Support Act 101: 13
Group Therapy Skills

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Disclaimer

- The information contained in this material can change as we learn more about the brain and the ways it is impacted by the environment, trauma, medications, substances of misuse, and other things.

- The material in this webinar is intended for use by licensed clinicians, or licensed-eligible clinicians receiving clinical supervision.

- Always follow the guidelines of your agency, ethical and legal standards of your certifying Board, evidence-based practice methods; local, state and Federal laws as well as your judgement and commonsense when working with clients.
Questions?

If you have any questions, please do not hesitate to contact me at

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SUPPORT Act Courses

1: Tele-Behavioral Health in the Time of COVID-19 (No longer available—Incorporated into all courses!)
2: Client Engagement
3: Suicide
4: Crisis & De-Escalation
5: Withdrawal Syndromes & Withdrawal Management
6: Trauma-Informed Care
7: Overview of SUD
8: Opioids & Stimulants

9: SUD Treatment Basics
10: Screening & Assessment
11: Co-Occurring Disorders
12: Individual Therapy Skills
13: Group Therapy Skills
14: Addressing SUD Bias & Building Provider empathy
15: SUD & Cultural Humility
Recommendation

I highly recommend you review the following courses prior to this one:

2: Client engagement (which includes Motivational Interviewing)
6: Trauma-Informed Care
9: SUD Treatment Basics
12: Individual Therapy Skills
Program Content

I. Facilitated Groups

II. 12-Step & Related Peer Support Groups

III. Tele-Behavioral Health Basics
Facilitated Groups
“Treatment groups provide a context in which addicted clients can gain support, encouragement, feedback, and confrontation from peers who understand from personal experience how addicted individuals think, feel, and act, including the manipulations, schemes, and diversions that sometimes use to rationalize their substance use and other maladaptive behaviors.”

(Herron & Brennan, 2015, p. 328)
Group therapy can be superior to individual SUD counseling because:

- Peers carry credibility
- Positive peer pressure can be helpful
- The therapist’s role is spread among group members
- More people can be treated simultaneously when compared with individual therapy
- The group support/culture can extend outside of the group meeting
- Group provides a safe environment where participants can practice new social and problem-solving skills with one another
Modes of Group Therapy

Time-limited Groups versus Ongoing Groups

Open Groups versus Closed Groups
Types of Group Therapy (SAMHSA, 2012)

- Psychoeducational Groups
- Skills Development Groups
- Cognitive Behavioral/Problem Solving Groups
- Support Groups
- Process Groups
Psychoeducational Groups
(SAMHSA, 2012)

- “Psychoeducational groups educate clients about [SUD] and related behaviors and consequences” (p. 2-4)
- Usually time-limited, open group format
- “Highly structured and often follow a manual or curriculum. The leader usually takes a very active role in discussions” (p. 2-5)
- Typically used with clients beginning treatment and clients who are in a pre-contemplative or contemplative stage of change
- Can also be used to help families of clients with SUD to understand their loved-one’s illness and how they can be supportive
Skills Development Groups
(SAMHSA, 2012)

- There are similarities with Skills Development groups and Cognitive Behavioral/Problem Solving groups
- These are typically time-limited groups and can be open or closed; they usually are smaller than other groups
- Purpose is to “cultivate skills people need to achieve and maintain [recovery]” (p. 2-6), and this can include skills unrelated to SUD
- Provides a forum for clients to practice their new skills
- Facilitators are encouraged to “hold positive expectations for change and not shame individuals who seem overwhelmed” (p. 2-7)
Cognitive Behavioral/Problem Solving Groups (SAMHSA, 2012)

- Time-limited groups; can be open or closed
- May utilize a treatment manual and/or educational materials
- Goals are made by each member and the focus of the group is on immediate problems
- “[SUD] as a learned behavior that is subject to modifications through various interventions, including identification of conditioned stimuli associated with specific addictive behaviors, avoiding of such stimuli, development of enhanced contingency management strategies, and response desensitization” (p. 2-8)
Support Groups

(SAMHSA, 2012)

- Peer groups have been a part of SUD treatment longer than any other type of group.
- Peers can role-model healthy behaviors and use their personal experiences to help others.
- Often open-ended, and can be open or closed.
- Are usually less-directive than other groups.
Process Groups (SAMHSA, 2012)

- Should only be led by trained professionals
- Can be open-ended or time-limited, open or closed
- Process groups “Delve into major developmental issues, searching for patterns that contribute to [SUD] or interfere with recovery. The group becomes a microcosm of the way groups members relate to people in their lives” (p. 2-12)
- “[Leaders] monitor how group members relate to one another, how each member is functioning psychologically or emotionally, and how the group is functioning” (p. 2-12)
- Leaders must also understand group process and group roles
Tuckman (1965) formulated a working model for group development that had four, and later (1977) five, stages:

- **Forming**: Group members look to the leader for guidance; safety; orientation; leader sets agenda
- **Storming**: Competition for power; conflicts over what power looks like; must move from testing and proving to problem-solving
- **Norming**: Cohesion; community-building; solving problems; shared leadership
- **Performing**: Not reached by all groups; true interdependence among group members
- **Adjourning**: Termination; disengagement from relationships
Some Group Member Roles

- Monopolist
- Help-rejecting complainer
- Silent member
- Rescuer/Helicopter
- Clown
- Bully
- Therapist co-opter
- Professional patient
Group Facilitation

- Role-model respect and appropriate communication
- Clarify communication using “I” statements
- Provide honest praise and validation
- Mediate differences between group members
- Confront inappropriate behaviors if group members do not confront them first
- Identify commonalities to help build cohesion
- Identify differences and learn how to address these differences with respect
Suggested Group Expectations

I recommend having the fewest number of rules possible to facilitate your group

1. Group starts and ends on time: You will not be admitted to group if more than ___ minutes late
2. You are welcome bring non-alcoholic beverages to group, but please no eating in group
3. Confidentiality reigns supreme
4. Allow others to speak: Everyone is entitled to their opinion
5. There is no such thing as a “dumb question”
Handling Intoxicated Group Members

- Be prepared for this, and don’t take it personally
- Recognize how the one person’s slip can trigger thoughts and urges to use among the rest of the group
- Differentiate between a lapse and a full-blown relapse; this could indicate a need for a higher level of care
- See lapses as a learning opportunity for the group member
- Generally, if the person is intoxicated in the group meeting itself, they are asked to leave the meeting (ensure they can get home safely) and meet with the facilitator before returning to group
10 Common Errors Made in Group Treatment by Beginning Counselors

BY GREIF, G.L., AS CITED IN INABA & COHEN, 2014
10 Common Group Treatment Errors

1. Failure to have a realistic view of group treatment
   ▶ Group treatment requires a long-term perspective

2. Self-disclosure issues and the failure to drop the “mask” of professionalism
   ▶ Prepare for this in advance
   ▶ Neither too much disclosure nor too little disclosure is helpful

3. Agency culture issues and personal style

4. Failure to understand the stages of group formation

5. Failure to recognize counter-transference issues
   ▶ Be aware of these feelings and address them in supervision
10 Common Group Treatment Errors

6. Failure to clarify group rules
   ▶ I have few rules, and review them at the beginning of each session

7. Failure to use the entire group effectively by focusing on individual problem-solving
   ▶ Re-direct questions and requests for advice back to the group

8. Failure to plan in advance
   ▶ Have a plan, don’t wing it; but be flexible to respond to needs and issues that members bring to group

9. Failure to integrate new members into the group

10. Failure to understand interactions in the group as a metaphor for drug-related issues occurring in the group member’s family origin
12-Step and Related Peer-Support Groups
AA: Key Concepts

- **Alcoholics Anonymous aka “The Big Book:”** Contains the writings of Bill W. and Dr. Bob (founders of AA) plus the common themes of AA; predominately made up of first-hand accounts of addiction and recovery.

- **Confidentiality = Anonymity (“My name is Paul…”)**

- **By helping someone else, we help ourselves**

- **Higher Power: Anything greater than ourselves**

- **“Just for today”**

- **“A Friend of Bill”**

- **Recovery as a transformational process and whole-life change that is greater than sobriety alone**
AA: The 12 Steps

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

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

- Narcotics Anonymous (formed in 1953)
- Methadone Anonymous
- Pills Anonymous
- Cocaine Anonymous
- Gamblers Anonymous
- Double Trouble Recovery
- Al-Anon

- Ala-teen
- Medication-Assisted Recovery Anonymous
- Sexaholics Anonymous
- Over-eaters Anonymous
- Secular Organizations for Sobriety
- Celebrate Recovery
Strengths of 12-Step Groups

- Creates a community and resources for the client
- Peers give credibility and provide an example that recovery is possible and sustainable
- Groups are free
- Groups are usually offered in a variety of settings and at various times
- Some groups are tailored for specific populations (male-only, female-only, etc.)
- By helping others, client also work in their own recovery
- Most groups encourage members to: “Take what you need and leave the rest!”
Weakness of 12-Step Groups

- Some groups can be dogmatic; with an emphasis on labels and negative self-talk
- Some groups can be dominated by strong members
- Members can be discouraged from treating co-occurring mental illnesses with medication (and/or psychotherapy) or engaging in medication-assisted treatment
- The group setting or existing group members can trigger trauma reactions in clients
- The possibility of predation exists within the groups, especially toward newer members who can be vulnerable
SMART Recovery

- Started in 1994: **Self-Management and Recovery Training**
- Utilizes CBT, REBT and MET to help people change
- Can work as a stand-alone program or in conjunction with other programs
- Group meetings for support combined with individual work
- Based on The 4-Point Program (can be worked in any order):
  1. Building and Maintaining Motivation
  2. Coping with Urges
  3. Managing Thoughts, Feelings and Behaviors
  4. Living a Balanced Life
Tele-Behavioral Health Basics
We first need to admit that most of us do not enjoy “connecting” with clients this way; “I didn’t go to school for this!”

We also need to acknowledge that not all clients have access to technology to participate in tele-behavioral health and so we have to improvise.

Therefore practitioners and clients are using phones, Skype and FaceTime to conduct sessions; and getting creative in other ways.

Clinicians do not have to use HIPAA-compliant video conferencing technology during the current National Emergency; Health & Human Services will waive any penalties for HIPAA violations related to the platform used during this emergency.
Tele-Behavioral Health: Clinician

- Have a space set up where you can connect with your client without being disturbed
- Your work-space should provide some privacy for your client
- Internet connectivity and/or phone signal strength should be tested prior to engaging in tele-behavioral health
- If conducting a group therapy session, educate clients on muting themselves unless they are speaking
- I recommend against using your personal phone, but sometimes this cannot be avoided
  - If using a personal device, I would set firm boundaries with clients regarding when they can and cannot contact you
You’ll likely notice that the flow of clinical sessions will be slower than in-person.

Be aware that you will likely need to speak slower than in person.

Try to express empathy with your voice, especially when not connecting via video.
Tele-Behavioral Health: Client

- Try to have a private space where you can connect with your counselor that is also free from interruptions and distractions
- Test out your communications system (connectivity) prior to meeting with your counselor
- Most of us (counselors especially) don’t like meeting this way, so remember this is temporary and we (like you) look forward to meeting face-to-face again
Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

- A statement explaining what tele-behavioral health will look like for you and the client (methods to be utilized: FaceTime, phone, etc.)
- A statement discussing the risks of tele-behavioral health (technology limitations and failures; possible/unintentional breaches of confidentiality)
- A statement agreeing that the sessions will not be recorded by either party
- A statement emphasizing that the content of the session is confidential and that a written release is required from the client to release information
- A statement noting the limits of confidentiality, including having to report suspected child abuse, vulnerable adult abuse, danger to self or others
A statement explaining what steps must be taken should the clinician believe that the client is a danger to themselves, a danger to others or is unable to care for themselves

- This could include a statement that participation in tele-behavioral health may not be appropriate and a higher level of care could be required

A statement describing how you will handle technical problems should they arise

A statement explaining that the client must disclose their physical location during the session and an individual the clinician can contact in case of an emergency

A statement that you are continuing to maintain treatment records during this time
Documentation

- **If you don’t write it down, it never happened**
- Record, in detail, all aspects of client interactions, including any known precipitating events, interventions, outcomes, staff members involved and all contacts with outside agencies
- Record where the client says they are contacting you from
- Do this as quickly as possible following the session
- **Stick to the facts**; do not presuppose or assume anything
- See documentation as a necessary means to protect yourself, the people you serve, and your organization
References
References


