Thoughts on Questions Posted by Participants
Participating in 3 June 2020 IRETA Webinar Entitled:
Engaging Reluctant Participants in SUD Groups Counseling: Gimmicks for Group
Robert J Chapman, PhD

---

1. I was wondering how do you engage youth groups because it seems that they resist most gimmick especially if it is virtually.

- As I mentioned during the webinar, my experience with virtual counseling, individual or group is—pardon the pun—virtually non-existent and my experience with adolescents is with 17+ year-old individuals in college, a somewhat unique subset of all adolescents. That said a couple of thoughts: (1) the make-up of the group is critical. 1 or 2 adolescents in a group with older clients will be difficult if not impossible to engage; the cultural rift is just too great. Discussing the appropriateness of a referral to a different group with a supervisor or clinical director may be appropriate at this point. If the group is populated by adolescents, then it is important for the facilitator(s) to "earn" the group's trust and respect. This can be accomplished in any number of ways, but expecting members of the group to challenge the facilitator(s) authority is to be expected as adolescents are known to do this routinely. In addition, to know that even if 1 or 2 adolescents are challenging the facilitator(s), the rest of the group is watching. NOTE: if there is something of an even split between adolescents and adults, be mindful of the tendency to segregate themselves that adolescents have. There are also numerous other "alternate foci" that can arise in such situations…one or more adults parenting adolescents or trying to redeem themselves for "sins committed" with their adolescent children, etc. All-in-all, the "juice isn't worth the squeeze" with a mixed adolescent – adult counseling group, however, this can work in a psychoeducational group. (2) A "reverse grab-bag" group may be useful. With this group, the clients each write a topic or question on a slip of paper they would like the facilitator(s) to address. When introducing this group, you announce that you will answer any "reasonable" question, honestly – no questions about how much money do you make or how often do you have sex will be read or answered. You also can announce that each group will end with the facilitator(s) selecting 1 question from the bag to address. The facilitator, drawing the question, answers the question and the group then ends, according to its usual closing ritual…**OR**…the facilitator then uses the question and his/her answer as a springboard to group discussion, for example, *having heard my answer to that question, who can relate or has had a similar experience.*

2. I recently, for the first time, had a patient state that she was in group to "recover from selling drugs" (bit of background: referred to our agency from DSS to hopefully reunite with her children, she DOES have a SUD diagnoses but absolutely in pre-contemplative stage. patient's motivation is reunification with children) I've just never heard this presented before and would love feedback from colleagues.

- Not knowing more about this individual, it is difficult to formulate a specific recommendation. A common rule in any counseling is to start where the client is rather than to expect the client to meet you where you want to start. That said, if the client is motivate to stop selling drugs, then that is a good place to start, however, a word of caution: if this is the only individual in the group who sold drugs and all she is willing to talk about is selling and not her use, this can become an alternate focus in the group and therefore, disruptive. Try to make the selling secondary to the use by asking—or having the group ask—how her use could make her desire to quit selling difficult and/or the role that use may have played in her selling the first place. Of course, the underlying issue that eventually becomes a primary focus is even if she were to stop selling but continue to use, what is the likelihood that she would get her kids back and even if she did, would be able to keep them…and how difficult will it be to get them back a second time!

3. Is it easier to work in a closed group or open?

- My experience was that neither one was "easier," just different. Because of this, there are different ways of approaching and engaging each type of group…and as mentioned in the webinar, different dynamics that can surface in each. I found "closed" groups to be more predictable regarding the group's personality and its "SOP" – standard operating procedure - was more stable from session to session. Likewise, it was easier to key in on "something going on" when working with a cast of "usual suspects" each time the group met. On the other hand, open groups afforded a greater opportunity for "older members" to orient and mentor "newer members." This is neither better nor makes facilitating either group easier, just different.

4. Does Dr. Chapman have any suggestions for curricula/workbooks for these groups?

- Unfortunately, I do not. That said, I am not sure that I would be quick to employ such a tool unless the group's purpose was specific and its focus rather narrow…think mandated DUI group. The more a tool like a workbook was employed the less spontaneous the group risks becoming. Like education based on "teaching to the test," a group that's purpose was to complete a workbook runs the risk of becoming strictly didactic and therefore, mechanistic.

5. What a privilege. Such an accomplished and experienced clinician. His sharing is invaluable.

- Thank you. In my career I was fortunate to have some great professors in my undergraduate and graduate programs and a common theme running through all their mentoring was the concept of "paying it forward." Counselors do many things but near the top of the list is that we teach. Good teachers impart information; great teachers motivate students (clients?) to want to learn.

6. How might you adapt the grab-bag technique to telehealth?

- Interesting question. As I mentioned earlier, I have no experience as a practitioner with telehealth. It occurs to me, however, calling on my experience teaching hybrid courses with virtual components, that something like a simple table in a word document could be created with the number of cells equal to the number of members of the group…or perhaps "X" cells ***more*** than the number of clients in the group. The cells would be numbered and each member of the group could be directed to "pick a number" or be assigned a number…or pick in the order of how long each had been a member of the group…or whatever…be creative whenever you can to keep groups "spontaneous" and empowering for the group – the more control the group has to affect what goes on, the great members are to participate. The facilitator could then "click" that hyperlinked number in the table on her/his shared screen and display "the word or statement" on which the client would then need to comment. Following his/her comment, is/he could then "pass" the topic to another member of the group for comment before s/he then picked a number to reveal the next topic or question, and so on. You likely have more experience with telehealth than I do so "play with this idea" a bit and make it your own as you improve on it ☺

7. [Regarding grab bag] - Love that idea of making it a safe place/giving an out for participants to ask for help…

- Chances are you will know if any member of the group is functionally illiterate or not, but hand writing grab bag entries is always a safe bet – not to mention that your introduction suggests a bit of spontaneity on your part. Keep in mind that the instruction also enables visually challenged individuals the opportunity to participate without having to call additional attention to themselves in the group.

8. How do you engage group members to participate in group discussions where they feel topics are not directly relevant to their own substance use. (example: discussing matrix model methamphetamine topics with those who have other substance use disorders)

- This is always a challenge and will vary from group to group…or resistant client to resistant client. A 1st step is to ensure that this is a legitimate concern or issue. Some pre-contemplative clients will seize upon anything that they can say is different about their situation to feign an inability to "relate" and therefore balk at participating. If the client is just flat out being obstinate then this may become a management issue, one best dealt with individually outside of group, at least initially. If the concern is legitimate, however, then finding a common denominator—or denominator**S**—the client shares with others in the group to demonstrate the similarity this client has even in the midst of apparent diversity. I would suggest that the facilitator NOT suggest what this might be for the client but direct the group to help the client discover this. NOTE: if you are fortunate enough to have another member or 2 of the group who walked a mile in those same shoes

(although not necessarily related to a specific type of drug) then having the group "help" this client becomes that much easier.

9. I have used a credit card to chop saccharin and form into lines for reaction This helped clients who said they were good and did not and could control their use and weren't tempted Inpatient work.

- Yes, there are any number of ways of "simulating triggers" to present the group with opportunities to "face their demons" directly. As I mentioned in the webinar, however, I strongly suggest using this approach in groups in an in-patient environment as triggers, once activated, can be powerful threats to sobriety. As an aside, resist the temptation to conduct a 1-on-1 session with this client "in the group." Have the group engage the client when addressing the trigger. In the chapter I wrote on "gimmicks for group" (https://www.dropbox.com/s/eolnxh4dxb1wdc3/Gimmicks%20text.doc?dl=0) review the "Dear Al" gimmick. It is not related to the "Bottle Gang," but the way it is processed in group may offer some ideas/inspiration on how to take your gimmick to the next level.

10. this not a question but rather experience, I work with clients who are in intensive outpatient groups that are internally and externally motivated, I'm very interested in gaining knowledge from this webinar, Thank You.

- I have no data to support this, but I suspect that there is a correlation between where one is on the continuum of readiness to change and his or her external vs. internal motivation to be in treatment. My hunch is pre-contemplative and contemplative clients are externally motivated whereas preparatory and action stage individuals more internally motivated ☺

11. any tips for initial engagement re: getting people INTO groups in the first place (ie, non-mandated)?

- This is a difficult question to address because there are so many variables that can present barriers to agreeing to attend let alone participate in group. As I mentioned in the webinar, there are culturally different individuals for whom group "anything" is the antithesis of what they have learned about dealing with personal issues. This is particularly common in clients who come from "collective cultures" where personal issues/business are kept private and only addressed within one's small, often familial group. You may find an article I wrote entitled, *Cultural bias in alcoholism counseling* to be of some interest regarding this[1]. Also, as mentioned in the webinar, the utility of group can become a topic for consideration in individual counseling. As with any issue related to change, Motivational Interviewing is an invaluable tool in motivating change talk in a

[1] Chapman, R. J.(1995). Cultural bias in alcoholism counseling. In R. Hornby Ed., *Alcohol and Native Americans*, pp. 113-118. Sinte Gleska University Press: Mission, SD. If unable to find this article, email and I will send a copy.

client. Just as one helps move individuals through the stages of readiness to change related to substance use using MI, so can this approach help motivate consideration of the role group can play in moving towards the change objective already embraced in individual therapy.

12. At what level would you consider ejecting a person to maintain group process?

- Again, the answer to this is, *it depends.* If the individual's behavior is so disruptive as to make group work impossible, then a therapeutic discharge may well be "therapeutic." I would not threaten or use this to punish a client, however. I would want to exhaust all my "gimmicks" to engage…or at least elicit compliance…from this individual before considering ejecting the individual from the group. Such a step should always include intentionality and result in a therapeutic decision to act rather than be an emotional reaction triggered by one's frustration or anger. Taking this a step further, clearly if the individual was making threats, against me or especially against others in the group—*I know where you live*—ejecting the individual from the group becomes a distinct possibility, but let me share a person story: While conducting the individual interview and use assessment with a gentleman in a DUI program I was co-facilitating—I was the counselor who screened and assessed all participants while my colleague was in charge of the psychoeducational aspect of the group—he became so incensed when I shared my assessment that he appeared to have an alcohol use disorder necessitating treatment, that he started screaming at me, stood up, and literally started throwing the desks around in the classroom we were in. There was such a commotion that my colleague came into the room to ensure that I was okay. I assured him I was and he left. The individual started to calm down after this outburst and we were finally able to talk…he still was not happy, but came to understand the reasons for my assessment and reasons for my decision about treatment. I still went home that night and literally nailed the windows shut in my basement to ensure my family's safety, but he was upset not so much because he denied there was a drinking problem but because he knew he would not get his driver's license back until and unless he successfully completed any treatment recommendation made by the DUI program. My point is that I did not recommend discharging this individual but, instead, acknowledged his upset and avoided reacting to it, which helped him realize that what causes a problem is a problem when it causes problems.

13. I've found that open ended questions fuel resistance.

- I understand but suspect it is not open-ended questions in and of themselves that invite resistance as much as the nature of the open-ended question…or possibly the language or even the way the question was presented. For example, look at the difference in these 3 open-ended questions that essentially ask the same thing: (1) Tell me, what about your difficulty with "X"; (2) Tell me something about your difficulty with "X"; (3) Regarding your use of "X," help me understand what that is like for you. I realize that at best this

example only allows you can only see how phrasing and syntax may affect the way the question might be received but imagine how facial expressions and/or a hint of contempt in one's tone of voice, intentional or simply perceived by the client, could affect any of these forms of the question – remember that although we can control what we say and how we say it, we are unable to control what our clients hears.

14. resistant clients challenge basic rules and norms to sleeping in group A certain amount of confrontation is necessary?

- Certainly, but how confronting occurs becomes the question. A parental confrontation is going to bread contempt and foster reactance. Reactance is a social psychological phenomenon that suggests that when feeling like one's power and freedom have been usurped or impinged, the individual will react in any way available to reassert control. Sleeping in group, whether truly sleeping or simply feigning sleep is a passive-aggressive way of reasserting control…*I may not have control over whether I am in this G.D. group or not, but I sure as Hell can control what I will and will not do while I am here!* There are any number of ways to "confront" the sleeping. I would suggest trying the back-door approach first…for example, having a group member nudge the client. If the sleeping behavior continued, ensure there is no physical or pharmacological reason to explain this behavior. If necessary, this may become a "disciplinary" issue, but I would "staff this" at least with my supervisor if not the clinical staff and/or discuss it with the client outside of group before deciding about excluding the client from the group.

15. question: what is the pro/cons of having groups designed for a particular stage of change?

- PROS: if everyone is essentially in the same stage of readiness to change, intercessions planned with the group can be those evidence-based approaches best suited to move individuals from that common stage of readiness to the next stage of readiness on the change continuum – consider https://www.aafp.org/afp/2000/0301/p1409.html or http://adultmeducation.com/FacilitatingBehaviorChange.html
- CONS: accurate assessment of one's stage of readiness to change is challenging (cf https://habitslab.umbc.edu/urica/). In addition, members of the group are likely to move forward or cycle back regarding stages of readiness at different paces. Even if you were able to start a group with all members at the same stage of readiness to change, it will likely not be long before there enough individual movement, advancement and regressions, that leave you with a varied group of changers.

16. How do you engage and support an individual of color in a predominantly white group?

- First, I'd suggest checking out if this is an issue or concern for the client. In addition, knowing the group as you do, determining if this is going to be an issue for the group or any of its individual members. If there does not appear to be an issue do not make it one

by addressing it. If it is, however, for the racially different (or gay, trans, female, adolescent, "whatever-the-difference individual," I would explore this with that individual 1-on-1. Hopefully, you've oriented your client to the group and its processes before the 1st session and knowing of the pending difference this client will have to the rest of the group, you can discern if it might be an issue. If after the 1st group…or if a concern seems to arise, explore this with the individual, asking about how s/he would like to see it handled. I'd suggest not introducing a "what can we do about this issue" type topic for the group to process w/o having consulted the individual in question 1st. In situations like this, it is likely a good idea to "staff the question" with colleagues and/or discuss with a supervisor, senior counselor, or "more experienced" colleague first. As an aside, although it may be possible to consider referring the client to another, more "similar" group, be careful you do not inadvertently convey an unintended message of racism by seeming to profile clients. Possible exceptions to this suggestion include "women's groups" and adolescent groups.

17. What suggestions do you have to get members to start a group that is facilitated by several different therapists? For example, they attend groups M-F but each day has a different therapist facilitating.

- I am not quite sure who these "members" are…clients? Clinical staff? Although it is not uncommon for a group to be exposed to different facilitators or teams running group, I suspect that a "different facilitator" every day…or at least a different facilitator/team each day of the week would not be the best strategy for developing group cohesiveness so important to accomplishing the work groups are designed to do. I suppose that if my agency was one staffed by numerous part-time counselors and this could not be avoided, the need to ensure that all these facilitators came together regularly to staff the clients in the group would be important. In addition, I would suggest that a log be kept where topics discussed in that day's group(s), including individual client behaviors, performance, mood, etc. are recorded. These "logged notes" would be in addition to official clinical notes so that "Tuesday's facilitator" would know what "Monday's facilitator" did/experienced in group and could attempt to forge some continuity between group sessions. For example, if John Jones had a break through Monday but Tuesday's facilitator was unaware of this, John's momentum could be lost.

18. What would you do with clients who say they are only drug dealers and don't use them? Maybe lied for early release or special consideration.

- Please see my reply to question #2 above…it is not complete, but does offer a couple of thoughts.

19. This has been so helpful! Thank you so much – we deal with mandated clients and there is always someone who does not want to engage. Love the ideas!

- Thank you.

20. I wonder if you could share a screen with questions hidden under numbered boxes. Participant picks number and facilitator reads question
- Hmm…great minds think alike ☺ See my response to question #6 above.

21. Group member continues to be disruptive and wants to dominate the group discussion. Time management Per Participant
- I suggest ensuring that the client's behavior is not indicative of an undetected co-occurring disorder. If it is not and is truly intentional disruption, then explore ways to use the group to address the issue. If the group is intimidated by this client or is so enamored of her/him that it acquiesces to her or his efforts to take over the group, then a more direct approach may be necessary. Also, please consider my reply to question #12 above.

22. TELEHEALTH: Google CEI (Clinical Education Initiative) here in NYC. They are currently offering FREE & extensive training on virtual counseling & groups online, & ALL of their webinars are Archived. ALSO, The ATTC Network.org (Addiction Technology Transfer
- Sounds like an excellent resource…as they say in A.A. meetings, "thank you for sharing" ☺

23. Do you encourage or discourage clients from meeting outside of group?
- This is one of those questions for which I do not have an answer, only an opinion. This means that what I share next is no more correct or appropriate than what you may believe…or what your agency's/supervisor's policy may be. That said, I would not encourage meeting outside of group, especially for social reasons. However, I would also not discourage members from the same neighborhood sitting with one another at a 12-step meeting or sharing a ride to meetings—attending mutual aid /self-help groups can be quite intimidating and having a familiar face to sit with can help assuage some of that anxiety. I would actively discourage intimate social relationships, that is to say, "relationships." I would not necessarily discharge members of a group who socialized outside of group, although this could be a fruitful topic for discussion within the group. I suggest being very careful, however, to not single out "John Jones and Mary Brown" as the "item of discussion."

24. I recently passed my CASAC exam after finishing the 350 hours training. I have been in prevention field for the past 25 years and struggle to see if I would be as successful as a CASAC counselor as I have had in prevention. I would love to have a chat with you Dr. Chapman to what I see is a clear-cut block in the intervention field. Will I have a chance to engage with you?
- First, congratulations. I will contact you privately.