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Focused Brief Group Therapy Treatment Manual

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FOCUSED BRIEF GROUP THERAPY TREATMENT MANUAL

PROFESSIONAL DISSERTATION

SUBMITTED TO THE FACULTY

OF
THE SCHOOL OF PROFESSIONAL PSYCHOLOGY
WRIGHT STATE UNIVERSITY

BY

JENNIFER ELAINE LOTZ, PSY.M.

IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY

Dayton, Ohio   **September, 2013**

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WRIGHT STATE UNIVERSITY

SCHOOL OF PROFESSIONAL PSYCHOLOGY

June 13, 2012

I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY **JENNIFER ELAINE LOTZ** ENTITLED **FOCUSED BRIEF GROUP THERAPY TREATMENT MANUAL** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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Abstract

Focused Brief Group Therapy (FBGT) was developed in a college counseling center in order to meet the mental health needs of the student population effectively within an 8 session limit. The model was developed to address pragmatic concerns by integrating best practice (AGPA, ASGW) and the local scientist model (practice based evidence). The goal of FBGT is measurable change in a focused area of interpersonal distress. The interpersonal circumplex, an empirically derived and scientifically validated model of interpersonal functioning, is used. Assessment is used to inform and guide treatment as well as to measure change. The model has been honed through its clinical use based on clinical observation and process-outcome measure analysis and statistics.

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Purpose of the Study

The number of students seeking treatment at University counseling centers is rising significantly each year (CSCMH, 2010). With limited resources, these centers are asked to do more to meet the growing demand for services. The question then becomes how to provide the necessary services for a college population in the most efficacious and efficient manner in order to best utilize the limited resources available (Cummings, Budman, & Thomas, 1998).

Common problems within the college population (i.e., depression, social anxiety, eating disorders) can be successfully treated in group therapy (Burlingame, Fuhriman, & Mosier, 2003). Numerous studies have shown that group therapy is as effective as individual therapy (Burlingame et al., 2003; Burlingame, MacKenzie & Strauss, 2003; Fuhriman & Burlingame, 1999; McRoberts, Burlingame, & Hoag, 1998). Group therapy is an efficient and efficacious treatment necessary for counseling centers to utilize to best address the needs of the student population. Long-term psychotherapy groups are impractical on a college campus both because students' schedules constantly change and due to the number of students requiring services. Therefore, there exists a need for brief group treatments that can address the psychological needs of the college population (Kincade & Kalodner, 2004).

Many college counseling centers have moved to briefer models of treatment (Draper, Jennings, Baron, Erdur, & Shankar, 2002). Clinicians are becoming more

focused in their identification of a core problem and establishing specific goals to treat

that problem only. As the demand for briefer more focused individual treatment rises,

there is a need for group therapy to become more focused as well (Cornish & Benton,

2001).

Literature Review

Focused Brief Group Therapy (FBGT) draws from the research and theories of multiple authors. It is solution-focused, behaviorally based, and interpersonally activated (Whittingham, Lotz, Gehle, & Harris, 2012). FBGT draws on the interpersonal work of Yalom's (2005) interpersonal process group and Kiesler's (1996) and others' (e.g., Horowitz, Alden, Wiggins, & Pincus, 2000) interpersonal circumplex. The treatment follows the best practice recommendation to screen potential group clients and utilizes the CORE-R Battery of group assessments (Burlingame et al., 2006).

Solution-focused

Solution-focused brief therapy is a practical, evidenced based approach with implications for group therapy (de Shazer et al., 2007). The basic tenet of solution-focused therapy is a focus on what is "working" for the client and the intention to increase those behaviors while decreasing the behaviors that "don't work" (de Shazer et al., 2007). When something is not working, the client is encouraged to try something different.

Brief group therapy requires treatment to be solution-focused and action oriented (Piper & Ogrodniczuk, 2004). Solution-Focused Group Therapy (SFGT) suggests that the problem should be outlined and clarified collaboratively between the client and the therapist (Banks, 2005). The problem is framed with acceptance and positive feedback. The client then decides what they want to change and examines if those changes will create the desired effect (Whittingham et al., 2012). A rapid installation of hope is

created by strength-based interventions as clients are able to utilize strengths they already possess.

Behavioral Activation

Behavioral activation (BA) is a key component of FBGT. BA, a form of behavioral therapy, systematically increases activation through graded exercises to increase the client's experience with sources of reward, identifies processes that inhibit activation, and teaches problem-solving skills (Martell, Addis, & Jacobson, 2001). Houghton, Curran, and Ekers (2011) state the focus of behavioral activation is the behavior that stems from presenting symptoms (e.g., social avoidance due to depression). Based on a meta-analysis of group therapy outcomes, Burlingame et al. (2003) concluded that "… the acquisition of information and the practice of relevant behaviors are prerequisite to treatment gain" (p. 11). The use of behavioral activation in group therapy has been found to be effective (Porter, Spates, and Smitham, 2004). FBGT an integrative approach that keeps clients focused on behavior change while using the interpersonal process group format (Whittingham et al., 2012).

Interpersonal Theory

FBGT is a semi-structured interpersonal process group. It is run in much the same way as a Yalom (2005) interpersonal process group and integrates the use of the interpersonal circumplex (IPC) (Kiesler, 1996; Horowitz et al., 2000). The IPC provides a visual map of an individual's interpersonal style and can be used in problem identification and treatment planning.

Interpersonal group therapy. Interpersonal theory postulates that psychopathology is the result of maladaptive interpersonal beliefs, due to parataxic

distortions, and the behaviors that result from these beliefs (Yalom & Vinogradov, 1993). Yalom (2005) defined parataxic distortions as the distortion in the perception of others, which occurs when an individual reacts to another based on their fantasy of that individual rather than realistic attributes. Yalom (2005), proposed eleven therapeutic factors of group therapy used to address the root interpersonal causes of group members' psychopathology, which include (a) instillation of hope; (b) universality; (c) imparting information; (d) altruism; (e) corrective recapitulation of the primary family group; (f) development of socializing techniques; (g) imitative behavior; (h) interpersonal learning; (i) group cohesiveness; (j) catharsis; (k) existential factors.

According to Yalom (2005), these therapeutic factors are what lead to change for group members. Hope alone can be a healing factor in an individual's life and within group. Often members feel isolated and think they are the only one to feel and think the way that they do. Sharing experiences with other members is cathartic. The experience of relating and connecting with one another over universal human experiences is also healing. Within group, not only are members working on themselves, but they are also helping one another. Being able to affect another positively can change a person's view of their ability to be of worth to others and increases self-efficacy.

Yalom (2005) proposes that group members learn from one another and group leaders. Imparting information whether provided explicitly or through advice giving is one aspect of this. More importantly, modeling of behaviors by group leaders and more senior group members can be an important aspect in social learning for newer members as they imitate the successful behaviors of others. Members are able to develop

socializing techniques within group and increase their interpersonal skill through many of these processes.

Additionally, Yalom (2005) proposes that group echoes the primary family unit as leaders become parental figures and other members take the role of siblings. It is thought that transferential reactions will occur as members relive early social relationships within the group. Transferences are then used to help understand behaviors in order to create a corrective experience of primary family groups. Group cohesiveness is essential to foster positive interpersonal relationships that serve as healing and corrective experiences. Without cohesiveness, it is unlikely that group members will be able to grow and learn from one another.

Yalom (2005) conceptualized group therapy as a social microcosm, expecting members to behave within the group in a similar manner as outside of group. Group then becomes a place where members can gain insight into how their behaviors are interpreted by others and to practice new behaviors. They are able to learn from one another, as they relate to and interact with other members. The goal is to gain the interpersonal skills necessary to navigate social systems.

The therapist's job within this theory is primarily concerned with establishing the norms of the group, which includes working within the here-and-now (Yalom, 2005). Yalom (2005) emphasizes the need for group members to reflect on the experiences they have within the group, the self-reflective loop, in order for emotional experiences to be therapeutic. Most importantly, the therapist works through process illumination and activates the self-reflective loop in order for the group to reflect on itself and the here-and-now interactions that occur. Group members may begin to imitate this behavior and

encourage the self-reflective loop and process commentary as well. By processing what is happening with the group, as it is happening, group members will feel energized and within this heightened state, they will do their greatest learning from one another (Yalom, 2005). Self-involving self-disclosures (i.e., what the therapist is thinking or feeling in the here-and-now) are used within this framework but Yalom & Vinogradov (1993) warn that personal self-disclosures (i.e., personal information about the therapist) should be used judiciously.

Interpersonal circumplex. The IPC has a long history in the field of psychology (e.g., Sullivan, 1953; Leary, 1957; Kiesler, 1996) and "… remains the most popular approach to representing the interpersonal domain" (Gurtman, 2001, p. 98). The circumplex has two main axes, the vertical, which represents power, and the horizontal, which represents affiliation (Figure 1). The Power axis represents the amount of power an individual seeks in their interpersonal relationships and ranges from Dominant to Submissive. The affiliation axis represents an individual's agreeableness with others and ranges from Hostile to Friendly. All other points on the IPC are "a weighted combination of these two components" (Gurtman, 2001, p. 98). Interpersonal flexibility is adaptive, allowing an individual a range of interpersonal behaviors that can be used appropriately in different situations (i.e., dominant in a supervisory role and submissive in a supervisee role). Interpersonal rigidity likely leads to disruptions in an individual's relationships with others (i.e., asserting dominance with a supervisor).
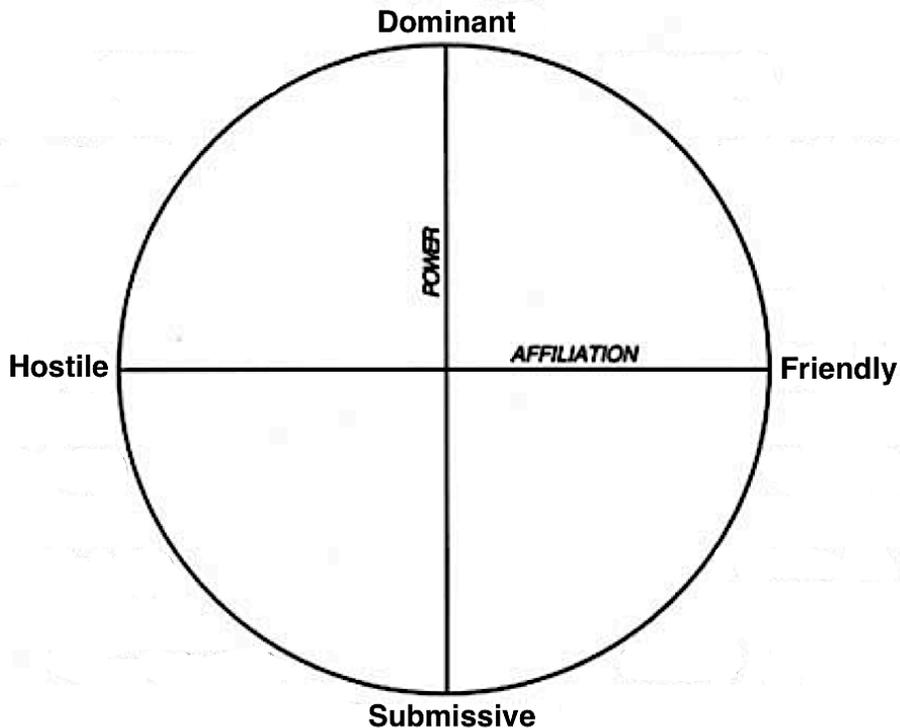
Figure 1. The Interpersonal Circumplex.

      In addition to the IPC providing a representation of an individual's interpersonal style, it has further implications regarding interpersonal invitations. An action taken along the vertical axis (Power) invites a response from the opposite end of the axis (i.e. Dominance invites Submissiveness and Submissiveness invites Dominance) (Gurtman, 2001). The Affiliation axis works differently. An action taken on one end of the horizontal axis, invites a response from the corresponding side of the axis (i.e., Hostile invites Hostile and Friendly invites Friendly) (Gurtman, 2001). The IPC provides a visual map of individual's interpersonal styles as well as a way to predict how those individuals will interact with others depending on their interpersonal style.

Pre-group Preparation and Screening

      Numerous authors assert and some ethical codes mandate the need for pre-group preparation (ACA, 2005; MacKenzie, 1997; Price, Hescheles, & Price, 1999, Yalom,

2005). Research has shown that pre-group preparation increases the effectiveness of treatment and reduces pre-mature dropout (Bednar & Kaul, 1994; Burlingame, Fuhriman, & Johnson, 2002). These studies have shown greater group cohesion, greater adherence to tasks and goals, better attendance, less anxiety, greater understanding of expected roles and behaviors, as well as higher expectations for group in those who have had pre-group preparation.

Pre-group preparation prepares a client for group therapy and allows group leaders the opportunity to assess if group is appropriate for the client. Yalom (2005) describes the goals of this phase of treatment:

- Clarify misconceptions, unrealistic fears, and expectations

- Anticipate and diminish the emergence of problems in the group's development

- Provide clients with a cognitive structure that facilitations effective group participation

- Generate realistic and positive expectations about the group therapy. (p. 294)

Screening allows the leaders of therapy groups to differentiate potential group members who are not appropriate for group from those who are. Yalom (2005) proposes that it is more of a process of deselecting those who are not appropriate rather than a matter of inclusion or exclusion. Yalom (2005) identified those who are brain damaged, paranoid, hypochondriacal, addicted to drugs and alcohol, acutely psychotic, or sociopathic as not ideal for group.

Assessment

The original CORE battery, proposed by a taskforce of the American Group Psychotherapy Association (AGPA), was originally developed in the 1980s (Burlingame

et al., 2006). The original version failed to gain mainstream popularity due to cost and difficulty scoring, and thus, the AGPA set about to create a more usable second version (Strauss, Burlingame, & Bormann, 2008). The AGPA's second attempt at providing a guide for group assessment, the CORE BATTERY-REVISED (CORE-R), was released in 2006. Since that time, researchers and clinicians have begun to utilize the assessment methodologies proposed by the CORE-R Task Force. The goal of group assessment is to enhance the practice of group psychotherapy. One of the primary motivations for the revision was to match the current practice of psychotherapy: accountability and the importance of outcome data being a principle factor as the field has moved towards evidence based practice (Burlingame et al., 2006).

The CORE-R breaks group assessment into three sections: group selection methods, process measures, and outcome measures (Burlingame et al., 2006). The purpose of the CORE-R was to create a cohesive manual for group assessment that presents all the measures currently available for use in group work. The manual suggests that clinicians should select measures that are most applicable for their setting and population. FBGT uses particular tools introduced by the CORE-R for each of the three phases of group (screening, process, outcome) (See figure 2). The CORE-R additionally provides sample handouts for screening sessions and provides exclusion and inclusion criteria.
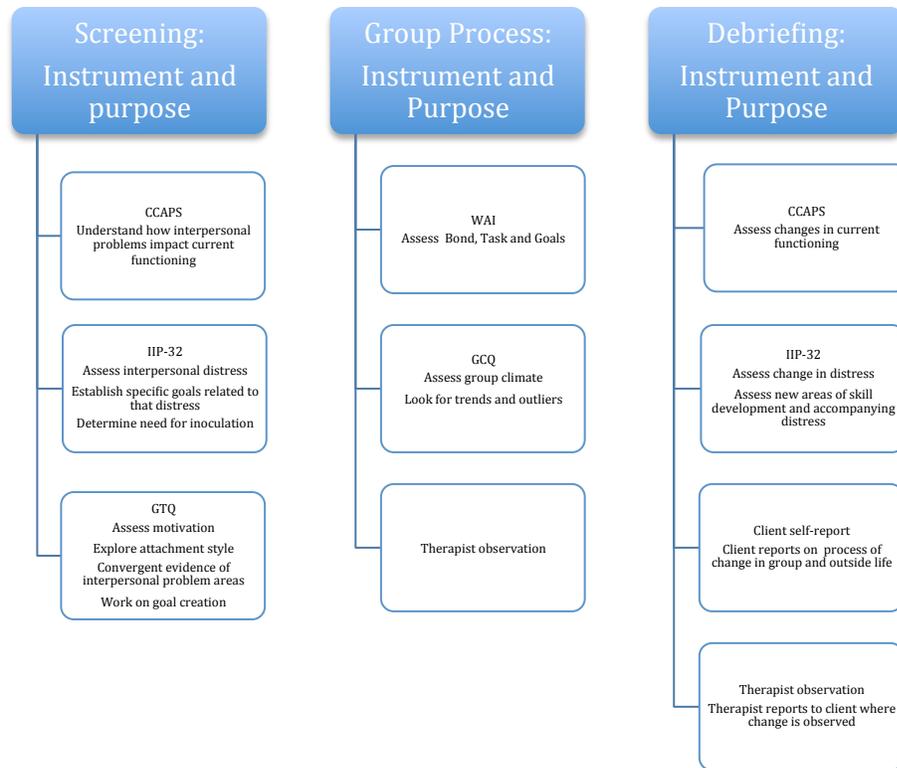
```
Screening:                    Group Process:                Debriefing:
Instrument and                Instrument and                Instrument and
purpose                       Purpose                       Purpose

CCAPS                         WAI                           CCAPS
Understand how interpersonal  Assess Bond, Task and Goals   Assess changes in current
problems impact current                                     functioning
functioning

IIP-32                        GCQ                           IIP-32
Assess interpersonal distress Assess group climate          Assess change in distress
Establish specific goals related to  Look for trends and outliers  Assess new areas of skill
that distress                                               development and accompanying
Determine need for inoculation                              distress

GTQ                           Therapist observation         Client self-report
Assess motivation                                           Client reports on process of
Explore attachment style                                    change in group and outside life
Convergent evidence of
interpersonal problem areas
Work on goal creation

                                                            Therapist observation
                                                            Therapist reports to client where
                                                            change is observed
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Figure 2. Assessment Purposes in FBGT at each stage of group (Whittingham et al., 2012).

Screening and outcome. Screening assessment tools can help the clinician to deselect those group candidates who are most likely to fair poorly and dropout prematurely. The CORE-R itself recommends screening sessions for all potential group members in addition to the use of assessment and handouts (Burlingame et al., 2006). FBGT utilizes the Counseling Center Assessment of Psychological Symptoms (CCAPS) (Locke et al., 2011), Group Therapy Questionnaire (GTQ) (MacNair-Semands & Corazzini, 1998), and Inventory of Interpersonal Problems-32 (IIP-32) (Horowitz et al., 2000) to screen potential group members. The CCAPS and IIP-32 are additionally used as outcome measures. The use of assessment tools such as the CCAPS, GTQ, and the IIP-32 in screening and pre-group preparation is to identify the client's appropriateness

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for group, help formulate an interpersonal diagnosis, treatment goals, and a treatment plan to meet the specified goals. The use of the CCAPS and IIP-32 in outcome measurement is to measure any changes in symptomology and presenting problems.

Counseling Center Assessment of Psychological Symptoms (CCAPS). Due to FBGT being developed for use in college counseling centers, it is appropriate to use the CCAPS (Locke et al., 2011; Sevig, Soet, Malofeeva, & Dowis, 2006) for screening and outcome purposes. The CCAPS was developed with a balanced rational/empirical design that makes it highly relevant for clinical work in counseling centers. While the CCAPS is not included in the CORE-R, it is used similarly to the Outcome Questionaire-45 (OQ-45) (Lambert et al., 1996).

The CCAPS currently comes in two forms. The CCAPS-62 contains 62-items and eight scales (i.e., Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concerns, Family Distress, Hostility, and Substance Use). With the comprehensive nature of the CCAPS-64, it is recommended for use in initial and post-treatment assessment. The CCAPS-34 is a 34-item instrument with seven scales (i.e., Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concerns, Hostility, and Alcohol Use). The proposed use of the CCAPS-34 is for repeated measurement during each session or specified intervals.

Inventory of Interpersonal Problems-32 (IIP-32). The second instrument used in both screening and outcome assessment is the Inventory of Interpersonal Problems-32 (IIP-32) (Horowitz et al., 2000). While the IIP-32 is suggested as an outcome measure only by the CORE-R, FBGT utilizes it during screening and pre-group preparation as

well as outcome. This is a unique aspect of the FBGT approach as the IIP-32 is used to identify areas of interpersonal difficulty and is used in the formation of the goal.

The IIP-32 is based on interpersonal circumplex theories with a long history in the field of psychology (e.g., Sullivan, 1953; Leary, 1957; Kiesler, 1996). Individuals complete a self-report measure on items that measure behaviors that are difficult to complete or behaviors they do too much. A total score is calculated in addition to normative and ipsative scores for the eight subscales:

1. Domineering/Controlling: Problems related to controlling, manipulating, exhibiting aggression toward, and trying to change others.

2. Vindictive/Self-Centered: Problems related to distrusting and being suspicious of others, being unable to care about other's needs and happiness, and perhaps being vindictive.

3. Cold/Distant: Problems related to being unable to express affection toward or to show love for another person, leading sometimes to an appearance of being cold.

4. Socially Inhibited: Problems related to feeling anxious or embarrassed in the presence of others and experiencing difficulty in getting into social interactions, expressing feelings, and socializing with others.

5. Non-assertive: Problems related to experiencing difficulty in making personal needs known to others, experiencing discomfort in authoritarian roles, and being unable to be firm with and assertive towards others.

6. Overly Accommodating: Problems related to experiencing difficulty in feeling anger and expressing anger for fear of offending others and being gullible and easily taken advantage of by others.

7. Self-sacrificing: Problems related to trying too hard to please others and being too generous, agreeable, trusting, caring, or permissive in dealing with others and avoiding conflict.

8. Intrusive/Needy: Problems related to being overly self-disclosing and attention seeking and experiencing difficulty in spending time alone. (Horowitz et al., 2000; MacKenzie, 1997)

The total score can be used as a global measure of "overall interpersonal distress" (Horowitz et al., 2000, p. 1). There are standard (based on a normative sample) and ipsatized (individually-based) T scores for each of the eight subscales. Standard scores show the degree of distress within each interpersonal domain; whereas, the ipsatized scores identify the areas the client experiences as problematic. The ipsative data is charted onto an interpersonal circumplex (see figure 3). Scores above 70 are considered very high (more than 2 standard deviations above the mean).
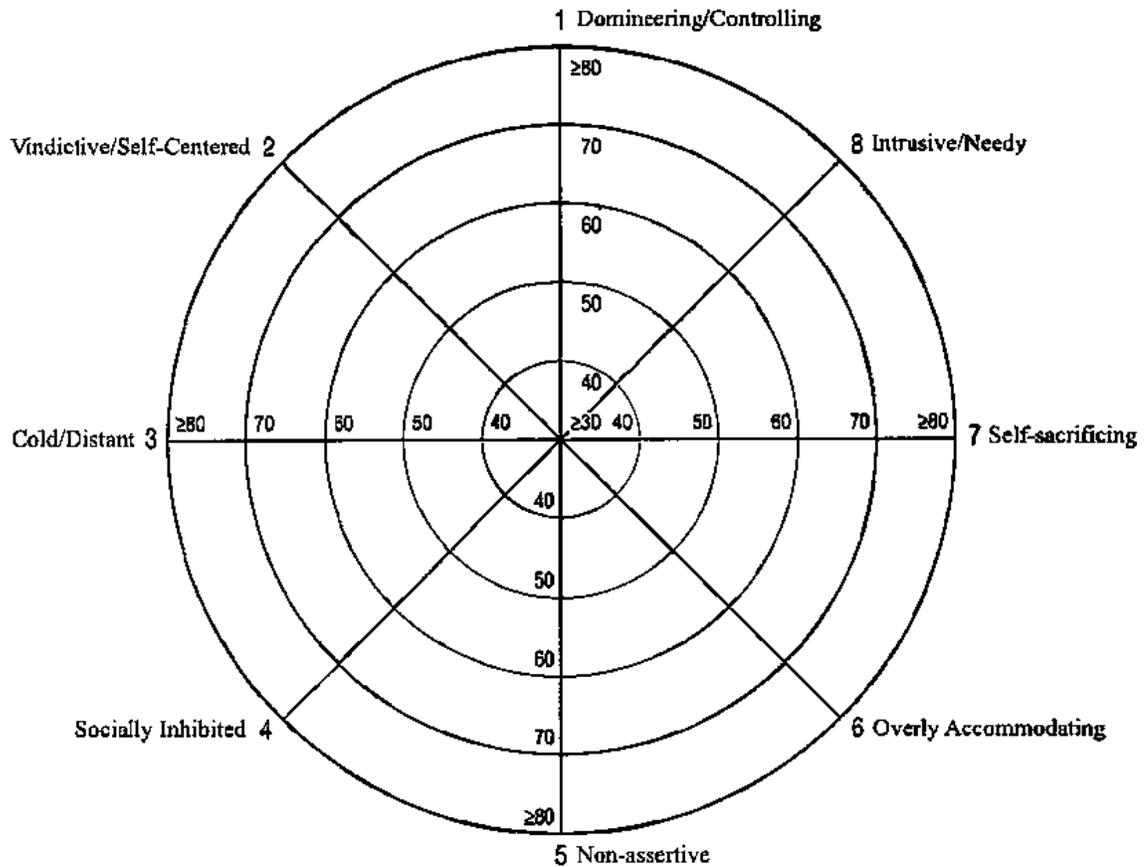
1 Domineering/Controlling

≥80

70

60

50

40

Vindictive/Self-Centered 2

8 Intrusive/Needy

Cold/Distant 3   ≥80 70 60 50 40 ≥30 40 50 60 70 ≥80   7 Self-sacrificing

40

50

60

Socially Inhibited 4

70

≥80

6 Overly Accommodating

5 Non-assertive

Figure 3. Inventory of Interpersonal Problems-32 (IIP-32). Scores are charted on a

circumplex like the one pictured above (Horowitz et al., 2000).

Group Therapy Questionnaire (GTQ). The GTQ is a self-report measure used to

assess several areas of functioning, which may affect a group member's appropriateness

for group and their ability to do the work of the group. It specifically measures "previous

therapy experiences; expectation for group; family roles, symptoms of substance use and

abuse; somatic symptoms; suicidal thoughts and crisis; goals for group; barriers to

successful group treatment; and fears about group" in addition to a 34-item interpersonal

checklist and a brief projective drawing of the primary family unit (Burlingame et al.,

2006, pp. 15).

The GTQ can serve to identify exclusion criteria and to identify potential barriers to treatment for clients selected to join the group. If the client is actively abusing substances, is actively suicidal or in crisis, or endorses somatic symptoms, these items on the GTQ may serve as exclusion criteria for the client from group. Conversely, low expectation scores and expressions of fears regarding joining the group can be addressed in the screening session in an effort to increase motivation and assuage any fears the client may have. Based on clinical experience, it is possible for an individual to come to a screening with a distrust of the process and a great many fears and leave feeling hopeful and excited for the group to begin. The ability to identify those clients that need motivational interventions during the screening session can be key in successful outcomes for those clients low on group expectations.

Assessment of family roles and the projective drawing of the family can be quite telling. Specifically, group leaders may be able to predict how the group member will react to each of the group leaders as well as to the group as a whole. These predictions can be used with the client during screening to predict challenges they may experience in their role as a group member. The group leaders can discuss these challenges with the client and develop strategies to encourage their attempts at new behaviors before group begins.

The checklist of interpersonal problems can help to identify areas of concern and goals of treatment. It is typical that problem areas found on the checklist will correspond to high scores on the IIP-32. For example, using the interpersonal circumplex used by the IIP-32, those that fall into the Hostile-Dominant quadrant may check "excessive arguments". Someone in the Hostile-Submissive quadrant may check " difficulty

socializing". Friendly-Dominant may check "feel devastated when close relationships end". Friendly-Submissive may check "feeling too dependent on others".

The GTQ also assesses what the client hopes to change through group and gives them an opportunity to list their goals. This can lead into the pre-group preparation work of defining goals for the client. Taken with the IIP-32, clinicians can develop a working theory of the client's ways of interacting with others before the first meeting. During the screening, the therapist can then take this information in conjunction with what the client reports during the session to formulate an interpersonal diagnosis and goals for group.

Process. Burlingame et al. (2006) defines process as whatever occurs during group sessions both explicit (i.e., behavior, quality of interactions) and implicit (i.e., members' experience of leader empathy, group cohesion). The purpose of process measures is to assess the experience of individual members as well as the group as a whole. The working alliance and group cohesion are necessary for individual and group success. It therefore becomes advantageous to be able to assess both of these variables throughout treatment in order to identify and intervene should problems occur at either an individual or group as a whole level. The two measures used by FBGT include the Working Alliance Inventory (WAI) (Horvath & Greenburg, 1989) and the Group Climate Questionnaire (GCQ) (MacKenzie, 1983).

Working Alliance Inventory (WAI). A strong working alliance facilitates the effectiveness of interventions and predicts positive outcomes (Horvath & Symonds, 1991). The WAI is a 36-item self-report measure designed to assess the working alliance established between client and therapist. It consists of three scales (Bond, Task, Goals) in addition to a Global scale. The Bond score reflects the attachment between client and

therapist relating to mutual trust, acceptance, and confidence. The Goal score measures the agreement of client and therapist on the desired outcome targeted by treatment. The Task score measures the agreement between the therapist and client on the tasks required (i.e., in-therapy behaviors and activities) to reach that goal. (Burlingame et al., 2006)

   Group Climate Questionnaire (GCQ). The GCQ was designed to measure group members' perceptions of the "climate" or perceived tone within the group. The GCQ is a 12-item scale measuring each member's perceptions of the group's level of engagement, avoidance, and conflict. The Engaged scale measures the group cohesiveness and group members' willingness to participate within group. A high score reflects a positive working environment with a high level of individual involvement. The Avoiding scale measures the reluctance of members to take responsibility for psychological change. High scores reflect an avoidance of conflict, superficial discussions, over-reliance on leaders for direction, and strict adherence to norms established by the group. The Conflict scale measures the amount of interpersonal friction present within the group. High scores indicate distrust, aggressive confrontations, and withdrawal from one another. Clinicians can average group members' scores into a group level score to get a general sense of the perceived climate and use individual scores to identify clients whose experience may differ from that of the group. The GCQ can be used to identify the group developmental stage (MacKenzie, 1983). Further, sharing the results of the measure with the group can be used as an intervention itself. (Burlingame et al., 2006)

Discussion

This manual is an initial step towards formalizing the FBGT treatment. In its current form, this manual requires further training and instruction by a clinician experienced in running and supervising FBGT groups. It also assumes the users of the manual have had an academic course in group therapy and have general practice in running psychotherapy groups. The next step in formalizing this treatment approach will be in the creation of a book. The book should include a full theoretical overview, more case examples and sample scripts, as well as a chapter on the supervisory process of FBGT. It should also include more detail on using this treatment with diverse populations with case examples. A FBGT book would be a formalized treatment that clinicians would be able to use in their own practice without any additional training. This will be a difficult process as the treatment continues to evolve.

As this therapy has been developed and refined to answer real world issues as they occur in the clinical setting, it will continue to evolve and become more refined over time. As the treatment changes, it will require future versions of the manual to be continually updated to reflect these changes. For example, FBGT is currently working within the quarter system framework of an 8 session limit; however, Wright State University is currently transitioning to semesters. FBGT will undergo inevitable changes to become a 12 session model. In order to accommodate both the quarter and semester system, the next version of the FBGT manual will need to address this issue.

There currently exists some contradiction between FBGT being a strength-based, solution-focused treatment and the current use of the IIP-32. The treatment currently involves identifying areas of interpersonal distress and focuses goals around building skills to alleviate that distress. The treatment is goal-focused, which is not the same thing as solution-focused. In order for FBGT to be solution-focused, treatment will need to focus more on the strengths the client possesses. This may be partially accomplished by using a different IPC assessment measure.

There is a need to re-examine the assessment measures used in FBGT. In an effort to move the treatment to be more strength-based, the Inventory of Interpersonal Strengths (IIS) (Hatcher & Rogers, 2009) could be a possible substitute for the IIP-32. The IIS uses the IPC to chart results and is more consistent with a solution-focused model. Additionally, the Group Questionnaire (GQ) is a new process measure that includes elements of both the GCQ and the WAI (Golightly, Beecher, Burlingame, Gleave, & Jensen, 2012). The GQ is administered on a computer with electronic scoring that can track clients over the course of group. The GQ would provide useful information to be used with the group and is simpler to administer, score, and track data (as opposed to using both the GCQ and the WAI). However, as opposed to the WAI and GCQ, which have no cost, the GQ is proprietary.

Current outcome data is promising; however, further research on the effectiveness of FBGT is necessary to validate the treatment. It is likely that as a formalized approach is used across multiple sites, data collection and analysis will continue. This will be a critical element to support the treatment for a wider distribution and use.

Appendix

FOCUSED BRIEF GROUP THERAPY TREATMENT MANUAL

BY

JENNIFER ELAINE LOTZ, PSY.M.

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Chapter 1: Introduction to the Manual

Focused Brief Group Therapy (FBGT) is a newly developed treatment grounded in theory and best practices and honed through its clinical use (Whittingham, 2011). Early research at Counseling and Wellness Services at Wright State University has shown promising results (Whittingham, Lotz, Gehle, & Harris, 2012). This manual is intended to serve as a guideline for centers seeking to utilize the principles and techniques of FBGT. This manual should be used in conjunction with training provided by a clinician experienced in running and supervising FBGT.

The purpose of FBGT is to provide a brief, interpersonal model of treatment that can be utilized to treat numerous interpersonal difficulties common in the college student population. It requires clinicians to focus treatment around specific areas of interpersonal distress based on empirically derived interpersonal sub-types from the interpersonal circumplex (Horowitz, Alden, Wiggins, & Pincus, 2000). Behavioral goals are collaboratively constructed with the client. Goals are designed to address specific areas of interpersonal distress and are a focus of treatment from beginning to end. By maintaining focused attention on the goals of members and the group as a whole, the limited time available for treatment is maximized and members themselves are increasingly motivated to make changes in a relatively short time period.

FBGT was developed at a university counseling center utilizing best practices from the Association for Specialists in Group Work (ASGW), the American Group Psychotherapy Association (AGPA), and the CORE-R (Thomas & Pender, 2008; AGPA, 2007; Burlingame et al., 2006). It is a practice based evidence approach in that is employs real-time assessment of client functioning to inform treatment (Burlingame &

Beecher, 2008). It is also a local clinical scientist model that utilizes assessment

reflectively to (a) enhance client outcomes; (b) provide process checks thus mitigating

dropout; (c) provide continuity of care by triangulating evidence prior to debriefing; (d)

create detailed profiles of interpersonal sub-types and their patterns of change; (e) allows

for program evaluation/outcome assessment. This manual will become the next step in

formalizing this treatment approach so that it may be utilized at other centers.

Chapter 2: Pre-group Preparation

FBGT considers the pre-group preparation and screening phase of treatment to be one of the most critical stages of group therapy. This includes preparing clients for treatment and the preparation required of group leaders. Literature states groups lose between 17-57% of members (Yalom, 2005). Thus, appropriate referrals are crucial. Clients' initial introduction to the idea of group therapy can determine their attitude towards group treatments and whether or not they follow through with a group referral. Therefore, special attention will be paid in this chapter on how to make a good referral to group treatment that lessons the chances of failure to begin and premature dropout. This begins with how to be a good "referrer".

Group programs often falter by losing potential clients at various stages of treatment. While time will not be spent in the manual devoted to the managerial aspect of a group program, FBGT does recommend some element of tracking of referrals for group treatment. Briefly, by understanding where the clients are being lost, one can help intervene on an individual or systemic level depending on where the losses are occurring. These losses can occur when a referral is never made, when the client fails to follow up on a group referral, when the client attends a screening but does not attend a group, and group dropout. Solid training in group referrals and creating a group culture within a treatment center are key elements in this process.

Creating a Group Culture

A group program will find the most success when a "group culture" exists within a treatment center. This requires full support from all members of the staff. A center that believes in group and makes their group program a priority, will find the most success.

This often requires education on the benefits of group therapy. It will require patience to change the culture of a center if that center does not immediately support establishing a group program. Once a "culture of group" is established, therapist buy-in becomes the next step.

It is important for therapists to believe that the treatment they are providing will be effective for the client. If group therapy is considered a product, the therapist must believe in the product in order to effectively "sell" the product to clients. This can be tied into the common factor research, which supports the importance of therapist allegiance to a treatment (Wampold, 2001). Not only will this belief make the therapist better at leading therapy groups, it can also help to instill the hope and belief in the client that this treatment will work for them and their specific problems.

Making the Referral

It then comes to the point where group is introduced to clients. This can occur during intakes or with clients already established in other services. Pre-group preparation with clients begins with their therapist. The goal of every therapist making a referral to group should be that the client would follow through on the referral and attend group. A successful referral depends on properly identifying the group most suitable for a client's presenting problems, introducing group to a client so that they understand the benefits of group for their specific presenting problems, and address possible resistance. This will be later built upon during the screening phase of treatment by the group therapists as well.

Therapists should be instilled with a "why not group" mentality. This is based on the premise proposed by Yalom (2005) that there exists a group for every client. When

looking to make a referral for specific groups, the therapist should ask themselves why the client would not be appropriate for a particular group and if no exclusion criteria are met, the client should be encouraged to attend a group.

Basics. It is important to remember the basic elements when making a referral to a group. Logistical considerations often interfere with a client following through with attendance in a group. It is important for the referring therapist to ensure that the client can consistently make the time and location of the group. Additionally, clients currently in crisis, somaticizers, rigid externalizers, actively abusing substances, and very extreme cases of Hostile Dominance (based on the interpersonal circumplex) may need close evaluation prior to making a FBGT referral (Burlingame et al., 2006; Muran, Segal, Samstag, & Crawford, 1994; Yalom, 2005). Burlingame et al. (2006) defines Somaticizers as the client that "reports many somatic symptoms and does not report psychological reasons for his/her pain; strong denial of issues" (p. 12). The rigid externalizing client does not deny their pain but does not assume personal responsibility for their situation, preferring to blame, and/or credit external sources. The Hostile Dominant client likely has "many interpersonal conflicts in his/her life, appears aggressive, defensive, agitated, or hostile in his/her relationships" (Burlingame et al., 2006, p. 12).

Who to refer to FBGT. FBGT is considered a time-limited inter-personal process group. Therefore, clients' with presenting problems that can be defined as inter-personal in nature, should be referred to a FBGT group. Often times, it requires the skill of the therapist to see beneath presenting symptoms and diagnosis to form an

"interpersonal diagnosis" (see Chapter 3 on Screening for information on making an interpersonal diagnosis).

How to speak to clients about FBGT. How a client is first introduced to the possibility of joining a group can be critical to their success in group. Once the initial recommendation is made, it is recommended that the therapist ask the client what their initial reaction is to the suggestion. If it is positive, provide the basic information of the group to the client and ensure that logistically they can attend a group. The referring therapist can allow the group therapist to work with the client to develop an interpersonal diagnosis and goal for the group with the client at the screening (See chapter 3). If the reaction is more negative, or perhaps even neutral, the therapist may need to address the client's resistance before making a group referral. Common reactions may be:

- "I'm afraid people will judge me."
- "It was hard enough for me to come in here and tell all this stuff to one person."
- "I have enough problems without having to deal with someone else's."
- "I want 1:1 counseling/therapy. You are just trying to pass me off."
- "It's just not for me."

Resistance. Therapists are often met with resistance to group therapy at first introduction. There are many reasons that clients resist group therapy. It is important to assess the source(s) of the resistance in order to facilitate a successful referral to a group screening. Frequently, the source of the resistance may be the very reason that group would be the most beneficial treatment modality (i.e., social anxiety). It is important to remember the fundamental skills of a therapist when addressing resistance. Warmth and

empathy are critical in order for a client to feel heard, understood, and validated, which allows them the safety within the therapeutic relationship to be pushed and challenged to take the risk of joining a group.

Co-leader Dynamics

An important element of FBGT is the emphasis placed on the relationship between leaders. Therefore, before the start of group, group leaders take the IIP-32 to further understand their own interpersonal style and how it may affect the relationship between co-leaders as well as how group members will affect the leaders. It is recommended that before running a group together, group leaders share their results with their partner and discuss potential for conflicts with one another as well as with each group member's respective styles. It is recommended that the discussion of the impact of group leaders interpersonal style has on the group, should be continued throughout treatment.

Chapter 3: Screening

FBGT has suggested the use of "bookending" treatment with use of screening before the start of group and a debriefing appointment at the conclusion of group (more on debriefing in Chapter 7). Screening is a critical moment in group therapy. It is the first time the client meets their potential group therapist(s), allows the client the time to deepen their understanding of how group works, and specifically, how it will work for them and the problems they present with. The therapist's basic skills of warmth and empathy are critical. The client must feel that the therapist is listening to them and understands their problems. The therapist should be listening for themes within what the client shares and from the results of the assessment measures in order to form an interpersonal diagnosis and a personal goal for the client in group. Finally, the screening session can be used to increase the client's belief in group and their motivation to complete group treatment. A Group Screening Worksheet (Appendix A) can help guide the screening session.

Use of Assessments

FBGT relies on the use of the Inventory of Interpersonal Problems-32 (IIP-32) and the Group Therapy Questionnaire (GTQ) for the screening appointment. It is recommended that group clients be asked upon referral to show up early to their screening appointment in order to complete paperwork. It is critical for the therapist to have time to score and review the results of both assessments in order to facilitate the group screening session efficiently and effectively.

      Using the GTQ in screening. When reviewing the GTQ before screening, special attention should be paid to items involving client motivation and possible

exclusion criteria. If the client has low motivation, plan to spend more time addressing this in the screening session. The goal of the therapist is to have every client leave the screening session excited for group to start and hopeful that it will be an effective form of treatment for them. Potential for exclusion can be seen with the somatization, crisis questions, and substance abuse questions. Should "red flags" arise within their answers, it is recommended to spend more time clarifying and assessing the client's appropriateness for group before proceeding with the other tasks of the group screening session. Use the checklist of interpersonal problems as well as the client's list of goals to formulate the interpersonal diagnosis and begin the discussion of a group goal (See sections below).

Instillation of hope. When the client's motivation is perceived as low, it is critical for the therapist to spend time to understand why and intervene accordingly. Often, client's express fear that no one will be like them in group or that their problems are so unique they cannot be helped in a group format. Validation and normalizing of these fears is important as most group clients enter into the group feeling this way. Usually, these fears can be assuaged by discussing past clients with similar problems completing group successfully. It can even be helpful to encourage clients to share these fears upon entering the group, as they may be surprised by how many others share their same concerns.

Red flags. Those who score high on somatization are considered to be rigid externalizers and judged to be poor candidates for a process type group as they are likely to disregard the feedback they are provided. Clearly, those in a current crisis should

receive individual attention until the crisis is resolved. At such a time, they can be re-evaluated for their appropriateness to join a group.

Substance use itself does not signal that a client should be excluded; however, the client's use should be explored further. Substance dependence is considered an exclusion criterion. Substance abusers may be appropriate in a FBGT provided they do not attend group intoxicated and are able to internalize feedback they receive. There is evidence to suggest that substance abuse is related to attachment styles and can be linked to interpersonal deficits (Flores, 2004). Therefore, an individual with substance abuse problems may in fact benefit greatly from an interpersonal-process type group. It becomes an issue of clinical judgment whether a particular client is appropriate for the FBGT group or not. If the AOD issue is current, severe, and may impact group functioning and/or the client's ability to benefit from group they should not be referred to group therapy. Additionally, the client should not use this group to deal with addiction issues. If currently addicted or even early in stages of recovery, it is not advised to place the client in a FBGT.

Family roles. While it may be less of a concern during the screening, group leaders should pay attention to questions related to the client's role within their family. With the view that group is a recapitalization of the primary family unit, with group leaders serving as the parent(s) (Yalom, 1995), these questions can be predictive of the role the client will assume within group and the relationship they will form with each respective group leader.

Using the IIP-32 in Screening. Within FBGT, the IIP-32 is used to predict how a client will interact with group leaders and within the group. It is expected that in group,

clients with interact with others as they do in their normal lives. Dominant individuals will compete for dominance and submissive people will tend to allow others to speak, while they remain quiet. Friendly individuals will attempt to promote peace and avoid conflict, while hostile individuals may intentionally try to provoke conflict (Carson, 1969; Horowitz & Strack, 2011). FBGT promotes creating groups that are balanced in regards to interpersonal style; however, recognizing the realistic applications of the treatment, the group can be run with any combination of interpersonal styles (Yalom, 1995). Awareness by the group leaders of how members are likely to interact with one another and the leaders is essential.

Results of the IIP-32 should be shared with the client during the screening session. It is not recommended to use the names associated with the scales as they may be found to be pejorative. Maintaining the therapeutic alliance, remaining culturally sensitive, and keeping with a strength-based approach, requires clinicians to be mindful of these elements when using the IIP-32. Binder and Strupp (1997) discuss the importance of maintaining the therapeutic alliance and feminist theories suggest avoiding pathologizing language (Brown, 2010). It is therefore critical to find an affirming way of discussing IIP-32 results. A good way to go about the discussion is talking about finding balance on each axis (i.e., Dominance-Submission, Self-Centered-Overly-Accommodating, Cold/Distant-Self-Sacrificing, Social Inhibition-Intrusive/Needy) and that on either extreme end, there is potential for problems. Dominance and Submission can be discussed in terms of power in relationships with others. Self-Centered and Overly-Accommodating can be described as where the individual places priority—the self versus others' needs. Cold/Distant and Self-Sacrificing can usually be described as

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the "Affiliation" axis, that is, if a person is warm or cold towards others. Social-Inhibition and Intrusive/Needy can be described as if the client goes towards others or tends to pull away. Clients often show an interest in the results and relate to what the scores say about their interpersonal style. This lends itself into then forming interpersonal goals based on the behaviors that appear to be distressing them the most (see section on Goals).

The results of the IIP-32 should be viewed through a multi-cultural lens. It is important to discuss how the client's culture may be affecting the results of the assessment. The therapist should ask if the distress occurs within their own family or culture, when interacting with the dominant culture, or across situations and cultures. Issues of acculturation may affect interpersonal relationships and FBGT can serve as an appropriate form of treatment if the client is seeking to enhance their relationship skills within the dominant culture. For example, a client from a Latin background may score high on Scale 8 (Intrusive/Needy). The behaviors associated with this scale may be socially appropriate within their own family and culture; however, it may be causing distress as they interact with the dominant culture. For this client, FBGT may be an opportunity to increase his/her interpersonal flexibility so that they may form satisfying relationships within their family and culture as well as those from other cultural backgrounds.

Inoculation

Some group members will unintentionally sabotage the group and themselves before the group has a chance to fully form. For example, at one Midwestern counseling center, a group collapsed quickly due to an inappropriate personal disclosure by a new

member during her first session in the group. The group was never given the opportunity to build cohesiveness and safety prior to the self-disclosure and never recovered. For this reason, inoculation is used before group begins. Inoculation is considered a preventive intervention, whereby the therapist recognizes a pattern of behavior of the client that could negatively affect the client and/or the group and sets an initial goal for the client to experiment with a different way of interacting with others when they start the group.

The IIP-32 can help bring attention to the potential for behaviors that may negatively affect the client's experience within group or prevent them from reaching their goals. Identifying how the problem is affecting their relationships and subsequently increasing their presenting problem (i.e., depression, anxiety, etc.) increases the client's self-awareness and can deepen the therapeutic alliance. If the interpersonal behavior has potential to be group destroying or self-sabotaging, an early intervention within the screening session itself may help the client from the start attempt new behaviors within the group, which may lead to the type of interpersonal changes expected from a process type group. Whittingham (2011) has named this "inoculation". It is important that inoculation is not shaming or degrading for the client.

An example of this process can be seen with a client who scores high (above T=70) on Scale 8 (Intrusive/Needy). This individual likely reveals personal information inappropriately, or seeks personal information about others too early in a relationship. If this client enters a group without being inoculated, they can cause a group to fracture as early as the first meeting as they can scare off the more submissive clients within the group. To begin the inoculation process with this client, ask them to describe the relationships they have with others. Tentatively ask if they find that their relationships

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typically, "crash and burn," that is, they feel close to someone quickly, but that person

inevitably lets them down and the relationship ends. Usually this individual will share

that they do share with others very quickly and then feel hurt when the other person either

proves untrustworthy or after being overwhelmed by the client, tend to ignore or reject

them. The client is then asked how they think that could play out within the group itself,

which allows them to begin seeing how their behaviors may affect future relationships

they will be asked to form within the group. Inoculation with this client can often lead

into an initial goal to prevent their maladaptive interpersonal behavior from negatively

affecting the group and the individual. For this client, the inoculation goal may be to

match the level of self-disclosure to that of other group members for the first two

sessions. This allows the client the experience of getting to know others without

revealing or seeking personal information too early in a relationship.

Making an Interpersonal Diagnosis

The interpersonal diagnosis typically is formed based on the results of the

screening assessment measures as well as both the self-report of the client of their

relationship difficulties as well as those behaviors observed by the therapist during the

screening session itself. The interpersonal diagnosis is not considered a formal diagnosis

and the concern is that it makes sense for both the therapist and the client. It can be

helpful to use the IIP-32 in formulating the interpersonal diagnosis, using the eight scales

of the IIP-32 to identify the area of interpersonal distress for each client (Please note that

clients can be high on multiple scales and high scores on the same scale can present

differently between individuals).

An example of this can be seen with a client that scores high on Scales 5 (Non-assertive), 6 (Overly Accommodating), and 7 (Self-sacrificing). It is likely that this client will defer to the therapist and quickly agree to suggestions made by the therapist. Therefore, it is even more critical to ask open-ended questions and to allow this client the opportunity to describe their prior relationship difficulties and collaborate on the goal formation. Share with the client the results of the IIP-32 and ask them first if the results are consistent with their view of themselves. It is important to ask how these areas of distress may be affecting their current relationships as well as how past and potential future relationships may be impacted. It is common for this client to feel they give more than they receive in relationships, feel taken advantage of or unheard, or that they are not worth as much as others. Explore with this client the impact this may have on them within the group and how they will interact with other group members. The goal is then developed to address the agreed upon greatest area of interpersonal distress.

Goals

Goals are a critical aspect of FBGT and repeatedly emphasized throughout treatment. The treatment itself requires clients to create a specific goal with their therapist that they will track and follow at every session. The four tenets of goals within FBGT are that they are (a) achievable; (b) time-limited; (c) measurable; (d) can be accomplished in the here-and-now. Achievable and time-limited require that the goal be something that the client can realistically achieve in the limited time inherent in the brief treatment. Measurable ensures that at the end of every session and at the de-briefing session, the client can clearly see whether the goals of the session and treatment have been accomplished. Here-and-now requires that the goal be something that can be

accomplished within the group, in the present moment. The goal should make sense to the client and be something they feel reasonably confident they can accomplish. If the client has been in group before, it is appropriate for the client to try a goal that may be more challenging. Possible goals for the client described in the section above (High scores on Scales 4, 5, and 6) may be:

- Ask for time twice over the course of group to discuss a problem the client is having.
- Provide constructive feedback to other members four times over the course of group.
- Disagree with another group member or leader once during group.

Often the goal(s) listed on the GTQ can be used to start the discussion (e.g., "I'd like to have more friends"). It is important for their goal(s) to be translated to fit the four tenets of goals and that the client can see the clear link between how the goal set for them fits with the problem they are trying to address by joining the group. For example, if the client with high scores on Scales 5, 6, and 7 states that they wish to have more friends, it is important to explore with the client what they believe is affecting their ability to form the quantity and quality of friendships they would like. If the client expresses feeling taken advantage of or taken for granted by friends, the first goal listed above may be appropriate in order to give the client the experience of prioritizing their needs in social relationships. This can lead to an increase in self-worth as their problems are worth the time of the group and they can experience what is like to have their needs met by others. Suggested goals based on high scores on the IIP-32 Scales can be found in the IIP-32 Quick Reference Guide (Appendix B).

Use of Handouts

Clients are presented with a lot of information during a screening session. It is recommended that a handout is reviewed in session with the client and given to them to review once again before the first meeting of the group. Suggestions are provided in the CORE-R Battery (Burlingame et al., 2006) as well as the Appendix of this manual (Appendix C).

Chapter 4: Beginning Stages

(Session 1, 2, 3)

FBGT follows the research suggesting that groups benefit most from being structured in the early and later stages of group, while allowing for more flexibility and an unstructured format for the middle stages (Johnson, 2009; Piper & Ogrodniczuk, 2004). FBGT was developed with an 8 session limit (as permitted by the quarter system of the university). Group treatment will be discussed by stages (beginning, middle, and ending) and by specific group session numbers.

Due to the limited nature of a brief treatment, at every session, clients should be reminded exactly how many sessions remain. In some respects, this creates an atmosphere that there is no time to waste. Clients are continually encouraged that with limited sessions, the time to work on their goals is here, today. The focus on goals is also seen with a check-in and check-out completed at every session. This follows the logic of group treatment as a whole, following a similar format of having more structure at beginning and ending of each session, with the middle part of the session left open for processing in the here-and-now.

Initial Meeting

The initial meeting is often filled with anxiety as group members experience group therapy and one another for the first time. The goal of this session should be to build group cohesion and create a sense of safety within the group as well as to build on the earlier instillation of hope in the treatment. If there are "veterans" within the group, they can often be used to normalize the anxiety and instill the hope for progress. Often, the anxiety felt by the majority of members can be the first step towards building

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connections and cohesion as every member can share their anxiety and fears openly and feel the validation of others sharing their same feelings and concerns. A worksheet is available to help guide the first session (Appendix D).

Beginning sessions. Each group begins and ends with a check-in and check-out. It is thought that the check-ins/outs bring structure to the beginning and end of each session that helps ease clients into and out of the group session. FBGT includes three items in the check-ins/outs. The first and second being a mood and energy check. This forces clients to focus their awareness inwardly in the moment. It also allows the leaders to assess where the group is for that particular day. The third item of the check-in is to have the client share what their goal for that particular day will be.

For the first session, before a formalized goal is set (Session 2), the check-in is introduced with some modification. Rather than sharing a goal for the day, clients are asked to share what their initial reaction was when first introduced to the idea of joining the group and veterans are additionally asked to share what their general experience of group has been in the past. This serves two purposes. The first is building connections between clients who are likely to have shared similar reactions as well as instilling hope based on the veterans' feedback.

Introductions. After check-in has been introduced to the group, an introduction activity should be used to "break the ice" (Appendix E). The simplest method is to break the group into dyads and have them interview one another. They then can come back to the larger group and introduce their partners. Another example is a "Speed Friending" activity that can also help to increase the energy of the group if during the check-in the overall energy level is assessed as low. With "Speed Friending", each member has a

chance to talk briefly (3minutes) with each of the other members. Afterwards, the group

is asked to process what the experience was like and something of note they remembered

about other members. Group members should be advised before the activity to keep it

"light" and not to discuss anything too personal. It can be helpful to provide examples of

"light" subjects (i.e., pets, siblings, major, hobbies/activities, favorites books/TV

shows/movies). Leaders should be prepared to block and protect against inappropriate

disclosures if necessary. When blocking, be sure to do so in a gentle, non-shaming way.

For example, "I can see that this is something that means a great deal to you and I

appreciate your openness and willingness to trust the group. If it would be alright with

you, I think we should save this for another session when we will have adequate time to

address your needs."

The introduction activity is also a time to be building connections and cohesion

within the group. Most clients will find something they have in common with one or

more other members. Using the processing time to discuss what the activity was like to

complete as well sharing what they remember can foster connectedness as well. Often

members will feel validated that others were listening and attending to what they shared

enough to remember. They will often be surprised by what someone else is able to relate

and connect with. The activity should take up much of the first session and by its end,

members should feel more at ease with one another. This is intended to build upon

Yalom's (2005) therapeutic factor of cohesiveness.

Rules of group. This is the point of the initial meeting that is necessary to have

but can often lead to clients disengaging and tuning out. It is recommended that this is

kept as short as possible and rely on the screening and handout provided to go over most

of the group rules. Be sure to discuss policies regarding attendance, tardiness, out of group contact, confidentiality, etc. Emphasize the importance of the group rules but it is recommended that they should be covered quickly.

Ending session. Check-out includes the mood and energy check and a reflection on whether the goal set during check-in was accomplished or not. Note any changes individuals may have experienced in mood and energy and process if appropriate. If the client has accomplished their goal for the day, positive feedback should be provided. If they did not, this provides a time to process what stopped them from completing their goal and brainstorming what the group as a whole can do the following week to support the client in reaching their goal. During the check-out of the first session, group members should be asked to spend time over the next week thinking about what they would like to have as their goal for the remainder of the group as Session 2 (and 3) is when the goals will be formalized.

Session 2 (and 3)

The remainder of the sessions in the early stage of treatment should focus on fostering cohesiveness and socializing the group in the here-and-now and in giving and receiving feedback. A Session 2 Worksheet is available in Appendix F to guide the session.

Beginning and ending of group session. The standard mood/energy/goal check-in/out should be completed with one minor modification. The members should be asked to share the initial goal that they were asked to think about over the previous week. They should be reminded that it does not have to be fully formed as session 2 is dedicated to solidifying the goal for each member.

Positive feedback activity. In an effort to continue to emphasize connections and cohesion within the group, a positive feedback activity should be included in both sessions two and three (Appendix G). The group leader should keep this simple, as goals should take up the majority of session two. Simply asking the members to provide positive feedback (i.e., positive first impression or something they were able to connect with the person about from the first session) to the person to their left (or right) will suffice. Time should be allowed to process as appropriate if a significant moment occurs between group members. For example, a client may share that they felt isolated in their problems but were able to form a connection to another group member who shared a similar feeling. Asking the clients how they felt giving and receiving the feedback as well as asking other group members their experience of the exchange can be a powerful introduction to feedback loops and here-and-now processing. The feedback loop will act as a reinforcer of the behavior (Yalom, 2005) and will encourage more here-and-now processing. At the end of the activity, process with the group what it was like to both provide and receive positive feedback. Continually use this time to further build the links between group members. Within this activity, the goals of the therapist should be to begin to socialize the group into the here-and-now, introduce feedback loops, and foster positive and warm feelings in the group members towards one another and the group as a whole (group cohesion).

Linking through focused goals. Piper & Ogrodniczuk (2004) recommend group leaders keep the group goal-focused; therefore, goals are repeatedly emphasized in FBGT (e.g., note cards, reminders, check in/out, emphasizing the time-limited nature of the group and the need to work quickly). Preliminary goals should be established with group

members during the screening and it is often helpful to provide clients with a notecard

with the initial goal during Session 2 as a reminder to keep them focused on the goal.

Group leaders should be highly directive in assisting members to share briefly what led

them to join group and what they hope to get from the experience. Clients should read

their goal to the group from their note card and share the background and history as to

why this is their goal. Extensive time should be spent with each member in Session 2

(and 3 if time requires). An example of introducing goal setting:

> "We have provided you each with a note card of the goal you set during your
>
> screening. We ask you to share that goal with the group and speak briefly about
>
> what led you to join group and what you would like to gain from the experience.
>
> This should include how you think this goal fits with this. Who would like to go
>
> first?"

This process is additionally used to continue to build the connections and links

between group members. Linking early in group builds the cohesiveness necessary to get

the group working (Morran, Stockton, & Whittingham, 2004). As each member takes

their turn defining their goal, other members should be brought into the experience. This

can occur in several ways. The first being when two group members have similar

experiences/problems, and subsequently, similar goals. This taps into Yalom's (2005)

therapeutic factor of universality. The group members should be encouraged to share the

connections they feel with other members at these times. Group leaders can encourage

this by saying:

- "Many of you may share similar problems and goals. If something someone is saying is resonating with you, please give that person the feedback in the moment."
- "Is anyone connecting with what [Insert client name] has said?"

The second way linking occurs during goal setting is when group members have what can be described as "opposite" experiences/problems, and subsequently, complementary goals. This may be thought of as the "shadow" described by Jung (1951). The shadow represents our weaknesses or part(s) of the self that are underdeveloped. By linking group members with opposite problems, the client is given a physical role model for the behaviors they are seeking to develop.

For example, a client with a high score on Scale 2 (Vindictive/Self-centered) on the IIP-32 may be linked with a client with a high score on Scale 6 (Overly-accommodating). The 2 client may fear that by caring for others they will not have their needs met while the 6 client fears that if they do not put others first, no one will care for them. The goal of linking the goals of these two members, who represent one another's shadow self, is to pull their interpersonal styles towards one another, creating balance between the priority placed on self versus other. Setting the 2's goal to ask for feedback once per session on whether they are taking up too much time within the group may be linked to the goal of the 6 client to provide direct, honest, constructive feedback to another group member once per session. The Scale 2 individual will increase their understanding of how their tendency towards self-centeredness affects others and subsequently their ability to maintain relationships with others, while the Scale 6 individual will experience asserting themselves and that this can be valued and actually

bring one closer in a relationship as a result. The two members will learn how to

recognize and appreciate their opposite in the form of the other group member, which in

turn breaks down their rigid schemas (i.e., if I assert myself, no one will like me). By

linking in this manner, these two group members find a productive way of connecting to

one another when they may otherwise have struggled to fine that connection.

Assessment. Process measures should be introduced in Session 2. The frequency

in which the WAI and the GCQ is administered is flexible; however, within an 8 session

group, it is recommended to administer at Sessions 2, 5, and 8. During Session 2, a

baseline is established for the group as a whole and on the individual level. It can be

helpful to make an Excel worksheet to track the data over the course of the group.

Giving the measures early on can also help identify if the group as a whole or individuals

are struggling to connect with the group and/or group leaders and allows for an early

intervention on a group-as-a-whole or individual level as appropriate. It is recommended

to use clinical judgment to decide if an intervention is necessary and what type to use.

The WAI specifically measures the Bond the member feels to the leaders as well

as Task and Goal agreement. For Session 2 specifically, this can be very important as the

goals and tasks of therapy are established more firmly in this session. If a client scores

low (Global Score less than 5), it is recommended that this be addressed as early as

possible in order for the client to reach the maximum benefit of attending group. It

should be noted that group member's perceptions of group leaders might differ based on

interpersonal styles (Kivlighan, Marsh-Angelone, & Angelone, 1994). In this manner,

using the WAI throughout treatment allows for tracking if there are sudden changes for

an individual. This may indicate that a critical incident occurred within group for that

individual that the therapist may have been unaware of. Any significant change in scores should be explored further with the client, privately if necessary, in order to maintain a strong working alliance with group leaders.

The GCQ should be used again similarly to the WAI in that it can be used to track group as a whole climate but also individual changes that may signal a problem. It should be noted that items on the GCQ ask members to score based on how they perceive the group and not how they personally feel towards the group. Like the WAI, personality differences may account for variation between individuals (i.e., a submissive client may be more sensitive to conflict and rate it higher than a more dominant group member).

The results of the GCQ can also be brought back to the group if there are interesting results. For example, if there is a trend to rate Avoidance within the group high, it may be interesting to bring this back to the group to process what that Avoidance may be about. It is likely that when Avoidance is high, Conflict ratings will be low. Often conflict avoidant groups will occur if a norm has been established within the group that there must be harmony. This measure in particular can help introduce the idea of conflict and how it can be beneficial within a group and process group members' feelings towards that.

Chapter 5: Middle Stages

(Session 4, 5, 6)

By Session 4, group members should have a well-defined goal, feel bonded to the group, and begin to understand the process of feedback loops and here-and-now processing. This phase of group is primarily focused on meeting the goals of the members, which requires the introduction of constructive feedback. The middle stage is when the group should begin working on its own if it has been set up correctly, which is why it is called the "performing stage" in the literature (Tuckman, 1965). Check-in/outs should continue weekly, as should the reminder of how many weeks are left of the group. Goals should continually be emphasized, especially with those who may have not been meeting their goals in earlier sessions. It becomes the therapist's job during this stage to continually encourage feedback loops and here-and-now processing. Generally, sessions are left open for group members to lead the discussions with therapist interventions occurring only when necessary. The WAI and GCQ should be administered in session 5 to assess for possible problems within the group that may require further intervention. A Middle Stage Worksheet can help guide treatment (Appendix H).

Constructive Feedback

The one critical element that is to be introduced at this stage of the group is constructive feedback. This can be quite difficult for many group members either to give, receive, or both. Often the submissive clients struggle with giving the feedback and the dominant clients have a harder time receiving it. Constructive feedback should be introduced in Session 4. It can be anticipated that the session will be spent processing feelings towards constructive feedback and do not be discouraged if the group is not yet

ready to give this type of feedback. There can be a great deal of fear associated with

giving (i.e., "people won't like me if I tell them what I really think of them") and

receiving feedback (i.e., confirming their present fears that others judge them harshly).

How to talk about constructive feedback. Use the following or similar phrasing

to introduce constructive feedback:

> "We consider the feedback given to other group members to be a gift. It is
>
> rare in life that we are presented with an honest outsider's impression of
>
> how we come across to others but how invaluable is the awareness gained
>
> from this information? If we can see ourselves through others' eyes, we
>
> may in fact realize we have values and attributes that were previously
>
> unknown to ourselves. Additionally, we may discover that there are parts
>
> of ourselves, behaviors that we have, that are keeping us apart from others.
>
> It may be scary at first but it is not the thing to be feared, but to be desired.
>
> Desired for its innate ability to help us understand ourselves, how we
>
> affect others, and how that in turns affects the type and quality of
>
> relationships we are able to form."

Constructive feedback should always be given in conjunction with positive

feedback, in order for it to be best heard and assimilated by the receiver (Morran,

Stockton, Cline, & Teed, 1998). Group members will have to be taught how to do this

and group leaders can demonstrate as needed. It is important for feedback to be

behaviorally based, verses characterological or personality attacks. Feedback loops

become ingrained in this process and both giver, receiver, and witnesses of feedback can

process how it looked and felt to give, receive, or witness the feedback that was being

given. This in turn acts as a reinforcer.

Chapter 6: Ending Stages

(Session 7, 8)

As the group comes to a close, group leaders should be prepared to take a more directive role than they have the past few weeks to bring structure to the end of treatment (Johnson, 2009; Piper & Ogrodniczuk, 2004).

Session 7

In Session 7, leaders should ask group members to begin thinking about whether they plan to continue with group for another quarter (or semester) or if they feel they have gotten what they needed from the group experience (or if logistical constraints bar their continuing). Some members will know right away their plans, others may still not know by the time they enter a debriefing session.

The session should remain open for working on goals. During check-in, members should be asked to reflect on their goal and whether or not they have felt they have met that goal. If not, some time should be spent in Session 7 processing what has kept them from reaching their goal and if appropriate, help the client to reach their goal within Session 7. Members should be informed that the final session will consist of an activity that will take up most of the session and so this session will be their last chance to reach their goal. The IIP-32 should be given at the conclusion of this session. The final IIP-32 will be used as an outcome measure and should be shared with the client during the debriefing session.

The Final Session

The final session is a time to celebrate group member's accomplishments and to say goodbye in a way that will feel good for everybody. Most of the session will be spent

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in a closure activity but there should be time allotted at the beginning of the session to allow members to process what being in the group has meant for them, what they have gained, and what they hope to continue to work on as they move forward. Remember to administer the WAI and GCQ at the conclusion of the last session. A Final Session Worksheet is available in Appendix I to help guide the session.

       Activity. Most of the final session should be spent on a closure activity. An activity that includes feedback that the client may take with them at the conclusion of group is recommended. This can be done in several ways, but the following activity has been found to be quite meaningful for members and can serve as a reminder of the changes group members have made after group has long ended. The full activity can be found in Appendix J.

1. Give each group member, including the leaders, an envelope. Group members should write their name on it, making it their own. Envelopes should then be placed in the center of the circle.

2. Provide group members slips of paper (enough for each other person in the group). Write positive feedback for each member on each slip of paper. This feedback can include positive first impression, attractive qualities, contributions to the group, etc. Members should not sign their names on the feedback due to confidentiality.

3. Place feedback in one another's envelopes to be taken home should they choose.

Once everyone has completed the feedback, the remainder of the session should be spent processing the activity. Some members will not wait to read the feedback and

others will want to take it with them to read later. Both are acceptable and that choice should be processed. Questions to ask:

- What does it mean for you to (not) wait to read the feedback?

- How do you feel in the moment reading the positive things other members have to say to you?

- What was it like to write down positive feedback for other members?

- Did anything you write or read surprise you?

- How are you feeling now, having completed this activity?

- Do you feel closer to the group right now, or further apart?

There are of course many questions that can be asked and the group and the discussion that emerges should guide the discussion. Be prepared for a wide range of reactions, as different interpersonal styles tend to react different to this activity and saying goodbye in general.

Check-out. Check-out is done differently in this final session. Group members should still reflect on their mood and energy; however, when speaking of their goal, they should reflect on how they feel they did over the course of group and how they plan to proceed having completed the group. Frequently, members will reflect on how they will use the skills learned within the group in their outside lives. It is important during this session for clients to begin thinking about how to use skills and knowledge learned in group in their outside lives in order to reinforce the changes they have made. Group members should be encouraged to view group as only the beginning and that they can use the time they have spent in group as a jumping off point to making lasting changes in how they relate to others.

Chapter 7: Debriefing

The debriefing, like the screening session, is considered the "bookend of treatment". This is the time for group members to meet individually with group leaders to reflect on the process of being in group, what they have learned, and how they plan to move forward with their lives. This is considered a critical point of treatment as it can help members recognize just how much they did accomplish in a short period and understand how they can continue that growth on their own. There are several key points that should be covered within the debriefing. It should also be noted that there are some differences for the client who wishes to continue in group versus the client who has chosen to end group treatment after the debriefing appointment. A Debriefing Worksheet is available in Appendix K to help guide the debriefing session.

Triangulation of Data

Triangulation of data is the process of combining assessment data, client self-report, and therapist observation to understand the client's progress at the close of group. Triangulating the data provides the clinician multiple data points and perspectives to evaluate the client's progress within group. Before the debriefing, group leaders should review the outcome measures (i.e., IIP-32 and CCAPS). Assessment provides invaluable data, however, it is important to view the results through the lens of the therapist's observations and the client themselves. Therefore, during the debriefing, it is recommended to share the results with the clients in order to make the most sense of changes made over the course of group. This process is considered collaborative with the client. Assessment results, clinical judgment, and client feedback often agree; however, at times data may appear contradictory.

If a discrepancy is present, it should be discussed with the client. Confounding issues (i.e., recent crisis) or issues unrelated to what occurred in group (i.e., events that occurred outside of group) may be the cause of assessment results being inconsistent with the client and therapist report. It is also possible that assessments were completed incorrectly. It is key to discuss with the client the results and if they are consistent with their self-view. It is possible that the deeply rooted interpersonal changes that result from attending an interpersonal process group may take longer to appear on objective measures of more stable traits. For this reason, clinical judgment and the client's self-report are equally as important in assessing changes and progress made from group.

Goal Reflection

A critical aspect of the debriefing is for the client to reflect on the process of being in the group and the progress they feel they have made towards their initial goals. Use open-ended questions to allow the client to reflect on the experience. Surprises from group, challenges/obstacles, what the client enjoyed the most should also be explored. How goal completion and future goals is discussed will depend on whether the individual plans to continue with group further or end with the debriefing.

Clients continuing with group. For clients continuing with group, the debriefing becomes a mix of debriefing and reintegrates some aspects of the initial screening session. Specifically, a new goal for the next group should be explored and defined. The client should be encouraged to challenge and push him or herself further than they had in their initial experience. Part of being a returning "veteran" of group is that in some respects it carries more responsibility. A veteran knows how to be a group member, and becomes a role model in some respects. This new role should be processed with the

client with them reflecting on how this new role may shape their future goals and role within the group. Very often, veterans feel proud of themselves in this new role and gain a deeper awareness of their changes when new members enter a group that remind them of themselves at their initial group meeting. The veteran is expected to create a more challenging goal for himself or herself as well as to be the voice of encouragement for new members.

Clients ending group. For the client ending group, the debriefing is the last time they will meet with the group leaders. It will be important to cover most of the same things as with those clients re-joining a group with one main exception. A greater emphasis should be spent on translating the work within group into external experiences. The leaders should ask how, if any, the client has made changes in their outside lives and process how that has been for them and their relationships. If they have yet to begin these changes, it is recommended to process what has held them back so far and what will help them to enact changes made within group outside of group. It is possible that the client will need to brainstorm within the debriefing ways in which they can start to make changes in their normal daily lives. The client should be given plenty of positive feedback regarding their progress within group and their contribution to the group itself. Group again should be described as merely a starting point and group leaders should empower the client to continue on the path they have started and reminded that they can always return to group later if they need a "refresher".

Appendix A

Group Screening Worksheet

Overall Goals:
Create Working Alliance
Generate a goal
Instill hope

Before Session Begins:
___Review information provided by referral source (i.e. intake, referral forms, etc.)
___Score and review IIP-32 and GTQ-S
___Generate hypothesizes of possible interpersonal diagnosis
___Identify possible areas of concern (i.e. dropout potential, low motivation, current crisis, etc.)

Screening Session:
Establish Working Alliance:
___Warmth and Empathic attunement
___Encourage client to ask questions and address concerns and/or fears
___Validate and Normalize feelings of apprehension, nervousness, anxiety
___Connect presenting problems with Interpersonal Distress/Issues
___Connect Interpersonal Distress/Issues to a Goal
___Connect Goal to specific tasks of group

Pre-group preparation:
___Ensure day/time of group will work
___Discuss confidentiality in group setting
___Introduce concepts: Here-and-now and Feedback
___Discuss risks and benefits of experimenting with new behaviors in group
___Emphasize importance of Being Genuine
___Discuss the role of Conflict in group and ensure Safety
___Address any areas of concern for client or therapist
___Provide client with the Group Handout

Brief Interpersonal Interview:
___Past and current Family Relationships
___Past and current Friendships
___Past and current Romantic History
___Past and current Relationships with Peers, Coworkers, Authority Figures
___Discuss strengths and areas to improve within each of these areas

Review of Assessments with the client:
___Share results of IIP-32 with client and check for consistency with client subjective experience
___Inoculation (if necessary)

Goal Setting:
___Behaviorally focused
___Measurable
___Achievable
___Time-limited
___Here-and-now

Screening Assessment Review

*Use the IIP-32 Quick Reference Guide to fill in the sections below based on the group members highest score(s).

Highlight Potential Strengths:
1)_____
2)_____
3)_____
4)_____

Potential Presenting Problems:
1)_____
2)_____
3)_____
4)_____

Predict Potential Group Problems:
1)_____
2)_____
3)_____
4)_____

Potential Goals (Inoculation?):
1)_____
2)_____
3)_____
4)_____

IIP-32 Quick Reference Guide
*Use with the Screening Session Worksheet

Scale 1: Domineering/Controlling

Problems related to controlling, manipulating, exhibiting aggression toward, and trying to change others.

Potential Strengths:
- Leadership abilities
- Assertiveness (Role Model for "The 5")

Potential Presenting Problem:
- Problems with authority figures
- Overly-aggressive
- Controlling

Potential Group Problems:
- May battle others (including group leaders) for dominance
- Potential to try to control and manipulate others in the group

Potential Goals:
- Provide positive feedback to other group members twice per session.
- After giving feedback to another group member, ask for feedback on how it was received once per session.

Scale 2: Vindictive/Self-Centered

Problems related to distrusting and being suspicious of others, being unable to care about other's needs and happiness, and perhaps being vindictive.

Potential Strengths:
- Self-care (Role-model for "The 6")
- Independent

Potential Presenting Problem:
- Lack of intimate relationships
- Problems with trusting others
- Often fights with others

Potential Group Problems:
- Taking up disproportionately more group time than others
- Distrusting of group leaders and other members
- May struggle to be supportive of other's goals
- May lash out at other group members if an attack is perceived

Potential Goals:
- Ask for feedback once per session on whether the group member is taking up too much time within the group.
- Provide positive feedback on other's growth once per session.

<u>**Scale 3: Cold/Distant**</u>
Problems related to being unable to express affection toward or to show love for another person, leading sometimes to an appearance of being cold.

Potential Strengths:
- Objective
- Independent

Potential Presenting Problem:
- Difficulty showing affection to others
- Lack of social relationships

Potential Group Problems:
- May struggle to bond with group members and leaders
- May be overly critical of others

Potential Goals:
- Provide positive feedback to another group member once per session.
- Share a personal struggle with the group once over the course of the group and ask for feedback on how others experience you at this time.
- Ask follow up questions to something another group member said three times over the course of the group.

<u>**Scale 4: Socially Inhibited**</u>
Problems related to feeling anxious or embarrassed in the presence of others and experiencing difficulty in getting into social interactions, expressing feelings, and socializing with others.

Potential Strengths:
- Introspective
- Independent

Potential Presenting Problem:
- Socially Anxious
- Socially Avoidant
- Lack intimate relationships and social support
- Lonely and isolated

Potential Group Problems:
- May struggle to initiate connections with other members
- May struggle sharing feelings or personal information

Potential Goals:
- To initiate a conversation in the group at least twice during the next eight sessions.
- Make eye contact with another group member while giving or receiving feedback twice per session.

<div align="center">**Scale 5: Non-assertive**</div>

Problems related to experiencing difficulty in making personal needs known to others, experiencing discomfort in authoritarian roles, and being unable to be firm with and assertive towards others.

Potential Strengths:
- Team-player
- Role model less dominant for "The 1"

Potential Presenting Problem:
- Overly submissive/lack of assertiveness
- Lack of confidence
- Dissatisfied with interpersonal relationships

Potential Group Problems:
- May struggle to use group time
- May struggle with providing constructive feedback to others

Potential Goals:
- Provide constructive feedback to another group member three times over the course of group and ask for feedback on how perceived after doing so.
- Ask for time to discuss a problem once over the next eight sessions.

<div align="center">**Scale 6: Overly Accommodating**</div>

Problems related to experiencing difficulty in feeling anger and expressing anger for fear of offending others and being gullible and easily taken advantage of by others.

Potential Strengths:
- Gets along with others
- Role model warmth for "The 4" and less dominant for "The 8"

Potential Presenting Problem:
- Difficulty saying "no" to others
- Difficulty asserting oneself
- Easily taken advantage of

Potential Group Problems:
- May dismiss personal problems or see them as "less important" than those of other group members
- Likely to subvert their needs to others in the group
- May struggle giving constructive feedback or challenging others
- May agree to a goal that is not right for them

Potential Goals:
- Provide direct, honest, constructive feedback to another group member once per session and ask for feedback on how perceived doing so.
- Ask for 10 minutes of time during 3 sessions to discuss a problem over the next eight sessions.

Scale 7: Self-sacrificing

Problems related to trying too hard to please others and being too generous, agreeable, trusting, caring, or permissive in dealing with others and avoiding conflict.

Potential Strengths:
- Warm, caring, and sympathetic of other group members
- Role model warmth for "The 4" and less dominant for "The 8"

Potential Presenting Problem:
- Putting others before themself
- Overly trusting
- Repressed anger

Potential Group Problems:
- May dismiss personal problems or see them as "less important" than those of other group members; Likely to subvert their needs to others in the group
- Unlikely to voice disagreement or anger with group members and leaders

Potential Goals:
- Ask for time to discuss a problem once over the next eight sessions and ask for feedback regarding how you are perceived when asserting your need.
- After providing feedback to another group member, ask for feedback on whether the feedback was constructive or supportive in nature.

Scale 8: Intrusive/Needy

Problems related to being overly self-disclosing and attention seeking and experiencing difficulty in spending time alone.

Potential Strengths:
- Can invigorate group; potential to become a leader of the group
- Positive role modeling for "The 4/5/6"
- Group members will often bond more easily to this type

Potential Presenting Problem:
- Self-disclose too early in relationships
- Overly demanding of others
- Intrusive into other's lives
- Need for control in relationships

Potential Group Problems:
- May battle for dominance
- May disclose deeply personal information very early in the group
- May be overly intrusive of others too soon

Potential Goals:
- ∗ Inoculation: For the first two sessions, match the amount of personal information shared to other group members.
- Provide feedback in the here-and-now to other group members twice per session and ask for feedback on how other members experience you in those moments.
- Ask for feedback once per session regarding the amount of time you used in the session.

Appendix C

Group Screening Handout
Welcome to Group!

Facilitators: _____   **Day/time:** _____

Group Member Roles
Many people are apprehensive about joining a group and experience some anxiety about doing so. It is common for people to worry that they will talk too much or not say enough; or that others will not accept them in the group. Some people are also concerned that the group will not help them. Here are some things that you can do to maximize the chances that group will be a meaningful and healing experience for you:

- **Attendance & Presence:** It is very important that you are able to be here every week. Understand that your presence in the group is essential for you, for the other members who depend on you for support and feedback, and for the cohesiveness of the group as a whole. It is likely to disappoint and discourage other members if you are absent. Facilitators may inquire about group members' feelings about your absence or lateness. If you must miss a meeting, inform the group the previous week. If you must cancel due to illness or an emergency, please call one of the group facilitators at _____, before the session begins. The group will begin and end on time.
- Being as **genuine** as you can be will allow others to help you more directly.
- **Goals:** Think about what you would like to work on in group and work actively towards change. Ask the group for help.
- **Taking Risks:** Respect your safety needs and don't press yourself to reveal more than you are comfortable revealing. On the other hand, gently challenge yourself to take more risks with self-disclosure so that your other needs are met as well.
- Use group to talk about yourself and your concerns. Many people struggle with whether or not it is OK to **use group time**. They worry that their concerns are not important enough or they believe that others need the time more than they do. Group will be most helpful to you if you can find a way to talk about yourself.
- **Express your thoughts and feelings**. Notice if you are holding back from doing this and talk about your fears of sharing in the group.
- **Experiment with New Behaviors:** "Try on" new behaviors in the group and ask for feedback from others when you do so. Although this means taking risks, it is usually well worth it.
- **Feedback:** Give others feedback. This allows you to practice being direct, honest, and assertive, but it also helps the other members to know how they are perceived. We are here to help each other, not to judge one another.
- **Conflict:** Each group member's perspective is valid and adds to our enriched understanding of relationships. Everyone in the group has the right to speak and to be heard. Disagreement must be expressed respectfully. It is certainly appropriate to express anger, but it must be expressed in a way that does not threaten or intimidate others.

- Be **patient** with yourself and the group. It will take time for you to feel comfortable in group and it will take time for the group to develop trust. You are encouraged to commit to the group for a sufficient amount of time before deciding whether it is the right treatment for you.
- **Time Between Group Sessions:** When you are not in group, think about group and what kinds of reactions you are having. When you return to group the next week, share as many of these thoughts and feelings as you feel comfortable sharing.
- **Do not compare the significance of problems**. No one's struggle is more or less important than anyone else's is.
- **Out of Group Member Contact:** Your experiences in group can help you develop more satisfying relationships outside of the group, but the group is not intended to provide you with social relationships. Social relationships between group members are best avoided while participating in group. They complicate what is discussed in group and can promote the development of subgroups and cliques. In addition, group provides a unique opportunity to discuss topics that you might avoid in social relationships. Sexual relationships between group members are particularly destructive and are strongly discouraged. We ask you to discuss any outside contact you may have with other group members in the next group meeting, so that every group member is working with the same information and has an equal opportunity to be helpful. In the unlikely event that you discover in your first meeting that you know someone in the group, we will discuss this in group and determine how to proceed.
- Group members agree to not use non-prescribed mind or mood-altering **substances** before group meetings.

Group Facilitators Roles & Expectations

- **Protecting Group Members/Promoting Safety**: As facilitators, we commit to providing support and encouragement of each group member. In this role, we may also step in when conflicts arise.
- **Energizing/Involving Group Members:** Especially in the earlier phases of group, we believe our role includes assisting group members in sharing their stories, getting to know one another, and beginning to take risks in group. As the group progresses, group members often will take more ownership of these processes.

Confidentiality

- We ask that everything that is said in group remain confidential (unless it is about yourself and you choose to share it with someone) and that you agree to not reveal the identity of other group members to anyone outside the group.
- Professional limits to confidentiality

Group Facilitators can be reached by calling _____

(Frick, 2009)

First Session Worksheet

<u>Overall Goals:</u>
Setting structure
Laying down ground rules
Establishing Cohesion
Establish group norms

<u>Check-In</u>
___Remind group that there are 7 sessions remaining after today's meeting
___Mood/Energy/Initial response to joining group

<u>Business items:</u>
___Ensure day/time of group works for all members
___Attendance/tardiness policy
___Confidentiality
___Out of group contact
___Other

<u>Introduction Activity</u>
___Activity
___Process
___Linking

<u>Check-Out</u>
___Mood/Energy/Goal

Appendix E

First Session Activities

"Interviews"
Estimated time to complete: 15minutes + processing time
Materials: Pen/pencils and paper

Directions:
1) Have the group break into pairs (and a group of three if there are an odd number of group members).
2) Ask group members to "interview" one another. Members are asked to stay on "light" subjects (i.e., pets, siblings, major, hobbies/activities, favorites books/TV shows/movies, etc.). They may take notes with pen/pencil and paper if they wish.
3) Halfway through, instruct the pairs to switch if they have not done so already.
4) After 15 minutes, ask that the group return to form a circle.
5) Ask a volunteer to introduce his or her partner and continue until each group member has been introduced.
6) Once all members have been introduced, process as a group how each member experienced the activity. Sample processing questions can be found below.

"Speed Friending"
Estimated time to complete: 15 minutes + processing time
Materials: Stopwatch or watch

Directions:
1) Have group members break into pairs. Let them know they have 3 minutes to get to know one another. They should be instructed to stay on "light subjects" (i.e., pets, siblings, major, hobbies/activities, favorites books/TV shows/movies, etc.).
2) After 3 minutes is up, instruct members to find a new partner. This should be repeated until each group member has had the opportunity to meet with every other member of the group.
3) Have the group reform a circle and process the experience. Sample processing questions can be found below.

Process Questions:
- What was it like doing this activity?
- Was there anything about another group member that caught your attention, surprised you, or made you want to get to know them better?
- Did you find yourself connecting with another group member? Who was that and why?
- Do you feel more or less anxious after getting to know others a bit better?
- How do you feel now, after completing this activity?

Appendix F

Session 2 Worksheet

<u>Overall Goals:</u>
Continue to build cohesion
Introduce feedback
Bring group into here-and-now
Refine goals

<u>Tasks:</u>
___Reminder: 6 sessions remaining after today's meeting
___Check-In: Mood/Energy/Goal
___Positive Feedback Activity
___Goal Setting:
      ___Behaviorally focused
      ___Measurable
      ___Achievable
      ___Time-limited
      ___Here-and-now
___Link group members:
      ___During Activity
      ___Through common or complimentary goals
___Check-Out: Mood/Energy/Goal

<u>Assessment:</u>
___Administer WAI and GCQ

Appendix G

Session 2 & 3 Activity

"Positive Feedback"
Estimated time to complete: 30 minutes

Directions:
1) Group members should be sitting in a circle.
2) Introduce activity by saying, "We will start today by introducing positive feedback. We will ask you to provide positive feedback to the person to your left (or right). This may include a positive first impression, something you were able to connect to with the person from the first session, or something that was memorable about them.
3) Ask a volunteer to begin and continue until each member has both given and received positive feedback.
4) Once finished use the processing questions below to discuss the experience of the activity for group members.

Process Questions:
- How did it feel to give positive feedback to another group member?
- How did it feel to receive positive feedback from another group member?
- Which was easier for you, to give or receive the positive feedback?
- Were you surprised by the feedback you received?

Appendix H

Middle Stage Worksheet

<u>Overall Goals:</u>
Reinforce cohesion
Bring group into here-and-now more purposefully
Address resistance
Keep goal/time focused; Hold "feet to the fire"
Train group in feedback delivery
Invite members to attempt behavioral goals
Model and encourage feedback loops

<u>Tasks:</u>
___Reminder:___# of sessions remain
___Check-In: Mood/Energy/Goal
___Open Discussion
___Check-Out: Mood/Energy/Goal

<u>Assessment (Session 5)</u>
___Administer the WAI and GCQ

Appendix I

Final Session Worksheet

<u>Overall Goals:</u>
Re-establish structure to end
Wrap up any remaining items
Keep group focused on termination
Reflect on goals

<u>Tasks:</u>
___Check-In: Mood/Energy/Goal
___Unfinished business
___Activity
___Future plans
___Thanks
___Check-Out

<u>Assessment</u>
___Administer the WAI and GCQ

Final Session Activity

"Lasting Feedback"
Estimated time to complete: 45 minutes

Materials:
    Envelopes
    Strips of colored paper (approximately 3 by 8.5inches)
    Pens, pencils, or markers
    Clipboards or other hard surface to write on

Directions:
1) The group should be seated in a circle
2) Introduce the activity as a way for the group members and leaders to give a final gift to one another through positive feedback. This gift is something members and leaders can take with them to remind and encourage them to continue to work on the skills learned in group.
3) Ask that all group members and group leaders write their name on the outside of an envelope, making it their own. Then place the envelope in the middle of the circle.
4) Each group member should be given enough strips of paper for each of the other group members (including group leaders). This feedback can include positive first impression, attractive qualities, contributions to the group, etc. Members should not sign their names on the feedback due to confidentiality.
5) Once finished, place the positive feedback into each respective group member's envelope.
6) Once everyone has finished, process with the group the experience of doing the activity. Some members will not wait to read the feedback and others will want to take it with them to read later. Both are acceptable and that choice should be processed. Use the process questions below as appropriate.

Process Questions:
- What does it mean for you to (not) wait to read the feedback?
- How do you feel in the moment reading the positive things other members have to say to you?
- What was it like to write down positive feedback for other members?
- Did anything you write or read surprise you?
- How are you feeling now, having completed this activity?
- Do you feel closer to the group right now, or further apart?

Appendix K

Group Debriefing Worksheet

<u>**Overall Goals:**</u>
Reflect on experience
Goal reflection
Summarize progress
Generalize experience

<u>**Before Session Begins:**</u>
___Triangulation of data
    ___Review outcome data (IIP-32 and CCAPS)
    ___Client report
    ___Therapist observation
    ___Change?

<u>**Debriefing Session:**</u>
___Reflect on Experience of Group
___Reflect on progress made towards the goal
___Summarize progress
___Provide feedback
___Review of Assessments with the client
    ___Share results of IIP-32 with client and check for consistency with client experience
___Generalize skills and experience for use in outside life

Appendix L

Further Reading/Additional Resources

CORE-R Battery
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