

BASICS OF GROUP COUNSELING AND PSYCHOTHERAPY

An Introductory Guide



SECOND EDITION

Jerrold Lee Shapiro, Lawrence Stephen Peltz,
and Susan Bernadett-Shapiro

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Second Edition

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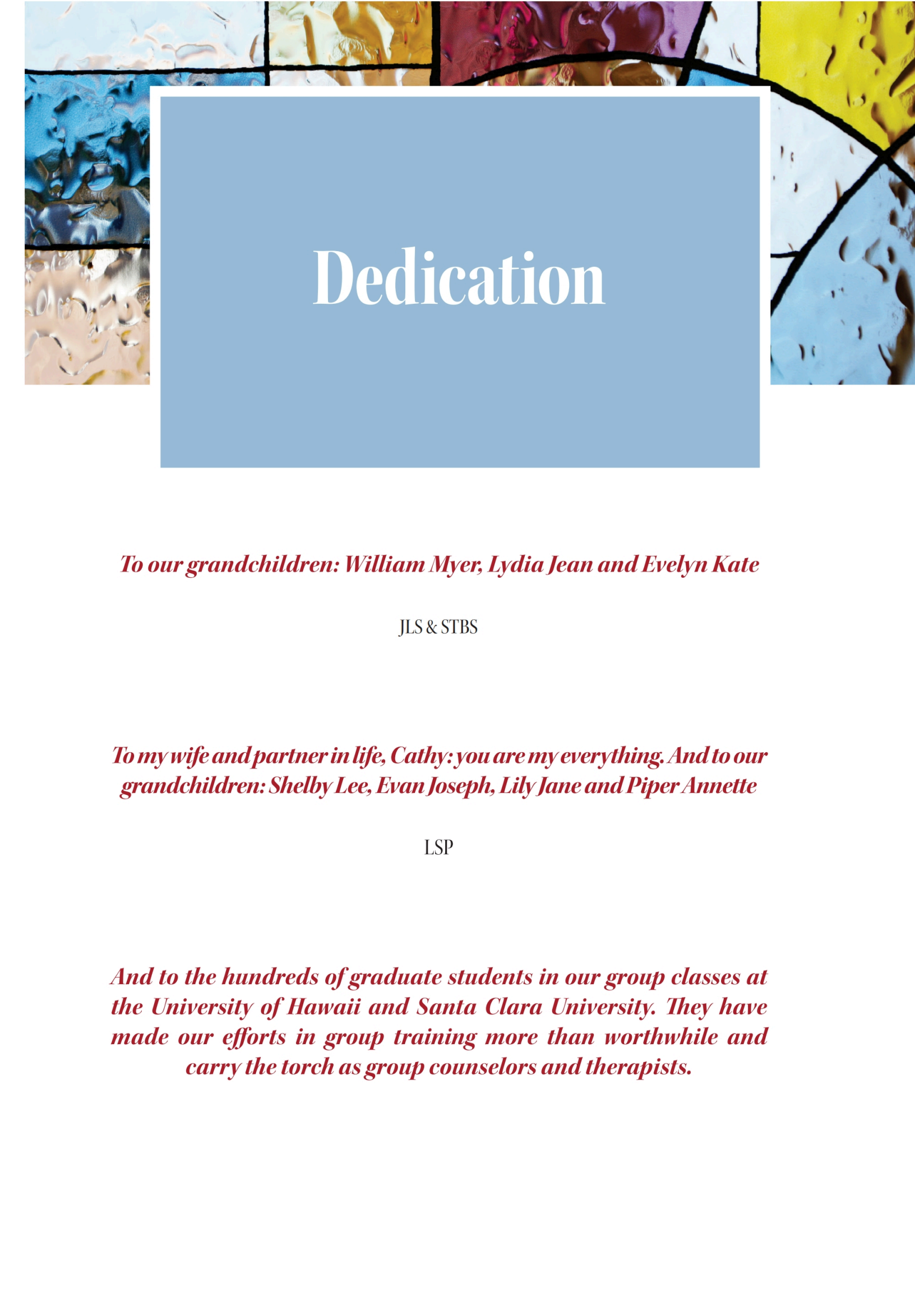
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Basics of Group Counseling and Psychotherapy

AN INTRODUCTORY GUIDE

Second Edition



Dedication

To our grandchildren: William Myer, Lydia Jean and Evelyn Kate

JLS & STBS

To my wife and partner in life, Cathy: you are my everything. And to our grandchildren: Shelby Lee, Evan Joseph, Lily Jane and Piper Annette

LSP

And to the hundreds of graduate students in our group classes at the University of Hawaii and Santa Clara University. They have made our efforts in group training more than worthwhile and carry the torch as group counselors and therapists.

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Introduction to this Edition

This text and manual is an updated iteration of our earlier book on brief group treatment (Shapiro, Peltz, & Bernadett-Shapiro, 1998). It has been revised and updated to account for changes since the beginning of the 21st century.

The authors of this text have been counselors and psychotherapists for decades. During those years, group counseling and psychotherapy have been a significant aspect of our work. Dr. Shapiro did his first group as an intern at the VA outpatient clinic in Boston in 1965, Dr. Peltz has been actively doing groups since the mid-1970s, and Dr. Bernadett-Shapiro since the 1980s. We have been teaching introductory and advanced classes in group counseling and therapy and leading training groups throughout those years. Characteristically we have been involved as leaders, members or supervisors of between 15 and 20 groups annually.

In those years, we have developed a series of methods for graduate students in mental health fields to learn about group process and the basics of leading groups designed for personal change. These methods have been taught to masters and doctoral level students in our graduate programs with continual refinements.

This text offers the best we can offer in terms of how a new trainee or counselor new to group treatment can learn how to understand what is going on in her/his groups, what interventions are most likely to be effective, and when to make those interventions,

The book focuses primarily on brief closed groups. Characteristically, the term *brief treatment* or time-limited (MacKenzie, 1990) refers to groups that last somewhere between 20–30 hours in length or about 2–3 months in duration. Although we discuss the open-ended, changing membership outpatient groups that are still popular in some clinical settings today, the bulk of the process and outcome evidence derives from groups with stable membership and are relatively short term.

Like most clinical training, reading a book will not make for a well-trained clinician. This is intended as a start to competent, effective clinical work with groups. It is expected that training, which is described in detail in the text, must include membership in a group, understanding of how different theories address group counseling and psychotherapy and co-leadership of at least two to three groups under direct supervision.

There is no “one-size-fits-all” effective approach to counseling and therapy. Each client and each group brings unique experiences, values, traits, and needs to each group. Effective counseling and therapy require group leaders to understand these from client perspectives and to adjust interventions based on what best suits the clients and the ability to discern the best timing for interventions.

This introductory text provides a psychological GPS of sorts to help leaders with the timing of interventions. We will describe in detail the normal, natural trajectory of groups of all kinds and identify those that do not fit into the progression. Based on the group process, we recommend particular interventions be made at specific junctures in the group. One example of the failure to do this is for group leaders to attempt to make therapeutic recommendations when the group is in the earliest forming stages. Such therapeutic endeavors delivered at this time characteristically fall on deaf ears. However, the very same interventions made when the group and individual members are ready and receptive are usually far more impactful.

In all of the groups discussed in this book, diversity of background, culture, ethnicity, values, and so on, is usually a great benefit. By contrast, groups whose members have wildly diverse levels of ego strength, and psychological pathology are very likely to fail.

The work in this book is best when readers have a concurrent or prior experience as members of a training group, experiential lab group, counseling group, or the like. We also recommend the use of task groups for projects in this class as a way to underscore similarities and differences in group process across types of groups.



Preface

This text represents its authors' long professional and personal association. The three of us met and worked at the University of Hawaii during the 1970s: Dr. Peltz in counseling psychology in 1973 and Dr. Bernadett-Shapiro in the graduate nursing program in 1978. Our professional and personal collaboration has continued to the present. I have provided this personal account to explain these frameworks and their impact on our work.

I have been involved in the practice of group therapy, group counseling, and growth groups since 1965. Curiously, my interest in groups and other multiperson therapies did not begin auspiciously.

As a graduate student intern in 1965, my first exposure to groups was a "current events group" that met several days a week at the VA Outpatient Center in Boston. The group was used essentially as a holding area for male patients (primarily with dual diagnosis or ambulatory schizophrenic diagnoses) and was charged with "getting the men to talk about current events." The predominant therapeutic tool was the morning edition of the *Boston Globe*. Although I was never convinced that any learning or meaningful discussion about current events ever occurred, something interesting happened over the 3-month duration of our group. Despite no apparent lessening of the patients' symptoms, attendance was fairly stable, and I grew to like several of the group members. Meanwhile, two floors away, a psychologist and social worker held a discharge planning group that I was allowed to observe through a two-way mirror. Members of this group seemed to experience rapid, marked amelioration of their symptoms. My longing to do similar work remained unrequited during that training. I had similar

experiences in internships at Downey VA Medical Center in Illinois and again at the Boston VA Outpatient Center in 1966.

As in intern at Hawaii State Hospital in Kaneohe in 1966 and 1967, I was given my first “therapy” group. At that time, it was common practice in psychology to provide interns with patients *they could not possibly harm*. This group met on Monday, Wednesday, and Friday morning from 7:45 to 9:15. The members were six men of Japanese descent, all of whom were diagnosed “chronic undifferentiated schizophrenic.” The shortest hospitalization stay of any of the members was 19 years. My supervisor observed all sessions of this group from behind the ubiquitous two-way mirror, and we discussed the sessions immediately after they ended. I have three very clear memories of this group: (1) the discrepancy between my initial tolerance for silence (approximately 23 nanoseconds) and that of the patients (approximately 23 hours); (2) my never discovering whether three of the patients spoke any English, pidgin English, or Japanese (my co-therapist was a Japanese-speaking psychiatric nurse); and (3) my undying gratitude for the federal government’s mandate that most holidays were to be observed on Mondays or Fridays.

A second group, which I co-led with a very talented senior social worker during my intern year, was a Tuesday-Thursday afternoon group of acting-out adolescents. It is no small wonder to me that, for the next three decades, this background led me to devote much of my clinical and research interest to group processes. Between 1965 and 2017, I was directly involved with more than 700 growth, therapy, counseling, and industry groups as a leader, member, researcher, supervisor, and consultant. Since 1969, as a full-time professor, I have also taught courses and developed vertically integrated training programs in group counseling and therapy in graduate programs in New York, Hawaii, and California—most recently at Santa Clara University.

All this involvement has convinced me that group treatment should be the cornerstone of any major mental health treatment program. I believe there are many advantages of group treatment that go far beyond the obvious economic benefits. Research and clinical writings also support this contention. I am also aware of the most unfortunate continuing aspect of group leadership in institutional, organizational, and treatment centers: *Very few of the people who lead groups are formally trained in group process*. Many group leaders are well-trained individual counselors or therapists who have been assigned to groups without completing even one course or supervised practicum in group work. Even with the best intentions, such leaders tend to do individual therapy with an audience rather than use the most powerful and dramatic effects of group process and influence.

This book is based on a crucial supposition: *Group leaders must be aware of group process*. The book represents an attempt to provide a road map for graduate students and new group leaders. However, it is not an attempt to chart

every street, road, or lane. The point of view presented here is my belief that interventions in any successful group (or any other type of treatment) depend a great deal on timing. If I don't know where the group is at any given moment, I am far more likely to take wrong turns in my attempt to get where I want to go.

The inexorable generic process provided in this book is designed to serve the leader as a signpost and reference map. It is as theory-free and objectively descriptive as my colleagues and I could make it. We have spent many hours observing and consulting with leaders whose perspectives are widely divergent; the process described gives substantial attention to their approaches.

Our personal approaches to counseling, therapy, or task groups are closely related. Dr. Bernadett-Shapiro's primary orientation is object relations. Both Dr. Peltz and I describe ourselves as existential, with his approaches tending toward the American cognitive end of that realm and mine tending toward the European dynamic end. We all are informed by systems approaches. We are sure that the illumination shed by our varying perspectives will leave important areas of the landscape in shadows. Certainly leaders of groups with widely different theories, goals, and populations may have to adapt portions of the process for their maximal personal use.

We apologize for the fervency with which some of this book was written. The apparent certainty we exude is not intended to sell something to the unwary. Rather, it expresses the enthusiasm of practitioners who have embraced group process for 50 years and extol its virtues as an old friend and lover. Even after all these years and hundreds of groups, each of us enters each new group with anticipation, excitement, and hope. We are all active clinicians, currently leading brief treatment groups. Dr. Bernadett-Shapiro has taught group leadership at two universities and is the consultant-supervisor for the experiential groups in the graduate counseling psychology program at Santa Clara University. Dr. Peltz is co-leading couples groups and adult groups, and he and I regularly co-lead men's groups in the community. As part of my work as a faculty member at Santa Clara University, I direct group training and teach introductory and advanced group classes throughout the academic year.

Although much of this book was written for our students in counseling and clinical psychology and in social work, we hope that experienced group practitioners will also find something new in it or remember an older precept of value that has drifted away.

As you read this text, you may notice that many of the references may seem dated. Wherever possible, we have used the most comprehensive source. Thus, many of the outcome research references date back to the 1970s, a time of great interest in and prolific research on group outcome and process. We refer to several recent studies that have added to our knowledge of group therapy and counseling. However, when a recent study primarily replicates older data or

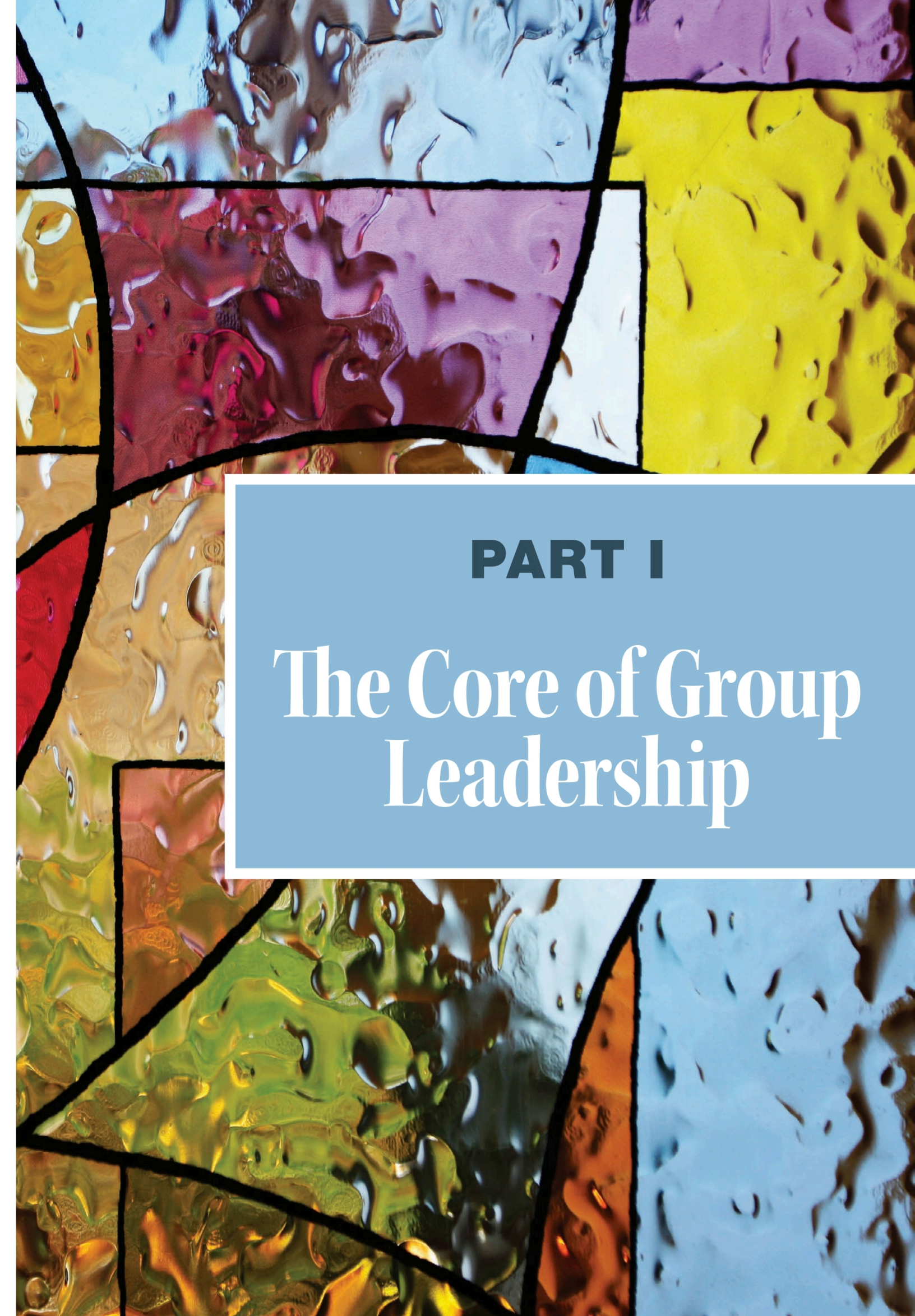
observations, we have chosen to cite the primary source to honor the pioneering work in the field.

We would like to acknowledge many wonderful people who have guided our learning about group therapy and counseling over the years. In particular, we want to thank all of our students in the group training classes and advanced leader training programs at the University of Hawaii Counseling Program (1970–1978), School of Professional Nursing and Social Work (1976–1981), and Santa Clara University (1982–present). Many of these students have become professional group leaders and teachers, and we take great pride in our small part in their success.

We also want to express our thanks to Acquisition Editor, Kassie Graves and the editorial and production staff at Cognella for their faith in this project and wonderful assistance in making this book a reality.

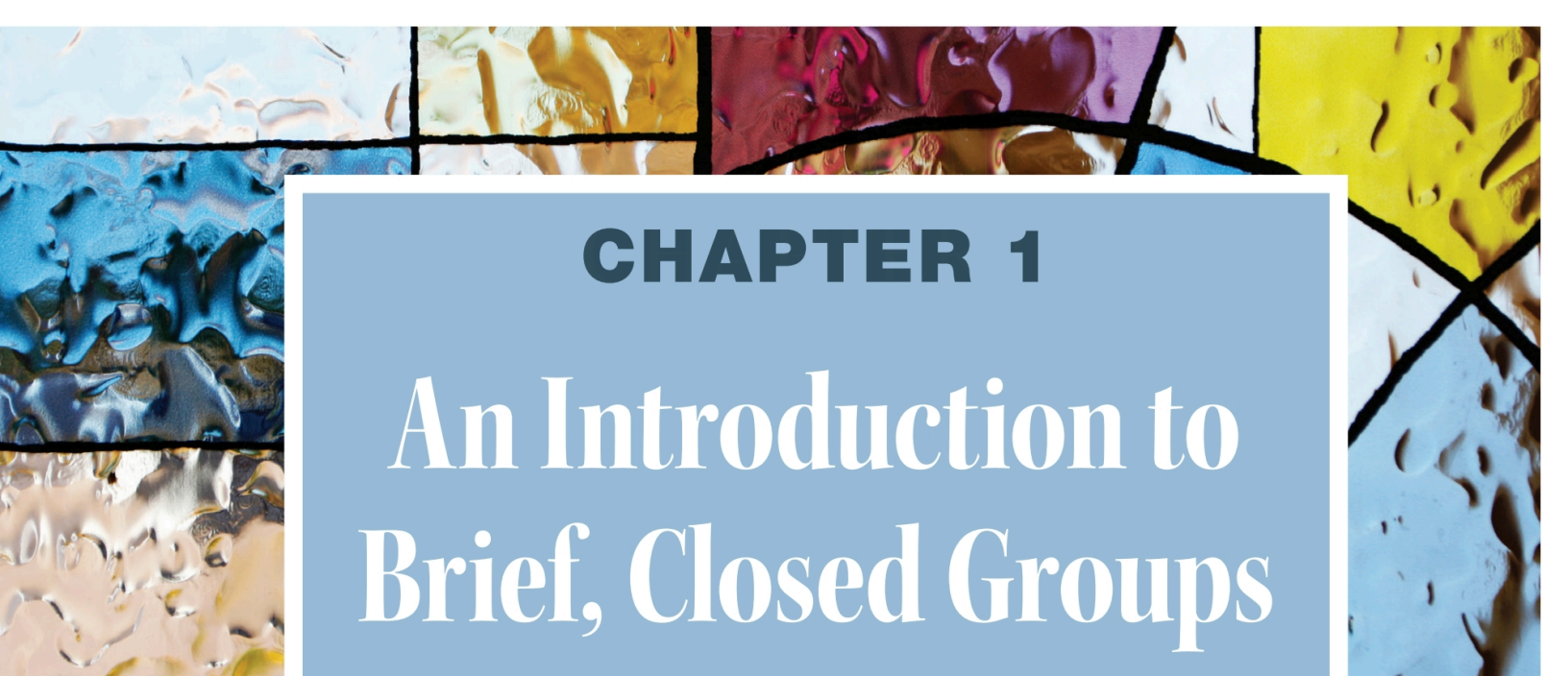
Jerrold Lee Shapiro, Ph.D.



The background of the entire page is an abstract composition of various colors and textures. It features large, irregular shapes in shades of blue, yellow, purple, red, and green, separated by thick black lines. The surfaces within these shapes have a marbled, liquid-like, or crystalline texture, giving the overall image a complex and dynamic feel.

PART I

The Core of Group Leadership



CHAPTER 1

An Introduction to Brief, Closed Groups

This text is designed for leaders of counseling, therapy, and growth groups who wish to bring a time-honored, proven, effective, ethical approach to treatment groups in an era in which cost containment and economic concerns are regarded at least as important as therapeutic and ethical considerations. The therapeutic approach is based on assumptions that are supported by research data, clinical observations, and the economics of modern health care.

- Groups are the treatment of choice in a brief therapy model.
- Treatment groups are most effective if they are closed, short term, and process-centered.
- Thematic groups with somewhat homogenous membership will be most effective in the short term.
- When groups are led properly, there is a generic, predictable developmental process.
- Multiperson treatments such as groups require different therapist skills than individual modalities.
- Training in group methods is necessary for effective treatment.

These assumptions provide the backdrop and the *raison d'être* for this text.

Groups as the Treatment of Choice

In a special edition of the *Journal of Specialists in Group Work*, Shapiro and Bernadett-Shapiro (1985) argued that the beginning of the 21st century would be marked by extensive growth in group treatments. Since then, experts commenting on managed care treatments such as Budman (1992), Budman and Gurman (1988), and Norcross, Alford, and DiMichele (1992) have echoed that forecast. In the most recent Delphi Poll of experts in the field (Norcross, Pfund, & Prochaska, 2013), group therapy and short-term treatment are listed in the top eight areas expected to increase in the decade 2013–2022.

Although we believe that group treatment will be prominent in the future, we acknowledge its long and successful past. Since the turn of the 20th century, and Pratt's (1906; 1907; 1908; 1911) early attempts at alternative (group) treatment for tuberculosis patients, groups have been used for virtually every patient population known (cf. Delucia-Waack, Kalodner, & Riva, 2014; Lubin & Lubin, 1987). Throughout this century, the use of groups and research on their effectiveness has varied as each major type of mental health treatment (medical, psychotherapy, family therapy, group therapy) have had periods of ascendancy and periods of relative disinterest from the bulk of practitioners. At the present time, primarily because of financial considerations, medical-biological treatments are ascending in popularity as are group counseling and psychotherapy approaches.

The unique advantages of group treatment include the following:

Cost

Research (i.e., Barlow, 2014; Burlingame, Fuhrman, & Mosier, 2003; Burlingame & Krogel, 2005; Shapiro, 1978, 2010) has indicated that group psychotherapy has been as successful as each other form of treatment in comparable or shorter time periods. Economics however, are not the sole advantage of group treatment.

Connectedness

Groups provide opportunities for socialization, a sense of shared experience, and a corresponding reduction of feelings of isolation. Many groups also lead to continuing care by way of postgroup support systems.

Reality Testing

The group environment provides opportunities for learning and practicing new behaviors in a setting that more closely resembles the “real world.” Feedback from other members will be different from the reactions of an individual therapist whose contract is to understand the client from the client's personal perspective. In addition, feedback may occur in real time instead of delayed experiences between sessions.

Vicarious Learning

In a group, each member has the opportunity to learn by observation of others. For many people, learning is best accomplished when one is not on “the hot seat.” Members may work through their own personal issues by witnessing the struggles and successes of others.

Minimization of Pathology

Not all of the therapy that occurs in a group comes from the leader. Much help is offered by members to each other. When someone receives assistance from another who is “just a member like me,” the receiver sees that his or her problems are not impossibly serious or unmanageable. The result may be development of a more positive and hopeful outlook.

Altruism

A common source of problems for individuals seeking mental health treatment involves low self-esteem. When members act benevolently toward their peers or provide insight or caring for other group members, they normally feel quite good about seeing the results of their efforts and about the act of helping itself. Feelings of altruism are incompatible with low self-esteem. A group setting in which one member can assist another offers a certain enhancement of self-esteem.

Experimentation

Group members are encouraged to experiment with novel behaviors and reactions and motivated to request feedback within a nurturing environment. The group is a setting in which members might rehearse new behaviors and/or get advance reactions to an anticipated event without the risk inherent in the event itself. They may then adjust their behavior accordingly in preparing for the real occasion.

Dilution of Transference Relationships

Although the primary and most powerful transference occurs between group members and group leaders, there is inevitable projection onto other members of the group as well. This shift allows all members to be more aware of such projections and eases working through of problems because the intensity is somewhat distributed throughout the group.

Universality

One of the most impactful experience of group is the growing understanding that everyone has problems, secrets, shame in their past, and struggles. As group members see the figurative skeletons in others’ closets, they get a more realistic perspective on how personal struggles are not unique. In the face of this information, their sense of isolation and feelings of being singularly pathological are minimized.

Short-Term Groups

Evaluating outcome research on time-limited groups is complicated by a host of factors: not the least of these is defining *brief treatment*. Many terms are used by different authors, Corey, Corey, and Corey (2014) and Yalom and Lecz (2005) use the terms “brief group counseling” and “brief group therapy.” MacKenzie (1993) called his groups “time-managed” and “time-limited” group psychotherapy. Budman (1992) used the more specific term, “time-effective” treatment, and Forsyth (2010) and Corey (2015) have called it “brief group work.” We prefer “brief group treatment,” which was used in our first edition (1998), and that is the term that will be used in this text.

Exactly what constitutes a label of “brief” is also a little unclear. Koss and Butcher (1986) considered brief treatment to involve groups that met for fewer than 25 sessions. Budman, Demby, and Randall (1980) used 15 session groups. Shapiro (1978) and his colleagues (Diamond & Shapiro, 1973; Shapiro & Diamond, 1972) reported on 30-hour groups and on 20-hour groups (six 2-hour sessions and one 8-hour marathon). Foulds (1971) and many other group leaders who practice in university settings (i.e., Corey et al., 2010; Shechtman & Toren, 2009) ran groups for an academic semester or quarter.

Reviewers of the time-limited group literature (Budman, Simeone, Reilly, & Demby, 1994; Dies, 1992a) conclude that these groups, when led by experienced professionals, are effective in alleviating symptomatology and fostering growth. In comparison with waiting list control groups, time-limited group members show significant improvement (i.e., Piper, McCallum, & Hassan, 1992). However, Piper et al. have also indicated that such groups may not be as powerful or comprehensive as longer term therapies or individual work of equal duration. A complicating factor for empirical comparisons is the experience of leaders; oftentimes groups in outcome studies are regularly led by trainees or inexperienced group therapists (Shapiro, 2010).

It is important to recognize that brief groups are not simply abbreviated forms of long-term groups. They have different goals and these are more clearly delineated. The format may also be different. Among the differences for brief treatment groups in this text are the following:

- Closed enrollment. The same members enter and leave the group together.
- Predetermined beginning and termination.
- Less than 6 months in duration (Cuijpers, van Straten, & Warmerdam, 2008; Hanson, Lambert, & Forman, 2002; Horowitz & Garber, 2006; Shapiro et al., 1998; Stice, Rohde, Seeley, & Gau, 2008).
- Limited, clearly set goals.
- Process oriented with a here-and-now focus.

- Predictable epigenetic trajectory.
- Often members have some identifiable commonality and the groups may have a specific theme (i.e., Drum & Knott, 2009).
- Professional leaders (co-leaders strongly recommended) (Shapiro, 2010; Shapiro et al., 1998).
- Screening for fit and level of ego strength is essential.

The upshot of these multiple criteria is that brief treatment groups must *be carefully geared to specific limited goals, conducted by trained professional leaders, and structured to maximize factors such as cohesion, altruism, and the other unique group treatment advantages by employing a process focus.*

Closed, Short-Term, Process-Oriented Groups

Many leaders prefer ongoing groups in which members enter and leave as is personally appropriate (i.e., Yalom, 1995; Yalom & Lescz, 2005). Arguments that this more closely simulates real life are undeniably compelling. As members enter and depart the group, individuals have the opportunity to work with their personal issues of separation and individuation, fears of intimacy, dependency and rejection. They can weigh their own considerations about when “it is time.” Certainly such groups have a valuable place in therapy.

However, there are also compelling advantages of groups beginning and closing together, such as the time involved in incorporating a new member or the adjustment to the loss of an senior one. In open groups with each change in the group population, there is an inevitable regression to earlier stages of group process. Because the developmental process (trajectory) is a core component in group effectiveness, interruptions of the process may inhibit the natural unfolding of the group progress and hence its impact. In a brief therapy environment, the team-oriented synergy of a closed group is particularly healing.

The focus on process (content within context) is particularly central to group members’ learning about themselves and their impact on others. A process focus provides a developmental psychological map of the interpersonal terrain. With this as a guide, the leaders may highlight more clearly the current reality of the group and the impact of individuals within that framework. A focus on process also trains individuals to explore the context and consequences of their actions as well as the content and apparent motivation. More than that, a *process focus* creates a unique setting for personal learning. A frequently disconcerting fact in the life of parents and teachers is that our children and students learn only when they are ready to learn. Repetitions alone, even those with the most compelling multimedia delivery systems are insufficient if the receiver is unprepared. A process focus sets the stage for learning in two ways: (1) It provides a focus on self and on the here and now interactions between self and others, eliminating

distractions, and (2) because it is socially unusual it adds a certain amount of functional anxiety and vigilance that facilitates learning.

Thematic/Relatively Homogeneous Groups

For short-term treatment, group members must be able to affiliate with each other fairly quickly. Doing so is easier when they feel commonalities between their abilities and needs and those of their peers. The most important homogeneity in a group is levels of ego strength or its converse, levels of pathology. Although groups have been shown to be effective with almost every level of pathology, they are overly affected by discrepancies. To a large degree, the most pathological individual in a group has the greatest influence in restricting the group's trajectory. It is analogous to the reality that the weakest link has a greater impact on the overall strength of the chain. Thus a group of persons with acute concerns are best not mixed with clients whose problems are chronic.

Content themes are of value for both attracting members to work on a predictable concern and also for centering the discussion around consensual issues. Broad themes in which each member sees part of himself or herself within the purview of the group are most effective. A theme is best utilized as a catalyst to group formation and development rather than as a definition or defense of member personalities.

Predictable Developmental Process

The first several chapters of this text are dedicated entirely to an observable process model. The model has emerged from 25 years of research and clinical work (Shapiro, 1978). It coordinates well with the work of other researchers and clinicians (i.e., Corey, 1990, 2014; Foulds & Hannigan, 1976). A four-phase, 30-stage model is detailed. Leaders are trained to observe the natural development of the group process. Effective interventions are tied directly to specific points in the evolving process trajectory. For example, different leadership actions are necessary when the group is in Phase II (Transition) or Phase III (Treatment) than when it is in Phase IV (Termination). Leadership challenges and the methodology to effectively employ them for the group's benefit are necessary to provide the transition to treatment. Premature attempts to intervene therapeutically and directly before these challenges emerge, may actually deter the group process.

Group Treatment, Individual Treatment, and Family Treatment

Group treatment requires a number of unique skills that are different from those necessary in individual or family modalities. Of particular note is the sophisticated ability to intervene at three different levels: intrapsychic, dyadic, and group. In individual work, the latter two are somewhat irrelevant except in addressing the transference or personal therapist-client interactions.

In couple or family therapy, the therapist must be aware of the system that exists between the clients outside of the therapy hour. Interventions are best geared to addressing this ongoing system. In group, the system that develops is only present during the group itself. Each individual is best served if he or she receives from the group interactions important personal information that is transferable to life outside the group. Yalom and Lecsz (2005) describe the group as a microcosm of the individual's interpersonal world. More colorfully, Tillich (1973) suggests that everyone significant, "your mother, your father, your brother, your sister, your cousins, your dog, your cat are all available in the group." In this way the group mirrors interactions within a member's family and social milieu.

Training in Multiperson Therapies

Although formal group treatment has an almost century-long history, the majority of group leaders today are still primarily or solely trained in individual and infrequently, family therapy methods. This book is primarily designed for those who are beginning schooling or practice in group treatment. It is no substitute for a rigorous training program or supervised experience. A model of minimal training requirements and basic skills are provided (Chapter 7).

Some Realities of Modern Health Care

Since the late 1980s, the health care crisis in America has been addressed increasingly by an economic model (DeLeon, VandenBos, & Bulatoa, 1991). Health maintenance organizations (HMOs) promise cost containment, and full health care from womb to tomb in return for a moderate regular premium and spreading risk across large populations. The dollars saved, however, may come at a high price. Members of such an insurance plan normally have less discretion about the type of treatment they may receive for any given ailment and to some extent, whether their plans will authorize any treatment at all. The bottom line for any business such as an HMO is the difference between dollars received in premiums and the expenses incurred from providing treatment. Maintaining and growing profit margins often means restricting and limiting "expensive" care and procedures.

In the United States, the Affordable Care Act (2010), often referred to as “Obama Care,” has made inroads in correcting some of these deficiencies. As this is written, it remains in place, but more than 50 unsuccessful efforts to repeal it have occurred and each “replace” plan has been far more economic than focused on health care. Alternative plans would sharply reduce overall coverage and mental health coverage in particular. To the extent that mental health services are truncated in the future, certain treatments will be favored or prescribed. The preferred treatments are medication and time-limited group therapy. In some European countries, such as Germany and England, the mode of therapy that is covered by national health service plans is characteristically limited to cognitive behavior therapy.

It is a harsh reality that mental health is not a high priority in such systems. Like other “lower status” medical specialties (e.g., pediatrics, obstetrics), practitioners have had to fight for the diminishing pot of dollars available. As a result, the quality of care inevitably suffers. Indeed, rewards in the form of bonuses and promotions are commonly given on the expense end of the equation rather than the care end. “Successful” providers are those whose computer track record shows that they see clients for the fewest sessions. Saving money by withholding treatment is often cherished within managed care. Primary care physicians or triage personnel receive bonuses for referring the fewest patients to expensive treatment.

Far more detrimental is the subtle withholding of treatment that occurs when clients for group therapy are assigned to a waiting list for several months, before an opening may occur. Several lawsuits have been filed against major providers who actually have lengthy waiting lists and little actual group therapy available. These organizations have been successfully sued for “care delayed, care denied,” using the long waits in place of treatment (Levin, 2015; NUHW, 2014; Pfeifer & Terhune, 2016).

Managed Care and Group Treatment

What are the implications of this for your practice? Your clients may be resentful in group because they were denied more costly individual psychotherapy or counseling. They may exhibit more pathology because less severe “problems in living” including family and marital issues are addressed at the primary care physician level and not referred or may not be covered by the insurance plan. They will be less likely to be “YAWVIS”¹ patients; more likely to have personality disorder diagnoses, borderline personality traits, or defensive structures. You may have more patients taking psychotropic medication in group therapy. As a group leader, you may have less ability to effectively screen your clients.

¹ YAWVIS is an acronym for the traditional patients who get the most care and highest interest from practitioners. These patients are young, attractive, wealthy, verbal, intelligent, and sexy

Dealing in such brief treatments with groups of patients having such a wide range of needs requires adjustments to your normal practice or leadership style. Normally, when time is short, the natural tendency for a leader is to speed up in an attempt to cover everything before time expires. Unfortunately, accelerating treatment in counseling and therapy frequently has a paradoxical effect. Increasing pressure to find solutions is routinely met with greater resistance to change.

This paradox is a prime reason to use a process-oriented model. With this model, patient resistance is coalesced and dealt with ontologically. By viewing resistance as an important part of the “readiness-to-learn” phenomenon in group, the process model actually increases the pace at which members approach desired outcomes by judicious moderating speed at certain crucial junctures, early in the group. By focusing directly, and in predetermined ways, on the developmental stages of resistance, group members who are beginning from a point of lower motivation have more of an opportunity to become open to healing.

It is important to understand that whatever theory or techniques that you customarily use will be effective with some segment of the population in your groups. The process model is designed as a substrate on which your particular theoretical perspective may be maximally effective. With this foundation, psychodynamic, behavioral, humanistic and psychoeducational groups can all be enhanced.

In too much of the literature, these theories are juxtaposed as competing approaches. By contrast, the current approach was designed by observing the commonalities of successful groups of every type. Similarities are most dominant early in the group process. In the treatment phase of the group, the different approaches demonstrate clear distinctions. Thus a Gestalt-oriented leader and a cognitive behavioral leader will seem to share more commonalities in approach in the transition phase and far less during the treatment phase.

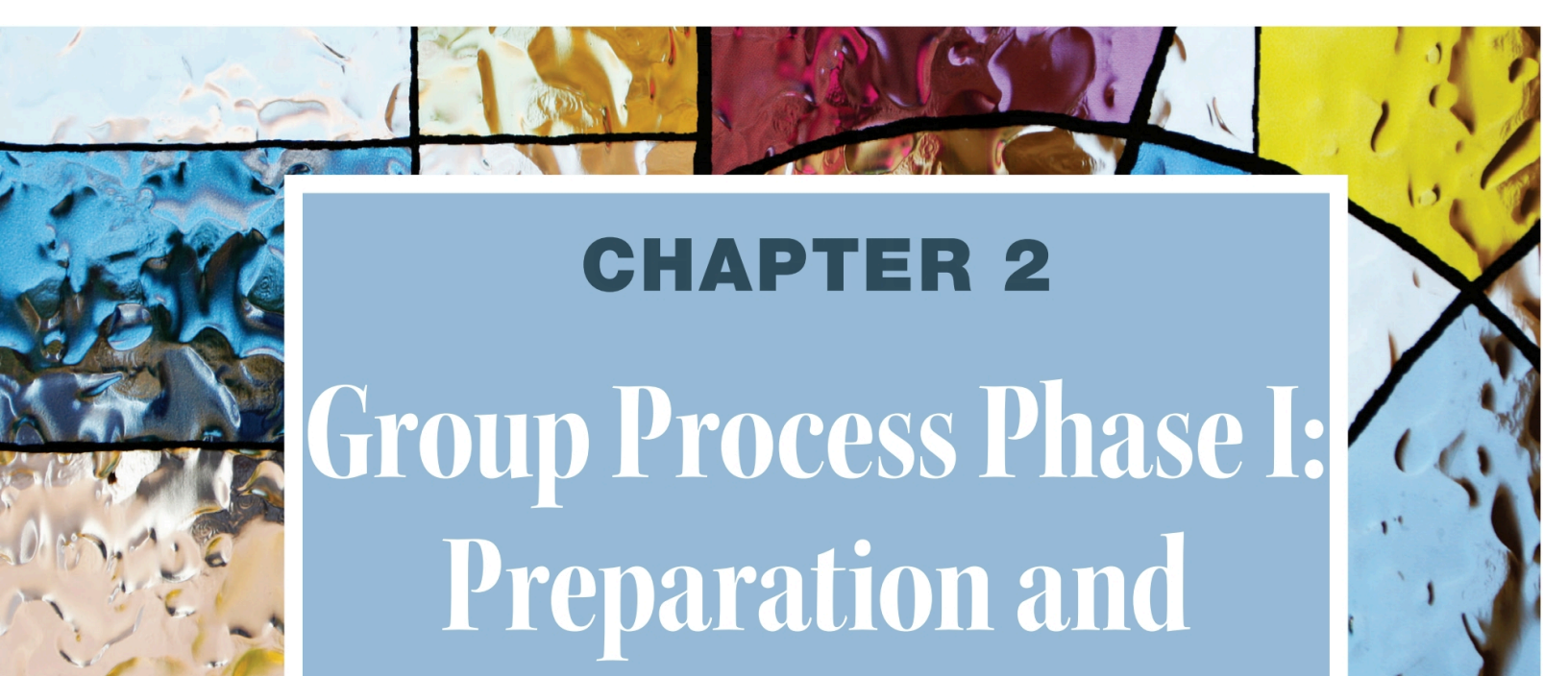
The ensuing brief treatment model is sensitive to cost containment, is adjustable across theoretical orientations, and is likely to maintain quality care at least within appropriately defined limits.

Summary

Group psychotherapy is a modality particularly well suited to emerging needs within mental health delivery systems for informed and proficient care. The group context encourages individuals to explore the consequences of their actions as well as the meaning and underlying motivation. A group process model is proposed as an efficient means of participant learning and behavioral change.

Leadership training in group process is essential. The most effective leadership interventions are tied to this predictable model of developmental generic group process. In addition, the leader must attend to three levels of process and intervention: intrapsychic, interpersonal, and group level.

Certain participant and treatment variables have been shown to optimize group treatment outcomes. The ideal group is closed, time-limited, homogeneous, and process-focused. Groups with specific limited goals, led by trained professional leaders using interventions geared to increase cohesion, appropriate self-disclosure and altruism amongst members are most productive.



CHAPTER 2

Group Process Phase I: Preparation and Orientation

- Stage 1: Determination of Group Goals and Population**
- Stage 2: Leader Announces Group Logistics**
- Stage 3: Members Apply for the Group**
- Stage 4: Screening**

“While I know each group is unique, I frequently have a sense of déjà vu in every group I lead.”

This casual lunch time comment between two group therapists in Hawaii one day in 1970 spurred a 25-year intensive study of groups, beginning with a survey of local and national experts on group process. The results of the survey and of group leadership literature indicates that experienced group leaders see distinct differences in their groups as well as commonalities that make them all appear similar.

Group Commonalities and Differences

This seeming contradiction is present in all forms of therapy to some extent. Most theorists point to communalities in recommended treatment approaches while

stressing the individuality of every patient. Nowhere is the apparent incongruity so poignantly expressed as in group therapy.

How Are Groups Different?

Yalom and Lecz (2005) among others, note the seeming infinite variety of content issues and problems addressed in groups. Specific material discussed, therapeutic interventions, and conflict resolution are unique to each group. Because each group is comprised of several different personalities at a particular period of time, singularity of expression and novel experiences are to be expected.

How Are Groups the Same?

Despite the variance in specific content and content themes between groups, the *process*, or pattern of interaction, within different groups is remarkably similar. In an effective and successful group, certain stages normally occur in a reliable sequence.

Stages of Group Models

As Table 2.1 shows, several authors have described predictable stages in group development—developmental schema in which successive stages are built on completion of previous ones. As early as 1936, Wender described four such stages for patients in neoanalytic group therapy. His process description included, (1) intellectualization, (2) transference between patients, (3) catharsis, and (4) group interest as patients moved through emotional difficulties to emerge with effective interest in their social sphere and society in general.

Battegay (1989) working with a compatible framework 53 years later, formulated a very similar five-stage developmental sequence: (1) exploratory contact, (2) regression, (3) catharsis, (4) insight, and (5) social learning. Battegay clearly states that such stages may well be limited to *closed, long-term, analytically oriented groups*.

Table 2.1 Several Conceptions of Predictable Group Stages

Author and Date	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Wender, 1936	Intellectual-ization	Trans-ference between patients	Catharsis	Group interest, social interest		
Dreikurs, 1951	Establishment of relations	Interpre-tation of dynamics	Gaining under-standing	Reorienta-tion		
Schutz, 1973	Inclusion	Control	Affection			
Tuckman, 1965 Tuckman & Jensen, 1977	Forming	Storming	Norming	Performing	Adjourning	
Shapiro, 1978	Introduction	Learning the rules	Therapy proper	Termination		
Henry, 1981	Initiating	Convening	Formation	Conflict	Mainte-nance	Termina-tion
Dies, 1985	Preparation	Early group sessions	Transition	Working	Termination	
Corey & Corey, 1987	Initial stage	Transition	Working	Ending		
Battegay, 1989	Exploratory contact	Regression	Catharsis	Insight	Social learning	
Mackenzie, 1990	Engagement	Differenti-ation	Working	Termination		
Yalom, 1995	Orientation, hesitant participation, search for similarities, search for meaning, and dependency	Conflict, dominance, rebellion	Cohesive-ness			

Dreikurs (1951), employing an Adlerian perspective, focused more on the educative process in groups. He perceived four stages: (1) establishment of relations, (2) interpretation of dynamics, (3) patients gaining understanding, and (4) reorientation.

Tuckman (1965) and Tuckman and Jenson (1977) colorfully described five stages as (1) forming, (2) storming, (3) norming, (4) performing, and (5) adjourning. Schutz (1973), whose work was more centered on growth groups, described “an inevitable sequence” of three stages: (1) inclusion, (2) control, and (3) affection. Members work through their conflicts of belonging to the group, establishing and maintaining their roles in the group pecking order, and explore their closeness to other members.

Yalom (2005), in the latest revision of his classic group psychotherapy text, sees an *initial stage* characterized by orientation, hesitant participation, search for similarities, search for meaning, and dependency. This is followed by the *second stage* characterized by conflict, dominance, and rebellion. The *third stage* for Yalom involves the development of cohesiveness.

These are markedly similar to Schutz’s formulations. However, Yalom describes several qualifying factors that can dramatically affect his indicated sequence: leadership qualities, patient qualities, additions to and deletions from membership, attendance, and so on. Yalom also suggests that discrete stages can be described reliably only early in a group’s development. As a group develops over time and subgrouping occurs, groups become more unique. One crucial factor in Yalom’s model is that it is based almost entirely on open-ended groups. Authors whose research is on closed groups are able to describe an extended process because of the essential progressive nature of their groups.

Shapiro (1978), describing a core group process for both therapy and encounter groups, formulated four inevitable process phases: (1) introduction, (2) learning the rules, (3) therapy proper, and (4) termination (transfer of training).

Corey, Corey, and Corey (2014) using a similar paradigm, based on their own considerable work with closed groups in a college population, described (1) an initial stage, (2) a transition stage, (3) a working stage, and (4) an ending stage. MacKenzie (1990) calls his stages (1) engagement, (2) differentiation, (3) working, and (4) termination.

The chronological process analysis presented in this text conforms to the whole group model espoused by Corey and Corey (1987), Fiebert (1963), MacKenzie (1990), and Shapiro (1978). Clearly, open-ended groups such as those described by Yalom will conform to this model only to the extent that there is stable membership over time. There is no question that predictability of process diminishes as membership changes.

Group process in closed groups is presented in four interlocking phases. Each phase is comprised of a number of identifiable stages and tasks. The four phases are as follows:

- I. Preparation
- II. Transition
- III. Intervention (Working or Treatment)
- IV. Termination

The process presented is descriptive of a *well-screened, optimally functioning, time-limited, closed group, led by an accomplished leader with therapeutically viable clients in a counseling, therapy, growth, or encounter format.*

This process is envisioned as both *inevitable* and *ideal*. It is inevitable in the sense that successful completion of each previous stage is considered prerequisite to engaging in and coping with subsequent stages. To some extent, however, this model is also an ideal. Many groups fail to complete all the stages. Hence, one aspect of the success of any group can be measured by progress through the process sequence prior to the termination.

Value of Predictable Process

Group leadership shifts with group process. Leadership behaviors that are effective at one stage in a group are often deleterious at other stages. It is axiomatic that group members such as patients in psychotherapy need to know where they are and the extent of their resources prior to developing new life paths. Thus in the words of a recent group participant, “If I don’t know where I am when I start out, in an hour I could be two hours from my desired destination.” It is essential that an effective group leader appraise the lay of the land before heading off to explore new directions. All change-based interventions described in this text are geared precisely to the existing process in the group.

The following process analysis represents the results of 20 years of the senior author’s research of group treatment and leadership and more than 50 years of personally leading, supervising, and observing groups and group leaders in a host of clinical settings. It is designed as a map to get the novice group leader to the right neighborhood. The unique streets, roads, lanes, and blind alleys must be individually discovered.

Despite best efforts to remain eclectic, any such formulation will represent several biases in theory, perception, and description. It behooves the reader to use this process formulation as a guide that must be adapted to personally relevant theories and populations. Differences in approaches to specific populations are described in the final part of the book. The primary theory that

underscores this work is a *dynamically oriented existential-humanistic psychotherapy*. Therapists with related theories (i.e., Gestalt, psychodynamic and object relations) will have little difficulty applying the principles. A greater bridge may need to be constructed to accommodate behaviorally based or psycho-educational theories. However, the core principles and process are claimed to be universal. Divergences between approaches will occur primarily in Phase III (treatment), where specific interventions will be more differentially based in the practitioner's theory.

Phase I: Preparation

Stage 1: Determination of Group Goals and Population

A group begins as a concept. Leaders normally respond to an identified need in a particular community. Once the need is recognized, and a group intervention chosen, the leaders must then reach the target population with information and enticement to apply for inclusion in the group. Establishing and maintaining a productive treatment group is no easy task, especially in a private practice setting. Careful planning and effective, ethical marketing are essential.

Within a managed care or capitated environment, the needs of the patients will by necessity be assessed by an agent of the responsible third-party payer. Leaders may be establishing groups based on needs or mandates of patients' coverages and economic demands as well as their clinical needs. The inherent ethical concerns will have to be addressed continually, both with potential group members and with the preferred provider organization (PPO), health maintenance organization (HMO), or insurer (cf., Rosenberg & Zimet, 1995).

For example, a particular HMO or PPO might cover its insured for substance abuse but not for marital difficulties. Under other circumstances a group might be free to focus on both or either. In a limiting environment, the treatment may have to be focused primarily on the importance of substance abuse in family discord and membership may be restricted by use of diagnostic codes that involve drug or alcohol problems.

Among the multitude of factors that will influence the group membership makeup are cost, location, time of day, length and number of sessions, leader characteristics and credentials, population, cultural factors, and the desired mix of clients. Only when these factors are carefully evaluated can the leader move to an invitation for members to apply. Each logistic criterion set by a leader will narrow the range of applicants and the heterogeneity among members.

Fees. The fee charged for group sessions will have a powerful impact on membership. Some fees are clearly too high for many potential patients. By contrast, some fees will be too low to draw certain populations.

Fees can range widely in a given area. A brief informal survey in the San Francisco Bay area conducted by the senior author in 2016–2017 revealed that average fees for outpatient fee-for-service groups were between \$30.00 and \$40.00 per hour/per patient. A typical 90-minute group session, with one or two leaders, cost \$45.00 to \$80.00. Most recent surveys indicate that groups for adolescents or children have slightly lower fees. Many such groups require monthly commitments of members or charge for the entire group (i.e., 10 sessions) at the outset. Members of a PPO or with providers with a capitated contract might be required to make a fixed copayment, with the leader billing a preset amount to the insurer or subcapitated organization for the balance.

In the San Francisco survey, lower fees were normally reported for groups conducted in church, school, or community settings. Several groups conducted in community agencies used subsidized sliding scales that ran from \$1.00 to \$15.00 per session. HMOs and employee assistance programs (EAPs) offered specific theme groups for members at nominal (if any) out-of-pocket cost.

Many group leaders have found to their surprise that fee setting is quite peculiar. High fees will eliminate certain portions of the population, but very low fee or “free” groups will do the same thing. As one potential participant at a free clinic stated, “if it’s free, it ain’t worth nothin’.” A curious trait of American society seems to be the perception that something that is free is not as good as things that cost a lot. One way to solve the dilemma of offering groups to people who cannot afford to pay for treatment is to make the group have an *apparent* price. Thus for one series of “free” groups at a community mental health center, patients were required to pay 50 cents per session. However, each member was given 50 cents worth of bus tokens at the end of each session. The groups had far higher attendance than comparable “free” groups.

Setting fees may be complex for a professional. If the fee is not determined by the referring entity such as a clinic or managed care organization, several factors must be balanced. Among these are the therapists’ experience and training, customary rates in the region, and needs and resources of the client population as well as the therapists’ need for income.

In private practice, determination of fees is often arithmetic. If the leaders each need to be compensated \$100/hour for their time, two leaders and a two-hour session means that they must bring in \$400 per group session. Thus if there are 8 members, each would pay \$50/session (\$25/hour).

Figure 2.1 Phases and Stages of Normal Group Process

Phase I: Preparation
Stage 1: Determination of Group Goals and Population
Stage 2: Leader Announces Group Logistics
Stage 3: Members Apply for the Group
Stage 4: Screening
Phase II: Transition
Stage 5: Leader Specifies Ground Rules
Stage 6: Introductions
Stage 7: The Initial (Short) Silence
Stage 8: The Short Silence Is Broken
Stage 9: Discussion of There-and-Then Topic
Stage 10: Natural Death of Discussion
Stage 11: The Long Silence
Stage 12: Members' First Sortie
Stage 13: Opening of the Discussion
Stage 14: Group Leader Focuses on Here-and-Now Process
Stage 15: Debriefing the Leadership Tests: Focus on Feelings
Stage 16: Leader Encourages the Expression of Emotion
Phase III: Treatment (Working; Intervention)
Stage 17: Internal Focus
Stage 18: Norms Are Solidified
Stage 19: Minority Members Identified; Inclusion Revisited
Stage 20: Intensity Increases
Stage 21: Leader Employs Therapeutic Skills
Stage 22: Problem-Solving Orientation Practiced
Stage 23: Expression of Feelings about the Process and the Group
Phase IV: Termination
Stage 24: Leader Announces Imminent End of Group Time
Stage 25: Invitation to Work
Stage 26: A Trust Boost
Stage 27: Transfer of Training
Stage 28A: Good and Welfare
Stage 28B: Closing Ceremonies
Stage 29: Leader's Closing
Stage 30: Aloha

Location. The most common locations for groups are community agencies, clinics and hospitals, churches, schools and colleges, private offices, and hotel meeting rooms. The specific group meeting site should be consistent with the desired participants.

The specific site for a group meeting will dramatically influence group composition. Some people are so uncomfortable with various settings, they would not consider attending any meeting in these places. Community agencies, for example, will attract some folks and repel others. A neighborhood community center might limit the number of applications from people who want anonymity, or who live in different neighborhoods.

Distance and travel time are also significant factors in the viability of a particular group setting. Many groups seem to be set around the early evening hours. Getting across town at these times in most major cities can be a traffic nightmare. Distance and commute time make up one factor, but this is not the sole determinant of participation. In Honolulu, a group held at the Kalihi community center (a poorer neighborhood) would not draw many potential group members from nearby more affluent Aiea or Pacific Heights. Almost every community has districts that are threatening to people from other locales. These discomforts range from fears about physical safety to a sense of estrangement with folks from different cultures or socioeconomic strata. For example, a group held in poorer neighborhoods on the south side of Chicago would have a completely different composition from that of a group held in a wealthy northern suburb such as Winnetka. Similarly, a university setting may be very comfortable and familiar for college graduates, but much less so for those who do not have college experience. Some potential members will avoid a church meeting place because of the denomination. Others will feel safer because of the presumed sanction of a religious setting.

Another factor is that some members prefer a group that is distant from their home or work sites to better safeguard confidentiality. Others prefer the close proximity to reduce travel time. Often within EAP programs, the work site is proffered and flex time provided by the employer. This arrangement will obviously suit some potential members better than others.

Time of Sessions. In some ways, the time of the session can be the most critical factor in enrollment. It must be acceptable to the desired population. Groups that meet in the morning are very unlikely to draw many working people. Similarly dinner hour groups will be less attractive to members with families and Saturday evening groups are anathema to “singles.” For many years, group leaders who wanted male participants traditionally avoided Monday evenings in the fall on the premise that they would not forego “Monday Night Football.” By contrast, it was an especially desired time for “women’s groups.” Groups for young mothers may be held successfully during the middle of the day if they provide a playroom and

child care. In general, most therapists hold group meetings in the late afternoon or early evening.

Some HMOs or agencies only offer groups during normal office hours or on a single weekday evening. Patients who cannot attend at designated times are simply discouraged. Because they are compensated by the number of people under contract or for regular staff salaries, rather than for services rendered, it may be economically beneficial for some organizational providers to restrict times available. This is the opposite of a consumer-oriented private practice situation.

Group leaders must also consider their own diurnal energy levels. Some leaders have their best energy for group work in the evening whereas others are fading at this time. Co-leaders of marathon groups often try to compensate their own periods of highest energy with their partner's lower times.

Length of Group Meetings. The total number of sessions and extent to which groups are open or closed also affect potential participation. Some members will choose a closed group with a predictable fixed number of sessions; others prefer the flexibility of the open environment. Closed groups that have more than 10 to 12 sessions (or 30 hours) may be too much of an initial commitment for some potential members. Open groups may also appear foreboding in length. Some people will be threatened by a group that appears too short to accomplish much without great intensity. In general, closed outpatient groups are commonly 6 to 20 sessions in length with the vast majority in the 10 to 12 session range.

Publicity. The manner in which members are sought is also a powerful factor in group success. Advertisements posted on telephone poles, social media electronic bulletin boards, or supermarket bulletin boards pull for different populations from those attracted by a professional note circulated among local individual therapists. Many clients are unwilling to commit their time or psyches to any methods that in any way sound unprofessional, yet an equal number shy away from the established health care provider in search of something more dramatic or unusual. It is incumbent on the leaders to predetermine which of these populations they wish to tap. Typically, groups that are oriented toward growth or education can be drawn with publicity that is more open and general. By contrast, therapy group members are more often referred by informed colleagues, other related professionals, such as primary care physicians, attorneys, or clergy, or by advertisements in medical centers.

Leader Characteristics and Credentials. Potential group members often show great interest in the qualifications of leaders. Some will be interested only in working with licensed professionals with advanced degrees. Some will be attracted to leaders with a particular theoretical approach. By contrast, people who are distrustful of traditional medicine may be attracted to "self-help" leaders who are themselves dealing with issues similar to the members.

In addition, cultural factors may be significant. Potential members will be reluctant to apply for inclusion in a group if they think the leader is unable to understand their ethnic or cultural concerns. For example, in a recent group offered for Japanese Americans whose parents were interred in camps during World War II, one leader had a Japanese surname and one had a European surname. It is doubtful that this group would have had as much success had the leader with the Japanese surname and appropriate cultural experience not been available.

One of the most successful and continuous group therapy programs in this country has been housed in the Vet Centers, an organization designed to assist Vietnam era veterans. One of the major advantages and appeals of such centers is the fact that they are staffed by veterans (combat and noncombat) as well as civilians.

Stage 2: Leader Announces Group Logistics

The announcement and statement of critical logistics is important in determining who will apply for the group and what may happen once it begins. Such factors as where and how the group is publicized; cost; meeting place; number of sessions and time of sessions; group goals; leader's reputation, theoretical background, and age; potential clients' perception of the professionalism and warmth of the leader will all substantially affect the subsequent group membership.

The following figures are examples of some characteristic announcements that have appeared in major cities around the United States. Names and identities or other distinguishing characteristics have been changed for professional reasons.

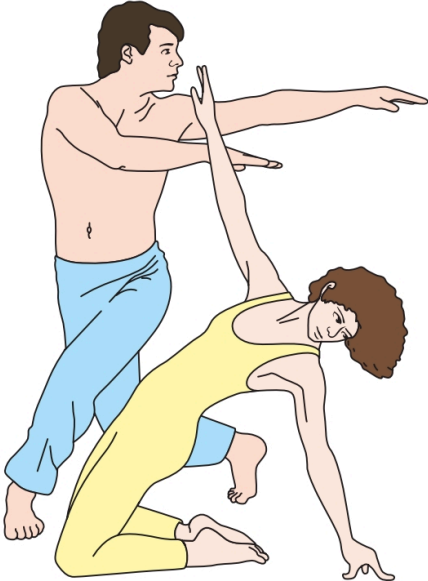
Figure 2.2 is an announcement for an awareness and movement group. It was advertised via flyers to people on a selected mailing list. An advertisement such as this is likely to draw such participants as students in mental health-related professions, mental health professionals, dancers, and other college-educated, somewhat sophisticated, middle-class working people. It is unlikely to draw severely disturbed or poverty-level participants. Members of such a group (in the encounter/workshop format) would typically be functioning adequately and would be interested in experimenting with growth activities.

Figure 2.2 Sample Group Announcement (Smith and Jones)

A Weekend Workshop

Awareness and Movement

Led by Bill Jones, Ph.D., and Jean Smith, M.A.



Bill is a certified clinical psychologist and a Gestalt therapist. He has been practicing psychotherapy for over 10 years in his community. He is also on the Ethics Committee of the State Mental Health Board and works as a program developer for the state's mental health services.

Jean is an advanced practitioner in Rolfing and a dance and yoga instructor. She teaches creative movement and has done substantial work in integrating movement techniques.

We will work with the group to help members integrate the different components of their beings. Through a series of movement exercises and individual and group work, members will have an opportunity to come to a better understanding of self and of the body as a source of energy and expression.

Dates: February 6 & 7, 2018

Schedule: Friday, February 6, 8–11 P.M.
Saturday, February 7, 10 A.M.–6 P.M.

Fee: \$45.00; students \$35.00

Location: Central Church
6245 Halekulani Lane
Honolulu, Hawaii 96823

Dr. Van Wheeler, whose announcement appears in Figure 2.3 is clearly positioning herself to attract a wealthy clientele. Cost, location, and presentation all are geared to eliminate patients and students in the middle and lower socioeconomic levels. Although this therapist is offering what seems to be similar to Smith and Jones (Figure 2.2), a very different participant is likely to apply for her group.

Figure 2.3 Sample Group Announcement (Van Wheeler)



Dr. Elizabeth Van Wheeler, B.A., M.Sc., M.D., Ed.D.,
is happy to announce an

AWARENESS WORKSHOP

Dr. Van Wheeler was educated at Oxford and Paris and is a lifetime member of the International Socioanalytic Association. This workshop will use a variety of techniques, especially movement and body awareness, to reintroduce and help reintegrate body energy and self. Members will become in touch with and learn new ways to express themselves.

Membership is very limited

Date: February 3, 2018, Friday, 7–10 P.M.
February 4, 2018, Saturday, 10 A.M.–6 P.M.

Fee: \$750.00. Catered lunch for Saturday is included.

Location: Penthouse, Hilton Hotel



A flyer-type advertisement (Figure 2.4) for group members appeared on university campus bulletin boards. It is unlikely that Guru Rakar will compete for the same populations that Dr. Van Wheeler (Figure 2.3) will attract.

Another quite different means of inviting members is with memoranda such as the one in Figure 2.5. This figure and the next four announcements are also for professionals, but they are presented in different ways. Figure 2.6 announces an entire season of scheduled groups developed by a group therapy center. In Figure 2.7, an individual psychotherapist establishes the relocation of her practice by announcing two new groups to her colleagues, asking for referrals.

Figure 2.8 is a notice of a group developed for and by psychotherapists. The last announcement (Figure 2.8) is a request for referrals from the director of a state mental health clinic.

Figure 2.4 Sample Group Announcement (Guru Shana Rakar)

A WEEKEND OF TRUTH THROUGH
MOVEMENT ENERGY



“COME INTO KNOWING”

The Peninsula Dynamic Spiritual Learning Center presents a weekend group experience with the renowned Guru Shana Rakar, recently returned from India, and his assistants Sandy Beach and Elaine Nixon, B.A. The guru will work with individuals in attaining knowledge in a group setting to enhance knowledge of self and of one’s own inner strengths.

Cost: \$50.00/one person; \$80.00/couple
Time: Sunrise to sunset, Saturday, February 3, 2018
Place: Behind Green Chapel

FIGURE 2.5 Sample Group Announcement (Quincy Mental Health Clinic)

MEMORANDUM

March 19, 2017

TO: Selected Psychotherapists in Private Practice
Selected Psychotherapists in State Mental Health Centers

FROM: Quincy Mental Health Clinic

Re: Referrals of Nonpsychotic Patients to an interpersonal skills group

This is to inform you that Drs. Joe Smith and Elaine Brown will be conducting weekly group therapy sessions on Tuesday evenings, 7–10 P.M., commencing May 1, 2018 for 12 consecutive Tuesday evenings. The group membership will consist of 8–10 patients who are diagnosed with neurotic or situational adjustment problems. The focus of this group is interpersonal, and it is seen as an excellent adjunct to ongoing individual therapy. If you have any nonpsychotic, “Axis I” patients that you feel would benefit from this group, referrals will be accepted and appreciated. Sessions will cost \$20.00 per participant per session. Sliding scale applies.

We will screen all members carefully for “goodness of fit” in the groups. Please contact Joe and Elaine at QMHC (617) 555–9590.

FIGURE 2.6 Sample Group Announcement (Kentucky)

THE KENTUCKY CENTER FOR GROUP THERAPY
Proudly Announces its lineup of groups for the Winter 2017 Season

MEN’S GROUP FOR MALES 21+ . Led by Martin Reilly, Ph.D. and Bill Bernstein, MSW. This group will meet on Thursday evenings from 7:30–9:30 for 10 weeks. The themes for the Winter groups are friendship, communication and work/home life balance.

WOMEN’S GROUP FOR FEMALES 21+. Led by Maggie Cotton Ph.D. and Jen Cohen, Ph.D. This group will meet on Wednesday evenings from 7:30–9:30 for 10 weeks. The themes for the Winter groups are balancing work, relationships and home life, assertiveness and communication skill building.

FRIDAY NIGHT COUPLES GROUP FOR MARRIED AND COMMITTED COUPLES will continue for another term. There is space for 2 or three new couples in this ongoing group. The group focuses on communication within and between couples, issues of security and freedom and stresses male-female dialogue. The group meetings are from 7:30 to 9:30 for ten weeks and are led by Drs. Myra and Will Stone.

THERAPISTS’ GROWTH/SUPERVISION GROUP WILL BE OPEN THIS WINTER FOR 4–6 NEW MEMBERS. This group which meets from noon to 2:pm on Fridays accepts licensed therapists in any discipline who wish to explore transference/counter-transference issues and professional/personal concerns. The leaders Martin Weiss, Ph.D. and Cindy Swarz, M.D. work from a Psychodynamic framework.

ANXIETY AND PHOBIA GROUP FOR ADULTS will begin on January 9 and run for 8 consecutive Mondays at 2:30 pm–4:30 pm. Dr. Cecily Brown will be leading this group.

All groups meet in our second floor Group room, Ste. 200, 2222 Bardstown,

PROFESSIONALS AND REFERRALS ARE WELCOME TO ALL OF THESE GROUPS.

PLEASE CALL OR FAX 555-5000 TO SCHEDULE A SCREENING INTERVIEW OR FOR FURTHER INFORMATION.