First Impressions: Treatment considerations from first contact with a groupworker to first group experience

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Abstract: The literature on groupwork largely lacks exploration of how to effectively use initial contact with a prospective group member to set the scene for efficacious engagement in group therapy, with the groupworker and fellow group members. By considering initial contact as a starting point for therapy, groupworkers can maximise clients' chances of engaging readily with a group to start working towards a positive outcome. This initial contact - 'intake interview', or 'invitation to engage in group therapy' - gives scope to early expressions of difficult emotions and provides group members with the tools they need to begin communication with their group and in exploring their emotions and needs effectively.

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Introduction

A number of groupwork theorists regard the screening interview (Toseland & Rivas, 2005; Yalom, 2005; Maione & Chenail, 2004; Nicols & Schwartz, 1991) and the first groupwork session (Doel & Sawdon, 1999; Shulman, 1999; Vinogradov & Yalom, 1989; Rose, 1989) as pivotal to the work that follows. Challenging a group member too quickly can lead to reluctant participation as can deferring an intervention for too long (Caplan, 2005). Not 'hearing' a group member properly can silence them altogether, while making observations too quickly can intimidate. It is this author's opinion that the first group member contact (often over the telephone, though sometimes in the screening interview, or offer of groupwork) can be just as important as the first session in motivating and encouraging group members to take responsibility for their participation in the group (Jenkins, 1990; Miller & Rollnick, 1991). Furthermore, it is this author's experience that, where denial, minimisation and fear can be significant obstacles to a group member's treatment goals, the initial contact can help to promote group member accountability, offer tactics for 'saving face' and suggest strategies to help the group member to risk lowering defences (Goldberg Wood & Middleman, 1992; Anderson & Stewart, 1983; Greenson, 1967). The first contact can introduce the group member to a supportive structure that can help and encourage forward movement at an appropriate pace.

Using the intervention strategies of the Needs-ABC Model (Caplan, in press), this paper elucidates important considerations and strategies for groupworkers to use when individuals apply to join their groups to help them to integrate as smoothly as possible into the group setting. They also help to provide a 'meta message' for all group members' interpersonal exchanges in first and subsequent meetings. A case example will be presented to illustrate some ways in which to use the information gleaned from the initial exchange in subsequent individual and group meetings with the group member. Suggestions will be made about how to use the initial phone conversation to prepare the group member for the screening interview, and how this can support and motivate the group member for the first group meeting. Using a case example, suggestions will be made about how to address situations specific to a group member's first contact - be

it the first telephone contact, the screening interview or the initial session contact - that could have a negative impact on their groupwork experience. Approaches to dealing with potential obstacles are dealt with in the screening interview or in the orientation session. These can include how potential participants can present themselves to the group initially and as they progress. It is assumed that general information such as fee structure (if any), contract signing, groupwork norms and values, etc. are also dealt with at this time.

The initial contact

Although there has been some movement towards group member empowerment during the therapeutic process (Caplan, 2005; Miller and Rollnick, 1991; Mullender & Ward, 1991; Jenkins, 1990), the issue of the individual's first contact with a helping professional, frequently by phone or e-mail, etc., has not been given a great deal of attention, with the exception of simple 'advice giving' by experienced practitioners on how to deal with applicants for individual therapy over the phone (Nuttall, 2005; Goldstein, 1999). Embarking on a process of change can make anyone apprehensive, so it stands to reason that many group members are 'on their guard' when taking the first step towards seeking help. Yet the promotion of effective therapy still appears to hinge on the concept of minimising the acceptance of 'resistant group members' into treatment or labelling them as problematic (see Greenson, 1967). A review of the literature indicates that many groupworkers assume that the presenting group member is ready to participate in the process of exploring new ways of thinking and behaving (Liebenberg, 1982; Anderson & Stewart, 1983; Froberg & Slife, 1987; Verhulst & van de Vijver, 1990). In fact, resistance may have a lot to do with the context within which treatment occurs (Anderson & Stewart, 1983), which can include systemic barriers such as court and institutional restraints, interactional issues such as cultural differences, and the groupworker's own perspectives and needs with regard to what is expected from a group member. While initial contact provides the groupworker with the opportunity to assess potential group members for suitability for inclusion in current or planned therapeutic groups, they also provide the opportunity

to encourage individuals to take positive steps towards emotional wellness by accepting an invitation to engage in group therapy.

Case example

Ethel, a 41-year-old, who had been married twice before and had no children of her own, called a substance abuse intake groupworker and anxiously told him that she had been both verbally and physically violent to her husband, Ted. She said he had asked her to leave when this behavior presented itself in front of his two children (8 and 11) from a previous marriage. Ted told Ethel that she had a serious drinking problem and that, when she drank hard liquor, she would 'get crazy.' Originally, Ethel had come to Canada with her mother from the UK and described her mother as being 'selfish' and unsupportive. Yet when Ethel's husband asked her to leave, she chose to live with her mother.

Ethel admitted that she had continued to drink and had become aggressive on the few occasions that her husband had allowed her to return home in an attempt to resolve their problems. Ethel reported that Ted had filed for divorce but said that she could continue to have visits with the children (to whom she felt very close) on condition that she sought treatment for her drinking problem. Ethel had previously entered treatment on three occasions, once prior to meeting Ted and the other two times during their marriage, completing only the last because of what she described as an 'ultimatum' from Ted. This time, Ethel appeared to want to return to treatment of her own volition and had begun to go to AA on a regular basis. She appeared to sincerely acknowledge that she had reached the critical point where something had to change, regardless of whether or not she could reconcile with Ted.

On the phone, Ethel stated: 'I know I have to change. I've been in treatment groups before, but I realise that I have yet to change my attitude. What I continued to do didn't get me very far. I want to learn from my past mistakes and to own my behavior, like you said.' She added: 'I'm also really depressed. I know I'm completely responsible for what's happened. I loved my husband very much and all I can think about is when we were one happy family. I come from a family where my father left my mother and my mother has basically humiliated me for 45 years. Ted is either away on work or doing stuff with his kids...and now he's gone, too. This group is my last resort. If I can't get help here, I don't know what I'm going to do.'

The Needs-ABC model

The Needs-ABC Model, originally developed by the author at the McGill Domestic Violence Clinic, uses an integrated therapeutic approach combining group member, groupworker, contextual and environmental process (Shulman, 1992; Caplan, 2005) with cognitive-behavioural/motivational (Miller & Rollnick, 1991; Ellis, 1997), narrative (White, 1990; Avis Myers, 2004) and emotion-focused (Greenberg & Johnson, 1988; Greenberg & Pavio, 1997) work. The model is focussed on group members' unmet relational needs. These needs can create a negative feeling that can lead to maladaptive behaviours as a coping strategy. In other words, we consider that the need drives the emotion and the emotion drives the behavior. The groupworker's task, therefore, is to identify the unmet needs evidenced in the group member's narrative, to illuminate these through the use of a process oriented, emotion-focused *universal theme* paradigm, and to explore *acquisitions of needs strategies* that are functional and appropriate (Caplan, in press). Once the unmet need has been acquired, the maladaptive behavior will gradually be extinguished. While a full exploration of the group member's needs can only occur during therapy, some initial work can be carried out in the context of the screening interview/offer to participate in group therapy.

First impressions

To return to our example, while Ethel appears to make sincere expressions of her desire to change, she also gives indicators of her fears to do so. Her litany of unpleasant experiences indicates the concrete way in which she tends to view the world as a series of negative events. She may be saying to herself: 'I'm scared you won't believe me. I don't want to be punished. I've been punished and humiliated enough. What I really want is confirmation that I'm not a sick person and recognition that I have decided to get help. What if I can't succeed after finishing this treatment? Even if I am successful, I'm worried that no one will be able to see what I've accomplished. If no one can trust me, why should I even try?'

The initial group intake worker could pick up on Ethel's apparent feelings of futility and fear and think: 'The prognosis for this group member is rather poor since she's been in three previous treatments. For her to have any chance at success this time would be a small miracle. As well, how can she even begin to set limits if she can't save her fights for when his kids aren't there? If I accept her into treatment, I am going to be held accountable...and what if she fails again?' Here, many factors can suggest a pessimistic prognosis. Ethel might, therefore, enter the treatment milieu prophetically labelled as a failure.

The offer of groupwork to the prospective group member

A more optimistic, encouraging approach to Ethel's apprehensions would probably help her to engage more readily in treatment. The challenge for the intake worker is to validate her concerns, examine possibilities for future strategies and simultaneously help her to set limits around behaviours that might disrupt her chances of beginning groupwork. On examination, Ethel's narrative reveals a number of possible themes that can be addressed. For example, when Ethel laments the absence of her husband on business, she might be describing her feelings of emotional *abandonment.* When she describes her attempts at controlling her drinking and her relationship with her mother, it is probable that she is describing feelings of *powerlessness* in her life. With this in mind, the group intake worker can make either of the following emotion-focused process statements:

Groupworker: *I imagine it might feel really frustrating when those you feel closest to keep running away. Is that your experience?* or

Groupworker: *I think a lot of people in your situation might be angry to think that so much of their lives are out of control.*

These statements recognise the disappointment Ethel feels at having little or no power over the degree of intimacy she needs from others. When Ethel uses the phrases 'Learn from my mistakes,' and 'If I can't get help here, I don't know what I'll do,' she may be indicating

her vulnerability to exploitation by others. The groupworker might acknowledge these feelings of apprehension in the following empathic way:

Groupworker: *If I'd been through what you've been through, I'd be really scared and certainly wouldn't know when to let my guard down.*

Here, the groupworker supports her lack of confidence rather than challenging it, belying her certainty that she must constantly be punished for speaking up. To Ethel's expressions of her inability to have a say in how her life unfolds, the groupworker could offer this:

Groupworker: *Do you feel sad to think that things never seem to go your way? It certainly would make me angry at myself, if I was in your shoes.*

Here, the groupworker has picked up on the possibility that some of the anger might be self-directed and has modelled appropriate self-disclosure. As well, this is an acknowledgement of her feeling of futility in the world and possible loneliness, potentially accounting for her drinking problem. However, even if the groupworker does not 'hit the nail on the head,' he or she has modelled disclosure of feelings to Ethel, who could respond either by agreeing that the groupworker has largely understand her viewpoint, or say something like:

Ethel: *I wouldn't really say I was angry. 'Bitter' describes it better. I am very bitter, sad and disappointed with the way my life has turned out.*

Towards the end of their conversation, the groupworker's task is to leave the group member with some feelings of optimism and encourage her to proceed to her next groupwork experience. This groupworker decided to summarise and validate Ethel's concerns in following motivational way:

Groupworker: *You know, Ethel, it is impressive that, despite all odds, you are still not willing to throw in the towel. If you are nervous that you might not succeed this time either, that's perfectly understandable, but your*

need to feel like a family, included and needed, seems to have driven you to desperate attempts to get your needs met. I think that you would find it useful to start working with a group that is being coordinated by my colleague, Shirley. I think you will like her. I am sure she will understand where you are coming from, and that she will help you to get to know the other people in the group. A lot of people find it useful to work with others who are in similar situations. I'm pretty sure that if we can help you to understand and clarify your emotional needs then you can help us and the rest of the group to help you plan a better way to get them.

By helping Ethel to consider a concrete goal that can be 'fine-tuned' as she moves along her treatment path, she is more likely to feel optimistic and encouraged by her treatment experience. As well, by suggesting that she needs to be the choreographer of her treatment, she can begin to feel more empowered by using the treatment process as a metaphor for her life.

What if …?

What if, despite all the groupworker's efforts, Ethel is still not convinced that she can follow through on her initial decision? What if she feels so self-defeated that, rather than being encouraged by the intake interview, she becomes more discouraged? Most helping professionals will agree that decision-making of any kind is a process; that it often takes individuals several 'tries' before they succeed. The goal, then, would be to attempt to engage Ethel in continuing to consider options for her problem. For example, the group intake worker might suggest alternative resources appropriate to Ethel or offer her the opportunity to meet or speak on the phone again to revisit her options. Overall, it is important to focus on and acknowledge the potential group member's needs and encourage the member to examine possibilities for satisfying needs.

Preparation for the group

Research has shown that the applicant's perception of the group intake worker is predictive of subsequent retention (Mohl, et al, 1991; Noel & Howard, 1989). That is to say, the more positive the experience, the more likely the group member will remain and engage in treatment. They should experience the interview as the extension of an offer to participate in group therapy, rather than a 'test' to see what is 'wrong with them'. Furthermore, the more informed the group member is about what to expect during the treatment process, the more likely they are to continue (Westra et al, 2000). This is especially true if the group facilitator is the one doing the intake interview (Noel & Howard, 1989). The group intake interview is, in fact, a 'first session' for the prospective group member. This implies that the way in which the group member views the groupworker, and the degree to which the group member takes responsibility for their therapy (see Orlinsky et al, 1994), has a strong impact on the course and outcome of the therapeutic experience. Group member expectations are the same as if they were to proceed to individual treatment, so 'joining' and other important therapeutic skills are being tested. The Needs-ABC model encourages the use of the same person for all group member contacts, though, admittedly, this is not usually possible. With regard to Ethel, one of her groupworkers was assigned to her case, having been appraised of the content of her discussion with the intake worker.

During the initial contact with Ethel, over the phone, she appears to have high emotional needs for reassurance and validation of her experience as 'victim.' She also seems to expect that the groupworker and/or the group will eventually punish and humiliate her. Ethel's seemingly overwhelming situation could be based on her fear that she is an incapable and unlovable person, and that she is forever the victim of alienation. Ethel appears to feel that, no matter how hard she tries, she can't attract anyone's positive attention. This view underlies several emotional themes that emerge in the context of group therapy during the weeks to come, including her fear that she is not worthy of love for love's sake; that all her relationships are conditional, and that she can't do anything to change her life.

Even from an empathic point of view, many intake workers might feel the need to challenge these fears and frustrations with statements

like: 'I know it's horrible not to feel trusted, especially by those you love. I suppose if you could have controlled your drinking things would have gone better for you.' Or: '*Anyone would be angry at feeling abandoned the way you have, but I guess when you lost it in front of his children it was 'the last straw.'*

On the surface, both these interventions appear empathic and supportive. However, they also amplify the group member's reality that she has been powerless to change the more shameful behaviours that she has perpetrated and give her little leeway to interpret and express her own situation. This could reinforce her sense of discouragement and her fear that she will be punished for her transgressions. For example, she might think: '*Even the groupworker thinks I'm bad. How could I have done what I did in front of those kids? Why can't I stop my drinking when I want to? Why am I even trying to get help...again?*'

Helping the group member to develop a sense of optimism is fundamental to any clinical interview, and is especially important in an evaluation for groupwork. Giving the applicant the possibility of feeling more in control of the therapeutic process will enhance feelings of safety (Caplan & Thomas, 1995) and hope (Yalom, 2005, Pretzer and Walsh, 2001). A more optimistic intervention would be: '*I know it's horrible not to feel trusted, especially by those you love. I suppose that one of the things you could have the group help you with is how you could redevelop the trust in others that you need to keep them close to you.*' Or: '*Anyone would be struggling with difficult emotions if they found themselves feeling abandoned and powerless to do anything about it. It might be helpful to bear that in mind. Perhaps you could consider sharing this in the group so that, together, you can figure out how to get some power back, rather than giving it up to your drinking or your more negative feelings.*' In this way, the worker is offering Ethel an opportunity to take charge of her life by giving her some suggestions as to how she can begin her treatment, as well as some therapeutic goals to aspire to. In closing, the groupworker could say:

Anyone considering joining a group is usually struggling with confusing feelings, like the bitterness and disappointment you mention, or emotions such as anger at others for betraying you, and at yourself for not being able to get their attention; fear and sadness about how you have tried to resolve your problems only to sabotage your efforts. When you start group

therapy, you can bring the issues that have been making you unhappy to the group and the groupworker. Beginning your work by knowing that you have something honest to share would be good. Perhaps you could even consider mentioning that, despite everything, you have not given up. Something to be proud of, eh?

These suggestions make concrete a plan for Ethel while still allowing her to make choices around when, with whom, and what to share. There is no doubt that Ethel will still be anxious about her next therapeutic experience, but now she will have some sense of power from knowing what she can take with her into her next course of treatment.

Conclusions: The group experience

Ethel's unresolved grief and her apparent Achilles' heel around issues of abandonment have resulted in a deep-seated resentment, and she seems to have displaced many of her angry feelings from her family of origin (particularly from her parents) onto her husband. She would appear to have feelings of being cast out on her own, being ganged-up on by her husband, mother and the legal system, and being victimised by a double standard whereby her husband can provoke and yet 'escape' treatment (punishment). Her compulsive use of violence, threats and other gestures of intimidation are manifestations of her desperate attempts to gain some mastery over her fears of abandonment by controlling her environment. Ethel may very well anticipate punishment by the group as a routine component of her Sisyphean world view. She is also clearly inviting others to carry her burden of responsibility for changing and growing (see Jenkins, 1990). These self-perceptions and sentiments shape Ethel's unconscious resistance to change in situations where she feels most vulnerable.

A prime directive of effective groupwork is that the group member must feel emotionally safe in the group setting. By giving Ethel something to 'hang on to,' the intake groupworker has provided her with some simple interpretations that she can present 'by rote' during her early contact with the group, to help her to feel that she is participating while she is evaluating and adjusting to her group experience and to

lay the foundations for a deeper engagement with her feelings. Any one need of Ethel's that is effectively recognised and validated by the groupworker will not only further include Ethel in the group, but will also include the group in her story, building group cohesiveness and helping her to feel more included and less vulnerable.

Finally, by considering a group member's vulnerabilities, needs, and life experiences from the outset, both group member and groupworker can feel more optimistic about the therapeutic process. By shifting the onus for doing the therapeutic work from the groupworker to the group member (Ormont, 1993) group members can direct the treatment towards their individual therapeutic needs (Caplan, 2005) and do so at their own pace. By being supported and guided to take charge of the work they must do in the treatment milieu, this 'taking of responsibility' can be a powerful metaphor for group members with regard to what they must continue to do on their own, as individuals, beyond the group treatment setting.

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