But just as in any group, the worker's belief in the value and importance of the group, his/her ability to articulate that value and importance are crucial. This is not unique to involuntary groups. In a sense, the involuntary group member becomes voluntary when s/he begins to appreciate that this group may have some worth.

In fact, such a dawning appreciation of the group's worth is a factor in *all* groups. Often, when we begin a group, even voluntary clients are actually involuntary. Scenarios abound in which members feel trapped, forced, obliged, or expected to participate. Pressure, be it from peers, parents, colleagues, or supervisors, often propels a person to attend a group that s/he starts out wishing to *not* be a part of.

Participation in a group can be viewed on a continuum ranging from free choice to legal mandate. Wherever a group member falls on that continuum, the choice to be a full participant is always his/hers to make. Whether a member's attendance comes about because s/he is mandated by a judge or other legal authority or whether it is the result of pressure from those around him/her, the decision to *participate* always rests with the individual.

Tough populations are not the exclusive domain of those whose groups are composed of members whose attendance is legally mandated. Group workers must often address members whose attitudes, especially in beginnings, radiate hostility and cynicism. Acting as if involuntary group members require a whole new approach is invalid. That textbook-group-work-stuff really does apply.

Roselle Kurland
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Editors

Spinning the Group Process Wheel: Effective Facilitation Techniques for Motivating Involuntary Client Groups

Harle Thomas
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ABSTRACT. This paper demonstrates the applications and implications for three essential categories of group work techniques with involuntary clients: process, linking and inclusion. Case studies from the McGill Domestic Violence Clinic's treatment group for batterers illuminate a didactic presentation for generating collaborative momentum in groups. Designed to provide a blueprint for those clinicians with less group facilitation experience, this catalogue of techniques will add to the repertoire of seasoned clinicians too. This text can act as a useful framework for instruction and evaluation in student supervision. The paper is accompanied by a glossary of 56 group work techniques and pitfalls for clinicians who work with involuntary client groups. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com]*

PREFACE

The authors work at the McGill Domestic Violence Clinic (MDVC), which is associated with the McGill University School of Social Work.

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The clinic runs a year-round, open model treatment group for men who abuse women (see Caplan and Thomas, 1995). During the academic year (September to April) the clinic trains graduate level students in methods of facilitating groups with involuntary clients. This paper is meant to organize the initial experience of this training into concrete categories of interventions, and an appendix of group work interventions accompanies this article.

Because the MDVC treats involuntary clients, addressing client (and therapist) resistance is crucial to effective treatment outcome (Anderson and Stewart, 1983; Liebenberg, 1983). While the fundamental clinic contract with involuntary clients is that they will take responsibility for their actions, permission is given to clients to establish their own pace for self-disclosure and appropriate change making (Thomas and Caplan, 1995). It is the responsibility of the facilitator to assure that permission is not given for the client to rationalize his dysfunctional behaviors (Jenkins, 1990).

INTRODUCTION

Group work facilitation, like any other profession, has its elements of art and science. While it is inspiring to witness masterful interventions by "experts in the field," it is important to recognize that such seemingly effortless strokes are made possible by a thorough understanding of techniques basic to doing effective group work (see Middleman and Wood, 1990 and Shulman, 1992). Further, clinicians may creatively implement these fundamental skills to better motivate clients whose reluctance to participate in group therapy creates inertia in the progress of group work.

One metaphor that captures the essence of effective group facilitation is that of the spinning wheel. Ideally, a group worker helps to generate initial momentum in the group process, and having done so, allows the momentum of clients working collaboratively to bring shape and meaning to the session. Occasionally, the facilitator intervenes to add a spin to the working wheel, keeping in mind that the lighter touch of the group worker typically encourages greater effort by the clients to keep the momentum going. It is the task of the facilitator to sense when the group's momentum is beginning to wane or wander off course and to generate renewed energy or direction without getting in the way.

However, there is a difference between spinning *the* wheel and spinning *one's* wheels. It has been our experience with trainees at the clinic that often they are initially overwhelmed by a sense of limitless options for leading a group. This feeling of not knowing where to begin can result in inertia in a number of ways. Such clinicians might find themselves "hooked" into one-on-one casework within the group, particularly with involuntary clients, where the facilitator questions each individual member of the group in turn using the other group members as allies (see Kurland and Salmon, 1992). These clinicians may also feel themselves getting frustrated with a group in which members remain polarized in rigid talker/listener roles. They might also find themselves becoming reluctant witnesses to the group ganging up on a member through advice-giving and confrontation (Ormont, 1993). Such non-intervention may compromise pertinent therapeutic issues such as group safety or may disallow appropriate group process by which group members are guided to collaborate on reaching treatment goals (Caplan & Thomas, 1995). Clinicians may tend to overcompensate by bringing fixed agendas into the group, by being overly directive or by making interventions that would have been more effective had they been spoken by a group member (Thomas and Caplan, 1997). In countering any potential loss of energy in the treatment group, the facilitator benefits from developing a framework of interventions for doing group work.

This paper outlines three categories of facilitation techniques which, in our experience, are the most important for counteracting inertia in group therapy: *process*, *linking* and *inclusion*. The section on process will explore how to handle resistance by developing universal, group-centered themes. Client process is defined as the way in which a client assimilates his reality. This perception of reality is shaped and filtered by each individual's world-view. World-view is based on each person's unique psycho-historical background, and world-view informs a client's emotions and behaviors (Wood and Middleman, 1992). Focus on client process is a key method of moving the group wheel from a stuck position. The section on linking will discuss the importance of establishing intra-and interpersonal connections among group members, which stimulate collaboration through validation. Linking redoubles the energy in the group through encouraging client ownership of the therapy process. The section on inclusion will use an excerpt from the MDVC group to show how encouraging reluctant

group members to participate meaningfully in the session promotes increased client ownership of the therapy.

We believe that group workers will generate a more effective treatment experience by concentrating their focus on the above categories of intervention. This framework provides a guide to help facilitators ask themselves during a group session whether they: (1) can make a statement which reveals the emotional message within the conversation of the group; (2) can link one client to one or more other participants; or (3) can include a client in the group's work. Subscribing to a "less is more" philosophy in these ways will govern the momentum of the group by cultivating a therapeutically effective balance between a clinician's over- or underinvolvement. The general rule to keep in mind is that the power of the group is most often more effective than the "whiz-dom" of the therapist.

PROCESS

For many clinicians process is a difficult concept to grapple with. The term seems to be defined and redefined by each theorist who discusses it. For example, compare Shulman (1992, p. 152) to Garvin (1997, p. 333) to Caplan and Thomas (1995, p. 46). We would like to define the concept of process, in general, as referring to the feelings, ideas, images and potential for growth that lie beneath the surface of conversational content (Caplan and Thomas, 1995). In particular, we separate process into group process and client process. Cohen and Garrett (1995) define group process as follows: "Group process refers to changes that take place in the group from moment to moment, session to session, and over the life span of the group." They go on to say: "The following processes have been identified as important for group workers to monitor: goal determination and pursuit, values and norms, roles, communication, conflict resolution, and attraction/cohesion" (Cohen and Garrett, 1995, p. 139). By client process we refer to the belief systems, hidden emotions, and thoughts that underlie a client's conscious actions and expressions.

Wood and Middleman (1992) have associated client process with the client's world-view. In the course of human development individuals organize their thoughts and beliefs in response to the events and conditions of their lives; each person develops his own unique world-

view. Psychological defenses are part of this organization, and inappropriate behaviors often occur as the end-product of a client's distorted view of how he fails to fit into society. Client process is also closely connected to relationship dynamics because one's opinion of oneself is built upon the success or failure of one's interpersonal exchanges. For example, one common process underlying the controlling behaviors of an MDVC group member is his fear that he will be taken advantage of by others. A focus on client process helps that client to understand that the way he is seeing things is not necessarily the only way he can choose to perceive what is happening. Further, such a focus gives the other members in the group an opportunity to reflect on the way that they organize their own thoughts and feelings. The benefit to all is the reshaping of attitudes and behaviors (choice-making) that produce more effective interpersonal skills. The group worker is challenged to: (1) discover how a client's thoughts are organized into his view of the world, and (2) respond to the content of the client's story with a statement regarding the client's unexpressed process.

Because students at the clinic have often commented on the difficulty of developing a process statement, this paper offers a "step by step" method to do so. To begin to incorporate process-oriented interventions in group work, the clinician is advised to look at the wide range of possible responses and select a small number of recurrent process themes. We will use examples from some that we encounter in our men's group. It is important to note that this reduction is meant to encourage facilitators to practice the technique of using process as an intervention; however, such a limited range is only meant to be an initial step and this is not a compilation of all the possibilities. Some of the major process themes that recur in the stories of involuntary clients are marginalization, lack of respect, avoidance of responsibility, incompetence, lack of importance, loss/grief, betrayal, abandonment and powerlessness.

Example of Client Process

In one example, a new MDVC client, speaking in a raised voice, offered the group the following statement: "My wife can't do anything right, and I always end up yelling and screaming at her." This abusive behavior can be defined as the result of an unconscious process of organizing thoughts and emotional coping mechanisms associ-

ated with a particular view of the world. There are a number of possible understandings of this client's emotional "Achilles' heel." The message, "I always end up yelling," could represent the client's underlying belief system that he is not respected in this world. Such a person might organize his actions and reactions based on the premise that, due to a lack of respect, yelling and screaming are the only ways in which he can be heard. The message, "My wife can't do anything right," could also represent a projection of the client's own feelings of incompetence and suggest a self-perception that others do not believe he is capable of making appropriate suggestions. The therapist heard the client continue the story. The client became angry when his intimate partner refused to give the details of why she was having problems with a project at work because explaining it was "just too complicated."

The group facilitator could take the following steps towards making a process statement:

1. *The therapist listens to his/her internal sensory awareness.*
   (a) *Empathy: therapist places self in client's shoes.*
   The therapist's initial thought is that the client feels anxious because of his vulnerability and senses the client's anger is a cover for some emotional insecurity.
   (b) *Introspection: therapist is attuned to feelings of counter-transference.*
   The therapist might feel discomfort at the possibility of colluding with the client by not immediately taking him to task for avoiding responsibility for his inappropriate actions.

2. *The therapist reflects on the function of the client's behavior.*
   (a) *Function of client's message.*
   The show of anger and control puts distance between the client and his unaddressed insecurity, but it also puts distance between the client and his partner.
   (b) *Hidden agenda of client's presentation.*
   The anger probably represents the client's perception of some negative message about himself being reinforced by his partner's behavior.
   (c) *Synthesis of previous or other client messages with this message.*
   The raised voice of the client suggests that the way in which he organizes interactions with his intimate partner is similar to the way he interacts in all his relationships; i.e., he's behaving similarly with the group as he is with his partner.

3. *The therapist constructs a hypothesis about the client's world-view.*
   (a) *Emotional deficit or insecurity is being covered by client defenses.*
   The client is afraid of intimacy because being close means being vulnerable.
   (b) *Perception of his status in society/relationships shapes client's behaviors.*
   The client perceives himself as less competent than others, and that thought leads him to believe that others condescend to him.

4. *The therapist formulates a process statement reflecting the client's world-view, taking into consideration the client's developmental stage in the group.*
   The therapist knows that the client is new in the group and needs to feel safe from diminishment in order for the treatment to progress. At the same time, the therapist wants to encourage the client to take responsibility for addressing his insecurities in non-abusive ways.

Process Statement: "It must be difficult to feel you have something important to say, and nobody seems to listen. I can assure you that any client who has the courage to take responsibility for safety in his relationships will always be heard in this group."

Implications for Process

The process statement is only one of a variety of process oriented techniques that help to put an appropriate spin on the collaborative efforts of the group (see Appendix). There are positive implications for the use of process-oriented interventions (Caplan and Thomas, 1995). Universalizing helps to shift the focus from individual client content to more global perceptions shared by the group. Joining is enhanced through these techniques because members are less likely to feel confronted or singled-out. Process helps to economize on lengthy dialogue leading to distraction by quickly getting to the underlying issues. Counter-transference is minimized because process orientation

allows the therapist to move constructively from the individual to the group. The process intervention allows the group members to "do the work," encourages objectivity in both the client and the therapist and promotes meaningful and supportive group discussion.

LINKING

Linking is another important way of bringing people together because no matter what the reason is for a group's convening, effective group work is largely dependent on all members working collaboratively. In the MDVC sessions this type of intervention is initially modeled by the facilitator and used by senior group members to strengthen cohesion and promote interactive efforts towards achieving treatment goals. It is recommended that a group worker consider two important opportunities for member participation that are enhanced through linking. Making an "individual" link invites a peripheral member into the group process. Making a "group" link provides a basis for bringing all of the members together to engage in group discussion.

Example of Individual Linking

In a group discussion, Jon, a 20-year old, self-effacing pizza delivery man expressed his extreme agitation about his relationship. He wanted to end it, but in the final analysis he felt he couldn't. This was one of the few times that this client disclosed in front of the group. Larry, a 50-year old, well-to-do lawyer, had previously discussed that he wanted to buy a new home for himself and his partner but was uncertain what to do since his relationship was so tentative at this point.

The therapist interjected by saying to the lawyer: "Larry, it is understandable that both you and Jon are having difficulty making a decision since you both are afraid of being hurt again." By identifying that both of them felt ambivalent and that the underlying process was a fear of betrayal, the lawyer was then able to send a supportive message to the younger man. He said: "Exactly! And I think it's great that Jon is here now so that he won't have to go through what I have for so many years." This intervention gave common ground to two seemingly disconnected group members and provided an opportunity for all of the group members to examine themes of betrayal in their lives.

Example of Group Linking

During the sign-in Gordy spoke of his difficulty about knowing whether to leave his relationship once and for all. Steve was concerned about whether he and his partner should take some time off from each other to get some perspective on their situation. Glen, even though things were going better, described his uncertainty with his ability to continue to meet his partner's expectations in the long run. The therapist, picking up on their uncertainty about a long-term commitment, at the end of the sign-in said: "It seems to me that a number of members in the group are having difficulty in establishing where their emotional responsibility in a relationship starts and stops." Through an exploration of the similarities in client process, the therapist is able to generalize a difficulty which is common to many group members: setting limits and boundaries within their interpersonal relationships. With this linking intervention the therapist creates initial momentum and direction for the group to follow; this, in effect, puts a "spin on the group wheel." From this point, the group went on to more deeply examine the discomfort members have in facing the insecurity that appropriate limit-setting often causes.

Implications for Linking

A number of implications for linking in group work are demonstrated in the above examples. The air of mutuality and reciprocity fashioned by these connections strengthens not only group cohesion but also individual self-worth for each client. The sense of safety in numbers provided by these intrapersonal connections is conducive to further self-disclosure. Linking promotes equal opportunity for participation as well as equal opportunity for ownership of the treatment. Such ownership is important for the client's assimilation of more constructive behaviors and attitudes; linking engages clients in bonding around treatment goals, while demonstrating the appropriateness of discussing different perspectives to central issues.

INCLUSION

One could argue that all techniques are geared towards including clients in the group. "Process" attempts to universalize themes, and such an effort is "inclusion"-oriented. Certainly, "linking" is another way by which group cohesion is established. However, the purpose of specifying particular inclusion examples is to demonstrate the advantage inclusion interventions have in reaching the more difficult involuntary clients. These clients appear to prefer to distance themselves from the group and often feel apprehensive about taking responsibility through meaningful participation. Participation is defined by a client's active collaborative involvement in achieving specific treatment goals. Clients can decline from participating by either saying little or talking at length about unrelated issues. There are several disadvantages of having a non-participatory client in the group. Group safety as well as group cohesion are at risk when a client declines to be involved (Ormont, 1993). Such negative modeling can generate a power-based confrontation or initiate bonding along counter-therapeutic themes. When two or more such members ally, the potential for group dysfunction becomes even greater. The overall effect of non-participation is that the "spinning wheel" of group momentum can be dragged to a halt.

Inclusion is more a concrete tactic for helping clients to participate in the group process rather than an intervention to access world-view or other psychodynamic issues. Inclusion supports any client's initial attempts towards addressing a treatment goal. Once the client becomes engaged, regardless of how awkwardly, there is then the potential to move him toward more authentic levels of self-awareness. Linking and the use of process statements give shape and refinement to these initial efforts. It is important for group workers to remember that it is not imperative to include everyone all of the time. It is, however, important that the therapist offer ongoing opportunities to each client to be included in the momentum of the group process.

Example of Inclusion

Sam, a 35-year old client, explained to the group the manner in which his wife would "shrug him off" when he tried to give her some suggestions with regard to difficulties she was having at her work. He said: "Every time I try to help her she tells me that she's too busy to discuss it right now." Therapist (to Fred who has been silent and aloof for some time): "Fred, can you relate at all to what Sam is saying?" Fred: "No, I really don't have anything to say about it." Therapist: "Well, okay. I just wouldn't want you to get the impression that the group is too busy to listen to what you have to say." (Pause) Fred: "You know, every time I make a suggestion to my boss he tells me, 'Why don't we talk about this later?' But later never comes." The therapist nodded understandingly, sat back and said nothing more. This successful inclusion-oriented intervention allowed the therapist to begin to track client process for Fred. He could later decide whether a linking or process intervention might help Fred to see that feelings of marginalization in the relationship with his partner are potential relapse triggers.

Implications for Inclusion

Inclusion can be considered the starting point for authentic work in the group. The MDVC begins and ends each group session with an inclusion exercise (see "Sign-in" and "Sign-out" in Appendix). Each client is given the opportunity to be heard without contradiction at the outset of each session, which promotes a sense of safety for the client, as well as for the group. This policy encourages a client's access to treatment ownership through self-paced contributions; there is an implicit expectation that everyone plays a part and is therefore important to the group. Negative preconceptions such as isolation, punishment, power differentials, etc., are significantly reduced when clients are given the sense of fair play (Verhulst and van de Vijver, 1990). Inclusion interventions utilized during the group include didactic and projective exercises which allow members to disclose their own point of view without feeling put on the spot. By ending the group with the sign-out, group members can take with them the feeling that "it's okay" to include oneself in the group.

CONCLUSION

This paper has demonstrated the applications and implications for three essential categories of group work techniques with involuntary clients: process, linking and inclusion. By using case studies from the MDVC treatment group for batterers, the paper has organized a didac-

tic presentation on generating momentum in groups. This "how to" educational tool was designed to provide a blueprint for those clinicians with less group facilitation experience for effectively conducting this type of therapy. Our recommendation to student facilitators, in order to counteract the overwhelming sensation of limitless options, is to focus throughout each group session on the three primary intervention categories described above. Further, putting a spin on the group process wheel is not the same as driving away with it; in most cases "less is more."

This text was also intended to assist clinicians in their professional development in facilitating therapy groups, particularly where there is reluctance among group members to "do the work." Our catalogue of techniques may also add to the repertoire of seasoned clinicians. Finally, the paper can act as a useful framework for the purpose of instruction and evaluation in student supervision. The Appendix of group work techniques is by no means exhaustive, but we believe it covers a wide range of useful interventions.

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APPENDIX

GROUP WORK INTERVENTIONS

N.B. The techniques presented below are placed in specific categories for heuristic purposes. While some techniques can be placed in more than one category, the authors feel that these divisions will be helpful to the learning process.

Process-Oriented Interventions

Process statement–Ricky: "My wife told me she was going to get some chocolate milk for me when she went shopping. She promised she would be back by 4:00 since I had to meet someone at 4:30. Not only did she return after 5:00 but she forgot the milk. I was really angry." Therapist: "It must make you sad to think that she doesn't always think of you as being important."

Universalizing–Carlos (at sign-in): "My supervisor told me that I was going to get more hours next month, but now it looks like I'm going to get laid-off. Now my wife thinks I lied to her." Therapist: "Well Carlos, I'm sure all of us have felt sad when someone we trust has let us down. Perhaps disappointment is something we could discuss when we open up the group after the sign-in."

Supportive statements (validation)–(1) Therapist: "Gaeton, it's really wonderful that even though this was a major disappointment for you, you are not asking the group to feel sorry for you. I'm glad to see you can own your feelings." (2) Therapist: "I guess it's a sign that things are looking better when the biggest concern you've had all week is whether you deserve to feel good about what you've accomplished in your relationship."

Paraphrasing–Frank, a client who arrived late, sweating and out of breath, recounted why he wasn't there on time. Therapist: "It looks as if you've had a difficult time getting here. Your father wouldn't let you out of work, and then when you arrived here, there was no parking. Maybe we can look at which of those issues bugs you the most."

Sign language/body language (process)–Therapist (after observing that members of the group are becoming fidgety): "Hey guys, what's up? It appears to me that a lot of people are talking but nobody's listening. Does any one else get that feeling?"

Clarifying (process)–Sven relates a drawn-out story to the group about the difficulty of reaching his girlfriend by phone and how he doesn't have too many friends. Therapist: "I guess what you are trying to say is that you wouldn't feel so lonely if your girlfriend would phone you."

Empathy–Colin: "I was really nervous about going to my in-laws after all that has happened between Janet [my wife] and me." Therapist: "I would be frightened also if I thought they might turn against me."

Empathic projection–Sheldon: "My wife seems to place all of her energy on the children. She even canceled out on me because Jimmy had a test the next day." Alex (empathizing with Sheldon's and his own wife) : "You made me realize something. If I was in my wife's shoes, I would probably do the same thing." Therapist: "Good point, Alex. What made you connect with Sheldon's story in that way?" Alex: "Well, it's really important for my kids to get a good education."

Bonding on treatment goals–Therapist: "I'll bet that there isn't a man in this room who isn't striving to have a relationship where his wife feels safe and trusts him."

Appropriate self-disclosure–Samuel: "Gee, it really frustrates me when my wife takes so long getting ready to go out." Therapist: "It really frustrates me, too, when I have to wait for people who are late. How do others in the group feel?"

Supportive challenge (client)–Therapist to a highly-defended client somewhat new to the group: "Coming from where you've come from, it makes sense not to let your guard down. But I'm sure in time you will be able to trust the group."

Supportive challenge (group)–Therapist to group who has just engaged in statements about being victimized by "all women": "It makes me very sad to think that you guys are so frightened that you can't take action to express your needs in a more positive way."

Reframing–Steve: "My wife really blew me away. When I got angry because she wouldn't listen, she walked out instead of yelling back." Therapist: "I guess she finally figured out a safe way to get your attention."

Humor–Therapist: "I know it's difficult to admit you were wrong. I was wrong once. I think it was 5 years ago. It was a Thursday."

Mirroring–Client to therapist about another client: "Why doesn't John shut up? He's hogging the whole group." Therapist: "I guess you're telling the group you're upset when John talks too much."

Metaphor–Lou: "You know, my life with my partner is great one day and terrible the next. Relationships with women are like riding a roller coaster." (Group members nod and chuckle knowingly.) Therapist: "There are other rides in the amusement park. Has anyone considered the 'tunnel of love?'"

Emergent theme development–Alan: "Even though I'm separated from my partner, I keep struggling not to call her up." Benoit: "I could never leave my relationship, no matter how bad it gets." Raymond: "My father died last week and I hate him now as much as I ever did." Therapist: "Letting go, in a relationship, seems impossible when strong feelings keep you tied to them."

Linking-Oriented Interventions

Linking–(1) *(client linking)* Therapist: "Juan, you sound a lot like Foster when you discuss the lack of trust in your relationship." (2) *(group linking)* Therapist: "I think George has a point. How many others in the group feel this way?"

Collaborative problem-solving–(1) Therapist to two clients who are engaged in an appropriate problem-solving dialogue but appear to be excluding the rest of the group: "Jamel, both you and Stan have an interesting problem. Perhaps we could ask the rest of the group for their help." (2) Therapist to client who appears to be controlling group by his incessant monologue: "Ivan, you have made a number of interesting points. Perhaps you could give some of the others a chance."

Sign language/body language (linking)–When Phillip was talking about his trouble with intimacy in the relationship with his partner, Joe immediately crossed both arms and legs. Therapist: "Joe, it seems to me that you can relate to what Phillip is saying."

Clarifying (linking)–Jordie catalogues his wife's shortcomings to the group, concluding that it is difficult to be responsible in the face of such provocation. Therapist: "Can anyone in the group tell me how this relates to why Jordie's here?"

Insight–Therapist: "Max, you're the expert on abandonment. Is there any suggestion that you have for Joel about what he needs to look at in his relationship?"

Tracking–Therapist, remembering what Farouk had said in last week's sign-in, tells him: "You know Farouk, what Sal just said reminds me of what you spoke about in last week's group."

Gestalt (microcosm to macrocosm)–Therapist, to group members expressing their disappointment that this week's session is not nearly as "productive" as last week's session: "Fantastic! How is this experience similar to what's going on in your relationships at home?"

Inclusion-Oriented Interventions

Sign-in–Starting each session with a round in which each member in turn is given a moment to contribute a personal reflection that relates to the purpose of the group. This reflection could take the shape of describing an event during the week, or telling what brought the client to decide to join the group, or pointing out a change that the group member has become aware of. The statements are brief (two to three minutes) and are usually responded to with a brief process statement by the group facilitator. Such statements often provide material for the therapist to link together to generate momentum for the general discussion which follows the sign-in.

Sign-out–Ending each session with a round in which each member in turn is given a moment to reflect on what has occurred in that session. Group members often say one thing that they have learned in the session, or tell what new idea they will implement in their lives, or state a task that they are going to try to accomplish in the coming week. These statements are brief (one minute) and are usually responded to with a phrase of encouragement by the facilitator.

Inclusion techniques–These interventions are used to encourage participation by the client while allowing the client to save face; the client should not feel as if he were being put in the hot seat. (1) Therapist, noticing a client has not spoken in some time: "Bill, you seemed to nod when Mohammed discussed his mother. Can you relate to this?" (2) Therapist to an apparently uninvolved client: "Victor, can you relate to anything being said right now? I'll bet you have also felt forgotten by your wife from time to time."

Sign language/body language (inclusion)–Therapist can use "traffic signaling" hand motions to stop inappropriate cross-talk, splinter groups within the main group, or encourage the participation of an uninvolved client while allowing the momentum of the central discussion to continue.

Limit-setting–(1) Therapist: "Zan, please hang on for a minute. It's easier for me when only one person speaks at a time." (2) Therapist at sign-in: "Ahmed, I know you have a lot to say but could you hold the rest until we open up the group?" (3) Therapist to verbally inappropriate client: "Whoa, Garth. It seems to me that there's something else going on here. What's up?"

Feedback–Therapist to client who has asked him directly for an answer: "I'll be glad to give my opinion, but first let's hear from the group." After the group has given suggestions, the therapist adds: "All of these were excellent suggestions. Another possibility might be. . . . "

Task setting–Therapist: "Perhaps the group can suggest something that Kyle

can do between now and next week to help him to listen better to his wife."

Goal setting–Therapist: "What does the group think that Rod has to achieve? What milestones will he be able to point to that indicate a change for the better in him?"

Point of view (reality testing)–Pedro states that his wife has hit him and that he had to sleep in his van overnight. Therapist: "I wonder if anyone can imagine what Pedro's partner's version of this story might be?"

Role playing–Jacques discloses that he had a terrible argument with his partner after which he stormed out of the house. Therapist: "If you could do this over again how would you do it this time? Perhaps we could ask a member of the group to play the part of your wife."

Reverse role playing–After Grant describes his frustration at not being able to communicate with his partner, the therapist suggests that Grant play the role of his partner while another group member plays Grant.

Confrontation–Chris repeatedly focused his problems outside of himself. Finally the therapist said: "I don't know what the group thinks, but it seems to me that Chris is having lots of trouble talking about his role in what's going on."

Interpretation–Nguyen: "Last week my wife went to her mother's instead of spending the time with me. I was furious." Therapist: "It seems to me that Nguyen is feeling a little left out. Does anyone else have an opinion on what's pushing Nguyen's button?"

Life-guarding (client safety)–Norman: "I hate women. Every time I try to speak to one, she puts me down." Therapist (sensing the group might attack this statement): "Norman, I think the group appreciates the struggle you're having in expressing the way you feel. I'm glad to see that you trust the group enough to explore ways of expressing yourself that might be more successful."

Life-guarding (group safety)–Therapist, sensing that the group is caving in on itself by tail-spinning into repeated expressions of negativism and avoidance of responsibility, says: "It makes me feel sad to think that, after all the work we've done, we are putting the blame on others for what we have already learned is our own responsibility."

Didactic instruction (handouts, charts and movies)–Serge: "Every time I get into a discussion with Margaret we start screaming at each other." Therapist: "Men usually have difficulty knowing what triggers their anger and then knowing what to do about it. Could anyone give a good description of the proper use of the 'Time-Out?'" Therapist follows up with appropriate handouts.

Projective exercises (visualizations)–Mario: "I was so angry at one point in my relationship that I grabbed the TV, lifted it over my head and held it

there for a second, and then I smashed it on the floor and walked out." Therapist: "That's a powerful story. I'd like to ask each man in the circle to put himself in that story and tell us whose face he would have seen on the TV screen when he held it over his head."

Emotional ownership (emotional disclosure vs. content solutions)–Reggie: "When my wife gets on the phone as soon as I come home at night, it really pisses me off." Therapist: "Reggie it's pretty clear to us that you sound angry, but I have impression that there is something else going on underneath." Therapist (indicating the use of the "Feelings Chart"): "Who in the group can suggest what other feelings are available to Reggie besides his anger, and why?"

Interventions to Be Avoided

One on one casework–The therapist conducts the group as if group members were a collection of individual clients and focuses on one client at a time, acknowledging other members only occasionally. This error dis-empowers clients of their responsibility to work collaboratively.

Rigid agenda–The therapist's agenda supercedes that of client or group in a way which disallows possibilities for discussion other than the topic at hand. This, in effect, silences group members who might otherwise feel they have some access into the group process.

Scapegoating–The therapist leads, follows or allows an attack on an individual group member. Sometimes called "hot seat" therapy, scapegoating impacts negatively on the whole group with regard to feeling safe or participating freely.

Bonding on negative issues: homophobia/women bashing/anti-authority–The therapist inadvertently colludes with group members who attack appropriate systems, minorities, groups of people, etc., by avoiding the task of authentically addressing such inappropriate behavior.

Stuck in content–Therapist fails to generalize concept to group but intervenes in a way that is so specific as to exclude some members who cannot relate to the concrete issue. For example, members without children may find it difficult to relate to an extended series of questions regarding a client's children.

Sarcasm–These expressions can be perceived as an attack on a group member and might encourage ridicule or scapegoating. Sarcasm also has the propensity to be disrespectful, compromising both individual and group safety.

Cynicism–This attitude can model distrust and hopelessness which promote feelings of vulnerability and futility about continuing therapy.

Sermonizing–Therapists can confuse this with being didactic. Sermonizing

places the worker in an overly powerful position, inhibiting group momentum, as well as demonstrating therapist rigidity.

Controlling–Too much direction, agenda-setting and talking by the therapist inhibits group momentum, dis-empowers group members from taking charge of their treatment and perpetuates a lack of safety among group members to self-disclose.

Hot seat–As above, a form of scapegoating which can sabotage an individual's participation for fear of being placed in the "hot seat" and bombarded with attacking questions and statements.

Punishing–Therapist statements that attack, berate, embarrass, etc., probably have more to do with therapist counter-transference issues than doing good therapy. This tactic affects the group negatively as a whole, as well as the client involved, with regard to safety, self-disclosure and responsibility taken by group members.

Collusion, aiding or abetting–This can take many forms, ranging from being deflected or intimidated by the client and therefore not challenging the client's false beliefs or misinformation, to taking responsibility for the client's work, to allying with the client in non-productive ways. Examples include permitting client or partner "bashing," allowing clients to seek pity or protecting clients from uncomfortable feelings such as guilt or grief.

Apathy–This often occurs when a client continues to place himself in a specific role or situation and nothing appears to help him extricate himself from it. The therapist might perceive this client as "terminally resistant" or disinterested in getting help. Statements made by this client might then be discounted, which will only perpetuate his stance.

Marginalizing–This is a discounting or "sloughing off" a client's need to be heard. This can happen when the therapist is involved in content to the exclusion of group process or is so focused on a particular agenda or client issue that he excludes apparently "extraneous" issues that arise from group process.