



THEORY AND PRACTICE OF GROUP WORK WITH ADDICTIONS

Melanie M. Iarussi

Group work is one of the most common forms of treatment for addictions and has been deemed clinically effective and cost-effective (Brook, 2015). According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2013 National Survey of Substance Abuse Treatment Services, 94.6% of substance abuse treatment programs reported offering group counseling as a treatment option, and a majority of these programs reported that 76% to 100% of their clientele received group counseling (SAMHSA, 2014). As such, the majority of individuals who participate in addiction treatment will engage in group work.

Group work requires the group leader to apply specific knowledge and skills to facilitate the interdependent group members' progress toward mutual goals (Wilson, Rapin, & Haley-Banez, 2000). Although group work might also include treatment with couples or families (see Chapter 9), this chapter focuses on group work with unrelated persons. In such groups, members have the opportunity to experience mutual support and understanding with others who also have addiction-related issues. In addition to giving and receiving social support, group members' additional therapeutic needs can be addressed, such as raising awareness that a problem exists or learning skills to refuse substances when they are offered (i.e., refusal skills training). This chapter starts with a brief account of the history of group work in addictions treatment and then describes the key concepts and theoretical underpinnings of this treatment modality. Next, how practitioners implement group work is explained, including a brief description of two evidence-based practices applied to group work. The strengths and weaknesses of group work with addictions are then presented, and finally, a case example illustrates how group work can be applied in addictions treatment.

A BRIEF HISTORY OF GROUP WORK IN ADDICTIONS TREATMENT

According to Blume (2002), the use of group work to treat addictions in the United States began in 1908 when group methods were applied by physicians to groups of individuals with alcohol dependence. In 1935, the origination of Alcoholics Anonymous (AA) further connected a group recovery setting with addiction. AA was founded on the basis of self-identified alcoholics helping one another maintain sobriety by sharing their stories in group meetings. Such meetings are typically not considered therapy but rather self-help or

mutual-help groups (a detailed description of AA and other 12-step and mutual-help groups is provided in Chapter 14). With the success and growing popularity of AA, the Minnesota Model was developed based on the 12-step approach used by AA. The Minnesota Model incorporated didactic educational group sessions as well as peer group sessions to supplement the AA groups that were required as part of the treatment program. In the 1950s, therapeutic communities were developed and relied heavily on group work, including encounter groups, in their treatment programs. In the 1960s, group treatment for alcohol dependence began to include applications of Jacob Moreno's psychodrama, further connecting group therapy and addiction treatment (Blume, 2002). By 1965, several inpatient rehabilitation programs reported relying heavily on group methods, and many outpatient treatment programs offered both individual and group therapy. Today, group work is widely incorporated into addictions treatment, granting the majority of clients who seek addiction treatment the opportunity to engage in group work. Further, AA and other mutual-help groups are used in conjunction with formal treatment.

KEY CONCEPTS AND THEORETICAL UNDERPINNINGS OF GROUP WORK IN ADDICTION TREATMENT

Group work lends itself as an ideal treatment for addictions. Addiction has been characterized as "a disease of isolation" in which recovery is possible within the context of a group (Roth, 2004). People who experience addiction are often isolated from others as a result of relationships being harmed or severed, therefore allowing the primary relationship to be with the substance or behavior. Further, people with addictions have often been part of impaired groups (e.g., family, social groups), and group work grants group members an opportunity to recapitulate and heal in a group of others who express acceptance and understanding. Given that it requires a *therapeutic alliance*, or a working relationship between the group leader and group member, group work can be effective in helping members experience healthy relationships. In addition, group work also requires *group cohesion*, or the relationships among the group members as well as the leader. Such relationships have implications for correcting group members' faulty attachments to others as well as providing the opportunity to correct interpersonal defenses that commonly manifest among people with addiction, such as denial, projection, or rationalization (Brook, 2015). As one of the therapeutic factors of group work, group cohesion is further described in the next section of this chapter.

Content and process are also important concepts in group work. The *content* of the group is the topic of discussion or the actual words used in the group. The content is typically consistent with the goals and purpose of the group. For example, for a group of individuals in the maintenance stage of change (the fifth stage of change in the transtheoretical model; see Chapter 10 for a full description), the content of the group may be relapse prevention. *Group process*, or the "nature of the relationship between interacting individuals—members and therapists" is of equal importance in group work (Yalom & Leszcz, 2005, p. 143). Group leaders must attend to the process of the group by observing how and why group members are making the statements they do and taking an active role in ensuring a healthy and productive group process for all members.

Groups in addictions treatment can be *open* or *closed* with open groups having ongoing admission and closed groups having all members beginning and terminating at the same

time. Groups can be used in a variety of treatment settings, including outpatient, inpatient, and partial hospitalization. Two types of group formats are common among addictions groups: psychoeducation and counseling/psychotherapy groups. Psychoeducation groups are typically brief and can be offered to a larger group compared with counseling or psychotherapy groups. Psychoeducation is often focused on prevention of substance use/addiction issues or relapse prevention. Examples include groups focused on the psychological and physiological effects of substance use and addiction, information about standard drinks and use patterns, impact of addiction on interpersonal and occupational functioning, and education about the recovery process and resources (Kominars & Dornheim, 2004).

The terms *counseling* and *psychotherapy* are commonly used interchangeably because both formats use specific interventions to address personal and interpersonal problems; however, distinctions can be made in that counseling groups focus on transitory issues whereas psychotherapy groups focus on chronic issues and restructuring personality (Morgan, 2004; Wilson et al., 2000). Common goals of counseling and psychotherapy groups include establishing and maintaining abstinence, learning and improving coping skills, identifying and managing emotions, and developing healthy relationships (Kominars & Dornheim, 2004).

Therapeutic Factors in Group Work

In group work, the group itself is the agent of change, which is particularly important in addictions treatment considering the isolation and relational issues with which clients enter treatment. Yalom and Leszcz (2005) outlined the therapeutic factors, or specific human experiences, that account for the effectiveness of group work. They are as follows: the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors (Yalom & Leszcz, 2005, pp. 1–2).

Each of the therapeutic factors is meaningful and important in addictions group work. Concerning *instillation of hope*, clients often present for addictions treatment feeling hopeless. They commonly have a trail of wreckage in their lives as a result of the addiction and have difficulty seeing that there is another way to live. Even when they decide to pursue recovery, it is a bumpy and difficult journey. Having hope for a positive future can be unshakable. Contact with group members who have successfully made healthy changes instills hope for clients that they too can make changes to improve their quality of life. The group leader can further instill hope by believing in and treating each and every client as if he or she is indeed capable of making positive changes and helping to build client self-efficacy.

Universality can directly counteract the feelings of isolation and loneliness that are common in addiction. By coming together to discuss experiences and grow, group members learn firsthand that they are indeed not alone and that addiction affects others in similar ways. Yalom and Leszcz (2005) cautioned that group members of a cultural minority might feel excluded, limiting the therapeutic factor of universality. To mitigate this possibility, group leaders are encouraged to acknowledge cultural differences but then move past the differences to the common human—or transcultural—experiences.

Imparting information is a common task of addiction groups, especially in didactic psychoeducational groups. Although the information itself is valuable, it is not uncommon for clients with addiction to be skeptical or hesitant to truly receive information imparted by "experts" or a person holding a position of authority (e.g., the group leader). As such, clients with addiction may be more inclined to receive information when it is imparted by their peers. Further, advice is often provided in group settings among members. Yalom and Leszcz (2005) noted that although the content of this advice is rarely useful, the process of offering it is indeed beneficial because it demonstrates care and understanding, which people with addiction may not experience in their daily lives.

Concerning *altruism*, given the toll addiction can take on personal relationships, clients with addiction often perceive themselves as having nothing positive to offer others or as being a burden in others' lives. When group members recognize that they can be helpful to others, it provides them with a counterperspective that they can indeed be of use to others in a positive way. This change in perspective can serve to boost a client's self-esteem as well.

Because many clients with addiction come from addicted families or families that were dysfunctional in some other way, the therapeutic factor of the *corrective recapitulation of the primary family group* is valuable in addiction treatment. Yalom and Leszcz (2005) noted that the therapy group can mimic the family group in that similar components occur, including authority/parental persons, peers/siblings, personal revelations, strong emotions, intimacy, and hostile or competitive feelings. Such experiences provide group members with the opportunity to become aware of, relieve, and correct conflicts experienced in the past with their primary family groups. Yalom and Leszcz (2005) emphasized the importance of correcting, not just reliving, the experience while engaged in group work, for it can be harmful to relive the experience in the group without a correction. Thus, it is important for the group leader to be aware of the therapeutic process and foster corrective experiences for group members.

People with addiction often use substances in social situations to manage perceived deficits in this area. Thus, the *development of socializing techniques*, or basic social skills (Yalom & Leszcz, 2005), is an important therapeutic factor in addictions treatment. Such learning can be explicit, such as when communication skills are the content of the group session, but it also occurs indirectly as group members provide each other feedback on how they interact and communicate on other content. For example, a group member might provide another member feedback such as, "It's difficult to understand what you're saying when you speak so softly that I can barely hear you."

Imitative behavior can be linked to developing social skills in that group members commonly mimic the behaviors of the group leader and of other (typically senior) group members. As such, the group leader can model appropriate communication skills as well support and acceptance to group members to help members develop these skills as well as to help create the culture of the group. Further, group members' self-efficacy can be increased through the vicarious experiences of other members. Bandura (1994) noted that when individuals witness others similar to them put forth effort and succeed, their beliefs that they too are capable of such behaviors and success increase.

Yalom and Leszcz (2005) considered the group to serve as a social microcosm in that group members represent a sample of the greater social world. Therefore, group members have the opportunity to learn how to develop and maintain healthy, satisfying relationships, or

engage in *interpersonal learning*, with their group members. Wegmann (2004) emphasized that addiction is perceived as a "lonely business" in which the afflicted individuals seem unable to create healthy relationships (p. 36). As such, this therapeutic factor is extremely valuable among addiction group work in which group members become aware of and take responsibility for their interpersonal tendencies and then make changes inside and outside of the group to form healthy relationships.

As previously mentioned, *group cohesiveness* describes the relational climate of the group as a whole. Yalom and Leszcz (2005) likened the importance of group cohesion on treatment outcomes to the counselor-client relationship in individual counseling. They elaborated to say that members of a group with strong cohesion "feel warmth and comfort in the group and a sense of belongingness; they value the group and feel in turn that they are valued, accepted, and supported by the other members" (p. 55). As noted in previous factors, the relationships between group members are essential to foster healing and recovery, especially among persons with addiction who have struggled with feeling worthy and accepted in their interpersonal relationships. Khanizian, Golden-Schulman, and McAuliffe (2004) noted that although it is natural for group cohesion to initially develop surrounding the common experience of being an addict, it is important for the group's cohesion to mature to other common experiences in order for group members to begin to associate with the "human mainstream." They contended that "ordinary problems, part of everyday life beyond the addiction, offer the group members a way into the ordinary world" (Khanizian et al., 2004, p. 460).

Catharsis is the emotional discharge of members in the presence of the group. Although this is an important factor in group work, Yalom and Leszcz (2005) clearly noted that catharsis alone is not sufficient for group members to make changes. The final therapeutic factor, *existential factors*, involves group members recognizing that life is indeed unfair at times and that this is inescapable. Further, it emphasizes that group members are responsible for how they live their lives. The implications of this factor among clients with addiction are important. The presence of the addiction itself can be perceived as an unjust circumstance. After all, no one asks to become addicted. Further, although the addiction itself cannot be avoided, individuals must take responsibility for how they are living their lives under the given circumstances.

Stages of the Group

In one of the most well-known theories of group development, Tuckman (1965) described the sequential stages: forming, storming, norming, performing, and adjourning. In the forming stage, the group members become acquainted with one another and with the group. Group members typically dread the first group meeting and therefore group leaders might employ interventions to alleviate anxiety and discomfort. As they become oriented to the group, members begin to conceptualize how they will meet their primary goal for joining the group as well as develop their niche within the social context of the group (Yalom & Leszcz, 2005).

Conflicts often arise in the storming stage of the group, and as group members struggle to determine issues of power and control, negative comments and criticism are common. Hostility toward the group leader

BOX 17.1 Small-Group Discussion

Have you experienced the therapeutic factors in groups other than therapy groups? If so, describe your experience. What did you find to be helpful? What was not helpful?

also emerges because group members are often disappointed by the limitations of the leader. During the norming stage, group members acclimate to the norms of the group and group cohesion develops, including trust between group members and the establishment of a safe environment. As the group moves into the performing stage, they work together to achieve their goals. In this stage of the group, members are actively engaged in reflection, authenticity, self-disclosure, and feedback (Yalom & Leszcz, 2005). In the adjourning stage, the important tasks of termination are addressed.

The process of termination warrants careful consideration especially when taking into account the importance of the relational components of group work. Unfortunately, oftentimes termination cannot be predicted, such as in the case of client premature termination or the need to terminate a client from a group for a rule violation or another issue that might be harmful to the client or the group (e.g., suicidal or homicidal ideation). Termination has the potential to initiate discomfort among group members and the group leader because it can be colored by previous good-byes in their lives. Therefore, the group leader must be self-aware to be certain not to avoid issues of termination. Termination should be approached as a process, as opposed to a single event. As such, to the extent possible, the group leader should help the group members be mindful of the impending close of the group and incorporate interventions to help group members process and achieve closure related to their personal group work journey.

GROUP WORK IN PRACTICE

With the key concepts and theoretical underpinnings of group work in addictions treatment described, the focus of this chapter now turns to group work in practice. Essential components to implement group work include being an effective group leader, creating and maintaining the group, and building a group culture.

Effective Group Leader

Based on the research of Kurt Lewin, there are three primary leadership styles for group leaders to consider: autocratic, democratic, and laissez-faire. Autocratic leaders do not involve members in decision making but act as a dictator of the group. Democratic leaders facilitate group discussion and decisions and consider group members' needs and feelings. Laissez-faire leaders are disengaged from the group and the decision-making process. Research has shown that the most effective style of leadership is one in which the leader shows care and concern about the group members while maintaining structure within the group, such as with a democratic leader (Johnson & Johnson, 2013).

In order to effectively lead a group, the characteristics and skills of the group leader must be carefully considered. First, the group leader should demonstrate the common factors known to enhance any therapy process, including empathy, active listening skills, and the ability to establish a strong therapeutic alliance (Miller, Forechimes, & Zweben, 2011). The group leader must have a stance of concern, acceptance, genuineness, and empathy toward group members (Yalom & Leszcz, 2005). Further, the group leader might avoid confrontation, for this has been linked to poorer outcomes in substance abuse counseling (see Miller, Benefield, & Tonigan, 1993) and has been cautioned against in group work for

addictions (Marano & Yalom, 1991). Instead of confrontation, the group leader can seek to understand resistance to change and help group members take an honest look at their behaviors, without judgment or blame (Khanzian et al., 2004). Brook (2015) suggested the use of "supportive confrontation" in which the leader fosters an atmosphere of empathic "holding" within the group, which is characterized by understanding and acceptance, as a member explores difficult emotions or dysfunctional behaviors (p. 465). Group leaders should avoid behaviors that would elicit resistance, such as blaming, criticizing, labeling, and shaming (Miller et al., 2011).

Self-awareness and monitoring are essential tasks of the group leader to ensure he or she is staying focused on the group and treating group members appropriately and respectfully. Further, because all groups will be multicultural, group leaders must strive to be multiculturally competent to be able to effectively work with diverse group members and have an awareness of how social oppression and privilege can impact group process (Singh, Merchant, Skudrzyk, & Ingene, 2012). Concerning the tasks for the group leader, per Yalom and Leszcz (2005), the leader is responsible for (a) creating and maintaining the group, (b) building a group culture, and (c) activating and illuminating the here and now.

Creating and Maintaining the Group

In order to implement a successful group, practitioners must consider several clinical and logistical issues. Such considerations include the time and location of group meetings, the goal of the group and its members, the composition of the group, and processes for screening group members. Ideally, group members have the opportunity to attend successive group meetings with the same members in order to develop maximum cohesiveness to provide members with the greatest possible benefit of group work.

Accessibility of the Group

Group meeting times and places are ideally set to enhance members' abilities to access the group meeting. For example, the leader should avoid establishing a group meeting time that might conflict with a popular 12-step group meeting, especially if self-help or mutual-help group attendance is a required or an encouraged component of the treatment program. Concerning location, groups should meet in an accessible location taking into account various degrees of ability (e.g., accessible for clients who use assistive technology) and means (e.g., accessible by public transportation). Further, social issues should be taken into consideration, such as offering excuses for time off work, providing bus passes or parking validations, and child care considerations. Issues of literacy and potential clients' native languages should be taken into consideration when developing print materials related to the group.

Goals

In addiction treatment groups, abstinence is often a prescribed goal either by virtue of the treatment program or by the referral source (e.g., probation or parole, a drug-free workplace employer). The goal of the group, whether it be abstinence, harm reduction, or otherwise, should be made clear to group members prior to members joining. In terms of goals and group compositions, the group leader should decide whether all members must

have the same goal upon entering the group or if goals can vary. If goals can vary, it is important to consider how one member who is focusing on harm reduction and continuing to use might influence another member who is pursuing abstinence. Some treatment programs structure the groups so that members are grouped according to their readiness to change, and therefore, members are more likely to have compatible goals. Regarding the duration of the group, some groups may be ongoing whereas others have a fixed number of sessions. Research has shown outcomes are improved as a result of a longer duration in group treatment (Brook, 2015). Makeup policies and procedures should be established and implemented whenever a member misses a group session.

Another consideration concerning treatment goals is whether goals can extend beyond addiction into broader life issues (Miller et al., 2011). Because addiction impacts all of life's facets, group members will likely have concerns beyond the addiction itself, such as mental health concerns (e.g., depression, anxiety), relationship issues, or career-related difficulties. The parameters of the group should be described to prospective group members, including a description of what is to be of focus beyond the addiction itself.

Composition of the Group

The size of a group can vary contingent on the purpose of the group. For example, a psychoeducational group with the primary purpose of imparting information might consist of many members. On the other hand, a group that focuses on cognitive behavioral skills training with the purpose of group members learning, trying out behavioral skills, and receiving feedback during group sessions might include no more than 10 members.

The group leader must consider the impact of having a homogeneous group versus a heterogeneous group related to specific member characteristics. Differences based on gender, age, race, ethnicity, and culture should be considered. If a member is a minority in a group, the group leader must be sensitive to this. Maintaining a person-centered approach by approaching all clients as individuals and as experts on themselves and their own lives can help to mitigate some of the difficulties that arise with a heterogeneous group (Miller et al., 2011).

At times a homogeneous group is beneficial in order to provide culturally relevant treatment. For example, women have been found to have greater success and treatment retention when participating in women-only groups compared with mixed-gender groups (Stevens, Abitier, & Gilder, 1989). Further, LGBTQ individuals might benefit from an LGBTQ-affirming group (Center for Substance Abuse Treatment, 2009), and veterans might fare better in homogeneous groups given the group members will share common experiences and enhance the therapeutic factors. However, according to SAMHSA's (2014) 2013 National Survey of Substance Abuse Treatment Services, addiction treatment groups specific to veterans were offered by only 13% of providers, and only 12% of providers offered groups specific to LGBTQ individuals. According to this same study, 86% of addiction treatment providers offered at least one program or group for a specific population (SAMHSA, 2014). Groups for women were the most popular, and 44% of providers reported offering them. However, only 17% of providers offered groups for pregnant women or women who were postpartum. Thirty-nine percent of providers offered groups specific to men, and 30% offered adolescent groups. Only 12% of providers reported offering groups for older adults. Groups for people with co-occurring disorders were offered by 43% of providers whereas

groups for people who experienced trauma were offered by 29%, persons who experienced intimate partner violence by 20%, and people who experienced sexual abuse by 20%. pertaining to people experiencing criminal justice issues, 33% of providers offered groups for criminal justice clients with concerns other than driving under the influence (DUI) or driving while intoxicated (DWI) whereas 29% offered DUI/DWI-specific groups. These findings are promising in that gender-specific groups are more commonly offered, and yet other groups for individuals who would likely benefit from a more homogeneous group, such as veterans, LGBTQ individuals, and older adults, are sparsely offered.

Client's stages of change (see Chapter 10 for a full description) should also be considered in a group's composition. Group members will have varying needs depending on their readiness for change. For example, a group member in the fifth stage, maintenance, might benefit from focusing on relapse prevention whereas a member in the second stage, contemplation, might benefit from exploring his or her ambivalence about change. Velasquez, Maurer, Crouch, and DiClemente (2001) developed a manual for group treatment based on the stages of change. In this model of treatment, a group might be formed with members who are all in the precontemplative stage of change, and the group's focus might be on raising problem awareness. Another group may consist of members who are in the action stage of change and focused on abstaining from substance use. However, group members may benefit from hearing about the experiences of other members who are further along in their change process, which serves as a benefit to a heterogeneous group.

Screening

Once the goals and the group composition are determined, selecting group members is an important task of the group leader. Not every client will be appropriate for the group setting in addiction treatment. Individuals who are suicidal, homicidal, or acutely psychotic, who experience antisocial personality disorder, or who might deviate from the group are typically not appropriate for group work in addiction treatment (Brook, 2015; Yalom & Leszcz, 2005). The leader might also consider another form of treatment if the individual refuses to attend the group or expresses a lack of interest, expresses strong discomfort in groups, has impulse control or anger management problems, is disrespectful to the group rules, has language barriers, or is a young person who may be negatively influenced by other group members (Miller et al., 2011). The leader must also match group members to the appropriate group based on ability to function, maturity, level of motivation to change, and phase of recovery (Brook, 2015). Recommendations for member screening include the group leader meeting with each prospective group member individually to assess for appropriateness for the group (Miller et al., 2011) as well as to observe prospective members in the group setting (Yalom & Leszcz, 2005). Individual meetings with group members can also be used to answer any questions the member might have about the group and to enhance the member's motivation to engage in the group to help prevent premature termination (Brook, 2015; Miller et al., 2011).

Building a Group Culture

An essential factor in the success of group work in addiction treatment is fostering a culture that promotes recovery (Margolis & Zweben, 2011). The group culture is largely composed of the rules and norms of the group. The rules of the group are typically

established by the group leader; however, in some cases group members might collaborate on the group rules. The rules greatly impact the culture of the group and should be focused on fostering the goals of the group and the growth and development of the group members. The group leader is responsible for reinforcing the rules of the group to create structure within the group. Structure is especially important in addiction group work due to the relative lack of structure in the lives of the group members (Brook, 2015). Further, by setting appropriate limits, the group leader fosters safety within the group setting.

Group rules often include an expectation that group members will keep confidentiality, meaning that members will not discuss the identities of group members or other group members' experiences outside of the group. This rule, although difficult to enforce, is essential in creating the safe environment needed to promote trust and group cohesion. The group rules can also include guidelines about which group members can talk and when during group work sessions. For example, a group may begin with a round in which each member has a turn to speak about his or her successes or struggles with maintaining abstinence. Talking rules might also include guidelines for when and how members can respond to each other's comments, or engage in "cross-talk" (i.e., group members sharing how they feel about one another) (Mariano & Yalom, 1991). Other group rules may pertain to physical contact between group members. For example, are group members permitted to hug one another or to pat one another on the back as demonstrations of support? The answer should take into consideration the unique histories and cultural backgrounds of the group members, and the leader should decide what will be most appropriate and helpful for the group members.

BOX 17.2 Small-Group Discussion

Imagine you are leading an intensive outpatient group for clients with addiction. This is a closed group of eight members that meets three times per week for 3 hours. Sam, a group member who is abstaining from cocaine and marijuana for the first time, has been doing well in the group and tested negative on all drug screens. Then, about halfway through treatment, Sam seemed to have difficulty staying awake during a group session. Sam's eyes were red and glassy, and the group members did not speak to Sam as they typically would. As the group leader, how would you proceed?

Another group rule might apply to group members' contact with each other outside of the group. Although a supportive network is provided in the group setting, group members' convening outside of the group could potentially lead to intimate or romantic relationships and perpetuating unhealthy relationship patterns, including engaging in addictive behaviors or substance use. Thus, the group leader may be tempted to prohibit or discourage members from convening outside of the group; however, this rule can be impractical and difficult to enforce (Margolis & Zweben, 2011; Miller et al., 2011). Margolis and Zweben (2011) noted that the norm of the group of providing support can be helpful to group members beyond the specified meeting times and suggested the group leader invite conversation about the possible risks of out-of-group interactions and encourage discussion about such contacts within the group setting.

A group rule should also be established related to intoxication. It is common for members to be prohibited from participating in group when they are under the influence of alcohol or a drug. Individuals who are intoxicated will not benefit from the group

and may even pose harm to other group members. Thus, the group leader should have predetermined ways of confirming intoxication (e.g., a urine drug screen, a breathalyzer) and then assist the intoxicated individual in leaving the agency in a safe manner. To minimize the disruption to the group, the group leader will likely need to draw on agency resources or other professionals to assist in the alcohol and/or drug screening and transporting the individual (Miller et al., 2011). The group may also benefit from an open discussion about such situations (Margolis & Zweben, 2011).

Norms of the group are important to consider when building the culture of the group. Yalom and Leszcz (2005) described norms as "an unwritten code of behavioral rules . . . that will guide the interaction of the group" (p. 120). Yalom and Leszcz (2005) encouraged group leaders to establish norms derived from the therapeutic factors of acceptance and support, universality, imparting information, interpersonal learning, altruism, and hope. By doing so, group leaders foster a group culture that will maximize the group as an agent of change. For example, the group leader might encourage and reinforce members' providing spontaneous support to each other when describing their struggles in remaining abstinent. The leader can also model nonjudgmental acceptance and genuine care and concern of members. In another example, the group leader might model a certain skill (e.g., refusal skills, relaxation skills) prior to asking members to try out new skills themselves. In this way, the leader models taking risks without adverse effects. The group leader is responsible for maintaining the culture of the group by attending to the group process and fostering group cohesion.

How members are oriented to the rules and expectations of the group is an important consideration. When conducting open groups, the majority of the group orientation is typically covered with the new member in an individual meeting with the group leader. It should be considered how the new member will be introduced and assimilated into the ongoing group. For example, is the new member expected to share his or her background with the group? Do existing members share their story with the new member? Miller and colleagues (2011) suggested that existing members share how long they have been part of the group and some of the benefits they have experienced as a result of their attendance. In a closed group, the orientation can begin in an individual meeting with the group leader and continue with all group members during the first group meeting. In the orientation to the group, whether this occurs with the group or on an individual basis, the details, expectations, and rules of the group should be presented and agreed on by each member to facilitate a group culture that promotes recovery. A written form can be helpful to clearly provide the rules and expectations of the group and to have a written commitment from group members to abide by these protocols (Margolis & Zweben, 2011). Exhibit 17.1 provides an example of such a form.

BOX 17.3 Application Activity

In groups of three to five, develop an addictions treatment group. With your classmates, determine the purpose and goals of the group, the group composition, the details of the group (meeting time and location, open or closed group, duration of the group), the rules of the group, and the norms you would like to establish as group leaders. What other considerations would you need to have in order to help your group be successful?

EXHIBIT 17.1 ■ Example of a Group Rules and Expectations Form

To participate in the (insert group name) group, we ask that you make the following commitments to help the group run well for the benefit of all members:

- 1) Group members must come to each group. If you cannot make it to group, please let the group leader know in advance if possible.
 - 2) Please be on time to each group session.
 - 3) Group members must come to each group sober. If you come intoxicated, you will not be permitted to attend group and arrangements will be made so that you can safely leave the agency.
 - 4) Group members are expected to be open and honest in group, including while discussing alcohol and/or drug use and addictive behaviors.
 - 5) Group members must keep the identities of group members confidential. This means you will not provide information about who is in the group with people who are outside of the group. This information is confidential and must stay in the group setting.
 - 6) Group members do not discuss the experiences of other members outside of the group. This information is confidential and must stay in the group setting.
 - 7) Contact with group members during group sessions is encouraged. Although contact outside of group sessions can be helpful, group members do not become involved in relationships that may be harmful, including any relationship that would prevent group members from being open and honest in the group sessions. Romantic and sexual relationships with group members are prohibited.
 - 8) In this program, you are committing to complete a minimum of 12 weeks of group sessions. Please let the group leader know if you plan to terminate the group early.
- I have read and agree to abide by the above rules and expectations of the group.

Name: _____

Date: _____

Note: Adapted from Margolis and Zweben (2011).

TYPES OF GROUP TREATMENT

There are many types of group work for addictions treatment. Although group treatment can require 12-step meeting attendance and/or incorporate 12-step work in group treatment, there is a clear distinction between the mutual help offered by 12-step meetings and the professional help and methods provided in group work, and these differences should be made clear to group members. Psychodynamic, interpersonal, process, motivational enhancement, and cognitive behavioral groups are all common approaches used in group work in addiction treatment. Exhibit 17.2 provides resources to learn more about group work grounded in these approaches. Due to their status as evidence-based practices in addiction counseling, the following is a review of group applications of motivational interviewing (MI) and cognitive behavioral therapy (CBT). Both MI and CBT have been successfully applied to group work and can be used together in sequence or integrated to have a synergistic effect to enhance treatment outcomes. For example, MI can be used prior to a CBT group to enhance motivation for change and engagement in treatment. Or MI and CBT can be integrated in that the group leader uses MI and CBT with group members.

EXHIBIT 17.2 ■ Selected Resources for Specific Types of Group Work With Addictions

Type of Group	Resources
Psychodynamic	Albanese, M. J., & Kharitlan, E. J. (2002). Self-medication theory and modified dynamic group therapy. In D. W. Brook & H. I. Spitz (Eds.), <i>The group therapy of substance abuse</i> (pp. 79-91). New York: Haworth. Flores, P. J. (2007). <i>Group psychotherapy with addicted populations: An integration of twelve-step and psychodynamic theory</i> (3rd ed.). New York: Haworth. Kharitlan, E. J. (2012). Reflections on treating addictive disorders: A psychodynamic perspective. <i>American Journal of Addiction</i>, 21, 274-279.
Interpersonal process	Leszcz, M. (1992). The interpersonal approach to group psychotherapy. <i>International Journal of Group Psychotherapy</i>, 42, 37-62. Malat, J., Leszcz, M., Negrete, J. C., Turner, N., Collins, J., Liu, E., & Toneatto, T. (2008). Interpersonal group psychotherapy for comorbid alcohol dependence and non-psychotic psychiatric disorders. <i>American Journal on Addictions</i>, 17, 402-407. doi:10.1080/10550490802268223 Malat, J., Morrow, S., & Stewart, P. (2011). Applying motivational interviewing principles in a modified interpersonal group for comorbid addiction. <i>International Journal of Group Psychotherapy</i>, 6, 557-575. doi:10.1521/ijgp.2011.61.4.556
Motivational enhancement	Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1992). <i>Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence</i> (NIAAA Project MATCH Monograph Series, Vol. 2, DHHS Pub. No. [ADM] 92-1894). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism. Velasquez, M. M., Maurer, G. G., Crouch, C., & DiClemente, C. C. (2001). <i>Group treatment for substance abuse: A stages-of-change therapy manual</i>. New York: Guilford Press. Wagner, C., & Ingersoll, K. (2013). <i>Motivational interviewing in groups</i>. New York: Guilford Press.
Cognitive behavioral	Carroll, K. M. (1998). <i>Therapy manuals for drug addiction: A cognitive-behavioral approach: Treating cocaine addiction</i> (NIH Pub. No. 98-4308). Bethesda, MD: Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. Wenzel, A., Liese, B. S., Beck, A. T., & Friedman-Wheeler, D. G. (2012). <i>Group cognitive therapy for addictions</i>. New York: Guilford Press.

Motivational Interviewing

As previously noted, clients pursue addiction treatment on a continuum of readiness for change. Indeed, most clients who present for addiction treatment lack sufficient motivation to change their behaviors. Because motivation affects treatment adherence and outcomes, interventions designed to enhance client motivation are often implemented. When motivational interviewing is used in a group setting, the group leader is nonconfrontational and draws on the power of intrinsic motivation. Strategies used to enhance motivation can include providing psychoeducation about the stages of change and about the effects of addictive behaviors, raising members' awareness about their addictive behaviors, exploring values, and evaluating relationships and the group members' role in their relationships and overall environments (Velasquez et al., 2001). Such strategies are employed in the style of MI, including creating an environment grounded in compassion and empathy (Miller & Rollnick, 2013). Group leaders using MI use counseling skills that encourage clients to engage in the group process, such as open questions, reflections and paraphrases, and summarizations (Kretzel & Neugebauer, 2015). Kretzel and Neugebauer (2015) proposed the following suggestions when using MI in group addictions treatment:

- Talk less, listen more. Remember that the primary goal is to facilitate, elicit, and evoke, rather than to teach.
- Focus on the process of change. Listen for underlying commonalities across problem areas and use [reflective listening] to highlight MI-related themes, such as ambivalence, discord, stages of change, etc. Try to avoid prolonged discussions of the specifics of particular problem areas, unless you are certain they apply to everyone.
- Listen carefully. Model careful and empathic listening in every group interaction.
- Address group processes. Where there is conflict, boredom, anger, etc., be willing to address these in an open-minded and respectful manner.
- Highlight strengths. Openly affirm effort, strength, courage, honesty, etc.
- Avoid excessive "solution talk." Many group members (and some therapists) are quick to offer solutions and suggestions. (p. 29)

Research on MI groups has found that this approach can increase clients' perceived autonomy and self-efficacy; enhance their readiness to change, including intentions to change specific behaviors; and increase treatment engagement and retention, including participation in aftercare. MI groups have also been found to increase problem recognition and reduce social isolation and negative group processes (Wagner & Ingersoll, 2013).

Cognitive Behavioral Group Therapy

Research has shown CBT groups to be effective in reducing substance use, reducing emotional distress, and improving coping (Irvine, Bowers, Dunn, & Wang, 1999; Miller & Wilbourne, 2002). These groups are typically structured and include cognitive and behavioral strategies to assist clients in modifying their addictive behaviors. The group leader will often teach clients about the cognitive model (Beck, 2011) and then apply group members' experiences to the cognitive model (Wenzel, Liese, Beck, & Friedman-Whetzel,

2012). Cognitive strategies to facilitate change include identifying and evaluating thoughts and beliefs that encourage addictive behaviors. Coping skills are often taught to help group members learn to manage difficulties in their lives without using. Such skills might include learning how to manage cravings to use, moderating intense emotions, or using effective communication in relationships. Skills are often learned via the group leader first describing the skill and how it can be useful. Then, the leader demonstrates the skill to show members how to use it. By demonstrating the skill, the group leader also models taking risks for the sake of growth and development and cultivates a culture of embracing vulnerability. Finally, the group members try out the new skills and often receive feedback from the group leader and members (Miller et al., 2011). Homework derived from the group session is typically assigned toward the end of each group meeting to help members progress toward their goals in between sessions (Wenzel et al., 2012).

STRENGTHS AND WEAKNESSES OF GROUP WORK WITH ADDICTIONS

Like all treatment formats, group work offers strengths as well as some possible disadvantages to consider. Both the benefits and the costs should be considered when employing group work in addictions treatment, and efforts to prevent or mitigate disadvantages should be made prior to and during group work.

Strengths

Group work offers many benefits compared with other types of treatment, including individual counseling. The group format is often desirable to providers and to clients due to its cost-effective nature. Group work can be offered less expensively compared with individual therapy because one therapist can assist multiple clients simultaneously. Further, from a provider's perspective, group work reduces the negative financial impact of no-show clients.

As described earlier in this chapter, group work provides opportunities for clients to experience the therapeutic factors unique to group work. These include experiencing a sense of connectedness to others and opportunities to learn from other group members, which are the antithesis to the isolation caused by addiction. Groups can provide a sense of hope, and members are likely to receive more helpful information in the group setting compared with individual formats. Group members can also transition in their self-perception as a drain to others to someone who is dependable and capable of helping others. They can also correct faulty experiences from their primary family group. In addition, the content of therapy can also be better suited for group formats. For example, clients in need of social skill development will be better able to try out these skills and receive feedback in a social (i.e., group) setting.

Weaknesses

Given the lower professional-to-client ratio, clients are provided less individual attention in group work. As such, certain clients might be more apt to take a passive approach to treatment or mentally disengage during

BOX 17.4 Class Discussion

As a practitioner, would you prefer providing individual or group counseling with addictions treatment? Discuss your reasons with your classmates.

group sessions. In order to mitigate this possibility, group leaders can structure group sessions and incorporate group interventions that foster client engagement and involve the entire group or as many members as possible.

In addition, group work is more complex on a relational level. The group leader must create and maintain a therapeutic alliance with each group member as well as manage relationships between group members, including fostering and maintaining group cohesion, or rapport within the group. In addition, group work often moves at a faster pace compared with individual therapy, and interactions between group members require spontaneous yet thoughtful responses from the group leader. Redirection of group members is often needed in order to ensure the group remains focused and productive. For example, clients might be apt to tell "war stories" of their using days in an effort to establish credibility or to compete with their peers. Such conversation is not beneficial, and the group leader should redirect when such conversation ignites.

Another potential disadvantage to group work in addiction treatment is the issue of confidentiality. In individual counseling, the clinician is bound to ethical codes that require confidentiality. Although confidentiality is commonly established as a group rule, it is difficult to monitor and enforce. Because group members are not held to professional standards to maintain confidentiality for their peers, group work relies on group members' trustworthiness in upholding the confidential nature of the group sessions. In addition, addictions affect all types of people and professionals. Therefore, group members "outing" themselves as a person who experiences addiction can have professional and personal implications. For example, consider a surgeon who is well connected in the community and whose family is well known. The surgeon attends group treatment for opioid addiction and discloses his or her addiction to a group of people who are familiar with the hospital at which the surgeon works and with the surgeon's family. Herein the confidentiality of the surgeon's issues with addiction is easily breached.

CASE STUDY RESPONSES

Group work could be a powerful treatment modality for Gabriel. First, let us explore the type of group that would likely be most appropriate. Then, we will look at how the therapeutic factors and specific methods applied to group work might be helpful for Gabriel. Finally, a summary of the possible advantages and disadvantages of group work are described for this client.

Type of Group

If possible, Gabriel would benefit from a group composed of racially diverse members. Regardless, the group should be led by a group leader who practices multicultural group counseling, including having the ability to see each group member as an individual and using an empathic approach. The group leader should also facilitate group members moving past their differences to recognize their similarities in order to instigate cohesion. This would also help activate the therapeutic factor of universality in that Gabriel would be able to recognize that he is not alone in his struggles with substance use and addiction.

Given that he is questioning his sexual orientation, Gabriel may benefit from participating in an LGBTQ-affirming group, or a group specific to LGBTQ individuals. However, the

group leader would need to assess whether Gabriel is ready for such a group or if he might need to explore his sexual orientation in individual counseling first to reduce the risk of his own homophobia causing harm to other group members.

Considering Gabriel's mental health symptoms, he would benefit from a group whose scope encompassed mental health as well as substance-related issues. In such a group, Gabriel would be granted opportunities to gain insight into any connections between his substance use and his mental health symptoms and to develop skills to help him manage his mental health symptoms. Overall, Gabriel would likely benefit most from a comprehensive group that he could attend as long as needed, because the longer Gabriel engages in the group, the greater the likelihood he will be successful.

Application

Although Gabriel has been in treatment before, he must believe that he can indeed be successful in reaching his goals this time around. The group modality can be helpful by instilling hope and enhancing his self-efficacy as Gabriel engages with other members successfully pursuing recovery. Given that his longest period of abstinence occurred while he worked with a sponsor in AA, the interpersonal nature and cohesion of group work would likely be an effective treatment modality to help Gabriel reach his goals. Interpersonal learning from the group sessions would facilitate Gabriel becoming aware of and modifying unhealthy patterns in his relationships. He would learn that he has something to offer other group members (i.e., altruism), which would then extend into his personal life, such as improving his relationship with his niece. Concerning his family of origin, with effective group leadership Gabriel would have the opportunity to engage in corrective recapitulation of the primary family group, especially related to Gabriel's relationship with his father.

Concerning group methods, MI could be used in group sessions to create a compassionate and accepting environment based on empathy, which would help Gabriel feel comfortable and accepted as he shares his experiences with the group. This approach also facilitates multicultural counseling given its emphasis on understanding the worldview of the client. By using MI, the group leader would assess Gabriel's readiness to change and employ appropriate interventions. If Gabriel was in an earlier stage of change (e.g., contemplation), the group leader could use MI to help elicit Gabriel's personal motivations for change and for treatment. CBT components could be used to help Gabriel learn skills to help him be successful in his recovery (e.g., relapse prevention), improve his relationships (e.g., communication skills), and manage his mental health symptoms (e.g., thought stopping). The group format would enable Gabriel to learn from other group members, practice new skills in a safe and accepting environment, and receive feedback.

Advantages and Disadvantages

As mentioned, the interpersonal nature of group work would be a great strength of this treatment modality for Gabriel. This format would have the potential to help Gabriel gain insight and develop skills to help improve his relationships and connectedness with others in his personal life, including a recapitulation and correction of his relationship with his father. The group format would also help instill hope necessary for Gabriel to pursue a successful recovery and guide him to see himself as someone who has a lot to offer others.

One potential weakness of group work would be the temptation for Gabriel to use the intimacy of the group setting in a misguided way. Given his pattern of sexual relationships with women, if Gabriel participates in a mixed-gender group, he would likely benefit from abiding by a rule that prohibits members from interacting romantically or sexually outside of group meetings. Gabriel's current experience of questioning his sexual orientation would also require careful consideration. The group leader must screen appropriately and be culturally competent to be sure Gabriel is not harmed by any other group member's potential homophobia and vice versa. Ideally, Gabriel would be placed in a group in which the parameters of the group allow him to explore his sexuality, and if not, then he might consider individual counseling to engage in this work.