 3) goal evaluations, including their goal importance and confidence ratings (Abstinence: Client Handout 3.4; Goal Choice: Client Handout 3.5)
- **Revisiting the Decisional Balance Exercise:** Discussion of any additions or changes in clients' decisional balance exercise answers from Session 1 through Session 4
- **BSCQ Changes:** Review of the prepared personalized profiles of clients' high-risk situations for alcohol or drug use using the BSCQ completed at assessment and at Session 3 (Client Handout 4.9)
- **Implementation of Options:** Discussion of implementation of the exercise relating to new options to deal with the high-risk trigger situations
- **Revisiting Mt. Recovery and Relapse Prevention:** Review of the high-risk triggers reading
- **Where Are You Now Scale:** Comparative review of the clients' completed Where Are You Now scale (Client Handout 3.6) over treatment
- **End of Session:** Wrap-Up and what stood out
identified and group members are given an opportunity to provide support for or critiques of other members’ behaviors. Except for structured group activities (e.g., homework assignments), it is not necessary to have all members participate in every round-robin discussion. All members should, however, participate in each group session. What builds group cohesion is not the amount of time that a member participates but, rather, getting everyone actively participating.

Round-robin discussions begin with the group leaders introducing a topic and then opening up the discussion to the group members. If no one initially comments, the group leaders can ask the entire group who would like to start the discussion, or the leaders can ask a specific

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**TABLE 5.2. Ways to Bring Different Members and Topics into Group Discussions**

<table>
<thead>
<tr>
<th>Group focus</th>
<th>Leaders’ comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Look for commonalities in the discussion.</td>
<td>• “Who else has had that kind of experience?”</td>
</tr>
<tr>
<td></td>
<td>• “Who else has similar feelings?”</td>
</tr>
<tr>
<td></td>
<td>• “Who else feels the same way as Mary?”</td>
</tr>
<tr>
<td>Include more group members in the discussion.</td>
<td>• “What does the group think are some reasons why someone might decide to drink or use drugs after being abstinent for several months?”</td>
</tr>
<tr>
<td>Invite all members to comment (used with homework exercises).</td>
<td>• “What stood out about the decisional balance exercise that each of you completed for this session?”</td>
</tr>
<tr>
<td>Elicit supportive statements from the group about other members’ changes.</td>
<td>• “It sounds like several members have made big changes in their substance use since last week. How does the group feel about these changes?”</td>
</tr>
<tr>
<td>Address an issue raised by one member and invite others to comment.</td>
<td>• “It sounds like Bill is ambivalent about not using cocaine. How have others dealt with similar feelings?”</td>
</tr>
<tr>
<td>Get other members to provide additional suggestions.</td>
<td>• “Okay, so Bill has provided one suggestion for how Mary might handle her difficulties with her daughter. What other options can the group think of to help Mary?”</td>
</tr>
<tr>
<td>Get all members to comment on a particular topic.</td>
<td>• “How would each of your lives be different six months from now if you stopped using alcohol and drugs?”</td>
</tr>
<tr>
<td>Invite others to provide alternative responses to one member’s harsh response.</td>
<td>• “Mary, that is one way of looking at what has happened to Bill. What are some other ways of looking at what happened with Bill?”</td>
</tr>
<tr>
<td>Address an uncomfortable interaction and invite others to comment.</td>
<td>• “I am getting the sense that others seem to be uncomfortable with what has just happened.”</td>
</tr>
<tr>
<td>Address tension that has arisen between group members; group leaders call a time-out to process what has happened.</td>
<td>• “It sounds like a lot is happening, and I want to call a ‘time-out.’ We can come back to the topic later, but let’s look at what is happening in the group right now.”</td>
</tr>
<tr>
<td>Address a sensitive issue raised by a member and invite others to comment.</td>
<td>• “Mary has revealed some very personal things about herself. That must have been difficult. How do others in the group feel about what Mary just shared?”</td>
</tr>
<tr>
<td>Acknowledge members’ nonverbal responses and invite them to translate nonverbal responses into verbal responses.</td>
<td>• “I noticed when Mary discussed her difficulties with her husband, that many of you were nodding in agreement. What do the head nods mean?”</td>
</tr>
</tbody>
</table>
member to start. When members voluntarily comment in the first few sessions, group leaders should reinforce their comments (e.g., “This is exactly what we are looking to have members do in group”).

**Round-Robin Discussions and Group Cohesion**

Round-robin discussions not only ensure that all group members participate regularly, but they also promote the development of cohesion using group processes (e.g., members identify commonalities and provide supportive comments to other members). To use the group time efficiently during pregrou ps preparation (see Chapter 6), group leaders need to allocate time to cover the planned session procedures (e.g., Session 1: beginning and ending groups; reviewing self-monitoring logs; discussing members’ decisional balance exercises; presenting members with feedback materials; explaining homework exercises for the next session).

A major goal of group therapy is to have the group members, rather than the group leaders, be the main source of reinforcement and support for other members. Besides providing emotional support to each other, group members can also offer one another consensual validation and advice on how to handle problems. As is discussed in the next chapter, the goal is to have the *music come from the group*. Viewed this way, group members should be doing most of the talking, while the group leaders orchestrate the discussions and bring members into the conversations. Early in the formation of the group, the leaders need to encourage participation by all members. Identifying commonalities among members is a key way to develop group cohesion.

**Starting and Ending Groups Using Round-Robin Discussions**

Because some group members report initial anxiety about speaking in groups, a goal in the first session is to develop a safe climate for sharing and self-disclosure. One way to facilitate this is to start the first group session by having all members introduce themselves. The first session contains several nonthreatening round-robin discussion topics (see the Group Therapist Handout 5.1; e.g., introductions of members, normalizing members’ concerns about groups, what members expect out of treatment). Using nonthreatening group discussions during the first part of Session 1 can help establish group cohesion, something that is essential for positive group therapy outcomes (Dies, 1993; Satterfield, 1994; Yalom & Leszcz, 2005). Similarly, in ending group sessions, it is important to do so in a way that maintains cohesion and positive feelings about group therapy. The following shows some ways for group leaders to end groups using round-robin discussions.

**USING ROUND-ROBIN DISCUSSIONS TO END GROUPS**

- “What was it like being in your first group session?” or “What was it like to hear from others with similar problems?”
- To promote skill-based acquisitions from session to session, group leaders can ask, “What can you take away from today’s group that you could implement between now and the next group?”
This next question, which is asked during the last 5 minutes of open and closed groups, in many ways is like a motivational interviewing summary of each member’s perspective, including the group leaders, about what happened in the group.

“We have talked about a lot of things in group today. Let’s go around and have everyone, including the group leaders, tell us one thing that stood out about the group.”

**INTEGRATING MOTIVATIONAL INTERVIEWING STRATEGIES AND TECHNIQUES INTO A GROUP FORMAT USING ROUND-ROBIN DISCUSSIONS**

This part of the chapter provides specific suggestions about how to use specific motivational interviewing strategies and techniques in a group format using round-robin discussions. Because motivational interviewing strategies were discussed in detail in Chapter 2, only brief descriptions of the techniques as related to their use in round-robin discussions are presented here.

**Using Round-Robin Discussions with Homework**

Because groups have multiple members, it is not possible to have everyone discuss answers to their homework exercise, as would occur in an individual therapy session. As discussed in Chapter 3, homework has been a mainstay of cognitive-behavioral interventions for many years and has several benefits: (1) it strengthens what is discussed in therapy; (2) members are engaged in treatment outside of sessions; (3) it allows group leaders to point out commonalities during a discussion, which, in turn, provides a basis for building cohesion; (4) written homework exercises help to keep all group members on the same page; and (5) importantly, research has shown that those who comply with homework have better treatment outcomes, perhaps because they are working outside of sessions (Burns & Spangler, 2000; Kazantzis et al., 2000).

A way to avoid or minimize compliance problems with homework is to explain its rationale and how it fits into the treatment (Addis & Jacobson, 2000; Kazantzis, Deane, Ronan, & L’Abate, 2005). Discussing the need to complete homework exercises is equally important, whether the treatment format is individual or group. As discussed in Chapter 1, 90% of group clients in the GRIN study (L. C. Sobell et al., 2009) completed and brought their homework and self-monitoring logs to sessions. We believe this high compliance rate is directly related to our therapists’ explaining the rationale and importance of doing homework exercises.

The discussion of homework exercises, which involves all group members, starts with the group leaders asking members to discuss what they got out of the homework exercise. The leaders can then ask, “Who else has had similar experiences?” Questions like this can be used to identify commonalities among members.

The Identifying Triggers exercise (Client Handout 4.6) provides a good example of how to use homework exercises in a round-robin discussion. This homework exercise, which is handed out and explained to members in Session 1, is discussed with clients in Session 2. This exercise asks clients to identify and discuss two high-risk trigger situations related to their alcohol or drug use that occurred in the preceding year (see Session 2 in Chapter 4). In individual therapy, clients would discuss both trigger situations with their therapists. However, because there is
not enough time to have all group members discuss both trigger situations in the group, each member is asked to select and discuss one of their two trigger situations. The trade-off is that although group members have less time to discuss their personal situations, they benefit by sharing their experiences with other group members who can be supportive and who can offer advice about how they have handled similar situations. The Group Therapist Handouts contain discussions of how to present the homework exercises using a round-robin format.

**Incomplete Homework**

If clients come to group without their homework or self-monitoring logs, we recommend that the group leaders ask them to complete them before or at the start of the group. This, of course, requires that the group leaders check that the various assignments have been completed before starting the group. Although this might seem disruptive, the alternatives (i.e., not having the assignments completed, leaders not knowing whether members have completed their homework) can diminish members’ participation.

It is important for group leaders to address noncompliance with homework early because if one or more clients repeatedly do not complete their homework, other members might get the impression that it is not important to do so. However, as discussed earlier, if the group leaders explain the rationale and importance of doing homework at the first session, compliance is usually not a problem. If a group member repeatedly fails to complete the assignments, the group leaders should address this in a nonjudgmental, motivationally enhancing manner (e.g., “It looks like some folks are struggling to complete their homework before group. I know we are all busy, but I’m wondering what advice others have for how to fit these assignments into one’s schedule?”).

**Using Round-Robin Discussions with Personalized Feedback Materials**

Groups provide a rich forum for discussing feedback materials. Using round-robin discussions, we have group members comment on the personalized feedback materials we provide them in group. Members are also encouraged to discuss their reactions to the materials. As shown in Table 4.1, several types of motivational feedback handouts are part of the GSC group intervention. The four Group Therapist Handouts contain examples of ways group leaders can present feedback throughout the group sessions. The following example is a generic way of presenting feedback.

“We will be giving everyone a lot of information today. The first type of feedback is based on the information you provided in your assessment session and relates to your past alcohol or drug use. The reason we give you feedback about your [insert risky problem behavior here] is to provide you with information that you can use to make more informed choices about changing. Let’s have everyone look at the personalized graphs we prepared of your [insert risky problem behavior here] and tell the group what stands out for you about these summaries.”

Motivation for change often occurs when people recognize a discrepancy in their risky problem behavior (i.e., a difference between how they are acting and how they think they should act). Personalized feedback is one way to address such discrepancies. As discussed in Chapter
2, the way feedback is presented is important. Feedback or information presented in a neutral, nonjudgmental manner is more likely to be positively received by clients than is being lectured to about the negatives of their behavior or told that they have to change. The ultimate objective of providing feedback is for clients to recognize that their risky problem behaviors are not within the norms and, if continued, can result in more serious consequences.

**Using Round-Robin Discussions with a Decisional Balance Exercise**

The decisional balance exercise (Client Handout 3.1), designed to address ambivalence about changing, asks clients to consider both the good and less good things about changing and not changing their alcohol or drug use (or other risky problem behaviors). This exercise is used to help clients recognize that there are rewards associated with their substance use, although those rewards are short term and could result in long-term negative consequences. The discussion of both the good and less good things about engaging in a behavior also helps clients make sense of their actions, and it makes salient that a continuation of the behavior risks highly undesirable outcomes.

As discussed in the first handout for group therapists (5.1), the decisional balance round-robin discussion invites all group members to talk about their responses and what they have learned from this exercise. This discussion provides an excellent opportunity for the group leaders to identify similarities among members and to prompt group discussion about the need to make decisions based on long-term goals. The ultimate objective of a decisional balance exercise is to help clients recognize their ambivalence about changing and to get them thinking about what it would take to change. Although several discussion topics are listed here, all topics do not have to be addressed, only those relevant to the ongoing group discussion.

**POSSIBLE DISCUSSION TOPICS FOR USE WITH THE DECISIONAL BALANCE EXERCISE**

- “What did each of you get out of this exercise?”
- “How did the use of the decisional balance exercise affect your thinking about your [insert risky problem behavior here]? ”
- “What are the good and less good things about doing this exercise?”
- “What strikes you most about this exercise?”
- “What surprised you most about doing this exercise?”

**Using Round-Robin Discussions to Support Self-Efficacy**

Group leaders need to recognize small gains that clients make from session to session. Reinforcing gains is best done by getting group members to comment about the positive changes other group members have made. If a group member discusses changes but other members fail to comment, the group leaders need to elicit comments from them by saying something like, “Bill was drinking thirty drinks per week before he came to group, and now he is down to one or two per day. How does the group feel about what he has done?” Getting group members to reinforce each others’ gains is a good example of how group members serve as agents of change.
Using Round-Robin Discussions to Present Affirmations

An affirmation is a motivational interviewing strategy used to recognize clients’ strengths, successes, and efforts to change. Affirmations can be used for individual clients within the group and for the group as a whole. The following are two examples of how to use affirmations in a group:

“Everyone has done a good job of completing their decisional balance homework for this week. Now that we have discussed the good things and less good things about each person’s substance use, let’s go around and see what one thing it would take for each person to change right now.”

“When Mary came in she said she could not go a day without using cocaine. As we just heard, she hasn’t used for a week. What does that say about her?”

Using Round-Robin Discussions to Present Reflections and Open-Ended Questions

As in individual therapy, the group leaders can use open-ended questions and reflections to encourage members to contribute to the group. When group leaders use open-ended questions, members’ responses are usually richer or tell more of a story (e.g., “How do people feel about that?” or “When you use cocaine, what does it do for you?”). Open-ended questions can be asked with no particular member in mind, or they can be directed to a specific member if the group leader feels that member can provide relevant comments to another member. The following are some examples of group-focused questions and reflections.

**EXAMPLES OF OPEN-ENDED QUESTIONS AND REFLECTIONS FOR GROUP DISCUSSIONS**

- “That sounds like an important issue. Who else can relate to what Bill has said?”
- “How does that relate to why each of you is here?”
- “How have others handled similar situations?”
- “Mary, it sounds like some of your friends have put a lot of pressure on you to drink. How have others dealt with social pressure to drink?”
- “Mary, that is one way of looking at how Bill can handle his mother-in-law. What other suggestions can the group give Bill?”

On occasion, especially when group leaders are concerned about minimal participation by members, questions and reflections can be directed to a particular member rather than the entire group. For example, a group leader might say, “That sounds like an issue that many can relate to. What about you, Bill?” At other times, the group leaders might reflect something that is important to a particular member, such as, “Bill, you appear to be torn about wanting to change.” They might also further explore a topic by saying, “Mary, can you tell the group about what led to your decision to leave your job?”
Judicious Reflections Are at the Heart of Group Work

In motivational interviewing, reflections are the primary way of responding to clients. Reflections are important because they validate therapists’ understanding of clients’ behaviors and they build empathy. When group leaders recognize that a member has said something significant in the group, it is important to have the group (rather than the leaders) focus on what has occurred. For example, the group leader can say, “Let’s spend some time thinking about what Mary has just said.” In this way, the members have the responsibility for interpreting and reflecting the client’s comment.

Group Leaders as Process Consultants

Group leaders have the unique role of acting as process consultants. In this regard, their responsibilities include drawing the group’s attention to what is important and pointing out appropriate behaviors for the rest of the group. The following are some examples of reflections that group leaders can use for such purposes (see Chapter 2 for additional examples of how to use reflections).

**EXAMPLES OF HOW TO USE REFLECTIONS IN GROUP DISCUSSIONS**

- “Mary has just shared some very strong feelings with the group. Let’s go around and see how others feel about [insert topic related to the discussion].”
- “It sounds like most members are saying that balancing a career and raising children is very stressful. Let’s go around and have those who have had such experiences share how they have handled them and point out what were some of the biggest challenges.”
- “That sounds like an important issue that Bill has raised. How have others handled similar situations?”

Group leaders need to reflect group members’ responses that are most relevant to the target behavior, and they need to do it in ways that will promote change talk by members. Summary statements, a form of reflections, can also be used to (1) review and highlight relevant information provided by the group, (2) relate a response by one member to an earlier comment by another member, and (3) transition the group discussion from one topic to another.

Using Round-Robin Discussions to Roll with Resistance

Dealing with difficult or resistant clients in individual therapy is usually easier than handling such clients in a group setting. In groups, the problem can be exacerbated if the group leaders attempt to manage a resistant client individually within the group. Suggestions for handling such situations follow. Group cohesion can also be damaged if members with strong personalities monopolize the group or influence other members by discouraging them from talking. Specific ways to handle monopolizing or chatty clients are discussed in Chapter 8. Some disruptions can be avoided by discussing acceptable group behavior (e.g., not talking over other members, not raising voices) at the first group session.
Dealing with Resistance

Group leaders should avoid confronting members in the group. For example, when dealing with an angry group member, the group leaders should pull other members into the conversation and ask how they have dealt with such feelings (e.g., “Mary, it sounds like you feel you had no choice in coming here and you are angry. If I recall, other group members have had some similar experiences. Who can share with Mary how they have handled such situations?”). In the end, the group leaders need to summarize what happened in the group (e.g., “Mary, although you would rather not be in group today, it sounds like the alternative was jail. I think what the group was trying to get you to think about is what alternative seems better for you now?”).

When dealing with resistant group members, it is important for group leaders to remember two things: (1) “think Group” (Dies, 1994, p. 86) and throw questions and comments back to the group (i.e., pull group members in and ask how others have dealt with such situations and feelings); and (2) group leaders should not interpret any of the group members’ comments as a personal attack. The group leader’s response (e.g., throwing it back to the group) should be in relation to the leader’s role, and not in a personal role.

PREPARING POTENTIAL GROUP MEMBERS DURING THE ASSESSMENT

Prior to the first group meeting, potential group members attend an individual assessment session with a therapist, preferably a therapist who will be one of the group leaders. The assessment procedures have been presented in detail in Chapter 3, but the following procedures should also occur at the end of the assessment for potential group members. All potential group members should be given the “Introduction to Groups” handout (Client Handout 5.1). Providing clients with this handout is not only an essential component of group preparation, but it also represents an opportunity to discuss the value of the group and address any concerns that clients may have about group therapy.

THINGS TO MENTION TO POTENTIAL GROUP MEMBERS AT THE ASSESSMENT

- “We have a handout about group therapy that addresses some concerns people have had about groups.”
- “Many studies have found that group treatment works as well as individual treatment.”
- “Group gives people an opportunity to do several things that they cannot do in individual therapy, such as sharing experiences with other members and learning how others have dealt with similar problems. Group members also receive support from others dealing with similar problems, which in turn allows members to know that they are not alone in trying to change.”
- “Last, and very importantly, what members share in groups is confidential. What is said in group stays in group!”
GROUP THERAPY CAN BE LIMITED BY CULTURAL OR OTHER FACTORS

Although groups can be a highly efficient way to deliver clinical services, there will be some situations in which the applicability of group therapy is limited by cultural or other factors. A specific case we experienced concerns a sister study to the GRIN study that was conducted in Mexico City using GSC materials translated into Spanish. In that study the overwhelming majority of clients were male (Ayala et al., 1997, 1998). Although the individual therapy condition was replicated, it was not possible to replicate the group therapy condition. In fact, not a single group was conducted in the group therapy arm of the study. According to the investigators, this occurred because nearly all of the potential clients were male, and they were not willing to participate in a treatment in which they would be discussing their substance use problems in front of others (which would conflict with the machismo aspect of the culture). Thus, although group treatment is cost effective, in Mexico cultural factors prevented implementation of the intervention with male Hispanic/Latino clients.

SUMMARY

The four handouts, 5.1–5.4, for group therapists at the end of this chapter are specifically designed to help group leaders integrate motivational interviewing and cognitive-behavioral strategies and techniques into group therapy, particularly using round-robin discussions. These four group therapist handouts were adapted from the GRIN study protocol (see Sobell & Sobell, 2009). Readers will also find it helpful to refer back to Chapter 4, which describes the GSC treatment components at length.

It is our hope that this chapter, coupled with the description of the treatment model in Chapter 5, describes and illustrates the group adaptation of GSC in sufficient detail to allow therapists to successfully integrate a motivational interviewing approach and cognitive-behavioral techniques to achieve a cohesive therapy group. The remaining chapters further discuss how to conduct effective groups and how to deal with challenges that may arise when conducting group therapy.
THERAPIST HANDOUT 5.1
Objectives, Procedures, Client Handouts, Pregroup Planning, and Sample Round-Robin Discussions

Group Session 1

INTRODUCTION

Each of the group therapist handouts for group sessions is intended to help group leaders integrate cognitive-behavioral and motivational interviewing techniques and strategies into a group treatment format. Throughout each session, leaders should look for and acknowledge commonalities among members and encourage members to be supportive of other members’ changes.

If the group leaders want to keep copies of the group members’ homework exercises and self-monitoring logs, they should develop a procedure that allows them to copy the information before or after the group, as members will need the forms during the group.

In each round-robin discussion, there is a list of suggested questions and topics. Although several topics and questions are provided, group leaders need not ask all questions or address all topics; instead, questions and topics should be selected as they relate to what is happening in the group.

SESSION OBJECTIVES

- Review and discuss members’ goal evaluations; provide guidelines or information on contraindications for use if appropriate.
- Review members’ self-monitoring logs with respect to their goals.
- Provide members with personalized feedback based on assessment measures.
- Evaluate and discuss members’ motivation to change.
- Give homework and instructions for Session 2.

SESSION PROCEDURES

- Introduce session, complete any remaining assessment inquiries.
- Review and discuss members’ completed self-monitoring logs, copy or record data.
- Give members personalized feedback from assessment forms and discuss.
- Review and discuss members’ completed goal evaluation.
- Review and discuss members’ completed decisional balance homework answers.
- Ask members the five-million-dollar question; affirm that changing is a “choice” people make.
- End session: What stood out about today’s session? Remind members to do homework.

CLIENT HANDOUTS

- Reading: Identifying Triggers (Client Handout 4.5)
- Exercise: Identifying Triggers (Client Handout 4.6)
- Copies of Client Handout 5.1 for the group members when discussing the group rules

(cont.)
PREGROUP PLANNING

Pregroup planning is seen as critical for several reasons: Retention of group members contributes to members' satisfaction, builds group cohesion, and results in positive group outcomes. Although pregroup planning only takes 15 to 20 minutes, it is important to do it prior to every group. Pregroup planning for the first session is more extensive and may take slightly longer than planning for other sessions. It includes the following.

- Review assessment information on all members.
- Know something about each group member before the group starts, including their first names.
- Use 3” x 5” cards to make brief notes about each member (e.g., age; first name; marital status; problem type, length, and consequences; medical problems; referral reason).
- On a separate sheet of paper draw a circular diagram for the group and write in the first names of each member as they sit down at the first session; this allows you to know who is sitting where and to be able to call on clients using their names.
- Arrange the chairs in a circle for the number of expected group members and the two leaders; for better communication, the group leaders’ chairs should be positioned opposite one another (to save these chairs place a clipboard or other materials on them ahead of time).
- Have new homework available for members (Client Handouts 4.5 and 4.6).
- Prior to this session prepare and highlight key points in each group member’s “Personalized Feedback Handout: Where Does Your Alcohol Use Fit In?” (Client Handout 4.1) or “Where Does Your Drug Use Fit In?” (Client Handout 4.2).

**Note to Group Leaders:** To prepare these handouts, use information collected from the TLFB and other measures administered at the assessment and discussed in Chapter 4 (go to [www.nova.edu/gsc/online_files](http://www.nova.edu/gsc/online_files) for measures and forms).

- Group leaders also need to decide who will take the lead for each of the major discussion topics in this session (e.g., introduction, self-monitoring, homework, ending group).

**FIRST ROUND-ROBIN DISCUSSION**

- Introduce group leaders and welcome members to group.
- Have members introduce themselves.
- To begin, one of the group leaders can say, “Why don’t we start by spending a few minutes talking about the benefits of group therapy and what groups are about?”
- In addition to presenting basic information about the group, the leaders can also say, “Another thing that is important to think about is that each group member is an agent of change, and the goal is to learn from each other and to be supportive of change. Another way of thinking about this is that solutions come from group members, not from the therapists.”
- After this initial discussion, group leaders can say, “Now that we have gone over the benefits of group and what is expected of group members, what other concerns do group members have?”
- After going over the basics, the group leader can start by saying, “Let’s go around and have each member tell us what you expect to get out of group.”

Normalize members' feelings about groups by saying, “Although it’s natural for members to initially feel uncomfortable in groups, groups provide members an opportunity to learn from others with similar problems. There are benefits to having members provide advice and feedback to one another.”

(cont.)
Further Discussion Focus: Leaders can ease members into talking in groups with general questions such as, “Let’s go around and have everyone tell us [insert one of the following questions here; ask one question one at a time].”

- “What brought each of you into treatment?”
- “Tell us two or three words that best describe you.” Next ask, “Now, thinking about those words, how do they relate to why you are here?”

ROUND-ROBIN DISCUSSION

Topic: Group Rules

Because group rules are intended to shape appropriate group behaviors, promote positive group norms, and reduce clients’ anxieties, one of the most important discussions that group leaders can have with group members early in the first session relates to group rules. The group rules most commonly advocated and their rationales are listed in Table 5.3. Although every group member should have received a handout describing the group (Client Handout 5.1) at their assessment, each should be given another copy of this handout at the first session.

Each group rule in Table 5.3 needs to be reviewed. They include: maintaining confidentiality, not socializing outside of group, attending group on time and calling if you cannot come to a group, not using alcohol or illicit drugs before group, not discussing absent members in group, completing homework assignments and bringing them to group, participating regularly, and exhibiting appropriate behaviors in groups (i.e., no yelling, no profanity, no use of cell phone during groups, no talking over one another).

ROUND-ROBIN DISCUSSION

Topic: Group Treatment Program

Discussion Focus: Brief review of the GSC treatment program, including mention of the following.

- There will be four 120-minute group sessions, typically with 6 to 10 members.
- Homework exercises and readings will be assigned.
- Members will participate in self-monitoring and goal setting for alcohol or drug use.
- Group members will learn a general approach to problem solving that will help them guide their own change and motivate them to take responsibility for their own change.
- One of the group leaders will call each group member 1 month after the last session to check on how everyone is doing and if more services are needed.

(cont.)
### TABLE 5.3. Group Rules and Their Rationales

**Confidentiality.** Group discussions are confidential: *What is said in group, stays in group!*

Rationale: Confidentiality is the sine qua non group rule; without it, members are unlikely to share or even come to group.

**Do not socialize outside of groups.** Although some interactions will occur outside of the group (e.g., waiting room conversations, riding home on public transportation), it is best to avoid having clients socialize with one another while they are in the group.

Rationale: Socializing outside of the group can undermine clients' treatment by blurring boundary issues. Even if clients go out for coffee after a group, they form a relationship that others cannot share, and the stronger the relationship, the more likely it is to interfere with group interactions.

**Attend groups on time.** Members are expected to make groups a priority and attend all sessions, arrive on time, and remain for the entire session unless there is an emergency. Members who are unable to attend a session are expected to call beforehand.

Rationale: Attendance is important, as each meeting builds on the previous session and missed groups cannot be made up.

**Do not use alcohol or illicit drugs before group.**

Rationale: Coming to the group under the influence of alcohol or drugs can be disruptive to group interactions and tends to put the focus on the intoxicated member rather than the group as a whole.

**Do not talk about group members who are not present.**

Rationale: Members who are not in the group any longer or unable to attend a session cannot speak for themselves. Discussions about absent members can undermine trust in the group.

**Complete homework assignments and bring them to group.**

Rationale: Because the completed assignments are discussed in the group, it is disruptive if some members have not completed their assignments. To enhance compliance, therapists need to give members an explanation about the rationale for and the importance of completing assignments (see Chapters 5 and 6).

**All members need to participate in all group sessions.**

Rationale: It is important for members to actively participate in the group (i.e., share their problems and feelings with others). Participation is very important, as each member is viewed as an agent of change, helping other members, being supportive, and providing feedback to others.

**Exhibit appropriate behaviors in groups.** (1) Take turns speaking and do not talk over one another; (2) respect the rights of others to express their opinions; (3) cell phones must be turned off during the group; (4) profanity, screaming, and yelling are not appropriate; strong emotions need to be communicated in a manner that is not disruptive and allows group members to help one another.

Rationale: Members should be respectful of one another and of the leaders. Individual outbursts or disruptions take the focus off of the group process.

(cont.)
ROUND-ROBIN DISCUSSION

Topic: Review Members’ Completed Self-Monitoring Logs for Their Alcohol or Drug Use since the Assessment Interview (Alcohol: Client Handout 3.2; Drug: Client Handout 3.3)

Discussion Focus

- The discussion can start with a group leader saying, “Let’s go over the self-monitoring logs and look at everybody’s alcohol and drug use in the past week.” Follow up by asking a member to begin the discussion, “[Insert client name], give us a general picture of what your alcohol or drug use was like this past week?”
- **Note to Group Leaders:** Unless relevant, avoid specific details of a client’s drinking or drug use (i.e., do not have members present a day-by-day description, as this takes too much time and usually is not that informative).
- If major changes have occurred or if a member handled a difficult situation and did not use, the group leaders can ask the group how they feel about the group member’s change.

ROUND-ROBIN DISCUSSION

Topic: Goal Evaluations (Abstinence: Client Handout 3.4; Goal Choice: Client Handout 3.5)

**Note to Group Leaders:** When groups have members with both abstinent and low-risk limited drinking goals, the group leaders can start by saying, “We are going to review each member’s goal form and we want you to freely comment on each others’ goals and how realistic they are.”

Abstinence Discussion

- Using a motivational interviewing approach, ask group members to discuss reasons for not using alcohol and drugs.
- Group members should provide sound reasons for being abstinent (e.g., relate it to what would be risked by using substances).
- The motivation for abstinence should be, “I have chosen not to use alcohol or drugs because that is the best way for me to avoid future problems” rather than trait attributions (i.e., reasons should not be statements such as “Because I have a disease” or “Because I have no will power”).

Framing abstinence as a choice, albeit a difficult one, allows discussion of how to accomplish change, whereas a statement of inability to change can lead to a self-fulfilling prophecy.

Goal Choice Discussion

- This discussion should begin with the leaders explaining that persons with contraindications to drinking are advised not to drink at all and describing the recommended guidelines for those who do not have contraindications and choose a low-risk drinking goal. For any member who has selected a low-risk drinking goal but has contraindications to drinking, the leaders can point out that the member may not have been aware of the contraindication but should now take it into account.
- Ask group members who have selected a low-risk drinking goal and do not have contraindications, “Have you ever been able to drink at low levels and without problems before?”

(cont.)
Group members can also be asked under what conditions low-risk drinking might pose a risk. This discussion can be facilitated by giving members considering a low-risk limited drinking goal a printed set of guidelines that outline risks that can be discussed.

**Note to Group Leaders:** If a group member’s goal exceeds the recommended guidelines or the person wants to engage in low-risk drinking but has contraindications to alcohol use, group leaders should engage other group members to comment on the risks the person would be taking. To prompt other members to comment on those whose goal exceeds the guidelines, ask, “As we have been listening to everyone describe their goal evaluation, we need to remember that recommended low-risk drinking limits are very low. What advice can group members provide to each other in terms of how realistic other members’ goals are?”

**Additional Goal Evaluation Topics:** With respect to members’ alcohol or drug use goals, group leaders can use the following questions to get group members talking about their goals.

- “How realistic is your goal?”
- “What obstacles, if any, are you experiencing in trying to achieve your goal?”
- For clients who have made significant changes in their alcohol or drug use, you can ask, “You made some very major changes in your alcohol or drug use. How were you able to do that and how do you feel about these changes?”

**Members’ Goal Evaluations Related to Their Confidence in Achieving Their Goals and the Importance of Their Goals**

- Group leaders can open the discussion by saying, “Now that we have discussed everyone’s goal, let us look at the second part of the goal evaluation, where everyone was asked to evaluate the importance and confidence of achieving their goal. To start, let’s look at what everyone put down for the importance of their goal and why you chose your rating.”
- During this discussion, the group leaders should look for commonalities. Several members will not rate reaching their goal as the most important thing in their lives, but instead will rate other things (e.g., health, job) as more important. With this discussion, the idea is to encourage members to discuss the importance of changing.
- After a discussion of the importance, the group leaders can move on to how confident members are in achieving their goals by asking, “Okay, now let’s do the same thing for everyone’s confidence ratings.”
- Ask group members, “What number did you put down for how confident you are right now in terms of reaching your goal, and why?” This could be followed up with, “What would have to happen for your goal to go from a [insert current #] to a [higher #]?"

**ROUND-ROBIN DISCUSSION**

**Topic:** Discussion of Personalized Feedback Handouts (i.e., summaries of pretreatment alcohol use, Client Handout 4.2; drug use, Client Handout 4.3)

**Note to Group Leaders:** Each member’s personalized feedback summary should have been prepared in advance and highlighted (e.g., yellow marker) on the printout you will give all group members during this discussion (i.e., highlight aspects of alcohol or drug use you want members to notice).
Discussion Focus: The crucial aspect of the feedback is comparing group members’ personal alcohol or drug use with normative data on substance use. Having members comment on their personalized feedback engages them in a discussion about their current substance use and risk as opposed to group leaders telling them such information. The intent is for group leaders to generate discussion so members understand that their present alcohol or drug use is not normative and that if they continue, such use is predictive of long-term risks (i.e., negative consequences).

Feedback Based on the Timeline Followback That Members Completed at the Assessment (Alcohol Use: Client Handout 4.1; Drug Use: Client Handout 4.2)

Start by giving group members their personalized feedback summaries.

- “If you remember, we asked each of you many questions about your alcohol and drug use at the assessment, and one thing you did was to fill out a calendar describing your alcohol or drug use prior to entering treatment. We will be giving everyone feedback today about your alcohol or drug use so you can use this information to make more informed decisions about changing your alcohol or drug use. Let’s have everyone look at the pie charts and tell the group what stands out about these summaries for you.”
- With alcohol clients, it is not unusual for them to be surprised at how heavy their drinking is compared with the general population, especially if many of their friends also drink heavily. Similarly, drug clients also report to us that they are surprised that so very few (e.g., ≤ 1%) people used many of the illicit drugs such as heroin or cocaine in the previous year.

Feedback Based on the AUDIT (Client Handout 4.1) and DAST-10 (Client Handout 4.2)

- “At the assessment interview, we also asked you about consequences you might have experienced because of your alcohol or drug use over the past year. Your answers yielded a score that reflects the severity of your alcohol (AUDIT) or drug (DAST-10) use. It is on the last page of your feedback summary. Let’s look at these graphs and your scores and tell the group what stands out about this feedback.”
- For surprised members, group leaders can say, “A few of you look surprised at the feedback. What’s surprising about it?”

ROUND-ROBIN DISCUSSION

Topic: Decisional Balance Exercise (Client Handout 3.1)

Discussion Focus: This exercise, a motivational tool designed to help clients understand their ambivalence and why changing might be difficult, involves a discussion of group members’ reports of good and less good things about changing their alcohol or drug use. Listing both the short- and long-term costs and benefits in one place can help them justify and strengthen decisions about changing. Throughout this discussion, group members are invited to comment on their perceptions of other members’ statements about the good and less good things related to their alcohol and drug use and what it would take to change. Possible group discussion topics include

- “What did each of you get out of this exercise?”
- “How did the use of a decisional balance exercise affect your thinking about your alcohol or drug use?”

(cont.)
Objectives, Procedures, Client Handouts, Pregroup Planning, and Sample Round-Robin Discussions (page 8 of 9)

- “What good and less good things had you not recognized before doing this exercise?”
- “What surprised you most about doing this exercise?”

**Note to Group Leaders:** Members’ discussion about their decisional balance exercises should include some mention of the following.

- What they recognized about their reasons for drinking or using drugs (i.e., good things about use)
- Potential obstacles to change

**ROUND-ROBIN DISCUSSION**

**Topic: Five-Million-Dollar Question (Client Handout 3.1)**

**Discussion Focus:** After discussing members’ decisional balance exercises, ask the group, “What if you were each offered five million dollars to not use alcohol or drugs for just one day? What would you do?”

**Note to Group Leaders:** The Five-Million-Dollar Question is used to show members that for a price, they would change their behavior. The important point from this exercise is that, although change might be difficult, it is a choice people can make. This point can often be made after members report why they would change.

Remember to invite group members to comment on each other’s responses to the Five-Million-Dollar Question. To make the point that change is possible, group leaders can say, “Since we do not have five million dollars, what would be your personal price for changing your alcohol or drug use?” or “What would it take for each of you to tip the scale in favor of changing?”

**Homework Assignments for Session 2: Identifying Triggers Reading (Client Handout 4.5) and Exercise (Client Handout 4.6)**

- Give each group member the Identifying Triggers reading and exercise
- Tell group members, “This is a short reading and homework exercise to complete for our next group meeting. The exercise is intended to help you identify your high-risk situations for alcohol or drug use and the consequences of use. Usually, the reasons for using are short-term consequences. What we are asking you to do is explained in the handout. When you complete this homework and bring it back to the next group, it provides an opportunity to talk more about these high-risk trigger situations and to examine why they’ve been a problem for you. A future homework will help you develop ways of handling those situations by doing things other than using alcohol or drugs.”
- “The reading will help you understand how to complete the homework and also will help you consider taking a long-term perspective on changing your alcohol or drug use. The reading and exercise are easy to complete and should take about 10 minutes.”
- Finally, tell group members that next week you will have them select one of their two high-risk triggers from the exercise to discuss further.

(cont.)
ROUND-ROBIN DISCUSSION

**Topic: End of Session 1, Wrap-Up, and What Stood Out**

Have each group member and the leaders comment on their group experience and one thing that stood out about the group.

**Discussion Focus:** Tell members that this and all subsequent groups will end by asking each member to comment on one thing that stood out for them in the group. Because the group leaders are part of the group, they also summarize, but they go last. Comments by the leaders are intended to reinforce behaviors they observed in the group or how certain issues were discussed and dealt with by the group members. Start the next two wrap-ups by calling on someone who volunteers. If no one comments, ask one member to start.

**What Was Group Like?:** “Now that we have completed the first group session, what we would like to do is go around asking everyone how it felt to be in the group today, particularly in relation to what you expected.”

**What Stood Out?:** Have each group member and the leaders comment on one thing that stood out in the group. “We have talked about a lot of things in group today. What one thing stood out?”

**Remind Group Members:** (1) to attend all group sessions, (2) to call if they cannot make a session, (3) to continue to use the self-monitoring logs and bring them and the homework exercise to the next session, and (4) that one of the leaders will call the day before group to remind everyone about the next group.

**POSTGROUP DISCUSSION**

- The postgroup discussion typically takes about 5–10 minutes.
- Discuss what happened in the group, both good and less good things.
- Group leaders should make notes about what they want to highlight in the next session and about anything notable about group members.
- Prior to the next group session, for each group member prepare a Client Handout 4.7: BSCQ Profile of high-risk situations for alcohol or drug use.
THERAPIST HANDOUT 5.2

Objectives, Procedures, Client Handouts, Pregroup Planning, and Sample Round-Robin Discussions

Group Session 2

SESSION OBJECTIVES

- Review members’ progress.
- Identify high-risk situations for members based on homework and BSCQ.
- Give homework and instructions for Session 3.

SESSION PROCEDURES

- Introduce session.
- Review and discuss members’ completed self-monitoring logs; copy or record data.
- Review and discuss members’ answers to Identifying Triggers homework exercise.
- Give members BSCQ feedback profiles and discuss relationship to Identifying Triggers homework answers.
- Have members complete Where Are You Now Scale (Client Handout 3.6) and compare their answers with their answers at the assessment.
- End session: Ask what stood out about session; remind members to do their homework.

CLIENT HANDBOUTS

- Exercise: Developing Options and Action Plans (Client Handout 4.8)
- Have the group members’ Where Are You Now Scale for them to check where they are at this session.

PREGROUP PLANNING

- Group leaders review what happened at the last group.
- Group leaders decide who will take the lead on which discussion topics (e.g., self-monitoring, homework).
- Prepare and have BSCQ personalized feedback profiles for members based on assessment interview.
- Have new homework for members (Client Handout 4.8).
- Have group members complete Where Are You Now Scale.

(cont.)
ROUND-ROBIN DISCUSSION

**Topic:** Review Members’ Completed Self-Monitoring Logs for Their Alcohol or Drug Use since Session 1 (Alcohol: Client Handout 3.2; Drug: Client Handout 3.3)

**Discussion Focus**

- The discussion can start with a group leader saying, “Let’s go over the self-monitoring logs and look at everybody’s alcohol and drug use in the past week.” Follow up by asking a member to begin the discussion, “[Insert client name], give us a general picture of what your alcohol or drug use was like this past week.”
- **Note to Group Leaders:** Unless relevant, avoid specific details of a client’s drinking or drug use (i.e., do not have members present a day-by-day description, as this takes too much time and usually is not that informative).
- If major changes have occurred or if a member handled a difficult situation and did not use, the group leaders can ask the group how they feel about the group member’s change.

ROUND-ROBIN DISCUSSION

**Topic:** Identification of High-Risk Trigger Situations for Alcohol or Drug Use (Reading: Client Handout 4.5; Exercise: Client Handout 4.6)

**Discussion Focus**

- Discuss the reading and exercise on identification of high-risk trigger situations for alcohol and drug use, including taking a realistic perspective on change (i.e., Mt. Change) and viewing slips as learning experiences.
- Probe group members’ understanding of the reading on identifying triggers of alcohol and drug use (Client Handout 4.5). There are two parts to this exercise: (1) identifying and evaluating personal high-risk triggers to alcohol or drug use and (2) a relapse prevention approach to change and taking a realistic perspective on change.
- A good question leaders can ask about the reading is, “The reading talks about taking a long-term view of change and that there might be some bumps in the road. What do you think is meant by this?”
- Another topic for members is to have them discuss the Mt. Change diagram (see picture in Client Handout 4.5). For example, the leaders could say, “What would you say is the major message of Mt. Change in terms of dealing with your alcohol or drug use?”
- Have clients select and discuss one of their two identified triggers from the exercise: “Let’s go around and have each member tell us about one of the high-risk trigger situations they described for their alcohol or drug use.”
- **Note to Group Leaders:** As part of this discussion, look for and acknowledge commonalities among members in terms of high-risk situations. Leaders can recognize commonalities with reflections: “So it looks like a high-risk situation for both Bill and Mary is when they are angry. Who else feels at risk when they experience strong emotions?”

**Note to Group Leaders:** With regard to the reading, members should recognize that for many people change might be associated with slips but that the important thing if a slip occurs is to continue up the mountain. However, it is also essential that the leaders not convey a self-fulfilling prophecy to the group (i.e., that they will have slips). A good way of presenting the concept is to have one of the group leaders ask, “Why do schools have fire drills?” Most members come up with the obvious response,
“So you’re better prepared if a fire occurs.” The leaders can follow this with, “That’s the same idea here. Hopefully you won’t have any slips, but it makes sense to be prepared in case they occur.”

It is also important for group members to recognize that, if slips occur, they should interrupt them early and learn from them. If a group member brings up a slip in group, one of the leaders can say:

- “Mary, can you tell the group what you think triggered the slip that occurred last Wednesday. What was different about Wednesday?”
- “How have others in the group handled a slip?”
- “What is another way of looking at a slip than as a failure?”

**ROUND-ROBIN DISCUSSION**

**Topic: Review Brief Situational Confidence Questionnaire (BSCQ) Feedback and Relationship to High-Risk Triggers (Client Handout 4.7)**

**Discussion Focus**

- Give members copies of their BSCQ Profiles (Client Handout 4.7) that were prepared based on the BSCQ they completed at the assessment.
- Have group members compare their BSCQ profiles with their two individual high-risk situations from the Identifying Triggers exercise. Ask how the two high-risk triggers in their homework exercise relate to their generic BSCQ profile.
- For a majority of members, their BSCQ profiles and triggers from the Identifying Triggers exercise will be similar.
- Point out for those whose BSCQ profiles and triggers are similar that the general BSCQ profile names are a shorthand that can help them more easily identify situations that could trigger future alcohol or drug use and that they should be vigilant in such situations. One of the leaders can ask, “Why is it important to know the types of situations in which you might be at risk of heavy drinking or drug use?”

**Note to Group Leaders:** In the discussion it will help members to recall their high-risk situations if the leaders label the members’ BSCQ profiles with shorthand names of the different BSCQ profiles listed in Table 4.2 (e.g., Good Time profile; Negative Affective profile; Testing Personal Control profile).

**ROUND-ROBIN DISCUSSION**

**Topic: Review of Members’ Completed Where Are You Now Scales (Client Handout 3.6)**

**Discussion Focus**

- Give members the Where Are You Now Scale completed at the assessment and ask them to answer the same questions again but for Session 2.
- “When you first came in, we asked each of you to rate how serious you thought your alcohol or drug use was on a 10-point scale. How would each of you rate your alcohol or drug use today on that same scale, where 1 = the most serious concern and 10 = no longer a concern?”
- Have members try to remember what number characterized where they were at the assessment interview on this scale.
- Ask members, “How did you go from a [## at Assessment] to a [## now]?”

(cont.)
Objectives, Procedures, Client Handouts, Pregroup Planning, and Sample Round-Robin Discussions (page 4 of 4)

- This scaling question is a motivational interviewing technique that allows members to give voice to changes they have made.
  - As part of this discussion, look for and acknowledge commonalities among members, and encourage them to be supportive of changes others are making.
  - For members who have not changed, the leaders can ask, “What would you need to do to move up a number or two?” or “What kinds of things have gotten in the way of your changing?”

DEVELOPING NEW OPTIONS AND ACTION PLANS HOMEWORK ASSIGNMENT FOR SESSION 3 (CLIENT HANDOUT 4.8)

Discussion Focus

- Give each member Client Handout 4.8, which asks them to develop new options and action plans for the two high-risk trigger situations they described in the exercise on identifying high-risk triggers associated with their alcohol or drug use.
- Group leaders can say to members, “This exercise is intended to help you learn how to handle those situations you identified as high-risk triggers by doing things other than using alcohol or drugs. This exercise will ask you not only to come up with some new options you could implement but also to evaluate how well they might work to help you resist using alcohol or drugs. Then you decide which are your best options and develop plans for how to put them into action. The exercise should take about 10 minutes to complete.”
- Finally, ask group members to complete the exercise at home and bring it to Session 3. Tell them that next week each member will be asked to talk about the options and action plans he or she developed for one of their two high-risk trigger situations.

ROUND-ROBIN DISCUSSION

Topic: End of Session, Wrap-Up, and What Stood Out

Discussion Focus

- What Stood Out?: Have each group member and the leaders comment on one thing that stood out in the group: “We have talked about a lot of things in group today. What one thing stood out?”
- Remind Group Members: (1) to attend all group sessions, (2) to call if they cannot make a session, (3) to continue to use the self-monitoring logs and bring them and the homework exercise to the next session, and (4) that one of the leaders will call the day before group to remind everyone about the next group.

Postgroup Discussion

- The postgroup discussion typically takes about 5–10 minutes.
- Discuss what happened in the group, both the good things and less good things.
- Group leaders should make notes about what they want to highlight in the next session and about anything notable about the behavior of group members.
THERAPIST HANDOUT 5.3

Objectives, Procedures, Client Handouts, Pregroup Planning, and Sample Round-Robin Discussions

Group Session 3

SESSION OBJECTIVES

- Review members’ progress.
- Discuss members’ change plans.
- Discuss new options and action plans for the high-risk trigger situations.
- Give homework and instructions for Session 4.

SESSION PROCEDURES

- Introduce session.
- Review and discuss members’ completed self-monitoring logs; copy or record data.
- Have members complete second BSCQ.
- Review and discuss members’ answers to homework exercise “Developing New Options and Action Plans.”
- Discuss possible opportunities for testing options before Session 4.
- End session: Ask what stood out about session; remind members to do their homework.

CLIENT HANDOUTS

- Homework: Request for Additional Sessions form (Client Handout 4.10)
- Homework: Goal Evaluation form (Client Handout 3.4 for members with an abstinence goal; Client Handout 3.5 for members with a low-risk limited drinking goal)
- BSCQ form (Appendix D) to be completed in session by each group member

PREGROUP PLANNING

- Group leaders review what happened at the last group.
- Group leaders decide who will take the lead on which discussion topics (e.g., self-monitoring, homework).
- Have new homework for members.
  - Request for Additional Sessions form (Client Handout 4.10)
  - Goal Evaluation form (Client Handout 3.4 for members with an abstinence goal; Client Handout 3.5 for members with a low-risk limited drinking goal)
- Have a new BSCQ form for each group member to complete in this group session (Appendix D).

(cont.)

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Objectives, Procedures, Client Handouts, Pregroup Planning, and Sample Round-Robin Discussions (page 2 of 3)

ROUND-ROBIN DISCUSSION

**Topic:** Review Members’ Completed Self-Monitoring Logs for Their Alcohol or Drug Use since Session 2 (Alcohol: Client Handout 3.2; Drug: Client Handout 3.3)

**Discussion Focus**

- The discussion can start with a group leader saying, “Let’s go over the self-monitoring logs and look at everybody’s alcohol and drug use in the past week.” Follow up by asking a member to begin the discussion: “[Insert client name], give us a general picture of what your alcohol or drug use was like this past week.”
- **Note to Group Leaders:** Unless relevant, avoid specific details of a client’s drinking or drug use (i.e., do not have members present a day-by-day description, as this takes too much time and usually is not that informative).
- If major changes have occurred or if a member handled a difficult situation and did not use, the group leaders can ask the group how they feel about the group member’s change.

ROUND-ROBIN DISCUSSION

**Topic:** Discuss New Homework Exercise on Developing Options and Action Plans (Client Handout 4.8)

**Discussion Focus**

- Ask each member to discuss the options and action plan for one of his or her two identified trigger situations from the homework.
- The goal is to use a motivational interviewing approach to have group members give voice to their change plans.
- “What kinds of options and action plans did you develop for your high-risk situations?”
- “Which option did you select as the most realistic to implement and why?”
- **Note to Group Leaders:** Tell members that it is important, when possible, to break action plans into small steps so that progress can be identified.
  Ask each member, “What trigger situations can you anticipate occurring between now and the next session in which you could put into practice your options and action plans?” [This question is used to identify possible future high-risk situations that group members might encounter and ways to deal with those situations in advance.]

IN-SESSION ASSIGNMENT

**Complete Brief Situational Confidence Questionnaire (Appendix D)**

**Discussion Focus**

- Give each member a BSCQ to complete during the session and tell him or her, “This form assesses how confident you are at the present time that you can resist the urge to drink heavily or use drugs. At the assessment you completed this form, and we want you to complete it again. Next week we will discuss and compare your answers today with your answers when you first came in.”

(cont.)
GOAL EVALUATION FORM HOMEWORK ASSIGNMENT FOR SESSION 4 (ABSTINENCE: CLIENT HANDOUT 3.4; GOAL CHOICE: CLIENT HANDOUT 3.5)

Discussion Focus

- Give each member either Client Handout 3.4 (members with an abstinence goal) or Client Handout 3.5 (members with a low-risk limited drinking goal) and ask them to complete the form at home and bring it to the next session.

“This is the same form you completed and brought into Session 1. We would like you to fill it out again and bring it to the next session, where we will compare your answers with your answers when you first came in.”

REQUEST FOR ADDITIONAL SESSIONS FORM HOMEWORK ASSIGNMENT FOR SESSION 4 (CLIENT HANDOUT 4.10)

Discussion Focus

- Give members the Request for Additional Sessions form (Client Handout 4.10) and ask them to complete the form at home and bring it to the next session.

“As was mentioned at the assessment, next week will be our last group session. Some people will feel they do not need any additional sessions as they have made sufficient progress, whereas others will want to continue in treatment. Additional sessions will occur as individual sessions rather than in groups. On this form you can indicate whether you want additional sessions, and if so, how many and what you would like to accomplish. If you want more sessions, we can discuss your request individually after the group next week.”

ROUND-ROBIN DISCUSSION

End of Session, Wrap-Up, and What Stood Out

Have each group member and the leaders comment on one thing that stood out in the group. “We have talked about a lot of things in group today. What one thing stood out?”

Remind Group Members: (1) to attend all group sessions, (2) to call if they cannot make a session, (3) to continue to use the self-monitoring logs and bring them and the homework exercises to the next session, and (4) that one of the leaders will call the day before group to remind everyone about the next group.

POSTGROUP DISCUSSION

- The postgroup discussion typically takes about 5–10 minutes.
- Discuss what happened in the group, both the good things and less good things.
- Group leaders should make notes about what they want to highlight in the next session and anything notable about the behavior of group members.
- For all members, prepare personalized comparative BSCQ profiles (assessment and Session 3) of high-risk situations for alcohol or drug use (Client Handout 4.9).
- For all members, prepare a personalized comparative (assessment to Session 3) feedback form of their alcohol or drug use (Alcohol: Client Handout 4.3; Drug: Client Handout 4.4).
Objectives, Procedures, Client Handouts, Pregroup Planning, and Sample Round-Robin Discussions

Group Session 4

SESSION OBJECTIVES

- Review members' progress.
- Revisit and review members' motivation and goals.
- Discuss end of treatment and aftercare call, or schedule further sessions.

SESSION PROCEDURES

- Introduce session.
- Review and discuss members' completed self-monitoring logs in relation to goal; copy or record data.
- Discuss opportunities for testing options since last session and the outcomes.
- Give members their personalized feedback comparisons of alcohol use (Client Handout 4.3) or drug use (Client Handout 4.4) over the course of treatment and discuss.
- Revisit goals, revise if necessary.
- Revisit decisional balance exercise, revise if necessary.
- Give members the BSCQ comparison (Client Handout 4.9) of assessment and Session 3 answers and discuss.
- Revisit and review members' understanding of the Mt. Change diagram and taking a realistic long-term perspective on change.
- Have members complete the Where Are You Now Scale and compare it with their assessment and Session 2 answers.
- Discuss Request for Additional Sessions form (Client Handout 4.10) completed as homework by members.
- Ensure that the members know how to contact the program if they need further treatment. Also, mention that one of the group leaders will contact them in about 1 month to check on how they are doing and whether anything else is needed.
- End session: Ask what stood out about the session.

PREGROUP PLANNING

- Group leaders review what happened at the last group.
- Group leaders decide what discussion topics (e.g., self-monitoring, homework) each will take the lead on for this session.
- Have a copy for each member of his or her BSCQ comparative feedback profiles (assessment and Session 3; Client Handout 4.9).
- Have a copy for each member of their comparative (assessment to Session 3) feedback profiles for alcohol use (Client Handout 4.3) or drug use (Client Handout 4.4).
- Have the Where Are You Now Scale for members to complete again.

(cont.)
ROUND-ROBIN DISCUSSION

Review Members’ Completed Self-Monitoring Logs for Their Alcohol or Drug Use since Session 3
(Alcohol: Client Handout 3.2; Drug: Client Handout 3.3)

Discussion Focus

- The discussion can start with a group leader saying, “Let’s go over the self-monitoring logs and look at everybody’s alcohol and drug use in the past week.” Follow up by asking a member to begin the discussion: “[Insert client name], give us a general picture of what your alcohol or drug use was like this past week.”
- **Note to Group Leaders:** Unless relevant, avoid specific details of a client’s drinking or drug use (i.e., do not have members present a day-by-day description, as this takes too much time and usually is not that informative).
- If major changes have occurred or if a member handled a difficult situation and did not use, the group leaders can ask the group how they feel about the group member’s change.

ROUND-ROBIN DISCUSSION

Topic: Discussion of Comparative Personalized Feedback about Changes in Alcohol or Drug Use
Before and During Treatment (Alcohol Use: Client Handout 4.3; Drug Use: Client Handout 4.4)

Discussion Focus: Alcohol Use

- Give members copies of their alcohol feedback handouts (Client Handout 4.3). This feedback form allows members to give voice to changes in their alcohol use.

  “These handouts display your alcohol use when you first came in and over the course of treatment. The first graph compares how frequently each one of you drank during the 90 days preceding your treatment and how frequently you drank during the time you were in the program up to last week. The second graph compares how much you drank per day during the 90 days preceding your treatment and during the time you were in the program up through last week. In looking at these two graphs, how would each of you say your drinking has changed?”

Discussion Focus: Drug Use

- Give members copies of their drug feedback handouts (Client Handout 4.4). This feedback form allows members give voice to changes in their drug use.

  “These handouts display your drug use when you first came in and over the course of treatment. The graph compares how frequently each one of you used drugs during the 90 days preceding your treatment and during the time you were in the program up through last week. In looking at these graphs, how would each of you say your drug use has changed?”

(cont.)
ROUND-ROBIN DISCUSSION

Topic: Comparative (Assessment and Session 3) Goal Evaluations (Abstinence: Client Handout 3.4; Goal Choice: Client Handout 3.5)

Discussion Focus

- This evaluation form was handed out as homework at the last session. The discussion will focus on members’ alcohol or drug use during treatment and how it relates to their goals and possible changes in their goals.
- “First, let’s look at your new goal and compare it with your goal when you first came in. What changes, if any, have you made and what led to these changes?”
- “Looking at your self-monitoring logs, how consistent is your recent alcohol and drug use with your second goal statement?” For members whose behavior is not consistent with their goals, ask the group, “Who has some ideas about why things haven’t been working for [insert member’s name]?”
- “How and why have your importance and confidence ratings changed?”
- If change has occurred, ask, “How does the change feel and how has it affected your confidence level compared with when you first came in to treatment?”
- The leaders can get other members to comment by asking, “Who else has had similar experiences?”
- Supportive comments from other members about members who have changed can be elicited by asking, “Both Bill and Mary have made some major changes. How do others feel about what they’ve done?”
- Finally, group leaders can ask, “What do members have to do to maintain the changes they have made?”

ROUND-ROBIN DISCUSSION

Topic: Revisiting the Decisional Balance Exercise

Discussion Focus

- Have members look back at their decisional balance exercises from Session 1 and revisit what they wrote down. The discussion relates to any additions or changes in members’ answers from Session 1.
- “Let’s look at the decisional balance exercise each of you completed at the start of treatment. Are there any new good or less good things that you did not identify earlier?”
- “Have any of the original good or less good things proved to be different from what you expected, and why?” [Often members will report that anticipated negative consequences of changing did not occur after all.]

ROUND-ROBIN DISCUSSION

Topic: Discuss Changes in the Brief Situational Confidence Questionnaire (BSCQ; Client Handout 4.9)

Discussion Focus

- Review the BSCQ personalized profiles of members’ high-risk situations for alcohol or drug use completed at assessment and at Session 3.
Objectives, Procedures, Client Handouts, Pregroup Planning, and Sample Round-Robin Discussions (page 4 of 5)

- Give members feedback comparing their first and second BSCQ profiles. Using a motivational counseling style allows group members to give voice to changes they have experienced in their confidence to resist the urge to drink heavily or use drugs.
- “What changes have you noticed in the situations you previously identified as high risk?”
- “What led to your change in confidence?”

ROUND-ROBIN DISCUSSION

Topic: Discussion of the Implementation of Options to Deal With the High-Risk Trigger Situations since the Last Session

Discussion Focus
- “Who can tell us about an opportunity they had to put one of their action plans to work and how it turned out?”

ROUND-ROBIN DISCUSSION

Topic: Revisit Mt. Change and Relapse Prevention

Discussion Focus
Revisit the concept of taking a realistic, long-term perspective on change. Look for statements that change may be slow and that if a slip occurs one can learn from it, get up, and keep on going.

- “Think back to Session 2 when we talked about Mt. Change and taking a long-term perspective on change. Based on our previous discussions and group meetings, what does taking a realistic perspective on change mean to you now?”
- “How are you going to accomplish this?”

ROUND-ROBIN DISCUSSION

Topic: Review Members’ Where Are You Now Scale Answers over Treatment (Client Handout 3.6)

Discussion Focus
- Give members the Where Are You Now Scale completed at the assessment and Session 2 and ask them to answer the same questions again for Session 4.
- “When you first came in, and again at the second session, we asked each of you to rate how serious you thought your alcohol or drug use was on a 10-point scale. How would each of you rate your alcohol or drug use today on that same scale, where 1 = the most serious concern and 10 = no longer a concern?”
- Have members try to remember what number characterized where they were at the assessment interview on this scale and what number they put down at Session 2. Then ask, “How did each of you get from where you were when you first entered treatment to where you are now, and how do you feel about this?”
- Look for and acknowledge commonalities, and encourage members to praise others for change.

(cont.)
REQUEST FOR ADDITIONAL SESSIONS

“Before we wrap up, last week we gave you a Request for Additional Sessions form to fill out and bring in today. For those of you who are requesting additional sessions, we'll meet with you individually after the group to discuss it.”

ROUND-ROBIN DISCUSSION

End of Session, Wrap-Up, and What Stood Out

Have each group member and the leaders comment on one thing that stood out in the group. “We have talked about a lot of things in group today. What one thing stood out?”

Remind Group Members: “One of us will be calling each of you in about a month to ask about your progress and to schedule additional sessions if needed.”

POSTGROUP DISCUSSION

- The postgroup discussion typically takes about 5–10 minutes.
- Discuss what happened in the group as a whole, both good things and less good things, and what lessons the leaders can take away from the entire group experience.
Introduction to Groups

RESEARCH SHOWS THAT GROUPS ARE AS EFFECTIVE AS INDIVIDUAL THERAPY.

GROUPS GIVE YOU AN OPPORTUNITY TO
- Share your experiences with others.
- Learn how others deal with their problems.
- Receive support from those who have similar problems.
- Help others deal with their problems.

HOW TO BENEFIT FROM GROUPS

ATTEND ALL SESSIONS: Attend all sessions and arrive on time. If for some reason you cannot make the group, call in advance and tell the group leaders.

DO THE READINGS AND HOMEWORK ASSIGNMENTS: You will be given readings, homework exercises, and self-monitoring logs to complete at home and bring back to the groups. This helps use the time in groups more efficiently. The assignments and self-monitoring logs will be discussed in the group.

PARTICIPATE: To get the most out of the groups, members need to participate during every group session and take turns speaking.

SELF-DISCLOSE: Use the group to help you with your own problems by sharing with the rest of the group.

WORK TOGETHER: The group accomplishes more when members work together, much like a sports team.

GROUP RULES

CONFIDENTIALITY: What is discussed in the group is not repeated outside the group.

DO NOT SOCIALIZE OUTSIDE OF THE GROUP

AVOID DISRUPTIVE BEHAVIORS

NO ALCOHOL OR DRUG USE: It is important not to use alcohol or drugs before coming to the group.

TURN CELL PHONES OFF DURING GROUPS

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PART III

Conducting and Managing Groups

Pregroup Planning, Group Cohesion, and Difficult Situations and Clients
CHAPTER 6

Building Group Cohesion

Music Comes from the Group

There is highly persuasive evidence that pregroup preparation expedites the course of group psychotherapy.
—Yalom and Leszcz (2005, p. 294)

In group psychotherapy, the relationship between the leader and the group member seems to be less important than the group members’ relationships with each other as a group.
—Schoenholtz-Read (1994, p. 157)

GROUP PREPARATION AND PLANNING

Pregroup planning and preparation are critical to the retention of members in groups and contribute to members’ satisfaction, group cohesion, and group outcomes (Burlingame, Fuhriman, & Johnson, 2001; MacKenzie, 1994; Rosenberg & Zimet, 1995; Satterfield, 1994; Yalom & Leszcz, 2005). Research has shown that pregroup planning has many benefits, including reducing dropout rates, increasing attendance, increasing self-disclosure by group members, increasing group cohesion, facilitating early group participation, reducing overall apprehension about groups, and, most important, increasing motivation to change (reviewed in Piper, 1993; Rosenberg & Zimet, 1995; Satterfield, 1994; Yalom & Leszcz, 2005).

Selling the Group

As discussed in Chapter 1, although research has shown that groups generally are as effective as their individual-therapy counterparts, many clients nevertheless believe that groups are not as effective as individual therapy (Yalom & Leszcz, 2005). Because several studies (Budman et al., 1988; Hofmann & Suvak, 2006), including the one in this book (L. C. Sobell et al., 2009), have reported that clients overwhelmingly prefer individual to group therapy, it is important to market groups to clients.

When possible, group leaders should meet with potential members prior to the first group session to explain how groups work and to address concerns about participating in groups. Dis-
Cussions with potential group members typically include (1) how the group works; (2) the role and expectations of group members (e.g., to learn from their peers, to be supportive of other members, to provide constructive feedback); (3) group rules; and (4) the importance of all members participating at each group. Because most clients can be expected to be ambivalent about attending group therapy, providing information about the benefits of groups and expectations of members should be done in a manner that is consistent with motivational interviewing principles (Miller & Rollnick, 2002). Potential members can be given a handout about the benefits of groups (see Client Handout 5.1 for a sample), including practical information about the logistics of groups such as parking or who to contact if a problem arises.

Group rules are intended to shape appropriate group behaviors, promote positive group norms, and reduce clients' anxieties. The group rules most commonly advocated and their rationales were listed in Table 5.3 (Bieling et al., 2006; MacKenzie, 1994; Yalom & Leszcz, 2005). Among the most important are attending group on time, maintaining confidentiality, not using alcohol or illicit drugs before group, not talking about group members who are not present, participating regularly, not socializing outside of groups, completing homework assignments and bringing them to group, and exhibiting appropriate behaviors in groups (i.e., no yelling, no profanity, no use of cell phone during groups, no talking over one another).

**Preparation Prior to Each Session**

Pregroup planning includes everything from making sure the room where the group will meet is ready and has the right number of chairs (MacKenzie, 1994) to discussing issues regarding specific members. Generally, pregroup preparation and planning should take about 15 to 20 minutes. To facilitate nonverbal communication in the group, it has been recommended that cotherapists sit opposite one another (Yalom & Leszcz, 2005). Before the group starts, when the chairs are being arranged, the group leaders can place their handouts or a clipboard on the chairs where they will be sitting. As described in Table 6.1, prior to each group the cotherapists should complete several tasks (e.g., discussing the group’s objectives; determining how responsibilities will be shared, such as who will keep track of time spent on different tasks; discussing members’ progress and special issues, such as how to better engage silent members; housekeeping tasks, such as having sign-in sheets and relevant homework assignments). Finally, when the group is ready to begin, empty chairs should be removed from the circle.

**TABLE 6.1. Tasks for Cotherapists Prior to Each Group Therapy Session**

- Specify the objectives and tasks to be accomplished and the topics to be discussed during the session.
- Decide who is going to start and end the group and who will take responsibility for starting the discussions related to specific session topics and homework exercises. For open groups, it is a good idea to think about general discussion topics in advance so there is some structure.
- Review notes from the previous session to identify topics that were to be followed up and discussed at the next group session. Also, briefly review each group member’s participation in and progress over the course of group sessions. If therapists use an ongoing logbook to make their postgroup notes, it will be easier to recall what happened in the previous session.
- Make sure that relevant paperwork needed for the session is available (e.g., sign-in sheets, confidentiality forms, group rules, handouts).
- Arrange chairs in a circle and have only enough for the number of anticipated participants plus the group leaders.
**Postgroup Discussions**

Postgroup discussions are also important (Dies, 1994; Yalom & Leszcz, 2005) and usually last 10 to 15 minutes. Topics that can be discussed include how the group went and any concerns or problems that arose from the group discussions. If something did not go as planned (e.g., discussion of planned exercise), the cotherapists can discuss why and how to handle it next time. Based on the postgroup discussion, a plan for the next session can be developed, including identifying members and topics to address (Heimberg & Becker, 2002). If trainees are present, the postgroup discussion provides an opportunity for them to ask questions. Last, issues that need to be followed up or addressed in the next session should be written in an ongoing group log so they can be recalled prior to the next group meeting.

**GROUP: A LIVING, LEARNING HALL OF MIRRORS**

The group experience is a key part of the learning process for group members. Discussing one’s successes or difficulties in groups allows other members to learn from such interactions, to be supportive, and to offer suggestions for change. In this sense groups can be thought of as a *living, learning hall of mirrors* in which members have the opportunity to practice behaviors, see how they are perceived by others, and get feedback, both positive and negative, from other group members (R. R. Dies, personal communication, February 19, 1996; Dies, 1992, 1994; MacKenzie, 1994). Groups provide a context in which real-life experiences and situations can be simulated in safe circumstances with feedback from others (e.g., “Bill, could you tell the group how the meeting went last week that you and your wife had with your children’s counselor?”). Group members, in contrast to the group leaders, can provide different perspectives on members’ behaviors and offer social support and peer pressure to encourage members to change. Groups also provide an opportunity to learn from other members through observational or vicarious learning. In discussing the benefits of groups, Satterfield said, “Group interactions also provide a natural arena to test social hypotheses, practice newly acquired skills, and create a ‘therapeutic’ mirror showing the objective social consequences of a patient’s actions and beliefs” (1994, p. 186).

**MUSIC COMES FROM THE GROUP: THERAPISTS AS ORCHESTRA CONDUCTORS**

As discussed in the Acknowledgments section, several years ago we attended two workshops presented by Dr. Robert Dies. During the trainings, he discussed two important concepts that we feel are key to understanding how to successfully manage groups. The first, *Think Group*, is intended to help therapists remember that the group itself is an agent of change and not to do individual therapy in group settings (also see p. 86 in Dies, 1994). The second concept—*Music Comes from the Group* and *Therapists as Conductors*—relates to the role of therapists in developing interactions among group members. In group therapy, the leaders’ task is to get the music to come from the group, which involves the members accepting responsibility for change and group processes driving the change. As we discuss subsequently, the concepts of *Music Comes*...
from the Group and Therapists as Conductors are straightforward and visually communicative. Over the years, we have found these two simple and eloquent concepts to be very effective in communicating to trainees how to manage and think about group processes.

Most group therapy experts recommend having two leaders, or cotherapists. Cootherapists can be likened to orchestra conductors, with group members being the instruments composing the orchestra. The leaders’ task is to get group members to work together, helping each other change. To apply the analogy Music Comes from the Group, an orchestra sounds good only when the instruments play together appropriately. In group therapy, for the music to successfully come from the group, the members should be doing most of the talking (i.e., playing the music) and interacting to facilitate change. Sometimes the conductor (i.e., group leader) will want to hear from the entire orchestra and will invite the whole group to respond (e.g., “Who else can identify with what Bill has said?”). At other times, the conductor/group leader will want a particular section of the orchestra (e.g., trombones) to play (e.g., “Bill, can you help Mary out?”) or will want to hear a different instrument (e.g., “Bill, we haven’t heard from you today. Can you offer Mary some suggestions for how she can handle her situation at work?”). At other times, the conductor/group leader may hear one instrument/group member play badly and will ask another instrument/group member to demonstrate how to play the part (e.g., “Bill, that is one way of handling things. Who can offer Mary another suggestion?”). Last, on rare occasions, a conductor/group leader might feel that the sound from the entire orchestra is not good. When this happens, the conductor/group leader may put down the baton and call a time-out, saying, “A lot is happening in group right now, and I’m not comfortable with what I’m hearing. Let’s stop and talk about what’s going on.” The ultimate goal of the orchestra conductor/group leader is to enable the members of the orchestra/group to work together (i.e., cohesion) to produce a harmonious sound.

COHESION: A POTENT FORCE IN GROUP THERAPY

Cohesion, a dynamic process that fluctuates over time, has been associated with positive outcomes (Beal, Cohen, Burke, & McLendon, 2003; Burlingame et al., 2001; Rose, 1990; Satterfield, 1994; Tschuschke, Hess, & MacKenzie, 2002) and with several key group attributes (Burlingame et al., 2001; Satterfield, 1994; Stokes, 1983; Yalom & Leszcz, 2005). Those attributes include: (1) productivity, (2) participation in and out of the group, (3) self-disclosure, (4) risk taking, (5) regular attendance, (6) pregroup preparation, (7) feedback, and (8) compliance with homework exercises. According to Yalom and Leszcz (2005), “group cohesiveness is not only a potent therapeutic force in its own right. It is a precondition for other therapeutic factors to function optimally” (p. 55). For these reasons, cohesion can be viewed as the glue that holds the group together and as a sine qua non for effective group therapy.

Building Cohesion in Groups

To develop group cohesion, group leaders need to look for and highlight similarities among members based on information from the assessments (e.g., types of problems clients have) and from interactions during group sessions (e.g., how clients have handled or avoided problems). Group leaders can use commonalities among members (1) to draw more group members into the discussion, (2) to demonstrate that others have had similar experiences, and (3) to prompt
members to share how they have handled similar problems. Good group preparation by the leaders is important for developing group cohesion. For example, if two or more members have undergone a recent divorce and the topic comes up in group, one of the group leaders can say, “If I recall, Mary is not the only one who has gone through a divorce. Who can share with Mary how they’ve dealt with this?” A leader could also ask, “Who else has had similar experiences?” or “Who else can identify with what Mary is feeling?” Although some group members will mention similarities and differences with other clients, at times the group leaders will have to prompt the group (“Who can offer Mary some advice about how they’ve dealt with being served with divorce papers and having to look for an attorney?”). Although clients tell different stories, there are common themes therapists can identify and ask others to comment on (“Perhaps others who have dealt with [insert type of problem] can share with Mary how they handled the situation?”).

Building group cohesion starts at the first group session, in which clients begin by talking about relatively safe topics (e.g., introducing themselves, describing their expectations from the group). As clients reveal their thoughts and feelings, it is important for the therapists to establish a favorable climate by commenting on the similarities and reinforcing clients for relating to each other and sharing their experiences. For example, following a member’s appropriate participation, the leader can say, “Mary, that is exactly what we are looking for. We want each of you to share your experiences with the group.” It is also important that the leaders ensure that all members have an opportunity to participate. As illustrated in Chapter 5, round-robin discussions can be used to ensure that all group members participate regularly.

**Cohesion: The Glue That Holds Groups Together**

Burlingame and colleagues (2001, p. 373) have defined cohesion as “the therapeutic relationship in group psychotherapy emerging from the aggregate of member–leader, member–member, and member–group relationships.” Yalom and Leszcz (2005) consider group cohesion to be one of the most important therapeutic factors in group therapy. In his book *Group Dynamics*, Forsyth (2006) asserts that “a cohesive group is a unified one, so members literally ‘stick together’” (p. 136).

In sports psychology, group cohesion is also very important. Sports psychologists talk about cohesion as integrating the members of a team (Moran, 2004). Interestingly, the concept has been used to explain the success of sports teams that were not expected to do well. Two key examples are the “Miracle on Ice” U.S. men’s hockey team that won the 1980 Olympic gold medal and the 1997 Florida Marlins baseball team, a group of very young and inexperienced players who started performing well, believed in themselves and in each other, and went on to win the World Series.

**The Group Is Greater Than the Sum of Its Parts**

The importance of group processes is summed up in the observation that more can be accomplished by members working together as a group than as individuals (Forsyth, 2006; MacKenzie, 1994). Burlingame and colleagues (2001) have summarized and discussed six empirically supported principles related to therapeutic relationships in groups. These six principles are reproduced from the original article in Table 6.2. What is striking is that many of the member-to-member and leader-to-member interactions discussed by Burlingame and colleagues are con-
consistent with the cognitive-behavioral strategies and the motivational interviewing approach used in the GSC treatment model. In retrospect, the many parallels between the GSC approach and group processes might explain why we were able to successfully integrate cognitive-behavioral techniques and a motivational interviewing counseling approach into a group therapy format. In the next two paragraphs, words and phrases common to the Burlingame and colleagues study are italicized.

**Member-to-Member Interactions**

Several member-to-member interactions have been shown to increase group cohesion and contribute to successful groups (Burlingame et al., 2001): (1) being supportive of each other's changing; (2) responding empathically (i.e., with genuine regard); (3) giving feedback to others in a nonjudgmental manner (minimizing negativity is more likely to get members to accept feedback and to be less resistant to change); (4) members assuming responsibility for their own change; and (5) complying with structured behavioral activities in groups (e.g., homework exercises and self-monitoring logs foster commonalities in terms of disclosures and shared feedback about ways to handle problems, all of which lead to greater group cohesion).

**Leader-to-Member Interactions**

With respect to leader-to-member interactions, the following have been shown to produce positive results in groups (Burlingame et al., 2001): (1) reflective listening demonstrates that the leaders have heard and understood members; (2) being empathic, accepting, and warm; (3) reinforcing effective interpersonal feedback; (4) communicating at the start of group that discomfort and apprehension about being in groups is normal (i.e., normalizing behaviors that members
may think only they are experiencing); and (5) communicating the importance of completing group assignments.

**Measures of Group Cohesion**

Most who have written about group psychotherapy have stressed the importance of measuring cohesion. Although several different group cohesion questionnaires have been developed (Kanas, Stewart, Deri, Ketter, & Haney, 1989; MacKenzie, 1983; Treadwell, Lavertue, Kumar, & Veeraraghavan, 2001; Tschuschke et al., 2002), the assessment of group cohesion has not received the research attention it deserves. In the GRIN study, we used the Group Cohesion Questionnaire—Short Version (GCQ-S) because it was brief and easy to score (Kanas et al., 1989; MacKenzie, 1983; Tschuschke et al., 2002).

The 12 items on the GCQ-S are rated on 7-point Likert scales. The measure yields three scores: (1) **Engagement** (5 items, range = 0–30), a positive atmosphere within the group, or cohesiveness; (2) **Conflict** (4 items, range = 0–24), interpersonal friction within the group; and (3) **Avoidance** (3 items, range = 0–18), members not taking personal responsibility for group work. In terms of group cohesion, desirable group characteristics on the GCQ-S would include high engagement, very low conflict, and relatively low avoidance.

In the GRIN study, all group clients were asked to complete the GCQ-S at their last session (Session 4). After only four sessions, the GRIN study found that the GSC group treatment resulted in high feelings of group cohesiveness and engagement, low levels of interpersonal conflict, and low avoidance of group work (L. C. Sobell et al., 2009). We have postulated that several factors may have contributed to the high cohesiveness: (1) as part of the pregroup preparation, all potential group members were given an introduction that described the group, its benefits, and the expectations of members (Client Handout 5.1); (2) because brief treatments necessitate focusing on specific goals, the development of group processes may have been facilitated because members and leaders knew that the group would meet for only four sessions; (3) group leaders were instructed to reinforce and support the discussion of commonalities and appropriate interactions among members; and (4) the homework exercises and weekly self-monitoring logs of substance use that clients completed outside of the sessions served to focus the group discussions on common themes.

**SUMMARY**

In this chapter we have focused on three important topics: (1) pregroup planning and preparation, (2) *Music Comes from the Group*, and (3) building group cohesion. Developing group cohesion is essential because it is associated with positive outcomes. Perhaps nothing better captures the importance of group cohesion than the phrase *it is the glue that holds the group together*. As discussed throughout this chapter, there are several ways group leaders can foster the development of cohesion: (1) pregroup planning and preparation, including helping potential members understand their roles and group expectations before joining the group; (2) ensuring that all members have an opportunity to contribute to group discussions; (3) getting members to discuss commonalities and comment on similar experiences they have had; (4) promoting self-disclosure by members; and (5) encouraging members to reinforce other members’ behavior changes.
CHAPTER 7
Managing Groups

Structural Issues

Group therapy is unique in being the only therapy that offers clients the opportunity to be of benefit to others. It also encourages role versatility, requiring clients to shift between roles of help receivers and help providers.
—YALOM AND LESZCZ (2005, p. 13)

This chapter and Chapter 8 are concerned with managing groups, but from different perspectives. This chapter addresses a multitude of structural issues (e.g., composition, attendance, role of cotherapists, breaking eye contact) that are critical for group leaders to understand when conducting group therapy. In contrast, Chapter 8 addresses ways to manage difficult clients in groups.

When comparing group with individual therapy, there are advantages and disadvantages, many of which are structural in nature (Morrison, 2001; Piper & Joyce, 1996; Satterfield, 1994; Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003; Yalom & Leszcz, 2005). The major differences between the two formats are listed in Table 7.1. Although managing groups is more com-

### TABLE 7.1. Advantages and Disadvantages of Group versus Individual Therapy

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>More clients can be treated in groups, thus reducing costs to clients and payers.</td>
<td>More difficult to manage because of simultaneously working with multiple clients, the greater potential for nonparticipation by some members, and the potential problems managing members’ behavior (e.g., monopolizing, disruptions).</td>
</tr>
<tr>
<td>Groups can provide peer support that cannot be achieved in individual therapy.</td>
<td>Higher dropout rates at entry and over treatment.</td>
</tr>
<tr>
<td>Group members can provide emotional support and reinforcement to each other.</td>
<td>Generally, less client satisfaction with groups.</td>
</tr>
<tr>
<td>Group members can learn from one another (e.g., serve as role models; offer suggestions for changing).</td>
<td>Special training and skills needed by therapists to handle complex group dynamics and interactions.</td>
</tr>
<tr>
<td></td>
<td>Attendance issues: missed group sessions cannot be rescheduled; if too many members drop out or miss groups, it can become difficult or impossible to run the group.</td>
</tr>
<tr>
<td></td>
<td>Group members may feel that their confidentiality and/or privacy is less protected.</td>
</tr>
</tbody>
</table>
plex, demanding, and challenging than conducting individual therapy, the structure of groups has several important advantages over individual therapy. These advantages, correspondingly, afford members opportunities (e.g., social support) not available in individual therapy.

ASSEMBLING GROUPS

Open Groups

Open groups do not have a fixed number of sessions and, consequently, do not usually have start or stop dates. Space permitting, new members can join at any time. At any given time, because of the nature of open groups, some members will have attended many sessions, others just a few sessions, and others will be new to the group. The mix raises several issues: (1) whenever a new member enters, group rules and expectations must be reviewed; one way to address this is to ask a senior group member to introduce new members to the group and to explain the group rules; (2) session-to-session continuity is harder to maintain; and (3) because of constant member turnover, open groups are not as amenable to structured tasks as are closed groups.

Closed Groups

Closed groups meet for a preset number of sessions with explicit start and stop dates. After the first session, closed groups typically do not add new members. Because all members start simultaneously, to maximize treatment gains closed groups often use structured activities (e.g., homework assignments) and specific topics for different sessions. When the number of group sessions is few, group leaders need to develop group cohesion early (i.e., starting at the first session). A serious issue with closed groups is getting and maintaining a critical mass. We and others have found three things that can help maximize attendance: (1) conduct a pregroup meeting in which potential members are told about the benefits of the group and are given a brochure describing the benefits and the group rules (Client Handout 5.1)—this can be done in a group or individually; (2) stress the importance of attending all group sessions and on time; and (3) very importantly, as a reminder call or e-mail clients the day before each group.

Starting and Stopping Groups on Time

It is imperative to start groups on time even if only a few clients are present rather than waiting for more to arrive because to do otherwise undermines the norm the leaders are trying to instill (Bernard, 1994). Stopping groups on time is similarly important. Although a crisis can occur near the end of group, they are rare and usually can be managed by the leaders after the group. Occasionally, however, members will wait until the end of the group before bringing up a topic. For example, for clients who wait until the last few minutes of group to bring up important, but not crisis-related, issues (e.g., losing a job, getting a C in a class), we recommend that the group leaders respond by saying something like, “Mary, it sounds like losing your job is an important issue. We want to be able to devote enough time to discussing it in the group, but with only a few minutes left before the group ends, this will be difficult. Do you mind if we discuss it at the start of group next week?” Most clients will agree with such a request, and one of the group leaders needs to make a note to remember to bring the matter up for discussion at the next session.
**Attendance Problems**

Attendance problems are not unique to therapy groups. It is common practice, for example, for many professionals and businesses (e.g., doctors, dentists, hairdressers) to call clients or patients to remind them of their appointments. One way to reduce attendance problems is to discuss the importance of attending groups when recruiting potential group members. When clients are constantly late or miss appointments, such behavior can be disruptive and must be addressed. However, it is best to have the group address the issue (i.e., let the “Music Come from the Group”) rather than having the group leaders confront members. With clients who repeatedly come late or barge in and disrupt the group, therapists can get the group involved with a comment such as “This is the third time Mary has been late. I’m wondering how the group can help Mary get to group on time.” Our experience has been that comments from group members are more likely to affect the client’s behavior than the therapists’ comments.

**Missing Groups**

When clients fail to attend individual therapy sessions, it is costly for practitioners (i.e., lost time and revenue). However, whereas individual therapy sessions can be rescheduled, if a client misses a group, that group will continue to meet, and there is no way to capture the essence of the group’s interactions in a makeup session. Thus, calling clients the day before group sessions can help reduce the number of missed group sessions, and it only takes a few minutes. With clients’ permission, a short message about the group can be left on an answering machine or a cell phone. In the GRIN study, the therapists called all group clients the day before their upcoming sessions. It would have required a separate study to evaluate a causal relationship between those calls and attendance, but it is striking that the group members in this study missed far fewer sessions ($n = 25$) than clients in the individual-treatment condition ($n = 210$; L. C. Sobell et al., 2009).

**Members Who Rabbit: Leave an Ongoing Group Session**

Although it is not common, eventually most group therapists will encounter a group member who walks out of group prematurely, either dramatically or quietly. Although leaving group early should have been discussed as part of the group rules (i.e., members do not leave before the end of the group unless it is an emergency), this will not prevent its occurrence. If a group member attempts to leave or walk out, one of the cotherapists should go after the person to find out why the person left. Group members can walk out for different reasons (e.g., to get attention; because they are angry about what occurred in group). For example, one group member who walked out in the middle of a group session told us that she left because the group discussion brought back vivid memories of an assault she had suffered years earlier. Whatever the reason, one of the cotherapists needs to also leave the group and find out the member’s reason for leaving, deal with the situation, and, if appropriate, get the individual to come back to the group. The therapist who remains in the group must trust that if the group member returns, the cotherapist will have the situation under control. The reason that the member chose to leave the group does not necessarily need to be discussed with the rest of the group when the person returns. In addition to not forcing uncomfortable self-disclosures, there is a need to maintain and respect the flow of what has been happening within the ongoing group. Therefore, what has
Managing Groups

occurred (i.e., the member’s leaving) should not be a topic of group discussion unless the leaders feel it is important for group cohesion.

SESSION STRUCTURE: LENGTH AND SIZE

Most outpatient groups meet weekly, and their length typically ranges from 90 to 120 minutes. Although there is no consensus on what constitutes an ideal group size, recommendations vary from 6 to 12 clients with two therapists. One issue for all groups is group size, which can vary from week to week, creating what has been characterized as feast or famine. If only a few clients (e.g., one to three) show up for group, our suggestion is to ask them if they want to hold the group. If it is decided that a meaningful group cannot be conducted, then at a minimum we recommend that the group leaders meet with those present for 15–20 minutes to allow them to share how their week went since the previous session and to address any outstanding concerns.

THE ROLE OF COTHERAPISTS/GROUP LEADERS

The consensus among group psychotherapy experts is that using two therapists, called cotherapists, facilitates the conduct of group therapy (Dies, 1994; Yalom & Leszcz, 2005). One therapist typically assumes the active role while the other attends to the nonverbal behaviors of the group members and manages the group activities. In addition, cotherapists can switch roles during the group. There are several advantages to using cotherapists: (1) it is easier to manage and address structured exercises; (2) tasks can be shared—one therapist can manage the clinical tasks (e.g., homework, forms) while the other manages time allotment so all session topics and exercises get discussed; and (3) if one therapist is stuck or uncertain how to proceed, his or her cotherapist can jump in to provide direction.

During all phases of the group, communication between cotherapists is critical (Bieling et al., 2006; Yalom & Leszcz, 2005). For example, during group round-robin discussions one of the cotherapists can monitor the time spent on a topic, while the other therapist is responsible for getting members to participate and share their experiences with each other (see Chapter 5 for specific examples).

Although it is rare for cotherapists to cross-talk or follow one another in a discussion, both need to be communicating, verbally and nonverbally, with each other during sessions (Bernard, 1994). If there is some confusion about what is happening in the group, it is important for cotherapists to check signals with each other. For example, one cotherapist can say to the other, “Doug, is it okay if we stay on the topic of how to handle relapses a bit longer?” or “Doug, help me out. I’m confused about where the group is going with the topic of grief.” Last, although therapists will have different styles and orientations, at times cotherapists may have different ideas about how to proceed. Although this is to be expected, open conflict between cotherapists should be avoided at all costs. If one therapist contradicts the other in front of group members, this can lead the members to question the value of the group and undermine group cohesiveness. The cotherapists can discuss these issues at the postgroup discussion, when group members are absent (reviewed in Morrison, 2001).
Changing Therapists in Open Groups

Because open groups have no start or stop dates, it is conceivable that a cotherapist might leave the group, particularly if one of the cotherapists is a trainee. In such cases, there is a need to be sensitive to the transitioning of both old and new therapists. An important reason for being sensitive to the changing of group therapists is that clients are sharing intimate information with the group, including the therapists. It has been our experience that abrupt changes in group leadership can be disconcerting to clients and should be avoided whenever possible. Ideally, the transition should be gradual, and group members should be informed in advance about when the change in cotherapists will occur. In the open groups that we currently run, we transition our doctoral students as cotherapists every 3 months. Group members are informed in advance about these changes and their rationale, and they also know that one of the two cotherapists will remain, and this provides some stability. In terms of the actual transition, we have found that it works well when we are able to overlap the new therapist with the old therapist for a few weeks. Last, during the transitioning of the old and new cotherapist, it is important to gently work the new cotherapist, especially a trainee, into the flow of the group by having him or her progressively contribute more each session.

SELECTING GROUP MEMBERS: COMPOSITION AND BALANCE

Yalom and Leszcz (2005) have asserted that the fate of a group is related to client selection. Choosing clients who fit common criteria (e.g., divorced clients, trauma victims, problem drinkers) provides a greater potential for bonding between members and for developing cohesion. Moreover, the degree of homogeneity among members is a criterion that has been found to be associated with good group functioning and positive outcomes. In practice, homogeneity allows the leaders to use inherent similarities among group members (e.g., PTSD, substance abuse, relationship issues) to build cohesion by asking them to discuss shared experiences. In seeking harmony in groups, Dies (R. R. Dies, personal communication, February 19, 1996) has suggested applying the principle of Noah’s Ark (trying to have at least two members who share a major characteristic). Having at least two members who share a major characteristic is particularly important in some instances (e.g., having more than one woman in a group of male substance abusers).

OTHER SIGNIFICANT GROUP ISSUES

Silence Is Golden

Some therapists, especially new group therapists, have difficulty with silence (Dies, 1994). In this regard, it is important to recognize that silence is a behavior. If no one is speaking for an extended time, something is happening, and the leader might say, “It’s very quiet in here. I’m wondering what is going on?”

Breaking Eye Contact with Clients

In group therapy, the goal is to have group members mainly talking to other group members and not to the group leaders. When members are new to a group, they often try to maintain eye
contact with one of the leaders when speaking. When this occurs, the leader needs to break eye contact with the client. Although this feels awkward and unnatural, our experience has been that when a group leader breaks eye contact, clients will look at another group member and eventually get accustomed to speaking to the entire group. Although breaking eye contact is difficult, it is helpful for building group cohesion.

**Clients Speak with Their Bodies**

People speak with their bodies, such as smiling, nodding, looking away, or crossing one's arms. Nonverbal cues are especially important in groups in which members may be reacting to interactions among members. Although most nonverbal cues relate to body language (e.g., shrugs, smiles, rolling of the eyes), sometimes they will be more obvious (e.g., group members moving their chairs out of the group circle). Group leaders need to be constantly vigilant and acknowledge any significant nonverbal behavior. The following are some examples of how the leaders can bring nonverbal behaviors to the group's attention.

**EXAMPLES OF ADDRESSING NONVERBAL RESPONSES**

- “When Mary just talked about her recent divorce, a few of you nodded.” [Note: Often when therapists leave their response at this, group members will respond. If there is prolonged silence, the group leader can follow up with, “What are the nods about?”]
- “Several people in the group are smiling. What do the smiles mean?”
- “Bill has been sharing some difficult feelings with us, and many of you are looking down. I’m wondering what’s happening.”

**Clients Who Do Not Complete Their Homework**

Another issue related to the group leaders' maintaining control of the group is communicating to members the importance of doing their homework and bringing it to each group session. As discussed in Chapter 3, we (L. C. Sobell et al., 2009) and others (Dies, 1994; Garland & Scott, 2002; Kazantzis et al., 2005) have found that clients will complete homework assignments if they understand their rationale and that the assignments relate to the problems for which they are seeking treatment. Clients can be reminded to bring their homework at the same time the therapist calls them about the group meeting. For clients who regularly fail to bring their homework to the group, therapists can turn the issue over to the group by saying, “Bill seems to be having trouble completing his homework assignments. What suggestions does the group have for him?”

**Transitioning to a New Topic**

As in individual therapy, there will be times when a discussion rambles, gets sidetracked, or continues too long, and this can interfere with addressing other matters. An easy way to address this is to say, “It sounds like the group has a lot to say on this topic. We have a few more things to cover this session, so let's switch gears and we can come back to this topic later.”
**Coming to Groups under the Influence of Substances**

Clients who come to groups under the influence of alcohol or illicit drugs not only challenge the group rules but also invite disruptions if they remain in the group. Clients who come to groups under the influence should be reminded that one of the group rules discussed previously was to not use alcohol or drugs on the day of groups. When a client is asked to leave, it is essential that therapists ensure that he or she does not drive home under the influence.

**TERMINATION OF GROUPS**

The issue of treatment termination is important whether it involves individual or group therapy. Termination involves two critical considerations: addressing unfinished business and helping members plan for what they are going to do after treatment (Dies, 1992). With time-limited groups, the topic of termination should be addressed early in treatment so clients are aware of when the group will end and can plan for what to do if they need additional treatment (Heimberg & Becker, 2002; Yalom & Leszcz, 2005). For many clients, a brief treatment will sufficiently address their needs and result in positive outcomes. For clients seeking additional services, the available alternatives can be discussed with them individually.

**Aftercare Calls**

As discussed in Chapter 4, part of the GSC treatment model includes having therapists make aftercare phone calls to clients 1 month after the last group or individual session. These calls are intended to be supportive of change while at the same time providing an opportunity for clients to talk about any difficulties they have experienced and to request additional treatment if necessary. In the GRIN study (L. C. Sobell et al., 2009), at the 1-year follow-up, 64% of the substance abusers interviewed said they felt that the aftercare calls were helpful, and 23% said they would have liked more calls.

**SUMMARY**

This chapter discussed several structural issues involved in the conduct of therapy groups. These issues ranged from differences between open and closed groups to group composition to how to handle members who miss groups, routinely come late, or leave during an ongoing session to breaking eye contact. The complementary roles of cotherapists were addressed. By working together, cotherapists can effectively manage a group while simultaneously observing important features of the developing group process (e.g., nonverbal behaviors). A host of other circumstances that can make conducting therapy groups difficult were discussed, including ways of dealing with those situations. Finally, the major advantages and disadvantages of conducting groups compared with individual therapy are listed in a tabular presentation.
Managing Difficult Clients in Groups

A questionnaire sent by the American Group Psychotherapy Association to practicing group therapists inquired about the critical issues necessary for group therapists to master. Over fifty percent responded, “Working with difficult clients.”

—Yalom and Leszcz (2005, p. 391)

Group clients bring the full range of their psychopathology to treatment; in addition, the interpersonal, subgroup and group-as-a-whole dynamics that are played out in the group treatment setting result in an enormous range of problematic situations over the course of time.

—Bernard (1994, p. 156)

Over the years, group therapy experts have commented that therapists can expect to encounter challenging clients and difficult situations when running groups (Bernard, 1994; Bieling et al., 2006; Yalom, 1985). In fact, in their book, Bieling and his colleagues (2006) stated that in their experience “each group a therapist conducts is likely to have at least one client that presents a challenge to group process, to other group members, and to group leaders” (p. 104). Our experience has been similar to that of Bieling and colleagues. It is not uncommon to encounter difficult and challenging clients in groups. Consequently, this chapter addresses ways to manage difficult clients in groups. To help readers picture and remember the clients and behaviors being addressed, we refer to difficult client types with the following shorthand labels: Silent Sam, Late Laura, Tommie Therapist, Chatty Cathy, Monopolizing Mike, Resistant Roberta, and Interrupting Ivan. Although a discussion of difficult clients is woven into this chapter, Table 8.1 contains specific sample dialogues to give readers a quick reference for ways to respond to such clients in groups.

THINK GROUP: INTERRUPTING CLIENTS FOR THE GREATER GOOD

Interruptions occur frequently in everyday conversations, and as might be expected, they occur during group therapy. However, interruptions during group therapy can interfere with the development of group cohesion. Although isolated interruptions will occur, when clients repeatedly disrupt the group, group leaders need to have the group address the disruptive behaviors, but in a constructive manner.

The following is an example of how group leaders can deal with Chatty Cathy or Monopolizing Mike clients who dominate the group discussion. In such cases, these clients are often
TABLE 8.1. Suggestions for Responding to Difficult Clients in Groups

Silent Sam
With such clients the goal is to find a way to get all members, especially those who are less verbal, to participate in all group sessions.

- “Mary, we haven’t heard from you tonight.”
- “Mary, I noticed that you haven’t said much tonight. How has your week gone?”
- “Bill has just shared his frustrations with the group. Mary, I know you’ve said you felt frustrated in similar situations. What advice can you give Bill?” [This example directly targets a silent client by asking him or her to offer advice or suggestions to another client.]

Late Laura
Although most clients who come late to groups are aware of their behavior, some fail to understand the effect their behavior has on the group. Having the group respond to such clients is more likely to result in changes (e.g., coming to subsequent groups on time) than is being told they are late by group leaders. The following responses would be used only with clients who are repeatedly late or who miss several group meetings.

- “This is the third time Mary has been late. What suggestions can the group provide to help her get here on time?”
- “I’m wondering how others feel about Mary being late for group several times.” [Although this response is more direct than the first example, open discussion of some issues can increase members’ sensitivity to their own behavior, as well as help them understand how their behavior affects the entire group.]

Tommie Therapist
Such clients may have been attending a group for several sessions, or they may have considerable prior therapy experience. At times, such clients’ interactions in groups will parallel those of a therapist. Although such advice can sometimes be helpful to group members, on other occasions the advice can be disruptive or too direct.

- “Bill, your comments have been helpful. Let’s see how others view Mary’s concerns.”
- “Bill, that is one way of looking at how Mary can handle the situation. What additional options can others offer Mary?”

Chatty Cathy and Monopolizing Mike
Such clients dominate group discussions. Group leaders need to find effective ways to interrupt such clients, as they are often unaware of the impact that their behavior has on the group. A strategy that group leaders can use when a Chatty Cathy client is talking is to direct questions to the group as a whole. For example:

- “Bill, it sounds like a lot has happened with you this week. I am wondering what has happened with other group members.” (The group leader then calls on another member.) “Mary, how did your week go?”
- “Mary, you seem to have had a lot going on this past week. Let’s take a look at what’s been happening with you for a few more minutes, and then let’s see how others have been doing this past week.”

Interrupting Ivan
The behavior of such clients in groups is disruptive, as they frequently interrupt ongoing group discussions.

- “We seem to be having an active discussion about [insert topic] today, but several members are talking at the same time. I’m wondering how this is affecting the group and what the group thinks we should do.”
- “I know we all have important things to say, but we need to respect each other and let others finish what they are saying before the next person speaks.”

Resistant Roberta
Clients who feel they are forced or coerced to attend groups (e.g., by a spouse, probation officer, employer) are often not happy and, consequently, participate minimally, if at all.

- “Bill, as with many people, it appears that you are upset about your probation officer telling you that you have to come to treatment. What suggestions does the group have for Bill?”
- “Mary, it sounds like you feel you had no choice in coming to group and you are angry. Who else with similar experiences can share with Mary how they’ve handled such situations?”
unaware of the impact their behavior has on the group, and thus group leaders need to find effective ways to interrupt them.

**TAKING CONTROL OF THE GROUP**

- "Mary, you seem to have had a lot going on this past week. Let’s keep looking at what you’re saying for a few more minutes, and then let’s see how others have been doing."

- After a few minutes, the group leader can pull other members in the discussion by saying, "Mary, clearly a lot has happened with you over the past week. Let’s find out how the week has gone for others." [Note: After this comment, the group leader can direct the group discussion by calling on another member.] "Bill, how did your week go?"

Over the years, we have found that group leaders may be hesitant to interrupt clients because they are worried about what the other group members will think. In most instances, group leaders need to trust their own feelings as a barometer of what is happening in the group. More often than not, if the group leaders are not comfortable with a member constantly interrupting or talking over other group members, the other members will feel similarly. Moreover, it is unlikely that this is a one-time occurrence (i.e., such clients have been engaging in similar behaviors for some time). With Interrupting Ivans, group leaders need to interrupt them, thank them for sharing their experience, and then pull other members into the discussion. One way to pull other members in when an Interrupting Ivan or a Chatty Cathy is talking is to direct a question to the group as a whole. At such times, it is important for the group leaders to remember to *Think Group*. If the group leaders let one group member go on and on, the rest of the orchestra cannot play well. However, group leaders also must remember to deal with disruptive clients in a way that does not create anger or conflict within the group.

At other times, a group discussion may result in several members speaking at once, and the resulting sound is not music to anyone’s ears. On such occasions, the group leaders may find it necessary to call a time-out. In this regard, the group leader acknowledges that there is some confusion and stops the group to figure out what is going on and regroup.

**THINK GROUP: BRINGING ORDER TO CHAOS**

- "We seem to be having an active discussion about [insert topic] today. There are a lot of folks talking at once. I’m wondering how the interruptions are affecting the group, and what the group thinks we should do?"

- If several members are talking at once, the leader could say, “I know we all have important things to say, but we need to respect each other and let others finish before the next person speaks.”

**BALANCING VOICES IN THE GROUP**

A major goal for group leaders when conducting groups is having all clients participate regularly. With Silent Sam clients it is important for group leaders to make active and continuous
efforts to get them involved in the group. Such efforts are important for developing group cohe-
sion. To do this, the group leaders must orchestrate opportunities to prompt reluctant or shy
group members to participate. For example, the group leader could say, “Mary, we haven’t
heard from you tonight” or “Mary, you have been quiet tonight. How did your week go?” A good
way of getting silent clients to participate is for the group leaders to recognize commonalities
and steer the discussion in that direction: “Bill has just shared his frustrations with the group.
Mary, I know you’ve told us you have felt frustrated in similar situations. What advice can you
give Bill?” Not all group members have to speak at length on every topic, but it is desirable to
have a balance of voices in the group.

Time management is an issue that makes balancing voices very important, particularly for
time-limited groups (Heimberg & Becker, 2002; MacKenzie, 1996). A good example is handling
clients known as storytellers. Such members, if left unmanaged, can derail a group with long,
rambling stories. In time-limited groups, group leaders need to be vigilant in attending to group
processes, and when the group gets sidetracked, one of the group leaders needs to bring the
group back on topic.

Sometimes the issue of balancing voices involves the roles clients take on rather than the
amount of time that they speak, such as with a Tommie Therapist client. Such clients may have
been attending a group for several sessions, or they may have considerable prior therapy experi-
ence. Whatever the reason, at times they attempt to take on the role of therapist. On occasion,
this can be very helpful. For example, in an open group, a senior group member can explain
group rules to new members and help ease their transition into the group. Such clients, how-
ever, can also be disruptive if they start to give advice freely or provide their opinions as if they
were trained therapists. In such cases, a group leader could say, “Bill, that is one way of looking
at how Mary can handle the situation. What additional options can others think of for Mary?”

Another issue relates to group members who feel they are forced or coerced to attend
groups (e.g., by a spouse, probation officer, employer). Resistant Roberta clients are often not
happy, and consequently they participate minimally, if at all, in groups. Like clients who are
late, clients who are forced to come to group are best managed by the leaders using the group
as the agent of change. With such clients, the group leader can ask the group to comment about
a member’s behavior. For example, the group leader could say, “Bill, as with many people, it
appears that you are upset about your probation officer telling you that you have to come to
treatment. What suggestions does the group have for Bill?” In such situations, other group
members are likely to share how they have coped with circumstances in which they have had
little choice. Such responses can also be directly encouraged by the leader saying, “Mary, it
sounds like you feel you had no choice in coming to group, and you are angry. Who else with
similar experiences can share with Mary how they’ve handled such situations?” As discussed in
Chapter 6, having the “Music Come from the Group” typically will be more effective than hav-
ing the group leaders isolate or lecture a group member.

MANAGING CONFLICT AND CALLING TIME-OUTS

Yalom and Leszcz (2005) state that, “To some degree, certain tensions are always present in every
therapy group” (p. 169). In fact, most group psychotherapy experts acknowledge that some degree
of conflict in groups is normal and unavoidable. Such is not at all surprising when we remember
that groups consist of multiple clients with different personalities. When conflicts do arise, how-
ever, cotherapists must recognize them and manage them to a successful resolution. Many clients, particularly in a group setting, will feel uncomfortable with conflict or anger expressed in a group. At such times, one of the group leaders needs to address the discomfort with the group as a whole. For example, the group leader might say, “There is a lot going on right now, some of which feels a bit uncomfortable. Let’s talk some about what we think this is about.” Alternately, the group leaders can ask specific clients to comment: “Bill and Mary, a lot has been happening in group tonight, and you both look a bit uncomfortable. What do you think is going on?” Sometimes when a group leader interrupts the group’s discussion to reflect back what is happening, it can have a secondary gain by allowing group members who are upset to calm down.

**Therapists Should Use Their Feelings as a Barometer**

Group leaders need to use their own feelings as a barometer of what is happening affectively in the group (Dies, 1994). For example, if the group leaders are reacting to the member-to-member interactions, then it is likely that other members are having similar feelings. Although some conflict in groups is to be expected, the best way to manage group conflict is for the group leaders to throw it back to the group. There are times, however, when dealing with the conflict might not be immediately productive, and on these occasions, time-outs can be helpful.

Time-outs are typically called in relation to very strong emotional reactions the group has had to what a member has said. In such cases, the group leader calls a time-out by saying, “Okay, let’s take a time-out. It seems like a lot is going on in group right now. Let’s all step back a minute and process what just happened.” On rare occasions, leaders may have to get the group’s attention by calling a time-out similar to that of a basketball coach by forming their hands into a “T.” During the time-out the group leaders need to focus the discussion on the group’s affective response to the situation, rather than the topic being discussed. For example, suppose the topic was domestic violence, and one member asserted that his partner deserved to be hit. This could easily escalate as other members react strongly and negatively to what the one member said. Likewise, there may be times when members are so upset that the most prudent thing to do is to let them calm down. Here a group leader might say, “Right now things seem very emotional. I think it might be best for us to come back and revisit this topic next week when we’ve all had some time to reflect on what happened in group today.”

In summary, when calling a time-out or when responding to an interruption, it is important to focus on the affect that members are experiencing rather than the issue at hand. In the end, the group leaders need to remember to be supportive of all group members for their contribution to the group. In this regard, the group leader could say, “Sometimes difficult issues get raised in groups. However, we can learn from different perspectives and by addressing difficult issues in a reasoned, calm manner as we have done here.” Such an approach also allows the disruptive member or members to observe appropriate ways to discuss sensitive topics.

**SELF-DISCLOSURE**

**Self-Disclosure by Clients**

Although there may be disagreement about what to disclose, experts in group psychotherapy such as Yalom and Leszcz (2005) and Dies (1992) agree that "self-disclosure is absolutely essential in the group therapeutic process" (Yalom & Leszcz, 2005, p. 130, original emphasis). How-
ever, if a client discloses embarrassing or sensitive information and the group is not supportive or no one responds, this can affect whether members self-disclose in the future or even return to the next group session. Members may not respond because they do not know what to say or because they feel very uncomfortable about what was disclosed. In either case, the group leaders need to reflect what happened and reinforce self-disclosure. For example, “Mary just told us about a very personal situation in her life, and no one said anything.” When group leaders say something along these lines, it gives those in the group permission to comment. Another way group leaders can attempt to get members responding if one member self-discloses and no one responds is to say, “I am wondering how we can offer Mary support with respect to what she has told us?” In terms of reinforcing a client’s self-disclosure in group, one of the group leaders might say, “I notice that Mary has taken a big step by revealing some very personal things about herself. This must have been difficult. How do others in group feel about what Mary just said?” Finally, the group can also be prompted to use self-disclosure as a starting point for sharing: “Bill took a big risk in sharing what happened to him over the past week. Who else can relate to what happened to Bill?”

**Inappropriate Client Self-Disclosure**

Another issue for consideration relates to members bringing up topics (e.g., abuse) that are not deemed appropriate for the group discussion. Frequently, such issues relate to only one client and are not appropriate for the group unless the entire group is dealing with similar issues (e.g., a PTSD group). In addition, when inappropriate topics are disclosed in group, they can negatively affect group cohesion. For example, when trauma survivors disclose details of their traumatic incident, it can lead to concern about how the other group members perceive them and to their decompensating. In addition, if the group members respond with little or no empathy or if they sound judgmental, it can add to the blame or guilt that these clients (i.e., trauma survivors) might be experiencing.

The introduction of inappropriate topics is usually easy to recognize (e.g., other members will look down and/or there is total silence). When group leaders recognize that a topic is not appropriate for the rest of the group, they can say, “Mary, although it sounds like that is an important issue for you, often such concerns are better handled in individual therapy. Let me follow up with you after the group.” There are, of course, several kinds of issues that might be inappropriate for groups. More often than not, such issues do not relate to what brought the group members into treatment (e.g., upcoming political elections; political views; discussing how one feels about gays and lesbians in a smoking cessation group). In the end, decisions about the appropriateness of topics rest with the judgment of the group leaders.

**Self-Disclosure by Therapists**

In group therapy, the phrase *self-disclosure by therapists* has a different meaning from the way that phrase would be used in individual therapy (Dies, 1994). In individual therapy, self-disclosure usually refers to therapists’ revealing information about themselves (e.g., “I’ve been divorced twice” or “I’ve smoked marijuana once, too”). In contrast, self-disclosures by cotherapists in a group typically are expressions of here-and-now feelings about what is happening in the group. For example, a group leader might say, “I’m feeling uncomfortable with what has just happened. Who else is feeling that way?” Of course, self-disclosures by group leaders
could involve revealing personal information to the group. However, in such cases the disclosure should have a specific intent or therapeutic rationale, as would be the case in individual therapy.

Therapist self-disclosure of feelings about the group can provide a good way of dealing with dilemmas around difficult topics and issues, especially when the leaders are having trouble gauging the group's reaction. Following are some examples of how this can be accomplished.

**EXAMPLES OF THERAPIST SELF-DISCLOSURES RELATED TO FEELINGS ABOUT THE GROUP**

- "It feels like there is some tension in the room after what just happened. I wonder how others are feeling?"
- "I get the feeling that everyone would like to say more about the situation, but many of you seem to be a bit anxious talking about [insert sensitive topic]."
- "What does the group think is happening?"
- "Mary, we can't imagine what that must have been like for you. Can you share how you are feeling right now with the group?"
- "It sounds as if everyone is feeling a bit anxious."

**PERSONALIZING PROBLEMS USING AFFECT**

Another key way of encouraging members to become more involved in the group is to personalize problems and get members to discuss their feelings (Dies, 1994). Following are a few examples of how therapists can encourage such discussion while centering on affect.

**EXAMPLES OF GETTING MEMBERS TO PERSONALIZE PROBLEMS USING AFFECT**

- "Mary, how would it feel to be in that situation?"
- "Bill, that sounds like it has been difficult for you. Who else has had similar experiences?"
- "How have others felt when similar things have happened to them?"
- "How would you feel if that were to happen to you?"
- "How does that relate to why you are here?"

**SUMMARY**

In several chapters throughout this book, including the present one, we have discussed skills therapists need to effectively conduct and manage groups. These skills include (1) building cohesion by looking for commonalities among members; (2) using reflective listening; (3) ensuring that all group members participate regularly; (4) managing multiple clients at one time; (5) managing resistance and dealing with conflict; (6) turning difficult situations into learning opportunities for group members; and (7) most important, letting the “music come from the group.”
The Way Ahead

Savings from transitioning to the most cost-effective treatment modality may free resources that could be reinvested to improve access to substance abuse treatment for a larger number of individuals in need of such treatment.

—MOJTABAI AND ZIVIN (2003, p. 233)

Knowledge of individual psychopathology and clinical interventions is necessary but not sufficient to become a skilled group therapist.

—MARKUS AND KING (2003, p. 203)

Health and mental health care costs have risen steadily over the past decade (Cummings, O’Donohue, & Ferguson, 2002; Orszag, 2008). Rising costs put increased pressure on health and mental health providers, insurance companies, policy makers, and politicians to monitor and provide information about the efficacy and efficiency of services provided. Part and parcel of such scrutiny is an increased concern for accountability.

For all areas of health and mental health, central planning issues concern cost containment and how to allocate limited resources. Cost-effectiveness is the intersection of efficacy and efficiency. From this perspective, evidence-based treatments are the starting but not the end point of cost containment considerations. For example, cost-effectiveness can be expected to play a major role in funding decisions when comparing two or more equally effective treatments. In practice, this means that for more expensive or resource-intensive treatments to be selected, they must produce outcomes much better than less costly treatments in order to justify the additional costs. This suggests that group therapy will increasingly be the treatment of choice except when there is evidence of superior outcomes with individual treatment. Presently, demonstrations of such superiority are lacking.

PUTTING COST-EFFECTIVE TREATMENTS INTO PRACTICE

There is considerable evidence that brief treatments should, in most cases, be the first treatment of choice for those with SUDs. Studies evaluating different treatment formats and lengths have favored briefer, less resource-intensive treatments and services, whether they have compared outpatient with inpatient treatment, outpatient detoxification with inpatient detoxification, or
brief treatments with a few minutes of physician advice (Feldman, Pattison, Sobell, Graham, & Sobell, 1975; Fleming et al., 1997; French, 2000; Heather, 1989; Holder, Longabaugh, Miller, & Rubonis, 1991; Longabaugh et al., 1983). In addition, although intensive treatments for SUDS have not been shown to be any more effective than less intensive treatments, they are more costly (Mojtabai & Zivin, 2003). In this regard, although some individuals in brief treatments will not improve and will need additional services, such concerns can be addressed using a stepped-care model of treatment similar to that used in the medical field (Davison, 2000; M. B. Sobell & Sobell, 2000).

**Stepped-Care Treatment Model**

As shown in Figure 9.1, when using a stepped-care model the first intervention is evidence-based, usually the least intensive and intrusive, and has consumer appeal and a reasonable chance of success. If the first treatment produces satisfactory results, monitoring and follow-up visits may be all that are necessary. If the intervention does not produce positive results, treatment can be “stepped up” by extending the same treatment (i.e., more sessions) or implementing a different and perhaps more intensive intervention (e.g., pharmacotherapy for smokers in behavioral treatment that is not currently effective). Using a stepped-care model, decisions about further treatment are based on a person’s response to previous treatments. In this way, only those needing services that are more intensive receive the more costly treatments.

The substance abuse field, albeit slowly, has been moving in the direction of less intensive treatments. For example, in the early 1980s the vast majority of alcohol and drug treatment programs were inpatient or residential, but today such treatment programs are in the minority (Substance Abuse and Mental Health Administration, 2003; Swift & Miller, 1997). As cost containment continues, it can be expected that services will be evidence-based and cost-effective. In this regard, the time-limited group treatment described in this book is evidence-based, consistent with a stepped-care model of service delivery, and would be a good first treatment of choice for many individuals with SUDs.

ARE GROUPS COST-EFFECTIVE?

As discussed in Chapter 1, the number of studies that have evaluated the cost-effectiveness (i.e., presented cost and time figures) of group therapy is limited. However, as seen in the following example, it is easy to make a prima facie case that groups have a cost-effectiveness edge over individual therapy.

**COST EFFECTIVENESS OF GROUP VERSUS INDIVIDUAL THERAPY**

**Example:** Eight clients seen for six weekly sessions

- **Individual therapy:** 1-hour session conducted by 1 therapist
- **Group therapy:** 2-hour sessions conducted by 2 therapists
- **Therapist time for individual sessions:** 48 hours [8 different clients x 6 sessions each (1 hour per week) x 1 therapist]
- **Therapist time for group sessions:** 24 hours [6 group sessions (with 8 clients per group) x 2 hours per group session x 2 therapists]

The preceding example results in a 50% savings of therapist time for group therapy versus individual therapy. Moreover, the efficiency advantage for all groups is greater with more clients per group. Consider the preceding example with 10 rather than 8 clients. The individual therapist time would be 60 hours, whereas the group therapist time for 10 clients (i.e., 6 sessions x 2 hours per group session x 2 therapists) would still be 24 hours, which is a 60% savings in therapist time. In fact, in the randomized controlled trial of group versus individual GSC treatment described earlier in this book, a similar analysis found that group therapy produced a savings of 41.4% in the therapist’s time (L. C. Sobell et al., 2009). In addition, if a member misses a group, the group session still takes place. However, when clients fail to attend individual sessions, therapists cannot use this time to see other clients. Thus, even in the absence of studies of cost-effectiveness, there is a significant advantage to group therapy. As cost containment continues to be a priority in the provision of health services, it is likely that groups will be favored over individual therapy unless there is a specific justification for individual therapy.

WHERE IS THE TRAINING?

Over the years, as experts in the field of group therapy have commented on the challenges and complexities of conducting groups (Dies, 1980; Fuhriman & Burlingame, 2001; Markus & King, 2003; Piper & Joyce, 1996; Scheidlinger, 1994), they have also acknowledged the need for adequate training (Fuhriman & Burlingame, 2001; Markus & King, 2003; Thorn, 2004). In a survey of training in group therapy provided by accredited programs in psychiatry, psychology, and social work, several notable shortcomings were identified (Fuhriman & Burlingame, 2001). For all three disciplines, there was a significant gap between trends occurring in the field of group therapy and what was taught in their graduate programs. For example, although 83% of psychologists surveyed conduct group psychotherapy, only 21% had been required to take a group therapy course or practicum as part of their training.
If, as predicted, the prevalence of group therapy continues to increase over the next several years, a serious priority will be to ensure that there are competently trained therapists to conduct groups. Because of the challenges and complexities of conducting group therapy, training needs to include more than didactic seminars (Markus & King, 2003). Rather, there should be a major focus on group therapy as a part of professional training, analogous to how training is provided for individual therapy.

GROUP THERAPY: THE WAVE OF THE FUTURE

For 20 years, Norcross and colleagues have been conducting Delphi polls using a panel of experts to predict trends in psychotherapy. In the most recent survey (Norcross, Hedges, & Prochaska, 2002), experts predicted that four therapy formats would increase, two of which are group and short-term therapy. If one were to speculate as to why these two formats were included, it would likely relate to their economic advantage over long-term therapy formats that were judged to be on the decline. It also might reflect an increasing recognition that change often occurs early in treatment.

Group Therapy in the Health Care System of the Future

As discussed in Chapter 1, the literature provides evidence of equal effectiveness and lower costs for groups compared with individual therapy. This is consistent with the outcome of the GRIN study. The similar outcomes for group and individual therapy will make it difficult for practitioners to ignore groups as an effective and cost-efficient treatment modality in the future.

Based on what we have presented in this book, the following comments are offered with respect to group therapy and its place in our future health care system.

- Pressures to contain rising health care costs will continue to increase, with an emphasis on providing less costly, evidence-based services, including group therapy.
- Although health care cost containment is necessary, it must not jeopardize quality of care.
- Group therapy is complex and challenging, and group therapists need to be adequately trained.
- Most graduate training programs need to change their curricula to ensure that practitioners are competently trained to provide group therapy.
- More research is needed on how to make groups more acceptable to clients.
- Treatment services should be provided consistent with a stepped-care treatment model in order to maximize efficiency without sacrificing individualized care.

SUMMARY

In this final chapter, we suggested that time-limited group therapy is a cost-effective intervention in a stepped-care model of treatment. Throughout this book we have made the case, as have other group therapy experts, that conducting group therapy is complex and challenging.
To this end, however, adequate training in how to effectively conduct and manage the dynamics of interpersonal interactions in groups is lacking at many levels. Nevertheless, as pressure for health care cost containment continues to mount, time-limited group therapy will be viewed as cost-effective in general and an approach particularly well suited for helping individuals whose health and mental health problems are not severe. In summary, as the popularity of group therapy has grown over the past decade, a major challenge will be to ensure that there are competently trained practitioners to conduct such groups.
APPENDICES
APPENDIX A

AUDIT Questionnaire

These questions refer to your use of alcohol. Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?
   0 never 1 monthly or less 2 to 4 times/month 2 to 3 times/week 4 or more times/week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   0 none 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

3. How often do you have six or more drinks on one occasion?
   0 never 1 less than monthly 2 monthly 3 weekly 4 daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   0 never 1 less than monthly 2 monthly 3 weekly 4 daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   0 never 1 less than monthly 2 monthly 3 weekly 4 daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   0 never 1 less than monthly 2 monthly 3 weekly 4 daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   0 never 1 less than monthly 2 monthly 3 weekly 4 daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   0 never 1 less than monthly 2 monthly 3 weekly 4 daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   0 no 1 yes, but not in the last year 2 yes, during the last year

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?
    0 no 1 yes, but not in the last year 2 yes, during the last year

AUDIT Score: ____________________________

The Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organization to evaluate a person's use of alcohol and the extent to which drinking is a problem. The AUDIT contains 10 questions. Most questions relate to the past year while a few ask about lifetime use. Questions are scored from 0 to 4. Scores can range from 0 to 40. Higher scores typically reflect problems that are more serious. If a person's score is 8 or greater, it is suggestive of an alcohol problem. The AUDIT is available in several languages and can be freely used as it is in the public domain.

**SCORES RELATED TO SEVERITY OF ALCOHOL USE**

<table>
<thead>
<tr>
<th>Score</th>
<th>Degree of Alcohol Problem Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1–7</td>
<td>Low</td>
</tr>
<tr>
<td>8–16</td>
<td>Moderate</td>
</tr>
<tr>
<td>17–25</td>
<td>High</td>
</tr>
<tr>
<td>26–40</td>
<td>Very High</td>
</tr>
</tbody>
</table>
APPENDIX B

Drug Use Questionnaire (DAST-10)

The following questions concern information about your potential involvement with drugs excluding alcohol and tobacco during the past 12 months. Carefully read each statement and decide if your answer is “No” or “Yes.” Then fill in the appropriate box beside the question.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter drugs in excess of the directions and any nonmedical use of drugs. The various classes of drugs may include cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months:

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you used drugs other than those required for medical reasons?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you abuse more than one drug at a time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are you always able to stop using drugs when you want to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you had “blackouts” or “flashbacks” as a result of drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you ever feel bad or guilty about your drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Does your spouse (or parents) ever complain about your involvement with drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Have you neglected your family because of your use of drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have you engaged in illegal activities in order to obtain drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(cont.)

**DAST-10 SCORING KEY**

**SCORING:** For every “Yes” answer to Questions 1–2 and 4–10 score 1 point, and for Question 3 score 1 point for a “No” answer.

<table>
<thead>
<tr>
<th>SCORE</th>
<th>DEGREE OF PROBLEM RELATED TO DRUG ABUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Problem Reported</td>
</tr>
<tr>
<td>1–2</td>
<td>Low Problem Level</td>
</tr>
<tr>
<td>3–5</td>
<td>Moderate Problem Level</td>
</tr>
<tr>
<td>6–8</td>
<td>Substantial Problem Level</td>
</tr>
<tr>
<td>9–10</td>
<td>Severe Problem Level</td>
</tr>
</tbody>
</table>
**APPENDIX C**

**Drug Use History Questionnaire**

<table>
<thead>
<tr>
<th>DRUG CATEGORY</th>
<th>Ever Used</th>
<th>Total Years Used</th>
<th>Year Last Used (e.g., 1998)</th>
<th>Frequency of Use Past 6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALCOHOL</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>CANNABIS: Marijuana, hashish, hash oil</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>STIMULANTS: Cocaine, crack</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>STIMULANTS: Methamphetamine—speed, ice, crank</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dextedrine</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Xanam, Diazepam, Roofies</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>HEROIN</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>STREET OR ILLICIT METHADONE</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>OTHER OPIOIDS: Tylenol #2 &amp; #3, 282’s, 292’s, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*If EVER USED is NO for any given line, the remainder of the line should be left blank.*

*Infrequent Use (= 2 x/year) or Brief Experimental Use (< 3 months lifetime use) = write 87*

*Frequency Codes:
- 0 = no use
- 1 = < 1x/month
- 2 = 1x/month
- 3 = 2 to 3x/month
- 4 = 1x/week
- 5 = 2 to 3x/week
- 6 = 4 to 6x/week
- 7 = daily

APPENDIX D

Brief Situational Confidence Questionnaire (BSCQ)

Listed below are eight types of situations in which some people experience an alcohol or drug problem. The questions are to be answered in relation to your alcohol or primary drug problem.

Imagine yourself as you are right now in each of the following types of situations. Indicate on the scale provided how confident you are right now that you would be able to resist drinking heavily or resist the urge to use your primary drug in each situation by placing an “X” along the line, from 0% “Not At All Confident” to 100% “Totally Confident,” as in the example below.

Right now I would be able to resist the urge to drink heavily or resist the urge to use my primary drug in situations involving …

1. UNPLEASANT EMOTIONS (e.g., If I were depressed about things in general; If everything was going badly for me).

2. PHYSICAL DISCOMFORT (e.g., If I would have trouble sleeping; If I felt jumpy and physically tense).

3. PLEASANT EMOTIONS (e.g., If something good would happen and I would feel like celebrating; if everything was going well).

Right now I would be able to resist the urge to drink heavily or resist the urge to use my primary drug in situations involving . . .

4. TESTING CONTROL OVER MY USE OF ALCOHOL or DRUGS (e.g., If I would start to believe that alcohol or drugs were no longer a problem for me; If I would feel confident that I could handle drugs or several drinks).

I feel . . .

Not At All Confident

Totally Confident

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

5. URGES AND TEMPTATIONS (e.g., If I suddenly had an urge to drink or use drugs; If I were in a situation where I had often used drugs or drank heavily; If I began to think of how good a rush or high had felt).

I feel . . .

Not At All Confident

Totally Confident

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6. CONFLICT WITH OTHERS (e.g., If I had an argument with a friend; If I were not getting along well with others at work).

I feel . . .

Not At All Confident

Totally Confident

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

7. SOCIAL PRESSURE TO USE (e.g., If someone would pressure me to “be a good sport” and drink or use drugs with them; If I would be invited to someone’s home and they would offer me a drink or drugs).

I feel . . .

Not At All Confident

Totally Confident

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

8. PLEASANT TIMES WITH OTHERS (e.g., If I wanted to celebrate with a friend; If I would be enjoying myself at a party and wanted to feel even better).

I feel . . .

Not At All Confident

Totally Confident

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
References


References


