Group Psychotherapy as Evidence-Based Practice: *Blending Process Group Therapy, Stages of Change, and Psychoeducation*

or

“Group Therapy for Substance Use Disorders: Dead or Alive?”

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A STORY FROM PLUTARCH

Mark Antony and Cleopatra on a fishing trip
Questions

• What is Group Therapy?
• How is group different from a class?
• Parable of the Spoons (Yalom)
A Group versus a Class

• “ideal modality...the leader acts as a facilitator of interpersonal process”

• Why? “In these types of open, more democratic and cohesive groups, members are more likely to discuss, explore, and begin to discuss their substance use problems”

• “maximum benefit ...derived from active participation and interaction with other members rather than being passive recipients of a leader’s domineering and controlling efforts”

• Predictor of positive outcome: client does most of the talking

• Predictor of negative outcome: therapist does most of talking

• Connors, Diclemente, Velasquez, & Donovan. (2013) Substance Abuse Treatment and the Stages of Change, Guilford Press, pp. 156, 157
What Group Therapy is NOT

• “group therapy is *not individual therapy done in a group*, nor is it equivalent to *12 Step program practices.* “

• “Group therapy requires that individuals understand and *explore* the emotional and interpersonal conflicts that can contribute to substance abuse.’

• “The group leader requires specialized knowledge and skill, including *a clear understanding of group processes* and the *stages of development of group dynamics*”

• Substance Abuse Treatment: Group Therapy Inservice Training -Based on Treatment Improvement Protocol TIP 41, U.S. Department of Health and Human Services, p. 1-5
TIP 41 Model

• “Emphasis is placed on interpersonal process groups, which help clients resolve problems in relating to other people, problems from which they have attempted to flee [experiential avoidance, escape behavior] by means of addictive substances” p.1-3
Tip 41: 5 group therapy models

1. Psychoeducational groups
2. Skills development groups
3. Cognitive Behavioral groups
4. Support groups
5. Interpersonal Process groups

“the interpersonal process group model is not widely used in substance abuse treatment because of the extensive training required to lead such groups” p. 1-4
Points from TIP 41 on Interpersonal Process group therapy for Substance Use disorders

1. Changes **intrapsychic** (within a person) and **interpersonal** (between people) dynamics

2. “the group becomes a **microcosm** of the way group members relate to other people in their lives”

3. “Rely on **here-and-now** interactions of members. Of less importance is what happens outside the group or what happened in the past”

4. “Leaders must be trained in psychotherapy”  p.2-4
What the Sobels say about Group Therapy for Substance Use Disorders

Pointers from the Sobels

1. “two major problems have plagued cognitive-behavioral group treatments are (1) their **failure to systematically use group processes** which...dilutes their power...(2) failure to integrate cognitive-behavioral techniques with group processes” “**interventions usually focus on treating the individual in the group rather than the group...they ignore the power of the group**” pp.149-150

2. “use 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” p. 151

3. The group itself becomes the therapist, not the professional: “this discussion format is designed to get support, feedback, and advice ...primarily from group members rather than group leaders” p. 151
4) Group leaders build the culture of the group: “the goal for the first session is to develop a safe climate for sharing and self disclosure” p. 156 [think of training the group as a whole to adopt the philosophy of Motivational Interviewing]

“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” p. 150

“Major goal ...is to have group members, rather than leaders, be the main source of reinforcement and support for other members”
Pointers from the Sobels- continued

6) Need for training in Group Therapy, Group processes

“many group therapists have had little to no formal group training”

“experts in the field of group therapy feel that specialized training is essential”

“skills needed to conduct individual therapy do not generalize to group therapy”

“The 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)”  p. 152
Pointers from the Sobles- continued

7) “Group members should be doing most of the talking” “the music comes from the group...the group leaders orchestrate the discussion and bring members into the conversations” p. 156

8) All group members should participate, balanced participation should be part of the group’s culture. (not just your favorites or the “star”)

9) “Most group therapy experts recommend having two group leaders, or co-therapists” p. 192
What Marsha says... Marsha Linehan, (2015) 

• “Group treatment has much to offer, over and above what any individual therapy can offer. First, therapists have an opportunity to observe and work with interpersonal behaviors that show up in peer relationships but may have only rarely occur in individual therapy sessions.
“...second, clients have an opportunity to interact with other people like themselves, and the resulting validation and development of a support group can be very therapeutic. DBT encourages outside-the-session relationships about skills group clients, as long as those relationships---including any conflicts---can be discussed inside the sessions.
3. clients have an opportunity to learn from one another, thus increasing avenues of therapeutic input.

4. ...the transference is diluted

5. If a norm of practicing skills between sessions can be established, such a norm can increase skills practice.

6. Skills groups offer a relatively nonthreatening opportunity for individual clients to learn how to be in a group.
“over the years, many DBT teams have tried to convince me that one skills leader is all that is needed for most groups. I remain unconvinced.” p. 35

“it is surprising how helpful a coleader can be in attending to the process issues that arise."
Aren’t DBT groups highly scripted?

• “It was clear from the beginning that treatment had to be flexible and based on principles, rather than tightly scripted with one protocol to fit all clients”. Linehan, 2015, p. 13
Learning Objectives:

• Review the Advantages of Group Therapy
• Understand the therapeutic factors in Group Therapy
• Identify the group leader’s role in creating the necessary conditions for a therapeutic group experience
• Examine 3 stages of group development/process
• Recognize behaviors that undermine the group
ADVANTAGES OF GROUP THERAPY

• Natural context for observation of patient’s interactive style with a cross section of other people

• Socially acceptable/politically correct persona versus “Real Self”

• Opportunity to practice new behaviors before generalizing to the bigger world (better for social learning)

• Sample of the bigger, more diverse world—allow the conflicts to happen, then explore them (CPE role play, reverse genders at a cocktail party)
ADVANTAGES OF GROUP THERAPY-CONTINUED

Homogeneous groups-Sexual abuse survivors, recovering substance abusers, college students, grief groups, etc.

• Yalom & Leszcz, p. 19, “a pervasive body of outcome research has demonstrated that group therapy is a highly effective form of therapy...at least equal to individual therapy in its power to provide meaningful benefit”.

• Cost effective, resource effective
THERAPEUTIC FACTORS IN GROUP THERAPY

1. “Remoralization” recovery of hope, universality, acceptance
2. Corrective Emotional Experience of one’s Family of Origen
3. Interpersonal Learning and Self Understanding (how others perceive me, how my behavior effects others)
4. Catharsis (a necessary but not sufficient factor; an emotional experience with out the ‘corrective’; catharsis alone is associated with a negative outcome).
5. Modeling (how we learn most of what we know) Movie Clip, Down and Out in Beverly Hills
“One achieves mental health to the extent that one becomes aware of one’s interpersonal relationships.”

Sullivan, 1940
3 Stages of Group Development

The Theory and Practice of Group Psychotherapy

Irvin D. Yalom with Molyn Leszsz
Group leader’s task of creating the necessary conditions for a therapeutic Group experience

• Pre-screening members
• Assure emotional safety
• Set the group rules
• Educate what the purpose of the group will be
Stage One: Pre-group-Formation of the group

• Decide who your target audience is
• Promote the group to potential clients
• Screening and selecting group members: *not everyone is right for every group* are the potential member’s needs and goals compatible with group leader’s objectives?
• Exclusion Criteria
• Prepare Physical Environment
Possible Exclusion Criteria:

- Psychosis
- Mania
- Intoxicated at the time of intake for the group
- Organic Brain Disorder
- Sociopathy
- Paranoid Personality Disorder
- Extreme suicidality (exception: DBT Skills training group)
Virtually no exclusion criteria

- Mania, paranoid, hostile: **ALL are Welcome**

- **3 Group rules:**
  1) Confidentiality
  2) No interrupting  
     (“because everyone in here is important, and it is important that we hear from everyone 
  3) “3 Redirects and you are out” 
     this is not a punishment, it is just that you are too hyper to be in the group process, and we ask that you come back next week and try it again”
Be careful not to Exclude “spicy” patients

- Often persons with issues with authority, mood deregulation, personality disorders, etc. provide much energy for the group
- Opposite of “a class” where you want to exclude disruptive persons
- **Group Psychotherapy** is a place where you explore the person’s interpersonal process, especially dysfunction: what some may consider exclusion criteria is in reality inclusion criteria
“Spicy” Patients, continued

- Be ready to highlight the process
- Ask group members what they think about the “spicy” patient’s behavior
- “Roll with Resistance” (Motivational Interviewing)
- Model tolerance for dissenting opinions
- Exclude the group member only after attempts to use the group process fails and he/she is disruptive to the progress and cohesion of the group
What Yalom says about *spicy* Group members

- “Many clients have problems with rage or are arrogant or condenscending or insensitive or just plain cantankerous. The therapy group can not offer help without such traits emerging during the member interactions. In fact their emergence is to be welcomed as a *therapeutic opportunity*. ...it is essential for the work of therapy.” p. 138
- “At the same time, too much conflict early in the group can cripple it’s development”
- First: Culture of safety and support must be established
PREPARE THE PHYSICAL ENVIRONMENT

1. No Tables
2. Cross-cultural Universality of “the circle”
Stage 2: Creating the Group Culture

- In **individual therapy**: Agent of Change = relationship between the therapist and the patient

- **Group Therapy**: Agent of Change = relationship between the patient and the Group (not therapist!!!!)
Culture of Effective Group

- Group radically departs from regular social etiquette
- Members must readily comment on immediate feelings they experience vis-à-vis other group members
- Non-judgmental acceptance of others
- Extensive self-disclosure
- Desire for self-understanding
- Eagerness to experiment with new ways of doing things
Group Leader - *Shaping Norms of the Group*

Group leader needs to be the Cultural engineer of the group
Group Leader

- Shaping norms
- CAN the Group Leader shape the norms of the group?
- Should the Group Leader shape the norms of the group?
- HOW does the Group Leader shape the norms of the group?
Shaping Norms of the Group

Operant Conditioning
- Reward with Praise desired behaviors when they spontaneously occur
- Behaviors to Reinforce:
  - Self-disclosure
  - Open expression of emotions
  - Promptness
  - Self-exploration
- Nonjudgmental acceptance of other group members

Modeling
- Nonjudgmental acceptance of others’ strengths and problem areas
- Non-punitive openness to others disclosure
- Pre-Masters Esmail as “the Master Therapist” in group therapy
- Honesty and spontaneity in group
Shaping Group Norms-continued

Operant Conditioning
- Negative behaviors are: *behaviors which discourage what you want in group-disclosure, spontaneity*, etc.
- Negative behaviors, once group cohesiveness has developed, are excellent interaction to explore, but early in group they can destroy the fledgling group

Modeling
- Admit mistakes
- Model non-defensiveness
- “tell me more about why you think I am a bad psychologist, I want to understand your perspective”
Shaping Group Norms-continued

Operant conditioning

- **Extinction**: do not praise critical remarks
- **Redirect to on-target behaviors-encourage “I” statements**
- **Punishment**: use rarely, if at all-you can not develop a non-punative group culture by punishment. “the beatings will continue until moral improves!”-

Modeling

- Judicious self-disclosure by therapist
Reward

• Risk taking
• Acknowledging feared thoughts (Aggressive and sexual) (Cleveland Gestalt Institute)
Who is your patient?

• The Group itself
• In another sense, the Group is the Therapist, you are the therapist’s Supervisor
• However you are still responsible for each individual’s safety, well being, and progress
Trust it the Foundation of the Group
Ways to Establish Trust

– Preparation
– Appropriate selection of group members
– Establishment of ground rules
– Talking about rights, respect and confidentiality
– Showing interest in group members and the group as a whole
– Serious attitude about the group
– Accepting negative feelings;
– preventing group members from always problem-solving for each other
Stage 3: Working in the *Here and Now*: 2 Factors

- #1 *Here and Now* takes precedence over current or past events in the life of a group member, or historical events in the group.
- *Disclaimer*: this does not mean that persons can not talk about the past or the world outside the group, but that the ultimate benchmark is the *here-and-now*.
- Some therapists are phobic of the here-and-now.
#2 Illumination of the Process

• “what’s going on here?”
• **Process** is the nature of the relationship between participants
• **Cognitive Framework**—to help group members understand what went on in group, internalize the experience, generalize it to the outside world
• **Real-life – laboratory** in which the group and the group therapist can discover the cognitive and behavioral blindspots of each group
Example of process versus content: question asked of therapist

• Appease therapist by being a dutiful student?
• Become the teacher’s pet?
• Establish a dependent, submissive relationship?
• To enact contact with the psychological healer?
• Avoid exploring one’s inner experience?
• Show off to other group members?
• To show that the therapist does not know anything more than the patient?
Process focus

• Socially Taboo!
• Is the POWER of the group
• Therapist’s Tasks in Here-and-Now

1. **Activation** - Cue members to focus on the here and now

2. **Give Permission to break the Social Taboo** - in fact we are encouraging group members to break the law, albeit in a spirit of unconditional acceptance (group culture). “you have come to a psychological nudist colony”

3. **Model here-and-now Process Illumination**

4. **Reinforce ‘here and now’ Process Illumination** by group members

5. **Use praise liberally but authentically**
Encouraging here-and-now

• “who here do you feel most warm towards?”
• “with whom would you have to summon your most courage to ask for help?”
• “we are about half way thru our group time today, I wonder how each of us feel about how we have used the time so far?”
• “Bill, whenever you talk in group I become bored very quickly. My intuition tells me you are a deep person, but I feel as if I’m at Kings Island, I never get thru the line and onto the ride.”
Levels of Process Illumination-*in descending order*:

1. Ask the Group to Identify the Process
2. Tell the group what you are observing
3. Interpret the process for the group. (Yalom, p. “the mature leader resists the temptation to make brilliant virtuoso interpretations, ... but instead searches for methods that will permit clients to achieve self-knowledge through their own efforts.”)
Process Illumination-from Behavioral Observation to inference and interpretation

1. “you are interrupting me”
2. “your voice is tight and your fists are clenched”
3. “whenever you talk to me you are taking issue with me”
4. “when you do that, I feel threatened and sometimes frightened”
5. “I wonder if you feel competitive towards me”
6. “I’ve noticed that you interact with other men in the group in a similar fashion, you become abrasive when they try to help you” Adapted from Yalom, p
Rational for Process Illumination
(from Yalom)

1. Here is what your behavior is like
2. Here is how your behavior makes others feel
3. Here is how you behavior influences the opinions others have of you
4. Here is how your behavior influences your opinion of yourself

*Are you satisfied with the world you have created?
Example of Process Illumination

• “You act like a cartoon character”
• “I get so pissed at you, I wish you would just stop”
• patient became more aware of his behavior, and as a result his inner process
• Patient realized he was always trying to deflect anticipated wrath for “attention seeking”
• Corrected his view of himself, others and how his behavior effected others
PI and Change (yalom, p 182)

- **Therapeutic Assumption**: each client possesses the capacity to change *through willful choice*
- “the therapist attempts to escort the client to the crossroads where he or she can choose, willfully, in the best interests of his/her own integrity”
- therapist can not create will
- “what you can do is remove encumbrances from the bound or stifled will of the client”
- **Honoring patient’s Ambivalence** – “although the person’s behavior sabotages many of his/her mature needs and goals, at the same time it satisfies another set of needs and goals”
Resistance to here-and-now PI

• Culturally engrained norms die hard
• First day a nudist camp, don’t forget to put your clothes back on when you leave!
• Yalom-like learning a new language
A Deeper Look: *Content vs. Process*

The **content** of the discussion consists of the explicit words spoken, the substantive issues, the arguments advanced, and can culminate in therapeutic themes.

**Process** starts with:

- How often does a member participate?
- Who speaks to whom?
- Verbal responses to conflict?
A Deeper Look: *Content vs. Process*

• The *process* refers to the nature of the relationship between interacting individuals. Beyond the verbal content, the process focuses on the “how” and “what” of what is spoken.

• The process is the current beneath the content.

• Sometimes the true meaning is different than what is spoken. Examples: patients put forth treatment clichés while their non-verbal behavior suggests they do not trust each other enough to open up to each other or in the presence of the Group Leaders.
Recognition of Process

Consider a group meeting in which a client, Karen, discloses much heavy, deep personal material. The group is moved by her account and devotes much time listening, to helping her elaborate more fully, and to offering her support. The group therapist shares in these activities but entertains many other thoughts as well. For example, the therapist may wonder why, of all the members, it is invariably Karen who reveals first and most. Why does Karen so often put herself in the role of the group patient who all the members must nurse? Why must she always display herself as vulnerable? And why today? And that last meeting! So much conflict!

After such a meeting, one might have expected Karen to be angry. Instead she shows her throat. What might be her motivation?
Interventions

- **Summarizing** – reflecting back or asking the group members what has been said, shared or covered in group

- **Open-Ended Questions** – avoid as the primary mode of communication

- **Interpreting** – offering possible explanations for group member’s thoughts, feelings or behavior, which is *usually best to save for later stages* to avoid creating a dependency on the group leader for answers. When I make interpretations I usually couch them as a *hypothesis to be tested*, with a 50% chance of being wrong or right, I am encouraging openness to personal exploration, not giving them the enlightened truth
Interventions

• **Confronting** – artfully challenging discrepancies between a member’s verbal and nonverbal messages (Columbo)

• **Affirming** – providing encouragement and reinforcement, especially when members are disclosing personal info

• **Facilitating** – setting the tone for clear, direct and safe communication, fostering “member to member” communication style
Interventions

• **Initiating** – help maintain a direction without fostering a dependency on the leader for what happens next

• **Setting Goals** – challenging group members to set goals and then providing accountability

• **Giving Feedback** – providing honest observations and encouraging others to do so as well (descriptive not judgmental)
Interventions

• **Protecting** – safeguarding members from physical or psychological harm, but avoiding over-protectiveness (let them take risks in group)

• **Self-Disclosure** – judiciously disclose *for a specific purpose* personal information. Often this will be modeling opening up to the group. Doing this is an *intervention* on the *culture* of the group

• **Humor** – judiciously model appropriate laughter as a good medicine.  **Question**: why should this be done in moderation?
Interventions

- **Blocking** – stopping counterproductive or aggressive behavior in group in a sensitive manner. Group leader must decide whether to block these behaviors or explore them.

- **Application** – helping members to apply what they’ve learned in group to their daily lives

- **Delegating** – passing along the responsibility for leadership during discussions, exercises and activities
Interventions

• **Suggesting** – helping the member develop an alternate course of thinking or action. It may include giving information, advice, “homework assignments,” trying experiments inside and outside of group and encouraging member to look at situation from a different perspective.

Corey & Corey, 1997
Turning Dysfunctional Behaviors into opportunities for personal change and growth

Turning the raging river into the source of power
Problem Group Members

- Idolater
- Junior therapist
- Placater
- One Upper
- Aggressive, in your face, client
- Monopolizer
- Help-rejecting complainer
- “good patient”
- Passive patient
- “the Victim”
- Class Clown
Problem Group members- overview

• **Opportunity**: first “praise the Lord!”; they are putting their distorted way of interacting right out in front of you

• This is were you get therapeutic **traction**!

• You can now reach out and grasp their **dysfunctional interpersonal style**

• Generate hypotheses about their **irrational thinking** (view of self and others, ex friend who talked a lot)
The Idolater

- Idealizes the therapist
- Novice or narcissistic therapist may take the bait
- Too good to be true
- Intervention: *explore their expectations*
- “Expectation is the foundation of resentment”
The Junior Therapist

• Aligns with, defends, praises the Group Therapist

• Avoidance of their task of being a group member, hiding under the therapist’s skirt

• **Intervention:** explore their desire to be “special”, to be ‘mommy’s favorite’, to align with an authority or parental figure. Explore whether this is a reoccurring role in their lives that has left them unfulfilled.
The Placater

• Always complementary, “if you can’t say something that is nice, say nothing at all”.

• Although the placater does not realize it, they are working at cross purposes with the goal of the group, which is to be real, not “nice”

• It is often very difficult for other group members to challenge the chronically “nice” member (projective identification)

• Word Scramble: “catonire tmanoorif” (psychoanalytic term)

• likely underlying resentment and judgment of others. Consider artificial persona versus real personality that we present to the world
Monopolizer

- “compelled to chatter incessantly....the monopolist’s compulsive speech is an attempt to deal with anxiety” Yalom and Leszsz, pp. 391-2.
- Shutting up monopolist benefits neither M or the group
- **Two pronged approach:** “both the monopolizer and the group has allowed itself to be monopolized”
- **Explore** with the group it’s lack of assertiveness (fear of harming the M, incurring group leader’s anger, would rather let the M do all the work due to anxiety or laziness?)
Monopolizer- continued

• **Paradox:** you do not want to hear *less* from the monopolist, you want to hear *more*. Explore how compulsive speech is used for concealment of self

• **Intervention:** explore with the group their reaction to the monopolist, have group disclose *their reactions* to, *not* interpretations of, the monopolist. (what, not why)

• **Later interpretation:** monopolist may be trying to control their anxiety, while getting attention

• **Research shows:** Monopolizers misinterpret their experience of themselves, thinking they are not the most active persons in the group
The One-upper

• Very competitive, constant need to be “right” and in control
• Interventions: roll with it, model tolerance for divergent viewpoints. Don’t be intimidated by patient’s “one uppsmanship”
• Allow a member to member dialogue
• Acknowledge the member’s wish to be heard and understood
“I Know Better” – Constant need to be right, in control and routinely competitive (one upping the leader.)

Response: Roll with it, model tolerance for divergent viewpoints. Don’t be intimidated by the patient’s “one-upsmanhip”. Allow for “member to member” dialogue. Acknowledge the member’s wish to heard and understood.

In Your Face – the group facilitator’s sensitivities, weaknesses, insecurities and needs are a focus of this person’s interest. Response: Stay calm and reflective – “you seem to be angry with me” or “you seem to challenge everything I say.” Express your awareness of the situation, you’re not angry and you’re not feeling rejected.
• The Setter-Upper – this member “gently” and with “concern” puts you against their individual therapist or other agency members. **Response:** Avoid personalizing the situation. Wonder aloud about the process. Look for the set-up as they talk about other interpersonal relationships.

• The Good Client – does everything right. Cooperative, responsible, appears to deal with anger appropriately, compulsive – perfectionistic. **Response:** Affirm effort, explore approval needs – “John, you seem to work so hard at always doing the right things. This is very commendable, but what happens to you if you have done something and it does not turn out as well as you had expected or planned?” Use other members affirm his ability to accept his imperfect self.
The Nontalker (The Silent Member) – “a chain is as strong as its weakest link.” This member can strongly affect group cohesiveness. Other group members are building deeper cohesion by reciprocal disclosure, while this person is playing it safe.

Response: Be sensitive to the many reasons why someone may be silent. Begin by simply acknowledging their passivity, allow them to discuss their discomfort. Don’t try to pry them open, but facilitate other group members sharing their response to this person. Look to fellow members to support.

The victim Easily identified by their whining (“why does everything happen to me?”) – when members attempt to help, the response is often “yes, but.” Can be a powerful negative force in the group. Response: Don’t gratify the “whining.” Allow members to share the impact it is having, acknowledge discrepancies in stated desire for help and refusal to accept from the group. Focus on self-efficacy (Fehr, 1999).
The Class Clown

• Frequently seen in adolescent populations
• Let them clown a bit
• Educate – from a psychological perspective, what is humor? (coping mechanism-usually positive unless it is overused and not understood)
• Then invite them to explore the pain behind the jolly persona
• Smokey Robinson, “take a good look at my face, if my smile seems out of place, if you look closer it’s easy to trace, the tracks of my tears”
• They must know that you genuinely care for them, this is not a criticism, the group will not attack them.
Countertransference

You’re not a bad therapist . . . You’re a human one!
Countertransference Categories

1. **Realistic responses** – the response to the client will be the same by any therapist.

2. **Responses to client’s behavior** – If the client is flattering, the therapist may feel flattered; if client is aggressive the therapist may feel frightened.

3. **Responses to material troubling to the therapist** – these particular issues are unresolved & cause conflict in the therapist’s life (i.e., issues of abuse). Ex. Damage the Cookie Monster

4. **Characteristic responses of the therapist** – this is the totality of the therapist, the person he or she is in life. A person who is generally defensive is probably defensive when working with clients.
What should one do with all of these reactions?
Valuable Questions- Processing My Countertransference

- “What’s actually happening here?”
- “Why do I feel this way toward this client?”
- “Why am I having these thoughts about this person?”
- “What is being evoked inside me?”
Countertransference: Yalom suggests

• Have your own individual and group therapy
• DBT Consultation Team
Part II: Stages of Change Group Therapy for Substance Abuse/Dependence

• Based on Group Treatment for Substance Abuse: A Stages of Change Therapy Manual, Velaquez, M; Mauer, G; Crouch, C; & DiClemente, C. (2001), Guilford Press

• The Problem: doing the right thing at the right time: film clip-Jack Nicholson & Shirley McClain in Terms of Endearment
Velasquez, et. al : 2 Sequences for 2 categories of client

1. **Sequence #1: P/C/P** (precontemplation/contemplation/preparation) 14 sessions
   advertising to potential students at Summit: Unit F is the unit whose patients do not have a psychiatric disorder

2. **Sequence #2: A/M** (Action/Maintenance) 15 sessions
TTM: Transtheoretical Model Overview-
5 distinct stages of change

1. **Precontemplation**- not seeing a problem
2. **Contemplation**- seeing a problem and considering *whether to act*
3. **Preparation**- making concrete plans to act soon
4. **Action**- doing something to change
5. **Maintenance**- working to maintain the change
TTM- Processes of Change-
Experiential processes

1. Consciousness Raising - learn about negative effects of the behavior; mindfulness (DBT)

2. Dramatic Relief

3. Self Re-evaluation - how current behavior conflicts with values and life goals

4. Environmental Re-evaluation - (Bandura- reciprocal determinism), how does the behavior effect relationships

5. Social Liberation creating alternatives in social world that reinforce change

Refuge Coffee Bar
Processes of Change- Behavioral Processes

1. **Stimulus Control** - avoiding cues, triggers
   - weight watchers-
   - Frisch’s breakfast bar

2. **Counterconditioning** - substituting healthy behavior for unhealthy behavior, altering response to stimulus
   - ex: stress- relaxation techniques rather than drinking

3. **Reinforcement Management** - rewarding positive behavior
   - WW-reach goal weight, spend money on reward, not necessities

4. **Self-Liberation** - belief in one’s ability to change
   - Bandura’s Self-Efficacy theory

5. **Helping Relationships** - need to develop
   - Esmail view-
   - people rise or fall to the level of social reinforcement
TTM: Processes of Change-
Behavioral Processes continued

4. **Self-Liberation**- belief in one’s ability to change- Bandura’s Self-Efficacy theory.

5. **Helping Relationships**- need to develop, _Esmail view_- people rise or fall to the level of social reinforcement
Do the TTM Model of Velasquez & the Yalom Model of Group Therapy “jive”?

- **Velasquez**: “In shaping the group, your experience and behavior, as well as the expectation of the group members, will guide the formation of norms.... You can shape the norms both directly (by leading discussions of appropriate and inappropriate behavior) and indirectly (using verbal and nonverbal reinforcement; redirecting questions to the group rather than responding yourself; modeling acceptance, honesty and genuiness. Keep in mind that norms are established early in the course of a group and not easily change subsequently (Yalom, 1995). The ideal group has norms that allow the processes of change to operate with maximum effectiveness” p. 34
Velasquez: Examples of helpful group norms, p. 34

- Nonjudgmental acceptance of others
- Willingness to self-disclose
- Participation by all members
- Respecting confidentiality
- Valuing the importance of the group
- Recognizing the available support in the group
- Respecting others (constructive criticism, no name-calling)
- Willingness to accept feedback
Velasquez: *here and now* focus of group

- “Help clients remain in the ‘here and now’. Many clients who have abused alcohol and other drugs for extended amounts of time tend to dwell on their past rather than focusing on the present or future. Group settings provide a unique opportunity ...clients help one another stop reliving the past, ...pay attention to their current situation.”  p. 35
Velasquez: here and now focus of group-taken directly from Yalom

1. Here is what your current behavior is like
2. This is how your behavior makes others feel
3. This is how your behavior influences others around you
4. How does your behavior influence your opinion of yourself?   (Velaquez p. 35)
PCP Sequence: 14 Sessions (session # and primary objective listed below)

1. Introduce Stages of Change
2. Raise consciousness: frequency, quality, pattern of use
3. Raise consciousness: how alcohol harms the body
4. Raise consciousness: how drugs harm the body
5. Raise consciousness: reason for using
6. Self Re-evaluation: who is concerned?
7. Self Re-evaluation: how does using conflict with my values?
8. Decisional Balance: Pros and Cons
9. Environmental Re-evaluation: how does my behavior affect persons in my life, my social universe?
PCP sequence: Session objectives - continued

10. Environmental Re-evaluation: how does behavior effect my roles?

11. Self-Efficacy: Confidence & Temptation [4 triggers- negative emotions, physical problems, social pressure, cravings-withdrawal ]

12. Self-Efficacy: Problem Solving (versus acting on feelings)

13. Self-Liberation: setting a goal for behavior change

14. Review of Sequence and termination
Action/Maintenance [A/M] Sequence: Session Objectives

1. Consciousness raising: Stages of Change (may be skipped if P/C/P & A/M run back to back)
2. Stimulus Control: triggers-avoiding or altering
3. Counterconditioning: Stress management via relaxation training
4. Reinforcement Management: learning to self-reinforce (for many of our clients, using is the only self-reinforcement they know)
5. Counterconditioning: altering response to cues- improving communication
6. Counterconditioning: Effective Refusal Skills
7. Counterconditioning: Managing Criticism
8. Counterconditioning: Replacing Maladaptive thoughts
Action/Maintenance Sequence - continued

9. Counterconditioning: replacing cravings/urges healthy, substance-free actions & behaviors
10. Stimulus control: avoid substance oriented situations, substitute healthier activities
11. Self-liberation: developing an Action Plan
12. Self-liberation: what to do after a slip
13. Social Support: [proactively] identify helping relationships
14. Social Liberation: increasing alternatives for non-problematic behavior
15. Review and Termination